

Equipping Title X for the Future

By Rachel Benson Gold

Providing critical financial support to a nationwide network of family planning provider agencies has been at the heart of the federal Title X program since its enactment nearly four decades ago. Among the various federal and state programs that subsidize clinical family planning services, Title X is uniquely equipped to play this role. And it will remain an essential role long into the future, even assuming Medicaid coverage expansions and eventual broader-based health insurance reform. Without a vibrant provider system, simply having a source of payment will still be little more than a hollow promise to many young and low-income people in need of contraceptive and closely related preventive health care (related article, Winter 2008, page 6).

Today, Title X undergirds a network of family planning clinics located in nearly three in four U.S. counties. Despite stagnant funding levels through much of the last quarter century, rising costs of everything from medical supplies to personnel and the challenging politics of being the federal government's only program dedicated to providing family planning, this network continues to serve nearly five million women (and a small but important number of men) each year. Still, clinics have not been able to reach and serve everyone in need. As the ranks of the uninsured continue to increase, new data demonstrate that more women across the country—many more in some areas—are in need of publicly funded services* (see map, page 20).

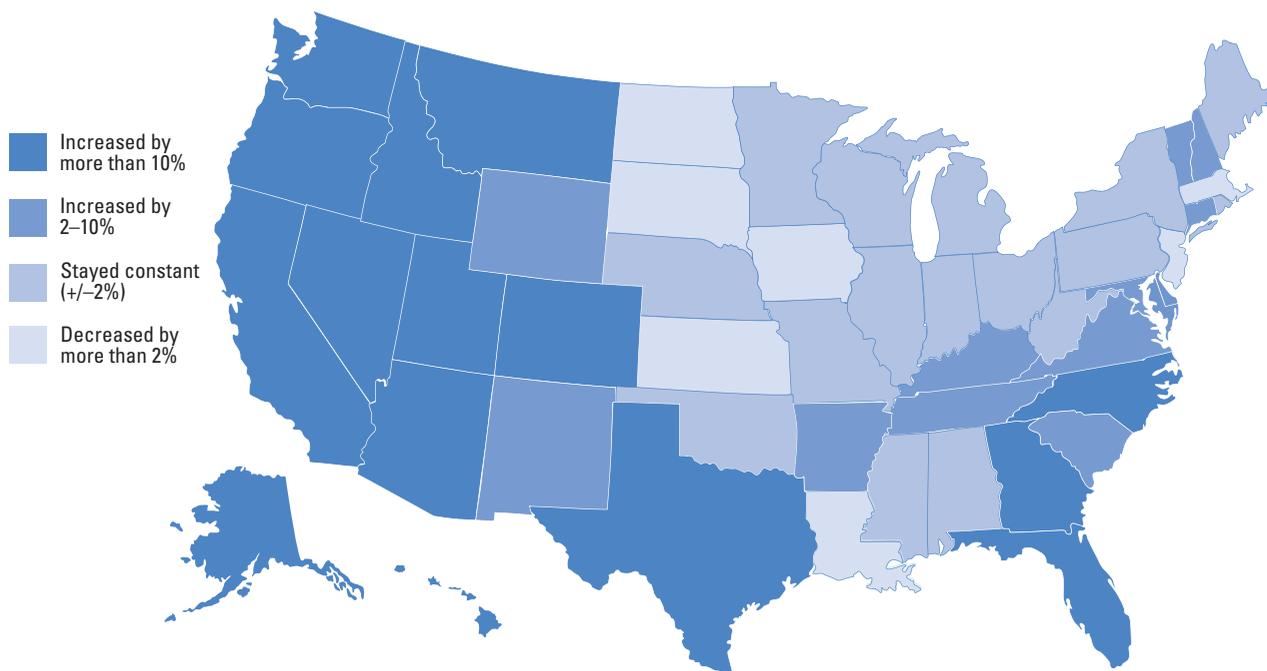
*Women are considered in need of publicly funded contraceptive services if they are sexually active, fertile, not seeking pregnancy and either have an income below 250% of poverty or are younger than 20 (and thus presumed to have a low personal income).

Meeting both the ongoing and the still-unmet need for services is a daunting challenge that will require providers to continue to do virtually everything they are already doing, even as they redouble efforts aimed at those who can be both hard to reach and challenging to serve. Even now, clinic clients come from a range of backgrounds and cultures, and speak a widening array of languages. (Latinas—a highly heterogeneous group in itself—alone comprise one in five women currently in need of publicly funded family planning services.) Moreover, clients increasingly are coming to clinics with complex health care needs, requiring a broadening package of care, or at least of diagnosis and referral services. Furthermore, there are residents of isolated rural areas; those who face complex issues such as homelessness, incarceration and substance abuse; and those living with physical disabilities or in foster care—all of whom may need family planning services.

The demands facing the provider network are at once pressing and expanding, and Title X must be equipped to meet them. First, it must have increased funding to support high-quality clinical care—including counseling, education and outreach—in a way that both leverages the potential of and compensates for the shortcomings of Medicaid and other funding sources (related article, Spring 2007, page 13). Equally important, however, it must support clinics' infrastructure needs more expansively than it now does, embrace new ways to assess the full impact of the program, and craft better mechanisms to ensure that care is supported by the latest scientific evidence and medical recommendations.

INCREASING NEED

Across the country, the number of women in need of publicly funded contraceptive services increased by 7% from 2000 to 2006—and by more than 10% in 15 states.



Source: Guttmacher Institute, 2008.

Supporting Provider Infrastructure

In the early days of the national family planning effort, supporting clinic infrastructure essentially meant establishing new clinic sites. As the effort matured, the focus shifted to meeting the ongoing infrastructure needs of a network that today encompasses 4,400 clinics serving 4.7 million clients each year. These basic needs—from paying utility bills to purchasing examining tables, paper gowns and other medical supplies, including contraceptives—will exist as long as clinics exist.

As client needs have changed, however, providers have been struggling to adapt their infrastructures to make services genuinely accessible within their communities. In some areas, this has led programs to seek to put clinics—or satellite clinics—where clients live, work and attend school. In urban areas, providers are working to locate clinics where they are easily accessible through public transportation; in rural areas, clinics are geographically scattered, albeit with limited operating hours.

To meet the needs of their communities, many providers are struggling to extend clinic schedules to serve clients who work long hours, often in inflexible employment situations that make coming to a clinic during traditional hours impossible. As models, some programs are looking at so-called minute clinics, such as those springing up in shopping malls and pharmacies, which are open late into the evening on weekdays and for several hours on both weekend days. These sorts of reconfigurations take significant financial support, which in turn requires an understanding on the part of the clinics' funders—by and large the federal and state governments—that these efforts are integral to their ability to reach and serve their target populations.

In fact, an even wider concept of infrastructure is required. This broader vision must include the investments in electronic medical records and health information technology necessary to allow clinics to be active participants in the emerging health care marketplace of the 21st century.

Absolutely fundamental, meanwhile, to meeting the needs of an increasingly diverse clientele is an expanded emphasis on the human resources that lie at the heart of the family planning clinic effort. From the legislation's initial passage in 1970, training has been recognized as an important component of the Title X program. That effort must be given the priority and support it needs to ensure that clinic staff are fully cognizant of the latest medical protocols and best-practice techniques, and that a sufficient supply of clinicians and other staff is available to provide culturally sensitive, client-centered care appropriate for the community. Moreover, a focus on human resources would make funding available to pay staff at all levels—from the front-line staff that schedule appointments to counselors and clinicians—competitive wages and benefits sufficient to address the high staff turnover rates that plague safety-net providers nationwide.

Clinic staff must be tailored to provide a widely diverse clientele with the services appropriate to their needs. A new client likely will require an extended visit, to allow for a complete medical history; a range of diagnostic tests; and counseling and information on contraceptive options, the risk of STIs and other sexual and reproductive health issues. Returning clients need to be asked about any life changes that may affect their reproductive health needs, kept abreast of new information and technologies, and given support for their ongoing challenges in attempting to prevent unplanned pregnancy and STIs.

Some clients or potential clients need even more. Just reaching out to immigrants or homeless clients, for example, and helping them feel comfortable enough to come into the clinic for care will entail a redoubled effort on the part of the clinic system. Once at the clinic, many such clients will need language assistance, and others will need help in navigating the multiple issues in their lives, often requiring making connections to other health or social services in the community.

Many clients, especially those just starting a contraceptive method, need specialized and time-intensive counseling. Teens may have special confidentiality concerns and often require extra

time with staff to receive education and information to counterbalance misinformation from friends or unreliable Internet sources. Other clients have complex needs stemming from homelessness, domestic violence, substance abuse or mental health issues, and may require additional counseling, services and referrals to other providers in the community.

Having both a sufficient number and an appropriate mix of personnel is critical to enabling staff to take the time during each visit to connect with and listen to a client and respond to her individual needs. And it can allow staff to develop a rapport with a client by, for example, seeing her at successive visits.

Research has demonstrated how important this can be. A study published in *Women's Health Issues* in 2002 found that women who said that they had received "personalized" counseling in the past two years that addressed their individual needs and preferences were more likely to currently be using a contraceptive method. According to a more recent Guttmacher Institute study, women who reported not feeling able to call their contraceptive provider with a follow-up question were more likely than others to experience a gap in their contraceptive use over the course of a year.

Assessing Effort and Impact

Shifting the concept of infrastructure to include a greater emphasis on the human resources necessary to carry out the program's mission needs to be supported by a new way of measuring both effort and impact. Historically, the scope and impact of the Title X effort has been measured largely in simple terms of the number of clients seen and the unplanned pregnancies prevented as a result of the contraceptive services provided. Although these measures will always be critical to assessing the program's import, they alone are no longer sufficient.

Simply counting the aggregate number of clients served, therefore, is not adequate to gauge the effort and resources providers are expending. Instead, the program must look more closely at who is being served. This will require a new

system that can incorporate the reality that not all clients require the same level of program resources and attempt to account for the extent to which providers are reaching out to and serving these higher-cost clients.

To adequately balance expenditures against impact, the system also must account for the fact that some long-acting contraceptive methods that provide high levels of protection for long periods of time also have high up-front costs to providers. Amortizing that effectiveness over time will reduce the current disincentive to providers to offer these methods to clients because of those high initial costs. It will also provide a better understanding of the actual level of contraceptive protection being provided, as well as its cost effectiveness.

Moreover, any attempt to fully assess the impact of the services provided by family planning clinics must account for the breadth of the services offered. One of the central strengths of the Title X effort has always been that contraceptives are provided to clients within a package of closely related preventive care. Clinic clients, for example, routinely receive breast exams to screen for breast cancer and Pap tests to screen for cervical cancer or cervical abnormalities that may lead to cancer. These screenings detect numerous cases of breast and cervical cancer early, when they can be most successfully treated. At the same time, by detecting precancerous cervical changes that also can be treated, they help prevent cervical cancers from occurring in the first place.

Clinics are also providing their male and female clients with testing and treatment for a widening array of STIs. By doing so, clinics are on the front lines of stopping the spread of these debilitating and costly conditions. Diagnosing and treating chlamydia, for example, can prevent the pelvic inflammatory disease and infertility that otherwise could result. And the HIV testing done in clinics facilitates both getting individuals in for treatment and curbing the spread of this devastating disease.

These critically important services—and providing them in accordance with ever-changing med-

ical guidelines—are claiming a growing share of clinic revenues. Their beneficial public health impact should be measured, and attributed to the clinics that provide them.

Maintaining and Updating Standards

With their broad focus on preventive and reproductive health services and education, Title X's clinical care program guidelines have defined the provision of high-quality family planning services in public settings. These guidelines stipulate that a client's visit include counseling and education, a complete medical history, physical assessment, laboratory testing for relevant conditions and the ability to choose from "a broad range" of contraceptive methods. Clinics are required to have policies for making referrals as a result of abnormal physical examination results or lab findings.

The current program guidelines, developed in conjunction with the American College of Obstetricians and Gynecologists (ACOG), were released in 2001. These guidelines stipulate that a complete physical exam, including a pelvic exam and a Pap test, should be performed as part of a regular family planning visit, although clients may defer that exam for up to six months. In the intervening years, however, the U.S. Preventive Services Task Force, the American Cancer Society and ACOG have all concluded that women need not obtain a Pap test until age 21 or three years after becoming sexually active, whichever comes first; older women should have a Pap test at least every three years. Under these new recommendations, a Pap test and pelvic exam would not be required for all family planning clients; however, offering the exams to all clients—along with educating them about the importance of regular preventive care—remains fundamental to Title X's public health mission, especially given that a substantial proportion of clients view clinics as their regular source of health care. Yet, doing so requires trained counselors and educators who have sufficient time to spend with clients and address their individual needs, underscoring again the critical role of the human resources that support the entire family planning effort.

Meanwhile, the fact remains that there is something of a disparity—or at least the common per-

ception of one among providers—between what the Title X guidelines say and other, now-generally accepted medical standards about when and for whom Pap tests and pelvic exams are appropriate. Clearly, Title X guidelines should reflect the latest medical consensus, and discrepancies such as these should be avoided to the extent possible. To that end, a process could be established so that updated medical guidance, such as the new Pap test protocols, could be automatically incorporated into program guidelines without delay. (In fact, they were referenced in an October 2003 Office of Population Affairs Program Instruction, indicating that Title X–funded providers should ensure that their programs adhere to the new protocols.) Such a mechanism also would have allowed for the immediate incorporation of the recent recommendations by the Centers for Disease Control and Prevention that all teenagers and adults up to age 64 be routinely tested for HIV as a normal part of medical practice, irrespective of an individual’s risk factors or the HIV prevalence in the community (related article, Spring 2008, page 13).

Next Steps

Although the fundamental role of Title X—to provide access to the highest quality contraceptive services and related preventive care to young and low-income women and men—is an enduring one, the ways in which the program needs to go about fulfilling that role must change to meet evolving realities. To do so effectively necessitates a reinvigorated program that reflects these new imperatives.

Unfortunately, Congress last formally examined and reauthorized the program in 1985, more than two decades ago. And although the underlying structure, focus and fundamental priorities of Title X remain as relevant as ever, many of its operational requirements and evaluation mechanisms now seem badly out-of-date, leaving program staff and providers without the full measure of support they need and deserve to meet the challenges that are confronting them on a daily basis. In large part, the failure of Congress to initiate a reauthorization has been driven by the well-justified fears on the part of the program’s most ardent supporters of the political risks of opening the program up in what has widely been perceived as an unfavorable political climate. It is to be hoped that this situation will soon change, enabling the program at long last to be examined and given both the credit it deserves and the retooling it needs to be fully equipped to move with maximum effectiveness into the future. www.guttmacher.org

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