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Implementation of Title X Family Planning Services in Primary Care: A Qualitative Study of a Primary Care Network in Georgia

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ABSTRACT

Context: There is increasing interest and value in integrating family planning services into primary care. Title X services provide an opportunity to expand low-cost access to these services. This study sought to identify and describe implementation factors that influenced the integration of a package of Title X services into a unique primary care setting within a Georgia primary care network whose community health center sites are primarily federally qualified health centers.
Methods: We used an implementation science approach and were guided by the Consolidated Framework for Implementation Research. From December 2019 to September 2020, we conducted interviews with administrators and providers working at grantee and sub-grantee organizations about their experiences integrating Title X services into their existing practice.
Results: Factors associated with the *Inner Setting* were especially important for integrating Title X in these settings. Participants identified specific needs related to resources such as electronic medical record (EMR) and reporting templates. Contextually specific clinical training for provision of long-acting reversible contraception and sexual health counseling, as well as administrative training for reporting and documentation efforts, was particularly needed. Grantee and sub-grantee organizations were able to leverage internal and external networks and adaptations to the intervention to successfully implement Title X services and to expand reach to new clients.
Conclusions: Integrating family planning into primary care may expand access to low-income and underserved populations. Approaches that incorporate flexibility and provide tailored resources for primary care settings such as EMR and reporting templates and trainings, and that leverage multiple forms of support and knowledge sharing, may be particularly important for helping to implement Title X services.
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The Title X Family Planning Program (Title X) has provided federal funding for comprehensive family planning services to millions of low-income and uninsured individuals in the United States for more than 50 years (Fowler, Gable, Lasater, & Asman, 2020). Title X–funded health centers are mandated to provide "a broad range of acceptable and effective family planning

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methods and services," including contraceptive education, counseling, and methods; infertility services; breast and cervical cancer screening; sexually transmitted infection (STI) prevention, screening, and treatment; HIV testing and referral; and pregnancy diagnosis and counseling (Office of Population Affairs, 2021). Historically, Title X grants have been awarded to state and local health departments and specialized family planning providers. Federally qualified health centers (FQHCs) and other safety net providers have most commonly been awarded Title X funding as sub-grantees (National Association of Community Health Centers, 2017). However, changes in the U.S. health care environment, including funding reductions, new clinical and quality guidelines, and diverse health plan coverage (insurance marketplaces and Medicaid expansion) have led to changes in the Title X provider network nationally (National Family Planning & Reproductive Health Association [NFPRHA], 2014).

The designation of FQHCs as Title X grantees is part of an increasing trend toward integrating family planning services into primary care settings. In 2014, the Centers for Disease Control and Prevention indicated that primary care providers "will be expected to integrate family planning services for all persons of reproductive age" (Gavin et al., 2014). Integrating Title X family planning services into primary care has been shown to expand access to health care services for existing patients, increase patient satisfaction, and improve adolescent family planning provision (Mead et al., 2015; NFPRHA, 2014; Wood et al., 2014). However, many different organizational models have been proposed, and there are limited data on common factors associated with successful implementation strategies.

In 2014, for the first time in 30 years, the Title X grant for Georgia was awarded to a new grantee, The Family Health Centers of Georgia, Inc (FHCGA). With this grant, FHCGA established the Georgia Family Planning System (GFPS), a collaboration of FQHCs from across the state as well as Grady Health System community health centers (CHCs) and other community-based health centers. GFPS became the first grantee network solely of primary care agencies, most of which had never received Title X funding, and represented a new model for fully integrating Title X family planning services into primary care. This model provides an opportunity to explore learnings about implementing family planning, and specifically Title X services, into primary care in the context of a new health system.

Implementation science provides a useful framework for assessing best practices when initiating new strategies. Implementation science involves the study of methods for promoting the uptake of evidence-based practices or other interventions into routine practice. Such studies can improve our understanding of how best to implement new practices and to improve overall program success (Durlak & DuPre, 2008). Using an implementation science frame, this qualitative case study explored factors that influenced the integration of Title X services into primary care within a unique setting of a primary care network in Georgia.

Methods

Study Design and Conceptual Framework

We used a qualitative exploratory case study design guided by the Consolidated Framework for Implementation Research (CFIR) to investigate the experiences of primary care agencies in integrating Title X services and to identify specific influences on implementation (Hafiz, 2008). A major strength of using CFIR as our conceptual framework is that it combines constructs across multiple theories of implementation organized into five domains (Damschroder et al., 2009). The framework includes constructs representing contextual factors that influence implementation and organizes them into five major domains, including 1) characteristics of the intervention, 2) outer setting, 3) inner setting, 4) characteristics of the individuals involved, and 5) the process of implementation. In this analysis, we conceptualize the unique package of services and protocols required by Title X as the *intervention* of focus. We then identify and describe implementation factors that influenced the integration of this package into new primary care settings at FQHCs and other CHCs.

Study Setting and Sample

The grantee, GFPS, is composed of a state-level network that includes 28 sub-recipient "agencies" that encompass 160 health center service sites spanning 156 counties in Georgia. Most agencies are designated as FQHCs, but a few are smaller community health centers. Community health centers are nonprofit private or public entities that focus on providing primary care to underserved populations. FQHCs are a subset of community health centers that are subject to numerous requirements to be eligible for federal funding, such as the provision of comprehensive primary care services regardless of ability to pay, sliding-scale fee structures, and maintenance of community-based governance. In addition, FQHCs qualify for specific reimbursement programs and are thus subject to further requirements and reporting. Agencies within the GFPS sub-grantee network are autonomous organizations, made up of one or more health centers, with their own leadership and staffing structures. They may differ in size, in reporting requirements, and in resources such as electronic medical record (EMR) systems. All agencies in the GFPS network, with the exception of Grady community clinics, were new to the Title X program previously. We included Grady sites in this study to incorporate the perspective of a sub-grantee who had previously received this funding. The sample for this study included GFPS and sub-grantee administrative staff and clinical providers.

Data Collection

As part of a larger mixed-methods implementation study, we conducted semi-structured interviews in person and via Zoom from December 2019 to September 2020. GFPS and sub-grantee administrative staff (management personnel such as directors, family planning leads, or quality coordinators) and clinical providers (doctors and nurses) completed an online survey about their health center's current family planning and Title X services. Survey respondents were then contacted via e-mail to ask if they would be willing to participate in qualitative interviews on their experiences with implementing Title X services. We also used snowball recruitment to identify further participants within each agency who were most suitable for inclusion based on their role. We purposively recruited administrators and clinicians to provide a balance of clinical and administrative perspectives on implementation experiences and ensured variation across size and urbanicity of sites. Recruitment continued until thematic saturation was reached.

Two interview guides were created, one for clinicians and one for administrative staff. Interviews addressed participant experiences with implementing Title X services, changes to clinic services, and barriers to and facilitators of providing these

services. Consent was obtained from all informants before the interviews, which lasted an average of 1 hour. This study was approved by the Emory University Institutional Review Board. All participants received a $50 gift card in recognition of their time.

Qualitative Analysis

Interviews were recorded and professionally transcribed. Verbatim transcripts were cleaned by a member of the research team and uploaded into MaxQDA18 software (Verbi Software, 2018) for coding. Qualitative analysis was conducted in line with the procedures of Thematic Analysis to assess factors that influenced implementation of services (Braun & Clarke, 2006).

Five researchers reviewed a set of transcripts ($n = 6$) to develop an initial coding scheme. We used a hybrid approach to develop deductive codes based on the interview guide and CFIR constructs, as well as inductive codes from the data to apply concurrently to transcripts. We selected specific CFIR constructs across all five domains for our analysis. Constructs were selected based on their fit with the study data and sentiments expressed by participants.

To finalize coding, two researchers double coded all transcripts and resolved coding disagreements through discussion with the research team. Codes were then reviewed and organized into sub-themes guided by the research question to represent patterns in participants' experiences of and perspectives about implementation and then grouped into larger themes. Themes were further refined in team discussion and were then labeled and organized according to the CFIR domains and constructs with which they most aligned.

Table 1
Participant and Agency Characteristics

Characteristics of Respondents and Agencies Represented	
Respondent Characteristics ($n = 17$)*	*n* (%)
Respondent role	
Provider	4 (25)
Administrator	12 (75)
Years with agency	
<1	1 (6)
1–4	3 (18)
5–10	10 (59)
10+	3 (18)
Agencies represented	
Grantee	1
Sub-grantee	13
Agency Characteristics ($n = 13$)	
Location of agency	
Urban	6 (46)
Rural	7 (50)
Geography of agency	
North	4 (30.8)
Atlanta MSA	5 (38.5)
Central	1 (7.7)
Coastal	2 (15.4)
South	1 (7.7)
Size of agency	
Number of family planning clinics in agency	
Small (1)	5 (38.5)
Medium (2–6)	5 (38.5)
Large (10+)	3 (23.1)

Abbreviations: MSA, metropolitan statistical area.
* One interview had two participants.

Results

We completed 16 interviews with a total of 17 informants. Participants included four clinicians (24%) and 13 administrators (76%) representing GFPS and 13 of its sub-grantee agencies (Table 1). Most respondents had served in their roles for at least 5 years. The size of agencies (number of family planning clinics) also varied, with most having at least two health centers in their agency that provided family planning services. Most agencies entered the network in 2014, except for two that entered in 2016, and had been implementing Title X services for approximately 6 years by the time of interview.

As depicted in Figure 1, the implementation of Title X services in FQHCs was influenced by factors across all five domains of the CFIR framework. We present themes in four CFIR domains, including those associated with the 1) characteristics of the intervention and model for integration, 2) outer setting, 3) characteristics of individuals, and 4) inner setting. Table 2 provides an overview of implementation themes and the associated CFIR domains and constructs, the prevalence of each theme in interviews, and full segments of illustrative quotes.

Characteristics of the Intervention

We identified two themes related to the attributes of the intervention that influence the success of implementation.

The GFPS model for Title X represented a new setting and a new approach to integrating family planning and primary care

As depicted in Figure 1, participants from grantee and subgrantee organizations reported that the GFPS model for integrating Title X services (*the intervention*) was unique because it involved 1) a new, nontraditional setting, and 2) a new approach to integration. The setting was nontraditional in that the GFPS network was the first Title X grantee solely administered through FQHCs and other CHCs. Consequentially, this necessitated "creativity" in incorporating family planning services and developing new methods for implementing them, because FQHCs were subject to additional regulations and requirements for service delivery that many other types of Title X organizations, such as health departments or specialized family planning centers, were not.

> "Because we are so different from the traditional family-planning program, [the traditional programs] don't really have the resources to help us." (Administrator)

The GFPS approach to integrating family planning services also differed from previous approaches to integrating Title X in FQHCs in that the grantee sought not to simply colocate services or to offer services on alternating days, but to fully integrate Title X and family planning care into everyday practice. For example, this approach included an integration of sexual and reproductive health (SRH) assessments at every visit and family planning services offered on all days at every participating site. Respondents described this approach to integration as part of their "everyday flow" and part of their "culture."

> "… so we have primary care physicians, and those type of visits, also, we have to do family planning services for those that qualified…If they didn't qualify, then we stopped there, and then just making sure that it was part of the everyday process with our patients. I think that that took a while because it was new, and then getting new staff, just also training them, making sure that they understand … patients

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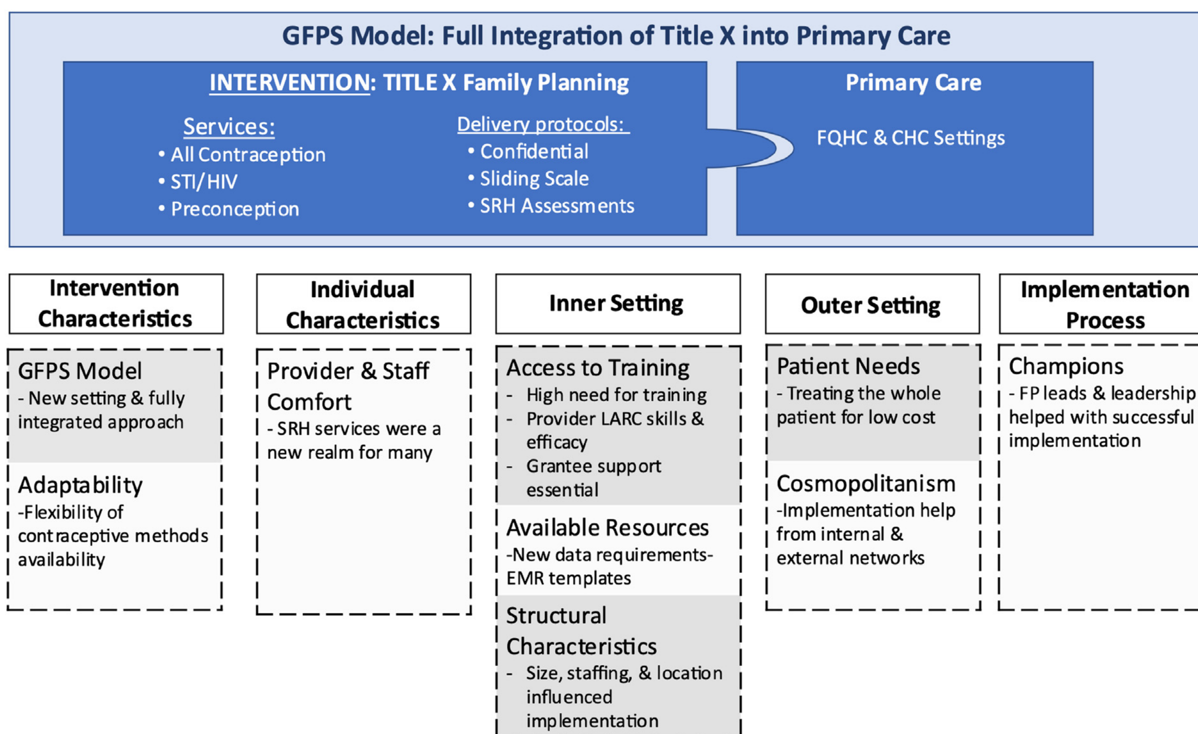

Figure 1. Implementation constructs influencing a unique model for integrating Title X services into a primary care network.

that come in, even if they come in for diabetes, they will have some family planning counseling, as well." (Administrator, Medium Urban Agency)

Adaptability

A key factor for successful implementation was allowing for flexibility in offering on-site, same-day access to all methods of contraception. Title X requires that grantees provide access to a broad range of contraceptive methods on-site or by referral. GFPS identified initial challenges with ensuring that sub-grantees provided access to all forms of contraceptives on-site, particularly long-acting reversible contraception (LARC) methods at every health center. These challenges were due to costs, low demand (attributed to population characteristics), and the lack of available trained providers. To address these barriers, GFPS developed a policy that sub-grantees must stock and provide all methods within their agencies. At the same time, sub-grantees could allow for variation at the clinic level with availability to be determined by each clinic's resources and local demand.

> "And so for us right now, when it concerns contraceptive methods, you just have to have a broad range with your agency. You need to have everything available at the agency level, but you don't necessarily have to have a LARC in Cairo, Georgia, because no one wants it. ... So if they need it, they can get it, because we make sure that they have it at the parent agency, at the main site" (Grantee Administrator)

As depicted in Table 3, most respondents reported that they provided LARCs on-site at least some of the time, but this varied and often depended on the availability of providers (as described further later in this article).

Outer Setting

We identified two themes associated with the outer setting, which includes constructs associated with external influences on implementation.

Patient needs

Understanding of the benefits of Title X for their patients was highly motivating for participants because they were aware of the importance of affordable SRH services among their patient population. Many participants reported that their role was providing services that addressed all their patients' needs in one location and emphasized the importance of access to affordable family planning services offered through Title X.

> "…the concept of the FQHC model and what [Agency A] does is comprehensive health care. So we want to be a full-service provider for patients no matter the reason they are originally coming in for. … So, we can not only treat them as a whole person, but we should be able to treat their whole family as well […] the goal is to be able to serve the community fully to make the whole family and then the community healthier." (Administrator, Large Rural Agency)

Sliding-scale fees, however, could still present challenges, and one site described difficulty in trying to accommodate patients' needs while maintaining financial sustainability.

Cosmopolitanism

Cosmopolitanism refers to the degree to which organizations are networked with other organizations (Damschroder et al., 2009). To aide with navigating implementation, the grantee and sub-grantees made use of external connections such as

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Table 2
Factors Influencing Implementation of Title X Services in FQHCs: Themes and CFIR Domains

CFIR Domains and Constructs (Short Definition)	Study Sub-Themes	Exemplar Quotes
Characteristics of the intervention		
GFPS fully integrated model	The GFPS model represented a new approach to integrating primary care and family planning in one process	"We also implemented that we were going to ask every patient at every visit, regardless of the reason that they were coming in, if they were planning a pregnancy in the next year. You know, the One Key Question with Title X. So getting that ingrained took a little time, but now we—they all kind of giggle about it when I talk about the One Key Question because they all know what that is. And we talk about it whether they are coming in for the flu, or whether they're coming in for a true family planning visit. We talk about reproductive health." (Administrator, Large Rural Agency)
Adaptability (The extent to which an intervention can be adapted or tailored to meet local needs)	Allowing for flexibility with same-day provision of all contraceptive methods on-site	"When we first started, again, because we were looking at things to the letter of the law, and everyone says that you should have a broad range available for all people at all times whenever they want it, we went in and said, 'You have to have everything all the time, always, everywhere, at all sites,' and that was unacceptable for our sub-recipient agencies, and so … we said, 'Okay, well, as we're tailoring these to the different agencies, what can we set as a standard, and then what can vary.' And so for us right now, when it concerns contraceptive methods, you just have to have a broad range with your agency. You need to have everything available at the agency level, but you don't necessarily have to have a LARC in Cairo, Georgia, because no one wants it. ... So if they need it, they can get it, because we make sure that they have it at the parent agency, at the main site." (Grantee Administrator)
Outer setting		
Patient needs (How patient needs in relation to an intervention are known and prioritized by the organization)	Treating the whole patient for low cost	"…the concept of the FQHC model and what [Agency A] does is comprehensive health care. So we want to be a full-service provider for patients no matter the reason they are originally coming in for. So maybe they're just coming in because they need to be seen because they have the flu, but we want to be able to let them know that we can provide family planning services, dental services, physical therapy, rehabilitation services. … So, we can not only treat them as a whole person, but we should be able to treat their whole family as well. And so that sort of I guess the goal is to be able to serve the community fully to make the whole family and then the community healthier." (Administrator, Large Rural Agency)
Cosmopolitanism (The extent of networking relationships an organization has with other organizations)	Grantees sought implementation help from both internal and external networks of support	"…it feels good in a way to be able to go to these things and hear the other people. It's not just you. You're not struggling by yourself, but they were able to overcome it and you're going to be able to overcome it too… just to know that it's not an island, you're not alone, to make sure that you are reaching out… So, I think that's the thing, just relying on each other to get that education and not feeling like it's overwhelming." (Administrator, Medium Rural Agency)
	External support	"Because we are so different from the traditional family planning program, [previous trainers] don't really have the resources to help us… They don't know FQHCs well enough." (Grantee Administrator)
Characteristics of individuals		
Individual characteristics (Individuals' attitudes toward intervention as well as knowledge related to the intervention)	SRH services were a new realm for many clinic staff and providers	"I think the biggest barrier was, for example, one of the questions that the nursing staff had to ask is, 'Are you sexually active?' [… or] 'Do you have more than one partner?' things like that, so it was just part of the template that they have to ask questions… but because it gets into specific details, they were not comfortable … Once we were able to kind of train them on how to ask these questions and that kind of stuff, then we increased the patient population in family planning services, but I think that was a barrier. It was more like, 'This is not comfortable,' although you would be surprised. The nurse is like, 'Oh, this is kind of new for me, so how do I ask that, like this is really uncomfortable,' you know? …so, I think that was really important. We did have an OB-GYN. She would come before, and she actually trained them …on how to go about these questions, so I think that was very helpful." (Administrator, Medium Urban Agency)
Inner setting		
Access to information (Access to digestible information and training about the intervention and how to incorporate it into work tasks)	Training needs	"I think that one of the biggest challenges, again, I mentioned this earlier, is just that it's such a—the way we're doing it is just so new. It's so different from what's been done before that we can't get the kind of technical assistance we need. We have become our own technical assistance …" (Grantee Administrator)
	Provider LARC training, skills, and self-efficacy	"So having providers that can place an IUD, that's fewer than the providers that can place like a Nexplanon. Merck has its own training, and they can get their checkoffs and it's really great. Skills are taught from a GYN provider to these other providers, so excellent training, but there's not really training like that out there for IUD placement, and so the cost difference between say a Nexplanon and an IUD is pretty significant. About Liletta, you know, how is that program where we can get them at pretty low cost, versus the Nexplanon which costs us a little over $400 on 340B pricing. So that when we have the majority of our providers that can place Nexplanon, if the patient wants a LARC that's more likely what they're going to get, and that uses that fund a lot more quickly for our patients that maybe they don't have insurance, or under insured that need that slide to afford their medication." (Administrator, Large Rural Agency)
	Grantee formal and informal support was essential	"GFPS was a huge help when we first started the process. They walked us through step by step and helped us with continual training and webinars and site visits and creating our policies and procedures with them. They were just hand in hand with us to get this ball rolling." (Administrator, Large Rural Health Center)

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Table 2 (*continued*)

CFIR Domains and Constructs (Short Definition)	Study Sub-Themes	Exemplar Quotes
Available resources (The resources available for implementation, including money, technology, physical space, and time)	Adjusting to new data and reporting requirements took time	"… if it's going to be a true confidential visit where the patient maybe doesn't want it in their electronic medical record, or they don't want any paper trail to the insurance company, our EMR is a bit of a hindrance in that as well. We have to do it all on paper forms in order to keep it confidential, which makes it harder for continuity of care if the patient were to ever go to another center. And I think that that's another issue, too, is that these EMR vendors I don't think that they fully understand the requirements of what we have to have as far as confidentiality and things like that goes. That even as much as we explain to them what we need they don't get it, so that's been a bit of a challenge." (Administrator, Large Rural Agency)
	EMR templates provided helpful solutions	"…we did have to create totally new templates …because it was completely new. We were getting sexual history, things like that, but it was not as defined … It had to really be specific to the patient. So, we did create templates and all that would pull that in. But then the thing is, like I say, when nursing staff or whatever gets kind of busy, then even with that kind of pushed in, that primary method is empty. So, unless they actually fill it in, there's nothing there. But yeah, so just trying to find ways of navigating that… And unfortunately, you have that struggle constantly with the providers of 'one more thing' or 'one more click.' And we're an FQHC– and [patient-centered medical home]. So, the thing is it's kind of like we're completely responsible for these patients, and it's kind of difficult sometimes to get even the providers to understand that. So, I think that's difficult too, when people come onboard, of just really knowing what—because an FQHC is totally different. I mean, we're totally different from any private practice or anything like that. And so, it's kind of getting that understanding of things don't work the same way here as they might elsewhere." (Administrator, Medium Rural Agency)
Structural characteristics (The size, age or maturity, or location of an organization)	The size, staffing, and location of sub-grantees influenced implementation	"[Our nurse practitioner] has just been trained to do IUDs … We have not had the training for the implants yet. She's been trained to take them out but not to put them in yet. There's not a [training] location that was close enough. The drug manufacturers usually do those. They haven't had one close that she could attend." (Provider, Small Rural Agency)
Implementation process		
Champions (Individuals who are dedicated to supporting, marketing, and ensuring implementation of an intervention)	Champions helped with successful implementation	"Our medical provider, he's now our CMO, Dr. [Name], but he is a huge champion for family planning… when the annual training is due or there's a new process [for] Nexplanon [if] the practice has changed for the insertion, so every provider who inserts it [needs] additional training. If I tell him, 'So-and-so still hasn't done the training,' he's right there calling, making sure they get the training, if they're current and they're updated. He's very proactive with the program." (Administrator, Large Rural Health Center)

Abbreviations: CFIR, Consolidated Framework for Implementation Research; CMO, chief medical officer; EMR, electronic medical record; FQHC, federally qualified health center; GFPS, Georgia Family Planning System; IUD, intrauterine device; LARC, long-acting reversible contraception; OB-GYN, obstetrician-gynecologist; SRH, sexual and reproductive health.

consultants, FQHC networks, and other Title X recipients. These contacts contributed specific expertise, such as support with grant writing, in using EMR templates, and with billing. External contacts were helpful but could often be unfamiliar with the unique GFPS model and thus limited in their ability to provide comprehensive support.

Participants also emphasized the importance of internal networks of implementation support. Sub-grantees provided one another with practical support during initial implementation and ongoing development such as sharing resources for LARC provision or strategies for seeking additional funding.

> "After working just with one other person for a long time, it was really helpful to have that system as a support and to be able to relate with other clinics that were providing the same services." (Administrator, Small, Rural Agency)

This was especially beneficial for smaller agencies with limited resources. Internal networking also established a sense of solidarity and mutual support among sub-grantees. These internal relationships were facilitated by annual meetings and training events organized by GFPS.

Characteristics of Individuals

We identified one theme associated with the influence of individual self-efficacy and knowledge on implementation.

Provider and staff comfort

Several sites described initial challenges with the readiness, buy-in, and the comfort of staff and providers to provide family planning services. Respondents said that many clinic staff and providers were not comfortable asking questions or counseling about SRH, particularly with adolescents. Some agencies also initially voiced concerns about pregnancy options counseling and some agencies or providers did not engage due to discomfort. Providers whose specialties were not obstetrics/gynecology (e.g., family practice, pediatrics) and those who were older were more likely to be uncomfortable in providing such services. Sites reported, however, that the training provided by GFPS was helpful in overcoming these challenges, as was having training and guidance from obstetrics/gynecology. Trainings were helpful not only in increasing awareness and comfort with asking these questions but also in doing so in non-stigmatizing ways.

> "I think the biggest barrier was, for example, one of the questions that the nursing staff had to ask is, "Are you sexually active?" [… or] "Do you have more than one partner?" things like that, so it was just part of the template that they have to ask questions… but because it gets into specific details, they were not comfortable … Once we were able to train them on how to ask these questions and that kind of stuff, then we increased the patient population in family planning services, but I think that was a barrier." (Administrator, Medium Urban Agency)

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Table 3
On-Site Provision of LARC Methods at Title X Agencies in Georgia

LARC Availability	No. of Agencies ($n = 13$)	Example Quote
On site, same day	4 (31%)	"I started around the time that the Title X funding came about with FQHC sites. I remember that we were just starting out. …I know, initially, we weren't doing IUDs. Now we're doing IUDs. …We have funding for [IUDs] now. We were also able to train all the providers that needed the board certification. They were able to obtain it, get the equipment we needed, and things like that. We had the funding to get the procedure equipment to do it. Funding always come down to it but then it also opens up doors to getting the providers trained to do it and things like that." (Provider, Larger Rural Agency)
On site, some	7 (54%)	"So, whenever I get new providers in, I will get with the rep to try to get them trained. However, if some of my providers are not comfortable then I will not proceed, and they will let me know whether they're comfortable or not or do they want to be a part of the LARC program…I have two providers at [Location A]. I have four at our women's center and that's at the hospital that do LARCs. So if I have a provider say on [Site B]—and I do have one that I've gotten trained twice. And we have not proceeded. So she just doesn't have the comfort level to proceed. But we do have an in-house referral process implemented. So if I have a patient that needs a LARC then they will refer that patient over there. So the patient is scheduled, before leaving their visit we'll get them scheduled. We found when we first started the referral process, we found the problem because if they leave it's hard to reach patients, hard to get them back in. So we try to go ahead and get them scheduled before leaving. And that seems to work for us. So the nurse or the MA when that referral is processed or the doctor orders it, then we go ahead and get her scheduled. And then I'm notified through ECW." (Administrator, Medium Urban Agency)
Referral only	2 (15%)	"So our provider, as I told you, is a new provider; however, she's since gone to the training on how to [insert LARCs]. But in order to get [trained for one]… Merck has to come on-site and do that. And so that's been a challenge because they don't offer it much or whatever, and then COVID hit, right? The other part of that is she has to have so many supervised hours. Well, she is our only provider and her supervisor provider, he's only contracted with us, right? So to get him to come in to supervise for X amount of hours in doing it, and our volume is not necessarily there—challenge number two. Now of course we're always looking for ways to overcome that challenge, and we had a perfect solution pre-COVID… our provider was going to begin going to another facility [that] was going to allow her to shadow and then—see her and then watch her, to get those hours, pre-COVID." (Administrator, Small Urban Agency)

Abbreviations: FQHC, federally qualified health center; IUD, intrauterine device; LARC, long-acting reversible contraception; MA, Medical Assistant; ECW, name of electronic health record system (eClinicalWorks).
Note: On site, same day = Respondents indicated their agency provides all LARC methods at each of their family planning clinics on site the same day of appointment.
Note: On site, some = Respondents indicated that their agency is not able to provide all types of LARC methods on site OR that provision is provider dependent (e.g., lack of training or provider preference).
Note: Referral only = Respondents reported that they are not currently offering LARC methods on site due to lack of trained provider, but provide referrals to other agencies.

Inner Setting

We identified six themes related to three constructs associated with the characteristics of the internal organization.

Access to knowledge and training

Multiple training needs. Most respondents described a high need for training to support implementation, including for both administrative and clinical processes. Training was especially necessary for data and coding processes, LARC insertion, and to address provider and staff comfort with SRH screenings. Because the GFPS model for providing Title X services was so different from the ones used by previous grantees, tailored training and assistance were harder to find.

> "I think that one of the biggest challenges, … is the way we're doing it is just so new. It's so different from what's been done before that we can't get the kind of technical assistance we need. We have become our own technical assistance…" (Grantee Administrator)

Some sites also noted that staff or provider turnover could present challenges to retaining a trained workforce.

LARC skills and self-efficacy. Per Title X requirements, most clinics were providing LARCs for the first time to their patients. Provider comfort, training, and precepting with LARCs were identified as some of the biggest needs for implementing Title X and as still one of the most challenging things to achieve (Table 3). Participants reported that providers had a range of experience with LARCs, but that most non-obstetricians/gynecologists had not administered them previously, especially to adolescents. When sites did not have trained providers, or those who were comfortable with insertion, service availability could be limited.

> "A lot of our family nurse practitioners, it's not in their scope of practice for IUDs [intrauterine devices] or since a lot of our supervising physicians are internal medicine or family practice and they don't insert IUDs then they don't feel comfortable supervising somebody to insert an IUD… And the Nexplanon is the same thing. We don't get that many of them, but we don't get enough to get the nurse practitioners checked off on inserting them. … we would like to have more of that, but it just seems difficult to get everybody trained. … we have tried [to recruit new providers], we just can't find them." (Administrator, Rural Medium Agency)

Some sites reported that when providers were not trained or comfortable, they would then refer patients to other providers within their agency. Several interviewees also identified ongoing challenges in accessing LARC training. These trainings often necessitated several hours for precepting, and finding time to do them could be difficult, especially for sites with few providers. A

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few sites also indicated that the ease of completing training and precepting varied by different LARC methods, thus also shaping which LARCs could be offered at each site.

To address these challenges, some reported engaging obstetricians/gynecologists already familiar with LARCs to train others, and others sent providers to larger sites to get precepting hours; several participants noted that learning to develop communications with pharmaceutical representatives was also helpful.

Grantee formal and informal support. The grantee played a key role in initial Title X implementation efforts across the network. Respondents noted that GFPS provided a combination of consistent, formal, and informal ongoing support to aid with the implementation of new services and data requirements. The training model included two yearly formal trainings for sub-grantee staff, an annual conference, and informal support. The latter included "lunch-and-learns," as well as ad hoc technical assistance through phone and e-mail. Agencies especially valued the accessibility of GFPS, and participants emphasized the benefit of regular communication.

> "GFPS was a huge help when we first started the process. They walked us through step by step and helped us with continual training and webinars and site visits and creating our policies and procedures with them." (Administrator, Large Rural Health Center)

Formal trainings targeted a set of staff leads from each agency using a "train-the-trainer" model whereby participants would then train their staff. Training and support on documentation and reporting was especially helpful (e.g., adapting EMRs, learning CPT codes).

Available resources

Adjusting to new data and reporting requirements. A prominent theme was that EMR and reporting systems presented an initial challenge for implementation, as new sub-grantees had to adapt to Title X documentation and reporting requirements as well as to billing and EMR coding for new services provided. Most respondents reported that, even with consistent support from GFPS, incorporating these requirements was initially challenging and required significant adjustments. These new processes included estimating the numbers of patients served (for funding allocation) and building new reporting processing, as well as correctly capturing patient services and information about poverty levels, methods of contraception, and SRH histories. Several respondents also identified challenges with developing EMR tools that allowed for confidentiality when treating minors or conducting STI testing. There were also variations in the EMR systems agencies used that meant there was not always one model to apply, and this could make finding the right resources more complicated.

Templates provided helpful solutions. Developing templates for EMRs and reporting, however, was one of the most frequently cited facilitators for implementation. The use of templates enabled easier coding as well as offering guidance in providing services (particularly in SRH assessments). Many sites reported using One Key Question to facilitate reproductive planning discussions. (One Key Question is a clinical framework that encourages health care providers, social service providers, and champions to routinely ask their patients about pregnancy desires and goals and to offer personalized counseling and care based on their response. Providers begin a conversation with their patient by asking the question "would you like to become pregnant in the next year?") In addition, report templates helped sub-grantees to more easily report data and to assess their progress. Coupled with support provided by GFPS, development of these templates increased respondents' capacity to implement Title X services and comply with mandated protocols. Other sites also reported having their own information technology specialists to assist with template creation or receiving assistance from EMR vendors and the Georgia Primary Care Association. Some sites still noted challenges, however, with ensuring that busy staff and providers filled out templates and cited the importance of continual training, reminder systems, and quality improvement.

> "We did have to create totally new templates …because [Title X services were] completely new. We were getting sexual history, things like that, but it was not as defined … It had to really be specific to the patient. … But then the thing is, when nursing staff or whatever gets kind of busy, then even with that kind of pushed in, that primary method is empty. So, unless they actually fill it in, there's nothing there… so just trying to find ways of navigating that." (Administrator, Medium Rural Agency)

Structural characteristics

Structural characteristics, such as the size, staffing, and location of sub-grantees also influenced the ease and efficiency of implementing Title X services and training. Provider turnover could affect both availability of services and training. For example, some sites with small staff also reported that they did not have providers perform LARC insertions because they had recently had providers leave and were waiting to get replacements or to get the replacement trained, or they experienced challenges with securing preceptors. Sites in more rural areas also had difficulty sending their providers to training locations.

> "[Our nurse practitioner] has just been trained to do IUDs … We have not had the training for the implants yet. She's been trained to take them out but not to put them in yet. There's not a [training] location that was close enough. The drug manufacturers usually do those. They haven't had one close that she could attend." (Provider, Small Rural Agency)

Process of Implementation

One theme emerged that addressed the processes the organization used for implementation.

Champions

Champions, or individuals dedicated to supporting implementation of Title X services, were also a critical component of successful implementation. Each sub-grantee had a designated "family planning lead" to serve as a point person for Title X services. The use of family planning leads at each agency helped to ensure that information and guidance were clearly communicated from the grantee to each agency. Participants reported that family planning leads helped to ensure the accuracy of reporting, to conduct staff training, and to promote the new services being offered. These leads often spearheaded training efforts. Champions were vocal about promoting and reminding staff to conduct SRH histories and planning discussions. These individuals led the way in integrating services into the everyday processes of the agency.

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> "A lot of repetition, repetition, repeat, it takes a lot. And it still does. I think that's the biggest thing. If you're not monitoring. If you're not constantly discussing—it could be something small. It takes just a bad communication day and your whole workflow will go down the tube." (Administrator, Medium Urban Agency)

Several sites also cited the impact of sub-grantee leadership as champions in promoting the program as a benefit for the agency and for patients. Others described how leadership was influential in providing and ensuring compliance with training.

Benefits of Title X for Reaching New Populations

Most respondents emphasized that a major benefit of having Title X funding was the ability to expand services to new populations of patients. These new populations were most often adolescents and men, who typically sought STI services (Supplemental Table 1).

> "… what I'm seeing that I think was just such a great thing for the community is even the providers, just having the education of how to speak to a teen that has questions about STDs … So, I think they got better training, because I want to say not all of them were comfortable or were not used to being in that setting. The fact that, 'Okay, now I have this training and I know how to kind of go about it with these teenagers to make sure that they're not scared or that they feel safe' … In general, we really increased our patient population in family planning … Being able to provide this service for some of the patients that could not afford it, I mean, that was good, and there is an increase in male [patients], absolutely." (Administrator, Medium Urban Agency)

Other populations that were further reached with Title X funding included lesbian, gay, bisexual, and transgender (LGBT) and Hispanic populations, which were engaged by additional community outreach. Respondents viewed Title X as a facilitator for expanding services to new populations through the inclusion of new services, additional resources to increase awareness, and developing relationships with other health organizations.

Discussion

There is increasing recognition of the need to better integrate family planning services into primary care to address rising inequities in reproductive health outcomes (Borrero & Callegari, 2020). This study assessed critical factors influencing the implementation of Title X family planning services in a Georgia primary care network whose community health center sites are primarily FQHCs. Although other models of integrating Title X services into primary care settings have been explored, these models focused on mergers, subcontracts, or transitions to becoming FQHCs (NFPRHA, 2014). Our assessment of the GFPS model provides a unique understanding of the full integration of Title X into primary care within a primarily FQHC system. We found nine CFIR constructs, particularly those associated with the *Inner Setting*, to be especially important for integrating Title X in these settings.

Implications for Practice

Although Title X services align well with the mission and services already provided by FQHCs, our findings indicate that additional resources and trainings are needed to support integration, particularly in preparing staff and providers to offer all methods of contraception, to address SRH more comprehensively and for new populations, and to conduct proper documentation and reporting. As highlighted, providing all methods of contraception on site in every clinic was challenging, particularly during the initial start-up. As other studies have shown, FQHCs can and do provide contraception, but rarely provide all methods (Beeson et al., 2014; Goldberg et al., 2015; Wood et al., 2014). Offering LARCs, in particular, required significant resources and in smaller clinics turnover also presented difficulties. Thus, *adaptability* may be critical for successful implementation in these settings and future implementations will thus require flexibility and creative adaptations, such as partnering with larger health systems, rotating providers for training, and allowing for flexibility in adapting service provision to the local needs and capacities of organizations.

Our study also indicates that in-depth SRH counseling was new for many primary care providers and staff and thus required additional training and adaptations to clinic workflow. Our findings support other studies showing that provider comfort with SRH care can be a major factor in implementing family planning services in primary care settings (Akers, Gold, Borrero, Santucci, & Schwarz, 2010; Goldberg et al., 2015; Hallum-Montes, Middleton, Schlanger, & Romero, 2016; White, Hopkins, Grossman, & Potter, 2018). Addressing SRH can often fall to the bottom of the list when providers have limited time (Akers et al., 2010; Coffey & Shorten, 2014). Further focus on SRH care and assessment during medical training is critical (Cappiello, Levi, & Nothnagle, 2016; Coleman et al., 2013; Harper et al., 2020).

As in our study, several assessments of family planning services at FQHCs have demonstrated that administrative processes and financial documentation are particularly burdensome to safety net providers and that additional requirements for Title X can pose further challenges (Hallum-Montes et al., 2016; NFPRHA, 2014). Both Title X and Section 330 data (for FQHC billing) require extensive and different documentation. Implementation planners should prepare to train extensively on both. A variety of functional supports were key to addressing needs associated with billing and reporting, program strategy, and clinical training. Many of these needs could be addressed through development of trainings and of new resources tailored to the unique context of these settings. As has been found in other primary care settings, EMR templates were helpful in navigating implementation challenges, in guiding clinical services, and in reporting (NFPRHA, 2014; Srinivasulu, Shah, Schechter, Prine, & Rubin, 2020). Use of tailored templates as well as coordination with EMR vendors will be particularly useful for future implementation of Title X in complex settings such as FQHCs.

The importance of *cosmopolitanism* is supported by other studies (NFPRHA, 2014; Piper, Haardörfer, Escoffery, Sheth, & Sales, 2021). Mutual support and information-sharing between organizations with similar structures could be further formalized to bolster future efforts at implementation. Formal and informal support from a coordinating agency or grantee familiar with the unique needs of primary care and FQHCs was also critical. Several participants also mentioned the importance of champions and leadership. Within organizations, champions who can help to promote services and to manage workflow and training should also be included.

FQHCs already engage with underserved populations, including those who are ineligible for Medicaid or other publicly funded support for family planning, and thus provide an

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important access point for care. Prior studies have shown that FQHCs that received Title X services are able to provide more comprehensive family planning services to their patients (Mead et al., 2015; Wood et al., 2014). Our study indicates that subgrantees also felt the provision of Title X services aligned well with their organizational mission to treat the “whole patient” and thus to better serve them. Our data further indicate that integrating Title X services into FQHC primary care may help expand access to holistic care for low-income populations, particularly for adolescents, men, and LGBTQ populations. Providing family planning services in these settings can be an important opportunity to reduce fragmentation and offer more comprehensive care (Borrero & Callegari, 2020).

Limitations

This study benefited from the perspectives of individuals with multiple roles in implementation, including grantees and subgrantees as well as administrators and providers. Our study also included agencies located in various geographic settings (rural, urban, suburban) across the state. Our study, however, also had limitations. In part because of the ongoing pandemic, our study population more heavily represented staff perspectives than those of medical providers. Further perspectives from providers, particularly those who are not obstetricians/gynecologists, could be helpful. Our study also did not incorporate patient experiences with care and thus is unable to report on how they experienced integration.

Conclusion

Integrating family planning services into primary care offers the potential to expand the reach of services to new populations and to address inequities in health outcomes. This study provides insight into critical factors influencing the integration of Title X services into the unique setting of an FQHC primary care network. Participants reported initial hurdles associated with ensuring access to a full range of contraceptive methods, providers who could insert them, and staff and provider comfort with reproductive counseling. Integrating new reporting requirements into existing contexts with complex reporting processes also proved challenging. Participants reported benefiting from tailored approaches and knowledge-sharing networks, as well as context-specific EMR templates and technical support. Pre-assessment of clinic staff experience and comfort with providing SRH services and LARC methods may help with planning. Implementation of Title X is not a one-size-fits-all process and thus requires strategies tailored to different settings. Approaches that incorporate flexibility and provide tailored resources for primary care settings such as trainings and EMR and reporting templates, as well as resources that leverage networks and multiple forms of knowledge sharing, may be particularly important for helping to implement Title X services and expand access to low-income and underserved populations.

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Supplementary Data

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