Ibis Reproductive Health

Abortion Care Network
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Documenting the impact of COVID-19 on independent abortion clinics: A qualitative study

Independent clinics ensure that people seeking abortion in the United States are able to access the high-quality health care they need, serving three out of every five people who have an abortion each year.[1] These clinics play an especially critical role in providing abortion care after the first trimester; in 2019, they represented 62% of clinics who provided care after 13 weeks, and 94% of clinics who provided care after 22 weeks.[1]

Prior to the COVID-19 pandemic, independent clinics, like all abortion providers across the United States, faced an increasing number of medically unnecessary regulations[2] and anti-choice extremism which made it extremely difficult to stay in business. In fact, over the past six years, 32% of independent providers have closed their doors. The spread of COVID-19 in the United States has triggered new, unprecedented challenges to abortion access for clients and for clinics. Clients may face delays in accessing care due to a number of factors related to COVID-19, including mandatory quarantine measures, travel restrictions and stay-at-home orders, and increased care-giving responsibilities. In addition, a number of states have tried to use the pandemic as a reason to temporarily ban most abortions by deeming abortion services "non-essential" or "elective" procedures.[3] As travel and legal barriers delay clients in accessing abortion care, there may be a surge of clients seeking abortion after the first trimester.

The COVID-19 pandemic has forced clinics to quickly adjust their protocols, including screening clients and staff for symptoms, and extending clinic hours and adjusting shifts to reduce the number of staff and clients in the clinic, all to ensure that their clients are able to safely access care and their staff are able to stay healthy while providing services.[4] According to the Abortion Care Network's (ACN's) latest Keep Our Clinics report, 92% of its member clinics indicated a need for financial support, and 50% reported an increase in the number of clients traveling for care since the pandemic started.[4] As clinics see an increasing number of clients traveling for care, and a potentially greater volume of later abortion clients, it is essential that clinics have the resources to accommodate these changes.

Study Design

During the week of April 20, 2020, staff at Ibis Reproductive Health conducted a qualitative study that aimed to capture in-depth information from independent abortion clinics on the financial impact of the COVID-19 pandemic. We invited 14 clinic administrators with clinics in 23 states spread across the four regions of the United States to participate. Given, the large percent of independent abortion clinics that provide second- and third-trimester care, we paid particular attention to inviting administrators that could speak to the impact of the pandemic on later abortion access/provision. Finally, we ensured that clinic administrators with experience of high COVID-19 death rates in their state and executive orders to pause services were invited to participate. Clinic administrators were asked to report on impacts experienced in the period March 1- April 23. This qualitative is meant to complement the Keep Our Clinics investigation, and identifies critical needs to ensure independent abortion clinics are able to continue providing comprehensive, high-quality abortion and other reproductive health care.

Key informants

We interviewed 12 clinic administrators, representing 16 abortion clinics. On average, administrators have been in their current role for ten years (ranging from 1-20 years) and their clinics have been in operation for 29 years (ranging from 4-50 years). Participating clinics offer a wide range of reproductive health services, including abortion, contraception, general gynecology care, and STI/HIV testing. All clinics provide first- and second-trimester abortion care and one clinic offers

third-trimester care. Clinics have a wide range of monthly operating costs ranging from $75,000 to over $350,000 based on the communities and number of patients served annually. To complement the narratives of independent providers, we interviewed two abortion funds that assist patients with abortion care in the South. One abortion fund provides financial support for procedure costs as well as practical supports (child care, travel, accommodation, etc.), while the other provides funds for the procedure costs only.

Key themes

COVID-19 increased the costs associated with abortion care provision

The COVID-19 pandemic has exacerbated financial challenges faced by independent abortion providers. To continue providing services during the pandemic and keep staff and patients safe, clinics have instituted a number of changes with accompanying costs. Similar to other health facilities, clinics have acquired supplies to ensure the health protection and safety of staff, increased cleaning services, and offered pay to staff who cannot work because of their vulnerability to the virus. Five respondents reported that they would have liked to implement protective measures for staff such as hazard pay, paying staff for some time prior to terminating or furloughing their positions, paying staff a bonus for working longer days, and bringing in a second shift to avoid burnout—but were unable to do so due to their financial situation.

"If we are able to save enough money—a normal business will have a[t] least two rounds of income in reserves, but we aren't able to do that because we don't generate enough income. So this is our constant state. So when you add on anything additionally, it's a significant hardship and it makes it difficult to plan for emergency, changes, and new program[s]."

US Centers for Disease Control and Prevention and/or state recommendations to observe physical distancing have impacted provision of care. Many clinics have responded by reducing the numbers of clients that can be in the clinic at a given time; only allowing support people into the clinic if there is a compelling reason (ex. if the patient is a minor, or requires language support); changing their hours of operation; and adding telehealth services (if allowed in their state) for patient intake, counseling, follow-up appointments for medication abortion, and contraceptive and STI treatment services. These changes led to additional costs, since many clinics did not have a telehealth infrastructure prior to the pandemic, are now seeing fewer patients, and have to pay staff overtime to compensate for longer working hours, leading to lower revenue for clinics. Some respondents reflected that they made the changes they needed to make without considering the cost implications of their decisions. *"Things were done because they had to be done, even if it's at a financial loss. Clinics eat the cost."*

Respondents reported direct and indirect impacts on their clinics, staff, and service delivery. Five respondents reported pausing clinic services temporarily. Reasons for pausing included clinic location (ex. one clinic is located inside a medical facility and was considered high risk for patients), state-based restrictions, and staff illness. Clinics have experienced changes in the location, number, and type of staff members at the clinic. Staff working at the call centers or in administrative roles, such as billing, are working remotely, while some staff who have underlying medical conditions that make them vulnerable to COVID-19 are not working. Some clinics have furloughed staff. In one case, the respondent expects that they will only be able to bring back approximately two-thirds of furloughed staff due to cost, and in other cases clinics have hired more staff to accommodate changes in patient volume.

"Unfortunately I am losing staff left and right. We are spread extremely thin. Uhm…its support staff which is my issue. So I have a sonographer […] she has underlying medical conditions, she hasn't been with us in four weeks. I have staff that are now caring for kids that are out of school, because they don't have anyone to watch their children. They want to work but physically can't come to work So I am actually in desperate need and I kinda joined forces with NAF and ACN who have now connected me with PP with hopes of – they furloughed staff and they had to lay staff off – […] to see if I can engage with the staff and offer them either temporary or permanent [positions]"

Many clinics have paused or limited their provision of non-abortion sexual and reproductive health (SRH) services such as gynecological care, HIV testing/treatment, fertility treatments, menopause evaluations, miscarriage management, and, in some cases, are only offering medication abortion or only one type of

surgical abortion during this time. Low reimbursement rates were of particular concern for respondents and pushed some to curtail the gestational age at which they typically provide care. One respondent made the decision not to provide care beyond 18 weeks until they could figure out how to address funding gaps from lower reimbursement rates, while another has refrained from increasing the gestational age at which they provide care because they felt it would not be financially sustainable. Some clinics have extended medication abortion provision to 11 weeks.

Referral patterns have changed, with some clinics getting more referrals from clinics that have paused, closed, or are no longer offering second-trimester care, or care for patients with fetal anomalies, multiple C-sections, or other medically complex conditions. Five respondents shared that they have seen an increase in later abortion patients, especially from other states, due to clinic closures in those states. Meanwhile, other clinics are referring all later abortion and/or medically complex patients to other clinics because they have stopped providing that care or want to minimize financial losses due to low reimbursement rates for later abortion procedures. Some clinics report finding it challenging to find places that will accept clients with pregnancy-induced medical conditions.

Financial impacts from COVID 19 have immediate and long term consequences

Within an eight-week period (March 1- April 23), respondents reported that the changes they had instituted to continue providing care or had experienced as a result of the pandemic (ex. changes in staff) amounted to a loss in revenue ranging from $15,000 to $180,000. One clinic with monthly operating costs of $300,000 said that they were losing 40% of their revenue and were unsure what their total losses might be since they were awaiting reimbursement on many of their services.

Administrators questioned their ability to sustain their clinics in the coming months with the uncertainties in reimbursement for telehealth, low reimbursement rates for an increased number of later abortion patients, and not knowing about the outcome of their applications to the Paycheck Protection Program. While some administrators estimated being able to continue providing services with such losses for another three months, many more administrators were uncertain of their longevity under these conditions and hoped that they would learn of successful grant applications, be able to resume surgical abortion and other SRH services, and/or have a better understanding of their finances in the coming months. Respondents were uncomfortable thinking about the possibility of their clinic pausing services or closing. This discomfort came from the memory of how challenging it was to open the clinic initially and, for some, past experience pausing services; one clinic reflected that a two-week pause resulted in a $50,000-$60,000 loss in revenue; another clinic that paused for three weeks reflected on the large number of patients that needed services each day as well as the increase in patients needing services at higher gestational ages making service provision challenging for staff in the first few weeks after reopening.

The decision to pause or close services was not taken lightly as it carried operational consequences: clinics continue to incur costs with no revenue (maintaining payroll, paying for malpractice and other insurance costs, mortgage, rent, utilities, and security) and incur costs to re-open (re-licensing, inspections, contracts with vendors, and retraining staff). One administrator with experience closing and re-opening clinics estimated losses from having one clinic's services paused at the time of the interview to be around $200,000. They pointed out that several expenses are fixed – "*even if staff are laid off, that might only be 30% of the total expenses*." As such, many administrators reflected that they would not want to pause services for more than 10-30 days and in the case of two clinics, pausing for a long period of time would result in them not resuming services. One administrator who had paused services due to COVID-19 exposure felt that they were able to use their time effectively to prepare for re-opening.

COVID-19 places additional burdens on patients and providers

States and anti-abortion organizations have exploited the Covid-19 pandemic to file lawsuits and introduce executive orders deeming abortion "nonessential" in an attempt to functionally ban abortion care or close

abortion clinics. These actions add another layer of burden for clinics as they now have to split time and limited resources between care provision and engagement with lawsuits. One respondent reported being served lawsuit in Texas and Minnesota during this period. Beyond litigation, respondents report increased harassment in the form of complaints to the city, police, and health departments—resulting in more visits to the clinic to inspect and ensure safety protocols are being observed—and protestors. "*Our [protestor] activity has increased, unfortunately. Specifically during this time I believe because they feel abortion is nonessential. So uhm, I had the police come into our facility twice on Friday because they are getting reports that we are not being compliant with social distancing.*" Physical distancing guidelines, which limit the number of patients that can be in the clinic at a time, result in some patients having more contact with protestors as they wait for their appointments.

Legislation that threatens patient access in states like Texas and Louisiana has a domino effect for both providers and patients. For providers, recent bans on abortion provision during the pandemic resulted in some clinics closing and re-opening multiple times, leaving patients confused about the availability of the service in the state. For many, ensuing clinic closures or cancelled appointments increased wait times for an appointment, thereby increasing the cost and/or pushing some individuals to seek care out of state. "*There are waitlists at clinics, upwards of 100 at some clinics, some people are going to be past the deadline of what you can be seen in Texas for, so they have to go out of state.*" Clinic pauses or closures also resulted in individuals requesting assistance to travel to other states for care. *"As far as access, especially when we're thinking about states outside of our region: so the ups and downs that were happening in Texas, uhm, the executive orders that went down in Louisiana, uhm, we started to get calls from those two states particularly, (about) folks traveling within the SE region, where we actually serve, to get care. Some of it even looked like transporting folks from Texas to Atlanta to come and have an abortion."*

Lack of access at later gestational ages because of COVID-related service disruptions resulted in some patients traveling out of state for care. Some clinics that provide services at higher gestational ages, have fewer state-mandated requirements (such as two-day waiting periods), or that utilize processes that reduce patient burden (such as sending counseling and health education materials ahead by mail) have experienced an influx of patients. Border closures between states—because of COVID 19—also impacted patients' access to clinics as well as the range of clinics that the abortion funds could work with to ensure provision of care. Significant increases in abortion patients at fewer clinics reduces appointment availability and can increase the patient wait time between initial clinic contact and the abortion procedure itself. *"[..] before all this happened, [..] the wait time for surgical abortion was probably just a day—maybe two on busy times, but now because of how we have to stagger appointments it's a week wait time—or about a week. Patients are stressed out like everyone else. We definitely have our patients calling us hoping for a cancelation so they can get in sooner."*

Fear of exposure to COVID-19 has even prevented some patients from obtaining abortion care. One clinic serving mostly out-of-state abortion patients reported a decline in the number of patients, and an increase in the number of no-shows and appointment cancellations due to patient fear of traveling during the pandemic: *"As a I mentioned, patients will schedule and something weird will come out on the news and they'll call back and say, 'you know what, it's not a good time to travel' because they're afraid. They're afraid of exposure, of not having control, of outcomes."*

Additionally, one abortion fund reported that they observed a delay in persons accessing care because of an inability to get practical support such as transportation, accommodation, child care, etc. These supports are especially important for those traveling across state lines to receive care. This inability to get practical support is due to COVID-related concerns expressed by volunteer staff. While there has been an increase in the number of requests for overnight stays and transportation, there has been a significant reduction in volunteers offering rideshare, home stays, or child care.

Both abortion funds reported that while there was a lower volume of calls during the period of March 1-April 23, the amounts being requested for the procedure were significantly higher. They cite a few reasons for this change: 1) financial stressors—many patients report having lost jobs and therefore being unable to make any contribution towards the abortion cost; 2) clinic pauses or closures in their community, which can increase funds requested as patients seek services at clinics where the cost of the procedure is higher; 3)

increased requests for practical supports and shifts in the types of practical support needed for patients traveling across state lines; 4) an increase in the number of patients seeking assistance for a second-trimester abortion procedure, many of which need to travel out-of-state for care.

Resources are insufficient for clinics to continue providing services

While clinics have established innovative ways to stay in operation during the pandemic, many have exhausted existing resources to stay afloat. Most clinics have identified and sought/applied for multiple sources of emergency funding including Resources for Abortion Delivery (RAD) COVID relief funding, Small Business Association Payroll Protection Program loans, private sector donations, individual donations, and a multitude of grants. A few respondents reported that RAD grants helped them with payroll, and in one case, was used to upgrade a telephone system so that staff could work remotely during the pandemic. While these funds have been helpful, high monthly clinic operation costs and instituting COVID-related safety and operational changes quickly consumed their emergency funding. As one clinic administrator shared, the RAD emergency funding only lasted two weeks. *"[…] so how many people are going to go out on workers comp and say they became sick at work? That will mean our workers comp insurance doubles or triples. […]Those things are coming and when they come, they come fast. If you don't have the money in the bank-that's it. You close. […] The funding we're getting now is good now, but if I don't have help at that moment--we can't run without workers comp- and it happens fast."*

Of note, a few clinics are ineligible for many emergency funding grants and therefore have access to fewer resources. Clinics with financial reserves have had to use some of these funds, originally set aside for other purposes (ex. buying their building, building fences, upgrading IT infrastructure, etc.) to continue providing services. However, reserves are limited; one administrator with multiple clinics shared that they only had one week's cash reserves on hand. Finally, while some clinics have attempted to raise additional funds through social media, crowdfunding campaigns, and annual days of giving, they have not been able to raise enough funds through these mechanisms and are in need of additional funds to prevent their clinics from closing. *"This isn't unique to us, a lot of clinics are struggling. It would just be awful if […] it's not even SCOTUS or anti's that take out abortion in this country—but a virus, or at least drastically lower the number of providers because they can't afford to stay open. [..] this is a critical emergency for abortion services in our country—and an immediate one. If there are any funders out there who do want to help abortion, [..] now is the time to do it with emergency funding."*

Summary

Interviews with 12 independent providers and two abortion funds provide a detailed and troubling description disturbing picture of the impact of the COVID-19 pandemic on abortion provision and access over the course of a six-week period. The costs incurred to ensure patients and staff are safe, that staff are retained, and that service is maintained has meant many clinics are operating at a financial loss, or at a significantly greater financial loss than prior to the pandemic. Further, state border closures; legislation or executive action using the pandemic to ban abortion by asserting it is not an essential service; pandemic-related fears; and surrounding clinics pausing, closing, or reducing the gestational age at which they provide services has resulted in changes in 1) the patient population (with some clinics serving more patients from out-of-state or serving patients at higher gestational ages), 2) service provision (decreased volume, reduced staff, use of telehealth, new referral patterns), and 3) abortion access (reduced appointment availability, increased wait times, etc.). While clinic administrators could not definitively indicate how long they could operate carrying financial losses incurred as a result of COVID-19, many reflected that their sustainability was at risk and that pausing services during the pandemic had been or would be detrimental to their longer term sustainability, with the consequences being greater the longer services were paused. Supports such as telehealth and emergency funding, while beneficial, will be insufficient to keep clinics afloat. The benefits of telehealth were limited by the uncertainties about reimbursement and for some clinics the ability to move only some services to a virtual platform. Meanwhile, emergency funds were quickly depleted, leaving the clinic with gaps in funding for current and future operations. The breadth of impacts seen on independent abortion providers in this short time span shows the fragility of the health system for abortion care. To keep abortion clinics open and the service available to those who need it, short-term emergency support as well as long-term investments in sustainability and systems change are needed.

References

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Addendum I: COVID-19 related changes in abortion provision from March 1 – April 23, 2020 (N=16; *12 respondents representing 16 clinics)*

Clinic changes since March 1, 2020	n	(%)
Clinic Changes		
Procured PPE and other equipment to safeguard staff	16	100%
Implemented COVID-based patient procedures	16	100%
Procured additional cleaning products	15	94%
Changed hours of operation	10	63%
Temporarily closed clinic/paused services	5	31%
Changes to the building	1	6%
Changes in security	5	31%
Staff changes		
Reduced number/type of staff	9	56%
Trained staff to keep self/patients safe	15	94%
Decrease in availability of abortion providers	7	44%
Changes in use of advanced practice clinicians	4	25%
Changes in use of other staff	7	44%
Furloughed staff	5	31%
Shifted to staff working in shifts or team assignments	9	56%
Physicians continuing to travel	3	19%
Expanded staff to support patient logistics	2	13%
Offered support to clinic staff such as overtime pay, increased pay, or increased sick leave for self or family	6	38%
Implemented new HR procedures for symptomatic or sick staff	11	69%
Service Changes		
Reduced types of sexual and reproductive health services offered at clinic (i.e. no non-essential services)	7	44%
Reduced volume of SRH services provided	11	69%
Implemented new service delivery models (ex. telemedicine/telehealth)	10	63%
Paused SRH services	7	44%
Shifts in abortion services provided	11*	69%
Increase in later abortion procedures	4	25%
Temporarily discontinued in-clinic abortion procedures	1	6%
Increase in medication abortion procedures	4	25%
Increased gestational age for medication abortions to 11 weeks	4	25%
No later abortions or referring later abortion clients	3	19%
Changed clinic flow/ appointments	13	81%
Increased number of referrals (to and from the clinic) Decreased number of referrals (to and from the clinic)	5	31%
Discontinued clinic escort volunteer program	3	19%
Other		
Negotiated with insurance companies for increased coverage	3	19%
Increase in board meetings (4-5 times per week)	2	13%
Nearby non-ACN clinic changes impacting client volume		
Non-ACN clinic paused clinic operations	8	50%
Non-ACN clinic closed at the time of the interview	3	19%
Non-ACN clinic reduced the gestational age at which they provide services	2	13%

*At time of interview, one clinic was only providing medication abortion <10 weeks and later surgical abortions

Addendum II: Existing and anticipated financial challenges and strategies to address them
A summary of the existing financial challenges that clinics were facing in 2019, how they planned to address them in 2020, and what additional challenges they expected to face in 2020.

Existing financial challenges
Of the 16 clinics, two-thirds reported that they were already experiencing several financial challenges. The challenges clinics were facing included legal (needing to fight litigations, retain lawyer), recovering from previous closures, low rates of and/or delayed reimbursement from insurance such as Medicaid and/or abortion funds, absorbing discounts given to clients to ensure that clients' out-of-pocket costs are low, paying for additional security measures, maintaining clinic building, paying for traveling physicians, licensing costs to increase base of local providers, increased staffing costs, losing federal Title X funds, allocating funds to ensure compliance with state regulators, and costs related to operational learning (especially for newer clinics).

How clinics planned to address these challenges
Clinics have been addressing their financial challenges using several approaches including setting up crowdfunding accounts, applying for RAD funding and other grants, finding local providers, reducing discount levels, employing strategies to increase Medicaid reimbursement rates such as meeting with state department officials (to change facility fee), starting a non-profit to receive donations, and applying for loans to purchase office spaces that can enable lower operational costs in the long run.

Challenges anticipated in 2020
Most funds had not anticipated additional challenges apart from the ones already plaguing their systems. One respondent flagged that their existence could be threatened based on the outcome of the Supreme Court decision. Some had been saving up to upgrade their IT infrastructure, recruit local providers with admitting privileges, hire more clinic staff, update equipment, switch to electronic record systems, attend to building repairs and structural improvements, and expand services and space to bring in more revenue. Ironically, some of these changes such as updating IT, employing local providers, switching to an electronic system, expanding service and space, moving to a more cost-effective space, etc. could have helped the clinics be better equipped to face the pandemic.

Addendum III: State-wide restrictions its impact on abortion access
A summary of some of the existing state-level restrictions and new restrictions imposed as a result of COVID-19

Existing state policies
When discussing existing state policies that impact clinic operations, respondents mentioned 24-hour waiting periods and ultrasound laws as two major barriers to accessing care. Existing waiting periods are especially restrictive in this context because people have to go to clinics multiple times, which increases cost and risk of exposure for both staff and patient. One respondent shared:
"The stupid two-visit requirement is endangering people's health and their exposure to the coronavirus. It's no question. Everyone has to come in twice for an ultrasound and then wait 24 hours. It's a double visit that's exposing staff and the patient, it's making congestion in the waiting room unnecessarily, it's decreasing our ability to offer care to people because it's like tying up the waiting room when we could just be seeing only the abortioner."

New state-based abortion policies (March 1-April 23)

- In Texas, new regulations combined with existing regulations, have impacted access to care within the state and in surrounding states, as existing clinics in Texas have had to close and stop providing services. Between March 1 and April 23, many respondents reported an increase in out-of-state patients seeking care at their clinic due to changes in abortion policies in Texas.
- Recent regulations in Oklahoma will allow medication abortion only after patients test negative for COVID-19. Although this allows for partial abortion care, with limited access to tests in clinics, this continues to restrict access in Oklahoma and impact clinic operations.
- In Ohio, medication abortion is only allowed before ten weeks. Surgical abortions require documentation explaining why it is an "essential" procedure.

Impact on clinics in specific states
A respondent mentioned that the lack of finances have made clinic operation disruptions in Texas "ten times more stressful." Factors such as the lasting impact of HB2, the legal fights with the Supreme Court, and not having cash reserves make it very challenging for the clinic to weather disruptions brought about by the legal battles around abortion access in Texas during the pandemic. The respondent estimated a loss of $81,000 (March 1-April 23) to the clinic. If political disruptions continued, they were concerned that the losses in the Texas clinic would end up pulling down the other clinics (because the revenue from the Texas clinic was offsetting some of the costs associated with running the other clinics). The respondent also mentioned that if the service disruptions continued, they may not have sufficient funds for payroll.

A respondent from Oklahoma described how they had paused all abortion services for over two weeks, and then resumed only medication abortion. They are unable to see later abortion patients because abortions are classified as elective procedures and patients can only be seen if they test negative for COVID-19. Since the clinic is back-ordered on COVID-19 tests, they are unable to see later abortion patients.

A respondent owning a clinic in New Jersey mentioned the need for the clinic to be a licensed ambulatory service center and needing a physician-trained anesthesiologist (not an advance practice clinician) to provide second-trimester abortion. Since anesthesiologists are very expensive and the clinic does not generate enough revenue, they see losses to the tune of $250,000. The respondent expected this situation to only worsen during the pandemic.