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RESEARCH ARTICLE

Providing Family Planning Services at Primary Care Organizations after the Exclusion of Planned Parenthood from Publicly Funded Programs in Texas: Early Qualitative Evidence

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Objective. To explore organizations' experiences providing family planning during the first year of an expanded primary care program in Texas.

Data Sources. Between November 2014 and February 2015, in-depth interviews were conducted with program administrators at 30 organizations: 7 women's health organizations, 13 established primary care contractors (e.g., community health centers, public health departments), and 10 new primary care contractors.

Study Design. Interviews addressed organizational capacities to expand family planning and integrate services with primary care.

Data Extraction. Interview transcripts were analyzed using a theme-based approach. Themes were compared across the three types of organizations.

Principal Findings. Established and new primary care contractors identified several challenges expanding family planning services, which were uncommon among women's health organizations. Clinicians often lacked training to provide intrauterine devices and contraceptive implants. Organizations often recruited existing clients into family planning services, rather than expanding their patient base, and new contractors found family planning difficult to integrate because of clients' other health needs. Primary care contractors frequently described contraceptive provision protocols that were not evidence-based.

Conclusions. Many primary care organizations in Texas initially lacked the capacity to provide evidence-based family planning services that women's health organizations already provided.

Key Words. Uninsured/safety net providers, health policies/politics/law/regulations, qualitative research

In April 2017, President Donald Trump signed legislation nullifying a rule issued in December 2016 by the U.S. Department of Health and Human Services that prevented states from excluding qualified providers such as Planned Parenthood from the federal Title X program because such providers also offer abortion care (Department of Health and Human Services and Office of Population Affairs 2016; Hirschfeld Davis 2017). Title X funds, which support a network of nearly 4,000 clinics that provide contraception and screening for sexually transmitted infections (STIs) and reproductive cancers for low-income women and men, cannot be used for abortion services. The U.S. Congress also has proposed recent legislation that would exclude Planned Parenthood from receiving Medicaid funds, even though Medicaid only can be used to pay for abortions in very limited circumstances, such as pregnancies resulting from rape or to save a woman's life (Winfield Cunningham 2017). These actions follow a series of largely unsuccessful state-level bills aimed at removing Planned Parenthood's affiliated clinics from publicly funded programs (Guttmacher Institute 2016; Hirschfeld Davis 2017).

Proponents of this legislation assert that excluding Planned Parenthood would have little impact on women's health because these same services could be offered by community health centers (Lee 2017; Winfield Cunningham 2017). Although community health centers offer family planning in addition to preventive and primary health care, several recent studies indicate that they have a more limited scope of reproductive health services, offer a narrower range of contraceptive methods, and serve fewer family planning clients compared with specialized women's health providers such as Planned Parenthood (Frost and Hasstedt 2015; Carter et al. 2016). Additionally, recent estimates indicate that community health centers would have to double the number of contraceptive clients they serve if Planned Parenthood clinics, which serve 32 percent of those receiving publicly supported contraceptive services, were barred from receiving Title X and Medicaid funding (Frost and Zolna 2017). However, the extent to which community health centers could immediately respond to such policy changes by expanding their services and providing

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women with timely care is still unknown because many of the proposed measures to exclude Planned Parenthood have not gone into effect.

A notable exception is Texas, a state that has aimed to deliver family planning services largely through community health centers and other public agencies since 2011, while excluding Planned Parenthood clinics. In 2011, the Texas legislature cut the biennial family planning budget from $111 million to $38 million and allocated the remaining funds through a tiered priority system that favored primary care organizations (e.g., federally qualified health centers [FQHCs], public health departments) over specialized family planning providers, including but not limited to Planned Parenthood. Over the following 24 months, 25 percent of publicly funded clinics in the state closed or discontinued family planning services and 54 percent fewer clients were served (White et al. 2015). Moreover, the funding cuts and Planned Parenthood's exclusion from the state's Medicaid fee-for-service family planning waiver program in 2013 reduced access to long-acting reversible contraception (LARC), such as intrauterine devices (IUDs) and contraceptive implants (White et al. 2015; Stevenson et al. 2016), which are the most effective at preventing pregnancy.

In an effort to repair the reproductive health care safety net, the state legislature allocated $100 million during the 2013 legislative session to a new Expanded Primary Health Care (EPHC) program that was designed to integrate family planning and primary care. Participating organizations were required to provide contraceptive counseling and on-site access to reversible contraceptive methods for the majority of women they served through the program, but they also could use EPHC funds to cover diagnostic screening for reproductive cancers and testing and treatment for chronic diseases (Department of State Health Services 2015). The majority of EPHC-funded organizations were FQHCs and public health departments and hospitals (Department of State Health Services 2015). Nonprofit women's health organizations and maternal–child health centers also received funding from the program, but agencies affiliated with an organization that provides abortion were ineligible, which effectively excluded Planned Parenthood.

In this qualitative study, we explore primary care organizations' experiences providing family planning through the EPHC program in Texas following the exclusion of Planned Parenthood from public programs. Specifically, we compare strategies to expand and integrate family planning and primary care services during the first year of the program across women's health organizations and two categories of primary care organizations: those that had provided family planning services through state contracts before 2013 and those

that were new family planning contractors. The results from this study provide early evidence about how easily community health centers can expand services and can inform debates about how policies that would primarily rely on these organizations to provide reproductive health services may affect low-income women's access to care.

METHODS

In November 2014—one year after the EPHC program began—we invited executive and medical directors or an organization's family planning program administrator to participate in a one-time interview about how the receipt of EPHC funding affected service delivery. After mailing a letter describing the study, we contacted administrators by email and phone to answer questions and arrange an in-person or phone interview. We selected a sample of 34 of the 52 EPHC-funded organizations to participate. We included at least two organizations in each of Texas's eight health regions in our sample; in regions with large metropolitan areas and a greater number of contractors, we invited up to nine organizations to participate and included both small and large providers. To capture a diversity of perspectives on service delivery, we selected FQHCs ($n = 17$), county health departments and hospitals ($n = 9$), and maternal–child health centers and nonprofit women's health organizations ($n = 7$). A nonprofit community action agency that received EPHC funding also was selected.

Between November 2014 and January 2015, we conducted semistructured in-depth interviews with at least one and up to five employees at each organization who were involved with the agency's family planning program. We used a qualitative approach to explore in depth the strategies that organizations used to implement or expand their family planning program. The interview guide was based on known gaps in family planning services that followed the 2011 funding cuts, as well as potential challenges to offering contraception at primary care organizations that have been noted in other studies (Akers et al. 2010; Beeson et al. 2014; Hopkins et al. 2015; White et al. 2015). Specifically, the interviews explored how organizations began offering services through the EPHC program, the range of reproductive health services offered on-site or by referral, protocols for providing contraception that were informed by the U.S. Medical Eligibility Criteria for contraception (Centers for Disease Control and Prevention 2010), other sources of funding for women's health care (e.g., Title X, the state's Family Planning program, and

the state-funded fee-for-service Texas Women's Health Program [TWHP]), and approaches to address family planning clients' primary health care needs; we also asked new primary care contractors about any family planning services offered prior to receiving EPHC funds. Participants provided verbal consent to be interviewed and were not compensated for their participation. Interviews lasted 67 minutes, on average, and were audio-recorded. Recordings were transcribed, and we reviewed transcripts for accuracy against the original recordings and removed identifying information. The study procedures were approved by the authors' university institutional review boards.

We used thematic analysis (Braun and Clarke 2006) to examine organizations' experiences expanding and integrating family planning services with primary care during the first year of the EPHC program. The preliminary coding scheme was based on the interviewers' notes and other barriers and facilitators to service delivery that have been reported in the literature (Akers et al. 2010; Goldberg et al. 2015). Two study authors conducted successive rounds of coding in which they independently coded each transcript and met to review consistency in applying codes and resolve differences. They revised the codebook during the coding process to clarify definitions of codes and capture emerging themes. We used *NVivo* 10 qualitative software (QSR International Pty Ltd, Victoria, Australia) to code and manage the transcripts.

Next, we developed matrices to summarize and compare codes across three types of organizations: women's health providers (i.e., specialized family planning clinics, maternal–child health centers) that had participated in state family planning programs before 2013; established primary care contractors (i.e., FQHCs and health departments) that had participated in state family planning programs before 2013; and new primary care contractors, including the community action agency, that were first-time recipients of state family planning funds. We used this categorization because we hypothesized that organizations' initial capacities to expand and integrate services would be different (Wood et al. 2014; White et al. 2015). Finally, we organized codes into main themes related to changes and challenges in family planning service delivery, which we highlight below using representative quotations from respondents.

Results

We interviewed 72 administrators at 30 of the 34 organizations invited to participate. Seven were women's health organizations, 13 were established

primary care contractors, and 10 were new primary care contractors (Table 1). The women's health organizations operated a larger number of family planning service sites compared with the established and new primary care contractors, most of which had between one and three clinics that provided family planning. The majority of organizations had family planning sites in counties where a Planned Parenthood clinic was currently or previously located. Compared to established and new primary care contractors, a larger proportion of women's health organizations received $2,000,000 or more in EPHC funding. In addition to EPHC, all organizations participated in the state-funded fee-for-service TWHP, with the exception of one new primary care contractor. More women's health organizations and established primary care contractors received funding from Title X and the state Family Planning program than new primary care contractors.

Four main themes related to organizations' experiences providing family planning during the first year of the EPHC program were identified that demonstrate notable differences across the three organization types: capacity

Table 1: Organization Characteristics and Participation in Family Planning Programs, Texas, 2014–2015

	Established Women's Health Organizations (n = 7) n (%)	*Established Primary Care Contractors (n = 13) n (%)*	*New Primary Care Contractors (n = 10) n (%)*
Family planning service sites			
1–3 clinics	2 (29)	8 (61)	6 (60)
4–9 clinics	2 (29)	4 (31)	1 (10)
10–15 clinics	3 (43)	1 (8)	3 (30)
Location of family planning service sites			
County had a Planned Parenthood clinic	6 (86)	8 (61)	9 (90)
County did not have a Planned Parenthood clinic	1 (14)	5 (39)	1 (10)
Expanded Primary Health Care Award			
<$500,000	1 (14)	5 (38)	1 (10)
$500,000-$999,999	2 (29)	1 (8)	4 (40)
$1,000,000-$1,999,999	1 (14)	4 (31)	3 (30)
$2,000,000-$5,250,000	3 (43)	3 (23)	2 (20)
*Other family planning program funding**			
Texas Women's Health program	7 (100)	13 (100)	9 (90)
Title X	3 (43)	4 (31)	1 (10)
State Family Planning program	3 (43)	7 (54)	1 (10)

*Percentages exceed 100 because organizations could report receiving funding from more than one program.

to expand family planning services; reaching family planning clients; commitment to integrate family planning and primary care; and variation in contraceptive provision and protocols.

Capacity to Expand Family Planning Services

With EPHC funding, respondents across all organization types agreed that contraceptive methods were more widely available to low-income women, especially IUDs and implants that are more expensive than other reversible methods. Women's health organizations and established primary care contractors, which had curtailed provision of these methods between 2011 and 2013, often reported it was easier to keep a sufficient supply in stock. Many new primary care contractors began using EPHC funds to subsidize the cost of contraception that patients previously had to pay for out of pocket. Similar to program administrators at other newly funded organizations, an FQHC respondent noted this was particularly helpful for women who wanted IUDs and implants: "*the patients' inability to pay for the device was what was keeping them from getting that kind of contraception. But with this program, they were able to. So that was a plus for some of those patients*." However, respondents from several FQHCs that had established or new contracts commented that, despite additional funding and discount pricing, access to IUDs and implants was still somewhat limited because of the high cost of the devices.

Some new primary care contractors also experienced difficulties expanding organizational capacity to offer family planning. For example, in a community where the local Planned Parenthood clinic closed, the director of a public health organization explained: "*There was a big learning curve there, and honestly, we got very, very little guidance. . . We were in the dark, and it was like, 'Okay, so now we're going to start doing family planning. . . Where did you get the implantable birth control?*" The director of women's health services at another new primary care contractor commented that it took several months after receiving funds before her organization could begin serving family planning patients because "*they did not have instruments. . .They were doing some Pap smears here but not a lot. . . They did not know where to order IUDs. They did not have consent forms.*" She later noted that because of the challenges locating vendors, securing contracts, and ordering supplies, the EPHC program "*would have worked well in a place that was already established.*"

Additionally, both established and new primary care contractors often lacked providers who were trained to place and remove IUDs and implants. To comply with the EPHC requirement to offer these methods on-site,

administrators hired new clinicians that already had these skills or made arrangements to train existing staff. However, respondents reported that providers were not always trained to place both implants and IUDs, and therefore, they only offered one of these methods. Even after training, some did not feel competent and comfortable enough to insert the methods. As the administrator at a newly funded primary care organization explained: "*Everyone is trained [to place implants], but some of the people just have not ventured in trying to do them.*" Provider preferences further limited which methods were offered, as this same respondent noted: "*We've been most familiar with . . . ParaGard [copper IUD]. And that's the one that we chose to use over the Mirena [hormonal IUD].*" As a result of these factors, almost half of all primary care organizations were not routinely offering both IUDs and implants at their sites.

Reaching Family Planning Clients

Respondents from women's health organizations reported that they could easily meet the EPHC program's goals by providing contraception and counseling to their existing clients, which was bolstered by their current outreach and marketing activities. Administrators from two organizations that saw significant decreases in their client base following the 2011 funding cuts commented that they focused considerable effort on reconnecting women in the community to their services: "*We have our community health workers out trying to get our patient base back and then. . . we're going to start our marketing so that we can hopefully let our patients [know] we do have money and we're able to see them.*" Like several other women's health organizations, this agency also began serving former Planned Parenthood clients because they had funding to provide birth control methods women wanted, especially LARC methods, or follow-up services for abnormal cervical cancer screening results.

Respondents from established and new primary care contractors discussed using a range of strategies to expand their family planning client population during the first year. The women's health program administrator at an established FQHC contractor described a typical set of activities to enroll women in family planning services: "*We work internally in our clinics, giving presentations there. But when we are out in the community, we are working very closely with our school districts. . . with our Head Start Programs. . . We work with a lot of faith-based organizations.*" Enrolling existing primary care clients (i.e., in-reach) was the most commonly reported approach, and about one-third of the primary care organizations hired new community health workers to disseminate information about family planning services outside of the organizations' usual networks.

Despite these efforts, administrators at both established and new primary care contractors frequently reported that they served fewer contraceptive clients than expected in the first year of the EPHC program. Respondents from several newly funded agencies specifically noted that they did not see a large influx of former Planned Parenthood clients, even though these organizations were located in communities that had Planned Parenthood–affiliated clinics. As the administrator at one organization noted, this was due in part to limited participation in the fee-for-service programs that had covered care for many Planned Parenthood clients: "*They [Planned Parenthood] took Texas Women's Health program. We are currently not taking the Texas Women's Health program.*" She went on to explain that "*we're doing the eligibility [for TWHP] . . . Then we have to send them to a local physician, and we have enough in town to take the ladies, so they're not going without care.*" The program administrator at a newly funded FQHC in another community commented: "*We were hoping that we would pick up a lot of those ladies that had lost their care through Planned Parenthood and—it's not that we didn't pick some up, we did, but they were already our [primary care] patients.*" He later noted that the organization served far fewer former Planned Parenthood clients than expected because there was not sufficient funding for advertising to attract new patients or even to cover their existing clients' health needs.

Commitment to Integrate Family Planning and Primary Care

Program administrators at women's health organizations reported that they were able and eager to accommodate the EPHC program's focus on integrating family planning and primary care. Many expanded hypertension and diabetes screening and management, as well as addressing other urgent care needs that women had: "*You come for your Pap smear and you have pink eye or a sore throat or earache . . . I mean, they're very happy that you can do something beyond the usual. And we would have done some of that in the visit anyway, but with EPHC you could do more.*" However, when these organizations hired physician assistants and family nurse practitioners to expand primary care services, these new providers required more extensive training so they could address family planning with all women seeking care. The executive director at one organization explained how she oriented newly hired staff to this model of care: "*I told them 'Make sure that you do family planning with everybody. . . even if they're coming in because they're coughing and feeling sick,' you know, 'Well, what are you doing for birth control?' Because we need to integrate family planning into every single patient [visit].*"

In contrast, program administrators and clinicians at both established and new primary care contractors commented that they had to make a "*philosophical shift*" in how they provided services to meet EPHC program goals. Providers at these sites needed training about key content areas to address during family planning visits (e.g., sexual activity, contraceptive needs, and intimate partner violence) because this was not a routine part of their practice. The most common approach organizations adopted to make this change was an integrated care model, in which family planning was addressed in clinical encounters with any woman seeking primary care or reproductive health services. Administrators at established and new primary care contractors adopting this model often developed checklists for patient charts to prompt conversations about family planning and met regularly with staff to revise their strategies. The medical director at a newly funded FQHC that used this approach explained: "*I have created templates for EPHC patients for all the visits. . . .it is also like a tickler for the provider to remember to ask those questions and . . . address the contraceptive needs on every patient.*"

Other organizations adopted a more segmented care model, where women were routinely referred to the organization's designated women's clinics following a brief discussion of their family planning needs. This was often the case for women desiring IUDs and implants, as the respondent from an established FQHC contractor explained: "*We decided to have the MAs [medical assistants] ask the question [about birth control], and then . . .if all you need is condoms or something like that, the [internal medicine] doctor can take care of that. . . Like let's say you say 'I want the LARC,' and then they would take the young lady over and make the appointment at the women's center."* Although organizations' women's clinics were separate from primary care services, they were typically located in the same facility complex. However, some organizations did not have women's clinics at all sites in their network or did not offer IUDs and implants there, and women needing these services had to travel to a different location, sometimes more than 30 minutes away, to obtain care.

Furthermore, neither of these service models was consistently successful. Some respondents, particularly those at new primary care contractors, stated it was difficult to accommodate this new focus on family planning. They explained that this was because of their patient population's extensive primary care needs and time constraints to address a range of health concerns during a single visit, as noted by the administrator at an FQHC: "*We are seeing women that have a lot of medical issues coming in, and then a lot of those [family medicine] doctors start focusing more singularly on those issues*." Others also commented that their existing patients simply did not have a need or interest in contraception.

Therefore, clinicians only addressed health issues that women raised in the visit, as the nursing director at a newly funded public health agency noted: "*Usually, we rely on the patient to bring up issues like that. . . But it would not be typical to—say if you come in for blood pressure control and you want a refill—we will unlikely address any family planning during that visit.*"

Variation in Contraceptive Provision and Protocols

Protocols for providing contraception, particularly IUDs and implants, varied across the organization types. Respondents at women's health organizations more frequently described using evidence-based criteria and protocols for determining patient eligibility and providing methods than those at established and new primary care contractors. For example, women's health organizations followed U.S. Medical Eligibility Criteria and provided IUDs to teens and women who had not had children, but respondents from about one-third of established primary care contractors and one of the new primary care organizations stated that clinicians would not provide the method to these groups. At an established public health contractor, the family planning director explained: "*The doctors won't put any kind of IUD device in unless they've had at least one child. The Nexplanon [implant]. . .I think they are doing that for even some of the people that haven't had kids yet, [but] they all have to be at least 18 to begin with.*"

While respondents from the three types of organizations commented that clinicians preferred visits for IUD and implant placement to occur when women were menstruating to ensure that they were not pregnant, established and new primary care contractors less frequently offered same-day placements and instead required additional visits before insertion. Respondents usually explained that women needed to have the results from screening for chlamydia and/or gonorrhea infection before returning for another visit to get the device, even though this is not medically necessary. In a few cases, this requirement stemmed from misperceptions about the association between IUDs and pelvic inflammatory disease, but as the respondent from a new primary care contractor explained, this was not always the case: "*We know it is not required, but we feel better as a medical practice to make sure that there is no infection.*" As a result, some women made two or three visits before they could get one of these methods. At an established public health contractor, the family planning director detailed the protocol, implemented by several organizations, for providing interested women with an IUD: "*The STD test is usually done with their Pap smear when they decide that they may be interested in it. They get all of that done first and out of the way before they ever even go onto the education part of it,*" which she

noted required a second visit for intensive counseling and a third visit to get the method.

DISCUSSION

Previous studies have documented clear differences in family planning care provided by community health centers and other primary care providers compared to specialized family planning organizations, such as Planned Parenthood (Frost and Hasstedt 2015; Carter et al. 2016). This case study from Texas expands on these findings by demonstrating the challenges that can arise when primary care providers, particularly those with limited experience in reproductive health care, are expected to begin offering family planning services. Our interviews with program administrators also revealed that women's health organizations more easily adapted to the requirement of integrating family planning and primary care services during the first year of the EPHC program, pointing to the key role these providers have in the network of care for low-income women.

Unlike women's health organizations, primary care organizations in this study that were first-time recipients of family planning contracts reported numerous operational challenges to launching a family planning program, while other established primary care contractors experienced difficulties expanding reproductive health services they offered. These agencies often had to train staff about the sexual and reproductive health issues that need to be addressed when women presented at their clinics. Similarly, administrators had to reorganize the delivery of care and develop strategies that would facilitate the provision of family planning services. While many respondents embraced these challenges and welcomed the opportunity to provide holistic care to women, the leadership at other organizations found that it was difficult to accommodate this shift to integrate family planning and did not believe such a focus was realistic for their setting or patient population. The reasons they cited, such as women's perceived lack of need for contraception, competing service priorities, and reliance on patients to initiate discussions about contraception, correspond to other reports of primary care providers' barriers to contraceptive care (Lohr et al. 2009; Akers et al. 2010; Chuang et al. 2012). These findings suggest that even when funding is specifically tied to the provision of family planning, some community health centers and public health agencies may not be able to offer these services immediately and others may not readily adopt family planning at all into their model of care.

Like other studies (Beeson et al. 2014; Carter et al. 2016), we also identified more limited provision of LARC methods at primary care organizations —even established contractors—compared with women's health organizations. Clinicians who were already on the staff at these organizations often lacked training, and for some new contractors, clinician training was just one of many hurdles they faced starting a new family planning program. Even once providers were trained to place IUDs and implants, we found that not all of them felt comfortable offering these methods. As in other studies (Biggs et al. 2014; Luchowski et al. 2014; Biggs, Harper, and Brindis 2015), respondents at some of these organizations described protocols for providing these methods that were not evidence-based and instead restricted provision to adult women with children and required them to make multiple visits for medically unnecessary services. These practices are burdensome and may prevent women from obtaining timely access to the highly effective methods they would like to use to prevent pregnancy.

It is also worth noting that although most organizations had family planning service sites in counties where a Planned Parenthood clinic was located, administrators at several of the primary care organizations in our study reported they did not begin serving a large number of former Planned Parenthood clients. This may have been due to organizations' emphasis on recruiting their existing primary care clients into family planning services and their limited participation in the fee-for-service program, which covered many Planned Parenthood clients' reproductive health care. These results support other reports documenting a decline in the number of women served after Planned Parenthood was barred from participating in publicly funded programs in Texas, and the limited capacity community health centers may have to add new family planning clients (Stevenson et al. 2016; Frost and Zolna 2017; Texas Health and Human Services 2017). Although in some cases, women in these communities may have been referred to private practice clinicians that accepted TWHP coverage, such referrals may have led to delays in women obtaining needed care (Woo, Alamgir, and Potter 2016).

Community health centers, as well as public health departments, can be important partners in expanding the existing network of family planning providers and ensuring women obtain the reproductive health care they need. However, the more limited scope of family planning services currently offered by many of these agencies suggests that they will only be successful if they are provided with technical assistance to enhance and strengthen these services, such as skills training to provide a full range of contraceptive methods and education about evidence-based practices that will facilitate women's timely

access to care (Rosenbaum and Wood 2015; Carter et al. 2016). While it may take time for these organizations to develop this expertise, the current network of publicly funded women's health organizations already provides this type of care, and as evidenced by the current study, also more easily integrated family planning and primary care services and could provide more comprehensive care to new and existing clients.

A limitation of our study is that we only captured organizations' experiences during the first year of the EPHC program, and their capacity to serve clients may have strengthened over time. Also, we did not interview administrators from all organizations that received funding from the EPHC program. However, participating organizations received more than 80 percent of initial funding allocations and were diverse with respect to geography, size, and service models. Therefore, our results likely capture a wide range of experiences with this program in Texas. Finally, since this study was conducted, EPHC has been consolidated with the fee-for-service family planning program into the new Healthy Texas Women's program, which has reverted to a narrower focus on family planning. Future research is needed to assess how this programmatic change has impacted service delivery in the network of participating providers, which still excludes Planned Parenthood.

Although primary care organizations' experiences expanding family planning services in Texas are unique to the recent policy history and constellation of programs in that state, the challenges identified in this study foreshadow those that may arise if Congress succeeds in passing national-level legislation that prohibits Planned Parenthood from receiving federal funds. Because the fundamental shifts in practices that would be required to provide the same evidence-based care at many primary care organizations may not take place immediately, low-income women wanting to prevent pregnancy may be unlikely to obtain services when they need them. Therefore, to fulfill the goal that all low-income women have access to comprehensive reproductive health care, publicly funded family planning programs should continue to support a robust and diverse network of providers, including specialized family planning organizations.

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References

Akers, A. Y., M. A. Gold, S. Borrero, A. Santucci, and E. B. Schwarz. 2010. "Providers' Perspectives on Challenges to Contraceptive Counseling in Primary Care Settings." *Journal of Women's Health* 19 (6): 1163–70.

Beeson, T., S. Wood, B. Bruen, D. G. Goldberg, H. Mead, and S. Rosenbaum. 2014. "Accessibility of Long-Acting Reversible Contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs)." *Contraception* 89 (2): 91–6.

Biggs, M. A., C. C. Harper, and C. D. Brindis. 2015. "California Family Planning Health Care Providers' Challenges to Same-Day Long-Acting Reversible Contraception Provision." *Obstetrics & Gynecology* 126 (2): 338–45.

Biggs, M. A., C. C. Harper, J. Malvin, and C. D. Brindis. 2014. "Factors Influencing the Provision of Long-Acting Reversible Contraception in California." *Obstetrics and Gynecology* 123 (3): 593–602.

Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3 (2): 77–101.

Carter, M. W., L. Gavin, L. B. Zapata, M. Bornstein, N. Mautone-Smith, and S. B. Moskosky. 2016. "Four Aspects of the Scope and Quality of Family Planning Services in US Publicly Funded Health Centers: Results from a Survey of Health Center Administrators." *Contraception* 94 (4): 340–7.

Centers for Disease Control and Prevention. 2010. "U.S. Medical Eligibility Criteria for Contraceptive Use." *Morbidity and Mortality Weekly Report*, 59 Available at http://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf

Chuang, C. H., S. W. Hwang, J. S. McCall-Hosenfeld, L. Rosenwasser, M. M. Hillemeier, and C. S. Weisman. 2012. "Primary Care Physicians' Perceptions of Barriers to Preventive Reproductive Health Care in Rural Communities." *Perspectives on Sexual and Reproductive Health* 44 (2): 78–83.

Department of Health and Human Services and Office of Population Affairs. 2016. "Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients" *Federal Register* [accessed on January 21, 2017]. Available at

https://www.federalregister.gov/documents/2016/12/19/2016-30276/compliance-with-title-x-requirements-by-project-recipients-in-selecting-subrecipients

Department of State Health Services. 2015. "Primary Health Care and Expanded Primary Health Care Services: FY 2014 Annual Report." Available at https://www.dshs.texas.gov/phc/pdf/2014-PHC_EPHC-Report.doc

Frost, J. J., and K. Hasstedt. 2015. "Quantifying Planned Parenthood's Critical Role in Meeting the Need for Publicly Supported Contraceptive Care." *Health Affairs Blog* [accessed on January 21, 2017]. Available at http://healthaffairs.org/blog/2015/09/08/quantifying-planned-parenthoods-critical-role-in-meeting-the-need-for-publicly-supported-contraceptive-care/

Frost, J. J., and M. R. Zolna. 2017. "Response to Inquiry Concerning the Availability of Publicly Funded Contraceptive Care to U.S. Women, Memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee." Available at https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017

Goldberg, D. G., S. F. Wood, K. Johnson, K. (Holly) Mead, T. Beeson, J. Lewis, and S. Rosenbaum. 2015. "The Organization and Delivery of Family Planning Services in Community Health Centers." *Women's Health Issues* 25 (3): 202–8.

Guttmacher Institute. 2016. "Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2016" Guttmacher Institute [accessed on January 21, 2017]. Available at https://www.guttmacher.org/article/2016/07/laws-affecting-reproductive-health-and-rights-state-trends-midyear-2016

Hirschfeld Davis, J. 2017. "Trump Signs Law Taking Aim at Planned Parenthood Funding." *New York Times* [accessed on July 4, 2017]. Available at https://www.nytimes.com/2017/04/13/us/politics/planned-parenthood-trump.html?_r=0

Hopkins, K., K. White, F. Linkin, C. Hubert, D. Grossman, and J. E. Potter. 2015. "Women's Experiences Seeking Publicly Funded Family Planning Services in Texas." *Perspectives on Sexual and Reproductive Health* 47 (2): 63–70.

Lee, M. Y. H. 2017. "Paul Ryan's Claim That for Every Planned Parenthood Clinic, 20 Health Centers Provide Care." *Washington Post* [accessed on January 21, 2017]. Available at https://www.washingtonpost.com/news/fact-checker/wp/2017/01/18/paul-ryans-claim-that-for-every-planned-parenthood-20-health-centers-provide-care/

Lohr, P. A., E. B. Schwarz, J. E. Gladstein, and A. L. Nelson. 2009. "Provision of Contraceptive Counseling by Internal Medicine Residents." *Journal of Women's Health* 18 (1): 127–31.

Luchowski, A. T., B. L. Anderson, M. L. Power, G. B. Raglan, E. Espey, and J. Schulkin. 2014. "Obstetrician-Gynecologists and Contraception: Practice and Opinions about the Use of IUDs in Nulliparous Women, Adolescents and Other Patient Populations." *Contraception* 89 (6): 572–7.

Rosenbaum, S., and S. F. Wood. 2015. "Turning Back the Clock on Women's Health in Medically Underserved Communities." *Women's Health Issues* 25 (6): 601–3.

Stevenson, A. J., I. M. Flores-Vazquez, R. L. Allgeyer, P. Schenkkan, and J. E. Potter. 2016. "Effect of Removal of Planned Parenthood from the Texas Women's Health Program." *New England Journal of Medicine* 374 (9): 853–60.

Texas Health and Human Services. 2017. "HHS Women's Health Update, May 15, 2017." Available at https://hhs.texas.gov/sites/default/files//documents/about-hhs/leadership/advisory-committees/whac/zika-may-15-2017/whac-women-health-update-may-15-2017.pdf

White, K., K. Hopkins, A. R. A. Aiken, A. Stevenson, C. Hubert, D. Grossman, and J. E. Potter. 2015. "The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas." *American Journal of Public Health* 105 (5): 851–8.

Winfield Cunningham, P. 2017. "Planned Parenthood Defunded for One Year under GOP Health Bill." *Washington Post.* [accessed on July 4, 2017]. Available at https://www.washingtonpost.com/news/powerpost/wp/2017/05/04/planned-parenthood-defunded-for-one-year-under-gop-health-bill/?utm_term=.7241bb9a1f1a

Woo, C. J., H. Alamgir, and J. E. Potter. 2016. "Women's Experiences after Planned Parenthood's Exclusion from a Family Planning Program in Texas." *Contraception* 93 (4): 298–302.

Wood, S., T. Beeson, B. Bruen, D. Goetz Goldberg, H. Mead, P. Shin, and S. Rosenbaum. 2014. "Scope of Family Planning Services Available in Federally Qualified Health Centers." *Contraception* 89 (2): 85–90.

Supporting Information

Additional supporting information may be found online in the supporting information tab for this article:

Appendix SA1: Author Matrix.