Journal Pre-proof

Publicly funded family planning organizations' response to the COVID-19 pandemic in Texas

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PII: S1049-3867(22)00139-6

DOI: https://doi.org/10.1016/j.whi.2022.11.003

Reference: WHI 6894

To appear in: *Women's Health Issues*

Received Date: 11 April 2022

Revised Date: 3 November 2022

Accepted Date: 11 November 2022

Please cite this article as: Lerma K., Carpenter E., Chatillon A. & White K., Publicly funded family planning organizations' response to the COVID-19 pandemic in Texas, *Women's Health Issues* (2022), doi: https://doi.org/10.1016/j.whi.2022.11.003.

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Acknowledgments: The authors would like to thank Every Body Texas and the Texas Association of Community Health Centers for connecting us with organizations in their network. Kari White, principal investigator, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Funding: This research was supported by a grant from the Susan Thompson Buffett Foundation and a center grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (P2CHD042849) awarded to the Population Research Center at the University of Texas at Austin. Funders had no role in the study design; in the collection,

analysis and interpretation of the data; in the writing of the report; or in the decision to submit the article for publication.

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Manuscript Word Count

4658/4750

Abstract

Introduction

Following the onset of the COVID-19 pandemic, use of family planning services decreased, but there are limited data on how safety net providers were affected.

Methods

Between November 2020 and March 2021, we conducted in-depth interviews with administrators at health departments, federally qualified health centers (FQHCs), and specialized family planning organizations across Texas about pandemic-related changes in family planning services. We analyzed interview transcripts using an inductive thematic approach.

Results

Administrators at the 19 participating organizations described pervasive service disruptions. Some organizations closed for 6-8 weeks at the pandemic's onset due to safety uncertainties and difficulty interpreting Texas' March 2020 executive order prohibiting "non-essential" medical services; others later suspended services following staff exposures. Health departments and FQHCs commonly reduced family planning services to focus on COVID-19 response, leaving specialized family planning organizations to absorb displaced reproductive healthcare clients. Some of the advantages of service delivery modifications — including telehealth, curbside and drive-through prescription pickup, and medication-by-mail — were difficult to realize; barriers included low reimbursement, necessary patient exams, and clients' confidentiality concerns and lack of technological resources.

Conclusions

Texas' diverse network of family planning organizations illustrated a range of responses to the pandemic, and organizations often focused on their core missions—public health, primary care, or family planning.

Policy and Practice Implications

Where health departments and FQHCs play a large role in safety net family planning service delivery, reproductive healthcare may have been more disrupted. The sustainability of service modifications post-pandemic is not clear and will depend on supports available.

Keywords

Contraception

Family Planning

Reproductive Health

COVID-19 Pandemic

Telehealth

Contraceptive Access

Public Health

Introduction

The coronavirus disease 2019 (COVID-19) pandemic created widespread disruptions in health service delivery in the United States, including in reproductive healthcare. Providers made numerous shifts in their practices to continue offering contraception and other reproductive healthcare while limiting in-person contact, including adopting telehealth services, offering curbside prescription pick-up and self-administered injectable contraception, and deferring visits for non-urgent preventive care (Kaunitz, 2020; Keller & Dawson, 2020; Ranji, Frederiksen, & Salganicoff, 2020; Steenland et al., 2021; Stifani et al., 2021; Tschann, Lange, Ly, & Hilliard, 2020a, 2020b; Weigel et al., 2020; Burke, Sierra, Lerma, & White, 2022). Although health professionals recognized family planning as essential healthcare (Kaunitz, 2020), some temporarily suspended services to mitigate the spread of the virus or sharply curtailed the provision of some methods that required in-person visits, such as permanent and long-acting reversible contraception (Becker, Moniz, Tipirneni, Dalton, & Ayanian, 2021; Steenland et al., 2021; Tschann et al., 2020a, 2020b; Burke et al., 2022).

The pandemic exacerbated existing health inequalities and created new challenges for those living on low incomes due to widespread job loss and associated loss of health insurance (Bundorf, Gupta, & Kim, 2021; Office of Human Services Policy, 2021). Recent reports indicate that reduced access to family planning care was greatest among people living on low incomes and people of color (Kavanaugh et al., 2022; Lindberg et al., 2020). These changes, together with clients' concerns about attending in-person visits for care, contributed to documented decreases in contraceptive method visits and other reproductive health services in the beginning of the pandemic (Becker et al., 2021; Kavanaugh et al., 2022; Steenland et al., 2021; Tschann et al., 2020a, 2020b; Burke et al., 2022). The disparate effects may be related to a range of challenges that publicly funded family planning organizations experienced during the pandemic, about which there is limited information.

In this study, we explore how publicly funded family planning organizations in Texas adapted their services during the first year of the pandemic. In a state where approximately 25% of women aged 18-49 are uninsured (Kaiser Family Foundation), these safety net providers are critical to ensuring access to care. This network of organizations is diverse and includes academic hospitals, federally qualified health centers (FQHCs), health departments, and specialized family planning clinics. Texas, therefore, offers a useful case study through which to assess the varied impacts of the pandemic on organizations. Through in-depth interviews conducted with family planning administrators, we identify common changes to and challenges in delivering care and consider how these may have been shaped by differences in organizations' missions and scope of services. These findings help identify the resources needed to overcome new and persistent barriers to care and to sustain valued changes.

Materials and Methods

We contacted Texas organizations that received federal- or state-administered family planning funding to participate in an in-depth interview. Using a list of 90 funded organizations in fiscal year 2018 (the most recent year available), we stratified organizations across Texas' eight health service regions and, within each region, randomly sampled organizations based on probability proportional to size, where size was the number of clients served in the fiscal year. We included at least two organizations in each region and up to 10 organizations in regions that had a larger number of organizations. In total, 27 organizations were included in the initial sample.

In October and November 2020, we emailed leaders in each organization's family planning program to invite them to take part in the study. To participate, interviewees needed to be familiar with service delivery and with funding mechanisms in reproductive health programs. If

the individual contacted believed someone else at their organization would be a more suitable participant, they were asked to refer us to that person. We aimed to interview one individual per organization. We made five attempts at contact via email or phone. If we were unsuccessful, organizations were replaced with another from the same region to approximate proportional sampling. By this process, a total of 37 organizations were contacted during recruitment.

Data collection

The semi-structured interview guide explored each organization's response to COVID-19 and the observed impact on clinics, operations, and staff. Specifically, we asked about service delivery modifications and their sustainability and about changes to client volume and scope of services. Between November 2020 and March 2021, two researchers, trained to conduct in-depth interviews and familiar with reproductive healthcare delivery in Texas, conducted all interviews. Respondents provided verbal consent to participate and completed a 45-minute interview via web-based video conference or telephone. Respondents were offered a $50 gift card for participation. We audio-recorded, transcribed, and de-identified all interviews. The study was approved by the University of Texas at Austin Institutional Review Board.

Data analysis

We developed a codebook using an inductive approach that identified emerging themes in the transcripts. Two authors independently coded five transcripts, then met to confirm coding consistency and to refine coding definitions and add new codes to the codebook as necessary. They divided the remaining transcripts equally and coded them with the updated codebook. Once they had coded all transcripts, the research team examined common themes by organization type (e.g., academic hospital, health department, FQHC, or specialized family planning provider) to detect patterns and differences, and the coders developed coding memos

based on the coding reports. For this analysis, we focused on data that related specifically to pandemic onset service delivery changes. The remaining authors reviewed and provided feedback on these data, which served as the basis for the results. We used NVivo 12 for data management and coding.

Results

Of 37 contacted organizations, 18 did not participate; 10 were unable due to their COVID-19 response needs, five were unreachable, and three declined due to organizational policy. Overall, we completed interviews with 25 staff at 19 organizations: seven FQHCs, five health departments, five specialized family planning clinics, and two regional hospitals (Table). For three participating organizations, more than one staff member participated in the interview at the request of the organization. In these cases, the organization was typically large (consisting of more than one clinical site) and the interviewees had complementary expertise.

Table. Characteristics of participating publicly funded family planning organizations in Texas (n=19)

Type	**n**
Federally Qualified Health Center	7
Specialized Family Planning Organization	5
Health Department	5
Regional Hospital	2
Funding received[1]	
State and Title X Funding	13
State Funding Alone	6
Region	
North (Dallas/Fort Worth)	5
East/Gulf Coast (Tyler/Houston)	4
South/Rio Grande Valley (Harlingen/McAllen)	4
Panhandle and West (Lubbock/El Paso)	4
Central (Austin)	2

[1]State funding includes Healthy Texas Women and/or Family Planning Program funding.

We found that service disruptions, either early or later in the first year of the pandemic, were widespread among sampled organizations. Organizations generally pivoted to focus on activities consistent with their core missions (health departments and FQHCs on COVID-19 response, and specialized family planning organizations on reproductive healthcare). Respondents described that some of the advantages of service delivery modifications — including telehealth, curbside and drive-through prescription pickup and administration, and medication-by-mail — were difficult to realize.

Service disruptions

Respondents described a variety of service disruptions that, although temporary in most cases, adversely affected care. Nine facilities reduced services or closed at some point in the pandemic; four of these largely suspended reproductive health services or closed entirely for 6 to 8 weeks at COVID-19's onset. This stemmed from uncertainties around the safe delivery of routine healthcare during that period, as well as confusion about Texas' March 2020 executive order prohibiting "non-essential" medical services (Abbott, 2020), as respondents from two different health departments relayed. None of the organizations in the sample reported returning to full capacity following a service disruption. In some cases, organizations were not able to secure staffing to pre-pandemic levels and insufficient staffing limited the availability of services. One of these respondents explained:

> *When all this started back in March, we shut everything down like most everyone else did. We were pretty much shut down for that second half of March and most of April. I think we did start [scheduling] patients again in May with limited appointments and then also doing the curbside [services].*

Another common reason administrators cited for closures at the beginning of the pandemic was limited personal protective equipment (PPE). The ethics and logistics of obtaining PPE were complex, and providers wrestled with how to pay for these supplies: "*Like everybody else when it first began spreading, [we] struggled to find PPE. There were mixed*

messages from different funding streams, whether their money could be used to purchase PPE, which was very limiting." The family planning providers at FQHCs and health departments faced unique PPE challenges; some depended on PPE allocations or needed to ration their PPE supplies to maintain non-reproductive health services: *"We actually continue to have our shutdown because we were trying to make sure we were rationing enough PPE, the best that we could, to make sure those other [non-family planning] services were tended to."*

After supplies became more widely available in the summer and fall of 2020, organizations that suspended services did so primarily in response to staff members' COVID-19 exposures. Many administrators reported "*always feel[ing] short staffed,"* but when employees were out sick, staffing pressures were felt more strongly, forcing organizations to reduce services. Five organizations in areas with wide community spread of COVID-19 and staff exposures suspended all services for several weeks. One academic hospital provider reflected:

> *Our workforce is vulnerable just like everybody else, and most of the cases that we have had are from family members. What do you do if somebody in your family brings it home? I have two people out today who had a family member who had it, and technically the staff is exposed so that's a problem… We have to let them stay home.*

Many organizations paused annual exams and insertions of long-acting reversible contraceptives, as they had limited capacity for in-person appointments and reserved such appointments for time-sensitive or urgent medical issues. During this time of limited capacity, clients were triaged for immediate or emergent problems, such as treatment of a sexually transmitted infection or removal or replacement of long-acting reversible contraceptives. One organization described receiving client referrals for removal of long-acting reversible contraceptives because other facilities were not offering in-person appointments: "*We saw a good number of their patients who were having problems with IUDs and Nexplanon. We had to remove them. They couldn't get those removed themselves, and some of them were very upset that they couldn't get in to get these removed as quickly as they got them in."*

To protect outreach workers, some organizations paused or reduced community outreach activities that administrators had previously viewed as essential to connecting with clients and meeting their organizational missions to care for the underserved. An administrator at one of these organizations remarked:

> *[The pandemic] affected us a lot with our community outreach, because we have a real vast community outreach program. We usually do 50 to 60 outreach activities a year. We're always in the community [in non-pandemic times], and we have not been able to do that.*

Respondents expressed concerns that with curtailed outreach, community members might believe the clinic was closed or no longer providing services, therefore unnecessarily foregoing care. In response, administrators at several other organizations reported eventually adopting alternative outreach approaches to accommodate changed circumstances. As a specialized family planning provider described:

> *[Our community outreach program] was impacted because the community was in lockdown, and most clients assumed that we were closed… our [community health workers] were very creative in finding ways. They were wearing their gear and their face mask and everything. They even did door handlers with our information [that] if they [community members] needed to contact us, to call us, we were still open.*

Echoing this strategy, a health department respondent noted how outreach workers adapted:

> *The essential things that people in poverty use, gas stations, laundromats... We leave materials there… Gas stations are universal whether you're in poverty or not, but laundromats seem to be very specific to people because they can't afford a machine, so a lot of our people [clients] come through laundromats in the area.*

Creative problem-solving like this helped outreach programs continue to reach clients during the first year of the pandemic. Many respondents emphasized ongoing concerns in this area, however, and looked forward to a time when their outreach programs would fully recover.

Shifts in scope of practice to focus on organizational mission

In response to the pandemic, organizations often narrowed the scope of their services to focus on their core mission. Health departments and FQHCs largely focused on COVID-19 testing and contact tracing, then shifted to vaccine distribution. To do so, organizations "*pivoted a lot of people who could not perform their actual jobs that they were hired to do… to do other jobs that [the organization] needed them to do*." At some sites, this led to a reduction in the availability of reproductive health services, as one health department respondent reported:

> *They have been re-tasking us, asking us to cut back on our [family planning client] numbers because we have so many COVID cases in [the county] that I had to halve the number of the patients that I was seeing.*

These changes in organizational focus rippled through the provider network, as specialized family planning organizations, which largely did not shift to pandemic response, absorbed clients who might otherwise have obtained care elsewhere. Specialized family planning organizations reported that some health departments and FQHCs were referring more patients for services than they typically had before the pandemic's onset. One specialized family planning administrator explained this process:

> *When [the FQHC] got funding to do COVID — and the same thing with the health department — they redirected everything to this emergency. They closed their family planning, they weren't doing that…We had to fill in… Our job was not to take that patient away permanently, but just to help them at least in the meanwhile.*

Specialized family planning organizations also saw an influx of patients when other area providers closed entirely, as an administrator explained:

> *The [health department] closed and has not been opened since March [2020]. So every single person who typically went to the health department for STD [sexually transmitted disease] testing and treatment, is coming [here]... I bet we have had an increase of the new patients of 50%. It has just been absolutely crazy.*

Another health department participant emphasized that their organization was absorbing patients from shuttered private providers:

> *[Local OB/GYNs] closed for several different reasons. The main one because they didn't have any PPE or they were impacted, their staff. What we saw, what we experienced here was an increase on demand for services...We have a lot of walk-in patients looking*

> *for family planning services. Every day we have 2-4 patient looking for services, not just family planning, but women's health overall. It's been a challenging situation.*

In this way, changes in operations in one part of the network inadvertently but substantially affected other organizations' reproductive health workload, COVID-19 response, and capacity to provide walk-in services.

Initial transition to telehealth services

During pandemic onset, nearly all respondents' organizations moved to deliver services via telehealth. Many hoped that telehealth would permit continued service delivery at normal levels. Despite administrators' expectations for facilities and clients to "*take it [telehealth] by storm*," however, respondents described numerous challenges. Providers soon realized that some reproductive health services could not be provided remotely because they too often necessitated physical exams, in-person procedures, or other tests. As an FQHC administrator described:

> *I can tell you that for uptake around OBGYN services, it's not a really telehealth-friendly service. I think contraception, counseling, those things can be done. But the actual physical aspects of the things that go on in an OBGYN appointment cannot be addressed by telehealth.*

Additionally, because the transition to telehealth was so rapid, the initial rollout was difficult. An administrator at a specialized family planning organization detailed these early challenges, saying:

> *There's a lot of pivoting in the beginning. I think that was hard on all staff, not just our providers. It was a process. At what point, how much information does the medical assistant have to gather before the clinician gets on the phone? Do we have enough staff there so there could be a transition from that phone call handed over to the clinician? Or do we get into the, "Well, the clinician is not ready so she'll have to call you back." Then when the clinician called back, the patient wasn't there.*

As this quote illustrates, organizations that did not offer telehealth services prior to the pandemic had to quickly develop new procedures for consent, scheduling, and billing.

The implementation of telehealth, however, afforded the opportunity to move away from outdated practices and more often provide evidence-based services, such as contraception without an exam. An administrator at an FQHC described this shift, saying:

> *Medical practice in general changed, and things that they might have used to [say], "Oh no, you absolutely have to come in and I need to see you before I'll call in a refill," they're like, "No, it's only been six months, I'm okay with giving you another refill."*

Some of these changes required staff buy-in by emphasizing that staff were still providing high-quality care while keeping themselves and their clients safe from COVID-19 exposure. The administrator at a specialized family planning organization relayed their experience with this shift, stating:

> *During the pandemic, one of the things we told our providers is, "Normally, yeah, we want to have the labs, normally you want to have all that. This is not a normal time. We're going to have to make some exceptions that maybe somebody couldn't go get their labs, so give them another three months [of contraception]…You're going to have to do things different during this very unprecedented time. It doesn't mean you lower the quality of care, but we need to make sure that these people don't go without their medication that they need because that's also not good."*

In this way, shifting to telehealth during COVID-19 presented an opportunity for improving service alongside the corresponding challenges.

Despite substantial efforts to implement or expand telehealth, however, respondents frequently commented that a full telehealth approach faltered. Administrators considered the reimbursement rate for telehealth services to be too low to be sustainable. Additionally, many indicated that clients' technology barriers made scaling up difficult. Some clients lacked access to a smart phone or computer with the capability to run the telehealth software, to the necessary bandwidth to support video, or to cell or Wi-Fi service. As a specialized family planning

administrator noted, "*Some people don't have email. Some people aren't comfortable opening a document, particularly on their phones — because a lot of people don't have laptops or tablets*." Respondents also noted that, even without technology barriers, telehealth visits were more difficult for some. One reason was that clients did not feel comfortable describing their reproductive histories or current symptoms via phone or video. Among those who mentioned this was an administrator at a specialized family planning organization, who explained:

> *We tried telehealth, but it didn't really work well for our clients because a lot of them have privacy issues. They live in small homes or homes where there's not enough privacy, and the questions we ask are sensitive in nature, sexual histories and all that. Because a mother, a father, an uncle, a son or daughter might be in the next room and might hear some of the responses. That's what the women have told us.*

Respondents further commented that some clients preferred in-person care more generally, variation that providers often attributed to client demographics. Some stated that patients of color, and Latinx clients specifically, often preferred in-person visits because it helped them develop rapport and a sense of connection with their healthcare provider, especially for first-time encounters. An FQHC respondent reflected this view, saying:

> *I also think that there's some cultural aspects to that too. I think that people of color, they really do want the physician or provider to examine them. They want someone to lay hands on them and to say, "You're okay," or "They've checked me and I feel better." The telehealth doesn't provide that type of connection or that ability, so I do believe that there are many patients that still want that and telehealth can't provide that piece.*

Respondents also reported that "*younger patients are enthusiastic and [telehealth] comes more naturally [to them]*," and described older clients as less receptive to telehealth and facing more logistical and technological barriers.

Yet clients were not alone in their preference for in-person appointments: providers also desired a face-to-face connection. Beyond necessary physical exams, many providers described the need to evaluate the whole patient in person to best serve them. As one specialized family planning clinic director described:

> *We don't just care [about] physical [health], we care about the whole person. We'll look at someone, and if she just looks like something is off, we may even tell her to get dressed so we can have a conversation and find out what's going on in her life. Then usually, they break down crying, and we figure out what's going on. But sometimes, we're it, we're the only ones that the patient has to talk to.*

Respondents viewed this holistic assessment and ability to connect with clients in person as a necessary component of their jobs. As safety net providers, moreover, many emphasized their additional duty to connect clients with additional services, such as affordable housing, food assistance programs, and other supportive programs.

Creation of a hybrid model of care

Nearly all respondents noted that, to overcome concerns about and challenges to implementing telehealth and to mitigate COVID-19 transmission, their organization ultimately shifted to a hybrid model of care. They described conducting initial consultations by phone or video, gathering less sensitive information and evaluating eligibility for funding, followed by an in-person visit to address topics that required more privacy and provide services. Respondents explained that as early challenges to telehealth and hybrid models were addressed, services became more efficient for staff and clients, many of whom became more comfortable with new models of care. Notably, visits that previously took several hours were reduced to an hour or less, and clients responded positively to these changes. One health department respondent relayed:

> *They like that [telehealth] part of it, but it also minimizes the time that they have to take out of their day when they actually come for the visit. They just come in, they get their vitals, they do what they need to do, and they leave, and it's fast for them.*

This hybrid model also involved modifications to the delivery of other contraceptive services. Some organizations administered curbside contraceptive injections and distributed medications by drive-through, curbside pickup, or mail. One specialized family planning organization participant explained the wide range of options offered:

> *We do a lot of curbside services, we do pick up your supplies, we do the Depo shots [contraceptive injection]. You can receive services without having to come in the building.*

There was marked heterogeneity in the extent to which organizations relied on different low-contact approaches. While curbside contraceptive injections worked for several sites, some respondents noted drawbacks, such as maintaining patient confidentiality if the client was in the car with a family member. One health department respondent described a modified curbside approach, where "*patients come to the back door and the nurse would see them right there at the back door and either hand them their pills or give them their shot right there."* Other organizations allowed patients inside to pick up prescriptions but minimized contact by asking them to call ahead for phone-based medication counseling and to ensure the prescription was ready. Although no organizations initiated a new medication-by-mail service in response to COVID-19, those that already offered this service saw its use increase.

Although the hybrid model had some successes, respondents reported that challenges remained. These included logistical problems and other barriers to care that a hybrid model could not address. While remaining optimistic about the longer-term advantages of telehealth, for instance, an administrator at a specialized family planning organization explained:

> *I think for poor women… getting to a clinic is a huge barrier. They either have to drag children on the bus, find a ride, hire childcare — that's one problem we're still experiencing is, we tell patients now, "You're the only one who can come into the clinic for your visit." For a lot of women who have lost their jobs, lost their daycare, they have no one to leave their children with. This is a problem. We've even had a problem with women leaving children unattended in the car because they wanted to come in and be seen.*

As this quote illustrates, even a well-balanced combination of telehealth and in-person services cannot address all barriers to care faced by clients.

Discussion

This study adds evidence to the growing body of research establishing the importance of safety net providers during public health emergencies (Kavanaugh et al., 2022; Lindberg et al., 2020; Office of Human Services Policy, 2021; Ranji et al., 2020; Steenland et al., 2021; Burke et al., 2022) and details how family planning organizations serving people living on low incomes adapted their services to maintain access to care during COVID-19. Texas' reproductive healthcare environment, which features a diverse network of provider types, showcases the range of organizational responses. Health departments and FQHCs, for instance, reduced their reproductive health services in order to focus on COVID-19 response. In contrast and partly as a result, specialized family planning providers focused on filling the reproductive health access gap in their communities. In states where delivery of publicly funded family planning services is largely concentrated at health departments and FQHCs (Office of Population Affairs, 2022), therefore, safety net reproductive healthcare may have been especially disrupted by COVID-19. A recently published analysis of Texas Title X service delivery from the first year of the pandemic supports these findings and conclusions, as health departments had the greatest decline in encounters and specialized family planning providers accounted for a greater proportion of Title X encounters in the first year of the pandemic compared to the previous year (Burke et al., 2022).

Implications for Practice and Policy

Like many healthcare providers across the country (Kaunitz, 2020; Keller & Dawson, 2020; Ranji et al., 2020; Steenland et al., 2021; Stifani et al., 2021; Tschann et al., 2020a, 2020b; Weigel et al., 2020), those in our sample sought to quickly pivot to telehealth at the onset of the pandemic. However, organizations with limited telehealth infrastructure struggled to do so. Many sexual and reproductive health services, moreover, were viewed as ill-suited to telehealth because they are highly sensitive or require in-person care. These findings are consistent with prior reports that demonstrate that telemedicine accounted for only 20% of obstetrics and

gynecology visits during the first six months of the pandemic, compared to approximately half of gastroenterology, endocrinology, social work, psychology, and neurology visits (Patel et al., 2021). Furthermore, telehealth did not necessarily enable clients with limited access to or comfort with the necessary technology to get care (Weigel et al., 2020). Sustaining telehealth services after COVID-19 ends will therefore require technical assistance for organizations and client support. In order for the hybrid telehealth-in person model described here to continue after the pandemic, policy changes will be needed, such as increasing the reimbursement rate for telemedicine visits and addressing billing for hybrid care, which cannot be billed as two separate visits (Weigel et al., 2020). Reports of increased uptake of medications by mail also suggest that this should be a public health policy priority in the post-pandemic era to preserve Texans' access to care. Further, explorations of how to sustain person-centered, high-quality healthcare that offers the flexibility and efficiency of telehealth should be prioritized.

Our recruitment was limited by the COVID-19 public health emergency. Although many people we contacted were unable to participate due to ongoing pandemic response, we were nonetheless able to recruit a diverse group of providers from across Texas. Additional limitations include that these data only reflect the first year of the pandemic and that they do not include patient perspectives. More research is needed on patient preferences regarding non-traditional service delivery models, such as telehealth and hybrid visits, and barriers to such models.

Conclusion

We find that the pandemic substantially affected safety net family planning organizations in Texas. Reported challenges in delivering such care may help explain why people living on low incomes had reduced access to care during the first year of the pandemic. To ensure access to care as COVID-19 continues and once patients seek deferred care, public health practitioners,

469 researchers, and policymakers should identify patient-centered approaches to pandemic and
470 post-pandemic service delivery and support safety net providers in delivering that care.
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