XAVIER BECERRA
Attorney General of California
MICHAEL L. NEWMAN
Senior Assistant Attorney General
KATHLEEN BOERGERS
Supervising Deputy Attorney General
ANNA RICH, State Bar No. 230195
KARLI EISENBERG
BRENDA AYON VERDUZCO
Deputy Attorneys General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: 510-879-0296
Fax: 510-622-2270
E-mail: Anna.Rich@doj.ca.gov
Attorneys for Plaintiff State of California, by and through Attorney General Xavier Becerra

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

ALEX AZAR, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,

Defendants.

DECLARATION OF CLAIRE BRINDIS IN SUPPORT OF A MOTION FOR A PRELIMINARY INJUNCTION

Date:	April 18, 2019
Time:	12:30 p.m.
Dept:	Courtroom 5, 17th Floor
Judge:	The Honorable Edward M. Chen
Trial Date:	Not set
Action Filed:	March 4, 2019

I, Claire Brindis, declare that if called as a witness, I would testify competently to the following:

1. I am a Professor in the Departments of Pediatrics and Obstetrics and Gynecology and Reproductive Sciences at the University of California, San Francisco, where I have held positions as a researcher and faculty member since 1983.

2. I am a Founding Director of the Philip R. Lee Institute for Health Policy Studies. This Institute is an interdisciplinary health policy research unit that collaborates with universities, the private sector, government, and community-based organizations to address issues concerning health care delivery, access and quality of care, and health services outcomes. I have been associated with Center since its initiation and have served as one of its co-Directors since 2004, now Founding Director beginning in 2008.

3. I am a Director of the Bixby Center for Global Reproductive Health. This Center leads research and training programs around the world to improve reproductive health policies, treatment, and care guidelines around the world. I have been associated with this Center since its initiation and have served as one of its co-Directors since 2004.

4. I received a Master's Degree in Public Health in Maternal and Child Health, International Health, and Family Planning from the University of California at Los Angeles and a Doctoral Degree in Public Health (with a specialty in Behavioral Sciences) from the University of California at Berkeley.

5. A copy of my curriculum vitae is attached as Exhibit A.

6. My area of academic expertise is child, adolescent, and women's health policy. I have conducted research regarding reproductive health services for men and women, pregnancy and pregnancy prevention, and health care reform, among other topics. Of particular relevance, I served on the 2011 Institute of Medicine Women's Committee on Preventive Services for Women, which produced a report of recommendations for women's health, including an annual preventive health visit, counseling on sexually transmitted infections (STIs), and access to all Food and Drug Administration (FDA)-approved contraceptive services without copayment. I also served for nearly 20 years as the co-Principal Investigator for California's Family Planning,

Access, Care, and Treatment (PACT) Program, the state's Medicaid waiver program that provides family planning services to low-income men and women and one of the largest publicly funded therefore untreated sexually transmitted infections. I currently serve as the Principal Investigator for a National Institutes of Health-funded program, Building Interdisciplinary Research Careers in Women's Heath, which supports junior faculty conducting research aimed at improving women's health.

7. I have served as a research grantee, advisor, and/or consultant to a variety of federal government projects and agencies since 1983, including: member of the advisory panel for the U.S. Congress Office of Technology Assessment on Adolescent Health (1991); advisor to the Centers for Disease Control and Prevention (CDC) regarding adolescent pregnancy prevention efforts (1995-2000); member of the Adolescent Health Work Group, Maternal and Child Health Bureau, U.S. Department of Health and Human Services (DHHS) (1995-1996); member of the Steering Committee, Women's Health Panel, Bright Futures for Women's Health and Well-Being: National Guidelines Project, Maternal and Child Health Bureau, DHHS (2001-2002); member of the Technical Experts Advisory Committee for the Office of Population Affairs, Office of Family Planning, and CDC in connection with revision of the Title X Family Planning Program Guidelines, Adolescent Panel (2011). I have also served on several National Academy of Medicine Expert Committees on adolescents, young adult health, children and young adults with disabilities, women's health, and Title X.[1]

8. I have not been paid a fee for my work in connection with this case. I will be reimbursed for all reasonable and necessary out-of-pocket expenses incurred in connection with this engagement, such as travel expenses. This reimbursement is not contingent on the nature of my findings or conclusions, or on the outcome on this litigation.

9. On July 31, 2018, I submitted a comment letter in strong opposition to the proposed rule titled *Compliance with Statutory Program Integrity Requirements*, 83 Fed. Reg.

[1] *See* Inst. of Med., *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results* (2009), http://nationalacademies.org/hmd/reports/2009/a-review-of-the-hhs-family-planning-program-mission-management-and-measurement-of-results.aspx.

25,502 (proposed June 1, 2018), expressing my serious concerns from a public-health perspective in particular. That letter is attached as Exhibit B.

10. I have been asked to provide my opinion about the final rule "Compliance with Statutory Program Integrity Requirements," 84 Fed. Reg. 7714 (Mar. 4, 2019) (to be codified at 42 C.F.R. 59), (hereinafter "the Final Rule") published in the Federal Register on March 4, 2019, as it relates to this case, focusing on its public health consequences as well as impact on California and its Title X program.

11. In summary, my prior comments on the proposed rule apply with the same force to the final Rule. I have incorporated those prior comments here in my expert declaration on the Rule, updated with more recent data as appropriate. My conclusion is the same as before—and just as dire: The Final Rule would significantly and detrimentally alter Title X and put at risk the vital reproductive and other essential health care it has provided to millions of low-income individuals across the country for many decades.

I. The Final Rule

12. I am familiar with the Final Rule.

13. Among other things, I understand that the Final Rule imposes a gag on the medical profession that would have practitioners in the Title X program direct pregnant women toward continuing a pregnancy to term—regardless of what a patient actually prefers and needs. Among other things, this requirement would ban referrals for abortion while requiring referrals for prenatal care. It would further authorize biased and incomplete pregnancy counseling, and would compel speech from medical professionals when counseling on abortion. It would even limit *who* could counsel on abortion—imposing a speaker based prohibition on anyone but doctors or "advanced practice providers" ("APPs") from providing "nondirective pregnancy counseling," whether on abortion or otherwise.

14. I understand that the Final Rule also imposes "physical and financial" separation requirements on Title X providers that engage in so-called "prohibited activities"—essentially,

anything having to do with abortion—including speaking about or providing abortions with non-Title X funds.

II. The Final Rule Would Undermine Title X's Goal of Providing Comprehensive Family-Planning Services to Those Unable to Pay for Them

15. Over the course of its nearly 50-year history, the federal Title X program has proven successful in providing access to many important aspects of health care for low-income individuals. In 2017, Title X clinics[2] served 4 million patients nationwide, through a network of over 1,000 providers at 3,858 locations, with more than one million patients in California alone.[3] Most obviously, Title X programs have successfully provided a broad range of family planning services, including and especially contraceptives, to low-income women who would otherwise not have access to that care.

16. The standards that Title X programs have, prior to issuance of the Final Rule, been required to adhere to mandate delivery of non-judgmental, non-coercive family planning services and promotion of informed, voluntary decision-making. These include broadly accepted, evidence-based standards published by the U.S. Department of Health and Human Services and the CDC, "Providing Quality Family Planning Services," attached as Exhibit C.[4]

17. These Quality Family Planning recommendations are considered by the public health community to be the standard of care for all family planning practitioners. The American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Academy of Family Physicians all endorse non-directive options counseling as the most clinically appropriate role for family planning providers. This builds upon extensive research in the field of family planning counseling that supports that women want to be supported

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[2] Throughout this declaration, I use the term "Title X clinics" or "Title X providers" to refer to entities that have qualified for and received Title X funding according to the U.S. Department of Health and Human Services' evidence-based grant criteria in effect prior to the Rule.

[3] Christina I. Fowler et al., *Title X Family Planning Annual Report: 2017 National Summary* B-2 (2018), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[4] CDC, *Providing Quality Family Planning Services*, 63:4 Morbidity & Mortality Wkly. Rep., Apr. 25, 2014, available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

by family planning staff, but that they have the opportunity to make their own decision based upon information provided by their providers.[5]

18. The Quality Family Planning recommendations further recommend that providers offer a full range of FDA-approved contraceptive methods.

19. Access to a wide range of contraceptive methods is crucial for women's reproductive health, given their life course, ranging from primary prevention through inter-conceptual contraceptive needs and post-family formation, if in fact, they choose or are unable to bear children. Women often use multiple contraceptive methods in their lifetimes: 86% of women have used three or more methods by their early 40s.[6] Women rely on a variety of contraceptive methods and sometimes employ multiple methods simultaneously.[7]

20. Research shows that Title X-funding, when allocated according to program rules and criteria in effect before the Final Rule, succeeds in offering patients a wide range of contraceptive choices. Title X clinics are more likely than non-Title X family planning clinics to provide a full range of FDA-approved contraceptive methods: 72% of Title X providers offer the full range, compared with 49% of non-Title X clinics.[8] Title X clinics offer a choice among an average of 12 contraceptive methods on average, and 85% of Title X clinics offer at least one long-acting reversible contraceptive (LARC) method.[9]

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[5] *See* Edith Fox et al., *Client Preferences for Contraceptive Counseling: A Systematic Review*, 55 Am. J. Preventive Med. 691 (2018); Karen Pazol et al. *Impact of Contraceptive Education on Knowledge and Decision Making: An Updated Systematic Review*, 55 Am. J. Preventive Med. 703 (2018).

[6] Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982-2010*, 62 Nat'l Health Statistics Rep., February 14, 2013, https://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf.

[7] Megan L. Kavanaugh and Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14 (2017), https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[8] Mia R. Zolna & Jennifer J. Frost, Guttmacher Inst., *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols* 12 (2016), http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[9] *Id.* at 11.

21. LARC methods are widely recognized as the most medically effective and cost-effective forms of contraception.[10] LARC methods are highly effective, but come with high up-front costs for patients (over $1,000 per insertion) if unsubsidized.[11] Oral contraceptives could cost patients at least $50 per month ($600 per year) out-of-pocket.[12] Title X clinics' offerings of free or low-cost support enables very low-income women (up to 250% of poverty)[13] to make the contraceptive choice that is best for them, without facing the burden of making choices based upon their financial resources.

22. In California, Title X is complemented by the Family Planning, Access, Care, and Treatment (Family PACT) program, the state's Medicaid family planning expansion. Not all clinics that participate in Family PACT are Title X providers, but all Title X clinics in California are also Family PACT providers. Title X providers serve a disproportionate percentage of all Family PACT clients; in FY 2008-2009, Title X clinics represented only 13 percent of the clinics in the Family PACT network, but served half of all Family PACT clients.[14]

23. My research shows that, within Family PACT, Title X funding, as administered by California's long-time Title X grantee, Essential Access Health, results in family planning

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[10] Am. Coll. Obstetricians & Gynecologists ("ACOG"), *Committee Opinion No. 642, Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy* 2 (2015) (reaffirmed 2018), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co642.pdf?dmc=1&ts=20170629T1443175185 (characterizing implants and IUDs as among the most effective methods of contraception); James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5, 13 (2009); Paul D. Blumenthal et al., *Strategies to Prevent Unintended Pregnancy: Increasing Use of Long-Acting Reversible Contraception*, 17 Hum. Reprod. Update 121, 131 (2011).

[11] David Eisenberg et al., *Cost as a Barrier to Long-acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 J. Adolescent Health S59, S60 (2013), http://www.jahonline.org/article/S1054-139X(13)00054-2/fulltext.

[12] Planned Parenthood, How Do I Get Birth Control Pills?, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-do-i-get-birth-control-pills.

[13] The 2019 HHS poverty guidelines state $25,750 as the poverty level for a family of four. Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health & Hum. Svcs., *2019 Poverty Guidelines*, https://aspe.hhs.gov/2019-poverty-guidelines.

[14] Bixby Ctr. for Global Reprod. Health, *The Impact of Title X on Publicly Funded Family Planning Services in California: Access and Quality* 6 (2014), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/OPAreportRev_April2014.pdf.

providers that are more likely to participate in clinical training opportunities that help clinicians offer higher quality, evidence-based services and are more likely to use advanced technologies.[15]

24. Furthermore, my research shows that, within Family PACT, Title X funding leads to better access for clients to family planning services. A greater proportion of Title X providers than non-Title X public and private providers offered onsite services for the following birth control methods: intrauterine contraceptives (90% Title X, 51% public non-Title X, 38% private); contraceptive implants (58% Title X, 19% public non-Title X, 7% private); vasectomy (8% Title X, 4% public non-Title X, 1% private); and fertility-awareness methods (69% Title X, 55% public non-Title X, 49% private).[16]

25. Title X clinics in California's Family PACT program are significantly more likely to provide LARC methods, such as contraceptive impacts and intrauterine contraceptives, than non-Title X providers: the odds of a clinic providing LARC services are 35% less at public non-Title X clinics and 61% less at private clinics, compared to Title X clinics.[17]

26. Title X clinics are more likely to offer the option of insertion of a LARC in a single visit, without requiring the patient to make an appointment to return. Same-day insertion of LARC devices is an essential component of effective family planning because it eliminates the time and cost associated with follow-up visits and the risk that patients will be unable to return at a later time, or become pregnant in the interim.[18]

27. Title X clinics are more likely to provide contraceptives on site, helping women avoid a separate trip to a pharmacy or a repeat appointment: 72% of Title X clinics provide the pill on site, compared with 40% of non-Title X clinics.[19] The "quick-start" protocol for oral

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[15] *Id*. at 15.

[16] Heike Thiel de Bocanegra et al., *Onsite Provision of Specialized Services: Does Title X Funding Enhance Access?*, 23 J. Women's Health 428 (2014), https://www.liebertpub.com/doi/abs/10.1089/jwh.2013.4511. *See also* Bixby Ctr. for Global Reprod. Health, *supra* note 14 at 12.

[17] Bixby Ctr. for Global Reprod. Health, *supra* note 14 at 14.

[18] See ACOG, *Committee Opinion No. 615, Access to Contraception* 4 (2015) (reaffirmed 2017), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co615.pdf?dmc=1.

[19] Zolna & Frost, *supra* note 8, at 15, 19, 31.

contraceptives, wherein women start taking pill immediately rather than waiting until a specific point on their menstrual cycle (widely accepted by professional associations and experts), is more likely to be offered at a Title X clinic (87%) than at a non-Title X clinic (66%).[20] Title X clinics are also more likely than non-Title X clinics to supply contraceptives without requiring a pelvic exam: 88% of Title X clinics do not require a pelvic exam, compared with 76% of non-Title X clinics.[21] This practice follows clinical guidelines established by the World Health Organization and the American College of Obstetricians and Gynecologists.[22]

28. Title X funding helps clinicians receive training and spend time with patients to offer detailed contraceptive options counseling.[23] Title X clinicians spend more time on patients' initial visits for contraceptive care than clinicians at non-Title X clinics, particularly with patients who are younger, have limited English proficiency, or have other specific medical or personal needs.[24]

29. California's Title X providers are more likely than other publicly funded family planning providers to provide outreach services, and to offer extended clinic hours.[25] They are also more likely than other publicly funded family planning providers to provide sexual and reproductive health education to their communities.[26] Health education helps connect individuals to healthcare and information needed to support their reproductive health goals.

30. These data are all important because a patient's choice of a method of

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[20] *Id.* at 15, 17, 31.

[21] *Id.* at 17, 21, 31.

[22] World Health Org., *Selected Practice Recommendations for Contraceptive Use* (3rd. ed. 2016), https://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/; ACOG, *Committee Opinion No. 754, The Utility of and Indications for Routine Pelvic Examinations*, 132 Obstetrics & Gynecology e174 (2018), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co754.pdf.

[23] Adam Sonfield et al., Guttmacher Inst., *Moving Forward: Family Planning in the Era of Health Reform* 15 (2014), https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

[24] Jennifer J. Frost et al., Guttmacher Inst., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010* 15, (2012), https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

[25] Bixby Ctr. for Global Reprod. Health, *supra* note 14 at 15.

[26] *See* Bixby Ctr. for Global Reprod. Health, *supra* note 14.

contraceptive may be influenced by ease of access and on-site availability. Some patients are reasonably hesitant to choose a contraceptive method if it requires them to go to another site, and therefore will choose a less effective or perhaps, feel compelled to accept a more invasive method that is available on-site rather than facing barriers to accessing care elsewhere, such as transportation, scheduling challenges, lack of trust. Moreover, delayed access to care puts patients at greater risk of unintended pregnancy and sexually transmitted infections ("STIs"), including the complications that develop from belated detection. Thus, when providers do not provide all FDA-recommended methods or when they do so with delays, gaps in coverage may occur or a client may use a contraceptive method that is not her preferred choice or not the one that is most medically appropriate for her.[27] Title X providers have been very effective at preventing such gaps in coverage.[28]

31. Providing a range of contraceptive options helps Title X providers offer their clients more satisfactory methods of family planning, which in turn increases the effectiveness of contraception. Women who use a contraceptive method with which they are satisfied are more likely to use contraception correctly and consistently.[29] For instance, a study showed that only 35% of women who were satisfied with their use of oral contraceptives had skipped a dose in the previous three months, as compared to 48% of women who were unsatisfied.[30]

32. Current Title X provider practices reflect advances in contraceptive technology that have occurred in recent decades. Currently available LARC methods are now considered

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[27] Women may prefer specific methods not only because of their efficacy in preventing pregnancy, but also due to side effects, interactions with other medications, risk of sexually transmitted infections, and other considerations. Lauren N. Lessard et al., *Contraceptive Features Preferred by Women at High Risk of Unintended Pregnancy*, 44 Persp. on Sexual and Reprod. Health 194 (2012), https://www.guttmacher.org/journals/psrh/2012/09/contraceptive-features-preferred-women-high-risk-unintended-pregnancy.

[28] Adam Sonfield, *Why Family Planning Policy and Practice Must Guarantee a True Choice of Contraceptive Methods*, 20 Guttmacher Pol'y Rev. 103 (2017), https://www.guttmacher.org/gpr/2017/11/why-family-planning-policy-and-practice-must-guarantee-true-choice-contraceptive-methods.

[29] Jennifer J. Frost & Jacqueline E. Darroch., *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 Persp. on Sexual and Reprod. Health 94 (2008), https://www.ncbi.nlm.nih.gov/pubmed/18577142.

[30] *Id.*

easy to use, safe, long-lasting, quickly reversible, and highly effective in preventing pregnancy; they are also highly cost-effective over the long run, despite their up front cost.[31] Updated medical practice guidelines recommend their use for a majority of women of all ages.[32] Provider education and training makes a difference in the uptake of this highly effective form of birth control.[33]

33. The Final Rule puts all of this at risk. It would undoubtedly force clinics that currently provide the full range of contraceptive options out of the program—either because they would refuse to comply with the interference in the provider-patient relationship the Final Rule commands, or because they could not logistically and economically comply with the Final Rule's separation requirements, or both. Indeed, as Planned Parenthood itself made clear in comments on the proposed rule, *all* of its member affiliates and numerous States would be forced to withdraw from the Title X program if the Gag Requirement goes into effect. It would accordingly also eliminate a valuable resource to women who count upon their reproductive health provider as the entry point for any number of other medical services unrelated to reproductive health. And it would seemingly impose all of these hardships in service of emphasizing family-planning methods—such as natural family planning—that are universally regarded as ineffective.[34]

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[31] Donna Shoupe, *LARC methods: Entering a New Age of Contraception and Reproductive Health*, 1 Contraception & Reprod Med., Feb. 23, 2016.

[32] *See, e.*g., ACOG, *Committee Opinion No. 450: Increasing Use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, 114 Obstetrics Gynecology 1434 (2009); Am. Acad. of Pediatrics, *Policy Statement: Contraception for Adolescents*, 134 Pediatrics e1244, e1251 (2014).

[33] Tess L. Weber et al., *Exploring the Uptake of Long-Acting Reversible Contraception in South Dakota Women and the Importance of Provider Education*, 70 J. S. D. Med. Ass'n 493 (2017).

[34] *See* CDC, *Effectiveness of Family Planning Methods*, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf; *see also* Robert A. Hatcher, *Contraceptive Technology* 844-845 (21st Ed., 2018), available at http://www.contraceptivetechnology.org/wp-content/uploads/2013/09/Contraceptive-Failure-Rates.pdf; American Sexual Health Association, *Birth Control Method Comparison Chart* (2013), http://www.ashasexualhealth.org/pdfs/ContraceptiveOptions.pdf.

34. As I explained in my comment letter, when considering whether to finalize the proposed rule, the Department should have considered how the changes in Title X would undermine not only access to reproductive health care, but also to important primary health care screenings and referrals that many women depend upon, as well as the extent to which this impact would increase costs to the health care system.

35. As the Final Rule shows, HHS plainly failed to do so—largely ignoring or simply disregarding these serious health care consequences.

36. In my opinion, based on nearly four decades of work in this area, these public-health care consequences of the Final Rule will be numerous and severe. I focus on these in the sections below.

III. California Title X Clinics Are Diverse, and Include Clinics Specializing in Women's Health

37. California's diverse Title X provider network includes federally qualified health centers (FQHCs), community health centers, city and county health departments, hospitals, school-based health clinics, stand-alone family planning clinics, and Planned Parenthood affiliates. Each provider type plays an important role in enabling access to family planning services.

38. The Final Rule is clearly designed to make it impossible for reproductive health-focused providers, like Planned Parenthood health centers, to continue to serve people through the program. This is a grave public health mistake, one with far-reaching consequences.

39. High-quality, specialized women's health clinics, including Planned Parenthood affiliates and other specialty women's reproductive health clinics, are a valuable part of the Title X network. As the Guttmacher Institute has detailed, in 2015, Planned Parenthood facilities made up just 6% of publicly funded clinics providing contraceptive services, yet 32% of all female contraceptive clients who visited a publicly funded clinic visited a Planned Parenthood facility.[35]

[35] Jennifer J. Frost et al., Guttmacher Inst., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015* 1, 9(2017), https://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf. "Publicly funded clinic" is defined as "a site [that serves at least 10 contraceptive clients per year] that offers contraceptive services to the

40. A majority of women (6 in 10) who receive contraceptive services at a clinic focused on reproductive healthcare choose the specialist provider explicitly; for the remaining 4 in 10 women, the specialist reproductive healthcare clinic was their only healthcare provider in the past year, despite the presence of other healthcare providers in their communities.[36] Women explain their preferences for reproductive healthcare clinics by saying that "The staff here treat me respectfully" (84%), "Services here are confidential" (82%), and "The staff here know about women's health" (80%).[37]

41. Title X providers' focus on family planning and women's health issues serve an important function in the family planning network as models for evidence-based practice of reproductive healthcare.[38] The Final Rule will have the perverse effect of driving out some of the most effective health care providers from the Title X program, Planned Parenthood especially.

IV. The Final Rule Radically Underestimates the Costs That It Will Impose

42. Research has shown that consistent and correct use of contraception helps women avoid unintended pregnancies. Among women who are sexually active, but who do not want to become pregnant, only 5% of unintended pregnancies occur among women who consistently and correctly use contraception.[39]

43. Title X clinics help women achieve their desired timing and spacing of pregnancies. In 2015, Title X providers helped women avoid an estimated 822,000 unintended

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general public and uses public funds (e.g., federal, state or local funding through programs such as Title X, Medicaid or the federally qualified health center program) to provide free or reduced-fee services to at least some clients." "Female contraceptive client" is defined as "a woman who made at least one initial or subsequent visit for contraceptive services during the 12-month reporting period … includ[ing] all women who received a medical examination related to the provision of a contraceptive method, made supply-related return visits, received contraceptive counseling and a method prescription but deferred the medical examination, or chose nonmedical contraceptive methods."

[36] Jennifer J. Frost et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 Women's Health Issues e519 (2012), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2012.09.002.pdf.

[37] *Id.*

[38] Bixby Ctr. for Global Reprod. Health, *supra* note 14, at 15.

[39] Sonfield et al., supra note 23, at 8-9.

pregnancies, which would have resulted in approximately 387,000 births and 278,000 abortions.[40] The U.S. rate of unintended pregnancy would have been 31% higher, and the rate of teen unintended pregnancy would have been 44% higher, without the services provided by these Title X clinics.[41]

44. In 2017, Title X clinics served 3.1 million women at risk of unintended pregnancy, and 70% (2.2 million women) left their last appointment with either a most-effective contraceptive method (such as sterilization, implant or IUD) or a moderately-effective contraceptive method (such as the shot, the ring, the patch, or the pill).[42] These methods are far more effective at preventing pregnancy than the low-cost options that are available over the counter in a drugstore (such as make condoms and spermicide).[43]

45. Women who are able to time and space their pregnancies are able to focus on accomplishing their educational and professional goals. Title X clinics therefore support women's economic stability and advancement.[44] A survey conducted at Title X clinics in 2011 found that contraception helped 63% of women to take better care of themselves or their families, 56% to support themselves financially, 51% to complete their education, and 50% to obtain or keep a job.[45] The same survey found that 65% of women were seeking contraceptive care because they were unable to care for a baby or another baby, 63% were not ready to have children, 60% felt that contraception gave them control over their lives, and 60% wanted to wait to have a child until their lives were more stable.[46]

46. Access to contraception is associated with economic benefits and reduced incidence of adverse mental health conditions. Women's ability to use oral contraceptives is

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[40] Frost et al., *supra* note 35, at 1, 10.
[41] *Id.* at 1.
[42] Fowler et al., *supra* note 3, at ES-2, 30.
[43] Hatcher et al., *supra* n.34.
[44] Urban Inst., *'Birth Control is Transformative': Women Share Their Experiences with Contraceptive Access* (2019), https://www.urban.org/sites/default/files/publication/99912/birth_control_is_transformative_1.pdf
[45] Jennifer J. Frost & Laura Lindberg, *Reasons for Using Contraception: Perspectives of U.S. Women Seeking care at Specialized Family Planning Clinics*, 87 Contraception 465 (2013), https://www.ncbi.nlm.nih.gov/pubmed/23021011.
[46] *Id.*

correlated with their ability to obtain higher levels of education, participate more fully in the workforce, and receive more pay—a combination that has helped reduce the gender pay gap.[47] Indeed, one study shows that proximity to Planned Parenthood was associated with higher rates of high school completion among adolescent girls, one of the major drivers in preventing poverty.[48]

47. And since contraception assists women to decide whether and when to have children, it may help individuals avoid the increased instances of depression and anxiety and the decreased sense of happiness that accompany births from unintended pregnancies.[49]

48. Conversely, unintended pregnancies carry increased risks. There are several risks to infants and mothers that occur more frequently with unintended pregnancies than with planned pregnancies. In some instances, preexisting health conditions, such as having recently given birth, obesity, or diabetes, make it important for women to be able to delay becoming pregnant.[50] If women with these conditions become pregnant before the conditions are properly managed, they risk pregnancy loss, stillbirths, pre-term births, fetal growth that is either too small or too large relative to gestational age, birth defects, and increased risk of hypoglycemia (low blood

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[47] Martha J. Bailey & Jason M. Lindo, Nat'l Bureau of Econ. Research, *Access and Use of Contraception and Its Effects on Women's Outcomes in the U.S.: NBER Working Paper 23465*, (2017); Adam Sonfield et al., Guttmacher Inst., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children* 7-17 (2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[48] R. Alta Charo, *The Trump Administration and the Abandonment of Teen Pregnancy Prevention Programs*, 177 JAMA Internal Med. 1557 (2017).

[49] Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Studies in Family Planning 18 (2008), https://www.ncbi.nlm.nih.gov/pubmed/18540521.

[50] ACOG, *Committee Opinion No. 654, Reproductive Life Planning to Reduce Unintended Pregnancy* 127 Obstetrics & Gynecology 415 (2016), https://www.ncbi.nlm.nih.gov/pubmed/26942389 ,; ACOG, *Frequently Asked Questions No. 182, Obesity and Pregnancy* (2016), https://www.acog.org/-/media/For-Patients/faq182.pdf?dmc=1&ts=20170630T0349076575; ACOG, *Frequently Asked Questions No. 142, Diabetes and Women* (2016), https://www.acog.org/-/media/For-Patients/faq142.pdf?dmc=1&ts=20170630T0346285947.

Planned Parenthood discusses such conditions with patients to help inform physicians' and patients' discussions regarding timing and planning for a safe pregnancy. Planned Parenthood, *Pre-Pregnancy Health*, https://www.plannedparenthood.org/learn/pregnancy/pre-pregnancy-health; *see also* Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives, Family Planning, Overview, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning (regarding importance of pre-conception care).

sugar) or respiratory distress for the baby.[51] In addition, pregnant women who are obese may be at increased risk for a variety of adverse health outcomes, including increased instances of gestational diabetes and sleep apnea, and an increased risk for cesarean delivery.[52]

49. The effects of unintended pregnancies on infants after birth may persist into childhood and even adulthood. For example, children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, and they have lower educational attainment and more behavioral issues in their teen years.[53] Infants who are born to mothers who are overweight or obese (whether those pregnancies were intended or unintended) may have higher body mass indexes into adulthood, and infants who are born to mothers with diabetes may experience long-term risks of obesity, cardiovascular disease, and renal disease.[54]

50. In addition, because women experiencing an unintended pregnancy may not immediately be aware that they are pregnant, they are more likely to receive prenatal care only later in their pregnancies—or not at all.[55] They are also more likely during their pregnancies to smoke and consume alcohol, experience depression, and be victims of domestic violence.[56]

51. The Final Rule will undermine these benefits of access to contraception and family planning services. Meanwhile, the Final Rule radically underestimates the costs it will impose on

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[51] *See* ACOG sources cited *supra* note 50.

[52] ACOG, Frequently Asked Questions No. 142, *supra* note 50.

[53] Office of Disease Prevention and Health Promotion, *supra* note 50.

[54] Liliana Garcia-Vargas et al., *Gestational Diabetes and the Offspring: Implications in the Development of the Cardiorenal Metabolic Syndrome in Offspring*, 2 CardioRenal Med. 134, 136-38 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3376343/pdf/crm-0002-0134.pdf.

[55] Diana Cheng et al., *Unintended Pregnancy and Associated Maternal Preconception, Prenatal and Postpartum Behaviors*, 79 Contraception 194, 196 (2009).

[56] *Id.*; *see also* ACOG, Committee Opinion No. 654, *supra* note 50; Mary K. Ethen et al., *Alcohol Consumption by Women Before and During Pregnancy*, 13 Maternal Child Health J., 274, 278-79, 281 (2009), https://www.ncbi.nlm.nih.gov/pubmed/18317893; Christie A. Lancaster et al., *Risk Factors for Depressive Symptoms During Pregnancy: A Systematic Review*, 202 Am. J. Obstetrics & Gynecology 5, 11 (2010), https://www.ajog.org/article/S0002-9378(09)01014-X/pdf; Lois James et al., *Risk Factors for Domestic Violence During Pregnancy: A Meta-Analytic Review*, 28 Violence & Victims 359, 368-69 (2013), https://www.researchgate.net/publication/249995549_Risk_Factors_for_Domestic_Violence_During_Pregnancy_A_Meta-Analytic_Review.

patients, providers, and society, given the increase an unplanned and mistimed pregnancies it will likely cause.

52. That increase is a near certainty under the Final Rule—and indeed it is practically the Final Rule's goal, given in my view its solicitude for low-efficacy family planning methods like "natural family planning or other fertility awareness-based methods." 84 Fed. Reg. at 7,787 (to be codified at 42 C.F.R. § 59.2). Patients who lose access to contraceptive services at current Title X clinics are likely to use less effective forms of birth control. For example, in a study encompassing a variety of clinic types participating in California's publicly funded family planning program ("Family PACT"), individuals were asked what they would do if they had to pay for their family planning services.[57] Responses indicated that, on the whole, patients would use less effective means of contraception. Specifically, patients reported that their use of low-efficacy methods, such as condoms, would nearly double (from 25% to 46%).[58] Patients' projected use of medium-efficacy methods, such as contraceptive injections, oral contraceptives ("OCs"), and the contraceptive patch and ring, would decrease from 63% to 44%.[59] Patients' use of high-efficacy methods, such as IUDs, contraceptive implants, and sterilization, would decrease from 11% to 7%.[60] And use of no method of birth control at all would increase from 2% to 3%.[61]

53. It is no surprise that this decrease in the use of high-efficacy contraception methods and increase in use of low-efficacy methods will result in more unintended pregnancies. High-efficacy methods have failure rates of less than 1%, meaning that fewer than 1% of women using these methods will experience an unintended pregnancy within the first year of use.[62] Medium-efficacy methods have failure rates of 6-12%, because some women miss or delay

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[57] M. Antonia Biggs et al., Bixby Ctr. for Global Reprod. Health, *Findings from the 2012 Family PACT Client Exit Interviews* 53 (2014), http://www.familypact.org/Research/reports/10-24-2015CEI-Report.pdf.

[58] *Id.* at 53. Low-efficacy methods include condoms, diaphragms, and other barrier methods; natural family planning; abstention; and emergency contraception. *Id.*at 34.

[59] *Id.* at 34, 53.

[60] *Id.*

[61] *Id.* at 54.

[62] CDC, *supra* note 34; ACOG, Committee Opinion No. 642, *supra* note 10, at 2.

injection or ingestion of the pill.[63] Low-efficacy methods, including male condoms, have failure rates of 18% or higher.[64] Using no method of contraception has a failure rate of 85%.[65] These failure rates explain why the Guttmacher Institute estimated that in 2015, Planned Parenthood's provision of contraceptive services averted approximately 430,000 unintended pregnancies.[66]

54. This projected increase in unintended pregnancies is not speculative. It is rooted in experience. For example, after the State of Texas severely restricted public funding for family planning and excluded Planned Parenthood from its publicly funded family planning programs, a study in the New England Journal of Medicine reported a 35% decline in women using the most effective methods of family planning and a 27% increase in births among women who had been using an injectable contraceptive methods prior to Texas's restrictions.[67] The same study showed that the number of claims submitted for LARC contraceptives in counties where Planned Parenthood affiliates were located decreased sharply.[68] Researchers concluded that their

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[63] CDC, *supra* note 34; ACOG, Committee Opinion No. 642, *supra* note 10, at 1-2.

[64] CDC, *supra* note 34; ACOG, Committee Opinion No. 642, *supra* note 1010, at 2.

[65] James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397, 398 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638209/pdf/nihms458000.pdf.

[66] Guttmacher Inst., *Unintended Pregnancies and Abortions Averted by Planned Parenthood*, https://www.guttmacher.org/infographic/2017/unintended-pregnancies-and-abortions-averted-planned-parenthood-2015; s*ee also* M. Antonia Biggs et al., Bixby Ctr. for Global Reprod. Health, *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, at 16, 17 (2010), https://www.ansirh.org/sites/default/files/publications/files/familypactcost-benefitanalysis2007_2010apr_featured.pdf (in California, across all publicly funded contraceptive providers—including Planned Parenthood—it was estimated that, for every seven women who received publicly funded contraceptive services, two pregnancies were averted. There, in one year, it was estimated that provision of contraceptive services to 998,084 clients averted 286,700 unintended pregnancies).

[67] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. Med. 853, 858 (2016), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1511902. *See also* Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 Am. J. Pub. Health 851, 851 (2015). White and colleagues describe how, in 2011, prior to Planned Parenthood's outright exclusion from Texas's publicly funded family planning program, Texas substantially cut public funding for family planning providers and imposed a priority system of reimbursement for services that placed certain providers, including Planned Parenthood, at the bottom of the hierarchy. In the year following those cuts, 54% fewer clients received publicly funded family planning services. *Id.* at 855. Providers suspected that clients stopped seeking reproductive health care. *Id.* at 856.

[68] Stevenson, *supra* note 67, at 856-58.

"analyses suggest that the exclusion of Planned Parenthood affiliates from the Texas Women's Health Program had an adverse effect on low-income women in Texas by reducing the provision of highly effective methods of contraception, interrupting contraceptive continuation, and increasing the rate of childbirth covered by Medicaid."[69]

55. Iowa enacted similar restrictions in 2017. In April through June 2018, the state's family planning program covered only 970 family planning services like contraception, a 73% drop from the 3,637 services provided in the same period of the previous year, when Planned Parenthood and other similar providers were included in the program.[70] Additionally, the total number of patients enrolled in the program dropped 51% year-over-year, to 4,177 in June 2018 from 8,570 in June 2017.[71]

56. The fiscal costs of these additional unintended pregnancies are immense. In 2010, approximately $2.2 billion in public funds were spent on family planning and related sexual and reproductive health services (such as STI testing).[72] Those services were estimated to have averted approximately 2.2 million unintended pregnancies, among other adverse health outcomes.[73] The estimated public costs associated with those unintended pregnancies and outcomes—*i.e.*, maternity care, birth, child health care through 5 years of age, miscarriages or abortions, and treating the effects of undetected STIs—would have been $15.8 billion, $15.2 billion of which is attributable to publicly covered maternity and child health care.[74] Accordingly, publicly funded family planning and related care saved $13.6 billion in public

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[69] *Id.* at 858-59.

[70] Tony Leys & Barbara Rodriguez, *State Family Planning Services Decline 73 Percent in Fiscal Year as $2.5M Goes Unspent*, Des Moines Register, Oct. 18, 2018, https://www.desmoinesregister.com/story/news/health/2018/10/18/iowa-health-care-family-planning-contraception-services-planned-parenthood-abortion-medicaid/1660873002/.

[71] *Id.*

[72] Jennifer J. Frost et al., Guttmacher Inst., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 696 (2014), http://www.ncbi.nlm.nih.gov/pubmed/25314928.

[73] *Id.* at 692.

[74] Id. at 668, 696. The average public cost per birth, from prenatal care through infant care through 12 months of age, is $12,770. *Id.* at 712.

costs.[75] In other words, for every public dollar spent on contraceptive care, the public saved $7.09 in costs associated with unintended pregnancies and other reproductive health issues (through age 5).[76] To give another example, in 2007 California's Family PACT averted 286,700 unintended pregnancies that saved the state over $4 billion from conception to age 5 in the form of public-sector health care and social services.[77] For every public dollar spent on contraceptive care in California that year, the public saved $9.25 in costs associated with unintended pregnancies (through age 5).[78]

57. The Final Rule will not only raise the rate of unintended pregnancy, it will likely cause more abortions. It will do so by encouraging low-efficacy methods of family planning and decreasing access to contraceptives and, therefore, increasing unintended pregnancies. Studies show that, as the rate of contraceptive use by unmarried women increased in the U.S. between 1982 and 2001, rates of abortion for unmarried women also declined.[79] A study regarding California's Family PACT program estimated that the provision of contraception to approximately one million women and 100,000 men through that program in 2007 prevented approximately 122,200 abortions.[80] Similarly, when Iowa increased access to contraceptive services over the course of 2006 to 2008, studies found lower abortion rates.[81] It is likely that a decrease in contraceptive use will not only raise the rate of unintended pregnancy, then, but also raise the rate and number of abortions.

58. According to HHS, the Final Rule is justified in part because it would increase the availability of family planning methods such as "sexual risk avoidance" and "natural family planning." However, these family planning methods are universally regarded as ineffective and

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[75] *Id.* at 696.
[76] *Id.* at 668, 696.
[77] Biggs et al., *supra* note 66, at 23.
[78] *Id.* at 20.
[79] Heather D. Boonstra et al., Guttmacher Inst., *Abortion in Women's Lives* 18 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf.
[80] Biggs et al., *supra* note 66, at 6, 16.
[81] M. Antonia Biggs et al., *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 Contraception 167, 169 (2015), https://cloudfront.escholarship.org/dist/prd/content/qt9md7v7sn/qt9md7v7sn.pdf (study included 78 service sites, 24 of which were affiliated with Planned Parenthood).

inferior to the wide range of medically-approved alternatives, and would not promote public health.

59. The Final Rule would impose costs associated with loss of Title X health centers' access to testing, counseling, and treatment for sexually transmitted infections (STls) and reproductive cancers.

60. In 2017, Title X providers tested 61% of all female patients under age 25 (939,900 individuals) for chlamydia and performed 2.4 million gonorrhea tests, 1.2 million HIV tests, and 700,000 syphilis tests.[82] Of the HIV tests that were performed, 2,200 were shown to be positive.[83]

61. According to estimates from Guttmacher Institute, these STI services alone averted approximately[84] 90 to 400 cases of HIV[85] and 47,740 to 56,670 other STls—and, in turn, many pelvic inflammatory disease (PID) cases, ectopic pregnancies, and infertility cases.[86]

62. Reduced STI testing means that STIs will go undiagnosed or will be diagnosed much later. This will put STI-positive patients and their partners at greater health risk. In general, women who contract STIs suffer adverse reproductive health outcomes.[87] STIs in women are often asymptomatic[88] but can result in PID—a major cause of infertility—ectopic

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[82] Fowler et al., *supra* note 3, at 44-47.

[83] *Id.* at 44.

[84] The tool provided by Guttmacher requires inputting a state where the service is provided. California data was used as a case study (as it represents one of the largest states by population and numbers of Planned Parenthoods) for calculating the potential outcomes among all of the following examples.

[85] A range is provided because the estimated health outcomes depend on whether HIV tests were provided to male or female clients, which was not specified in Planned Parenthood's report. The result of 90 cases of HIV assumes all tests were administered to women; the result of 400 cases assumes all tests were administered to men.

[86] Guttmacher Inst., *Data Center, Health Benefits and Cost Savings of Publicly Funded Family Planning*, https://data.guttmacher.org/calculator. The tool provided by Guttmacher is limited in the type of STI tests that can be entered and the type of STls it indicates were averted. This range assumes that all STI tests provided by Planned Parenthood were for chlamydia, and reflects the number of chlamydia cases likely averted were that assumption true. The low end of the range assumes all tests were provided to women; the high end assumes all tests were provided to men.

[87] *See* David Friedel & Suzanne Lavoie, *Epidemiology and Trends in Sexually Transmitted Infections*, in *Public Health & Preventive Medicine* 155, 159 (Robert B. Wallace et al. eds., 2008).

[88] CDC, *Sexually Transmitted Disease Surveillance 2017* 3, 31, 37, 38, 40, 41 (2018),

pregnancy, and chronic pelvic pain.[89] Chlamydia infections also facilitate the transmission of HIV infections.[90] In some cases, pregnant women infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in ophthalmia neonatorum, which can lead to blindness and pneumonia.[91] Untreated syphilis infections in pregnant women can cause significant complications, including fetal death in up to 40% of pregnant women or preterm birth.[92] It can lead to infection of the fetus in 80% of cases, which can result in both physical and mental developmental disabilities.[93] Additionally, an undiagnosed or belatedly diagnosed STI means more opportunity for the infection to be spread to others.

63. Title X clinics provide services to screen for women's reproductive cancers, specifically Pap tests, HPV screening, and HPV vaccinations, all of which seek to detect and prevent cervical cancer. Pap tests, which are often performed alongside HPV tests, aim to detect any abnormal or precancerous cells and enable early treatment of cervical cancer.[94] HPV vaccinations protect patients from the strains of the virus that cause cervical cancer, as well as those that can lead to cancer of the vulva, vagina, anus, rectum, and oropharynx.[95]

64. In 2017, Title X clinics provided Pap tests to 18% of all female patients (649,300 individuals); 14% of these tests returned abnormal results that would call for further investigation

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https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf.

[89] Kristen Kreisel et al., *Prevalence of Pelvic Inflammatory Disease in Sexually Experienced Women of Reproductive Age—United States 2013-2014*, 66 Morbidity & Mortality Wkly Rpt. 80, 80 (2017); CDC, *Pelvic Inflammatory Disease (PID) – CDC Fact Sheet* (2017), https://www.cdc.gov/std/pid/PID-FS-July-10-2017.pdf. Approximately 10-20% of women with chlamydia or gonorrhea may develop PID without adequate treatment. CDC, *supra* note 88, at 37.

[90] CDC, *supra* note 88, at 3, 11, 23.

[91] *Id.* at 3.

[92] *Id.* at 23.

[93] *Id.* at 23, 38.

[94] Adam Sonfield, *Beyond Preventing Unplanned Pregnancy: The Broader Benefits of Publicly Funded Family Planning Services*, 17 Guttmacher Pol'y Rev. 2, 3 (2014), https://www.guttmacher.org/gpr/2014/12/beyond-preventing-unplanned-pregnancy-broader-benefits-publicly-funded-family-planning.

[95] CDC, *Human Papillomavirus: Why is HPV Vaccine Important* (2017), https://www.cdc.gov/hpv/hcp/hpv-important.html.

or possible treatment.[96] In 2010, it is estimated that Title X clinics helped to prevent 2,000 cases of cervical cancer.[97]

65. A 2010 analysis found that the publicly funded clinics' role in screening, testing, and preventing STIs during family planning visits saved an estimated $123 million taxpayer dollars that year, in the form of costs to treat PID or other results of untreated chlamydia or gonorrhea, HIV infections, and HPV sequelae.[98] Early detection of HIV can reduce transmission of the virus due to changes in individuals' sexual behavior following a positive diagnosis, as well as the effects of treatment on levels of the virus that could be transmitted.[99] Even a relatively small number of averted HIV/AIDS cases results in substantial savings.

66. HHS plainly failed to recognize, evaluate, and justify these additional consequences and costs that would likely occur if a large number of agencies—about 650 hundred Planned Parenthood centers alone—would no longer be part of the network of family planning agencies providing Title X services. These impose an unnecessary burden on the Title X program and the country.

V. The Final Rule Would Exacerbate Existing Health Care Disparities

67. The Final Rule would exacerbate the disparities in health care that are already pervasive across the country. The adverse consequences discussed above are likely to be felt most intensely by historically underserved populations, including populations living in rural America. As studies have shown, people of color in the United States are disproportionately unable to gain access to and benefit from high-quality health care.[100]

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[96] Fowler et al., *supra* note 3, at 41.

[97] Frost et al., *supra* note 72, at 693.

[98] *Id.* at 696.

[99] Gary Marks et al., *Meta-analysis of High-risk Sexual Behavior in Persons Aware and Unaware They Are Infected with HIV in the United States: Implications for HIV Prevention Programs*, 39 J. Acquired Immune Deficiency Syndromes 446 (2005), https://www.ncbi.nlm.nih.gov/pubmed/16010168.

[100] *See generally* Sec'y's Advisory Comm. on Nat'l Health Promotion and Disease Prevention Objectives for 2020, *Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S.* (2010), https://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf; Shiriki K. Kumanyika & C. Morrissink, *Bridging Domains in Efforts to Reduce Disparities in Health and Health Care*, 33 Health Educ. Behav. 440 (2006).

68. Specifically, although unintended pregnancies occur across all income levels, races, and ages, the rates of unintended pregnancies are higher among certain groups.[101] For example, 82% of pregnancies to mothers ages 15 to 19 are unintended.[102] Women whose income is below the federal poverty level and black women and Latinas also have higher rates of unintended pregnancies than other demographic groups.[103]

69. The increased incidence of STIs is also likely to disproportionately affect low-income patients and patients of color. For example, prevalence of gonorrhea, syphilis, and chlamydia is highly dependent on the geographic area in which women live and sociodemographic factors, with increased rates occurring among Hispanic and African-American populations and among lower-income individuals.[104]

70. Current Title X providers strive to address and minimize these disparities. They offer low- or no-cost services, without requiring insurance and who are eligible for services; they have convenient clinic locations and hours; and they offer cultural- and youth-sensitive services.[105] In California specifically, among all clinics that participate in the Family PACT program, Title X-funded clinics are more likely to reduce barriers to care through extended hours, multilingual services, and community outreach efforts.[106] These Title X-funded clinics have greater proportions of bilingual staff and are more likely to provide outreach to vulnerable or hard-to-reach populations, such as adolescents; males; lesbian, gay and transgender individuals; persons experiencing homelessness, those with limited English proficiency; migrant workers;

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[101] *See, e.g.*, Blumenthal et al., *supra* note 10, at 123.

[102] Office of Disease Prevention and Health Promotion, *supra* note 50.

[103] *Id.*; Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 New Eng. J. Med. 843, 846-47 (2016); Frost et al., *supra* note 72, at 668.

[104] *Id.* at 698.

[105] *See, e.g.*, Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 Guttmacher Pol'y Rev. 2, 4-5 (2008), https://www.guttmacher.org/sites/default/files/article_files/gpr110302.pdf; Katherine H. Mead et al., *The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents*, 57 J. Adolescent Health 87 (2015).

[106] Bixby Ctr. for Global Reprod. Health, *supra* note 14 at 15.

individuals coping with alcohol and substance abuse; refugees and immigrants; and persons with disabilities.[107]

71. A 2010 survey showed that a greater number of Title X clinics report being open at least two weekday nights and on weekends: 41% Title X, 23% public, non-Title X, 14% private. Title X clinics are also more likely to employ Spanish-speaking licensed clinical staff (84% Title X, 81% public non-Title X, 78% private) and unlicensed clinical staff (89% Title X, 71% public non-Title X, 58% private), as well as to post Spanish-language signage (95% Title X, 85% public non-Title X, 82% private).[108]

72. Title X providers' cultural competence is particularly important for traditionally underrepresented groups. For example, in a study of Latino adolescents, participants largely agreed with the guidelines from the National Council of La Raza, a Hispanic advocacy organization, which states that optimal pregnancy-prevention programs for Latino youth should include the following: having culturally sensitive and nonjudgmental staff, being responsive to Latino subgroup differences, emphasizing education, and recognizing cultural values regarding gender roles.[109]

73. Forcing high-quality current Title X providers out of the already limited network of providers available to these women and families will disproportionately harm already medically underserved populations. Other safety-net clinics that are not ethically forced to drop-out of the Title X program will likely not be able to pick up the additional demands for services and to provide care to a substantial proportion of the 1.6 million women, men, and adolescents who today receive vital family planning services from Planned Parenthood. Planned Parenthood clinics serve 41% of women who visit Title X clinics to receive contraception.[110] The Guttmacher

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[107] *Id.*; Heike Thiel de Bocanegra et al., *Enhancing Service Delivery Through Title X Funding: Findings from California*, 44 Persp. on Sexual and Reprod. Health 262, 265 (2012), https://onlinelibrary.wiley.com/doi/10.1363/4426212.

[108] Thiel de Bocanegra et al., *supra* note 107, at 265.

[109] Anne K. Driscoll et al., *In Their Own Words: Pregnancy Prevention Needs of Latino Teen Mothers*, 1 Cal. J. Health Promotion 118, 120 (2003), http://cjhp.fullerton.edu/Volume1_2003/Issue2-TEXTONLY/118-129-driscoll.pdf.

[110] Jennifer J. Frost et al., *supra* note 35, at 9 (data cited as of 2015).

Institute has estimated that other Title X providers (should they remain in the program) would have to increase their patient caseload by 70% to serve the women who currently receive care at Title X-funded Planned Parenthood sites.[111] In 13 states, these other providers would have to more than double their caseloads.[112]

VI. Title X Clinics Act as A Gateway to Other Healthcare Services

74. In addition to the delivery of family planning care, Title X providers play an essential and important role in connecting low-income individuals to a number of other vital health services. A survey of Title X clinics in 2016 showed that Title X clinics are the only source of medical care for 60% of their patients.[113] The confidentiality, low cost, and high quality of care that Title X clinics provide encourage many individuals to visit Title X clinics when they would otherwise refuse to visit a medical provider.[114]

75. Medical services provided by Title X-funded clinics include screenings for cervical cancer, diabetes, high blood pressure, and sexually transmitted infections (STls), among a range of other services aimed at primary prevention and referral. A study of California Family PACT providers indicated that most new clients received an initial health assessment; 83% of adults received a blood pressure test; more than 70% were screened for alcohol, tobacco and drug use; more than 60% were asked whether they had high blood pressure or diabetes; about half

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[111] Memorandum from Jennifer J. Frost and Mia R. Zolna to Senator Patty Murray, Response to Inquiry Concerning the Impact on Other Safety-Net Family Planning Providers of "Defunding" Planned Parenthood 2 (June 14, 2017), https://www.guttmacher.org/sites/default/files/article_files/guttmacher-murray-memo-2017_1.pdf.

[112] *Id.* at 6.

[113] Megan L. Kavanaugh et al., *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 Persp. on Sexual and Reprod. Health 101, 105 (2018), https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[114] Rachel Benson Gold, *The Role of Family Planning Centers as Gateways to Health Coverage and Care*, 14 Guttmacher Pol'y Rev. 15, 18 (2011), https://www.guttmacher.org/gpr/2011/06/role-family-planning-centers-gateways-health-coverage-and-care.

were asked whether they had gained, lost, or been maintaining their weight; and more than half were asked about interpersonal violence in the past 12 months.[115]

76. For many low-income individuals, especially women, access to this set of services represents the most trusted entry point to all medical care. Many patients are not aware of other services that may be offered in the community, and the Title X program serves as a gateway to other needed health care.

77. Title X clinics have relationships with other healthcare and social service agencies and are able to refer their patients when appropriate. For instance, 99% of Title X clinics have referral relationships with other medical providers, 97% refer to public providers, such as FQHCs or community clinics, 90% refer to private practices, 62% refer to social services agencies, and 47% refer to home visiting programs.[116]

78. The Final Rule's forced exit of existing, high-quality providers, combined with the removal of requirements, such that programs provide non-directive pregnancy options counseling, that methods of family planning contraceptives provided be medically and FDA approved, and/or that programs offer a wide range of contraceptive options, will encourage the introduction of lower-quality providers into the Title X program. Indeed, under the Final Rule, in California, a Title X provider could qualify for the funding without meeting the minimum requirements to become a Family PACT provider. The Final Rule will therefore make it harder for California Title X patients to connect with other needed healthcare services.

VII. The Final Rule Will Cause Harm Nationwide

79. The Final Rule will immediately shift Title X in a direction that will be harmful for women and costly for state and local governments.

80. The Final Rule's new limits on clinicians' ability to respond fully and accurately to patients' questions or requests concerning abortions; its removal of the requirement to offer nondirective options counseling to pregnant patients; the requirement that pregnant women to undergo coercive prenatal counseling and to receive advice on protecting the "unborn child"; and

[115] M. Antonia Biggs et al., *supra* note 57, at 85-88.
[116] Zolna & Frost, *supra* note 8, at 42.

the prohibition on referrals that identify abortion providers as such, all seek to limit the information patients receive and thus, to impede or coerce patients' informed decision-making. Without fully informed decision-making, women will be delayed from obtaining the care they desire or need, and may not receive it at all.

81. In addition, the Final Rule's requirement to involve or notify parents that their adolescent is receiving confidential healthcare reduces the likelihood that an adolescent will seek and obtain treatment from a Title X clinics. A survey of adolescent females seeking sexual health care showed that only 1% would stop having sex if a parental notification requirement were implemented, but 59% would stop using all sexual healthcare services.[117]

82. The Final Rule also limits the range and availability of contraceptive methods by encouraging non-traditional family planning providers that may offer only a single method of contraception, often natural family planning, at the expense of experienced providers that offer a range of FDA-approved contraceptive methods.

83. In addition to harms directed to women and patient care, the Final Rule will upend the existing Title X provider network by forcing Title X clinics to make an impossible choice: will they agree to provide care that violates medical and ethical guidelines in order to continue to provide some care to some patients, or will they forgo Title X funding in order to continue providing high quality care, but on a more limited scale?

84. If providers attempt to remain in the Title X program, they will have to obtain new office space, staff members, medical equipment, and office and records materials. The expense would be considerable, and would leave the clinics in a weak financial position from which to continue providing reproductive health services, especially as Title X funding levels have not increased in the previous four fiscal years.[118]

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[117] Diane M. Reddy et al., *Effects of Mandatory Parental Notification on Adolescents' Use of Sexual Health Care Services*, 288 JAMA 710, 713 (2002), https://www.ncbi.nlm.nih.gov/pubmed/12169074.

[118] U.S. Dep't of Health & Hum. Servs., Office of Population Affairs, *Funding History* (August 2, 2018), https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html.

85. Other Title X clinics that do not offer abortion services may be forced out of Title X because of the Final Rule's restrictions on abortion counseling and on "activities that encourage, promote or advocate for abortion," which include developing materials, attending conferences, paying membership dues, and providing education.

86. All Planned Parenthood grantees or sub-grantees have stated that they will be forced out of the Title X program if the Final Rule goes into effect. At least four states—Washington, New York, Hawaii, and Oregon—have given similar indications.

87. A survey in 2016 found that 26% of patients at Title X-funded clinics stated that it was the only place they could go for the care they need.[119]

88. Geographic realities would also impede FQHCs' ability to absorb Title X patients: there is no FQHC that provides contraceptive services in 33% of counties that currently have at least one Title X clinics. [120] In 47% of counties with a Title X clinic, contraceptive-offering FQHCs would have to at least double their capacity to provide care for contraceptive patients, and in 24% of counties with a Title X clinic, contraceptive-offering FQHCs would have to increase their capacity by at least six times.[121] 2.8 million contraceptive patients who receive care at Title X clinics that are not FQHCs live in the 1,625 counties where either FQHCs would have to double their caseloads or there is no FQHC providing contraception.[122]

89. This analysis of FQHCs is significant because these clinics are often focused on primary care and the Final Rule's imposes a requirement that Title X providers "offer either comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in close physical proximity to the Title X site." This requirement is unnecessary, given the work Title X clinics already do as healthcare gatekeepers, as described above.

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[119] Kavanaugh et al., *supra* note 113, at 104.

[120] Memorandum from Jennifer J. Frost and Mia R. Zolna to Senator Patty Murray, Response to Inquiry Concerning the Availability of Publicly Funded Contraceptive Care to U.S. Women 7 (May 3, 2017), https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

[121] *Id.*

[122] *Id.*

90. When clinics of all kinds leave Title X, the loss will not be evenly felt across the country. Rural areas or regions with few options for publicly funded family planning will be more affected if their Title X clinic leaves the program. Correspondingly, low-income individuals in those regions will suffer a greater burden to access affordable, high-quality family planning services, as well as other related services, such as STI screening and treatment.

91. Therefore, delays and gaps in care will result from the Final Rule's disruption of the Title X network. Patients will be shunted to clinics that are unable to handle the additional caseloads, and will be unable to see clinicians with whom they have an existing patient-provider relationship and who are likely to offer a broad range of contraceptive services.

92. And even if new, qualified clinics are eventually able to join Title X, the gap in time between the departure of existing grantees (perhaps in the middle of their grant periods) and the enrollment of new providers could cause serious harm due to delays in implementation. Patients may lack care for a period of months, a long time when viewed in the context of making decisions about pregnancy prevention and STIs.

VIII. Conclusion

93. Overall, the changes in the Final Rule will reorient Title X in a harmful direction that offers lower quality care to fewer patients. The benefits to individual and public health achieved by the Title X program over decades will be undone; as funding is redirected to inexperienced and unqualified entities that provide services at odds with widely accepted clinical standards of care for family planning providers.

94. Forcing Planned Parenthood and other current, high-quality Title X providers from the already limited network of providers available to women and families will undermine the effectiveness of the vital reproductive health services Title X has provided over the past decades to millions of low-income individuals in California and across the country. It will gravely harm low-income women and families who are already medically underserved, and exacerbate existing public health challenges and health disparities.

95. As high-quality clinics are pushed out of Title X, access to their services will be reduced, and fewer highly effective contraceptive methods will be prescribed and used. The results among the Title X population will be increased risk of unintended pregnancy, undetected and untreated STIs, and a general lowering of the standard of reproductive healthcare received by low-income individuals. These health effects will be felt at the individual level and as negative impacts on public health at large. Additional costs associated with unintended pregnancy will be borne by the state, and in turn, the nation.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on March 21, 2019 in San Francisco, California.

Claire Brindis, DrPH
Director, Philip R. Lee Institute for Health Policy Studies
University of California San Francisco

SA2018101519

EXHIBIT A

Claire Brindis
Curriculum Vitae

Prepared: December 13, 2018

University of California, San Francisco

CURRICULUM VITAE

Name: Claire D Brindis, DrPH, MPH

Position: Professor, Step 9
Pediatrics
School of Medicine

Address: Box 0936
3333 Calif. St, Laurel Heights, 266H
University of California, San Francisco
San Francisco, CA 94143-0936
Voice: 476-5255
Fax: 476-0705
Email: claire.brindis@ucsf.edu

EDUCATION

1968 - 1972	University of California, Los Angeles	B.A.	Sociology, Cum Laude
1972 - 1973	University of California, Los Angeles	M.P.H.	Public Health
1977 - 1982	University of California, Berkeley	Dr. PH	Public Health/Behavioral Sciences

PRINCIPAL POSITIONS HELD

1974 - 1977	Emory University	Assistant Professor	School of Allied Health
1982 - 1983	San Francisco State University	Assistant Professor	San Francisco State Health Education
1982 - 1987	University of California, San Francisco	Senior Research Associate	Institute for Health Policy Studies
1987 - 1992	University of California, San Francisco	Assistant Adjunct Professor	Institute for Health Policy Studies
1992 - 1998	University of California, San Francisco	Associate Adjunct Professor	Institute for Health Policy Studies

1998 - 1998	University of California, San Diego	Visiting Professorship	Iris F. Litt Society for Adolescent Medicine/Organon Adolescent Health Research, Sponsored by Society for Adolescent Medicine
1998 - 2000	University of California, San Francisco	Adjunct Professor	Pediatrics and Institute for Health Policy Studies
2000 - 2009	University of California, San Francisco	Professor, In-Residence	Philip R. Lee Institute for Health Policy Studies/Joint Appointment with Dept of Pediatrics & Obstetrics, Gynecology and Reproductive Health Sciences
2002 - 2002	Children's National Medical Center	Visiting Professorship	Robert S. Rixse Memorial Lecture, Washington, DC
2005 - 2005	University of Texas, Houston	Visiting Professorship	Morris Blum Memorial Lecture, Pediatric Grand Rounds University of Minnesota Adolescent Health Leadership
2006 - 2006	Howard University, and Johns Hopkins University	Visiting Professorship	The DC-Baltimore Research Center on Child Health Disparities: a consortium of the Department of Health, the Children's National Medical Center
2007 - 2007	University of New Mexico	Visiting Professorship	Center for Latinos and Health Disparity

2009 - present	University of California, San Francisco	Professor	Philip R. Lee Institute for Health Policy Studies/Joint Appointment with Dept of Pediatrics & Obstetrics, Gynecology and Reproductive Health Sciences
2014 - present	University of California, Hastings	Adjunct Professor of Law	UC Hastings College of the Law
2014 - present	University of California, San Francisco	Affiliated Faculty	University of California, Institute of Global Health Sciences
2016 - present	University of California, San Francisco	Affiliated Faculty	Institute for Computational Health Sciences
2016 - 2016	Pennsylvania State University	Visiting Professorship	Division of Health Services and Behavioral Research
2017 - present	University of California, Los Angeles	Affiliated Faculty	UCLA School of Public Health, Center for Health Policy

OTHER POSITIONS HELD CONCURRENTLY

1983 - 1999	University of California, San Francisco	Co-Director	Center for Reproductive Health Policy Research, Institute for Health Policy Studies,
1983 - 2005	University of California, San Francisco	Director	Hewlett Fellowship in Reproductive Health Policy, Institute for Health Policy Studies
1993 - 2014	University of California, San Francisco	Executive Director/Co-Principal Investigator	National Adolescent Health Information and Innovation Center; Department of Pediatrics and Institute for Health Policy Studies

1997 - 2014	University of California, San Francisco	Associate Director/Co-Principal Investigator, Public Policy Analysis Center	Department of Pediatrics and Institute for Health Policy Studies
1999 - present	University of California, San Francisco	Associate Director/Co-Principal Investigator	Div Adolescent Medicine, Department of Pediatrics
1999 - 2018	University of California, San Francisco	Director and Founding Director and Senior Scholar, 2018-current	Bixby Center for Global Reproductive Health, Obstetrics, Gynecology and Reproductive Sciences and Institute for Health Policy Studies
2002 - present	University of California, San Francisco	Core Faculty	Center for Social Disparities in Health; Dept. Family and Community Medicine
2005 - 2007	University of California, San Francisco	Associate Director	Institute for Health Policy Studies
2006 - 2007	University of California, San Francisco	Acting Director	Philip R. Lee Institute for Health Policy Studies
2007 - 2008	University of California, San Francisco	Interim Director	Philip R. Lee Institute for Health Policy Studies
2008 - present	University of California, San Francisco	Director	Philip R. Lee Institute for Health Policy Studies
1998 - present	University of California, San Francisco	Co-Director	Adolescent and Young Adult Health National Resource Center, Division of Adolescent Medicine, Department of Pediatrics
2016 - present	University of California, Berkeley	Affiliated Faculty	Berkeley Ph.D. Program in Health Policy

HONORS AND AWARDS

1988	Special Recognition Award	California Alliance Concerned with School Age Parents
1991	Community Leadership Award	National Family Planning and Reproductive Health Association, Washington, D.C.
1994	Integrity Award	Office of Inspector General, Office of Evaluation and Inspections, U.S. Department of Health, Human Services
2000	Mark Pearlman Outstanding Service Award	California Child, Youth and Family Coalition
2000	Beverlee A. Meyer Award in Excellence	California Department of Health Services
2000	Distinguished Service to the Public and the State of California	California State Senate Resolution, State of California
2001	Collaborative Award Winner, Special Recognition Award	Maternal and Child Health Branch, California Department of Health Services
2001	John C. MacQueen Lecture Award	Association of Maternal and Child Health Programs
2001	Women Faculty Recognition Award	University of California, San Francisco
2003	Champions of Diversity	University of California, San Francisco
2004	Executive Leadership in Academic Medicine (ELAM) Program for Women	Fellow-Hedwig van Ameringen
2005	Morris Blum Memorial Lecture, Pediatric Grand Rounds	University of Minnesota
2005	Commendation by Lieutenant Governor Cruz M. Bustamante Honoring Outstanding Research on Adolescent and Women's Health, Education, and Dissemination on These Important Issues, Fresno County Babies First Seminar.	State of California
2005	Directors Award: In Recognition of Contributions Made to the Health of Infants, Mothers, Children, Adolescents & Children with Special Needs	Federal Maternal & Child Health Bureau
2005	Special Election Award	Campaign for Teen Safety

2006	Hilary E.C. Millar Award for Innovative Approaches to Adolescent Health Care	Society for Adolescent Medicine
2006	Champion Award for vision and commitment in creating and sustaining the California Office of Family Planning and the Family PACT Program.	California Family Health Council, Inc
2006	Outstanding Researcher Award in honor of the dedication and leadership in the field of adolescent pregnancy, parenting and prevention.	Healthy Teen Network
2006	Award for service on No on 85 Campaign 'Above and Beyond'	Campaign for Teen Safety
2009	Chancellors Award for the Advancement of Women, 'In Recognition of Outstanding Contributions to the Advancement of Women'	University of California, San Francisco
2009	Telly Award, Bronze Award	Telly Award for Film, 'A Question of Hope', Social Issues Category
2011	Institute of Medicine of the National Academies (IOM) member	Elected Member
2012	Alumni Hall of Fame: Outstanding Contributions to the Field of Public Health	UCLA Fielding School of Public Health
2014	Carl S. Shultz Award for Lifetime Achievement	American Public Health Association: Population, Reproductive, and Sexual Health Section
2016	Lifetime Achievement in Mentoring Award	UCSF Faculty Mentoring Program
2018	75th Anniversary Honoree “In Recognition of 75 Most Influential Public Health Alumni”	UC Berkeley School of Public Health
2018	In Recognition for Outstanding Contribution to the Advancement of Women’s Reproductive Health	Bixby Center for Global Reproductive Health, UCSF

KEYWORDS/AREAS OF INTEREST

United States healthcare reform, adolescent and child health policy, health disparities, and social determinants of health, adolescent pregnancy and pregnancy prevention, adolescent and young adult health and risk-taking behaviors, reproductive health services for men and women, program evaluation ; Latino health, global reproductive health, migration and health, knowledge-transfer.

PROFESSIONAL ACTIVITIES

MEMBERSHIPS

1972 - present	American Public Health Association
1984 - present	Society for Public Health Education
1985 - present	Society for Adolescent Medicine
1985 - present	Society for Health Education
1988 - present	American School-Health Association
1995 - present	National Assembly for School-Based Health Care
2000 - present	AcademyHealth
2005 - present	National Alliance for Hispanic Health
2015 - present	Society of Family Planning

SERVICE TO PROFESSIONAL ORGANIZATIONS

1990 - 1992	American Public Health Association	Section Council Representative, Section on Family Planning and Reproductive Health
1992 - 1994	American Public Health Association	Governing Council
1996 - present	AcademyHealth	Member, Advocacy Committee
1993 - 1993	American Public Health Association	Annual Program Committee, Section on Family Planning and Reproductive Health
1996 - 2000	National Assembly for School-Based Health Care	Technical Advisory Committee, Survey of School-Based Health Centers
1996 - 2006	National Assembly for School-Based Health Care	Member, Advisory Panel, Center for Evaluation and Quality
1997 - 1997	Society for Adolescent Medicine	Managed Care Ad Hoc Committee

2000 - present	AcademyHealth	National Planning Committee for Annual Meeting, Chair, Session at Annual Conference. Elected Member, Board of Directors Secretary, Board of Directors
2001 - 2001	Society for Adolescent Medicine	Member, Advocacy Committee
2003 - 2003	American Public Health Association	Program Chair
2004 - 2005	American Public Health Association	Section President
2005 - 2007	American Public Health Association	Chair, Awards Committee, Member, Awards Committee
2005 - 2005	Society for Adolescent Medicine	Research (Standing) Committee
2009 - 2009	Society for Adolescent Medicine	Consultant, Diversity Task Force
2011 - present	National Academy of Medicine (formerly IOM)	Elected Member, Co-Chair with Sara Rosenbaum
2012 - 2016	National Academy of Medicine (formerly IOM), Section 1 Health Policy and Health Services Working Groups	Co-Chair with Sara Rosenbaum
2014 - present	Public Health Institute	Board Member
2015 - present	WestEd Justice & Prevention Research Center	Member, Advisory Board, Virtual Student Health Center Project
2015 - present	Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)	Member, National Survey of Children's Health (NSCH) Technical Expert Panel (TEP)
2017 -	Public Health Institute	Advisory Council, Initiative for Multipurpose Prevention Technologies (IMPT)
2018 – 2021	National Academy of Medicine (formerly IOM)	Elected Member, NAM Council
2018	AcademyHealth, Adolescents and Children Together for Health (ACT for Health)	Member, National Advisory Panel

SERVICE TO PROFESSIONAL PUBLICATIONS

1999 - present	Editorial Board, Journal of Adolescent Health; (10 papers)
1991 - present	Hispanic Health Care International; Editorial Review Board, Health Promotion Practice, (2 papers in each year)
1999 - present	Health Promotion Practice (2 papers in each year), Editorial Board
1999 - present	Journal of the American Public Health Association (5 papers)
1999 - present	Journal of the American Medical Association (6 papers)
1999 - present	Archives of Pediatrics and Adolescent Medicine (5 papers)
1999 - present	Family Planning Perspectives (8 papers)
1999 - present	Perspectives on Sexual and Reproductive Health (2 papers)
1999 - present	American Journal of Preventive Medicine, Guest Editor (Long Acting Reversible Contraceptive Methods in the Developing Word)
1999 - present	Maternal and Child Health Journal, Editorial Board (8 papers)
2017 - 2017	Maternal and Child Health Journal, Guest Editor (Long Acting Reversible Contraceptive Methods in the Developing World, September, 2017)
2017 - 2017	Journal of Adolescent Health, Guest Editor (Special Supplement on Teenage Pregnancy Prevention)

INVITED PRESENTATIONS - INTERNATIONAL

2005	Canadian Evaluation Society and American Evaluation Association, Toronto, Canada,	Keynote address
2008	Binational Conference Defining a Research Agenda on Migration and Health: The Voice of the Community. University of California	Invited Talk
2009	Binational Conference: IX Semana Binacional de Salud / Ninth Annual Binational Policy Forum on Migration and Health Santa Fe, NM	Plenary Talk
2010	The 21st Scientific Conference of the Saudi Heart Association. Riyadh, Saudi Arabia	Two invited talks
2010	Institut Jantung Negara (National Heart Institute), Kuala Lampur, Malaysia	Two invited talks
2011	Egyptian Society of Cardiology: Adolescent obesity, Systems Change, Pediatric Congenital Health Disease. Alexandria, Eygpt	Three invited talks
2011	Mexican Society of Cardiology Annual Meeting: Adolescent obesity. Puerta Vallerta, Mexico	Invited talk in Spanish

2012	Societatea Romana De Cardiologie. National Congress of Cardiology Annual Meeting. Bucharest, Romania. 2012. (Childhood and Adolescent Obesity and the Role of Comprehensive Prevention Approaches)	Invited Talk
2012	Pan American Health Organization (PAHO) What Works in Pregnancy Prevention: Current Scientific Evidence and Lessons Learned. San Salvador, Salvador. August 24, 2012 (Spanish and English).	Invited Talk (English and Spanish)
2014	World Bank: International Interagency Conference: Current Evidence, Lessons Learned and Best Practices in Adolescent Pregnancy Prevention in Latin America and the Caribbean, Managua, Nicaragua 2014.	Invited talk in Spanish
2014	Robert Wood Johnson Foundation, Social Determinants of Migrant's Health Conference: The Burden of the Invisibles: The Experiences of the Deferred Action for Childhood Arrivals Within a Socio-Economic Context. Bellagio, Italy, October 10, 2014	Invited Talk
2016	University of Ottawa, Building Health Systems and Health Equity for Populations Affected by Migration. "Health Equity Impact Assessment." Ottawa, Canada. May 16-17, 2016.	Invited Tak
2017	Instituto Nacional de Perinatologia, Mexico City, Mexico. Reunion Anual INPer 2017: Salud Sexual y Reproductiva del Adolescente: Impacto Perinatal: Presentation: El Embarazo de Adolescentes en Mexico y en California: Politicas Publicas y Consecuencias Programaticas, April 4, 2017.	Invited Talk

INVITED PRESENTATIONS - NATIONAL

2006	"A Profile of Adolescent Health and Healthcare Needs". National Institute for Health Care Management Foundation; Washington, DC	Keynote address
2006	"Future Directions in Adolescent Healthcare Delivery". Society for Research in Adolescent Health, Boston, MA	Keynote address
2006	"Teenage Pregnancy Prevention—Trends and Lessons Learned". Society for Adolescent Medicine, Boston, MA	Keynote address
2006	"Developing a Career in Health Policy and Advocacy". American Public Health Association Student Assembly, Boston, MA	Invited talk
2006	"Preventing Teenage Pregnancy: Recent Trends and Directions". Contraceptive Technology Annual Meeting, San Francisco, CA	Keynote address
2006	"The Health and Mental Health Needs of Adolescents". Association of Maternal and Child Health Epidemiology, 12th Annual Conference, OMNI Hotel CNN Center, Atlanta, GA	Keynote address

2007	"A Profile of Adolescent Health and Healthcare Utilization". The National Academies. Research Workshop on Adolescent Health Care Services and Systems, Washington, DC	Platform presentation
2007	"Using State Data to Respond to the Health Needs of Adolescents". Association of Maternal & Child Health Programs Annual Conference, Arlington, VA	Plenary talk
2007	"Health Care Coverage for Adolescents: Where are the Gaps?". AcademyHealth Meeting, Orlando, FL	Invited talk
2007	"Meeting the Needs of Adolescents: Promising State Directions". National Conference of State Legislators, Boston, MA	Invited talk
2007	"Responding to the Health Needs of Adolescent Males: Opportunities and Challenges". The National Campaign to Prevent Teen and Unplanned Pregnancy, Santa Monica, CA	Platform presentation
2007	"Preconception Health and Health Care". Second National Summit, in collaboration with the Department of Health and Human Services, Centers for Disease Control and Prevention, and the Health Resources and Services Administration, Oakland, CA	Invited talk
2009	"A Health Profile of America's College Age Students". American College Health Association. Building Bridges by the Bay: 2009 Annual Meeting, San Francisco, CA	Keynote address
2009	"The Role of Community-Based Organizations in Meeting the Health Needs of Women". National Institutes of Health, NIH/Office of Research in Women's Health and UCSF Center of Excellence in Women's Health, New Dimensions and Strategies for Women's Health Research, National Conference, San Francisco, CA	Platform
2009	"Evaluating Community Agencies Serving Women: Promising Findings". Johnson and Johnson Foundation and UCSF Center of Excellence in Women's Health. Fostering Excellence in Women's Health Through Academic - Community Partnerships, Annual Convening, Hotel Kabuki, San Francisco, CA	Invited talk
2010	"Meeting the Health Needs of Adolescents: Future Directions". GrantMakers in Health Annual Meeting on Health Philanthropy, Charting a Healthy Life Course for Children, Orlando, FL	Invited talk
2010	Using State Profile Data to Develop New Program Strategies". Association of Maternal & Child Health Programs Annual Conference. National Harbor, MD	Invited panelist
2010	"The Needs of Adolescents and Young Adults – Future Directions". AcademyHealth Annual Conference, Boston, MA	Invited panel presentation
2010	"Making Healthy People 2020 Come Alive for Promoting Adolescent Health". 20th Annual CityMatCH Conference. Making Healthy People 2020 Come Alive for Promoting Adolescent Health, Chicago, IL	Invited presentation

2010	"Maternal and Child Health Health Reform: Looking to the Future". AMCHP Annual Meeting, Washington, DC	Invited speaker
2011	“The Environment of Girl's Health and Next Steps in the Creation of a National Initiative to Improve the Health of Young Women and Girls”. Department of Health and Human Services, Office on Women's Health, Washington, DC	Invited briefing
2011	“Approaches for Supporting Pregnant and Parenting Teens”. Office of Population Affairs Office of Adolescent Pregnancy Programs; Washington, DC	Invited speaker
2011	“Male Adolescent Health: Future Directions”. The 2011 National Conference for Male Family Planning and Reproductive Health Services, San Francisco, CA.	Invited talk
2011	"IUD Summit: US Trends in IUD Use". Des Moines, IA.	Invited speaker
2012	“The Health Needs of Adolescents and Young Adults”. AcademyHealth Annual Research Meeting, Washington, DC.	Invited speaker and panelist
2012	“Lessons Learned in Adolescent Pregnancy Prevention". National Reproductive Health Conference Title X.	Invited speaker
2012	"Evaluation of the Iowa LARC Initiative: Early Research Findings". Policy Briefings, Des Moines, IA.	Invited speaker
2012	“A Profile of Adolescent and Young Adult Health”. 18th Annual Maternal and Child Health Epidemiology (MCH EPI) Conference. learning.mchb.hrsa.gov	Invited speaker and moderator
2012	“The Needs of Adolescents: How Can we Best Respond in an Era of Health Reform?” San Francisco Chapter of the National Association of Pediatric Nurse Practitioners. Stanford University, Stanford, CA.	Invited speaker
2012	"Making Do with Less: The Impact of State Budget Cuts on California’s Teen Pregnancy Prevention Programs". American Public Health Association Annual Meeting. San Francisco, CA.	Invited panel presentation
2012	"Stayin’ Alive and Thriving: Exploring Multiple Dimensions of SBHC Sustainability". American Public Health Association Annual Meeting. San Francisco, CA.	Invited panel presentation
2013	"Advancing the Maternal & Child Health Vision. The ACA, Adolescents and Young Adults". AMCHP Annual Conference.	Invited speaker
2013	"Improving the Health, Safety, and Well-being of Young Adults". Institute of Medicine, Washington DC.	Invited speaker

2013	"Taking Advantage of Natural Experiments for Child Health: Understanding How Policy Impacts Child Health Quality, Costs, and Utilization". AcademyHealth Annual Research Meeting, Washington, DC.	Invited speaker
2013	"Understanding Contraceptive Use in the United States". American Public Health Association Annual Meeting; Boston, MA.	Invited moderator
2013	"Following the Passion: Embedding the DNA of Research in a Policy Translation Career". American Public Health Association Annual Meeting. Boston, MA	Invited panel presentation
2013	"The California Hot Spots Study: Insights into Neighborhood-level Factors Associated with Teenage Pregnancy". American Public Health Association Annual Meeting. Boston, MA.	Invited Panel presentation
2013	"Exploring and Understanding Newer Reproductive Health Technologies: LARC Provider Perspectives from Colorado and Iowa". American Public Health Association Annual Meeting. Boston, MA.	Invited panel presentation
2014	"Improving Adolescent Health: State Data Resources". AMCHP Annual Conference. Washington, DC.	Invited speaker
2014	"Current Issues in Adolescent and Young Adult Health". AMCHP Annual Conference. Washington, DC.	Invited speaker
2014	"Accelerating Progress for Adolescent Sexual Reproductive Health: Results from a Multi-Country Needs Assessment". World Bank Group, Washington, DC.	Invited speaker (with Decker, M)
2014	"Adolescent Development, Implications, and Policy Needs". Ohio Adolescent Health Partnership. Columbus, OH.	Keynote address
2014	"Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Health Coverage and Mental Health Stressors". Robert Wood Johnson Foundation Nursing and Health Policy Collaborative/University of New Mexico: Assessing the Impact of Immigration and Health Policy. November 21, 2014.	Invited speaker
2015	"Improving Contraceptive Options Now". Project Advisory Board Meeting, MDRC (organizing foundation). New York, NY.	Invited panelist
2015	"The Health and Well-being of Young Adults: Highlights from an Institute of Medicine/National Research Council Report". Society for Research in Child Development, Philadelphia, PA.	Roundtable discussion
2015	"The Impact of the Affordable Care Act on Women." California Wellness Foundation sponsored presentation by the Commonwealth Club of San Francisco. SF, CA. (audio http://bit.ly/1xJHr7c) http://www.commonwealthclub.org/events/2015-03-16/impact-affordable-care-act-women	Invited presentation

2015	"Adolescents & Young Adults in Title V Transformation: Understanding Needs, Designing & Selecting Measures, and Achieving Outcomes." AMCHP Annual Conference. Washington, DC, January 24, 2015.	Invited speaker
2015	"The Health & Well-Being of Young Adults." AMCHP Annual Conference. Washington, DC. Washington, DC. January 26, 2015. http://events.tvworldwide.com/Events/AMCHPAnnualConference2015/TabId/1133/VideoId/1348/F5-The-Health-And-WellBeing-Of-Young-Adults-Highlights-From-An-Institute-Of-MedicineNational-Research-Council-Report-And-Implications-For-State-Ti.aspx	Invited speaker
2015	"Young Adults on Campus: Confronting the Health Challenges." Society for Public Health Education Annual Meeting, Portland, OR. April 23, 2015.	Plenary session
2015	"Partnering to Encourage Healthy Beverage Intake through Childcare: A Pilot Study." Pediatric Academic Societies (PAS), San Diego, CA. April 25-28, 2015.	Poster presentation
2015	"Strategies and Tactics for Achieving Meaningful Consumer Engagement in Health Care." AcademyHealth Advocacy Interest Group (ARM) Interest Group, June 13, 2015.	Invited panel presentation
2015	"In Their Own Words: Improving the Care Experience of Families with Children with Special Health Care Needs." AcademyHealth Child Health Services Interest Group, June 13, 2015.	Invited talk
2015	"Assuring Access and Use of Health Services by Adolescents and Young Adults under the ACA." U.S. Centers for Disease Control and Prevention, Atlanta, GA. August 17, 2015.	Invited presentation
2015	"Adolescents in the United States: Health Care for Adolescents: How to Improve it. U.S. Centers for Disease Control and Prevention, Grand Rounds. Atlanta, GA. August 18, 2015.	Invited panel Webinar
2016	"Assessing Youth-Friendly Health Services (YFHS) for Adolescent Sexual and Reproductive Health: A Systematic Review." Consortium of Universities for Global Health Conference. San Francisco, CA. April 9-11, 2016.	Poster presentation
2016	"Transforming HealthCare for Adolescents and Young Adults: Improving Quality and Access through Innovation and Collaboration." AMCHP Annual Conference, Washington, DC. April 6, 2016.	Lead panelist
2016	"Investing in the Health and Well-Being of Young Adults: A Health Profile of Young Adults: A Window of Opportunity for Early Cancer Intervention." Opportunities for Cancer Prevention During Early Adulthood, April 13, 2016, CDC National Association of Chronic Disease Directors. Decatur, GA.	Invited talk
2016	"Not Lost in Translational Science: Lessons Learned in Building a Research and Policy Pipeline." Emory University. Student Research Day, Atlanta, GA, April 21, 2016.	Keynote address

2016	"Make Your Own Adventure: Leadership in a Transformative Time" Emory University. Student Research Day, Atlanta, GA. April 21, 2016.	Invited talk
2016	"Policies: Health Equity Impact Assessment." WHO Collaborating Centre on Technology Assessment and Health Equity- Evidence, Process and Migrant Health, University of Ottawa, May 16, 2016.	Invited panelist
2016	"Evidence-Based Innovations to Support Women in Biomedical Research Careers." NIH Office of Research on Women's Health, Bethesda, MD. June 6, 2016.	Invited presentation
2016	"Policy Translation: A Multi-Method Approach to Evaluating California's Family Planning Policy and Program." Penn State College of Medicine: Division of Health Service and Behavioral Research: Seminar Series (Sponsored by BIRCWH Program). November 14, 2016.	Invited speaker
2016	"Mental Health Providers in School-Based Health Centers: A Potential Solution to Address Chronic Childhood Trauma." Forum on Promoting Children's Cognitive, Affective and Behavioral Health. The National Academies, Washington, DC. November 29, 2016.	Poster presentation
2017	"Advocacy for Global Family Planning/Reproductive Health Scale". IBP Consortium Meeting, Chaired by Public Health Institute, Oakland, CA. January 17, 2017.	Keynote address
2017	"Achieving relevance and visibility in an academic research career - opportunities and potential pitfalls." BIRCWH Leadership Webinar Series (Sponsored by BIRCWH Program). Webinar, June 15, 2017. https://youtu.be/4zaV92w1LuQ	Webinar
2017	"The Role of Long Acting Reversal Contraceptive: Taking the Pulse." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Invited presentation
2017	"Demonstrating School Health Center Impacts through a Results-Based Accountability Framework." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Poster presentation
2017	"Folks Do Fall Through the Cracks: Barriers to Care for Young Adults Churning Between Health Insurance Plans." American Public Health Association Annual Meeting, Atlanta, GA. November 6, 2017.	Invited presentation
2017	"Future Policy Directions for Opportunity Youth: Where Do We Go From Here?": Making Connections Matter for Adolescents. John Hopkins University, Baltimore, MA. December 6, 2017.	Invited presentation
2018	"Overview and Accomplishments of the AYAH-NRC National Strategies." Society of Adolescent Health and Medicine, Seattle, WA. March 15, 2018.	Invited presentation

2018	"What's New in Clinical Preventive Services? New Evidence, Guidelines, Policies – Challenges and Opportunities". Society of Adolescent Health and Medicine, Seattle, WA. March 14-17, 2018.	Invited presentation
2018	"Healthcare at a Crossroads: Where Do We Go From Here?" Initiative for Regulation and Applied Economic Analysis Conference, Montana State University, Bozeman, MT. April 5-6, 2018.	Invited 2 presentations
2018	"Through The Looking Glass: The Role of Clinical Preventive Visits in Improving Adolescent Health". Oregon Pediatric Society Conference, Portland, OR, April 28, 2018.	Invited presentation
2018	"Creating Access to Care for Adolescent and Young Adult Males". 2018 National Adolescent and Young Adult Male Summit, Washington, DC. June 7, 2018.	Invited Keynote
2018	"Advancing Health Equity and Justice in California: A Landscape Analysis". Grantmakers in Health Conference. Chicago, IL, June 19, 2018.	Invited presentation

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

2004	"Adolescent Pregnancy: A Current Profile and Dilemma for Clinicians and Other Decision makers," Clinical Conference of Child and Adolescent Psychiatry, Langley Porter, Psychiatric Institute, UCSF, San Francisco, CA	Invited lecture
2006	"The Use of Focus Group Research Methodology in Health Services Research," Health Policy Post-Doctoral Program, UCSF	Invited lecture
2006	"Conducting Effective Community Needs Assessments for Adolescent Health," Program in Maternal and Child Health, School of Public Health, UC Berkeley, CA	Invited lecture
2006	"A Profile of Adolescent Health – Miles to Go Before We Go to Sleep". Howard University Lecture Series, Washington DC	Invited lecture
2006	"Past, Present, and Future of Teenage Pregnancy Prevention", State of California, Maternal, Child, and Adolescent Branch, Teen Pregnancy Prevention Annual Meeting, Burlingame, CA	Keynote address
2006	"Adolescent Pregnancy and its Role in Health Disparities". Department of Health, DC-Baltimore Research Center on Child Health Disparities, Washington DC	Plenary talk
2006	"Creating a California Strategic Plan for Adolescents". California Adolescent Health Conference, Adolescent Health Collaborative, Oakland, CA	Plenary talk
2006	"Meeting the Needs of Adolescents in California". The California Wellness Foundation's Conference on Teenage Pregnancy Prevention, Oakland, CA	Keynote address

2006	"A Profile of Adolescent Health and Healthcare Coverage". Children's National Medical Center, Grand Rounds, Washington DC	Invited lecture
2006	"Teenage Pregnancy Prevention". Pediatric Grand Rounds, Department of Pediatrics, UCSF	Invited lecture
2007	"Future Directions in Teenage Pregnancy Prevention". The California Wellness Foundation Conference on Teenage Pregnancy Prevention, San Francisco, CA	Keynote address
2008	"Teenage Pregnancy Prevention --- Lessons Learned". 5th Annual Conference: The Adolescent Working Group, San Francisco, CA	Plenary talk
2008	"The Family PACT Program: Evaluation Findings". Family PACT Conference for California Counties: Optimizing Family PACT in a County Health System, Sacramento, CA	Invited talk
2008	"Parental Notification: What Can Be Learned from the Experience of Other States?" Grand Rounds, Department of Obstetrics, Gynecology, and Reproductive Health Sciences, UCSF, San Francisco, CA	Invited lecture
2008	"Translating Research in Policy: Lessons Learned". Institute for Health Policy Studies, Post-Doctoral Fellowship, UCSF, San Francisco, CA	Invited lecture
2008	" Meeting the Needs of Immigrant Youth: Promising Directions". The Center for Comparative Immigration Studies, (CCIS) Weaver Center, University of California, San Diego	Invited talk
2008	"Cross-Border Health: Creating an Agenda for Future Directions". Global Health Forum, UCSF, San Francisco, CA	Invited talk
2009	"Adolescent Pregnancy Prevention: Making Progress and Not Losing Ground". The California Wellness Foundation Conference on Teenage Pregnancy Prevention, Los Angeles, CA	Keynote address
2009	"A Profile of Adolescent Health – Beyond Teenage Pregnancy Prevention". Adolescent Sexual Health Symposium, ACT for Youth Center of Excellence, New York, NY	Invited talk
2009	"Women's Health in California – Making Inroads". The California Wellness Foundation Conference on Women's Health, San Francisco, CA	Invited plenary talk
2009	Testimony on the Role of School Based Health Centers. State of California Assembly Legislature, Committee on Schools and Community, Informational Hearing	Invited talk
2009	"The Role of Teenage Pregnancy Prevention in Improving Economic Outcomes". Berkeley Center on Health Economics and Family Security, University of California, Berkeley, CA	Invited panel moderator
2009	"Prevention of Adolescent Cancer". UCSF Helen Diller Comprehensive Cancer Center Annual Symposium: The Prevention of Cancer, San Francisco, CA	Invited speaker

2009	Expert Testimony on School Based Health Centers. State of California, Assembly Select Committee on Schools and Community	Invited speaker
2009	Health Care Reform (Part of a Mini-Medical School series), UCSF Medical School of Medicine, UCSF, San Francisco, CA	Invited lecture
2010	“Meeting the Needs of Pregnant and Parenting Adolescents – Evaluation Findings”. Adolescent Family Life Annual Conference, Oakland, CA	Invited speaker
2010	“Comparative Effectiveness Research: Opportunities and Challenges”. Clinical and Translational Science Institute and the San Francisco Coordinating Center, San Francisco, CA	Invited panelist
2010	“Qualitative Research Methods in Immigrant Health”. University of California Global Health Institute Center of Expertise on Migration and Health. First Annual Research Training Workshop. UC San Diego	Invited panelist
2010	“Health Care Reform in California: A UC View of Prospects and Challenges”. In cooperation with the California Senate Health Committee; California Program on Access to Care. UC Berkeley School of Public Health.	Invited presentation
2010	“Migration and Health in California”. University of California, Irvine Global Health Day.	Invited speaker
2010	“The Evaluation of the Family PACT Program”. School of Public Health, University of California, Berkeley.	Invited speaker
2010	"Teenage Pregnancy Prevention - What Lies Ahead?" The California Wellness Foundation Conference, San Francisco, CA	Invited speaker
2011	“Organizational Learning and Evaluation: Implications for Future Investments”. The California Wellness Foundation Conference, Los Angeles, CA	Invited speaker
2011	"Disparities in Health". Young Scholars Group, Department of Epidemiology and Biostatistics and CTSI, UCSF	Invited talk
2011	“Conducting Multi-Disciplinary Research in Family Planning Care". Bridging Interdisciplinary Research Careers in Women's Health (BIRCWH) health seminar series, UCSF	Invited talk
2011	“Promising Strategies: Improving Adolescent Health”. San Mateo County Teen Pregnancy Prevention Summit. San Mateo, CA.	Invited plenary speaker
2011	“Conducting Program Evaluation in Family Planning". Bixby Center for Global Reproductive Sciences Research Seminar. San Francisco, CA	Invited speaker
2012	“Reflections and Lessons Learned in Establishing the Women's Preventive Health Services”. 40th Annual Psychosocial Workshop. San Francisco, CA.	Invited keynote speaker

2012	“Lessons Learned in Developing a Research and Advocacy Career”. Clinic, Advocacy, Research and Training (CART) Group, Office of Developmental Primary Care, UCSF	Invited talk
2012	"Health Policy in Community Engagement". Fellowship of Fellows, UCSF	Invited talk
2012	Young Adult Health and Well-Being: Trends and Promises”. Promoting Positive Development in the Third Decade of Life: A Multidisciplinary and International Conference. Center for Advanced Study in the Behavioral Sciences, Stanford University, CA.	Invited panel presentation
2012	“Adolescent Health Insurance Coverage – How can the ACA Improve the Health of Adolescents”. Adolescent Health Care Conference. San Francisco, CA.	Invited Keynote
2012	“Migrant Health – Creating a Bi-National Agenda for Research". 7th Annual Summer Institute on Migration and Global Health.	Invited talk
2012	School of Medicine Pathways Explorers in Health and Society on Shaping a policy Translation Career.	Invited talk/panel
2012	“A Profile of Native American Adolescents in California”. State Indian Health Program. Sacramento, CA.	Invited talk
2013	“Health Care Reform”. Robert Wood Johnson Health and Society Policy Scholars Program. San Francisco, CA.	Invited lecture
2013	"Health Care Reform". (Part of a Mini-Medical School series), UCSF Medical School of Medicine, UCSF, San Francisco, CA	Invited lecture
2013	"Taking the Pulse and Moving Forward-Reducing Teenage Pregnancy in Santa Clara County". Santa Clara County Adolescent Pregnancy Prevention Network (APPN) Retreat.	Invited talk
2013	"Aligning Assets to Improve Community Health and Health Equity: SFHIP Lessons and Strategic Directions". San Francisco Health Improvement Partnerships. San Francisco, CA	Invited talk
2013	"Taking the Pulse: Improving the Health, Safety and Well-Being of Young Adults". UCSF Center for Vulnerable Populations Seminar Series, San Francisco, CA	Invited lecture
2013	“The Role of Program Evaluation and Advocacy”. Changing the World through Life Science Innovation Symposium. University of San Francisco, CA	Invited speaker
2013	"Adolescent and Young Adult Health: Implications for Public Health, Mental Health Policy, and Clinical Services". Department of Psychiatry, Child and Adolescent Psychiatry (CAP) Grand Rounds, UCSF, San Francisco, CA	Invited lecture

2013	"The Effect of Public Family Planning Services on Fertility". Implementation Science and the Global Response to HIV/AIDS. UCSF CFAR 2013 Symposium.	Invited speaker
2013	"Report Back from the Institute of Medicine Meeting: Improving the Health, Safety and Wellbeing of Young Adults". UCSF Center for Vulnerable Populations Seminar Series (also available as video at CHARM Website), San Francisco, CA	Invited lecture
2014	"Adolescent and Young Adult Health in San Francisco: Opportunities for Change". Health Working Group (AHWG), 11th Annual Provider Training: Patient-Centered Care for Young Women, San Francisco, CA	Keynote speaker
2014	"Funding Your Research Beyond the NIH". UCSF Faculty Development Day. UCSF Campus Council on Faculty Life. September, 2014	Invited panelist
2014	"How Will We Know it is Working: Monitoring the Impact of the ACA in Years to Come". PRL-IHPS-Osher Mini Medical School on Health Reform, UCSF, San Francisco, CA	Invited panelist
2014	“Assessing the Impact of Health Care Reform”. Health Policy Colloquium, UC Berkeley, Berkeley, CA	Invited panelist
2015	“Findings From the Family PACT Providers and Health Care Reform Implementation Study”. California State Department of Health Care Services. January 2015.	Invited presentation
2015	"No Federal Immigration Reform? What States Can Do to Improve the Health of Undocumented Workers". 2015 UC Global Health Day. UC Global Health Institute and UCLA. April 18 2015.	Plenary panel
2015	"Aligning Health Care and Social Determinants of Health". Spring Research Symposium: Healthy Communities Research at UC Berkeley. UC Berkeley School of Public Health. May 7, 2015	Invited talk
2016	"Alumni Health Care Roundtable on Health Care Reform". Moderator Janet Napolitano; Claire Brindis panelist. The (UCSF) Chancellor’s Breakfast/Alumni Weekend, San Francisco, April 9, 2016.	Invited panelist
2017	"Living in a Time of Uncertainty: Advancing Women’s Health in 2017 and Beyond". UCSF Monthly Collaboratory Series. San Francisco, CA. January 12, 2017.	Moderator/panelist
2017	"Making an Impact in Science through Positive Influence". Leadership Panel: “Understanding, Bridging, Inspiring.” UCSF Zuckerberg SFGH. Symposium, February 2, 2017.	Lead panelist
2017	"The Treat of the Trump Administration for Women’s Access to Reproductive and other Preventive Health Services for Women". UCSF Community Dialogue for Women’s Health, January 20, 2017.	Invited panelist

2017	"Lessons Learned in Translating Research into Policy." Research That Gets Results: A Symposium on Science-Driven Policy Change. Bixby Center for Global Reproductive Health. March 2, 2017.	Invited panel presentation
2017	"Science Advocacy 101". Forum with Vice Chancellor for Science Policy and Strategy. In the series of "Advocating for Science and Scientists in 2017 and Beyond." Graduate Division and the Science Policy Group at UCSF March 27, 2017. https://graduate.ucsf.edu/be-an-advocate	Invited panelist
2017	"Federal Policy in 2017: What Faculty Should Know and What They Can Do." University of California, San Francisco Academic Senate Division Meeting, May 11, 2017. https://senate.ucsf.edu/division-meeting.	Invited presentation
2017	"At the Policy Forefront: Evaluating California's Efforts in Assuring Access to Quality Reproductive Health." University of California, Sacramento Speakers Series: August 2, 2017. http://uccs.ucdavis.edu/events/2017-August-2-Brindis	Invited presentation
2017	"Trumpcare: Is It the Right Treatment for What Ails the American Health Care System?" Commonwealth Club, San Francisco. August 3, 2017. https://www.commonwealthclub.org/events/archive/podcast/trumpcare-it-right-treatment-what-ails-american-health-care-system	Invited presentation
2017	"Lessons Learned in a Policy Translation Research Career". Dean's Forum on Public Service. Herbst Hall Auditorium, UCSF Mt Zion Campus. August 28, 2017.	Invited presentation
2017	"At Risk – Protecting Women's Health During a Time of Uncertainly." The Yale Alumni Non Profit Alliance, San Francisco. November 14, 2017.	Invited presentation
2017	UCSF Preterm Birth Initiative World Prematurity Day: The CA Policy Roundtable Working Toward a Policy Action Agenda. San Francisco, CA. November 15, 2017.	Invited session chair
2018	"Personal Leadership Development". Johnson & Johnson Foundation: GenH Challenge: Personal Leadership Development. San Francisco, CA. January 18, 2018.	Invited presentation
2018	"Mentorship and Sponsorship are Crucial to Career Development for Women Faculty". UCSF Faculty Mentoring Program. Mentorship and Sponsorship are Crucial to Career Development for Women Faculty. San Francisco, CA. January 31, 2018.	Invited panelist
2018	"Discussion on Childhood Mortality". Clinical and Translational Research Fellowship Journal Club, Discussion on Childhood Mortality. University of California, San Francisco, CA. February 15, 2018.	Expert discussant

2018	"The Role of Policy Research within Precision Medicine". Marcus Mixer2: Marcus Program in Precision Medicine Innovation (MPPMI), UCSF Research Development Office's Team Science Program. University of California, San Francisco, CA. February 21, 2018.	Invited speaker
2018	"The Role of Academic Centers within the Field". First Annual Colloquium on Population Health and Health Equity. University of California, San Francisco, CA. May 28, 2018.	Invited panelist
2018	"Theories, Design, Strategies, and Instruments for Evaluating Advocacy and Policy Change Initiatives". San Francisco Bay Area Evaluator's Workshop. San Francisco, CA, June 20, 2018	Invited presentation
2018	"Policy Translation: Lessons Learned". RISE Speaker Series, Center for Vulnerable Population. University of California, San Francisco, CA. July 11, 2018	Invited presentation
2018	"Lessons Learned in Developing a Policy Translational Career in Reproductive Health". Brown Bag Luncheon Series, Philip R. Lee Institute for Health Policy Studies. University of California, San Francisco, CA. August 21, 2018.	Invited presentation
2018	"Advancing Health Equity and Justice in California: A Landscape Analysis". Hispanics in Philanthropy Advancing Latino Health Equity Convening. Oakland, CA. November 7, 2018.	Invited presentation
2018	"Through the California Crystal Ball: A Health Landscape and Future Direction". National Advisory Council and Faculty Task Force, California Health Benefits Review Program Annual Meeting. Berkeley, CA. November 15, 2018.	Keynote speaker

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1988 - 1991	Office of Technology Assessment Adolescent Health, U.S. Congress	Advisory Panel
1994 - 2000	Community Partnerships for Healthy Children Initiative, Sierra Health Foundation, Sacramento, California.	Evaluation
1995 - present	National Campaign to Prevent Teenage Pregnancy	Program Effectiveness Task Force, State and Local Leadership Task Force, Science into Policy National Advisory Latino Initiative
1995 - 2000	Community Coalition Partnership Programs for the Prevention of Adolescent Pregnancy, Centers for Disease Control and Prevention, Atlanta, Georgia	Consultant
1995 - 1997	Adolescent Pregnancy Prevention Initiative, The California Wellness Foundation.	Advisor

1995 - 2002	Adolescent Pregnancy Prevention Initiative, Johnson & Johnson Corporation and the Na¬tional Organization for Adolescent Pregnancy and Parenting (NOAPP), Washington, DC	National Advisory Committee
1995 - 1995	Adolescent Health Work Group, Maternal and Child Health Bureau, U.S. Department of Health and Human Services.	Member
1996 - 1998	Steering Committee on Welfare Redesign, California Department of Social Services	Member
1996 - 2000	Adolescent Managed Care Advisory Committee Children Now, Oakland, California	Member
1996 - 2000	Georgia Campaign to Prevent Adolescent Pregnancy, Jane Fonda, Turner Foundation, Atlanta, Georgia	Consultant
1997 - 1997	Kaiser Kids Health Insurance Initiative, Kaiser Permanente Health Plan	Consultant
1997 - 1997	Year 2000 Community Initiative, David and Lucile Packard Foundation	Consultant
1998 - 1998	Community Partnerships to Reduce Teenage Pregnancies, The Flinn Foundation, Phoenix, Arizona	Consultant
1999 - 1999	Messengers and Methods for the New Millennium; A Round Table for Adolescents and Contraception. National Campaign to Prevent Teenage Pregnancy, and Advocates for Youth, Washington, DC	Member
1999 - present	National Teenage Pregnancy Prevention Research Center, University of Minnesota and Centers for Disease Control and Prevention	National Advisory Board
1999 - present	California Adolescent Health Collaborative	Co-Director and Executive Steering Committee Member
1996 - 1997	Advocates for Youth, Washington, DC	Program/Policy Committee Chair, Executive Committee, and Chair, Board of Directors
1996 - 1999	Frontiers of Research on Children, Youth, and Families Committee, Institute of Medicine National Research Council, Washington, DC	Member
1997 - 1997	Open Society Foundation, New York, NY	Advisor
1997 - 2000	Development of Community Guidelines for Preventive Services, Centers for Disease Control and Prevention, Atlanta, GA	Advisory Committee

1997 - 2000	Preventing Teen Pregnancy: Sharing Lessons Learned" Project. Centers for Disease Control and Prevention, and University of South Carolina, School of Public Health	Expert Panel
1997 - 2001	Board on Children, Youth, and Families, National Research Council, Institute of Medicine, Washington, DC	Forum on Adolescence
1997 - 2002	Adolescent Pregnancy Prevention Replication Project, Kansas Health Foundation	Technical Review Advisory Committee
1997 - 1997	Partnership for Information and Communication. Maternal and Child Health Bureau, Washington, DC	Inter-Organizational Workgroup
1997 - 1999	National Health Promotion and Disease Prevention Objectives for the Year 2010, Centers for Disease Control and Prevention	Core Work Group for Developing and Implementing Adolescent Health Objectives
1998 - 1998	Pan American Health Organization (PAHO), Division of Health Promotion and Protection, Family Health and Population Program, Washington, DC. Policies for Adolescents and Young Adults of the Americas	Advisory Group
1998 - 1998	Development of a Family Health Initiative, Maternal and Child Health Bureau, Washington, DC	Advisory Committee
1998 - 2000	Health Initiatives for Youth, San Francisco	Member, Adolescent Health Working Group
1998 - 2004	Centro Mujeres, La Paz, Baja California Sur, Mexico	Advisory Board
1998 - 2010	Addressing Barriers to Student Learning: Closing Gaps in School/Community Policy and Practice, Center for Mental Health in Schools, Department of Psychology, UCLA	Steering Group
1998 - 2001	Girl Neighborhood Power! Building Bright Futures for Success Initiative, Healthy Mothers, Healthy Babies Coalition, Washington, DC	Steering Committee
1999 - 1999	CDC Teen Pregnancy Prevention Consensus Panel on Replication, Atlanta, GA	Panel Member
1999 - 2002	Association of Maternal and Child Health Programs, Adolescent Data and Systems project (cooperative agreement with Centers for Disease Control and Prevention, Division of Adolescent and School Health)	Advisory Panel
1999 - 2002	Women's Health Report Card Project, National Women's Law Center, the Focus on the Health of Women Project of the University of Pennsylvania Medical Center, and the Lewin Group, Inc	National Advisory Board

2000 - 2001	Adolescent Report Card Project, Children Now, Oakland, California.	Member
2000 - 2002	Sexuality and Reproductive Health Expert Panel of the Health, Mental Health and Safety in Schools Guideline Project, American Academy of Pediatrics, funded by Maternal and Child Health Bureau, U.S. DHHS	Chair
2000 - 2002	Workgroup on Standardizing Adolescent Performance Measures, Association of Maternal and Child Health Programs, Washington, DC	Member
2001 - 2001	State Team, Joint Work Group on School-Based Teen Pregnancy Prevention, California Department of Education, California Department of Health Services, National School Boards Association, Washington, DC.	Team Member
2001 - 2001	Workgroup on Teen Pregnancy Prevention Programs, California Department of Health Services, Sacramento, California.	Member
2001 - 2001	Workgroup, Implementation of California's School Health Blueprint, California Department of Education and Department of Health, Sacramento, California.	Member
2001 - 2002	Women's Health Panel, Bright Futures for Women's Health and Well-Being: National Guidelines Project, Maternal & Child Health Bureau, DHHS, Washington, DC	Steering Committee; Chair, Adolescent Health Committee
2001 - 2004	Policy Committee, California Chlamydia Action Coalition, sponsored by the California Department of Health Services, California HealthCare Foundation, and the University of California, San Francisco.	Member
2001 - present	National Expert Panel, 2003 Children's National Health Survey, National Center for Health Statistics, funded by Bureau of Maternal and Child Health	Member
2002 - 2002	National Advisory Board, Georgia Campaign to Prevent Teenage Pregnancy, Jane Fonda, Executive Director	Member
2003 - 2005	Delivery Improvement, Technical Expert Panel Meeting, U.S. Public Health Title X, Washington, DC	Member
2003 - 2005	International Planned Parenthood Federation- Latin America Development of Peer Provider Manual Project	Consultant
2005 - 2005	Johns Hopkins School of Public Health Maternal and Child Health Training Program	Advisory Committee

2005 - 2005	Grantmakers for Children, Youth & Families Maternal and Child Health Issues	Advisory Committee
2005 - 2005	Public Policy Institute, California	Advisory Committee
2005 - 2007	Contributions from the Behavioral & Social Sciences in Reducing and Preventing Teen Motor Crashes Institute of Medicine and the Division of Behavioral and Social Sciences and Education. The National Academies of Sciences, Washington DC.	Committee Member
2006 - 2006	CDC Adolescent Sexual and Reproductive Health Portfolio (ASRH	Member, Expert Panel Review
2006 - 2006	Centers for Disease Control Health Promotion and Disease Prevention Research Centers: Reproductive Health and Review Panel, Atlanta, GA	Child & Adolescent Health Review Panel
2006 - 2010	NARAL, Pro-Choice America Foundation	Board of Directors, Chair, Program Committee
2007 - 2007	Federal Office of Population Affairs, Washington, DC	Technical Experts Advisory Committee
2007 - 2009	Institute of Medicine (IOM) Committee: A Comprehensive Review of the DHHS Office of Family Planning Title X Program	Member
2008 - 2008	CARTA Study on Adolescent Sexual Health Disparities	Consultant
2008 - 2008	Advisory Council, San Francisco County Adolescent Health Working Group, San Francisco, CA.	Member
2009 - present	National Adolescent Health Objectives 2020, Centers for Disease Control and Bureau of Maternal and Child Health	Consultant
2009 - present	National Institute of Health (NIH)	Ad Hoc Challenge Grant Reviewer,
2009 - 2010	California Breast Cancer Research Program Priority Setting Process, Oakland, CA	Policy Evaluation Advisor
2009 - 2011	Institute of Medicine (IOM) Committee on Pediatric Health and Health Care Quality Measures	Member
2009 - present	National Institute of Child Health and Human Development (NICHD)	Scientific Reviewer
2009 - present	Tipping Point Community, San Francisco, CA	Evaluation Consultant
2010 - present	Reproductive Life Plan, Education, Access to Health care in College High Risk (REACH) Teens California Leadership Advisory Group	Advisory Group Member

2010 - 2010	AcademyHealth Abstract Review Committee	Member
2010 - 2011	Institute of Medicine (IOM) Committee on Preventive Services for Women	Member
2010 - 2010	Centers for Disease Control and Prevention (CDC) Division of Adolescent School Health (DASH), Expert Panel	Consultant
2011 - 2012	Guttmacher Institute	Board of Directors
2011 - 2011	Office of Population Affairs (OPA), Office of Family Planning (OFP), and the Centers for Disease Control and Prevention. Revision of the Title X Family Planning Program Guidelines, Adolescent Panel	Member
2011 - present	Public Health Institute	Board Member
2011 - 2012	Guttmacher Institute	Board Member
2012 - 2012	Department of Health and Human Services (HHS) and Health Research Services Administration (HRSA) Office of Women's Health Expert Panel on Curriculum Development in Women's Health	Expert Panel Member
2012 - 2012	AcademyHealth Aetna-National Assembly on School-Based Health (NASBHC) Care Coordination	Advisory Committee Member
2012 - 2014	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Chair
2013 - 2013	Department of Health and Human Services (HHS) and the Office of Adolescent Health (OAH) "Think Adolescent Health" agenda	Expert Panel Member
2013 - 2013	Department of Health and Human Services (HHS) and the Office of Adolescent Health (OAH) Technical Workgroup: Cost Study of Evidence-Based Teen Pregnancy Prevention (TPP) Programs.	Technical Working Group Member
2013 - 2013	National Academy of Medicine (NAM, formerly IOM) Workshop Panel	Member
2013 - present	Drexel University DrPH/Health Policy and Social Justice Advisory Committee	Committee Member
2013 - 2015	Patient Centered Outcomes Research Institute/PCORI Evaluation Group.	External Advisor
2013 - 2014	National Academies of Science (formerly IOM): Improving the Health, Safety and Well-being of Young Adults	Committee Member

2014 - present	National Academies of Science (formerly IOM) Interest Group: Health Policy and Health Care Systems	Committee Member
2015 - 2018	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Chair
2015 - present	Centers for Disease Control and Prevention. Division of the National Health Interview Survey: The National Survey of Children's Health	Technical Expert Panel Member
2016 - present	Public Health Institute (PHI) Audit Committee	Chair
2016 - 2018	California Health Interview Survey (CHIS) Teen Technical Advisory Committee (TAC)	Chair
2016 -	Urban Institute: Beyond Birth Control Project: Family Planning and Women's Lives Advisory Group	Consultant
2016 - 2018	National Academies of Sciences, Engineering, and Medicine's (the Academies) Committee on Improving Health Outcomes in Children with Disabilities	Member
2017 - 2018	AcademyHealth	Board Secretary
2017 - 2018	John Hopkins Bloomberg School of Public Health: The Bloomberg American Health Initiative	National Advisory Board
2017 - 2018	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee.	Technical Advisory Committee
2018 -	National Academy of Medicine, Committee on Science, Engineering and Medicine and Public Policy (COSEMPUP)	Committee Member
2018 - 2019	Urban Institute: Reproductive Health Care Access Group	Advisory Committee Member
2018 - 2019	National Academies of Sciences, Committee on Neurobiological and Socio-Behavioral Science of Adolescent Development and Its Applications	Committee Member
2018 -	Campaign for Male Youth, The Partnership for Male Youth	Advisory Panel Committee

UNIVERSITY AND PUBLIC SERVICE

SERVICE ACTIVITIES SUMMARY

In my interface between research and public policy, I am often called upon to help a variety of community groups, city and county governments, as well as the federal government in helping to translate research findings for purposes of planning and development of new projects. For example, I have been called as an expert in program development for a number of states

including California, Washington, Hawaii, South Carolina, New Mexico, Ohio, and Georgia in the areas of adolescent health policy, pregnancy prevention, and pregnancy treatment programs. With my methodological expertise in the area of program evaluation, I have also provided brief consultation on how to best capture data and document both the short, as well as longer term outcomes, of their program efforts. A fulfilling experience was being invited by the State of California Governor's Office and Department of Health, beginning in the 1990s, to help develop a Teenage Pregnancy Prevention Initiative, based upon evidence and best practices. It was through these efforts that California implemented a wide portfolio of different community, media, and policy interventions that has contributed to our state's lead in decreasing the incidence of adolescent pregnancy throughout our country and across diverse ethnic and racial groups. Many of the programs that I recommended, based upon the existing evidence, continued to operate in communities throughout the state, funded by both federal and state funds, until the first decade of the 21st century. However, when the political climate turned, many of these programs were eliminated and I researched the impact of these closures on adolescents' access to reproductive health information and services. This data was important for a number of advocates concerned with programmatic closures and have been used to seek and advocate successfully for additional funding to re-start those programs. In another area, we also provided expertise to the state as they developed programs aimed at helping women who are pregnant or parenting and who are chemically dependent throughout the state.

On the national level, I served on the Patient Centered Outcomes Research Institute's (PCORI) Evaluation Group (PEG) Task Force, as part of PCORI's Research Integration and Evaluation team. The PEG is reviewing the impacts and effectiveness of PCORI. On a personal note, I was gratified to serve on several NAM (previously name the IOM) Report Committees; the most influential was the Committee on Preventive Health Services for Women, which developed recommendations for preventive services for women without co-payments as part of health care reform. All eight of our recommendations were accepted by the Obama Administration and were embedded in the Accountable Care Act. This resulted in over 80 million women receiving contraceptive coverage without co-payments in 2017. I recently completed work on several other NAM study committee, resulting in a major report entitled, Improving the Health, Safety, and Well-Being of Young Adults (2013) and Opportunities for Improving Programs and Services for Children with Disabilities (2018). For each study, I represented the Committee as we present the findings nationally to our policy funders and other national stakeholders. Earlier in 2013, I served on the NAM workshop planning committee for the study on Young Adults and provided the major overview talk on this topic, helping to shape the final study scope of work. I have also served as an external expert reviewer of several NAM reports, including "The Safety and Quality of Abortion Care in the United States" and "The Integration of Immigrants into American Society" for the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine. Currently, I am serving on the Committee on the Neurobiological and Socio-Behavioral Science of Adolescent Development and its Applications. Furthermore, in late 2018, I was elected by the full membership of NAM to serve as a member of the NAM Council (2018-2021), which represents the President's active kitchen cabinet, shaping NAM's agenda.

I have also sought opportunities to more widely disseminate research information in formats that assist communities in being able to use research and program evaluation to help shape programs and policy. For example, in co-leading a research project pertaining to Latina childbearing, we were commissioned to develop a film aimed at state policy makers. Recognizing that the film would be useful for other groups, I sought to focus on its wide dissemination, not only in California, but nationally where the issue has become a pressing one

for many communities that have not had the same history of programmatic efforts in this arena. I also sought to assure that the film would be available in Spanish, thus creating a resource for communities both in the US and in the Spanish speaking world. The film and a variety of educational materials are now available on our website for downloading, along with community guides providing suggestions for how to use the film in community settings. In other arenas, I have been called upon to provide expert testimony both in Congress and in Sacramento as policy makers seek to identify viable models for improving the health of children and adolescents. I have also provided congressional staff briefings on topics that range from health care reform and the federal and state Children's Health Insurance Program, to violence prevention to adolescent pregnancy prevention. Long after the briefing is over, I continue to work with the policy staff to provide support as they attempt to incorporate evidence-based research into their decision-making. For example, I serve on the Advisory Council for efforts sponsored by City and County of San Francisco Health Department focused on Increasing Patient-Centered Care for Young Women. I also serve on the Steering Committee on a joint SF City and County Health Department and UCSF partnership (led at UCSF by Dr. Anda Kuo) to improve the coordination of health and well-being services for children and adolescents living in our county.

On our own campus, I have worked to balance my responsibilities as the Institute's Director, along with concurrent efforts to integrate the message of the importance of health services, population health, and health policy in a variety of campus initiatives, including Precision Medicine, the Institute for Computational Health Sciences, including serving on the Executive Committee and the Health/Clinical Informatics Committee, and the Mid-Career Recruitment Committee. In addition, I represented IHPS on the Long Range Development Planning Committee (LRDP), serving as a Liaison to its Community Advisory Group, as well as on the Bridge Committee for the past 7 years. I also serve on the SOM Campus Space Planning Committee and have served on the campus' Diversity Council, as well as the Limited Submission Review Committee.

Even more "up- stream" has been my effort to serve (for the past 6 years) as a year-long mentor to individuals in under-represented groups as part of the Office of Outreach & Academic Advancement Post Baccalaureate program. In addition, I have been actively involved in mentoring and engaging a number of junior faculty on our campus, as well as being actively engaged in recruiting faculty "of color" to our campus. In these and other cases, I look beyond IHPS' walls to consider how I can support these diverse faculty members as they transition to UCSF.

UNIVERSITY SERVICE

UC SYSTEM AND MULTI-CAMPUS SERVICE

1996 - present	Maternal and Child Health Training Program, School of Public Health, UCB	Advisory Board
2007 - 2009	UC Santa Cruz-Silicon Valley Management School	Advisory Board
2000 - present	California Program on Access to Care, California Policy Research Center, University of California, Office of the President	Board Member

2005 - 2006	Inter-Campus Research Program on Children and Adolescent Health / UC Consortium on Children, Family and Community	Steering Committee
2006 - 2008	UC Mexus for the Social Sciences, Humanities & the Arts	Faculty Grants Review Committee
2007 - present	UCSF Global Health Sciences, UC Davis, UCB, UC San Diego, and UCLA	Steering Committee
2007 - present	UC Santa Cruz-Silicon Valley Management School	Advisory Board
2009 - present	UCB and UC Davis, Migration and Health Research Center (MAHRC)	Advisory Board Member
2009 - 2009	Health Services and Policy Analysis (HSPA), Division of Health Policy and Management, School of Public Health, University of California, Berkeley,	Affiliate Faculty Member
2010 - 2010	Review of Research Portfolio University of California, Office of the President	Expert Reviewer
2011 - 2017	Core Curriculum Committee for Multi-Campus University of California Global Health Initiative (UCGHI) MS in Global Health Program	Member
2012 - 2012	UC Berkeley's Center for Weight and Health California's Community Transformation Initiative (CACTI)	Advisory Board Member
2012 - 2014	California Health Interview Survey (CHIS) Adolescent Technical Advisory Committee	Chair
2014 - 2017	Maternal and Child Health, Measurement Research Network (MCH-MRN)	Co-Chair and Advisory Board Member
2015 - 2017	UC-Mexico Initiative Health Initiative of the Americas, Health Working Group (HWG)	Co-Chair and Member
2016 - present	The California Program on Access to Care (CPAC)	Chair and Member
2018 - present	UCLA Fielding School of Public Health, Research on ImmiGrant HealTh and State policy (RIGHTS)	Technical Advisory Committee Member
2018 - present	UC Berkeley's Center for Excellence (CoE) in Maternal and Child Health	Advisory Board Member

UCSF CAMPUSWIDE

1996 - 1999	Social and Behavioral Training in AIDS/HIV Research, Predoctoral training program, funded by University wide AIDS Research Program, sponsored by Department of Social and Behavioral Sciences, Center for AIDS Prevention Studies, and School of Nursing International Center for HIV/AIDS Research and Clinical Training Program	Advisor
1999 - 2001	Community-Based Research and Fellowship Program, Center for Health and Community	Advisory Board Member
2004 - 2004	Vice Chancellor's Community Partnership Task Force	Member
2004 - 2009	Chancellor's Council	Member
2004 - 2004	Stewardship Review, Institute for Health and Aging	Committee Member
2004 - 2006	Global Health Sciences, Research Subcommittee, Executive Committee, and Training Subcommittee	Member
2005 - 2006	Global Health Sciences Strategic Plan Working Group	Member
2006 - 2006	Program on Reproductive Health and the Environment (PRHE), Department of Obstetrics, Gynecology, and Reproductive Sciences	Advisory Committee
2006 - 2006	Center for Health and Community	Steering Committee
2006 - present	Program on Reproductive Health and the Environment (PRHE), Department of Obstetrics, Gynecology, and Reproductive Sciences	Advisory Committee,
2006 - 2009	Chancellor's Award for the Advancement of Women	Committee Chair
2007 - 2007	California Medicaid Research Institute (CaMRI), UCSF	Associate Director, Member, Steering Committee
2008 - 2008	Clinical and Translational Research Institute	Epidemiology Review Committee
2008 - 2009	Cardiovascular Research Institute	Member, Stewardship Review
2008 - 2010	UCSF Global Health Sciences Cuba Research Program in Health Diplomacy and Medical Education	Reviewer
2008 - 2011	Chancellor's Advisory Committee on the Status of Women (CACSW)	Member
2008 - present	Post Baccalaureate Program	Faculty Advisor
2008 - 2012	Resource Allocation Program (RAP) Clinical and Translational Science Institute (CTSI)	Multidisciplinary Review Committee

2009 - 2009	Department of Epidemiology and Biostatistics	Faculty Search Committee
2009 - present	First Generation Program	Faculty Advisor
2010 - 2010	Stewardship Review, Institute on Health and Aging (Dr. Wendy Max)	Chair
2010 - 2010	Graduate Group, UCSF Global Health Sciences	Member
2010 - 2013	Health Policy and Social Sciences Review Committee, Resource Allocation Program (RAP); Clinical and Translational Science Institute (CTSI)	Member, Health Policy and Social Sciences Review Committee
2010 - present	UCSF Coordination Committee-the San Francisco Bay Health Improvement Program (SF Bay HIP)	Member
2010 - present	Chancellor's Long Range Development Plan Oversight Committee	Member
2011 - 2012	School of Medicine Leadership Retreat Planning Committee	Member
2011 - 2012	Search Committee for the position of Vice Dean, Academic Affairs and Faculty Development	Member
2011 - 2012	Chancellor’s Martin Luther King Jr. Award Committee	Member
2011 - 2013	Limited Submissions Program (LSP)	Member, Steering Committee
2011 - 2014	Faculty Oversight Committee on Operational Excellence Initiatives	Member
2012 - present	Institute of Computational Health Sciences Executive Committee (ICHS)	Member
2013 - 2013	Search Committee for the position of Director of the Center for Health Professions	Member
2013 - 2013	International Research Advisory Council (IRAC)	Member
2013 - 2014	Search Committee for Executive Director, UCSF Center for Healthcare Value (CHV)	Member
2013 - present	Steering Committee, Precision Medicine	Member
2013 - 2018	Council on Campus Climate, Culture, and Inclusion (4CI)	Member
2014 - present	Search Committee, Dean, School of Medicine	Member
2014 - present	Graduate Group for the Doctoral Program, UCSF Institute for Global Health Science	Member
2014 - 2015	Knowledge Transfer Working Group, under the Benioff/Gates Pre-Term Birth Initiative	Co-Chair

2014 - present	UCSF Center for Vulnerable Populations	Member, Steering Committee
2015 - present	Multi-campus Research Programs and Initiatives: Sugar, Stress, Environments, and Weight Center (MRPI SSEW)	Member, Scientific Advisory Committee
2015 - present	Programming Committee for the Mission Bay East Campus Phase 1 Building	Member
2016 -	Academic Senate's Committee on Academic Personnel (CAP) Stewardship Review Committee (SRC) (RE: Dr. Nancy E. Adler)	Review Committee Member
2017 -	UCSF Faculty Mentoring Program Lifetime Achievement in Mentoring Award Selection Committee	Member
2017 –	Search Committee for Chief of Cardiology, San Francisco VA Medical Center	Member

SCHOOL OF MEDICINE

1996 - present	Institute for Health Policy Studies	Executive Advisory Committee
1998 - 1998	Faculty Review Committee, Institute for Health Policy Studies	Member
2000 - 2000	Ad Hoc Faculty Promotion Review Committee	Member
2000 - 2000	Ad Hoc Steering Committee for Integrated Clinical Studies	Member
2000 - 2000	Ad Hoc Search Committee	Member
2003 - 2005	Strategic Planning Committee, Institute for Health Policy Studies	Chair
2005 - 2007	Admissions Committee, School of Medicine	Member
2008 - 2008	Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Faculty Search Committee
2008 - present	School of Medicine Post Baccalaureate Program	Faculty Advisor
2009 - 2009	Search Committee for the Division Chief, Department of Obstetrics, Gynecology and Reproductive Sciences at San Francisco General Hospital.	Member
2009 - 2009	Space Committee, School of Medicine	Member
2010 - 2010	Search Committee, Department of Epidemiology & Biostatistics	Member
2010 - 2010	Search Committee, Director of Health and Society Pathway	Member

2010 - 2010	Dean's Faculty Oversight Committee	Research Administration Liaison
2010 - 2010	Search Committee, Faculty joint position in Health and Breast Cancer Risk Assessment; Department of Surgery, and Philip R. Lee Institute for Health Policy Studies.	Member
2011 - 2011	Compensation Plan Project Steering Committee, School of Medicine	Member
2011 - 2011	School of Medicine Leadership Retreat Planning Committee	Member
2013 - present	Internal Advisory Committee, Multidisciplinary Clinical Research Center (MCRC)	Member
2013 - present	Executive Committee, Institute for Computational Health Sciences (ICHS)	Member
2013 - present	Internal Advisory Committee, Multidisciplinary Clinical Research Center (MCRC)	Member
2015 - present	Building 33 Space Planning, Steering Committee	Member
2016 – 2017	Search Committee for New Chair, Department of Epidemiology and Biostatistics	Chair and Member
2019 - 2019	Bridge Funding Committee, School of Medicine	Member

SCHOOL OF NURSING

2004 - 2004	Search Committee, Department of Family and Community Nursing	Ad Hoc Chair
2007 - 2007	Health Disparities Tenure Track Search Committee, School of Nursing	Member
2009 - 2010	Dean's Search Committee School of Nursing	Member

DEPARTMENTAL SERVICE

1996 - 1997	Second Year Medical School Training, Integrated Curriculum, Department of Pediatrics	Task Force
1996 - 2000	Division of Adolescent Medicine.	Executive Committee
1996 - 2001	Pediatric Clinical Research Center.	Advisory Committee
2000 - 2000	Fellowship Review, Department of Pediatrics	Committee Member
2001 - 2005	Health Services/Health Policy, Strategic Planning Group, Department of Pediatrics	Strategic Planning Group

2008 - 2010	Faculty Search Committee, Chair of Pediatrics, Department of Pediatrics	Committee Member
2015 - 2016	Chief Nutritionist Search Committee, Clinical and Research Program, Chair of Pediatrics, Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Committee Member
2017 -	Director Search Committee Chair, Bixby Center for Global Reproductive Health	Committee Member

COMMUNITY AND PUBLIC SERVICE

1995 - 1997	Adolescent Pregnancy Prevention Initiative, The California Wellness Foundation.	Advisor
1996 - 1998	Welfare Redesign, California Department of Social Services.	Steering Committee
1996 - 2000	Adolescent Managed Care, Children Now, Oakland, California.	Advisory Committee Member
1999 - present	California Adolescent Health Collaborative	Co-Director and Executive Steering Committee Member
2000 - 2001	Children Now, Oakland, California	Adolescent Report Card Project
2001 - 2001	State Team, Joint Work Group on School-Based Teen Pregnancy Prevention, California Department of Education, California Department of Health Services, National School Boards Association, Washington, DC.	Team Member
2001 - 2004	California Chlamydia Action Coalition, sponsored by the California Department of Health Services, California HealthCare Foundation, and the University of California, San Francisco.	Policy Committee
2001 - 2001	Teen Pregnancy Prevention Programs, California Department of Health Services, Sacramento, California	Workgroup Member
2001 - 2001	Implementation of California's School Health Blueprint, California Department of Education and Department of Health, Sacramento, California	Workgroup Member
2002 - 2002	Georgia Campaign to Prevent Teenage Pregnancy, Jane Fonda, Executive Director	National Advisory Board
2008 - 2008	San Francisco County Adolescent Health Working Group, San Francisco, CA.	Advisory Council

2009 - 2010	California Breast Cancer Research Program Priority Setting Process, Oakland, CA	Policy Evaluation Advisor
2009 - 2012	Tipping Point Community, San Francisco, CA	Evaluation Consultant
2013 - present	Healthy People 2020 Adolescent Workgroup, Washington DC	Workgroup Member
2014 - present	Too Small to Fail, Menlo Park, CA. Moderated by Hillary Clinton, 22 Adolescent Health experts invited to a roundtable discussion of the Clinton Foundation initiative on their efforts to improve the health and well-being of children ages zero to five. Ongoing involvement.	Panel Participant
2014 - present	Internal Reproductive Integrative Skin (IRIS), Increasing Patient-Centered Care for Young Women, City and County of San Francisco	Member, Advisory Council
2015 - present	Advisory Board, WestEd Justice & Prevention Research Center, Teen Pregnancy Prevention Program within the Oregon Youth Authority	Member

CONTRIBUTIONS TO DIVERSITY

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As a Spanish-speaking immigrant to the U.S. in the late 1950s, my professional research and public service activities focused on social disparities and equity have been shaped by the bullying and marginalization that I experienced initially as a non-English speaker. My public health training (Master's and Doctoral Degree) also provided me with an opportunity to understand from a theoretical perspective how structural factors, policies, and social inequalities shape the health of the public, specifically, access to health care services, education, and other economic platforms aimed at improving health and well-being. Much of my research has focused upon the reproductive health needs of low-income women and men, as well as adolescents. For nearly 20 years, I led a team evaluating the Family PACT program, which cares for individuals up to 200% of poverty, with over two-thirds of the clients being of Latino/a heritage. Our comprehensive evaluation led to quality improvement, as well as policies related to reimbursing clinics who served undocumented individuals, in spite of the Federal position not to pay for such services. Other health topics in which I have conducted diversity-relevant research, include: teenage pregnancy prevention program evaluation, pre-term birth initiatives, substance abuse treatment services, immigrant health, in particular, the impact of migration on the health of immigrants, the physical and mental health needs of Dreamers (Deferred Action for Childhood Arrivals), and the effectiveness of community-based clinics, school-based health centers, and community-based organizations focused on reducing asthma and increasing health care access. I have also conducted research studies related to the needs of diverse adolescents and young adults' access to health insurance and health care access, with a strong emphasis on analyzing the data to further understand variations in patterns among ethnic and racially diverse young people. Most recently, my focus has turned

to issues of social determinants of health and their impact upon health care access and utilization among marginalized populations.

I have also promoted diversity and equality opportunity through my service activities as a campus leader. I served as Chair of the Chancellor's Committee on the Advancement of Women from 2007 to 2009. During my tenure, I led efforts to conduct retreats for junior faculty pertaining to the "soft issues" inherent in career advancement. I have been delighted to see how many of the ideas during those events have been incorporated into the Faculty Development Day. As a result of some of these activities, I was gratified to be awarded the Chancellor's Award for the Advancement of Women in 2009. I have also served on the Irene Perstein Award Committee, aimed at supporting junior faculty, many who represent diverse backgrounds, at crucial moments in their career. Most recently, I served as a member of the Council on Campus Climate, Culture, and Inclusion (4CI), chaired by Vice Chancellor of Diversity and Outreach, Dr. Renee Navarro (Please see sections on research, teaching and service for additional examples of my commitment to diversity). Finally, I was asked to serve as the Co-Chair of a Committee on Pre-Natal Health as part of a major UC Office of the President-Mexico binational Initiative, led by President Janet Napolitano and the Mexican Secretary of Health. The other two committee worked on topics related to Violence and Diabetes. I was honored to share my responsibilities with the Director of Mexico's NIH Perinatal Health. A number of bi-national research exchanges were established as a result of this endeavor.

TEACHING AND MENTORING

TEACHING SUMMARY

My primary teaching activities at UCSF focus on formal teaching within Pediatrics 180.01D, the core seminar for adolescent medicine. The program is the longest continually funded national training program in Adolescent Medicine (since 1977) and is one of seven federally funded interdisciplinary training programs in Adolescent Medicine. I also guest lecture in other courses offered in the Schools of Medicine, Pharmacy, and Nursing at UCSF and the UC Berkeley, School of Public Health, as well as advising post-doctoral, doctoral, and Master's Degree students within the School of Medicine and School of Nursing. Most recently, I have become an affiliated member of the Institute for Global Health Sciences, where I am currently chairing the Doctoral Committee for 3 of their Doctoral students, as well as serving on two Defense Committees. In addition, for 17 years, I was the Director and primary faculty member of the William and Flora Hewlett Foundation Postdoctoral fellowship in Reproductive Health policy and Program Evaluation for Latin American scholars. Under my guidance, the program successfully graduated more than 30 fellows from Mexico, Peru, Venezuela, Columbia, Nicaragua, El Salvador, Guatemala, and Brazil, many of whom are involved in senior academic and government positions with high levels of influence in their respective countries. I also conduct seminars in research methodology, program evaluation, reproductive health, and adolescent health in several training programs. As an example of other types of professional teaching, I have conducted several health policy lectures that have been taped for the UCTV website, and downloaded throughout the state, nationally, and internationally, along with webinars shown nationally through the federal Maternal and Child Health Bureau.

I have also worked across 10 UC campuses in the development of a UC system-wide Global Health Institute. We successfully competed and were awarded planning and implementation grants for two of the 3 initially selected areas: Immigrant and Transborder Health and Women's Health and Empowerment. Previously, I also served as an evaluation consultant on the UCSF-MUHAS Tanzania Twinning project funded by the Gates Foundation. This program focused on

the curriculum reform of the 5 school MUHAS campus: Medicine, Pharmacy, Nursing, Dentistry and Public Health. I have also developed a number of teaching aids that are being used both at UCSF and in a number of campuses across the country, for example, a long distance learning course on adolescent health, a Resource Curriculum on Adolescent Health for Schools of Public Health, in collaboration with the Association of Schools of Public Health, as well as power point presentations on Latino Adolescent Reproductive Health, Young Adult Health, and the impact of the Affordable Care Act (ACA). Most recently, I led and/or served as the moderator of 4 national webinars on the subject of adolescent health and disparities, the ACA and adolescents and young adults, and the potential impact of the ACA on young adult health, all of which have been widely disseminated. In addition, I either taught or moderated three sessions in a recent-6 part Mini-Medical School series on health policy, which is available through UCTV (http://www.uctv.tv). Along with other health policy lectures sponsored by the Institute (mentioned above), these have been downloaded by over 3 million viewers.

During my tenure as Director, the emergence of a dynamic relationship between UCSF and UC Hastings has provided the opportunity to establish an innovative Master's program that focuses squarely on health policy and law. In 2009, the UCSF-UC Hastings Consortium on Law, Science, and Health Policy was initiated to develop and support interdisciplinary collaboration on subjects at the intersections of these fields through education, research, and clinical training and service. The Consortium has since established programs in all three areas and has also spearheaded the development of a formal affiliation agreement between the universities, which included the stated desire to support development of the MS in Health Policy and the Law (HPL). This exciting endeavor, led by Dr. Daniel Dohan (Professor, DAHSM and IHPS Associate Director for Training and Development) and Dr. David Faigman (UC Hastings) College of Law, now Dean) was launched in Fall 2016. It is a one-year program designed to prepare students to be effective researchers and leaders in a dynamic new landscape, whether in health policy research or in health law. The MS HPL targets individuals with backgrounds in the clinical sciences, health sciences, public heath, public policy, or law.

To kick-start planning and implementation of this effort, we developed a proposal and were awarded the campus' second Chancellor's Education Innovation Award by the Executive Vice Chancellor and Provost's (EVCP) Office, representing a $400,000 loan to support the development of the new MS HPL. Our collaborative partner, Dr. Catherine Lucey, Vice Dean for Education in the SOM, has been instrumental in the degree's development. We were also fortunate to have the support of campus leadership (including Graduate Division Dean Elizabeth Watkins, former Librarian Karen Butter, former Vice Chancellor Joe Castro, School of Nursing Professor Mary Louise Fleming), and other expert faculty at UCSF and UC Hastings. The MS HPL represents a major commitment and is part of a larger coordinated effort by the Chancellor/EVCP and SOM, to establish a campus–wide, on-line program (vendor-supported) and WASC-approved degree. The MS HPL is being conferred by UCSF and UC Hastings, jointly taught, and administered by PRL-IHPS. We recently graduated the first cohort of students and have an active class of 35 students per cohort. I have participated in the development of course material on program evaluation and was asked to serve as an affiliated faculty member of UC Hastings School of Law.

FORMAL TEACHING

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2004 -	Adolescent Pregnancy: A Current Profile and Dilemma for Clinicians and Other Decision makers," Clinical Conference of Child and Adolescent Psychiatry, Langley Porter, Psychiatric Institute	Guest Lecturer		150
	2006 -	"The Use of Focus Group Research Methodology in Health Services Research," Health Policy Post-Doctoral Program, UCSF	Lecturer		30
	2006 -	"Conducting Effective Community Needs Assessments for Adolescent Health," Program in Maternal and Child Health, School of Public Health, UCB	Guest Lecturer		25
	2008 -	Parental Notification: What can be learned from the experience of other states? Grand Rounds, Department of Obstetrics, Gynecology, and Reproductive Health Sciences	Guest Lecturer		70
	2008 -	Translating Research in Policy: Lessons Learned. Institute for Health Policy Studies, Post-Doctoral Fellowship.	Guest Lecturer		20
	2009 -	Health Care Reform (Part of a Mini-Medical School series)	Guest Lecturer		60
	2013 -	Taking the Pulse: Improving the Health, Safety and Well-Being of Young Adults. UCSF Center for Vulnerable Populations Seminar Series	Guest Lecturer		20
	2013 -	Adolescent and Young Adult Health: Implications for Public Health, Mental Health Policy, and Clinical Services. UCSF Department of Psychiatry; Psychiatry, Child and Adolescent Psychiatry (CAP) Grand Rounds	Guest Lecturer		20

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2013 -	Building Interdisciplinary Research Careers in Women's Health (BIRCWH)	Guest Lecturer		20
	2013 -	Health Care Reform (Part of a Mini-Medical School series)	Guest Lecturer/Panelist		80
	2013 -	Report Back from Institute of Medicine Meeting: Improving the Health, Safety and Wellbeing of Young Adults. UCSF Center for Vulnerable Populations Seminar Series (also available as video at CHARM Website) Sept. 9, 2013	Guest Lecturer		50
	2014 -	How Will We Know it is Working: Monitoring the Impact of the ACA in Years to Come. UCSF IHPS-Osher Mini Medical School on Health Reform	Panel Member		80
	2008 - 2008	Pediatrics Core Seminar 180.01D	Lectures and responsible for Health Policy Core		15 - 20
	2006 - 2006	"Evaluation Methods Applied to School-Based Health Clinics," School of Nursing	Guest Lecturer		20
	2007 - 2007	Latino Adolescent Pregnancy Prevention. 2nd Year Medical School Elective	Guest Lecturer		30
	2008 - 2009	Adolescent Sexual Health in the Latina population, Latina Issues Elective, UCSF School of Medicine.	Guest Lecturer		40 - 60
	2010 - 2017	Pediatrics Core Seminar 180.01D	Guest Lecturer		25

MENTORING SUMMARY

As a Latina faculty member, I am particularly sought by Latino/a students who are interested in having me serve as a content and career mentor. I am the primary mentor for four to six fellows (Pediatrics and Obstetrics/Gynecology and Reproductive Health Sciences) each year, and I often meet with other postdoctoral fellows, graduate students, junior and senior faculty to discuss research designs, program development, grant development, and career development. I have been gratified to receive uniformly glowing comments from these interactions. I have also had an outstanding record in mentoring my large staff of researchers and helping them along in their career development, as well as the junior and senior faculty of IHPS.

As one of a relatively small number of Latina women in leadership on our campus, I have defined the area of mentoring of diverse trainees to be an important priority and responsibility, not only for the Institute, but also for the campus in general. As an immigrant, I have a particular sensitivity to the promotion of diversity and enhancing the opportunities of our faculty, trainees, and staff. I am a proud participant in our campus' First Generation Initiative (First to go to college-FG2C), formally and informally mentoring a number of medical, nursing, pharmacy, and dentistry students.

I also recognize that at this point in my career, I will be further promoting other members of our faculty and research staff to begin to take on a number of the lectures that I have been invited to provide for decades. This is part of the teaching-mentoring and transition focus as IHPS Director.

In recognition of my role as mentor across UC campuses, I was invited to also join the faculty at the UCLA School of Public Health, Center for Health Policy. I was gratified to receive the UCSF Campus Mentoring Lifetime Achievement in Mentoring Award in 2016, as well as honored in 2018 as one of the UC Berkeley School of Public Health's Most Influential Alumni (as part of their celebration of the School's 75th Anniversary).

PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Mentor Type	Role	Current Position
1990 - 1991	Marilyn Price	MSW, UCB		Research Advisor	
1990 - 1991	Margaret Martin	MPH, UCB		Research Advisor	
1990 - 1991	Chris Betzold	Master's in Nursing, UCSF		Research Advisor	
1990 - 1991	Sean Casey	MPH, UCB		Research Advisor	Research Associate, Alameda County Health Department
1990 - 1991	Myrna Epstein	MPH, UCB		Research Advisor	
1990 - 1991	Cate Teuten	MPH, UCB		Research Advisor	
1990 - 1991	Amy Wolfe	MPH, UCB and Nurse Practitioner, UCSF School of Nursing		Research Advisor	Nurse Practitioner, San Francisco County Health Department

Prepared: December 13, 2018

Dates	Name	Program or School	Mentor Type	Role	Current Position
1990 - 1991	Lee Smith	PhD, School of Nursing, UCSF		Research Advisor	
1990 - 1991	Christina Mellin	MPH, UCB		Research Advisor	
1990 - 1991	Pec Inman	PhD, School of Educational Psychology, U San Francisco		Research Advisor, Career Mentor	Assistant Professor, San Jose State University
1990 - 1991	Patricia Blasé	PhD, School of Nursing, UCSF		Research Advisor	
1990 - 1992	Georgiana Coray	PhD, School of Nursing, UCSF		Research Advisor	Nurse Director, San Diego (Deceased, 2010)
1990 - 1991	Wendy Jameson	MPH, UCB		Research Advisor	
1991 - 1992	Faith Wolfson	MSW, UCB		Research Advisor	
1991 - 1992	Lynn Wittenberg	MPH, UCB		Research Advisor	Research Associate
1991 - 1992	Meg Royce	MPH, UCB		Research Advisor	
1991 - 1992	Gina Sucato	MD, School of Medicine, U Pennsylvania		Research Advisor	Assistant Professor, Department of Pediatrics, U of Pittsburgh School of Medicine
1991 - 1992	Ila Rosen	MPH, San Francisco State University		Research Advisor	
1991 - 1993	Jesus Ramirez	MPH, UCB		Research Advisor	
1991 - 1993	Tam Nguyen	MA/Public Policy, UCB		Research Advisor	
1991 - 1993	Jaime Geaga	PA, MPH, UCB		Research Advisor	
1992 - 1993	Faith Wolfson	MSW, UCB		Research Advisor	
1992 - 1993	Zandy Kidd	MPH, UCB		Research Advisor	

Prepared: December 13, 2018

Dates	Name	Program or School	Mentor Type	Role	Current Position
1992 - 1993	Victoria Fontana	MSW, UCB		Research Advisor	
1992 - 1993	Rebecca Brook	BA/Health Law, UCLA		Research Advisor	
1992 - 1993	Michelle Pearl	MPH, UCB		Research Advisor	
1993 - 1996	Sheri Tye	MPH, UCB		Research Advisor	
1993 - 1994	Renu Karir	Joint Master's, Yale School of Management, Yale School of Public Health		Research Advisor	
1993 - 1994	Julia Cohen	MA/Public Policy, UCB		Research Advisor	
1992 - 1992	Susan Kools	PhD, School of Nursing, UCSF		Research Advisor, Career Mentor	Professor,School of Nursing, UCSF
1993 - 1994	Susan Starbuck-Morales	DrPH, School of Public Health, UCB		Research Advisor	Researcher, Humboldt State University
1993 - 1996	Susan Proctor	PhD, School of Nursing, UCSF		Research Advisor	
1993 - 1994	Diane Melendez	PhD, Division of Medical Anthropology, UCSF		Research Advisor	
1995 - 1995	Meg Wise	MPH, MSW, UCB		Research Advisor	
1995 - 1996	Sarah Teagle	PhD, School of Public Health, UCB		Research Advisor	Senior Researcher, RTI
1995 - 1998	Claire Horton	MD, School of Medicine, Emory and MPH, U North Carolina, Chapel Hill		Research Advisor	Clinical Faculty, San Francisco General Hospital

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Dates	Name	Program or School	Mentor Type	Role	Current Position
1995 - 1996	Margaret Martin	DrPH, School of Public Health, UCLA		Research Advisor	
1995 - 1996	Ellen Stein	MD,MPH, UCB		Research Advisor	
1995 - 1996	Neva Phair	Joint Program in Medical Sciences, UCB		Research Advisor	
1995 - 1998	Nicole Wicox	MPH, UCB		Research Advisor	Physician, San Francisco
1996 - 1998	Parag Nene	MD, School of Medicine, U Pennsylvania		Research Advisor	
1997 - 1998	Rupal Sangvhi	MPH		Research Advisor	
1997 - 2000	Xochitl Castaneda	PhD, Department of Anthropology, Amsterdam University		Research Advisor	Director, UCB Mexican-US Border Initiative
1998 - 1999	Carolyn Bradner	MD, School of Medicine, U Chicago and Post Doctoral Fellow, UCSF		Research Advisor, Career Mentor	Assistant Clinical Professor, Department of Pediatrics and Adolescent Medicine, UCSF
1998 - 2000	Deborah Sattley	MSW, School of Social Work, U Illinois		Research Advisor	Consultant
1998 - 2000	Sherri Tye	PhD, School of Public Health, UCB		Research Advisor	Parent
1999 - 2000	Monya Day	BA, Stanford		Research Advisor	
1999 - 2000	Kate Heumann	Master's in Public Policy, UCB		Research Advisor	

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Dates	Name	Program or School	Mentor Type	Role	Current Position
2000 - 2001	Sara Buckelew	MD, MPH, UCB and Post-Doctoral Fellow, UCSF		Research Advisor	Assistant Professor, Adolescent Medicine, Department of Pediatrics, UCSF
2001 - 2001	Olivia Simpson	MD, MPH, UCB		Research Advisor	
2001 - 2001	May Moo Podus	MPH, San Jose State University		Research Advisor	
2002 - 2002	Hilary Spindler	MD, Yale and PhD, UCLA		Research Advisor	UCSF, Global Health Research Associate
2002 - 2004	Signy Judd	PhD, School of Nursing, UCSF		Research Advisor	Research Coordinator, UCSF
2002 - 2003	Shrimant Mishra	MD, MPH,UCB		Research Advisor	
2002 - 2003	Gorette Amaral	MPH, UCB		Research Advisor	Ph.D., Stanford
2002 - 2003	Mona Jhuar	MPH, UCLA		Research Advisor	Program Officer, The California Endowment
2002 - 2004	Katrine Lofberg	MD, Medical School, U Washington, Seattle		Research Advisor, Career Mentor	Physician, Washington State U
2002 - 2004	Andrew Mihalek	MD, Medical School, UCD		Research Advisor, Career Mentor	Pulmonary Fellow, Harvard School of Medicine
2002 - 2004	Kristine Penner	Joint UCB/UCSF MD Program, MPH, UCB		Research Advisor	

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Dates	Name	Program or School	Mentor Type	Role	Current Position
2002 - 2007	Alexa Curtis	PhD, School of Nursing, UCSF		Research Advisor	Nurse Practitioner, Humboldt County, CA
2003 - 2005	Lisa Romero	DrPH, School of Public Health, UCB		Research Adivsor	Project Officer, CDC
2003 - 2005	Sonia Jain	PhD, Harvard U		Research Advisor	Research Director, West-Ed, San Francisco
2003 - 2005	Beth Chaton	PhD, LaVerne College, Claremont, CA		Research Advisor, Career Mentor	Program Director, Department of Education, Humboldt County, CA
2004 - 2005	Sarah Shulman	MS, PhD Oxford		Research Advisor	Director, Youth Development Organization
2005 - 2007	Lauren Ralph	MPH, UCB		Research Advisor	Ph.D., UCB, Research Associate, UCSF
2006 - 2007	Wanwadee Neamsakul	PhD, School of Nursing, UCSF		Research Advisor	Faculty Member, U Indonesia
2006 - 2007	Marcia Wertz	PhD, School of Nursing, UCSF		Research Advisor, Career Mentor	Assistant Professor, School of Nursing, UCSF
2007 - 2010	Linet Oyucho	PhD, Great Lakes U Kisumu, Kenya		Research Advisor	Lecturer, Doctoral Student, U of Ottawa
2007 - 2008	Alexis Armekanis	MD, Medical School, UCSF		Research Advisor	Psychiatry Resident, UCSF

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Dates	Name	Program or School	Mentor Type	Role	Current Position
2007 - 2009	Nan Jiang	PhD, School of Public Health, Indiana U, Bloomington		Research Advisor	Post-Docotorate in Tobacco Policy, UCSF
2007 - 2009	Dawn Richardson	DrPH, School of Public Health, UCB		Research Advisor	Post Doctoral Fellow, Health & Society, U Michigan
2007 - 2009	Naomi Schapiro	PhD, School of Nursing, UCSF		Research Advisor	Associate Clinical Professor, Family Health Care Nursing, UCSF
2007 - 2009	Nan Jiang	PhD School of Public Health, Indiana U, Bloomington		Research Advisor	Post-doctorate in Tobacco Policy, UCSF
2009 - 2009	Elodia Villasenor	MPH, San Francisco State University		Research Advisor	
2009 - 2010	Olubosola Olewole Busola	BA, Post-Bac Program, UCSF		Research Advisor	Post Bachelor Program/UC SF
2010 - 2012	Manuelito Biag	MPH, PhD, UC Davis		Career Mentor	Social Science Research Associate, Stanford University
2012 - 2012	Heather Knauer	MPH, UCB		Career Mentor	Research Associate, PRL-IHPS, UCSF
2012 - 2012	Nora Anderson	MPA, New York University		Career Mentor	Research Associate, PRL-IHPS, UCSF

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Dates	Name	Program or School	Mentor Type	Role	Current Position
2012 - 2012	Nicole Bennett	MPH		Career Mentor	Research Associate, PRL-IHPS, UCSF
2013 - 2014	Rachel Siemons	BA Postbac-Pre-med program, Bryn Mawr College		Thesis mentor	UC Berkeley-UCSF Joint Medical Program
2013 - 2013	Paulette Cha	BA Postbac-Pre-med program, Bryn Mawr College		Thesis Mentor	UCSF-UC Berkeley
2013 - 2013	Heidi Moseson	2nd year doctoral student at UCSF		Career Mentor	Doctoral program in Epidemiology at UCSF
2013 - 2013	Luis A. Rodríguez	RD, CNSC		Career Mentor	UCSF Medical Center/Childr en's Hospital
2013 - 2013	Satu Larson	2nd year doctoral student at UCSF		Career Mentor and Qualifying Exam member	Doctoral program in at S/N UCSF
2014 - 2014	Carlos Penilla	DrPH Student		Research and Career Mentoring	UC-Berkeley School of Public Health
2014 - 2015	Zesmayat Mekonnen	MA, first year mentor program		first year mentor program	UCSF
2015 -	Leena Bhalerao Singh	MA		Qualifying Exam committee	UCB
2015 -	Sara Kassabian	MA		Mentee/Trainee	UCSF
2016 -	Sophie Godley	MPH, Clinical Assistant Professor		Mentee	Boston University School of Public Health
2016 -	Grace Liu	MPH		Mentee	UCSF Global Health Sciences

Dates	Name	Program or School	Mentor Type	Role	Current Position
2016 -	Joseph Chuang	MS, MPHc		Mentee	University of Washington
2016 -	Stacy Osua	BA		Mentee	UCSF, Post Baccalaureate Program
2016 -	Ana Isabel Gonzalez	MA, MPH		Mentee	UCB, accepted for PhD program, University of Texas
2016 -	Carmen Maria Conroy	BA		Mentee	Yale NIH PREP research fellow
2017 - present	Lauren Lee Caton	BA, MS (2018)		Mentee	UCB, Public Health, Maternal and Child Health
2017 -	Cynthia Shen	BA in progress		Mentee	Cornell 2020
2018 -	Alex Valenzuela	BS Human Biology		Mentee	UCSF
2018	Fion Ng	RN, Master of Science in Nursing student		Mentee	UCSF, Pediatric Nurse Practitioner candidate 2019

POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1983 - 1985	Barbara Staggers, MD, MPH	Fellowship in Adolescent Medicine		Research, Professional Mentoring	Chief, Teen Clinics, Children's Hospital, Oakland

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1984 - 1986	Martin Anderson, MD, MPH	Fellowship in Adolescent Medicine		Professional Development	Chief, Division. of Adolescent Medicine, UCLA
1985 - 1988	Sheryl Ryan, MD, MPH	Fellowship in Adolescent Medicine		Professional Development	Chief, Division of. Adolescent Medicine, Yale University
1989 - 1991	Trude Bennett, DrPH	Hewlett Fellow		Research and Career advisor	Professor, School of Public Health, University of North Carolina
1990 - 1991	Jesus Jaime Guzman, MD	Hewlett Fellow, Mexico		Research advisor	Professor, Universidad de Guadalajara, Mexico
1990 - 1991	Noe Alfaro, MD, MPH	Hewlett Fellow, Mexico		Research Advisor	Professor, Universidad de Guadalajara, Mexico
1990 - 1991	Laura Laski, MD, MPH	Hewlett Fellow, Argentina		Research Advisor	Director, UN Family Planning Program, New York
1991 - 1992	Juan Carlos Ramirez Rodriguez, MD	Hewlett Fellow, Mexico		Research Advisor	Professor, Universidad de Guadalajara, Mexico
1991 - 1995	Jonathan Ellen, MD	Fellowship in Adolescent Medicine		Research and Professional Development	Professor/Vice Chair of Pediatrics, Johns Hopkins
1991 - 1995	Cynthia Kapphahn, MD, MPH	Fellowship in Adolescent Medicine.		Research and Professional Development	Associate Professor, Pediatrics Stanford
1992 - 1993	Elena Fuentes-Afflick, MD, MPH	Hewlett Fellow, US		Research Advisor	Professor, Department of Pediatrics, UCSF

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1992 - 1993	Julio Garcia, MD	Hewlett Fellow, Mexico		Research Advisor	
1993 - 1994	Monica Jasis, MD	Hewlett Fellow, Mexico		Research Advisor	Director, Centro Mujeres, Baja, Mexico
1993 - 1995	Isabelle Melese-d'Hospital, PhD	Hewlett Fellow, Mexico		Research Advisor	
1993 - 1996	David Bell, MD	Fellowship in Adolescent Medicine.		Research and Professional Development	Assistant Professor, Pediatrics, Columbia University
1994 - 1995	Gabriela Rodriguez, MS	Hewlett Fellow, Mexico		Research Advisor	Research Director, Family Planning Program, Mexico City, Mexico
1995 - 1996	Mariana Romero, MD	Hewlett Fellow, Argentina		Research Advisor	Medical Director, Family Planning Program, (CEDES) Buenos Aires, Argentina
1996 - 1997	Rosario Cardenas, MD	Hewlett Fellow, Mexico		Research Advisor	
1996 - 1997	Elena Zuniga, BA, PhD candidate	Hewlett Fellow, Mexico		Research Advisor	Director, UN Family Planning Program, El Salvador
1997 - 2000	Howard Pinderhughes, MD	Scholar, WT Grant		Research Advisor, Career mentor	Professor and Chair, School of Nursing, Social & Behavioral Sciences, School of Nursing, UCSF.

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1998 - 2002	Mary Ott, MD	U. of Pennsylvania and Postdoctoral Fellow in Adolescent Medicine		Research Advisor, Career Mentor	Associate Professor, Indiana University, Dept. of Pediatrics
1998 - 2000	Arik Marcell, MD	Fellowship in Adolescent Medicine		Research Advisor, Career Mentor	Associate Professor, Johns Hopkins University, Adolescent Medicine
1998 - 2000	Martha Perry	Fellowship in Adolescent Medicine		Research Advisor	
1996 - 1997	Xochitl Castenada, BA, PhD	Hewlett Fellow, El Salvador and Mexico		Research Advisor	Director, Health Inititatives of the Americas, Berkeley, CA
1997 - 1998	Jesus Chirinos, MD	Hewlett Fellow, Peru		Research Advisor	Professor, Catholic University, Lima, Peru
1997 - 1998	Maria Vivas-Mendoza, MD	Hewlett Fellow, Mexico		Research Advisor	
1998 - 1999	Guillermo Canton Calderon, MD	Hewlett Fellow, Guatemala		Research Advisor	Physician, Guatemala City, Guatemala
1998 - 1999	Maria Soledad Gonzales Montes, PhD	Hewlett Fellow, Mexico		Research Advisor	
1999 - 2000	Freddy Javier Cardenas, MD	Hewlett Fellow, Nicaragua		Research Advisor	Professor, University of Nicaragua
1999 - 2000	Enriqueta Valdez, MD	Hewlett Fellow, Mexico		Research Advisor	
2000 - 2001	Susana Chavez, MA	Hewlett Fellow, Peru		Research Advisor	

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2000 - 2001	Simon Nadew, MD	Visiting Fellow		Research Advisor	Medical resident, Family Practice, Ethiopia
2000 - 2001	Diana Martinez, MD	Hewlett Fellow, El Salvador and Mexico		Research Advisor	
2000 - 2003	Sophia Yen, MD	Fellowship in Adolescent Medicine		Research and Professional Development.	Clinical Instructor, Adolescent Medicine, Stanford University
2001 - 2002	Maria Claudia Gutierrez, MA	Hewlett Fellow, Columbia		Research Advisor	
2001 - 2002	Jane Pirkis, PhD	Harkness International Health Policy Scholar, Australia		Research Mentor	Senior Lecturer, Melbourne University Australia
2001 - 2002	Addis Abeba Salinas, MD, MA	Hewlett Fellow, Mexico		Research and Career Advisor	
2002 - 2003	David Breland, MD	Fellowship in Adolescent medicine		Research Advisor	Assistant Professor, Pediatrics, University of Washington
2002 - 2003	V. Melvin Sotelo, MA	Hewlett Fellow, Nicaragua		Research and Career Advisor	Family Planning Coordinator, Nicaragua
2002 - 2003	Lillian Wong, MD	Visiting Scholar		Program Director: Research, Clinical, Professional Dev.	Faculty, Chinese University of Hong Kong
2002 - 2003	Raquel Hurtado, MD	Hewlett Fellow, Peru		Research and Career Advisor	

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2003 - 2003	Loris Hwang, PhD	Fellowship in Adolescent Medicine		Career Advisor	Associate Adjunct Professor, Pediatrics/ Adolescent Medicine, UCSF
2003 - 2004	Erica Troncoso, MA	Hewlett Fellow, Mexico		Research Advisor	
2003 - 2004	Carmen Elisa Alvarez, MS	Hewlett Fellow, Columbia		Research Advisor	
2004 - 2005	Roberto Casto-Perez, MD	Hewlett Fellow, Mexico		Research and Career Advisor	Professor, School of Public Health, Mexico
2004 - 2005	Cecilia de Mello e Souza, MD	Hewlett Fellow, Brazil		Research Advisor	Professor, Sao Paolo, Brazil
2004 - 2006	Jane Burns, PhD	Harkness International Health Policy Scholar, Australia		Program Director, Research Mentor	Evaluation Director, Imagine, Australia
2006 - 2006	Jennifer Yu, PhD	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS		Research Advisor, Career Mentor	Research Associate, IHPS, UCSF
2006 - present	Aimee Afable-Munsuz, PhD	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS		Research Advisor, Career Mentor	Postdoctoral Fellowship, School of Pharmacy, UCSF
2007 - 2008	Kim Rhoades, MD, MS, MPH	Postdoctoral Fellow, Agency for Health Care Quality and Research, IHPS Philip R. Lee Fellow, UCSF		Research, Career Mentor	Assistant Professor of Surgery, Faculty, Stanford University
2008 - 2009	Helena Hart, MD	Philip R. Lee Fellow, IHPS, UCSF		Research, Career Mentor	Medical School, UCSF

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2009 - 2012	Christine Dehlendorf, MD, MAS	Department of Family and Community Medicine, UCSF		Research, Career Mentor	Assistant Clinical Professor of Medicine, Department of Family and Community Medicine, UCSF
2008 - 2012	Amy Donovan-Blondell, PhD	Department of Health and Aging, UCSF		Research, Career Mentor	Post Doc Fellowship, Institute for Health and Aging, UCSF
2009 - 2011	Pam Stoddard, PhD	Philip R. Lee IHPS Post-Doc		Career Mentor	Post Doc, Philip R. Lee Institute for Health Policy Studies, UCSF
2009 - 2012	Anisha Patel, MD	Philip R. Lee Fellow, IHPS, UCSF		Research, Career Mentor	Current Philip R. Lee Fellow, IHPS, UCSF
2011 - 2014	Sarah, Isquick, MD, MPH	Doris Duke Fellow, Philip R. Lee IHPS, Bixby Center		Career Mentor	Resident
2011 - present	Elizabeth Uy-Smith, MD, MPH	Primary Care Research Fellow		Career Mentor	Family and Community Medicine
2013 - 2017	Marissa Raymond-Flesch, MD, MPH	Fellow		Career Mentor	Adolescent and Young Adult Medicine
2013 - 2017	Satu Larson	Fellow		Career Mentor	Associate professor for SJSU School of Nursing, a pediatric nurse practitioner
2013 - present	Esme Cullen	Third Year Medical Student		Career Mentor	UCSF Medical Center
2013 - present	Paulette Cha	PhD Candidate		Career Mentor	University of Southern California

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2014 - 2016	Gina Robinson	PhD, UCSF	Career Mentor	Career Mentor	School of Nursing, UCSF
2014 - 2017	Michelle Ko	MD, PRL-IHPS Fellow		Career Mentor	PRL-IHPS Fellow
2014 -	Suzane M. Martinez, MD, PhD	MD, PhD	Career Mentor	Career Mentor	UCOP
2014 -	Sarah Combellick, MA	Research Associate	Career Mentor	Career Mentor	PhD candidate, UC Davis
2014 - present	Jacquelyn Torres, PhD, MD	Fellow		Career Mentor	Robert Wood Johnson Health and Society Scholar. Joint Fellow: UCSF/UCB
2015 - present	Elizabeth Dickson, RN, MSN	Fellow, RWJF Nursing and Health Policy Collaborative	Career Mentor	Career Mentor, Dissertation Committee	Faculty (tenure-track) University of New Mexico, College of Nursing
2015 -	Ilana Garcia-Grossman	MD Candidate, class of 2018	Career Mentor	Caree Mentor	UCSF
2016 -	Emily Behar, RN, MSN, MPH	Doctoral Student, Global Health Sciences	Career Mentor	PhD, Career Mentor	UCSF
2016 - present	Jennifer Shen	Fellow		Research and career mentoring	IHPS Postdoctoral Fellow
2016 - present	Emily Hall, RN, MSN, MPH	Doctoral Student	Career Mentor	PhD, Career Mentor	UCSF
2018 - present	Lauren Strelitz, MD, MSL	PhD Candidate, Fellowship in Adolescent Medicine	Research/ Scholarly Mentor	Career Mentor and Scholarly Oversight Committee	Dept. of Pediatrics, UCSF
2018 -	Marichianah Onono, MBChB, Msc	Doctoral Student, Global Health Sciences	Career Mentor	Qualifying Exam Committee & Chair	Department of Global Health Sciences, UCSF

FACULTY MENTORING

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
1999 - present	Marty Jessup	PhD, School of Nursing, UCSF		Research Advisor	Associate Professor, School of Nursing, UCSF.
2005 - 2006	Kristine Madsen	MD, MPH		Research Advisor	Assistant Adjunct Professor, Pediatrics, UCSF
2005 - 2007	Jennifer Reich, PhD	Postdoctoral Fellow, IHPS		Research and Career mentoring	Associate Professor, U of Denver
2005 - present	Daniel Dohan, PhD	Associate Professor Department of Anthropology and Health Policy		Career Advisor	Associate Director and Associate Professor of Training/IHPS/UCSF
2005 - present	Diana Greene Foster, PhD	Demographer		Research and Career Advisor	Assistant Professor, Department of Obstetrics, Gynecology, and Reproductive Health Sciences, UCSF
2006 - 2011	Mary Ott, PhD	Faculty, Indiana U Bloomington		Research supervision and career mentoring	Faculty, Indiana University, Bloomington

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Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2006 - present	Tracy Weitz, PhD	Department of Sociology, UCSF		Research and career mentor	Associate Professor, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2006 - present	Tracey Woodruff, PhD	Post-Doc and Faculty member, UCSF		Research and career mentor	Associate Professor, Dept. of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2007 - present	Jeff Belkora, PhD	Assistant Professor in Research, Surgery and Health Policy		Research and career mentoring	Assistant Professor in residence, Department of Surgery and IHPS, UCSF
2007 - present	Michael Cabana, MD, MPH	Associate Professor, Chief of General Pediatrics, UCSF		Research review and personal advisor	Chief of General Pediatrics, Department of Pediatrics, UCSF
2007 - present	Diane Rittenhouse, MD	Associate Professor in Residence		Career mentor	Associate Professor in Residence, Department of Family & Community Medicine and IHPS, UCSF

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Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2008 - present	David Becker, MD	Assistant Clinical Professor of Pediatrics		Research and career mentoring	Assistant Clinical Professor of Pediatrics, UCSF
2008 - present	Sara Buckelew, MD, MPH	Assistant Clinical Professor		Career mentoring	Assistant Adjunct Clinical Professor, Department of Pediatrics, UCSF
2008 - present	Adam Hersh, MD	Clinical Fellow and Assistant Professor, Dept. of Pediatrics, UCSF		Research and career mentoring	Assistant Professor, Department of Pediatrics, UCSF
2008 - 2011	Megie Okumura, MD	Assistant Adjunct Professor, Dept. of Pediatrics, UCSF		Research and career mentoring	Assistant Adjunct Professor, Department of Pediatrics, UCSF
2008 - present	Laura Schmidt, PhD, MPH, MSW	Associate Professor in Residence		Career mentor	Associate Professor, IHPS, and the Department of Anthropology and History, UCSF
2008 - present	Steve Takemoto, PhD	Assistant Adjunct Professor		Career mentor	Assistant Adjunct Professor, IHPS, and the Department of Orthopedic Surgery, UCSF

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2010 - present	Tilly Gurman, DrPH	Assistant Professor		Career mentor	Assistant Professor, Department of Global Health, School of Public Health and Health Services, George Washington University
2010 - present	Ushma Upadhyay, MPH	Assistant Professor		Research and career mentoring	Assistant Adjunct Professor, Bixby Center for Global and Reproductive Health
2013 - present	Anisha Patel, MD	Assistant Professor		Research and career mentoring	Assistant Professor, Department of Pediatrics, UCSF
2013 - present	May Sudhinaraset, PhD	Assistant Professor		Research and career mentoring	Assistant Professor, Department of Pediatrics, and Department of Epidemiology and Biostatistics UCSF

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2018 - present	Fatima Rodriquez, MD, MPH, FACC	Assistant Professor		research and career mentoring	Assistant Professor Cardiovascular Medicine, Stanford University School of Medicine

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AND CREATIVE ACTIVITIES SUMMARY

Methodologically, I conduct program evaluations and health policy analyses, using a variety of quantitative and qualitative techniques, assuring triangulation of data. This strength enables me to work with a variety of research collaborators, including evaluating: 1) the nation's largest 1115 Medicaid Waiver Family Planning Waiver; 2) California's statewide, community-based teenage pregnancy prevention, as well as pregnant and parenting adolescents initiative; 3) school-based health services; 4) the impact of the Affordable Care Act (ACA) on children, adolescents, young adults and women's health; 5) the role of patient engagement in health care system redesign, 6) UCSF-CA preterm birth initiative, and 7) health care access and needs of immigrants, with a particular focus on Deferred Action for Childhood Arrivals (DACAs). As a result of my work in the area of program evaluation, I collaborated with Dr. Annette Gardner in the writing of a book, Advocacy and Policy Change Evaluation: Theory and Practice, published by Stanford Press in 2017.

With colleagues in the Division of Adolescent Medicine, I also conduct policy research and analyses of The Healthy People 2010 and 2020 Adolescent and Young Adult Health Objectives, and analyses of national data sets documenting the lack of health insurance among adolescents and young adults, changes that these populations have undergone as a result of the ACA and the expansion of Medicaid, disparities in access and utilization of services, and use of mental health services. This body of research (between 2006-2012) was the basis for bringing national attention to the needs of adolescents and young adults, specifically, the disparities they face in accessing health care, in particular for mental health services. In order to offer policy makers with a set of potential action steps, our team identified innovative programs aimed at: increasing the delivery of preventive mental health services for adolescents: assuring that insurance companies are developing products for young adults; and maximizing health insurance enrollment for young adults who represent 30% of the nation's uninsured population. I completed one of the first studies of the ACA roll-out of health insurance coverage of young adults up to age 26 on their parent's health insurance plans from the perspective of states (published in a Law Journal in Winter, 2015). With my team of researchers in the Division of Adolescent and Young Adult Health (Charles E. Irwin, Jr. MD, Director) we have conducted analyses of large national data sets to ascertain the impact of the ACA on their access to health care and preventive health care visits. In 2006, our team received recognition for its body of work by the Society for Adolescent Health and Medicine

(the Hilary E. Millar Award for Advancing the Field of Health Policy for Youth to the UCSF National Adolescent Health Information Center).

An area of related interest is the role of confidentiality, electronic health care records, and access to sensitive health services in the era of health care reform. Studies have included in-depth interviews with health professionals and stakeholders regarding options for reconciling the need for health insurance explanation of benefits requirements and the need for adolescents and young adults to access sensitive health services (Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case of Explanation of Benefits (EOBs) http://healthpolicy.ucsf.edu/Protecting-Adolescent-Confidentiality) and a policy analyses regarding the Electronic Health Care Record (Sensitive Health Care Services in the Era of Electronic Health Records: Challenges and Opportunities in Protecting Confidentiality for Adolescents and Young Adults - http://healthpolicy.ucsf.edu/sensitive-health-care-and-electronic-health-records). With colleagues at the National Family Planning and Reproductive Health Association and George Washington University, we conducted a 3 year study entitled, “Confidential and Covered: Protecting Patients While Preventing Revenue Loss”. This study focused on developing and testing effective interventions that support the federal Title X Family Planning program’s historic commitment to client confidentiality, while preventing and mitigating revenue loss at Title X service sites due to the provision of confidential services as part of health care reform efforts.

With colleagues at UCSF, UC Berkeley, and UCLA, we assessed care integration (behavioral and primary care) in the California safety net within the context of the ACA, including conducting a set of interrelated research projects to: 1) document the level of integration of care in the safety net system in California, including integration with specialists, ancillary services, hospitals, behavioral health, and social services; 2) evaluate efforts to support Medi-Cal providers to adopt health information technology to facilitate functional integration; and 3) document the challenges encountered in outreach and enrollment for difficult to reach and enroll populations, including young men who previously were not eligible to receive subsidized health care. We have disseminated the findings to policy makers and stakeholders in California's health care safety net.

My own qualitative and quantitative research has also examined health and economic disparities among multi-ethnic/racial groups nationally (e.g., health insurance coverage; risk taking behaviors, including teenage pregnancy, suicide, and substance use; and health outcomes). I have special expertise on diverse Latino/a populations, global reproductive health, migration and health, as well as the impact of migration and acculturation on Latina/o immigrants. For example, I completed a study with collaborators at UCLA and UCB focused on the health conditions and health care access of young Latinos eligible for health care as a result of the Deferred Action for Childhood Arrivals (DACA) program (often referred to as “Dreamers” in social media). On this project, I worked closely with a Latina Fellow in Adolescent Medicine and Health Policy (now a junior faculty member), a medical student in the joint UCB-UCSF Medical School program, and hired several “Dreamers” to conduct the research. Results from this research (two briefs, 3 recently published articles) have been widely disseminated nationally, as well as serving as the basis for two briefings: one with state policymakers in Sacramento and the other with health providers and advocates. This data was used to support SB 4, which requires the provision of Medi-Cal (California’s Medicaid Program) to undocumented children living in California, beginning in March, 2016. Nearly 200,000 children and adolescents have benefitted from the program.

With Dr. Charles Irwin (Director), I serve as the co-Director of the Adolescent and Young Adult

Health National Resource Center, funded by the federal Bureau of Maternal and Child Health. In this policy-practice endeavor, The Center aims to promote adolescent and young adult (AYA) health by strengthening the abilities of State Title V MCH Programs, as well as public health and clinical health professionals, to better serve these populations (ages 10-25). Our work focuses on increasing the receipt of quality preventive visits for AYAs. This is a focus of many state Title V programs, including those that selected National Performance Measure (NPM) #10: percent of adolescents (ages 12-17) with a past-year preventive visit. A major foci of the center is the AYAH Collaborative Improvement and Innovation Network (CoIIN). We are adapting the CoIIN model to help selected states address the well visit for adolescents and young adults. The CoIIN model, used by many states to address infant mortality, combines collaborative learning and quality improvement methods to drive a national strategy. We launched our first CoIIN in May 2015 with Iowa, Mississippi, New Mexico, Texas, and Vermont. The second CoIIN was launched in April 2017 with Indiana, Maryland, Minnesota, New Hampshire, New Jersey, Washington, and Wyoming. As part of the Center, we have conducted analyses of the health and well-being of adolescents and young adults, the impact of the ACA on this population, as well as studied ways to improve access to health insurance coverage and preventive health services.

Over the past several years, I have also become increasingly interested in the area of acculturation, social disparities, and health, including: 1) developing a research and policy agenda for cross-border health between Mexico and the U.S., 2) the impact of acculturation on the incidence of obesity among three different groups of Latinos—those born in Mexico who have immigrated to the U.S., Mexican-born populations that speak English, and U.S. born Mexicans who speak English, 3) the role of family planning as a means of reducing health disparities among Latinas, 4) risk and protective factors in adolescent pregnancy among adolescent and young adult Latinas, as well as 5) the challenge of measuring acculturation, particularly among Latino/a adolescents. Some of my co-authored relevant reports are: “Creating a Health Research and Policy Agenda for Im/migration Between Mexico and California”, “Migration and Health: Mexican Immigrant Women in the U.S.,” and “A Health Profile of Immigrant Teenagers”, representing a multi-campus, cross-border collaboration between the National Population Council of the Government of Mexico (CONAPO), UCB School of Public Health Initiative of the Americas (ISA), UCLA School of Public Health, UC, Davis and UC Berkeley Migration and Health Research Center (MAHRC), and UCSF’s Bixby Center for Global Reproductive Health (I am one of its Directors). I have also collaborated on several projects focused on Latina youth, one of which was converted into a 22 minute, award winning film, A Question of Hope, (http://nahic.ucsf.edu/multimedia/901/); (Spanish voice-over, Una Cuestión De Esperanza: Reduciendo los embarazos de adolescentes latinas en California (http://bixbycenter.ucsf.edu/videos/video-lo-3.html).

With colleagues at the Institute, we conducted a three year evaluation of efforts to increase patient-centered care as part of the federal Center for Medicaid and Medicare Innovation Centers’endeavors. Funded by the Atlantic Philanthropies, the project entitled, the “Campaign for Better Care” (CBC), sought to engage vulnerable populations enrolled in public health plans to ensure that health reform measures reflected their needs, interests, and preferences. Three national advocacy organizations (Community Catalyst, the National Partnership for Women and Families, and PICO) developed models of consumer engagement in institutional decision-making. As part of the evaluation, the evaluation team developed a brief video to capture the voices of patients and providers, who share their stories about barriers in obtaining and providing health care. https://www.youtube.com/watch?v=TLveVpzP9cU

With colleagues at UCSF Benioff Children’s Hospital, Oakland and later at UCSF Medical

Center, and funded by NextGen and the Benioff Foundation, we conducted an evaluation of a provider intervention aimed at reducing the word-gap between middle income and low-income children. Research has documented the dramatic difference between middle and high income households in which children 0-4 years of age are exposed to greater degrees of language interactions with their parents, as compared to low-income households, where less verbal stimulation contributes to a significantly limited vocabulary. The intent of this project was to educate low-income parents on the significant brain development that occurs very early in childhood and the importance of language interaction (singing, talking and reading) to close this existing word-gap that hampers future educational outcomes. Evaluation results documented the value of the health care provider in educating families regarding the importance of reading to their babies, as well as children.

Over the past 7 years, I have also worked with a team to bring greater attention to the impact of sugar on population health, beginning with a collaboration with Drs. Robert Lustig and Laura Schmidt and reflected in the article, “The Toxic Truth about Sugar”. Since we began, we have established Sugar Science (http://sugarscience.ucsf.edu/, under the direction of Dr. Schmidt), and are currently working to launch the Sugar Industry Library (parallel to the Tobacco Industry Papers) (funded by the Arnold Foundation). Once established in Fall, 2018, the library will be made available to world-wide scholars interested in researching the impact of the industry upon the nation’s health, including the marketing of sugar-sweetened beverages leading to childhood obesity.

Underlying my research portfolio is an emphasis on the translation of research into policy, including not only publishing major research results in peer-reviewed journals, but also identifying different dissemination channels. For example, we published the cost-benefit analyses of the Family PACT program, helping to leverage over a billion dollars to serve low-income men, women, and adolescents. We have also translated this research into easy to use formats for policy makers, including briefs for Congressional, as well as state Legislators. The briefs include data on the number of pregnancies averted by their constituents, and the number of federal and state dollars averted through the prevention of those pregnancies. All of these dissemination and diffusion related efforts, along with my long standing research in the area of maternity and child health, led to my co-chairing the Knowledge-Transfer Working group, as part of the Benioff-Gates $100 million dollar, ten year commitment to reducing pre-term birth both in California and globally. Reflecting the wide variety of research interests, each has the theme of focusing on vulnerable and often marginalized populations, bringing the most comprehensive evidence to bear upon policy options, and engaging communities of stakeholders in identifying the most effective policy options available, given resources and evidence.

Finally, as the Director of the Philip R. Lee Institute for Health Policy Studies, I also play a major leadership role within the campus and the Institute in the area of building strong research, methodological, and training capacity in the area of health outcomes research, including monitoring the implementation of health care reform, and building the next generation of health services and health policy talented faculty across our campus.

RESEARCH AWARDS - CURRENT

1.	18-10026	Co-Pi		Decker/Brindis
	California Department of Public Health		07/01/2018	06/30/2021

Adolescent Health Evaluations
The objective of this project is to provide Adolescent Health Evaluations with multi-method monitoring and/or evaluations for three programs within the CDPH Adolescent Health Section. The purpose of the Adolescent Health Programs is to utilize effective, evidence-based or evidence-informed approaches and strategies to reduce rates of adolescent birth, repeat adolescent births and sexually transmitted infections among high-need youth populations.
Role: Co-PI

		PI		Brindis (PI)
2.	Laura and John Arnold Foundation		12/01/2017	11/30/2019
	Launching the Digital Food Industry Documents Archive			$ 1,603,712 total
	To launch a new Food Industry Document Archive in UCSF's digital Industry Documents Library (IDL) and develop a longer-term plan to continue to build the collections.			
3.	15-10047	PI		Brindis (PI)
	California Department of Public Health		07/01/2015	06/30/2018
	Teen Pregnancy Prevention Project Evaluation			$ 4,842,846 total
	Evaluation research that help characterize the funded programs and estimate how well they are meeting the State's objectives. Program evaluation results help public health professionals, educators, and policymakers to support more effective teenage pregnancy prevention interventions to reduce the negative social and economic consequences of this important public policy issue.			
4.	90AP2688-01-00 ACYF	Co-Investigator		Decker (PI)
	Family and Youth Services Bureau		09/01/2016	09/30/2021
	Digital Initiative for Youth (DIY)			$ 3,871,658 total
	An innovative youth-centered initiative to improve the sexual health and socio-economic well-being of youth in Fresno County, California			
5.		PI		Brindis (PI)
	Benioff Foundation		03/01/2017	06/30/2021
	The California Preterm Birth Initiative			$ 800,000 total
	The overall goal is to use evaluation findings to assess current programs and activities and offer insight into possible modifications that could realign initiative strategies to ensure outcome achievement.			
6.	2K12HD052163-17	Co-PI		Brindis/Adler (PI)
	NIH/NICHD		09/01/2015	07/31/2020
	UCSF-Kaiser Building Interdisciplinary Research Careers in Women's Health Program			$ 523,212 total

The goal of the UCSF/Kaiser BIRCWH program is to increase the number, quality, and breadth of women's health researchers. We aim to facilitate the career development of outstanding independent investigators experienced in multidisciplinary, translational, and clinical women's health research.

7. Contract No. 15388 PI Brindis (PI)
Alameda County Health Care Services Agency 07/01/2018 06/30/2020
Alameda County School Health Centers Evaluation $ 325,000 total

Evaluation of the Alameda County School Health Services (SHS) Coalition's school-based health centers and school-based behavioral health services. The study aims to document the SHS programs' impact on students' access to and utilization of health care, and improvements in their health status and behaviors.

8. U45MC27709 Co-PI Irwin (PI)
DHHS/HRSA Maternal and Child Health Bureau, National Adolescent Health Information Center 09/01/2018 08/31/2023
Adolescent & Young Adult Health National Resource Center (AYAH-NRC) $ 5,400,000 total

To enhance knowledge and inform practices of professionals and policy- and decision-makers regarding the consequences of public policies on young people. Specific goals are: (1) Analyze the effects of public policies, regulations and practices at the community, state and federal levels on the health of young people; (2) Formulate policy options and develop model public policies; (3) Disseminate findings and products to policy- and decision-makers at national, state and community levels

9. T71MC0003 Co-I Irwin (PI)
DHHS/HRSA Maternal and Child Health Bureau 10/01/1977 06/30/2022
Leadership Education in Adolescent Health Training Project $ 1,261,225 total

The goal of this project is to conduct policy analyses and research pertaining to adolescent health.

10. NU38PS004649 Co-I Kahn (PI)
US Centers for Disease Control and Prevention, Department of Health and Human Services 9/30/2014 9/29/2019
Economic Analysis for Prevention of Disease (EMPoD) $ 4,855,069 total

The overall goal is to support the prevention effectiveness of state and local public health jurisdictions by providing scientifically valid economic modeling tools populated with setting-relevant data.

10. 1TP2AH000045 Co-Investigator Dehlendorf (PI)
Department of Health and Human Services, Office of Adolescent Health 07/01/2015 06/30/2020
SpeakOut: Empowering teen to teen communication about highly effective contraception
The major goals of this project are to conduct rigorous evaluation of new or innovative approaches to prevent teen pregnancy.

11. SC15-1502-27481 Co-Investigator Tebb (PI)
Patient-Centered Outcomes Research Institute 12/01/2015 11/30/2020
Reducing Health Disparities in Unintended Pregnancies Among Hispanic Adolescents Using a Patient-Centered Computer-Based Clinic Intervention $ 548,885 total
The major goals of this project are (1) support the adolescents in making decisions about an effective method of contraception by increasing knowledge and self-efficacy; (2) improve the effectiveness and efficiency of the clinical encounter; and (3) reduce the incidence of unprotected sexual intercourse among Latina adolescents girls over time.

RESEARCH AWARDS - PAST

1. 35038-OS-332 PI
Centers for Disease Control (CDC 07/01/2000 12/01/2003
Evaluation of the CDC's Teenage Pregnancy Prevention Initiatives, subcontract to MACRO International $ 100,000 direct/yr 1 $ 281,990 total

2. 2002-7925/99-3654 PI
The William and Flora Hewlett Foundation 7/1/1983 6/30/2005
William and Flora Hewlett Fellowship in Latin American Reproductive Health Policy $ 55,302 direct/yr 1 $ 705,943 total

3. PI
The California Wellness Foundation 10/01/1997 06/30/2007
Evaluation of The California Wellness Foundation's Teen Pregnancy Prevention Initiative $ 190,887 direct/yr 1 $ 627,011 total

4. PI
Johnson and Johnson Foundation 06/01/2002 09/01/2004

	Evaluation of the National Center for Excellence in Women's Health University of California, Community Women Leadership Projects		$ 70,000 direct/yr 1	$ 145,000 total
5.	20021734	PI		
	The California Endowment		06/01/2002	06/30/2005
	Evaluation of the Community Clinic Consortia Policy Initiative		$ 100,000 direct/yr 1	$ 900,000 total
6.		PI		
	Johnson and Johnson Foundation		06/01/2002	06/01/2005
	Evaluation of the Bridges to Employment- Milpitas High School		$ 32,000 direct/yr 1	$ 90,000 total
7.		PI		
	Johnson and Johnson Foundation		06/01/2002	06/30/2005
	Evaluation of the San Jose Nursing Academy		$ 15,000 direct/yr 1	$ 45,000 total
8.	R06-CCR921786-0	PI		
	Center for Disease Control and Prevention, Department of Health and Human Services		09/01/2002	04/01/2005
	Participatory Research in School-Based Health Center Research		$ 27,296 direct/yr 1	$ 818,896 total
9.		PI		
	Federal Health and Human Resources Administration		10/01/2004	09/30/2005
	Adolescent Health Program Evaluation		$ 250,000 direct/yr 1	
10.		Co-PI		
	The California Endowment and the California Healthcare Foundation		07/01/2007	08/01/2008
	Developing a Latino/a Research and Program Agenda on Translational Health, with Global Health Sciences		$ 150,000 direct/yr 1	
11.	2008-2092	PI		
	The William and Flora Hewlett Foundation		02/01/2008	06/30/2011
	Common Ground, Common Goals: The Juncture of Schools and Health in Securing California's Future			$ 150,000 total

12. 20081866 PI Brindis (PI)
The California Endowment 01/01/2009 12/31/2011
Community Action to Fight Asthma Legacy; Statewide Asthma Initiative $ 156,521 total
This project analyzes the outcomes and lessions learned on the seven year initiative to create policies to reduce the environmental risk factors that affect asthma for school-aged youth. Policy change and policy advocacy occurred at the local, regional, and state levels and focused on policies related to housing, schools, and outdoor air.

13. 20081465 PI Brindis (PI)
The California Endowment 10/01/2008 1/31/2012
Evaluation of Statewide Burden of Asthma $ 156,521 direct/yr 1 $ 547,934 total
This evaluation assesses the impact of consortia in impacting policy in the area of environment, schools and homes. Coalition surveys, policy maker interviews, and pre and post data are being used.

14. 2008-12211 PI Brindis (PI)
The California Endowment 02/01/2006 06/30/2012
Health Journalism Fellowship Evaluation $ 90,037 total
Fellowship program to teach journalists to examine and report on the nuances of health care issues for multicultural populations, with a special emphasis on health disparities, its impact on health care access and the quality of services available.

15. 1013139 PI Brindis (PI)
Public Health Institute (subcontract) / CDC (Prime) 03/01/2007 09/29/2012
Reducing Asthma Disparities through Comprehensive, Community Activities $ 93,985 direct/yr 1 $ 469,925 total
This evaluation is tracking and monitoring a variety of community-based strategies aimed at reducing health disparities that result in the worsening of asthma health outcomes. Interventions being tested include evaluations of community-based coalitions, environmental strategies, and policy-focused advocacy activities.

16. C2004-501/4375 PI Brindis (PI)
Alameda County Department of Health Services 07/01/1998 06/30/2012
Evaluation of the Alameda County School-Based Health Care Network $ 62,834 direct/yr 1 $ 716,646 total
The study aims to document the SHS programs' impact on students' access to and utilization of health care, and improvements in their health status and behaviors

17. 1329AFK-ESP-2006 PI Brindis (PI)

US Department of Public Health, Office of Population Affairs (Subcontract) / CDC 09/01/2006 09/01/2012

Evaluation of La Clinica de la Raza, Inc. $ 281,955 direct/yr 1 $ 750,000 total

A multi-year, longitudinal, randomized evaluation of “group prenatal care” visits for pregnant and parenting adolescents vs. traditional prenatal care services is being conducted, including quantitative and qualitative methods

18. 1329AFK-ESP-2006 PI Brindis (PI)

US Department of Public Health, Office of Population Affairs (Subcontract) / CDC 09/01/2006 09/01/2012

Evaluation of La Clinica de la Raza, Inc. $ 281,955 direct/yr 1 $ 750,000 total

A multi-year, longitudinal, randomized evaluation of “group prenatal care” visits for pregnant and parenting adolescents vs. traditional prenatal care services is being conducted, including quantitative and qualitative methods

19. PI Brindis (PI)

The Colorado Health Foundation 03/01/2010 12/31/2013

School Based Health Care Initiative Evaluation $ 96,699 direct/yr 1 $ 290,007 total

Quantitative and qualitative methods are used to evaluate the Colorado Health Foundation’s $10.8 million School-Based Health Care Initiative’s processes, assess factors that contribute to school-based health care program sustainability, and identify best practices to guide operations of current and future school-based health care programs.

20. PI Brindis (PI)

The World Bank 9/1/2013 1/31/2014

Teen Pregnancy Prevention Evaluation and Technical Assistance $ 95,000 total

To provide training and technical assistance to family planning agencies, as well as monitor and evaluate the process and outcomes of the programs, as well as make recommendations regarding World Bank investments in Ethiopia and Nepal.

21. 8731749 Co-PI Grumbach/Brindis (PI)

Blue Shield Foundation 7/1/2013 6/30/2014

Assessing care integration in the California safety net $ 41,120 total

conducting a set of interrelated research projects to: 1) assess the level of integration of care in the safety net system in California, including integration with specialists, ancillary services, hospitals, behavioral health, and social services; 2) assess efforts to support MediCal providers to adopt health information technology to facilitate functional integration; and 3) disseminate the findings to policy makers and stakeholders in California's health care safety net.

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22. FPR PA006051 — Co-PI — Darney (PI)

Department of Health and Human Services Office of Population Affairs — 09/01/2009 — 08/31/2014

Innovative Evaluation of Title X and 1115 Waiver Family Planning Program — $ 100,000 direct/yr 1 — $ 476,176 total

Provide conceptual guidance to the development of project design and methodology and oversight of project planning and implementation.

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23. MCHB T71MC0003L — Co-PI — Irwin (PI)

Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services Maternal and Child Health Bureau, U.S. Department of Health and Human Services — 07/01/2007 — 06/30/2014

Interdisciplinary Leadership Education in Adolescent Health, Public Policy Analysis and Education Center for Middle Childhood Adolescent Health, and the National Adolescent Health Information Center — $ 1,449,231 total

Conduct policy analyses and research pertaining to adolescent health.

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24. — Co-PI — Brinids/Roby (PI)

Packard Foundation — 07/01/2013 — 1/31/2018

California Children’s Services Evaluation — $ 347,986 total

An evaluation of California’s Enhanced Primary Care Case Management (EPCCM) Program, the Provider-based Accountable Care Organization (ACO); Specialty Health Care Plan (SHCP); and utilization of existing Medi-Cal Managed Care Plans.

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25. 21663 — PI — Brindis (PI)

The Atlantic Philanthropies — 01/01/2013 — 12/31/2015

Philip R. Lee Institute for Health Policy Studies – Campaign for Better Care Evaluation — $ 1,200,000 total

To conduct an evaluation of the effectiveness of consumer mobilization in affecting health care system redesign and improving health outcomes for vulnerable older adults.

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26. 2010-066 — PI — Brindis (PI)

The California Wellness Foundation 07/01/2010 03/31/2015
Assessing the Impact of Federal and State Cuts on California's Teenage Pregnancy Prevention Programs $ 400,00 total
This study examines how state budget cuts that have resulted from the national and state recession have impacted the California programs and service providers devoted to the needs of youth at high risk of becoming pregnant for the first time and teen parents at risk for repeat pregnancy.

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27. 2008-2211 PI
California Endowment 2/01/2006 9/30/2015
Health Journalism Fellowship Evaluation $ 300,000 total

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28. Co-PI Jacobs/Brindis (PI)
Blue Shield Foundation-Subcontract 07/01/2014 3/30/2016
Medi-Cal Eligible but not Enrolled, Remaining uninsured in California: Qualitative and Quantitative Study of Deferred Action Childhood Arrivals (DACA) $ 40,999 total
Subcontract with UC Berkeley Labor Center. This project, bringing researchers from the UCLA Center for Health Policy, UC Berkeley, and UCSF, is analyzing California Health Interview Survey Data, as well as conducting 9 focus groups with Latino DACA-Eligible young adults. Study sites include Los Angeles and San Francisco Bay Area. Recruitment is being conducted by Dreamers and through a variety of social media channels.

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29. PI Brindis (PI)
California HealthCare Foundation 10/01/2014 12/31/2014
Evaluation of Health Reporting Project $ 21,000 total

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30. 639265-10S-1525 PI Brindis (PI)
ICF MACRO (Atlantic Philanthropy subcontract) 7/01/2010 12/31/2015
ICF Macro $ 495,123 total

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31. PI Brindis (PI)
National School Based Alliance 8/01/2014 8/30/2015
Evaluation of School Based Health Services $ 110,000 total

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32. PI Brindis (PI)
Alameda County 7/01/2014 6/30/2015

Alameda County School Health Services Evaluation $ 325,000 total

33. 07-65654 PI Brindis (PI)
California Department of Public Health, Maternal, Child and Adolescent Health 12/01/2013 11/30/2015
Building Capacity to Advance the Health & Well-being of Adolescents $ 1,462,687 total
To provide information, resources and expertise to support the provision of quality health care services to adolescents, increase the capacity of local Maternal, Child and Adolescent Health (MCAH) jurisdictions and their adolescent health practitioners to promote the health of adolescents, and to influence policy with the intent of improving the health and well-being of California's adolescents.

34. 04-35976 PI Brindis (PI)
California Department of Public Health 07/01/1997 06/30/2015
Teen Pregnancy Prevention Project Evaluation $ 1,312,800 direct/yr 1 $ 6,918,905 total
Evaluation research that help characterize the funded programs and estimate how well they are meeting the State's objectives. Program evaluation results help public health professionals, educators, and policymakers to support more effective teenage pregnancy prevention interventions to reduce the negative social and economic consequences of this important public policy issue.

35. 05-45221 Co-PI Darney (PI)
State of California, Office of Family Planning 07/01/2010 06/30/2015
Evaluation of the Family PACT (Planning, Access, Care and Treatment) Program $ 2,199,084 direct/yr 1 $ 11,717,235 total
This evaluation of the states' comprehensive family planning program includes billing data analyses, focus groups with providers and clients, exit interviews, cost-benefit analyses, and case studies

36. Co-PI Brindis (PI)
Next Generation (Benioff Foundation) 9/01/2014 8/30/2017
Evaluation of "Too Small to Fail" $ 850,000 total

37. Co-PI Brindis (PI)
National Family Planning and Reproductive Health Association 9/2014 8/2017
Confidential and Covered: Protecting Patients While Preventing Revenue Loss

This national, multi-site project, funded by the federal Office of Population Affairs, will develop and test interventions that support the federal Title X Family Planning program's historic commitment to client confidentiality, while preventing and mitigating revenue loss at Title X service sites due to the provision of confidential services as part of health care reform efforts

38.	20094	PI		Brindis (PI)
	California HealthCare Foundation		03/01/2017	02/28/2018
	UCSF/Hastings Speakers Series: ACA Potential Impact of the Trump Administration on Health Policy			$ 97,000 total
40.		PI		Brindis (PI)
	Programa de Investigacion en Migracion y Salud (PIMSA)		09/01/2016	02/28/2018
	Bi-National Perspectives on Adolescent Childbearing, Obesity, Diabetes and Cesarean Sections			$ 30,000 total
41.	P60MD006902	Co-Investigator		Bibbins-Domingo (PI)
	NIMHD		08/27/2012	02/28/2018
	Comprehensive Centers of Excellence Addressing Disparities in Chronic Disease with a Teen and Young Adult Focus			$ 779,767 total

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3. Abbey N, **Brindis CD**, Casas M, Schoonmaker S. Family life education for Hispanics: Practical guidelines for schools. Family Life Educator. 1(6):4-10. 1987
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5. Mitchell F, **Brindis CD**. Pew Memorial Trust policy synthesis: 3. Adolescent pregnancy: the responsibilities of policymakers. Health Serv Res. Aug; 22(3):399-437. PMID: 3679836. PMCID: PMC1065446 1987
6. Minkler DH, Korenbrot C, **Brindis CD**. Family planning among Southeast Asian refugees. West J Med. Mar; 148(3):349-54. PMID: 3363968. PMCID: PMC1026120 1988

7. Korenbrot C, Showstack J, Loomis A, **Brindis CD**. Birthweight outcomes in a teenage pregnancy case management project. Journal of Adolescent Health Care, 10:97-104. PMID: 2925477. 1989
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9. **Brindis CD**. Reducing adolescent pregnancy: The next steps for program, research, and policy. Family Life Educator, 9(1):3-63 (Special Issue). 1990
10. Korenbrot C, **Brindis CD**, Priddy F. Trends in rates of live births and abortions following state restrictions of public funding of abortion. Public Health Reports, Nov-Dec;105(6):555-62. PMID: 2124355. PMCID: PMC1580169. 1990
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14. **Brindis CD**. What it will take: Placing adolescents on the American national agenda for the 1990s. Journal of Adolescent Health, Nov; 14(7):527-30. PMID: 8312287. 1993
15. **Brindis CD**. Health policy reform and comprehensive school health education: The need for an effective partnership. Journal of School Health, 63(1):33-37. PMID: 8468971. 1993
16. Garcia Baltazar J, Figueroa-Perea JG, Zapata HR, **Brindis CD**, Perez-Palacios G. Reproductive characteristics of adolescents and youths in the metropolitan area of Mexico City, 1987. Salud Pública de Mexico, Nov-Dec; 35(6):682-91. PMID: 8128309. 1993
17. **Brindis CD**, Starbuck-Morales S, Wolfe A, McCarter V. Characteristics associated with contracep-tive use among adolescent females in school-based family planning programs. Family Planning Per-spectives, Jul-Aug; 26(4):160-4. PMID: 7957817. 1994
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SIGNIFICANT PUBLICATIONS

1. Amaral G, Foster D, Biggs MA, Jasik C Judd S, **Brindis CD**. Public savings from the prevention of unintended pregnancy: A cost analysis of family planning services in California. Health Services Research. Vol. 42(5) 1960-1980, 2007. http://www.hsr.org/hsr/abstract.jsp?aid=42386172996

   This paper was written collaboratively, building upon methodology that Dr. Brindis had established and developed previously to support the awarding of an 1115 Medicaid Demonstration Waiver to support subsidized family planning services for low income women and men up to 200% of poverty living in California. The analysis has been used successfully to justify federal investments in the state that have reached over a $1.5 billion dollars. Dr. Brindis helped to supervise the writing of the paper, wrote sections of the discussion, and oversaw revisions and resubmission.

2. Kreger M, Sargent K, Arons A, Standish M, **Brindis CD**. Creating an Environmental Justice Framework for Policy Change in Childhood Asthma: A Grassroots to Treetops Approach. American Journal of Public Health. 2011. Vol. 101, S1 208-216. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300188

   Dr. Brindis was Principal Investigator for the evaluation of The California Endowment's Asthma Initiative, which is the basis for this paper. Dr. Brindis contributed to the conceptual framework of the research, conducted analyses, as well as preparation of the manuscript.

3. Raymond-Flesch M, Siemons R, Pourat N, Jacobs K, **Brindis CD**. “There Is No Help Out There and If There Is, It's Really Hard to Find”: A Qualitative Study of the Health Concerns and Health Care Access of Latino “DREAMers.” Journal of Adolescent Health, Sept. 2014,55(3):323–328. 2014.

   This paper summarizes the first qualitative study of Deferred Action for Childhood Arrivals in the U.S. Dr. Brindis was co-investigator for this study, conceived the research design, conducted focus groups, directed the analyses, and collaborated in writing the manuscript, including overseeing revisions and resubmission.

4. Park MJ, Scott JT, Adams SH, **Brindis CD**, Irwin CE Jr. Adolescent and Young Adult Health in the US in the Past Decade: Little Improvement and Young Adults Remain Worse Off Than Adolescents. Journal of Adolescent Health. July; 55(1), 3-16. 2014.

   This paper is an analyses and synthesis of a variety of data sets available on the status of adolescent and young adult health, with analyses of trends over time. Dr. Brindis contributed to analyses, synthesis of available information, approach for the paper, and writing of the discussion section.

5. Adams S, Park MJ, Twietmeyer L, **Brindis CD**, Irwin CE Jr. Association between Adolesce Preventive Care and The Role of the Affordable Care Act. JAMA Pediatr,. 2018;172(1):43-48. doi:10.1001/jamapediatrics.2017.3140

   This paper is the first nation-wide analysis of the effect of the ACA on improving the content of preventive care services on adolescents over the past four years. I collaborated with my colleagues to conceptualize the hypotheses, assisted in reviewing the overall analyses of the data, and provided input into the final editorial work for submitting this paper.

CONFERENCE ABSTRACTS

1. Eliminating Health Disparities by Increasing Access to Family Planning Services: California’s Family PACT Program. (Presented with A. Biggs, G. Amaral, DG. Foster, H.T. de Bocanegra), AcademyHealth, Orlando, FL.
2. Cost effectiveness of Chlamydia control services among family planning clients. (Presented with M.A. Biggs, D. Greene Foster, J. Chow, G. Amaral), American Public Health Association, Washington, DC.
3. Cost effectiveness of advance provision of emergency contraception. (Presented with D. Greene Foster, T. Raine L. Cao, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC.
4. Cost effectiveness of advance provision of emergency contraception.(Presented with T. Raine, L. Cao, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC.
5. Cost savings from the provision of specific methods of contraception. (Presented with D. Greene Foster, M.A. Biggs, G. Amaral, H. T. de Bocanegra, D.P. Rostovtseva, P. Darney), American Public Health Association, Washington, DC
6. Bringing teens into the family planning clinic: The importance of diverse outreach strategies.(Presented with A. Arons, L. Ralph, N. Berglas, M.A. Biggs), American Public Health Association, Washington, DC.

7. Creating youth friendly clinics: Findings from California Case studies. (Presented with L .Maddock, S. Koenemann, S. Hunter), American Public Health Association, Washington, DC.
8. Teens reaching teens: Use of peer outreach workers in family planning clinics. (Presented with N. Berglas, A. Arons, L. Ralph, M.A. Biggs), American Public Health Association, Washington, DC.
9. Finding teens in TheirSpace: Using internet social networking sites to increase access to family planning. (Presented with S. Schwartz, L. Ralph, N. Berglas).American Public Health Association, San Diego, CA.
10. Teen Births Up, but We're Not Down: Why Age Matters When It Comes to Contraception. (Presented with S. Koenemann), American Public Health Association, San Diego, CA.
11. Pregnancy intendedness and decision-making among young Latinas: Findings from a qualitative study. (Presented with S. Schwartz, L. Ralph, M .A. Biggs, A. Arons), American Public Health Association, San Diego, CA.
12. Accidents Do Happen: Emergency Contraceptives, Teen Contraceptive Use and Knowledge of Reproductive Health Services. (Presented with L. Maddock, S. Koenemann, J. Malvin), American Public Health Association, San Diego, CA
13. Preventing Latina teen pregnancy: The important role of parents. (Presented with L. Ralph, M.A. Biggs, S. Schwartz, A. Arons, A. Minnis, K. Marchi), American Public Health Association, San Diego, CA.
14. A Coalition of School Based Health Centers and Key Evaluation Findings. (Presented with S. Geierstanger, S. Soleimanpour, A. Faxio), American Public Health Association, San Diego, CA.
15. Burden of Asthma on Schools. (Presented with M. Kreger, D. Hughes, K. Sargent, S. Sabherwal, A. Robles, M. Standish), American Public Health Association, San Diego, CA.
16. Evaluating a Movement: Using Systems Change Outcomes. (Presented with M. Kreger, D. Hughes, S. Sabherwal, K. Sargent, A. Robles, M. Standish), American Public Health Association, San Diego, CA.
17. They'll Use it if it's Free: Contraceptive Choices Among Uninsured low-Income Women. (Presented with D. Rostovtseva, M.A. Biggs, S. Holtby, C. McCain, C. Lewis, H. Thiel de Bocanegra, D.G. Foster, American Public Health Association, Philadelphia, PA.
18. Understanding Teens and the "Digital Divide: Can We Reach Low-Income Youth Online with Health Information? (Poster session with N. Berglas, S. Schwartz, L. Ralph), American Public Health Association, Philadelphia, PA.
19. Improving Attendance and Achievement by Improving Air Quality. (Poster session with M. Kreger, S. Sabherwal, K. Sargent, J. Nielsen, A. Robles, M. Standish), American Public Health Association, Philadelphia, PA.
20. He Was so Happy, So I Was Happy Too: Male Partner Influences on Latina Teen Childbearing Decisions. (Presented with S. Schwartz, L Ralph, M.A. Biggs) American Public Health Association, Philadelphia, PA.
21. Youth Friendliness: How Do Family Planning Clinics Measure Up? (Presented with N. Berglas, M.A. Biggs, S. Navarro), American Public Health Association, Philadelphia, PA.

22. Translating Research to Impact Public Policy: California's Experience with Parental Involvement Legislation for Minor's Abortion in the 2005, 2006, and 2008 Elections. (Presented with L. Ralph), American Public Health Association, Philadelphia, PA
23. Evaluating Policy Advocacy: Employing Systems Change Outcomes. (Presented with M. Kreger, D. Hughes, S. Sabherwal, K. Sargent, A. Robles, M. Standish), American Public Health Association, Philadelphia, PA
24. Discussing Intrauterine Contraception at the Family Planning Visit: A Missed Opportunity for Client Education. (Presented with S. Schwartz, M.A. Biggs, S. Holtby, C. McCain, D. Rostovtseva), American Public Health Association, Philadelphia, PA.
25. Unplanned Pregnancies Among Young Adult Latinas: The Influence of Partners, Fertility Concerns, and Individual Aspirations. (Presented with L. Ralph, S. Schwartz, M.A. Biggs) American Public Health Association, Philadelphia, PA.
26. Approaches to Evaluating Advocacy and Policy Change: An International Comparison. (Presented with J. Kaye, A. Jackson, M. Billera, A. Gardner, L. Nascimento, S. Geierstanger), American Evaluation Association, Orlando, FL.
27. How Traditional Evaluation Thinking and Frameworks Can Be Adapted for Advocacy/Policy Evaluation. (Presented with J. Kaye, S. Ladd, D. Dunet, E. Chappelle, L. Gase, M. Kreger, S. Sabherwal, K. Sargent, A. Robles, M. Jhawar, M. Standish, American Evaluation Association, Orlando, FL.
28. Clinica Alta Vista: Providing an Integrated Model of Prenatal Care for Latina Adolescents and Their Families. (Poster presented with S. Soleimanpour, S. Ng, V. McCarter.) AFL Annual Conference, Oakland, CA.
29. Does Experience Matter? Quality of Reproductive Health Care Provided to Latino Adolescents (Poster co-authored with: LA Botkin, SA Fishkin, C.D. Brindis, E. Ozer, C. Kapphahn). Society for Adolescent Medicine Annual Meeting. Toronto, CANADA.
30. Traditional versus Centering: Which model of care leads to improved outcomes for Latina pregnant and parenting teens and their infants? (poster co-authored with S. Soleimanpour, S. Ng, V. McCarter) American Public Health Association Annual Meeting. Denver, CO.
31. Burden of Asthma on California Schools: Losses in Student Attendance, Achievement, and Revenue. (presented with M. Kreger, A. Arons, K. O'Brien, M. Standish) American Public Health Association Annual Meeting. Denver, CO.
32. Evaluating Policy Advocacy: Lessons from an Environmental Policy Initiative in California. (presented with M. Kreger, A. Arons, M. Standish) American Public Health Association Annual Meeting. Denver, CO.
33. It takes a community: CBOs and family planning providers collaborate to increase access to reproductive health services for low-income populations. (Poster co-authored with S. Schwartz, N. Berglas) American Public Health Association Annual Meeting. Denver, CO.
34. Can you get pregnant when you're on your period? Negotiating Sex Education: Questions & Misinformation"(presented with E. Villasenor, S. Kaller) American Public Health Association Annual Meeting. Denver, CO.

35. Pushing the Envelope beyond the pill and condoms: Teen Knowledge and attitudes towards long acting, reversible contraceptives. (poster co-authored with L. Maddock, D. Richardson, J. Funk). American Public Health Association Annual Meeting. Denver, CO.
36. Health of young people in the United States, 1991-2008: Trends in critical national health objectives. (Presented with N. Jiang, L. Kolbe, D. Chul Seo, N. Kay) American Public Health Association Annual Meeting. Denver, CO.
37. Assessing Health Policy Change Using an Online Survey Instrument. (Presented with A. Gardner, L. Nascimento, S. Geierstanger). American Evaluation Association Annual Meeting. San Antonio, TX.
38. Burden of Asthma on California Schools: Statewide and Local Attendance and Financial Losses and academic Achievement Analysis. Presented with M. Kreger, R. Guide, M. Bullen, M. Standish). American Public Health Association Annual Meeting. Washington, DC.
39. Advocating for Healthy Schools: Employing a Systems Change Framework to Assess Health and Education Policy Advocacy in California: Breaking Down Silos." (Presented with M. Kreger). American Public Health Association Annual Meeting. Washington, DC.
40. Client Demographics and Service Characteristics of California Title X and Non-Title X Family Planning Providers. (Presented with H. Thiel de Bocanegra, F. Maguire, M. Puffer, K J Horsley). American Public Health Association Annual Meeting. Washington, DC
41. School Based Behavioral Health Services in a Diverse, Urban Setting: Making a Difference. (Presented with S. Soleimanpour, S. Ng, V. McCarter, S. Geierstanger). American Public Health Association Annual Meeting. Washington, DC.
42. Meeting the Needs of Latino and African American Youth: School Based Behavioral Health Interventions. (Presented with S. Soleimanpour, S. Ng, V. McCarter, S. Geierstanger). American Public Health Association Annual Meeting. Washington, DC
43. Taking the Pulse: Potential for Assessing the Impact of Yoga and Mindfulness Programs on Youth. (Poster Presentation with L. Maddock, S. Geierstanger, E. Hendrick, S. Ng, N. Berdjis). American Public Health Association Annual Meeting. Washington, DC.
44. A Question of Hope ("Una Cuestion de Esperanza"). US Film Festival. (Presented with M. Antonia Biggs, K. Marchi, P. Braveman). American Public Health Association Annual Meeting. Washington, DC
45. Lessons Learned From State Departments of Insurance/> Implementation of the Age 26 Health Reform Provision." (Poster presented with Alexander Blum and Amanda Giordano). AcademyHealth Annual Research Meeting, Washington, DC.
46. One Product, Multiple Health Needs, Saving Lives: A Multidisciplinary Approach for the Prevention of Unintended Pregnancies and Sexually Transmitted Infections. (Poster presented with Bethany Young Holt) California Wellness Foundation Conference on Women's Health. Los Angeles, CA.
47. Improving Reproductive Environmental Health through EPA Policy. (Poster presented with Plumb M, Trowbridge J, Charlesworth A, Woodruff TJ). American Public Health Association Annual Meeting. San Francisco, CA

48. Intervening at a Critical Juncture: Women's Motivation to Use Intrauterine Contraception Immediately Following an Abortion. (Poster presented with Biggs MA, Levy S, Teig E, Arons A) American Public Health Association Annual Meeting. San Francisco, CA.

49. Building on Youth Assets to Improve Reproductive Health: Teen Pregnancy Prevention Programs in California. (Poster presented with Maddock L, McCarter V.) American Public Health Association Annual Meeting. San Francisco, CA

50. Uneven Progress: An Assessment of Sex Education policies and Practices in California Public Schools. (Poster presented with Combellick S.) American Public Health Association Annual Meeting. San Francisco, CA.

51. Teen Pregnancy Prevention Education in California: Adapting Curricula to Fit the Local Context. (Poster presented with Arons A Decker M, Malvin J) American Public Health Association Annual Meeting. San Francisco, CA.

52. Free Drinking Water Access and Barriers to Improving Water Access and Intake in California Schools." (Poster presented with Patel A, Hecht K, Hampton K, Grumbach J, Chandran K, Braff-Guajardo E.) American Public Health Association Annual Meeting. San Francisco, CA.

53. Writing on the Wall: The effects of Neighborhoods on Teen Reproductive Health. (Poster presented with Isquick S, and Decker M). American Public Health Association Annual Meeting. San Francisco, CA.

54. Making Do with Less: The Impact of State Budget Cuts on California's Teen Pregnancy Prevention Programs." (Invited Panel presentation, with Yarger J and Malvin J). American Public Health Association Annual Meeting. San Francisco, CA.

55. Expanding Universal Coverage: Reproductive Health Vouchers in Cambodia (Poster presented with Brody C, Freccero J, Bellows B).American Public Health Association Annual Meeting. San Francisco, CA.

56. Stayin' Alive and Thriving: Exploring Multiple Dimensions of SBHC Sustainability. (invited Panel presentation with Kaller S, Geierstanger S, and Brown S). American Public Health Association Annual Meeting. San Francisco, CA.

57. The Last Bottle Standing: Sports Drink and Bottled Water Access in California Public Schools. Patel A, Braff-Guajardo E, Hampton KE, Grummon A, Brindis CD. [3806.113]Annual Pediatric Academic Societies meeting, Institute of Medicine National Academies.

58. Understanding Contraceptive Use in the United States. American Public Health Association Annual Meeting; **Brindis CD** Moderator.

59. A Qualitative Study of the Healthcare Access and Concerns of Latino Dreamers. With Raymond-Flesch M, Siemons R, Pourat N, Jacobs K, **Brindis CD**. Poster Presentation. 2014 Meeting of the Pediatric Academic Society. Vancouver, Canada. May 2014.

60. Adolescents and Young Adults Under Health Care Reform: Explanation of Benefits (EOBs) and Patient Confidentiality. Keynote Address, **Brindis CD**, AcademyHealth Child Health Services Interest Group, June 7, 2014.

61. Glass Half Full: A Comparison of Water Delivery Options to Improve Students' Water Intake in Schools. Patel A, Braff-Guajardo E, Hampton KE, Grummon A, **Brindis CD**.

Poster presentation. 2014 Meeting of the Pediatric Academic Society. Vancouver, Canada. May 5, 2014.

62. Where Have All the Teens Gone? Decline in Adolescent Female Participation in California's Family Planning Program Following Cuts in Outreach Funding. Panel with Yarger J, Daniel S, Biggs MA, Malvin J, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.

63. Operationalizing Resilience-Building and Life Course Planning with Pregnant and Parenting Adolescents in California. Panel with Kreger M, Tebb K, Truebridge S, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.

64. Implementation of the Affordable Care Act (ACA): How Are MCH Populations Doing? Panel with Walker DK, Witgert K, **Brindis CD**, Comeau M, Peifer KL. American Public Health Association Annual Meeting, New Orleans, LA

65. Meeting the Social-Emotional Needs of Students: Creating Alternatives to the School-to-Prison-Pipeline. Panel with Kreger M, Sargent-Cairoli K, Thrasher J, Rucker P, Redmond, C, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA

66. School Health Center Evaluation with a "Twist" of Quality. Panel with Shelly Kaller S, Lutsky M, **Brindis CD**. American Public Health Association Annual Meeting, New Orleans, LA.

67. Sexually Transmitted Infection Services and Adoption of Effective Contraceptive Methods. Poster Presentation with Daniel S, Biggs A, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA.

68. California Family Planning Providers' Challenges to Same Day Long-Acting Reversible Contraception (LARC) Provision. Poster Presentation with Biggs MA, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA. 2014

69. Potential Role of Family Planning in an Era of Health Care Reform: Patient Perspectives on Primary Care Needs and Insurance Eligibility. Poster Presentation with Daniel S, Biggs A, Malvin J, **Brindis CD**, Yarger J. American Public Health Association Annual Meeting, New Orleans, LA. 2014

70. Characteristics of the Undocumented Young Adults Eligible for the Deferred Action for Childhood Arrivals. Poster Presentation with Pourat N, Lucia L, Hadler M, **Brindis CD**, Jacobs K, Siemons R, Talamantes E, Raymond-Flesch M. American Public Health Association Annual Meeting, New Orleans, LA. 2014

71. Meeting Them More Than Halfway: Adolescent Perspectives on Patient-Centered Care. Poster Presentation with Uy-Smith EL, Lofink HE, Padrez R, Trudnak Fowler TE, Koenig KT, Fairbrother G, **Brindis CD**. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015

72. Measuring Up to the Common Core: What is Known About the Delivery of Primary Care Services in the School-Based Health Centers (SBHC). Uy-Smith EL, Grumbach K, **Brindis CD**. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015

73. Moving Beyond Health Care Access: Evidence-Based Practices for Young Adults. Irwin CE Jr., Lau J, Ozer E, **Brindis CD**. Workshop Session. Society for Adolescent Health and Medicine Annual Meeting, Los Angeles, CA. 2015

74. Headstand Yoga & Mindfulness School Program. Geierstanger S, Ng S, Maddock L, **Brindis CD**, Gutmann-Gonzalez A. Poster Presentation: California School Health Association Conference, San Diego, CA. 2015

75. Fulfilling the Vision: The Role of Enrollment Workers in Promoting Health Insurance Access." Raymond-Flesch M, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

76. Risk and Resilience Factors Associated with Frequency of School-Based Health Center Use. Soleimanpour S, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

77. School-Based Health Centers and Adolescents' Access to Reproductive Health Care. Soleimanpour S, Geierstanger S, Kaller S, Ng S, McCarter V, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

78. Lessons from the ACA's Medicaid Expansion Front-Lines: Perspectives of Enrollment Workers. Raymond-Flesch M, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

79. Transforming Statewide Policy into Community-Wide Practice: School Disciplinary Policy and Health Disparities. Kreger M, Sargent-Cairoli K, **Brindis CD**. American Public Health Association Annual Meeting, Chicago, IL. 2015

80. Evaluating Consumer Engagement in Health Care: Strategies and Tactics as an Evaluation Framework. **Brindis CD**, Hughes D, Schmidt LA, Jacobs L. American Evaluation Association Annual Meeting. Chicago, IL. 2015

81. Video: A Multi-Purpose Evaluation Method? **Brindis CD**, Hughes D, Schmidt LA, Jacobs L. American Evaluation Association Annual Meeting. Chicago, IL. 2015

82. The Political Prioritization of Preterm Birth: A Policy Analysis Using a Prioritization Framework." Poster Presentation. Consortium of Universities for Global Health Annual Conference. San Francisco, CA. 2016

83. Young Adults and the Affordable Care Act. Irwin CEJr, **Brindis CD**, Ozer E, Park J, Hemlin E. Workshop: Society for Adolescent Health and Medicine Annual Meeting, Washington, DC. 2016

84. What, Me Worry? Youth Perceptions of Pregnancy and STIs. **Brindis CD**. Oral Presentation, Abstract. American Public Health Association Annual Meeting, Denver CO. 2016

85. Cultivating Clinical Connections: Opportunities and Barriers to Increasing Youth Access to Clinical Sexual Health Services in California. Decker M, Gutmann-Gonzalez, **Brindis CD**. Poster Presentation. Society for Adolescent Health and Medicine Annual Meeting, New Orleans, LA. 2017

86. Honoring Their Roots: Crating and Cultivating Positive Connections with Latino Adolescents and Young Adults. O'Brien SJ, Mondardez J, Garcia-Huidobro A, **Brindis CD**. Raymond-Flesch M. Workshop Presentation. Society for Adolescent Health and Medicine Annual Meeting, New Orleans, LA. 2017

87. Impacto Perinatal: El Embarazo de Adolescentes en Mexico y en California: Politicas Publicas y Consecuencias Programaticas. **Brindis CD**, Decker MJ, Gutmann-Gonzalez A.

Instituto Nacional de Perinatologia, Mexico City, Mexcio. Reunion Anual INPer 2017: Salud Sexual y Reproductiva del Adolescente: April 4, 2017.

88. Barriers and Enablers to Care for Young Adults Churning Between Health Plans. Yarger J, Tilley L, **Brindis CD**. Oral presentation. American Public Health Association Annual Meeting, Atlanta, GA. 2017

89. Health Literacy Challenges for Young Adults Experiencing Churning Health Insurance Coverage. Tilley TL, Yarger J, **Brindis CD**. Oral presentation. American Public Health Association, Atlanta, GA. 2017

90. Use of an mHealth Application, Health-E You/ Salud iTu, to Improve Sexually Active Latina Adolescents' Contraceptive Knowledge, Self-Efficacy and Use. Tebb K, **Brindis CD**. Poster Presentation. Pediatric Academic Society (PAS) Meeting. Toronto, Canada. May 5-8, 2018.

91. An Opportunity for Intervention: Teen Dating Violence Among California's Adolescents in Out-of-Home Settings. Rutman S, Decker M, **Brindis CD**. Oral Presentation. American Public Health Association, San Diego, CA. November 10-14, 2018.

92. Improving Capacity to Implement an Evidence-Informed Case Management Intervention for Expectant and Parenting Adolescents: Results from a Statewide Training Evaluation. Tebb K, **Brindis CD**, Pressfield L, Campa M. Poster Presentation. American Public Health Association, San Diego, CA. November 11, 2018.

OTHER CREATIVE ACTIVITIES

1. Espinoza I, Anaya E, Ortiz R, Hernandez G, Bazeza B, Hinojosa S, **Brindis CD**, Laski L, Romero M. Manual de Capacitacion para Consejeria en Planificacion Familiar. Training manual for family planning counselors. Grupo Interinstitucional de Trabajo en Salud Reproductiva, Queretaro, Mexico and Center for Reproductive Health Policy Research, Institute for Health Policy Studies, University of California, San Francisco.

2. **Brindis CD**, Philliber S. Evaluating School Linked Services: Methods, Problems and Results. Philliber Research Associates, Accord, NY.

3. Card JJ, **Brindis CD**, Peterson J, Niego S. Evaluating Your Comprehensive Adolescent Pregnancy Pre-vention Program. (sponsored by the Centers for Disease Control and Prevention-http://www.socio.com/index.htm) Los Altos, CA: Sociometrics Corp.

4. Kent H, **Brindis CD**, Margolis R, Teipel K. Adolescent Health: A Community Perspective. Maternal and Child Health Continuing Education on DC-ROM. Rocky Mountain Public Health Education Consortium. University of Utah http://services.tacc.utah.edu/rmphec/http://services.tacc.utah.edu/rmphec/adolescent_health_outline.html

5. **Brindis CD**, Park J, Paul T. The RESOURCE Project- A Curriculum on Adolescent Health http//policy.ucsf.edu/index.php/resources/

6. A Future with Promise: A Chartbook on Latina Reproductive HealthPower Point http://crhrp.ucsf.edu

7. A Question of Hope: Reducing Latina Teen Childbearing in California. UCSF Center on Social Disparities in Health and the Bixby Center for Global Reproductive Health.

Produced by Ideas in Motion. Awarded “Telly” Award, Bronze Prize. 2009. http://bixbycenter.ucsf.edu/videos/video-lo-1.html

8. Adolescent Health Data: Youth Have It - Now What? LEAH. Webinar available at:http://leah.mchtraining.net/teleconference.php
9. Eliminating Health Disparities and Achieving Equity: A Framework for Advancing the Health, Safety and Well-Being of Adolescents. Webinar available at: http://www.mchcom.com March 11, 2009
10. Eliminating Adolescent Health Disparities and Achieving Equity: Empowering Youth. Webinar available at http://www.mchcom.com. April 29, 2009.
11. Promoting Health Equity in Adolescent Care: Framing the issues: Background, Research and Overview of Approaches. American Academy of Pediatrics. Webinar. July 30, 2009
12. Health Care Reform Implementation: Opportunities to Improve Adolescent and Young Adult Health. Webinar on Adolescent and Young Adult Health in the Post Reform Era, National Institute of Health Care Management Foundation (NIHCM) August 17, 2010.
13. Overview of Adolescent Health. AMCHP Webinar. October 29, 2010
14. Health Care Reform: What’s Next? Interview with Mark McClellan, MD, Brookings Institute. July 7, 2010. http://www.uctv.tv/search-details.aspx?showID=19462
15. Scorecard on Kid’s Health Care Ranks California 44th: A Commonwealth Fund survey compares the states on children's health care access and treatment.” http://www.baycitizen.org/health/story/score-card-kids-health-care-ranks-44th/
16. Inside Health Reform presented with Andrew Bindman, Mark Laret and Diane Rittenhouse who look at the passage and implication of health reform. January 3, 2011(panel moderator). http://www.uctv.tv/search-details.aspx?showID=20178
17. Unplanned Pregnancies in State Reach 4 in 10. USA Today, May 19, 2011**.** http://yourlife.usatoday.com/parenting-family/pregnancy/story/2011
18. UCSF Health Experts Shape Historic Blueprint for Women’s Health Care. Interview by Patricia Yollin, July 26, 2011**.** http://www.ucsf.edu/news/2011/07/10335/ucsf-health-experts-shape-historic-blueprint-womens-health-care
19. Interview regarding the Institute of Medicine Preventive Services for Women press release. KPCC, 89.3, Los Angeles**.** http://www.scpr.org/programs/patt-morrison/2011/07/20/19960/health-care-panel-recommends-full-coverage-of-cont
20. US Federal Government Institute of Medicine New Rules on Women’s Health Coverage. Interview by Ted Goldberg, KCBS Radio, 740 AM, San Francisco, CA. August 1, 2011.
21. US Federal Government Institute of Medicine New Rules on Women’s Health Coverage. Interview by Dave Blanchard, KUOW, (NPR affiliate) Seattle, WA. August 2, 2011.
22. US Federal Government Institute of Medicine New Rules on Women’s Health Coverage: Claire Brindis’ role in development of. Interview by Catherine Traywick for Science Today, Produced by University of California for CBS Radio Network. August 2, 2011.
23. From HP 2010 to HP 2020: Building a Bridge for Advancing an Adolescent Health Agenda. Framing Adolescent and Young Adult Health through Healthy People 2020. California Adolescent Health Collaborative. Webinar presented December 13, 2011.

24. The Toxic Truth about Sugar. UCSF interview with Robert Lustig and Laura Schmidt upon press release of Nature article http://www.youtube.com/watch?v=ffoOeW5wZ9s&feature=youtu.be&utm_source=Feburary+2012+Staff&utm_campaign=Pulse+Feb12+Staff&utm_medium=email
25. Self Magazine interview. The Toxic Truth about Sugar. 2012
26. Interview with Nana Queiroz of Correio Braziliense, February 8, 2012, RE: The Toxic Truth about Sugar: Nature article http://www.correioweb.com.br/
27. A Public Health Success: California's Adolescent Pregnancy Prevention Story. Webinar presented August. 1, 2012. University of California, Davis, in conjunction with CALPACT, a public health training center.
28. Implementing the Affordable Care Act for Adolescents and Young Adults: Practical Considerations. Webinar presented September 6, 2013. Maternal and Child Health Bureau, HRSA, Washington DC: http://learning.mchb.hrsa.gov/archivedWebcastDetail.asp?id=344
29. Interview with the Canadian Broadcasting Corporation. June 13, 2013: RE: Women's Reproductive Health and the Cost of Providing Services.
30. Virtual Networking Meeting for State Adolescent Health Coordinators. Webinar presented December 2, 2013. Maternal and Child Health Bureau, HRSA, Washington DC. 2013
31. KQED radio interview, July 10, local NPR affiliate station, San Francisco, CA. In response to release of report protecting Adolescent Confidentiality Under Health Care Reform: The Special Case Regarding Explanation of Benefits (EOBs). 2014
32. Adolescent Health Activities in State Title V Programs: Data From an Environmental Scan." Webinar presented April 14, 2014. Association of Maternal and Child Health Programs
33. Testimony in Support of the American Public Health Association's Comprehensive Sex Education Policy. Written submission, November 2014
34. Successful Teen Pregnancy Prevention: Connecting Clinical Care and Community Interventions. Webinar presented April 16, 2014. CAHC Advisory Council and ASHWG Steering Committee.
35. KPCC Southern CA Public Radio. Contribution to radio piece and website story: "Happy-health care birthday it's time to buy insurance" by Rebecca Pleven. June 10, 2015. http://www.scpr.org/blogs/health/2015/06/10/18038/happy-health-care-birthday-it-s-time-to-buy-insura/
36. Huffington Post: Quoted in: "This How Teens Have Sex, According to the CDC. Surprisingly Good News!" Author Anna Almendrala, Healthy Living Editor: July 22, 2015. http://www.huffingtonpost.com/entry/the-state-of-teen-sex_55aec49ae4b0a9b94852e702?1t027qfr
37. KPCC Southern CA Public Radio; Contribution to radio piece/website story: PriceCheck Blog: "Yes, you can give birth for $250" by Rebecca Pleven. August 15, 2015
38. KQED PBS Radio-Forum with Michael Krasny. "Comprehensive Sex Ed Now Mandatory for California's Middle and High School Students." One-hour interview. October 7, 2015.

39. Kaiser Health News (on-line article) “Health law increases coverage rates for women not yet pregnant.” By Lisa Gillespie. October 28, 2015
40. Institute of Medicine and National Research Council Report: Investing in the Health and Well-Being of Young Adults. Webinar presented February 3, 2015. Society for Public Health Education (SOPHE). http://www.sophe.org/education.cfm
41. Child and Adolescent Health. AMCHP/MCHB Title V Transformation Action Planning Town Hall Series presented June 2, 2015. Association of Maternal & Child Health Program.
42. Adolescents in the United States: Health Care for Adolescents: How to Improve it. U.S. Centers for Disease Control and Prevention. August 18, 2015. Atlanta, GA. (Invited panel presentation/Webinar.) http://www.cdc.gov/cdcgrandrounds/archives/2015/august2015.htm
43. KCBS San Francisco Radio. Over the Counter Contraception. Interview and commentary; February 14, 2016.
44. KPCC Southern CA Public Radio; Contribution to radio piece/website story: California women waiting longer to have their first child. Rebecca Pleven. January 14, 2016. http://www.scpr.org/news/2016/01/14/56839/calif-women-waiting-longer-to-have-their-first-chi/
45. L.A. School Report. California sprints to the head of the class on sex education, as all students this year will be taught about consent. **Brindis CD** cited. August 8, 2016. http://laschoolreport.com/california-sprints-head-class-sex-education-students-year-will-taught-consent/
46. Achieving Relevance and Visibility in an Academic Research Career – Opportunities and Potential Pitfalls. June 15, 2017. BIRCWH* Leadership Webinar. (*Building Interdisciplinary Research Careers in Women's Health)
47. The (Uncertain) Future of Women's Reproductive Health Care. July 19, 2017. Expert Panel Presentation, San Francisco. PRL Institute for Health Policy, BIRCWH* & Bixby Center for Global Reproductive Health. https://youtu.be/2nPD1yeowK
48. La Jornada Maya: https://www.lajornadamaya.mx/2017-04-10/Mexico-duplica-a-EU-en-riesgo-de-embarazos-adolescentes
49. Cronica: http://www.cronica.com.mx/notas/2017/1017950.html
50. Headlines that say GOP bill makes sexual assault a pre-existing condition are misleading. Lauren Carroll. Published on-line: Politifact, May 5, 2017. Claire Brindis, consultant.
51. Evaluating Activism. Stanford University Press Blog. Published June 13, 2017. Gardner A, **Brindis CD**. Article in relation to their book, Advocacy and Policy Change Evaluation. http://stanfordpress.typepad.com/blog/2017/06/evaluating-activism.html
52. Interview with "Take Two" on 89.3 KPCC regarding "Gag Rule" for Abortion Services Information. May 18, 2018.

ADDITIONAL RELEVANT INFORMATION

Brindis CD. Lost Opportunities in Accessing Reproductive Health Care-Can Pediatricians Still Make a Difference? Journal of Adolescent Health. Editorial. (46) No. 4, 305-306. 2010

EXHIBIT B

Claire Brindis
Title X Comments Submitted to HHS

Office of the Assistant Secretary for Health

Information Copy

Doc ID:	**SPS00398813**	*Date Due:*	
Corr. From:	**Claire Brindis**	*Task Date:*	
On Behalf Of:			
Date on Letter:	**7/27/2018**	*Date Inc Rec'd:*	**7/27/2018**

Subject: **FW: Title X Comments**
Synopsis:
Primary Issues: **None**

Action Office: **V. Huber**
Info Copies: **D. Mansdoerfer; S. Valentine; ASH; OPA**
Action Required: **Info Only**

Analyst: Vivian Stallion

Instructions: None

U.S. Department of Health and Human Services

Office of the Secretary

Executive Secretariat

INFORMATION COPY

******INFORMATION ONLY – NO ACTION REQUIRED******

DATE:	07/27/2018

OVERVIEW

SPS#:	00398813
FROM:	Claire Brindis
SUBJECT #:	FW: Title X Comments
POLICY COORDINATOR:	Jamar Hawkins, (202) 205-6380

ASSIGNMENT

AUTHORING AGENCY(S):	Office of the Assistant Secretary of Health (OASH)
TASK TYPE:	Info Copy
ROUND #:	1
RECIPIENTS:	
INFO COPY:	OASH

You are receiving this assignment as info-only. No action is needed from your office at this time. If you believe that your office should receive this control for clearance, please contact the Exec Sec policy coordinator listed above as soon as possible.

INSTRUCTIONS:

FW: Title X Comments

From: Brindis, Claire <Claire.Brindis@ucsf.edu>

Sent: Friday, July 27, 2018 12:23 PM

To: HHS Secretary (HHS/IOS) <secretary@hhs.gov>; huber@hhs.gov; Foley, Diane (HHS/OASH) <Diane.Foley@hhs.gov>

Subject: Title X Comments

Dear Secretary Azar, Ms. Huber, and Ms. Foley,

Thank you for the opportunity to comment upon the proposed Title X changes. Please review my attached letter.

Best wishes,

Claire Brindis

July 31, 2018

VIA ELECTRONIC TRANSMISSION

Alex Azar, Secretary of Health and Human Services
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201
secretary@hhs.gov

Valerie Huber, Senior Policy Advisor, Assistant Secretary for Health
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201
valerie.huber@hhs.gov

Diane Foley, Deputy Assistant Secretary for Population Affairs
Office of the Assistant Secretary for Health, Office of Population Affairs
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201
diane.foley@hhs.gov

RE: HHS–OS–2018–0008, Proposed Rule for Compliance With Statutory Program Integrity Requirements

Dear Secretary Azar, Senior Advisor Huber, and Deputy Assistant Secretary Foley:

I submit this comment letter in response to the Department of Health and Human Services' proposed rule entitled Compliance with Statutory Program Integrity Requirements, published in the Federal Register on June 1, 2018.[1]

I am a Professor in the Departments of Pediatrics and Obstetrics, Gynecology & Reproductive Sciences at the University of California, San Francisco and the Director of the Philip R. Lee Institute for Health Policy Studies. For nearly four decades, I have conducted research focused on child, adolescent, and women's health policy, as well as on the implementation of health care reform for low-income women. This includes, for example, an evaluation of an 1115 Medicaid Waiver to deliver a comprehensive array of family planning services under California's Family PACT program. That program demonstrated its positive impact in reducing the incidence of unintended pregnancy through the provision of FDA-approved methods of contraception; it increased the numbers of clients who switched from non-use of birth control or ineffective methods of contraception to more effective means; and provided a savings for the Federal and State government such that the program saved nearly $9.25 for every dollar invested in family planning. The program services were delivered in a culturally sensitive manner through a network of public and private clinics, with point of entry enrollment in the program for women up to 200% of poverty. For women with incomes between 200- 250% of the poverty line, Title X played an integral role in meeting their needs.

As a public health researcher, I write to express serious concerns about this proposed rule. Having worked in the field of family planning and women's health throughout the long history of the Title X Family Planning Program (Title X), I recognize the valuable role that Title X provides. In my home state of California, the country's most populous state. For example, as a result of Title X, more than 1 million individuals benefit from not only family planning care, but the important provision of many other important services related to women's health and well-being in my state. The proposed rule, however, would significantly and detrimentally alter Title X and put at risk the vital reproductive health services it has provided to millions of low-income individuals not only in California, but across the country for many decades.[2]

1. The Proposed Rule Would Undermine Title X's Goal Of Providing Comprehensive Family-Planning Services To Those Unable To Pay For Them.

Over the course of its nearly 50-year history, Title X has proven successful in providing access to many important aspects of health care for low-income Americans. Most obviously, Title X programs have successfully provided a broad range of family planning services, including and especially contraceptives, to low-income Americans who would otherwise do without this care. To give just one example, my research shows that a greater proportion of Title X providers than non-Title X public and private providers offered onsite services for the following birth control

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[1] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed Jun. 1, 2018) (to be codified at 42 C.F.R. pt. 59).

[2] It is my opinion that the proposed rule would also interfere with the doctor-patient relationship and deny Title X patients vital health information. In this comment letter, however, I focus on the public-health consequences of the proposed rule separate from this unwarranted interference.

methods: intrauterine contraceptives (90% Title X, 51% public non–Title X, 38% private); contraceptive implants (58% Title X, 19% public non–Title X, 7% private); vasectomy (8% Title X, 4% public non–Title X, 1% private); and fertility-awareness methods (69% Title X, 55% public non–Title X, 49% private).[3] These data are important because a patient's choice of a method of contraceptive—some of which are more effective, or less invasive—may be influenced by its onsite availability, since patients are reasonably hesitant to choose a contraceptive method if it requires them to go to another site. Thus, when providers do not provide all FDA-recommended methods, gaps in coverage may occur or a client may use a contraceptive method that is not the best personal or medical choice. Title X providers have been very effective at preventing those gaps.

Apart from the delivery of family planning care, Title X providers have come to play an essential and important role in providing any number of other vital health services for low-income Americans. This includes, for example, conducting screenings for cervical cancer, diabetes, high blood pressure, and sexually transmitted infections (STIs), among a range of other services aimed at primary prevention and referral. For many low-income Americans, especially women, access to this set of services represents the most trusted entry point to all medical care—many patients are not aware of other services that may be offered in the community, and a Title X program is truly a gateway to all other health care.

Indeed, for many low-income women, visits to a family planning provider are their only interaction with the health care system at all—including those with health insurance coverage. Family planning providers therefore, play a vital role in getting people insured. In 2015, nearly half of family planning clients at health centers funded by Title X programs were uninsured.[4] In a study published in 2017, four other researchers and I investigated how publicly funded Title X clinics were enrolling patients in health insurance, and the proportions reporting every enrollment activity were relatively high among Title X–funded sites (72–98%). Rural sites were especially important in providing enrollment education, on-site enrollment assistance, and referrals—71% to 97% of rural sites reported providing these services.[5]

The proposed rule puts all of this at risk. It would undoubtedly force clinics that currently provide the full range of contraceptive options out of the program—either because they would refuse to comply with the interference in the doctor-patient relationship the proposed rule commands, or because they could not logistically and economically comply with the physical separation requirement, or both. It would accordingly also eliminate a valuable resource to women who count upon their reproductive health provider as the entry point for any number of other medical services unrelated to reproductive health. It would could cut off many people from an opportunity to enroll in health coverage, especially in rural areas. *And it would seemingly impose all of these hardships in service of emphasizing family-planning methods—such as "sexual risk avoidance" and natural family planning—that are universally regarded as ineffective.*

Thus, when considering the proposed rule, the Department must consider how these changes in Title X would undermine not only access to reproductive health care, but also to important primary health care screenings and referrals, that many women depend upon, as well as the

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[3] Thiel de Bocanegra et al, Onsite Provision of Specialized Services: Does Title X Funding Enhance Access?, *Journal of Women's Health,* May 5, 2014. https://www.liebertpub.com/doi/abs/10.1089/jwh.2013.4511

[5] Yarger et al. The Role of Publicly Funded Family Planning Sites in Health Insurance Enrollment. *Perspectives in Sexual and Reproductive Health.* June 2, 2017. https://onlinelibrary.wiley.com/doi/epdf/10.1363/psrh.12026

extent to which this impact would reduce insurance coverage rates and increase costs to the health care system.

In my opinion, based on nearly four decades of work in this area, these consequences will be numerous and severe. Let me highlight a few of them.

Pregnancies that are unintended, and therefore riskier, will increase. There are several risks to infants and mothers that occur more frequently with unintended pregnancies than with planned pregnancies. In some instances, preexisting health conditions, such as having recently given birth, obesity, or diabetes, make it important for women to be able to delay becoming pregnant.[6] If women with these conditions become pregnant before the conditions are properly managed, they risk pregnancy loss, stillbirths, pre-term births, fetal growth that is either too small or too large relative to gestational age, birth defects, and increased risk of hypoglycemia (low blood sugar) or respiratory distress for the baby.[7] In addition, pregnant women who are obese may be at increased risk for a variety of adverse health outcomes, including increased instances of gestational diabetes and sleep apnea, and an increased risk for cesarean delivery.[8]

The effects of unintended pregnancies on infants after birth may persist into childhood and even adulthood. For example, children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, and they have lower educational attainment and more behavioral issues in their teen years.[9] Infants who are born to mothers who are overweight or obese (whether those pregnancies were intended or unintended) may have higher body mass indexes into adulthood, and infants who are born to mothers with diabetes may experience long-term risks of obesity, cardiovascular disease, and renal disease.[10]

In addition, because women experiencing an unintended pregnancy may not immediately be aware that they are pregnant, they are more likely to receive prenatal care only later in their

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6 ACOG, Committee Opinion No. 654, Reproductive Life Planning to Reduce Unintended Pregnancy (2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co654.pdf?dmc=1&ts=20170630T0350176108; ACOG, Frequently Asked Questions No. 182, Obesity and Pregnancy (2016), https://www.acog.org/-/media/For-Patients/faq182.pdf?dmc=1&ts=20170630T0349076575; ACOG, Frequently Asked Questions No. 142, Diabetes and Women (2016), https://www.acog.org/-/media/For-Patients/faq142.pdf?dmc=1&ts=20170630T0346285947. Planned Parenthood discusses such conditions with patients to help inform physicians' and patients' discussions regarding timing and planning for a safe pregnancy. Planned Parenthood, *Pre-Pregnancy Health*, https://www.plannedparenthood.org/learn/pregnancy/pre-pregnancy-health; *see also* Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives, Family Planning, Overview, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives (regarding importance of pre-conception care).

7 *See* ACOG sources cited *supra* note 6.

8 ACOG, Frequently Asked Questions No. 142, *supra* note 6.

9 Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives, Family Planning, Overview, https://www.healthypeople.gov/2020a/topics-objectives/topic/family-planning#nine; *see also* ACOG, Committee Opinion No. 654, *supra* note 6.

10 Liliana Garcia-Vargas, *Gestational Diabetes and the Offspring: Implications in the Development of the Cardiorenal Metabolic Syndrome in Offspring*, 2 CardioRenal Medicine 134, 136-38 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3376343/pdf/crm-0002-0134.pdf.

pregnancies—or not at all.[11] They are also more likely during their pregnancies to smoke and consume alcohol, experience depression, and be victims of domestic violence.[12]

The proposed rule will also cause more abortions. It will do so by encouraging low-efficacy methods of family planning and decreasing access to contraceptives and, therefore, increasing unintended pregnancies. Studies show that, as the rate of contraceptive use by unmarried women increased in the U.S. between 1982-2001, rates of abortion for unmarried women also declined.[13] A study regarding California's Family PACT program estimated that the provision of contraception to approximately 1,000,000 women and 100,000 men through that program in 2007 prevented approximately 122,200 abortions.[14] Similarly, when Iowa increased access to contraceptive services over the course of 2006-2008, studies found lower abortion rates.[15] It is likely that a decrease in contraceptive use will not only raise the rate of unintended pregnancy, then, but also raise the rate and number of abortions.

Reduced access to Title X health centers will also lead to reduced access to testing, counseling, and treatment for STIs. For example, in its most recent annual report, Planned Parenthood reported that its affiliates provided 654,218 HIV tests, 3,559,075 STI tests, 293,799 Pap tests; 27,354 HPV treatments, and 22,443 HPV vaccinations, among other services.[16] Using the Guttmacher Institute's tool for estimating the health benefits and cost savings associated with publicly funded family planning, these STI services alone averted approximately[17] 90 to 400 cases of HIV[18] and 47,740 to 56,670 other STIs—and, in turn, many pelvic inflammatory disease (PID) cases, ectopic pregnancies, and infertility cases.[19]

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11 Diana Cheng et al., *Unintended Pregnancy and Associated Maternal Preconception, Prenatal and Postpartum Behaviors*, 79 Contraception 194, 196 (2009).

12 *Id.*; *see also* ACOG, Committee Opinion No. 654, *supra* note 6; Mary K. Ethen et al., *Alcohol Consumption by Women Before and During Pregnancy*, 13 Maternal Child Health J., 274, 277 (2009); Christie A. Lancaster et al., *Risk Factors for Depressive Symptoms During Pregnancy: A Systematic Review*, 202 Am. J. Obstetrics & Gynecology 5, 7, 11 (2010); Lois James et al., *Risk Factors for Domestic Violence During Pregnancy: A Meta-Analytic Review*, 28 Violence & Victims 359, 368-69 (2013).

13 Heather D. Boonstra et al., *Abortion in Women's Lives*, at 18 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf.

14 Biggs et al., *supra* note 73, at 6, 16.

15 M. Antonia Biggs et al., *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 Contraception 167, 169 (2015) (study included 78 service sites, 24 of which were affiliated with Planned Parenthood).

16 Planned Parenthood, *supra* note 33, at 25.

17 The tool provided by Guttmacher requires inputting a state where the service is provided. California data was used as a case study (as it represents one of the largest states by population and numbers of Planned Parenthoods) for calculating the potential outcomes among all of the following examples.

18 A range is provided because the estimated health outcomes depend on whether HIV tests were provided to male or female clients, which was not specified in Planned Parenthood's report. The result of 90 cases of HIV assumes all tests were administered to women; the result of 400 cases assumes all tests were administered to men.

19 Guttmacher Institute, Data Center, *Health Benefits and Cost Savings of Publicly Funded Family Planning*, https://data.guttmacher.org/calculator. The tool provided by Guttmacher is limited in the type of STI tests that can be entered and the type of STIs it indicates were averted. This range assumes that all STI tests provided by Planned Parenthood were for chlamydia, and reflects the number of chlamydia cases likely averted were that assumption true. The low end of the range assumes all tests were provided to women; the high end assumes all tests were provided to men.

Reduced STI testing means that STIs will go undiagnosed or will be diagnosed much later. This will put STI-positive patients and their partners at greater health risk. In general, women who contract STIs suffer adverse reproductive health outcomes.[20] STIs in women are often asymptomatic[21] but can result in PID (a major cause of infertility), ectopic pregnancy, and chronic pelvic pain.[22] Syphilis and gonococcal infections also facilitate the transmission of HIV infections.[23] In some cases, pregnant women infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in ophthalmia neonatorum, which can lead to blindness and pneumonia.[24] Untreated syphilis infections in pregnant women can cause significant complications, including fetal death in up to 40% of pregnant women or preterm birth.[25] It can lead to infection of the fetus in 80% of cases, which can result in both physical and mental developmental disabilities.[26] And, of course, an undiagnosed or belatedly diagnosed STI means more opportunity for the infection to be spread to others.

If Title X programs close, primary care services regularly provided by Title X providers (and relied on by their patients) will also suffer. For example, a study of California publicly funded family planning providers indicated that most new clients received an initial health assessment and 83% received a blood pressure test; more than 70% were screened for alcohol, tobacco and drug use; more than 60% were asked whether they had high blood pressure or diabetes; about half were asked whether they had gained, lost, or been maintaining their weight; and more than half were asked about interpersonal violence in the past 12 months.[27]

And the public health consequences of forcing current Title X providers from the program are far from theoretical. At the state level, restrictions on family planning services similar to the proposed rule have been already been imposed. The health outcomes following those restrictions have demonstrated that Title X programs (and Planned Parenthood, in particular, in fact) plays an essential role in reproductive and preventive health care. To give just a few examples, a Planned Parenthood facility near Scott County, a small, rural community in Indiana, closed in 2013 due to cuts to public health funding.[28] Afterwards, there was no free HIV testing available in the community.[29] From 2014 to 2015, syringe-sharing in connection with injections of opioids led to an outbreak of 181 cases of HIV in the area, 89.5% occurred in Scott County. In contrast, between 2004 and 2013, only *five* such infections had been identified.[30] The

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20 *See* David Friedel & Suzanne Lavoie, *Epidemiology and Trends in Sexually Transmitted Infections*, in Public Health & Preventive Medicine 155, 159 (Wallace et al., eds., 2008).

21 CDC, Sexually Transmitted Disease Surveillance 2015, at 6, 43, 54, 55 (2016), https://www.cdc.gov/std/stats15/std-surveillance-2015-print.pdf.

22 Centers for Disease Control and Prevention, Pelvic Inflammatory Disease (PID) – CDC Fact Sheet (2014), https://www.cdc.gov/std/pid/pid-fact-sheet-july-2014-press.pdf; Kristen Kreisel et al., *Prevalence of Pelvic Inflammatory Disease in Sexually Experienced Women of Reproductive Age—United States 2013-2014*, 66 Morbidity & Mortality Wkly Rpt. 80, 80 (2017). Approximately 10-20% of women with chlamydia or gonorrhea may develop PID without adequate treatment. CDC, *supra* note 21, at 54.

23 CDC, *supra* note 21, at 6, 17, 31.

24 *Id.* at 6.

25 *Id.* at 31.

26 *Id.* at 31, 54.

27 Biggs et al., *supra* note 55, at 39, Table 21.

28 Hal C. Lawrence & Debra L. Ness, *Planned Parenthood Provides Essential Services that Improve Women's Health*, 166 Annals of Internal Medicine 443, 443 (2017); Philip J. Peters et al., *HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014-2015*, 375 N. Eng. J. Med. 229, 230 (2016).

29 Peters et al., *supra* note 28, at 230.

30 *Id.* at 230-31.

outbreak has been described as "one of the largest and most rapid HIV outbreaks the country has ever seen."[31] Researchers observed that "[r]esources related to the prevention and treatment of HIV did not exist in this community before the outbreak, and, as in many rural communities, access to basic health care, substance-abuse treatment, and HIV prevention services was limited."[32]

The consequences of the proposed rule on public health are, therefore, wide-reaching and very real. They are antithetical to the mission of Title X and counterproductive to the immense success the program has achieved in its long history. For that reason, I urge the Department not to implement the proposed rule.

2. The Reproductive-Health-Focused Providers That The Proposed Rule Targets Offer Effective Title X Public-Health Programs.

The proposed rule is clearly designed to make it impossible for reproductive health-focused providers, like Planned Parenthood health centers, to continue to serve people through the program. This is a mistake, one with far-reaching consequences.

Reproductive-health-focused providers play a central role in the network of federally funded health care providers. Since the Department singles out Planned Parenthood in its proposed rule, *see* 83 Fed. Reg. at 25,509, let me highlight some aspects of Planned Parenthood's work in particular to demonstrate this point.

In 2015, Planned Parenthood affiliates in the United States provided care for approximately 1,500,000 patients who received some form of federal funding assistance.[33] In 2015, Planned Parenthood facilities made up just 6% of publicly funded clinics providing contraceptive services, yet 32% of all female contraceptive clients who visited a publicly funded clinic visited a Planned Parenthood facility.[34] In a 2015 study of publicly funded clinics providing family planning services, each Planned Parenthood facility in the study served on average 2,950 female contraceptive clients (compared with 320 female contraceptive clients served on average at an FQHC, 560 served at a health department, and 720 served at a hospital).[35] Two-thirds of Planned Parenthood sites care for at least 50 contraceptive clients each week (compared with only one quarter of health department sites and fewer than one-fifth of

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31 Lawrence & Ness, *supra* note 28, at 443.

32 Peters et al., *supra* note 28, at 237.

33 Planned Parenthood, 2015-2016 Annual Report, at 11 (2017), https://www.plannedparenthood.org/uploads/filer_public/18/40/1840b04b-55d3-4c00-959d-11817023ffc8/20170526_annualreport_p02_singles.pdf.

34 Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, at 1, 9, Table 5 (2017), https://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf. "Publicly funded clinic" is defined as "a site [that serves at least 10 contraceptive clients per year] that offers contraceptive services to the general public and uses public funds (e.g., federal, state or local funding through programs such as Title X, Medicaid or the federally qualified health center program) to provide free or reduced-fee services to at least some clients." "Female contraceptive client" is defined as "a woman who made at least one initial or subsequent visit for contraceptive services during the 12-month reporting period . . . includ[ing] all women who received a medical examination related to the provision of a contraceptive method, made supply-related return visits, received contraceptive counseling and a method prescription, but deferred the medical examination, or chose nonmedical contraceptive methods."

35 *Id.* at 9, Table 5.

FQHCs).[36] Driving just Planned Parenthood from the Title X program would therefore, do outsized harm to the nation's public health, even without considering any other programs excluded by the proposed rule.

And rural and sparsely populated areas will be harmed most. In those areas, Planned Parenthood is often the only safety-net reproductive health care provider available to patients seeking publicly funded services. In well over half of the counties where Planned Parenthood health centers were located in 2015 (238 of 415), Planned Parenthood served at least half of the women obtaining publicly supported contraceptive services from a safety-net health center.[37] In nearly 10% of the rural counties (38 of 415), Planned Parenthood was the *only* safety-net family planning center.[38] Almost two-thirds (64%) of the 20.2 million women in need of publicly funded contraceptive care live in counties with a Planned Parenthood health center.[39] Moreover, 24% of those women live in counties where Planned Parenthood serves the majority of those obtaining publicly supported contraceptive care from safety-net providers.[40]

There is no rational public-health reason to target Planned Parenthood clinics, which are generally high performing and effective. For example, Planned Parenthood clinics are more likely than other publicly funded clinics providing family planning services to have met the Center for Disease Control's objective to provide the full range of FDA-approved methods of contraception (93% of Planned Parenthood clinics vs. 52%-61% of other types of clinics).[41] Ninety-nine percent of Planned Parenthood centers provided at least 10 reversible contraceptive methods on-site.[42] Planned Parenthood clinics are also more likely to offer a patient long-acting reversible contraception (LARC) methods to patients, which are widely recognized as the most medically effective and cost-effective forms of contraception.[43] Planned Parenthood health centers are also more likely to offer same-day LARC insertion,[44] a practice

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36 Mia R. Zolna & Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, at 34, Table 1 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf.

37 Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 12, 14 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2001216.pdf.

38 *Id.*

39 Memorandum from Jennifer J. Frost & Mia R. Zolna, Guttmacher Institute, to Senator Patty Murray, Ranking Member, Senate Health, Education, Labor and Pensions Committee, May 3, 2017, at 3, https://www.guttmacher.org/sites/default/files/article_files/guttmacher-murray-memo-2017.pdf. "Women in need of publicly funded contraceptive care" are defined as "[t]hose women who a) are younger than 20 or are poor or low-income (i.e., have a family income less than 250% of the federal poverty level) and b) are sexually active and able to become pregnant but do not want to become pregnant." *Id.* at 8.

40 *Id.* at 3.

41 Zolna & Frost, *supra* note 36, at 12, fig.3; *see also* Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives, Family Planning, Objectives, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives.

42 Zolna & Frost, *supra* note 36, at 12, 35, Table 2.

43 ACOG, Committee Opinion No. 642, Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy, at 2 (2015), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co642.pdf?dmc=1&ts=20170629T1443175185 (characterizing implants and IUDs as among the most effective methods of contraception); James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5, 13 (2009); Paul D. Blumenthal et al., *Strategies to Prevent Unintended Pregnancy: Increasing Use of Long-Acting Reversible Contraception*, 17 Human Reproduction Update 121, 131 (2011).

44 Zolna & Frost, *supra* note 36, at 20, 22 fig.10.

also recommended by the American College of Gynecologists,[45] that is widely viewed as an essential component of effective family planning because it eliminates the time and cost associated with follow-up visits and the risk that patients will be unable to return at a later time or will become pregnant in the interim. Planned Parenthood is more likely to offer emergency contraceptive pills[46] and more likely to dispense or prescribe oral emergency contraceptives ahead of time, so they are readily available to patients when needed without travel or wait times.[47] Planned Parenthood facilities are also more likely than others to offer copper IUDs as a method of emergency contraception.[48]

In addition to providing a broader range of contraceptive methods, according to a 2015 study, Planned Parenthood clinics also perform better than all other types of publicly funded clinics in terms of providing services that help patients better adhere to their preferred contraceptive plans.[49] Specifically, 83% of Planned Parenthood clinics provided initial oral contraceptive supplies and refills on-site.[50] Planned Parenthood clinics were also more likely than all other provider types to offer at least a six-month pill supply when providing oral contraceptives, which prevents women from having inadequate protection if they are unable to return for additional supplies.[51] Nearly all (99%) Planned Parenthood clinics used the quick-start protocol for oral contraceptives, [52] compared with 65–81% for all other clinic types.[53] Nearly all (almost 100%) Planned Parenthood clinics allowed eligible clients to delay pelvic exams, which historically were a precondition for potential contraceptive clients, but are now considered by broad medical consensus to be unnecessary in most cases.[54] That figure compares favorably with 76-83% for

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45 ACOG, Committee Opinion No. 615, *supra* note 6, at 4 ("Another common practice is requiring one medical appointment to discuss initiation of a LARC method and a second for placement of the device.... Clinicians are encouraged to initiate and place LARC in a single visit as long as pregnancy may be reasonably excluded.").

46 Zolna & Frost, *supra* note 36, at 35, Table 2.

47 *Id.* at 18; *see also* ACOG, Frequently Asked Questions No. 114, Emergency Contraception (2015), https://www.acog.org/-/media/For-Patients/faq114.pdf?dmc=1&ts=20170629T1614154354 (women can get emergency contraceptive pills ahead of time so they are available if needed).

48 Zolna & Frost, *supra* note 36, at 22; ACOG, Frequently Asked Questions No. 114, *supra* note 47 (copper IUD is most effective form of emergency contraception).

49 Marion W. Carter et al., *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*, 94 Contraception 340, 342-43 (2016).

50 Zolna & Frost, *supra* note 36, at 16; *see also* Susan Wood et al., *Health Centers and Family Planning: Results of a Nationwide Study*, at 30 (2013), http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1059&context=sphhs_policy_facpubs (75% of Title X-funded health centers provide oral contraceptives on site).

51 Zolna & Frost, *supra* note 36, at 15; ACOG, Committee Opinion, Over-the-Counter Access to Oral Contraceptives 2 (2012, reaffirmed 2016), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co544.pdf?dmc=1&ts=20170629T1622404364 ("Access to multiple pill packs at one time results in higher rates of continuation."); Diana Greene Foster et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 Obstetrics & Gynecology 566, 569 (2011) ("Dispensing a 1-year supply [of oral contraceptives, as opposed to a 1-month or 3-month supply] is associated with a 30% reduction in the odds of conceiving a pregnancy in the subsequent year and a 46% reduction in the odds of an abortion . . . .").

52 The quick-start protocol, i.e., starting contraceptive use on the day of an office visit, improves initial continuation rates for use of oral contraceptives. CDC, *U.S. Selected Practice Recommendations for Contraceptive Use, 2013*, 62 Morbidity & Mortality Wkly. Rep., at 23 (2013), https://www.cdc.gov/mmwr/pdf/rr/rr62e0614.pdf.

53 Zolna & Frost, *supra* note 36, at 17.

54 Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 63 Morbidity & Mortality Wkly. Rep., no. 4, at 11 (2014),

all other clinic types.[55] This is important because the requirement of a pelvic exam, which involves placing a speculum in the vagina, can be a significant deterrent for some women to seek care, especially those who are victims of sexual assault.

Setting contraceptives aside, Planned Parenthood health centers are also more likely to use rapid-result testing for HIV (tests that provide results more quickly than other forms of testing) than other publicly funded family planning clinics, enabling patients to begin treatment more quickly, or be counseled regarding the importance of using preventive measures.[56]

Planned Parenthood clinics are also especially well-suited to serve adolescents and young adults, populations that often have difficulty obtaining family planning services.[57] For example, 97% of Planned Parenthood clinics provided LARCs to adolescents, compared to 57-76% of other types of publicly funded family planning providers.[58] One study found that certain facility practices targeted to teens and young adults, such as more flexible hours, teen-friendly decor, online scheduling, and social media usage, were more prevalent at Planned Parenthood affiliates than at other providers.[59] In addition, researchers suggest that Planned Parenthood's name recognition may avoid some of the lack-of-knowledge barriers that prevent adolescents from obtaining care at other publicly funded providers.[60] One study found that a young woman's likelihood of becoming a mother and dropping out of high school decreased with a local presence of a Planned Parenthood clinic.[61]

Additionally, Planned Parenthood clinics are more likely to have staff trained to address the special needs of certain groups of clients, including lesbian or gay individuals (83% to 46%);

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https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf. Pelvic exams can cause fear and discomfort and are "not needed routinely to provide contraception safely to a healthy client." *Id.*; *see also* ACOG, Committee Opinion No. 615, *supra* note 6, at 2 ("There is no medical or safety benefit to requiring routine pelvic examination or cervical cytology before initiating hormonal contraception. The prospect of such an examination may deter a woman, especially an adolescent, from having a clinical visit that could facilitate her use of a more effective contraceptive method than those available over the counter.").

55 Zolna & Frost, *supra* note 36, at 18. In general, family planning-focused providers, like Planned Parenthood, are more likely than primary care/multi-specialty providers, like most FQHCs, to not misinform clients that pelvic exams or STI tests were necessary prior to contraceptive initiation. M. Antonia Biggs et al., *Findings from the 2012 Family PACT Client Exit Interviews*, at 39, Table 21 (2014), http://www.familypact.org/Research/reports/10-24-2015CEI-Report.pdf.

56 Jennifer J. Frost et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, at 12 (2012), https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

57 Katherine H. Mead et al., *The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents*, 57 J. Adolescent Health 87, 87-88 (2015) (summarizing reasons why adolescents have difficulty obtaining adequate family planning care); Megan L. Kavanaugh et al., *Meeting the Contraceptive Needs of Teens and Young Adults: Youth-Friendly and Long-Acting Reversible Contraceptive Services in U.S. Family Planning Facilities*, 52 J. Adolescent Health 284, 286 (2013).

58 Zolna & Frost, *supra* note 36, at 22, fig.10 (2016).

59 Kavanaugh et al., *supra* note 57, at 286. Planned Parenthood is more likely than other publicly funded family planning clinics to offer same-day appointments (62% compared to 42%-58%), to have shorter wait times for appointments (average wait time 1.2 days compared to 2.5-4.1 days), and to offer extended (evening and/or weekend) clinic hours (78% compared to 18-57%). Hasstedt, *supra* note 37, at 12-13.

60 Mead et al., *supra* note 57, at 87, 92.

61 Katherine Hicks-Courant & Aaron Schwartz, *Local Access to Family Planning Services and Female High School Dropout Rates*, 127 Obstetrics & Gynecology 699, 703 (2016). This study found that the abortion services provided at some Planned Parenthood clinics "did not drive the association between the clinics and reduced high school dropout rates." *Id.*

individuals experiencing intimate partner violence (81% to 68%); non-English-speaking individuals (82% to 65%); and men (77% to 59%).[62] A provider's cultural competence is particularly important for underrepresented groups. For example, in a study of Latino adolescents, participants largely agreed with the guidelines from the National Council of La Raza, a Hispanic advocacy organization, which states that optimal pregnancy-prevention programs for Latino youth should include the following: having culturally sensitive and nonjudgmental staff, being responsive to Latino subgroup differences, emphasizing education, and recognizing cultural values regarding gender roles.[63]

What does all of this mean? That the proposed rule will drive some of the most effective health care providers from the Title X program, Planned Parenthood especially. In volume and skill, the remaining providers will simply be unable to pick up the slack. I therefore urge the Department not to adopt the proposed rule and impose this consequence on the nation's public health.

3. The Proposed Rule Radically Underestimates The Costs That It Will Impose.

The proposed rule radically underestimates the costs it will impose on patients, providers, and society, given the increase an unplanned and mistimed pregnancies it will cause.

That increase is a near certainty under the proposed rule (indeed it is practically the proposed rule's goal, given its solicitude for low-efficacy family planning methods like "sexual risk avoidance" and natural family planning). Patients who lose access to contraceptive services at current Title X clinics are likely to use less effective forms of birth control. For example, in a study encompassing a variety of clinic types participating in California's publicly funded family planning program (Family PACT), individuals were asked what they would do if they had to pay for their family planning services.[64] Responses indicated that, on the whole, patients would use less effective means of contraception. Specifically, patients reported that their use of low-efficacy methods, such as condoms, would nearly double (from 25% to 46%).[65] Patients' projected use of medium-efficacy methods, such as contraceptive injections, oral contraceptives (OCs), patch, and ring, would decrease from 63% to 44%.[66] Patients' use of high-efficacy methods, such as IUDs, contraceptive implants, and sterilization, would decrease from 11% to 7%.[67] And use of no method of birth control at all would increase from 2% to 3%.[68]

It is no surprised that this decrease in the use of high-efficacy contraception methods and increase in use of low-efficacy methods will result in more unintended pregnancies. High-efficacy methods have failure rates of less than 1%, meaning that fewer than 1% of women using these methods will experience an unintended pregnancy within the first year of use.[69] Medium-efficacy methods have failures rates of 6-12%, because some women miss or delay

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62 *Id.* at 22, 38, Table 9.

63 Anne K. Driscoll et al., *In Their Own Words: Pregnancy Prevention Needs of Latino Teen Mothers*, 1 Cal. Journal of Health Promotion 118, 120 (2003).

64 Biggs et al., *supra* note 55, at 53.

65 *Id.* at 53. Low-efficacy methods include condoms, diaphragms, and other barrier methods; natural family planning; abstention; and emergency contraception. *Id.*at 34.

66 *Id.* at 34, 53.

67 *Id.*

68 *Id.* at 34, 54.

69 CDC, *Effectiveness of Family Planning Methods*, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf; ACOG, Committee Opinion No. 642, *supra* note 43, at 2.

injection or ingestion of the pill.[70] Low-efficacy methods, including male condoms, have failure rates of 18% or higher.[71] Using no method of contraception has a failure rate of 85%.[72] These failure rates explain why the Guttmacher Institute estimated that in 2015, Planned Parenthood's provision of contraceptive services averted approximately 430,000 unintended pregnancies.[73]

The increase in unintended pregnancies is no mere hypothetical. For example, after the State of Texas severely restricted public funding for family planning and excluded Planned Parenthood from its publicly funded family planning programs, a study in the New England Journal of Medicine reported a 35% decline in women using the most effective methods of family planning and a 27% increase in births among women who had been using an injectable contraceptive methods prior to Texas's restrictions.[74] The same study showed that the number of claims submitted for LARC contraceptives in counties where Planned Parenthood affiliates were located decreased sharply.[75] Researchers concluded that their "analyses suggest that the exclusion of Planned Parenthood affiliates from the Texas Women's Health Program had an adverse effect on low-income women in Texas by reducing the provision of highly effective methods of contraception, interrupting contraceptive continuation, and increasing the rate of childbirth covered by Medicaid."[76]

The fiscal costs of these additional unwanted pregnancies are immense. In 2010, approximately $2.2 billion in public funds were spent on family planning and related sexual and reproductive health services (such as STI testing).[77] Those services were estimated to have averted approximately 2.2 million unintended pregnancies, among other adverse health outcomes.[78] The estimated public costs associated with those unintended pregnancies and outcomes—i.e., maternity care, birth, child health care through 5 years of age, miscarriages or abortions, and treating the effects of undetected STIs—would have been $15.8 billion, $15.2 billion of which is

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70 CDC, *supra* note 69; ACOG, Committee Opinion No. 642, *supra* note 43, at 1-2.

71 CDC, *supra* note 69; ACOG, Committee Opinion No. 642, *supra* note 43, at 2.

72 James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397, 398 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638209/pdf/nihms458000.pdf.

73 Guttmacher Inst., *Unintended Pregnancies and Abortions Averted by Planned Parenthood*, https://www.guttmacher.org/infographic/2017/unintended-pregnancies-and-abortions-averted-planned-parenthood-2015; *see also* M. Antonia Biggs et al., Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007, at 16, 17 & fig.1 (2010), https://www.ansirh.org/sites/default/files/publications/files/familypactcost-benefitanalysis2007_2010apr_featured.pdf (in California, across all publicly funded contraceptive providers—including Planned Parenthood—it was estimated that, for every seven women who received publicly funded contraceptive services, two pregnancies were averted. There, in one year, it was estimated that provision of contraceptive services to 998,084 clients averted 286,700 unintended pregnancies.).

74 Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. Eng. J. Med. 853, 858 (2016). *See also* Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 Am. J. Pub. Health 851, 851 (2015). White and colleagues describe how, in 2011, prior to Planned Parenthood's outright exclusion from Texas's publicly funded family planning program, Texas substantially cut public funding for family planning providers and imposed a priority system of reimbursement for services that placed certain providers, including Planned Parenthood, at the bottom of the hierarchy. In the year following those cuts, 54% fewer clients received publicly funded family planning services. *Id.* at 855. Providers suspected that clients stopped seeking reproductive health care. *Id.* at 856.

75 Stevenson, *supra* note 74, at 856-58.

76 *Id.* at 858-59.

77 Frost et al., *supra* note 89, at 696.

78 *Id.* at 692.

attributable to publicly covered maternity and child health care.[79] Accordingly, publicly funded family planning and related care saved $13.6 billion in public costs.[80] In other words, for every public dollar spent on contraceptive care, the public saved $7.09 in costs associated with unintended pregnancies and other reproductive health issues (through age 5).[81] To give another example, in 2007 California's Family PACT averted 286,700 unintended pregnancies that saved the state over $4 billion from conception to age 5 in the form of public-sector health care and social services.[82] For every public dollar spent on contraceptive care in California that year, the public saved $9.25 in costs associated with unintended pregnancies (through age 5).[83]

The proposed rule would impose other costs as well. For example, a 2010 analysis found that the publicly funded clinics' role in screening, testing, and preventing STIs during family planning visits saved an estimated $123 million taxpayer dollars that year, in the form of costs to treat PID or other results of untreated chlamydia or gonorrhea, HIV infections, and HPV sequelae.[84]

The Department must recognize, evaluate, and justify these costs before it imposes this unnecessary burden on the Title X program and the country. If it finds—as I believe it will—that the benefits of the proposed rules cannot possibly outweigh these staggering costs, then I urge the Department not to adopt this unnecessary and costly proposed rule.

4. The Proposed Rule Would Exacerbate Existing Health Care Disparities

Finally, the proposed rule would exacerbate the disparities in health care that are already pervasive across the country. The adverse consequences discussed above are likely to be felt most intensely by historically underserved populations, including populations living in rural America. As studies have shown, people of color in the United States are disproportionately unable to gain access to and benefit from high-quality health care.[85]

Specifically, although unintended pregnancies occur across all income levels, races, and ages, the rates of unintended pregnancies are higher among certain groups.[86] For example, 82% of pregnancies to mothers ages 15 to 19 are unintended.[87] One in five unintended pregnancies

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79 The average public cost per birth, from prenatal care through infant care through 12 months of age, is $12,770. *Id.* at 712 Table A.1.

80 *Id.* at 696.

81 *Id.*

82 Biggs et al., *supra* note 73, at 23.

83 *Id.* at 20.

84 Frost et al., *supra* note 89, at 696.

Even a relatively few number of HIV/AIDS cases averted results in substantial savings. In 2014, the average Medicaid spending per enrollee was $5,736. Kaiser Family Foundation, *Medicaid Spending per Enrollee (Full or Partial Benefit)*, http://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. In 2011 (the last year for which data is available), the average Medicaid spending per enrollee with HIV/AIDS was $26,807. Kaiser Family Foundation, *Medicaid Enrollment and Spending on HIV/AIDS*, http://www.kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

85 *See generally* Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S. (2010), https://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf.

86 *See, e.g.*, Blumenthal et al., *supra* note 43, at 123.

87 Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives, Family Planning, Objectives, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives.

each year is among teens.[88] Women whose income is below the federal poverty level and black women and Latinas also have higher rates of unintended pregnancies than other demographic groups.[89]

The increased incidence of STIs is also likely to disproportionately affect low-income patients and patients of color. For example, prevalence of gonorrhea, syphilis, and chlamydia is highly dependent on the geographic area and sociodemographic factors, with increased rates occurring among Hispanic and African-American populations and among lower-income individuals.[90]

Current Title X providers like Planned Parenthood strive to address and minimize these disparities. They offer low- or no-cost services, without requiring insurance and who are eligible for services; they have convenient clinic locations and hours; and they offer cultural- and youth-sensitive services.[91] Forcing Planned Parenthood and other current Title X providers from the already limited network of providers available to these women and families will likely disproportionately harm already medically underserved populations. And all of these disparities will only widen while safety-net clinics that are not forced from Title X struggle to pick up the slack.

* * *

In short, the proposed rule would gravely harm the people that we serve and would exacerbate existing public health issues and health disparities. I strongly urge you to not finalize the proposed rule.

Sincerely,

Claire Brindis, DrPH

Professor of Pediatrics and Health Policy

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88 *Id.*

89 *Id.*; Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 N. Engl. J. Med. 843, 846-47 (2016); Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 668 (2014).

90 *Id.* at 1, 2, 18, 54, 69,70-75.

91 *See, e.g.*, Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 Guttmacher Pol'y Rev. 2, 4-5 (2008), https://www.guttmacher.org/sites/default/files/article_files/gpr110302.pdf; Katherine H. Mead et al., *The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents*, 57 J. Adolescent Health 87, 87-88 (2015).

EXHIBIT C

Claire Brindis
Centers for Disease Control and Prevention (CDC)
Quality Family Planning Guidelines

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 63 / No. 4
April 25, 2014

Providing Quality Family Planning Services

Recommendations of CDC and the U.S. Office of Population Affairs

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Disclosure of Relationship

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The *MMWR* series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027.

Suggested Citation: [Author names; first three, then et al., if more than six.] [Title]. MMWR 2014;63(No. RR-#):[inclusive page numbers].

Providing Quality Family Planning Services

Recommendations of CDC and the U.S. Office of Population Affairs

Prepared by
Loretta Gavin, PhD,[1] Susan Moskosky, MS,[2] Marion Carter, PhD,[1] Kathryn Curtis, PhD,[1] Evelyn Glass, MSPH,[2] Emily Godfrey, MD,[1] Arik Marcell, MD,[3] Nancy Mautone-Smith, MSW,[2] Karen Pazol, PhD,[1] Naomi Tepper, MD,[1] Lauren Zapata, PhD[1]
[1]*Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC*
[2]*Office of Population Affairs, US Department of Health and Human Services, Rockville, Maryland*
[3]*The Johns Hopkins University and the Male Training Center for Family Planning and Reproductive Health, Baltimore, Maryland*

Summary

This report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services. The primary audience for this report is all current or potential providers of family planning services, including those working in service sites that are dedicated to family planning service delivery as well as private and public providers of more comprehensive primary care.

The United States continues to face substantial challenges to improving the reproductive health of the U.S. population. Nearly one half of all pregnancies are unintended, with more than 700,000 adolescents aged 15–19 years becoming pregnant each year and more than 300,000 giving birth. One of eight pregnancies in the United States results in preterm birth, and infant mortality rates remain high compared with those of other developed countries.

This report can assist primary care providers in offering family planning services that will help women, men, and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy. The report provides recommendations for how to help prevent and achieve pregnancy, emphasizes offering a full range of contraceptive methods for persons seeking to prevent pregnancy, highlights the special needs of adolescent clients, and encourages the use of the family planning visit to provide selected preventive health services for women, in accordance with the recommendations for women issued by the Institute of Medicine and adopted by HHS.

Introduction

The United States continues to face challenges to improving the reproductive health of the U.S. population. Nearly half (49%) of all pregnancies are unintended (*1*). Although adolescent birth rates declined by more than 61% during 1991–2012, the United States has one of the highest adolescent pregnancy rates in the developed world, with >700,000 adolescents aged 15–19 years becoming pregnant each year and >300,000 giving birth (*2,3*). Approximately one of eight pregnancies in the United States results in a preterm birth, and infant mortality rates remain high compared with other developed countries (*3,4*). Moreover, all of these outcomes affect racial and ethnic minority populations disproportionately (*1–4*).

Corresponding preparers: Loretta Gavin, PhD, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC. Telephone: 770-488-6284; E-mail: lcg6@cdc.gov; Susan Moskosky, MS, Office of Population Affairs, US Department of Health and Human Services. Telephone: 240-453-2818; E-mail: susan.moskosky@hhs.gov.

Family planning services can help address these and other public health challenges by providing education, counseling, and medical services (*5*). Family planning services include the following:

- providing contraception to help women and men plan and space births, prevent unintended pregnancies, and reduce the number of abortions;
- offering pregnancy testing and counseling;
- helping clients who want to conceive;
- providing basic infertility services;
- providing preconception health services to improve infant and maternal outcomes and improve women's and men's health; and
- providing sexually transmitted disease (STD) screening and treatment services to prevent tubal infertility and improve the health of women, men, and infants.

This report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide family planning services by:

- defining a core set of family planning services for women and men,
- describing how to provide contraceptive and other clinical services, serve adolescents, and perform quality improvements, and
- encouraging the use of the family planning visit to provide selected preventive health services for women, in accordance with the recommendations for women issued by the Institute of Medicine (IOM) and adopted by HHS (*6*).

The collaboration between CDC and OPA drew on the strengths of both agencies. CDC has a long-standing history of developing evidence-based recommendations for clinical care, and OPA's Title X Family Planning Program (*7*) has served as the national leader in direct family planning service delivery since the Title X program was established in 1970.

This report provides recommendations for providing care to clients of reproductive age who are in need of family planning services. These recommendations are intended for all current or potential providers of family planning services, including those funded by the Title X program.

Current Context of Family Planning Services

Women of reproductive age often report that their family planning provider is also their usual source of health care (*8*). As the U.S. health-care system evolves in response to increased efforts to expand health insurance coverage, contain costs, and emphasize preventive care (*9*), providers of family planning services will face new challenges and opportunities in care delivery. For example, they will have increased opportunities to serve new clients and to serve as gateways for their clients to other essential health-care services. In addition, primary care and other providers who provide a range of health-care services will be expected to integrate family planning services for all persons of reproductive age, including those whose primary reason for their health-care visit might not be family planning. Strengthened, multidirectional care coordination also will be needed to improve health outcomes. For example, this type of care coordination will be needed with clients referred to specialist care after initial screening at a family planning visit, as well as with specialists referring clients with family planning needs to family planning providers.

Defining Quality in Family Planning Service Delivery

The central premise underpinning these recommendations is that improving the quality of family planning services will lead to improved reproductive health outcomes (*10*–*12*). IOM defines health-care quality as the extent to which health-care services improve health outcomes in a manner that is consistent with current professional knowledge (*10*,*13*). According to IOM, quality health care has the following attributes:

- **Safety.** These recommendations integrate other CDC recommendations about which contraceptive methods can be provided safely to women with various medical conditions, and integrate CDC and U.S. Preventive Services Task Force (USPSTF) recommendations on STD, preconception, and related preventive health services.
- **Effectiveness.** These recommendations support offering a full range of Food and Drug Administration (FDA)–approved contraceptive methods as well as counseling that highlights the effectiveness of contraceptive methods overall and, in specific patient situations, draws attention to the effectiveness of specific clinical preventive health services and identifies clinical preventive health services for which the potential harms outweigh the benefits (i.e., USPSTF "D" recommendations).
- **Client-centered approach.** These recommendations encourage taking a client-centered approach by 1) highlighting that the client's primary purpose for visiting the service site must be respected, 2) noting the importance of confidential services and suggesting ways to provide them, 3) encouraging the availability of a broad range of contraceptive methods so that clients can make a selection based on their individual needs and preferences, and 4) reinforcing the need to deliver services in a culturally competent manner so as to meet the needs of all clients, including adolescents, those with limited English proficiency, those with disabilities, and those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ). Organizational policies, governance structures, and individual attitudes and practices all contribute to the cultural competence of a health-care entity and its staff. Cultural competency within a health-care setting refers to attitudes, practices, and policies that enable professionals to work effectively in cross-cultural situations (*14*–*16*).
- **Timeliness.** These recommendations highlight the importance of ensuring that services are provided to clients in a timely manner.
- **Efficiency.** These recommendations identify a core set of services that providers can focus on delivering, as well as ways to maximize the use of resources.
- **Accessibility.** These recommendations address how to remove barriers to contraceptive use, use the family planning visit to provide access to a broader range of primary care and behavioral health services, use the primary care visit to

provide access to contraceptive and other family planning services, and strengthen links to other sources of care.
- **Equity.** These recommendations highlight the need for providers of family planning services to deliver high-quality care to all clients, including adolescents, LGBTQ persons, racial and ethnic minorities, clients with limited English proficiency, and persons living with disabilities.
- **Value.** These recommendations highlight services (i.e., contraception and other clinical preventive services) that have been shown to be very cost-effective (*17*–*19*).

Methods

Recommendations Development Process

The recommendations were developed jointly under the auspices of CDC's Division of Reproductive Health and OPA, in consultation with a wide range of experts and key stakeholders. More information about the processes used to conduct systematic reviews, the role of technical experts in reviewing the evidence, and the process of using the evidence to develop recommendations is provided (Appendix A). A multistage process was used to develop the recommendations that drew on established procedures for developing clinical guidelines (*20*,*21*). First, an Expert Work Group* was formed comprising family planning clinical providers, program administrators, and representatives from relevant federal agencies and professional medical associations to help define the scope of the recommendations. Next, literature about three priority topics (i.e., counseling and education, serving adolescents, and quality improvement) was reviewed by using the USPSTF methodology for conducting systematic reviews (*22*). The results were presented to three technical panels† comprising subject matter experts (one panel for each priority topic) who considered the quality of the evidence and made suggestions for what recommendations might be supported on the basis of the evidence. In a separate process, existing clinical recommendations on women's and men's preventive services were compiled from more than 35 federal and professional medical associations, and these results were presented to two technical panels of subject matter experts, one that addressed women's clinical services and one that addressed men's clinical services. The panels provided individual feedback about which clinical preventive services should be offered in a family planning setting and which clinical recommendations should receive the highest consideration.

CDC and OPA used the input from the subject matter experts to develop a set of core recommendations and asked the Expert Work Group to review them. The members of the Expert Work Group were more familiar with the family planning service delivery context than the members of the Technical Panel and thus could better comment on the feasibility and appropriateness of the recommendations, as well as the supporting evidence. The Expert Work Group considered the core recommendations by using the following criteria: 1) the quality of the evidence; 2) the positive and negative consequences of implementing the recommendations on health outcomes, costs or cost-savings, and implementation challenges; and 3) the relative importance of these consequences, (e.g., the likelihood that implementation of the recommendation will have a substantial effect on health outcomes might be considered more than the logistical challenges of implementing it) (*20*). In certain cases, when the evidence from the literature reviews was inconclusive or incomplete, recommendations were made on the basis of expert opinion. Finally, CDC and OPA staff considered the individual feedback from Expert Work Group members when finalizing the core recommendations and writing the recommendations document. A description of how the recommendations link to the evidence is provided together with the rationale for the inclusion of each recommendation in this report (Appendix B).

The evidence used to prepare these recommendations will appear in background papers that will be published separately. Resources that will help providers implement the recommendations will be provided through a web-based tool kit that will be available at http://www.hhs.gov/opa.

Audience for the Recommendations

The primary audience for this report is all providers or potential providers of family planning services to clients of reproductive age, including providers working in clinics that are dedicated to family planning service delivery, as well as private and public providers of more comprehensive primary care. Providers of dedicated family planning services might be less familiar with the specific recommendations for the delivery of preconception services. Providers of more comprehensive primary care might be less familiar with the delivery of contraceptive services, pregnancy testing and counseling, and services to help clients achieve pregnancy.

This report can be used by medical directors to write clinical protocols that describe how care should be provided. Job aids and other resources for use in service sites are being developed and will be made available when ready through OPA's website (http://www.hhs.gov/opa).

*A list of the members of the Expert Work Group appears on page 52.
†A list of the members of the technical panels appears on pages 52 and 53.

In this report, the term "provider" refers to any staff member who is involved in providing family planning services to a client. This includes physicians, physician assistants, nurse practitioners, nurse-midwives, nursing staff, and health educators. The term "service site" represents the numerous settings in which family planning services are delivered, which include freestanding service sites, community health centers, private medical facilities, and hospitals. A list of special terms used in this report is provided (Box 1).

The recommendations are designed to guide general clinical practice; however, health-care providers always should consider the individual clinical circumstances of each person seeking family planning services. Similarly, these recommendations might need to be adapted to meet the needs of particular populations, such as clients who are HIV-positive or who are substance users.

Organization of the Recommendations

This report is divided into nine sections. An initial section provides an overview of steps to assess the needs of a client and decide what family planning services to offer. Subsequent sections describe how to provide each of the following services: contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, STD services and related preventive health services. A final section on quality improvement describes actions that all providers of family planning services should consider to ensure that services are of high quality. More detailed information about selected topics addressed in the recommendations is provided (Appendices A–F).

These recommendations focus on the direct delivery of care to individual clients. However, parallel steps might need to be taken to maintain the systems required to support the provision of quality services for all clients (e.g., record-keeping procedures that preserve client confidentiality, procedures that improve efficiency and reduce clients' wait time, staff training to ensure that all clients are treated with respect, and the establishment and maintenance of a strong system of care coordination and referrals).

Client Care

Family planning services are embedded within a broader framework of preventive health services (Figure 1). In this report, health services are divided into three main categories:

- **Family planning services.** These include contraceptive services for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STD services (including HIV/AIDS), and other preconception health services (e.g., screening for obesity, smoking, and mental health). STD/HIV and other preconception health services are considered family planning services because they improve women's and men's health and can influence a person's ability to conceive or to have a healthy birth outcome.
- **Related preventive health services.** These include services that are considered to be beneficial to reproductive health,

BOX 1. Definitions of quality terms used in this report

Accessible. The timely use of personal health services to achieve the best possible health outcomes.*

Client-centered. Care is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions.†

Effective. Services are based on scientific knowledge and provided to all who could benefit and are not provided to those not likely to benefit.†

Efficient. Waste is avoided, including waste of equipment, supplies, ideas, and energy.†

Equitable. Care does not vary in quality because of the personal characteristics of clients (e.g., sex, race/ethnicity, geographic location, insurance status, or socioeconomic status).†

Evidence-based. The process of integrating science-based interventions with community preferences to improve the health of populations.§

Health-care quality. The degree to which health-care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.†

Process. Whether services are provided correctly and completely and how clients perceive the care they receive.¶

Safe. Avoids injuries to clients from the care that is intended to help them.†

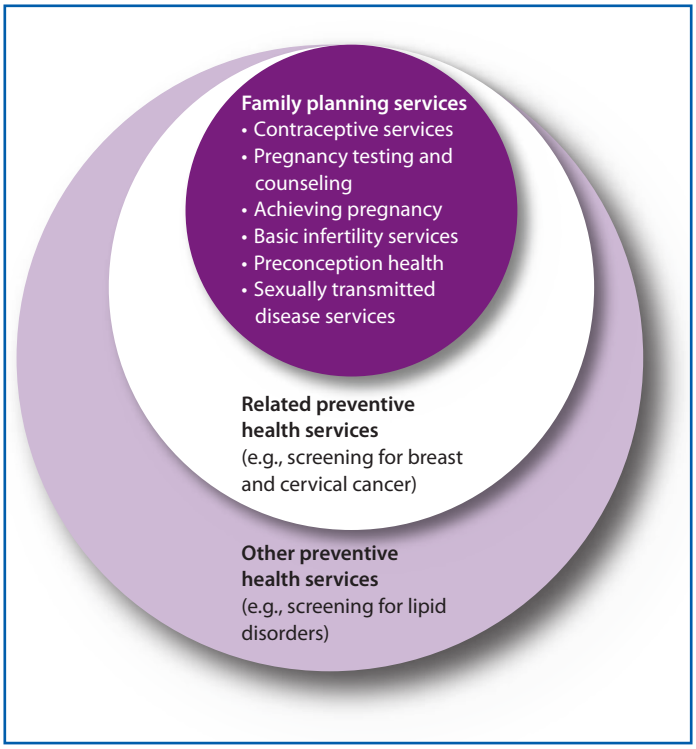
Structure. The characteristics of the settings in which providers deliver health care, including material resources, human resources, and organizational structure.¶

Timely. Waits and sometimes harmful delays for both those who receive and those who provide care are reduced.†

Value. The care provides good return relative to the costs involved, such as a return on investment or a reduction in the per capita cost of health care.*

* Source: Institute of Medicine. Future directions for the national healthcare quality and disparities reports. Ulmer C, Bruno M, Burke S, eds. Washington, DC: The National Academies Press; 2010.
† Source: Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Committee on Quality of Health Care in America, ed. Washington, DC: National Academies of Science; 2001.
§ Source: Kohatsu ND, Robinson JG, Torner JC. Evidence-based public health: an evolving concept. Am J Prev Med 2004;27:417–21.
¶ Source: Donabedian A. The quality of care. JAMA 1988;260:1743–8.

FIGURE 1. Family planning and related and other preventive health services



are closely linked to family planning services, and are appropriate to deliver in the context of a family planning visit but that do not contribute directly to achieving or preventing pregnancy (e.g., breast and cervical cancer screening).

- **Other preventive health services.** These include preventive health services for women that were not included above (*6*), as well as preventive services for men. Screening for lipid disorders, skin cancer, colorectal cancer, or osteoporosis are examples of this type of service. Although important in the context of primary care, these have no direct link to family planning services.

Providers of family planning services should be trained and equipped to offer all family planning and related preventive health services so that they can provide optimal care to clients, with referral for specialist care, as needed. Other preventive health services should be available either on-site or by referral, but these recommendations do not address this category of services. Information about preventive services that are beyond the scope of this report is available at http://www.uspreventiveservicestaskforce.org.

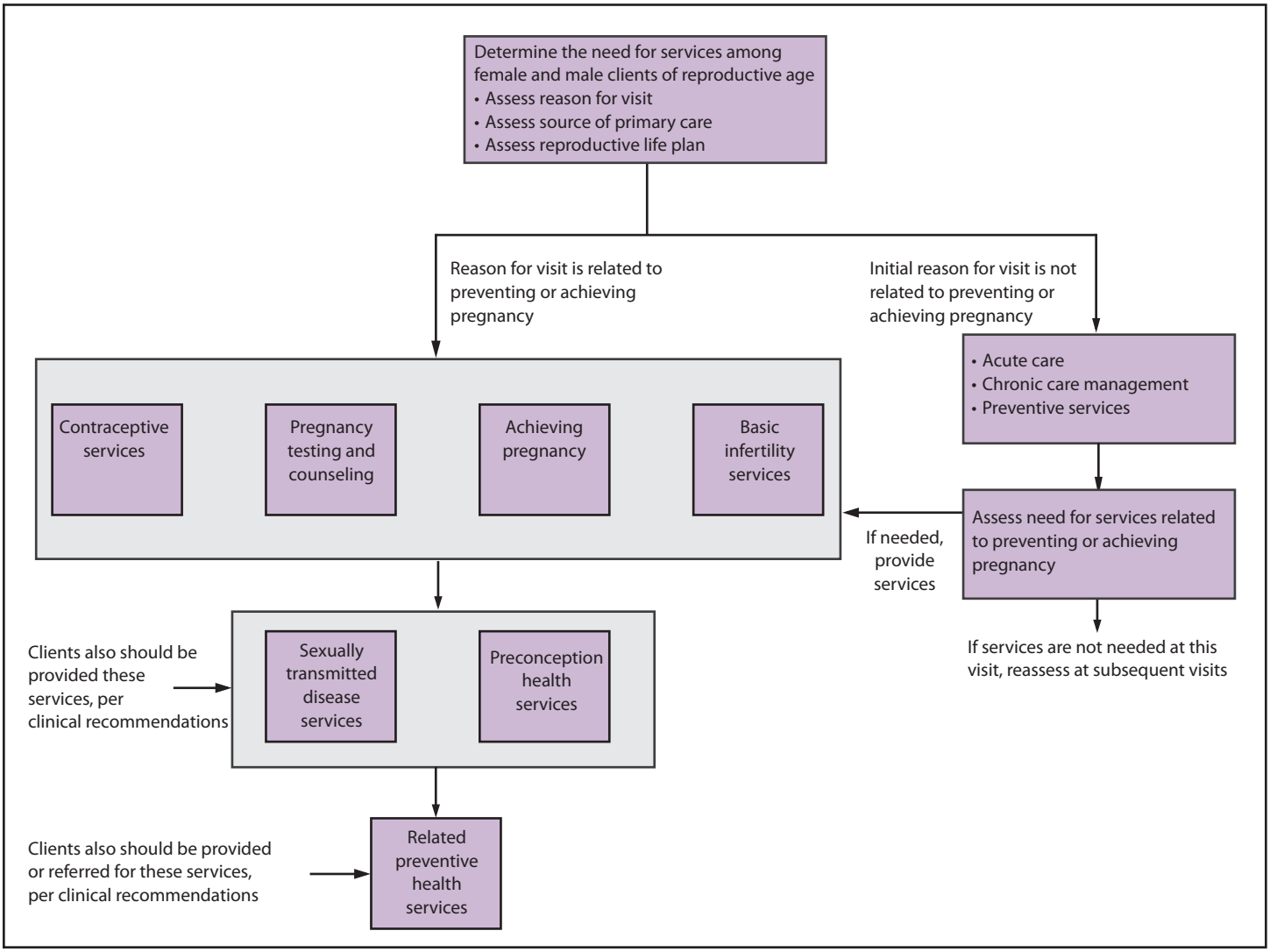
Determining the Client's Need for Services

These recommendations apply to two types of encounters with women and men of reproductive age. In the first type of encounter, the primary reason for a client's visit to a health-care provider is related to preventing or achieving pregnancy, (i.e., contraceptive services, pregnancy testing and counseling, or becoming pregnant). Other aspects of managing pregnancy (e.g., prenatal and delivery care) are not addressed in these recommendations. For clients seeking to prevent or achieve pregnancy, providers should assess whether the client needs other related services and offer them to the client. In the second type of encounter, the primary reason for a client's visit to a health-care provider is not related to preventing or achieving pregnancy. For example, the client might come in for acute care (e.g., a male client coming in for STD symptoms or as a contact of a person with an STD), for chronic care, or for another preventive service. In this situation, providers not only should address the client's primary reason for the visit but also assess the client's need for services related to preventing or achieving pregnancy.

A clinical pathway of family planning services for women and men of reproductive age is provided (Figure 2). The following questions can help providers determine what family planning services are most appropriate for a given visit.

- **What is the client's reason for the visit?** It is essential to understand the client's goals for the visit and address those needs to the extent possible.
- **Does the client have another source of primary health care?** Understanding whether a provider is the main source of primary care for a client will help identify what preventive services a provider should offer. If a provider is the client's main source of primary care, it will be important to assess the client's needs for the other services listed in this report. If the client receives ongoing primary care from another provider, the provider should confirm that the client's preventive health needs are met while avoiding the delivery of duplicative services.
- **What is the client's reproductive life plan?** An assessment should be made of the client's reproductive life plan, which outlines personal goals about becoming pregnant (*23–25*) (Box 2).The provider should avoid making assumptions about the client's needs based on his or her characteristics, such as sexual orientation or disabilities. For clients whose initial reason for coming to the service site was not related to preventing or achieving pregnancy, asking questions about his or her reproductive life plan might help identify unmet reproductive health-care needs. Identifying a need for contraceptive services might be particularly important given the high rate of unintended pregnancy in the United States.
  - If the client does not want a child at this time and is sexually active, then offer contraceptive services.
  - If the client desires pregnancy testing, then provide pregnancy testing and counseling.
  - If the client wants to have a child now, then provide services to help the client achieve pregnancy.

FIGURE 2. Clinical pathway of family planning services for women and men of reproductive age



– If the client wants to have a child and is experiencing difficulty conceiving, then provide basic infertility services.

- **Does the client need preconception health services?** Preconception health services (such as screening for obesity, smoking, and mental health) are a subset of all preventive services for women and men. Preconception health care is intended to promote the health of women and men of reproductive age before conception, with the goal of improving pregnancy-related outcomes (*24*). Preconception health services are also important because they improve the health of women and men, even if they choose not to become pregnant. The federal and professional medical recommendations cited in this report should be followed when determining which preconception health services a client might need.
- **Does the client need STD services?** The need for STD services, including HIV/AIDS testing, should be considered at every visit. Many clients requesting contraceptive services also might meet the criteria for being at risk of one or more STDs. Screening for chlamydia and gonorrhea is especially important in a family planning context because these STDs contribute to tubal infertility if left untreated. STD services are also necessary to maximize preconception health. The federal recommendations cited in this report should be followed when determining which STD services a client might need. Aspects of managing symptomatic STDs are not addressed in these recommendations.
- **What other related preventive health services does the client need?** Whether the client needs related preventive health services, such as breast and cervical cancer screening for female clients, should be assessed. The federal and professional medical recommendations cited in this report should be followed when determining which related preventive health services a client might need.

BOX 2. Recommended questions to ask when assessing a client's reproductive life plan

Providers should discuss a reproductive life plan with clients receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted disease, and preconception health services in accordance with CDC's recommendation that all persons capable of having a child should have a reproductive life plan.*

Providers should assess the client's reproductive life plan by asking the client questions such as:

- Do you have any children now?
- Do you want to have (more) children?
- How many (more) children would you like to have and when?

* Source: CDC. Recommendations to improve preconception health and health care—United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55(No. RR-6).

The individual client's needs should be considered when determining what services to offer at a given visit. It might not be feasible to deliver all the needed services in a single visit, and they might need to be delivered over the course of several visits. Providers should tailor services to meet the specific needs of the population they serve. For example, clients who are trying to achieve pregnancy and those at high risk of unintended pregnancy should be given higher priority for preconception health services. In some cases, the provider will deliver the initial screening service but then refer to another provider for further diagnosis or follow-up care.

The delivery of preconception, STD, and related preventive health services should not become a barrier to a client's ability to receive services related to preventing or achieving pregnancy. For these clients, receiving services related to preventing or achieving pregnancy is the priority; if other family planning services cannot be delivered at the initial visit, then follow-up visits should be scheduled.

In addition, professional recommendations for how to address the needs of diverse clients, such as LGBTQ persons (*26*–*32*) or persons with disabilities (*33*), should be consulted and integrated into procedures, as appropriate. For example, as noted before, providers should avoid making assumptions about a client's gender identity, sexual orientation, race, or ethnicity; all requests for services should be treated without regard to these characteristics. Similarly, services for adolescents should be provided in a "youth-friendly" manner, which means that they are accessible, equitable, acceptable, appropriate, comprehensive, effective, and efficient for youth, as recommended by the World Health Organization (*34*).

Contraceptive Services

Providers should offer contraceptive services to clients who wish to delay or prevent pregnancy. Contraceptive services should include consideration of a full range of FDA-approved contraceptive methods, a brief assessment to identify the contraceptive methods that are safe for the client, contraceptive counseling to help a client choose a method of contraception and use it correctly and consistently, and provision of one or more selected contraceptive method(s), preferably on site, but by referral if necessary. Contraceptive counseling is defined as a process that enables clients to make and follow through on decisions about their contraceptive use. Education is an integral component of the contraceptive counseling process that helps clients to make informed decisions and obtain the information they need to use contraceptive methods correctly.

Key steps in providing contraceptive services, including contraceptive counseling and education, have been outlined (Box 3). These key steps are in accordance with the five principles of quality counseling (Appendix C). To help a client who is initiating or switching to a new method of contraception, providers should follow these steps. These steps most likely will be implemented iteratively when working with a client and should help clients adopt, change, or maintain contraceptive use.

Step 1. Establish and maintain rapport with the client. Providers should strive to establish and maintain rapport. Strategies to achieve these goals include the following:

- using open-ended questions;
- demonstrating expertise, trustworthiness, and accessibility;
- ensuring privacy and confidentiality;
- explaining how personal information will be used;
- encouraging the client to ask questions and share information;
- listening to and observing the client; and
- being encouraging and demonstrating empathy and acceptance.

Step 2. Obtain clinical and social information from the client. Providers should ask clients about their medical history to identify methods that are safe. In addition, to learn more about factors that might influence a client's choice of a contraceptive method, providers should confirm the client's pregnancy intentions or reproductive life plan, ask about the client's contraceptive experiences and preferences, and conduct a sexual health assessment. When available, standardized tools should be used.

- **Medical history.** A medical history should be taken to ensure that methods of contraception being considered by a client are safe for that particular client. For a female client, the medical history should include menstrual history (including last menstrual period, menstrual frequency, length and amount of bleeding, and other

BOX 3. Steps in providing contraceptive services, including contraceptive counseling* and education

- Establish and maintain rapport with the client.
- Obtain clinical and social information from the client.
- Work with the client interactively to select the most effective and appropriate contraceptive method.
- Conduct a physical assessment related to contraceptive use, only when warranted.
- Provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow up, and confirm client understanding.

* Key principles of providing quality counseling including education have been outlined (Appendix C).

patterns of uterine/vaginal bleeding), gynecologic and obstetrical history, contraceptive use, allergies, recent intercourse, recent delivery, miscarriage, or termination, and any relevant infectious or chronic health condition and other characteristics and exposures (e.g., age, postpartum, and breastfeeding) that might affect the client's medical eligibility criteria for contraceptive methods (*35*). Clients considering combined hormonal contraception should be asked about smoking tobacco, in accordance with CDC guidelines on contraceptive use (*35*). Additional details about the methods of contraception that are safe to use for female clients with specific medical conditions and characteristics (e.g., hypertension) are addressed in previously published guidelines (*35*). For a male client, a medical history should include use of condoms, known allergies to condoms, partner use of contraception, recent intercourse, whether his partner is currently pregnant or has had a child, miscarriage, or termination, and the presence of any infectious or chronic health condition. However, the taking of a medical history should not be a barrier to making condoms available in the clinical setting (i.e., a formal visit should not be a prerequisite for a client to obtain condoms).

- **Pregnancy intention or reproductive life plan.** Each client should be encouraged to clarify decisions about her or his reproductive life plan (i.e., whether the client wants to have any or more children and, if so, the desired timing and spacing of those children) (*24*).
- **Contraceptive experiences and preferences.** Method-specific experiences and preferences should be assessed by asking questions such as, "What method(s) are you currently using, if any?"; "What methods have you used in the past?"; "Have you previously used emergency contraception?"; "Did you use contraception at last sex?"; "What difficulties did you experience with prior methods if any (e.g., side effects or noncompliance)?"; "Do you have a specific method in mind?"; and "Have you discussed method options with your partner, and does your partner have any preferences for which method you use?" Male clients should be asked if they are interested in vasectomy.
- **Sexual health assessment.** A sexual history and risk assessment that considers the client's sexual practices, partners, past STD history, and steps taken to prevent STDs (*36*) is recommended to help the client select the most appropriate method(s) of contraception. Correct and consistent condom use is recommended for those at risk for STDs. CDC recommendations for how to conduct a sexual health assessment have been summarized (Box 4).

Step 3. Work with the client interactively to select the most effective and appropriate contraceptive method. Providers should work with the client interactively to select an effective and appropriate contraceptive method. Specifically, providers should educate the client about contraceptive methods that the client can safely use, and help the client consider potential barriers to using the method(s) under consideration. Use of decision aids (e.g., computerized programs that help a client to identify a range of methods that might be appropriate for the client based on her physical characteristics such as health conditions or preferences about side effects) before or while waiting for the appointment can facilitate and maximize the utility of the time spent on this step.

Providers should inform clients about all contraceptive methods that can be used safely. Before the health-care visit, clients might have only limited information about all or specific methods of contraception (*37*). A broad range of methods, including long-acting reversible contraception (i.e., intrauterine devices [IUDs] and implants), should be discussed with all women and adolescents, if medically appropriate.

Providers are encouraged to present information on potential reversible methods of contraception by using a tiered approach (i.e., presenting information on the most effective methods first, before presenting information on less effective methods) (*38*,*39*). This information should include an explanation that long-acting reversible contraceptive methods are safe and effective for most women, including those who have never given birth and adolescents (*35*). Information should be tailored and presented to ensure a client-centered approach. It is not appropriate to omit presenting information on a method solely because the method is not available at the service site. If not all methods are available at the service site, it is important to have strong referral links in place to other providers to maximize opportunities for clients to obtain their preferred method that is medically appropriate.

BOX 4. Steps in conducting a sexual health assessment*

- **Practices:** Explore the types of sexual activity in which the patient engages (e.g., vaginal, anal, or oral sex).
- **Pregnancy prevention:** Discuss current and future contraceptive options. Ask about current and previous use of methods, use of contraception at last sex, difficulties with contraception, and whether the client has a particular method in mind.
- **Partners:** Ask questions to determine the number, gender (men, women, or both), and concurrency of the patient's sex partners (if partner had sex with another partner while still in a sexual relationship with the patient). It might be necessary to define the term "partner" to the patient or use other, relevant terminology.
- **Protection from sexually transmitted diseases (STDs):** Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. Topics such as monogamy and abstinence also can be discussed.
- **Past STD history:** Ask about any history of STDs, including whether their partners have ever had an STD. Explain that the likelihood of an STD is higher with a past history of an STD.

* Source: CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR 2010;59(No. RR-12).

For clients who have completed childbearing or do not plan to have children, permanent sterilization (female or male) is an option that may be discussed. Both female and male sterilization are safe, are highly effective, and can be performed in an office or outpatient surgery setting (*40*,*41*). Women and men should be counseled that these procedures are not intended to be reversible and that other highly effective, reversible methods of contraception (e.g., implants or IUDs) might be an alternative if they are unsure about future childbearing. Clients interested in sterilization should be referred to an appropriate source of care if the provider does not perform the procedure.

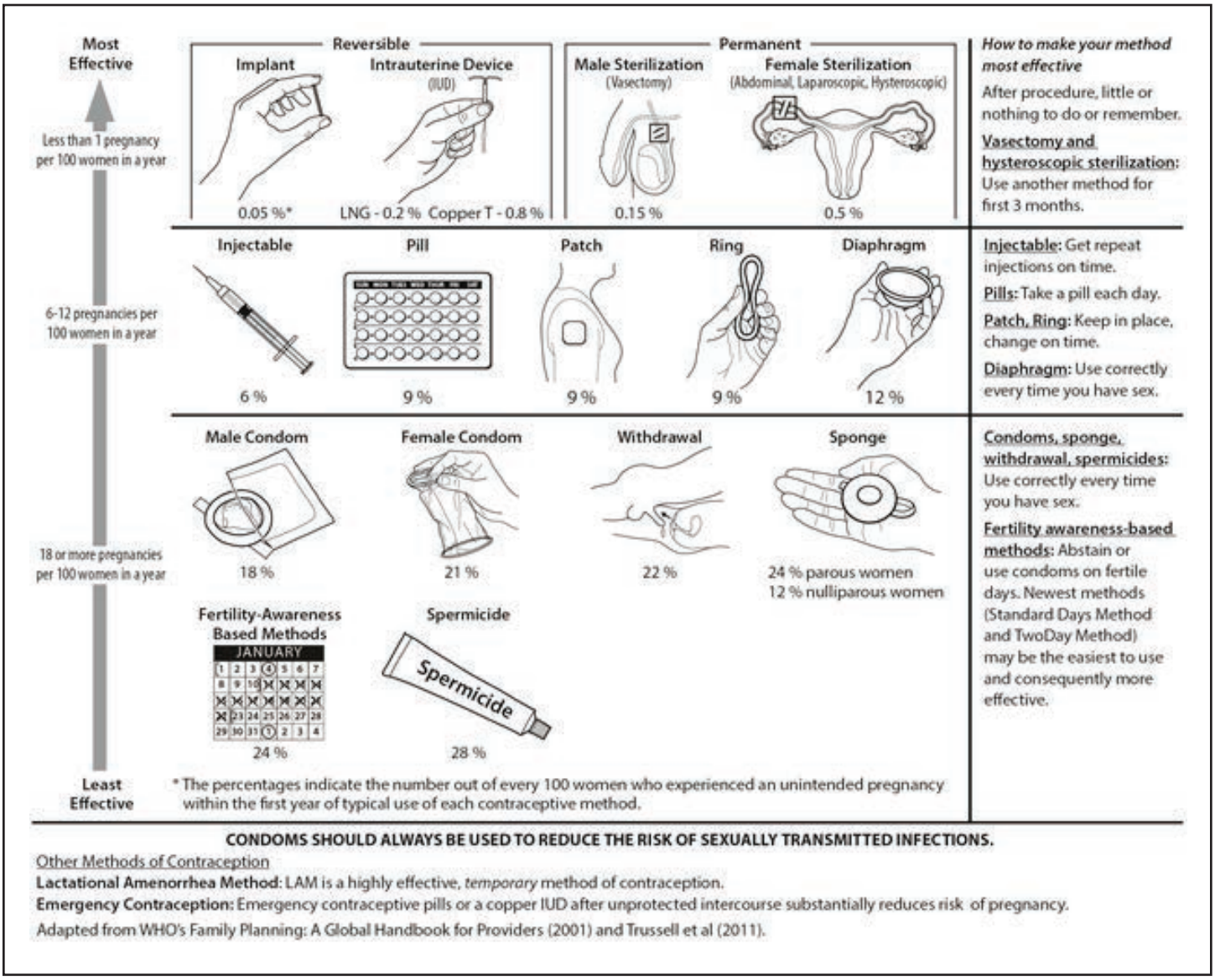
When educating clients about contraceptive methods that the clients can use safely, providers should ensure that clients understand the following:

- **Method effectiveness.** A contraceptive method's rate of typical effectiveness, or the percentage of women experiencing an unintended pregnancy during the first year of typical use, is an important consideration (Figure 3; Appendix D) (*38*,*42*).
- **Correct use of the method.** The mode of administration and understanding how to use the method correctly might be important considerations for the client when choosing a method. For example, receiving a contraceptive injection every 3 months might not be acceptable to a woman who fears injections. Similarly, oral contraceptives might not be acceptable to a woman who is concerned that she might not be able to remember to take a pill every day.
- **Noncontraceptive benefits.** Many contraceptives have noncontraceptive benefits, in addition to preventing pregnancy, such as reducing heavy menstrual bleeding. Although the noncontraceptive benefits are not generally the major determinant for selecting a method, awareness of these benefits can help clients decide between two or more suitable methods and might enhance the client's motivation to use the method correctly and consistently.
- **Side effects.** Providers should inform the client about risks and side effects of the method(s) under consideration, help the client understand that certain side effects of contraceptive methods might disappear over time, and encourage the client to weigh the experience of coping with side effects against the experience and consequences of an unintended pregnancy. The provider should be prepared to discuss and correct misperceptions about side effects. Clients also should be informed about warning signs for rare, but serious, adverse events with specific contraceptive methods, such as stroke and venous thromboembolism with use of combined hormonal methods.
- **Protection from STDs, including HIV.** Clients should be informed that contraceptive methods other than condoms offer no protection against STDs, including HIV. Condoms, when used correctly and consistently, help reduce the risk of STDs, including HIV, and provide protection against pregnancy. Dual protection (i.e., protection from both pregnancy and STDs) is important for clients at risk of contracting an STD, such as those with multiple or potentially infected partner(s). Dual protection can be achieved through correct and consistent use of condoms with every act of sexual intercourse, or correct and consistent use of a condom to prevent infection plus another form of contraception to prevent pregnancy. (For more information about preventing and treating STDs, see STD Services.)

When educating clients about the range of contraceptive methods, providers should ensure that clients have information that is medically accurate, balanced, and provided in a nonjudgmental manner. To assist clients in making informed decisions, providers should educate clients in a manner that can be readily understood and retained. The content, format, method, and medium for delivering education should be evidence-based (see Appendix E).

When working with male clients, when appropriate, providers should discuss information about female-controlled methods

FIGURE 3. The typical effectiveness of Food and Drug Administration–approved contraceptive methods



(including emergency contraception) encourage discussion of contraception with partners, and provide information about how partners can access contraceptive services. Male clients should also be reminded that condoms should be used correctly and consistently to reduce risk of STDs, including HIV.

When working with any client, encourage partner communication about contraception, as well as understanding partner barriers (e.g., misperceptions about side effects) and facilitators (e.g., general support) of contraceptive use (*43–46*).

The provider should help the client consider potential barriers to using the method(s) under consideration. This includes consideration of the following factors:

- **Social-behavioral factors.** Social-behavioral factors might influence the likelihood of correct and consistent use of contraception (*47*). Providers should help the client consider the advantages and disadvantages of the method(s) being considered, the client's feelings about using the method(s), how her or his partner is likely to respond, the client's peers' perceptions of the method(s), and the client's confidence in being able to use the method correctly and consistently (e.g., using a condom during every act of intercourse or remembering to take a pill every day) (*37*).
- **Intimate partner violence and sexual violence.** Current and past intimate partner sexual or domestic violence might impede the correct and consistent use of contraception, and might be a consideration when choosing a method (*47–49*). For example, an IUD might

be preferred because it does not require the partner's participation. The medical history might provide information on signs of current or past violence and, if not, providers should ask clients about relationship issues that might be potential barriers to contraceptive use. In addition, clients experiencing intimate partner violence or sexual violence should be referred for appropriate care.

- **Mental health and substance use behaviors.** Mental health (e.g., depression, anxiety disorders, and other mental disorders) and substance use behaviors (e.g., alcohol use, prescription abuse, and illicit drug use) might affect a client's ability to correctly and consistently use contraception (*47*,*50*). The medical history might provide information about the signs of such conditions or behaviors, and if not, providers should ask clients about substance use behaviors or mental health disorders, such as depression or anxiety, that might interfere with the motivation or ability to follow through with contraceptive use. If needed, clients with mental health disorders or risky substance use behaviors should be referred for appropriate care.

Step 4. Conduct a physical assessment related to contraceptive use, when warranted. Most women will need no or few examinations or laboratory tests before starting a method of contraception. Guidance on necessary examinations and tests related to initiation of contraception is available (*42*). A list of assessments that need to be conducted when providing reversible contraceptive services to a female client seeking to initiate or switch to a new method of reversible contraception is provided (Table 1) (*42*). Clinical evaluation of a client electing permanent sterilization should be guided by the clinician who performs the procedure. Recommendations for contraceptive use are available (*42*). Key points include the following:

- Blood pressure should be taken before initiating the use of combined hormonal contraception.
- Providers should assess the current pregnancy status of clients receiving contraception (*42*), which provides guidance on how to be reasonably certain that a woman is not pregnant at the time of contraception initiation. In most cases, a detailed history provides the most accurate assessment of pregnancy risk in a woman about to start using a contraceptive method. Routine pregnancy testing for every woman is not necessary.
- Weight measurement is not needed to determine medical eligibility for any method of contraception because all methods generally can be used among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
- Unnecessary medical procedures and tests might create logistical, emotional, or economic barriers to contraceptive access for some women, particularly adolescents and low-income women, who have high rates of unintended pregnancies (*1*,*51*,*52*). For both adolescent and adult female clients, the following examinations and tests are not needed routinely to provide contraception safely to a healthy client (although they might be needed to address other non-contraceptive health needs) (*42*):
  - pelvic examinations, unless inserting an intrauterine device (IUD) or fitting a diaphragm;
  - cervical cytology or other cancer screening, including clinical breast exam;
  - human immunodeficiency virus (HIV) screening; and
  - laboratory tests for lipid, glucose, liver enzyme, and hemoglobin levels or thrombogenic mutations.

For male clients, no physical examination needs to be performed before distributing condoms.

Step 5. Provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow-up, and confirm client understanding.

- A broad range of FDA-approved contraceptive methods should be available onsite. Referrals for methods not available onsite should be provided for clients who indicate they prefer those methods. When providing contraception, providers should instruct the client about correct and consistent use and employ the following strategies to facilitate a client's use of contraception:
  - Provide onsite dispensing;
  - Begin contraception at the time of the visit rather than waiting for next menses (also known as "quick start") if the provider can reasonably be certain that the client is not pregnant (*42*). A provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria (*42*,*53*):
    - is ≤7 days after the start of normal menses,
    - has not had sexual intercourse since the start of last normal menses,
    - has been using a reliable method of contraception correctly and consistently,
    - is ≤7 days after spontaneous or induced abortion,
    - is within 4 weeks postpartum,
    - is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum;
  - Provide or prescribe multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring

TABLE 1. Assessments to conduct when a female client is initiating a new method of reversible contraception

	Cu-IUD and LNG-IUD	Implant	Injectable	Combined hormonal contraception	Progestin-only pills	Condom	Diaphragm or cervical cap	Spermicide
Examination								
Blood pressure	C	C	C	A*	C	C	C	C
Weight (BMI) (weight [kg]/height [m]^2)	—†	—†	—†	—†	—†	C	C	C
Clinical breast examination	C	C	C	C	C	C	C	C
Bimanual examination and cervical inspection	A	C	C	C	C	C	A§	C
Laboratory test								
Glucose	C	C	C	C	C	C	C	C
Lipids	C	C	C	C	C	C	C	C
Liver enzymes	C	C	C	C	C	C	C	C
Hemoglobin	C	C	C	C	C	C	C	C
Thrombogenic mutations	C	C	C	C	C	C	C	C
Cervical cytology (Papanicolaou smear)	C	C	C	C	C	C	C	C
STD screening with laboratory tests	—¶	C	C	C	C	C	C	C
HIV screening with laboratory tests	C	C	C	C	C	C	C	C

Source: CDC. U.S. selected practice recommendations for contraceptive use 2013. MMWR 2013;62(No. RR-5).
Abbreviations: A = Class A: essential and mandatory in all circumstances for safe and effective use of the contraceptive method; B = Class B: contributes substantially to safe and effective use, but implementation might be considered within the public health and/or service context (the risk of not performing an examination or test should be balanced against the benefits of making the contraceptive method available); C = Class C: does not contribute substantially to safe and effective use of the contraceptive method; Cu-IUD = copper-containing intrauterine device; LNG-IUD = levonorgestrel releasing intrauterine device.
* In cases in which access to health care might be limited, the blood pressure measurement can be obtained by the woman in a nonclinical setting (e.g., pharmacy or fire station) and self-reported to the provider.
† Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. Medical Eligibility Criteria 1) or generally can be used (U.S. Medical Eligibility Criteria 2) among obese women (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010;59[No. RR-4]). However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
§ A bimanual examination (not cervical inspection) is needed for diaphragm fitting.
¶ Most women do not require additional STD screening at the time of IUD insertion, if they have already been screened according to CDC's STD treatment guidelines (Sources: CDC. STD treatment guidelines. Atlanta, GA: US Department of Health and Human Services, CDC; 2013. Available at http://www.cdc.gov/std/treatment. CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR. 2010;59[No. RR-12]). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. Medical Eligibility Criteria 4). Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (U.S. Medical Eligibility Criteria 3) (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010;59[No. RR-4]). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

to minimize the number of times a client has to return to the service site;
- Make condoms easily and inexpensively available; and
- If a client chooses a method that is not available on-site or the same day, provide the client another method to use until she or he can start the chosen method.

- Help the client develop a plan for using the selected method. Using a method incorrectly or inconsistently and having gaps in contraceptive protection because of method switching both increase the likelihood of an unintended pregnancy (*37*). After the method has been provided, or a plan put into place to obtain the chosen method, providers should help the client develop an action plan for using the selected method.

  Providers should encourage clients to anticipate reasons why they might not use their chosen method(s) correctly or consistently, and help them develop strategies to deal with these possibilities. For example, for a client selecting oral contraceptive pills who might forget to take a pill, the provider can work with the client to identify ways to routinize daily pill taking (e.g., use of reminder systems such as daily text messages or cell phone alarms). Providers also may inform clients about the availability of emergency contraceptive pills and may provide clients an advance supply of emergency contraceptive pills on-site or by prescription, if requested.

  Side effects (e.g., irregular vaginal bleeding) are a primary reason for method discontinuation (*54*), so providers should discuss ways the client might deal with potential side effects to increase satisfaction with the method and improve continuation (*42*).
- Develop a plan for follow-up. Providers should discuss an appropriate follow-up plan with the client to meet their individual needs, considering the client's risk for discontinuation. Follow-up provides an opportunity to inquire about any initial difficulties the client might be experiencing, and might reinforce the perceived accessibility of the provider and increase rapport. Alternative modes of follow-up other than visits to the service site, such as telephone, e-mail, or text messaging, should be considered (assuming confidentiality can be assured), as needed.

  As noted previously, if a client chooses a method that is not available on-site or during the visit, the provider

should schedule a follow-up visit with the client or provide a referral for her or him to receive the method. The client should be provided another method to use until she or he can start the chosen method.
- Confirm the client's understanding. Providers should assess whether the client understands the information that was presented. The client's understanding of the most important information about her or his chosen contraceptive method should be documented in the medical record (e.g., by a checkbox or written statement).

The teach-back method may be used to confirm the client's understanding by asking the client to repeat back messages about risks and benefits and appropriate method use and follow-up. If providers assess the client's understanding, then the check box or written statement can be used in place of a written method-specific informed consent form. Topics that providers may consider having the client repeat back include the following: typical method effectiveness; how to use the method correctly; protection from STDs; warning signs for rare, but serious, adverse events and what to do if they experience a warning sign; and when to return for follow-up.

Provide Counseling for Returning Clients

When serving contraceptive clients who return for ongoing care related to contraception, providers should ask if the client has any concerns with the method and assess its use. The provider should assess any changes in the client's medical history, including changes in risk factors and medications that might affect safe use of the contraceptive method. If the client is using the method correctly and consistently and there are no concerns about continued use, an appropriate follow-up plan should be discussed and more contraceptive supplies given (*42*). If the client or provider has concerns about the client's correct or consistent use of the method, the provider should ask if the client would be interested in considering a different method of contraception. If the client is interested, the steps described above should be followed.

Counseling Adolescent Clients

Providers should give comprehensive information to adolescent clients about how to prevent pregnancy (*55–57*). This information should clarify that avoiding sex (i.e., abstinence) is an effective way to prevent pregnancy and STDs. If the adolescent indicates that she or he will be sexually active, providers should give information about contraception and help her or him to choose a method that best meets her or his individual needs, including the use of condoms to reduce the risk of STDs. Long-acting reversible contraception is a safe and effective option for many adolescents, including those who have not been pregnant or given birth (*35*).

Providers of family planning services should offer confidential services to adolescents and observe all relevant state laws and any legal obligations, such as notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest, as well as human trafficking (*58,59*). Confidentiality is critical for adolescents and can greatly influence their willingness to access and use services (*60–67*). As a result, multiple professional medical associations have emphasized the importance of providing confidential services to adolescents (*68–70*).

Providers should encourage and promote communication between the adolescent and his or her parent(s) or guardian(s) about sexual and reproductive health (*71–86*). Adolescents who come to the service site alone should be encouraged to talk to their parents or guardians. Educational materials and programs can be provided to parents or guardians that help them talk about sex and share their values with their child (*72,87*). When both parent or guardian and child have agreed, joint discussions can address family values and expectations about dating, relationships, and sexual behavior.

In a given year, approximately 20% of adolescent births represent repeat births (*88*), so in addition to providing postpartum contraception, providers should refer pregnant and parenting adolescents to home visiting and other programs that have been demonstrated to provide needed support and reduce rates of repeat teen pregnancy (*89–94*).

Services for adolescents should be provided in a "youth-friendly" manner, which means that they are accessible, equitable, acceptable, appropriate, comprehensive, effective, and efficient for youth as recommended by the World Health Organization (*34*).

Pregnancy Testing and Counseling

Providers of family planning services should offer pregnancy testing and counseling services as part of core family planning services, in accordance with recommendations of major professional medical organizations, such as the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) (*95–97*).

Pregnancy testing is a common reason for a client to visit a provider of family planning services. Approximately 65% of pregnancies result in live births, 18% in induced abortion, and 17% spontaneous fetal loss (*98*). Among live births, only 1% of infants are placed for adoption within their first month of life (*99*).

The visit should include a discussion about her reproductive life plan and a medical history that includes asking about any coexisting conditions (e.g., chronic medical illnesses, physical disability, psychiatric illness) (*95,96*). In most cases,

a qualitative urine pregnancy test will be sufficient; however, in certain cases, the provider may consider performing a quantitative serum pregnancy test, if exact hCG levels would be helpful for diagnosis and management. The test results should be presented to the client, followed by a discussion of options and appropriate referrals.

Options counseling should be provided in accordance with recommendations from professional medical associations, such as ACOG and AAP (*95–97*). A female client might wish to include her partner in the discussion; however, if a client chooses not to involve her partner, confidentiality must be assured.

Positive Pregnancy Test

If the pregnancy test is positive, the clinical visit should include an estimation of gestational age so that appropriate counseling can be provided. If a woman is uncertain about the date of her last normal menstrual period, a pelvic examination might be needed to help assess gestational age. In addition, clients should receive information about the normal signs and symptoms of early pregnancy, and should be instructed to report any concerns to a provider for further evaluation. If ectopic pregnancy or other pregnancy abnormalities or problems are suspected, the provider should either manage the condition or refer the client for immediate diagnosis and management.

Referral to appropriate providers of follow-up care should be made at the request of the client, as needed. Every effort should be made to expedite and follow through on all referrals. For example, providers might provide a resource listing or directory of providers to help the client identify options for care. Depending upon a client's needs, the provider may make an appointment for the client, or call the referral site to let them know the client was referred. Providers also should assess the client's social support and refer her to appropriate counseling or other supportive services, as needed.

For clients who are considering or choose to continue the pregnancy, initial prenatal counseling should be provided in accordance with the recommendations of professional medical associations, such as ACOG (*97*). The client should be informed that some medications might be contraindicated in pregnancy, and any current medications taken during pregnancy need to be reviewed by a prenatal care provider (e.g., an obstetrician or midwife). In addition, the client should be encouraged to take a daily prenatal vitamin that includes folic acid; to avoid smoking, alcohol, and other drugs; and not to eat fish that might have high levels of mercury (*97*). If there might be delays in obtaining prenatal care, the client should be provided or referred for any needed STD screening (including HIV) and vaccinations (*36*).

Negative Pregnancy Test

Women who are not pregnant and who do not want to become pregnant at this time should be offered contraceptive services, as described previously. The contraceptive counseling session should explore why the client thought that she was pregnant and sought pregnancy testing services, and whether she has difficulties using her current method of contraception. A negative pregnancy test also provides an opportunity to discuss the value of making a reproductive life plan. Ideally, these services will be offered in the same visit as the pregnancy test because clients might not return at a later time for contraceptive services.

Women who are not pregnant and who are trying to become pregnant should be offered services to help achieve pregnancy or basic infertility services, as appropriate (see "Clients Who Want to Become Pregnant" and "Basic Infertility Services"). They also should be offered preconception health and STD services (see "Preconception Health Services" and "STD services").

Clients Who Want to Become Pregnant

Providers should advise clients who wish to become pregnant in accordance with the recommendations of professional medical organizations, such as the American Society for Reproductive Medicine (ASRM) (*100*).

Providers should ask the client (or couple) how long she or they have been trying to get pregnant and when she or they hope to become pregnant. If the client's situation does not meet one of the standard definitions of infertility (see "Basic Infertility Services"), then she or he may be counseled about how to maximize fertility. Key points are as follows:

- The client should be educated about peak days and signs of fertility, including the 6-day interval ending on the day of ovulation that is characterized by slippery, stretchy cervical mucus and other possible signs of ovulation.
- Women with regular menstrual cycles should be advised that vaginal intercourse every 1–2 days beginning soon after the menstrual period ends can increase the likelihood of becoming pregnant.
- Methods or devices designed to determine or predict the time of ovulation (e.g., over-the-counter ovulation kits, digital telephone applications, or cycle beads) should be discussed.
- It should be noted that fertility rates are lower among women who are very thin or obese, and those who consume high levels of caffeine (e.g., more than five cups per day).
- Smoking, consuming alcohol, using recreational drugs, and using most commercially available vaginal lubricants should be discouraged as these might reduce fertility.

Basic Infertility Services

Providers should offer basic infertility care as part of core family planning services in accordance with the recommendations of professional medical organizations, such as ACOG, ASRM, and the American Urological Association (AUA) (*96*,*101*,*102*).

Infertility commonly is defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse (*101*). Earlier assessment (such as 6 months of regular unprotected intercourse) is justified for women aged >35 years, those with a history of oligo-amenorrhea (infrequent menstruation), those with known or suspected uterine or tubal disease or endometriosis, or those with a partner known to be subfertile (the condition of being less than normally fertile though still capable of effecting fertilization) (*101*). An early evaluation also might be warranted if risk factors of male infertility are known to be present or if there are questions regarding the male partner's fertility potential (*102*). Infertility visits to a family planning provider are focused on determining potential causes of the inability to achieve pregnancy and making any needed referrals to specialist care (*101*,*102*). ASRM recommends that evaluation of both partners should begin at the same time (*101*).

Basic Infertility Care for Women

The clinical visit should focus on understanding the client's reproductive life plan (*24*) and her difficulty in achieving pregnancy through a medical history, sexual health assessment and physical exam, in accordance with recommendations developed by professional medical associations such as ASRM (*101*) and ACOG (*96*). The medical history should include past surgery, including indications and outcome(s), previous hospitalizations, serious illnesses or injuries, medical conditions associated with reproductive failure (e.g., thyroid disorders, hirsutism, or other endocrine disorders), and childhood disorders; results of cervical cancer screening and any follow-up treatment; current medication use and allergies; and family history of reproductive failure. In addition, a reproductive history should include how long the client has been trying to achieve pregnancy; coital frequency and timing, level of fertility awareness, and results of any previous evaluation and treatment; gravidity, parity, pregnancy outcome(s), and associated complications; age at menarche, cycle length and characteristics, and onset/severity of dysmenorrhea; and sexual history, including pelvic inflammatory disease, history of STDs, or exposure to STDs. A review of systems should emphasize symptoms of thyroid disease, pelvic or abdominal pain, dyspareunia, galactorrhea, and hirsutism (*101*).

The physical examination should include: height, weight, and body mass index (BMI) calculation; thyroid examination to identify any enlargement, nodule, or tenderness; clinical breast examination; and assessment for any signs of androgen excess. A pelvic examination should assess for: pelvic or abdominal tenderness, organ enlargement or mass; vaginal or cervical abnormality, secretions, or discharge; uterine size, shape, position, and mobility; adnexal mass or tenderness; and cul-de-sac mass, tenderness, or nodularity. If needed, clients should be referred for further diagnosis and treatment (e.g., serum progesterone levels, follicle-stimulating hormone/luteinizing hormone levels, thyroid function tests, prolactin levels, endometrial biopsy, transvaginal ultrasound, hysterosalpingography, laparoscopy, and clomiphene citrate).

Basic Infertility Care for Men

Infertility services should be provided for the male partner of an infertile couple in accordance with recommendations developed by professional medical associations such as AUA (*102*). Providers should discuss the client's reproductive life plan, take a medical history, and conduct a sexual health assessment. AUA recommends that the medical history include a reproductive history (*102*). The medical history should include systemic medical illnesses (e.g., diabetes mellitus), prior surgeries and past infections; medications (prescription and nonprescription) and allergies; and lifestyle exposures. The reproductive history should include methods of contraception, coital frequency and timing; duration of infertility and prior fertility; sexual history; and gonadal toxin exposure, including heat. Patients also should be asked about their female partners' history of pelvic inflammatory disease, their partners' histories of STDs, and problems with sexual dysfunction.

In addition, a physical examination should be conducted with particular focus given to 1) examination of the penis, including the location of the urethral meatus; 2) palpation of the testes and measurement of their size; 3) presence and consistency of both the vas deferens and epididymis; 4) presence of a varicocele; 5) secondary sex characteristics; and 6) a digital rectal exam (*102*). Male clients concerned about their fertility should have a semen analysis. If this test is abnormal, they should be referred for further diagnosis (i.e., second semen analysis, endocrine evaluation, post-ejaculate urinalysis, or others deemed necessary) and treatment. The semen analysis is the first and most simple screen for male fertility.

Infertility Counseling

Counseling provided during the clinical visit should be guided by information elicited from the client during the medical and reproductive history and the findings of the

physical exam. If there is no apparent cause of infertility and the client does not meet the definition above, providers should educate the client about how to maximize fertility (see "Clients Who Want to Become Pregnant"). ACOG notes the importance of addressing the emotional and educational needs of clients with infertility and recommends that providers consider referring clients for psychological support, infertility support groups, or family counseling (*96*).

Preconception Health Services

Providers of family planning services should offer preconception health services to female and male clients in accordance with CDC's recommendations to improve preconception health and health care (*24*).

Preconception health services are beneficial because of their effect on pregnancy and birth outcomes and their role in improving the health of women and men. The term preconception describes any time that a woman of reproductive potential is not pregnant but at risk of becoming pregnant, or when a man is at risk for impregnating his female partner.

Preconception health-care services for women aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcomes through prevention and management. It promotes the health of women of reproductive age before conception, and thereby helps to reduce pregnancy-related adverse outcomes, such as low birthweight, premature birth, and infant mortality (*24*). Moreover, the preconception health services recommended here are equally important because they contribute to the improvement of women's health and well-being, regardless of her childbearing intentions. CDC recommends that preconception health services be integrated into primary care visits made by women of reproductive age, such as family planning visits (*24*).

In the family planning setting, providers may prioritize screening and counseling about preconception health for couples that are trying to achieve pregnancy and couples seeking basic infertility services. Women who are using contraception to prevent or delay pregnancy might also benefit from preconception health services, especially those at high risk of unintended pregnancy. A woman is at high risk of unintended pregnancy if she is using no method or a less effective method of contraception (e.g., barrier methods, rhythm, or withdrawal), or has a history of contraceptive discontinuation or incorrect use (*38*,*39*). A woman is at lower risk of unintended pregnancy if she is using a highly effective method, such as an IUD or implant, or has an established history of using methods of contraception, such as injections, pills, patch, or ring correctly and consistently (*38*,*39*). Clients who do not want to become pregnant should also be provided preconception health services, since they are recommended by USPSTF for the purpose of improving the health of adults.

Recommendations for improving the preconception health of men also have been identified, although the evidence base for many of the recommendations for men is less than that for women (*103*). This report includes preconception health services that address men as partners in family planning (i.e., both preventing and achieving pregnancy), their direct contributions to infant health (e.g., genetics), and their role in improving the health of women (e.g., through reduced STD/HIV transmission). Moreover, these services are important for improving the health of men regardless of their pregnancy intention.

In a family planning setting, all women planning or capable of pregnancy should be counseled about the need to take a daily supplement containing 0.4 to 0.8 mg of folic acid, in accordance with the USPSTF recommendation (Grade A) (*104*).

Other preconception health services for women and men should include discussion of a reproductive life plan and sexual health assessment (Boxes 2 and 4), as well as the screening services described below (*24*,*103*,*105*). Services should be provided in accordance with the cited clinical recommendations, and any needed follow up (further diagnosis, treatment) should be provided either on-site or through referral.

Medical History

For female clients, the medical history should include the reproductive history, history of poor birth outcomes (i.e., preterm, cesarean delivery, miscarriage, and stillbirth), environmental exposures, hazards and toxins (e.g., smoking, alcohol, other drugs), medications that are known teratogens, genetic conditions, and family history (*24*,*105*).

For male clients, the medical history should include asking about the client's past medical and surgical history that might impair his reproductive health (e.g., genetic conditions, history of reproductive failures, or conditions that can reduce sperm quality, such as obesity, diabetes mellitus, and varicocele) and environmental exposures, hazards and toxins (e.g., smoking) (*103*).

Intimate Partner Violence

Providers should screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services, in accordance with USPSTF (Grade B) recommendations (*106*).

Alcohol and Other Drug Use

For female and male adult clients, providers should screen for alcohol use in accordance with the USPSTF recommendation (Grade B) for how to do so, and provide behavioral counseling

interventions, as indicated (*107*). Screening adults for other drug use and screening adolescents for alcohol and other drug use has the potential to reduce misuse of alcohol and other drugs, and can be recommended (*105*,*108*,*109*). However, the USPSTF recommendation for screening for other drugs in adults, and for alcohol and other drugs in adolescents, is an "I," and patients should be informed that there is insufficient evidence to assess the balance of benefits and harms of this screening (*107*,*110*).

Tobacco Use

For female and male clients, providers should screen for tobacco use in accordance with the USPSTF recommendation (*111*,*112*) for how to do so. Adults (Grade A) who use tobacco products should be provided or referred for tobacco cessation interventions, including brief behavioral counseling sessions (<10 minutes) and pharmacotherapy delivered in primary care settings (*111*). Adolescents (Grade B) should be provided intervention to prevent initiation of tobacco use (*112*).

Immunizations

For female and male clients, providers should screen for immunization status in accordance with recommendations of CDC's Advisory Committee on Immunization Practices (*113*) and offer vaccination, as indicated, or provide referrals to community providers for immunization. Female and male clients should be screened for age-appropriate vaccinations, such as influenza and tetanus–diphtheria–pertussis (Tdap), measles, mumps, and rubella (MMR), varicella, pneumococcal, and meningococcal. In addition, ACOG recommends that rubella titer be performed in women who are uncertain about MMR immunization (*108*). (For vaccines for reproductive health-related conditions, i.e., human papillomavirus and hepatitis B, see "Sexually Transmitted Disease Services.")

Depression

For all clients, providers should screen for depression when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow-up (*114*,*115*). Staff-assisted care supports are defined as clinical staff members who assist the primary care clinician by providing some direct depression care, such as care support or coordination, case management, or mental health treatment. The lowest effective staff supports consist of a screening nurse who advises primary care clinicians of a positive screen and provides a protocol facilitating referral to behavioral therapy.

Providers also may follow American Psychiatric Association (*116*) and American Academy of Child and Adolescent Psychiatry (*117*) recommendations to assess risk for suicide among persons experiencing depression and other risk factors.

Height, Weight, and Body Mass Index

For all clients, providers should screen adult (Grade B) and adolescent (Grade B) clients for obesity in accordance with the USPSTF recommendation, and obese adults should be referred for intensive counseling and behavioral interventions to promote sustained weight loss (*118*,*119*). Clients likely will need to be referred for this service. These interventions typically comprise 12 to 26 sessions in a year and include multiple behavioral management activities, such as group sessions, individual sessions, setting weight-loss goals, improving diet or nutrition, physical activity sessions, addressing barriers to change, active use of self-monitoring, and strategizing how to maintain lifestyle changes.

Blood Pressure

For female and male clients, providers should screen for hypertension in accordance with the USPSTF's recommendation (Grade A) that blood pressure be measured routinely among adults (*120*) and the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure's recommendation that persons with blood pressure less than 120/80 be screened every 2 years, and every year if prehypertensive (i.e., blood pressure 120–139/80–89) (*121*). Providers also may follow AAP's recommendation that adolescents receive annual blood pressure screening (*109*).

Diabetes

For female and male clients, providers should follow the USPSTF recommendation (Grade B) to screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) >135/80 mmHg (*122*).

Sexually Transmitted Disease Services

Providers should offer STD services in accordance with CDC's STD treatment and HIV testing guidelines (*36*,*123*,*124*). It is important to test for chlamydia annually among young sexually active females and for gonorrhea routinely among all sexually active females at risk for infection because they can cause tubal infertility in women if left untreated. Testing for syphilis, HIV/AIDS, and hepatitis C should be conducted as recommended (*36*,*123*,*124*). Vaccination for human papillomavirus (HPV) and hepatitis B are also important parts of STD services and preconception care (*113*).

STD services should be provided for persons with no signs or symptoms suggestive of an STD. STD diagnostic management recommendations are not included in these guidelines, so providers should refer to CDC's STD treatment guidelines

(36) when caring for clients with STD symptoms. STD services include the following steps, which should be provided at the initial visit and at least annually thereafter:

Step 1. Assess: The provider should discuss the client's reproductive life plan, conduct a standard medical history and sexual health assessment (see text box above), and check immunization status. A pelvic exam is not indicated in patients with no symptoms suggestive of an STD.

Step 2. Screen: A client who is at risk of an STD (i.e., sexually active and not involved in a mutually monogamous relationship with an uninfected partner) should be screened for HIV and the other STDs listed below, in accordance with CDC's STD treatment guidelines (*36*) and recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings (*123*). Clients also should follow CDC's recommendations for testing for hepatitis C (*124*), and the Advisory Committee on Immunization Practice's recommendations on reproductive health-related immunizations (*113*). It is important to follow these guidelines both to ensure that clients receive needed services and to avoid unnecessary screening.

Chlamydia

For female clients, providers should screen all sexually active women aged ≤25 years for chlamydia annually, in addition to sexually active women aged >25 years with risk factors for chlamydia infection (*36*). Women aged >25 years at higher risk include sexually active women who have a new or more than one sex partner or who have a partner who has other concurrent partners. Females with chlamydia infection should be rescreened for re-infection at 3 months after treatment. Pregnant women should be screened for chlamydia at the time of their pregnancy test if there might be delays in obtaining prenatal care (*36*).

For male clients, chlamydia screening can be considered for males seen at sites with a high prevalence of chlamydia, such as adolescent clinics, correctional facilities, and STD clinics (*36*,*125*,*126*). Providers should screen men who have sex with men (MSM) for chlamydia at anatomic sites of exposure, in accordance with CDC's STD treatment guidelines (*36*). Males with symptoms suggestive of chlamydia (urethral discharge or dysuria or whose partner has chlamydia) should be tested and empirically treated at the initial visit. Males with chlamydia infection should be re-screened for reinfection at 3 months (*36*).

Gonorrhea

For female clients, providers should screen clients for gonorrhea, in accordance with CDC's STD treatment guidelines (*36*). Routine screening for *N. gonorrhoeae* in all sexually active women at risk for infection is recommended annually (*36*). Women aged <25 years are at highest risk for gonorrhea infection. Other risk factors that place women at increased risk include a previous gonorrhea infection, the presence of other STDs, new or multiple sex partners, inconsistent condom use, commercial sex work, and drug use. Females with gonnorrhea infection should be re-screened for re-infection at 3 months after treatment. Pregnant women should be screened for gonorrhea at the time of their pregnancy test if there might be delays in obtaining prenatal care (*36*).

For male clients, providers should screen MSM for gonorrhea at anatomic sites of exposure, in accordance with CDC's STD treatment guidelines (*36*). Males with symptoms suggestive of gonorrhea (urethral discharge or dysuria or whose partner has gonorrhea) should be tested and empirically treated at the initial visit. Males with gonorrhea infection should be re-screened for reinfection at 3 months after treatment (*36*,*126*–*128*).

Syphilis

For female and male clients, providers should screen clients for syphilis, in accordance with CDC's STD treatment guidelines (*36*). CDC recommends that persons at risk for syphilis infection should be screened. Populations at risk include MSM, commercial sex workers, persons who exchange sex for drugs, those in adult correctional facilities and those living in communities with high prevalence of syphilis (*36*). Pregnant women should be screened for syphilis at the time of their pregnancy test if there might be delays in obtaining prenatal care (*36*).

HIV/AIDS

For female and male clients, providers should screen clients for HIV/AIDS, in accordance with CDC HIV testing guidelines (*123*). Providers should follow CDC recommendations that all clients aged 13–64 years be screened routinely for HIV infection and that all persons likely to be at high risk for HIV be rescreened at least annually (*123*). Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test. CDC further recommends that screening be provided after the patient is notified that testing will be performed as part of general medical consent unless the patient declines (opt-out screening) or otherwise prohibited by state law. The USPSTF also recommends screening for HIV (Grade A) (*129*).

Hepatitis C

For female and male clients, CDC recommends one-time testing for hepatitis C (HCV) without prior ascertainment of HCV risk for persons born during 1945–1965, a population with a disproportionately high prevalence of HCV infection

and related disease. Persons identified as having HCV infection should receive a brief screening for alcohol use and intervention as clinically indicated, followed by referral to appropriate care for HCV infection and related conditions. These recommendations do not replace previous guidelines for HCV testing that are based on known risk factors and clinical indications. Rather, they define an additional target population for testing: persons born during 1945–1965 (*124*). USPSTF also recommends screening persons at high risk for infection for hepatitis C and one-time screening for HCV infection for persons in the 1945–1965 birth cohort (Grade B) (*130*).

Immunizations Related to Reproductive Health

Female clients aged 11–26 years should be offered either human papillomavirus (HPV) 2 or HPV4 vaccine for the prevention of HPV and cervical cancer if not previously vaccinated, although the series can be started in persons as young as age 9 years (*113*); recommendations include starting at age 11–12 years and catch up vaccine among females aged 13–26 who have not been vaccinated previously or have not completed the 3-dose series through age 26. Routine hepatitis B vaccination should be offered to all unvaccinated children and adolescents aged <19 years and all adults who are unvaccinated and do not have any documented history of hepatitis B infection (*113*).

Male clients aged 11–21 years (minimum age: 9 years) should be offered HPV4 vaccine, if not vaccinated previously; recommendations include starting at age 11–12 years and catch up vaccine among males aged 13–21 years who have not been vaccinated previously or have not completed the 3-dose series through age 21 years; vaccination is recommended among at-risk males, including MSM and immune-compromised males through age 26 years if not vaccinated previously or males who have not completed the 3-dose series through age 26 years. Heterosexual males aged 22–26 years may be vaccinated (*131*). Routine hepatitis B vaccination should be offered to all unvaccinated children and adolescents aged <19 years, and all unvaccinated adults who do not have a documented history of hepatitis B infection (*113*).

Step 3. Treat: A client with an STD and her or his partner(s) should be treated in a timely fashion to prevent complications, re-infection and further spread of the infection in the community in accordance with CDC's STD treatment guidelines; clients with HIV infection should be linked to HIV care and treatment (*36*,*123*). Clients should be counseled about the need for partner evaluation and treatment to avoid reinfection at the time the client receives the positive test results. For partners of clients with chlamydia or gonorrhea, one option is to schedule them to come in with the client; another option for partners who cannot come in with the client is expedited partner therapy (EPT), as permissible by state laws, in which medication or a prescription is provided to the patient to give to the partner to ensure treatment. EPT is a partner treatment strategy for partners who are unable to access care and treatment in a timely fashion. Because of concerns related to resistant gonorrhea, efforts to bring in for treatment partners of patients with gonorrhea infection are recommended; EPT for gonorrhea should be reserved for situations in which efforts to treat partners in a clinical setting are unsuccessful and EPT is a gonorrhea treatment of last resort.

All clients treated for chlamydia or gonorrhea should be rescreened 3 months after treatment; HIV-infected females with *Trichomonas vaginalis* should be linked to HIV care and rescreened for *T. vaginalis* at 3 months. If needed, the client also should be vaccinated for hepatitis B and HPV (*113*). Ideally, STD treatment should be directly observed in the facility rather than a prescription given or called in to a pharmacy. If a referral is made to a service site that has the necessary medication available on-site, such as the recommended injectable antimicrobials for gonorrhea and syphilis, then the referring provider must document that treatment was given.

Step 4. Provide risk counseling: If the client is at risk for or has an STD, high-intensity behavioral counseling for sexual behavioral risk reduction should be provided in accordance with the USPSTF recommendation (Grade B) (*132*). One high-intensity behavioral counseling model that is similar to the contraceptive counseling model is Project Respect (*133*), which could be implemented in family planning settings. All sexually active adolescents are at risk, and adults are at increased risk if they have current STDs, had an STD in the past year, have multiple sexual partners, are in nonmonogamous relationships, or are sexually active and live in a community with a high rate of STDs.

Other key messages to give infected clients before they leave the service site include the following: a) refrain from unprotected sexual intercourse during the period of STD treatment, 2) encourage partner(s) to be screened or to get treatment as quickly as possible in accordance with CDC's STD treatment guidelines (partners in the past 60 days for chlamydia and gonorrhea, 3 to 6 months plus the duration of lesions or signs for primary and secondary syphilis, respectively) if the partner did not accompany the client to the service site for treatment, and 3) return for retesting in 3 months. If the partner is unlikely to access treatment quickly, then EPT for chlamydia or gonorrhea should be considered, if permissible by state law.

A client using or considering contraceptive methods other than condoms should be advised that these methods do not protect against STDs. Providers should encourage a client who is not in a mutually monogamous relationship with an

uninfected partner to use condoms. Patients who do not know their partners' infection status should be encouraged to get tested and use condoms or avoid sexual intercourse until their infection status is known.

Related Preventive Health Services

For many women and men of reproductive age, a family planning service site is their only source of health care; therefore, visits should include provision of or referral to other preventive health services. Providers of family planning services that do not have the capacity to offer comprehensive primary care services should have strong links to other community providers to ensure that clients have access to primary care. If a client does not have another source of primary care, priority should be given to providing related reproductive health services or providing referrals, as needed.

For clients without a primary care provider, the following screening services should be provided, with appropriate follow-up, if needed, while linking the client to a primary care provider. These services should be provided in accordance with federal and professional medical recommendations cited below regarding the frequency of screening, the characteristics of the clients that should be screened, and the screening procedures to be used.

Medical History

USPSTF recommends that women be asked about family history that would be suggestive of an increased risk for deleterious mutations in BRCA1 or BRCA2 genes (e.g., receiving a breast cancer diagnosis at an early age, bilateral breast cancer, history of both breast and ovarian cancer, presence of breast cancer in one or more female family members, multiple cases of breast cancer in the family, both breast and ovarian cancer in the family, one or more family members with two primary cases of cancer, and Ashkenazi background). Women with identified risk(s) should be referred for genetic counseling and evaluation for BRCA testing (Grade B) (*134*). The USPSTF also recommends that women at increased risk for breast cancer should be counseled about risk-reducing medications (Grade B) (*135*).

Cervical Cytology

Providers should provide cervical cancer screening to clients receiving related preventive health services. Providers should follow USPSTF recommendations to screen women aged 21–65 years with cervical cytology (Pap smear) every 3 years, or for women aged 30–65 years, screening with a combination of cytology and HPV testing every 5 years (Grade A) (*136*).

Cervical cytology no longer is recommended on an annual basis. Further, it is not recommended (Grade D) for women aged <21 years (*136*). Women with abnormal test results should be treated in accordance with professional standards of care, which may include colposcopy (*96*,*137*). The need for cervical cytology should not delay initiation or hinder continuation of a contraceptive method (*42*).

Providers should also follow ACOG and AAP recommendations that a genital exam should accompany a cervical cancer screening to inspect for any suspicious lesions or other signs that might indicate an undiagnosed STD (*96*,*97*,*138*).

Clinical Breast Examamination

Despite a lack of definitive data for or against, clinical breast examination has the potential to detect palpable breast cancer and can be recommended. ACOG recommends annual examination for all women aged >19 years (*108*). ACS recommends screening every 3 years for women aged 20–39 years, and annually for women aged ≥40 years (*139*). However, the USPSTF recommendation for clinical breast exam is an I, and patients should be informed that there is insufficient evidence to assess the balance of benefits and harms of the service (*140*).

Mammography

Providers should follow USPSTF recommendations (Grade B) to screen women aged 50–74 years on a biennial basis; they should screen women aged <50 years if other conditions support providing the service to an individual patient (*140*).

Genital Examination

For adolescent males, examination of the genitals should be conducted. This includes documentation of normal growth and development and other common genital findings, including hydrocele, varicocele, and signs of STDs (*141*). Components of this examination include inspecting skin and hair, palpating inguinal nodes, scrotal contents and penis, and inspecting the perinanal region (as indicated).

Summary of Recommendations for Providing Family Planning and Related Preventive Health Services

The screening components for each family planning and related preventive health service are provided in summary checklists for women (Table 2) and men (Table 3). When considering how to provide the services listed in these recommendations (e.g., the screening components for each

service, risk groups that should be screened, the periodicity of screening, what follow-up steps should be taken if screening reveals the presence of a health condition), providers should follow CDC and USPSTF recommendations cited above, or, in the absence of CDC and USPSTF recommendations, the recommendations of professional medical associations. Following these recommendations is important both to ensure clients receive needed care and to avoid unnecessary screening of clients who do not need the services.

The summary tables describe multiple screening steps, which refer to the following: 1) the process of asking questions about a client's history, including a determination of whether risk factors for a disease or health condition exist; 2) performing a physical exam; and 3) performing laboratory tests in at-risk asymptomatic persons to help detect the presence of a specific disease, infection, or condition. Many screening recommendations apply only to certain subpopulations (e.g., specific age groups, persons who engage in specific risk behaviors or who have specific health conditions), or some screening recommendations apply to a particular frequency (e.g., a cervical cancer screening is generally recommended every 3 years rather than annually). Providers should be aware that the USPSTF also has recommended that certain screening services not be provided because the harm outweighs the benefit (see Appendix F).

When screening results indicate the potential or actual presence of a health condition, the provider should either provide or refer the client for the appropriate further diagnostic testing or treatment in a manner that is consistent with the relevant federal or professional medical associations' clinical recommendations.

Conducting Quality Improvement

Service sites that offer family planning services should have a system for conducting quality improvement, which is designed to review and strengthen the quality of services on an ongoing basis. Quality improvement is the use of a deliberate and continuous effort to achieve measurable improvements in the identified indicators of quality of care, which improve the health of the community (*142*). By improving the quality of care, family planning outcomes, such as reduced rates of unintended pregnancy, improved patient experiences, and reduced costs, are more likely to be achieved (*10*,*12*,*143*,*144*).

Several frameworks for conducting quality improvement have been developed (*144–146*). This section presents a general overview of three key steps that providers should take when conducting quality improvement of family planning services: 1) determine which measures are needed to monitor quality; 2) collect the information needed; and 3) use the findings to make changes to improve quality (*147*). Ideally, these steps will be conducted on a frequent (optimally, quarterly) and ongoing basis. However, since quality cuts across all aspects of a program, not all domains of quality can necessarily be considered at all times. Within a sustainable system of quality improvement, programs can opt to focus on a subset of quality dimensions and their respective measures.

Determining Which Measures Are Needed

Performance measures provide information about how well the service site is meeting pre-established goals (*148*). The following questions should be considered when selecting performance measures (*143*):

- Is the topic important to measure and report? For example, does it address a priority aspect of health care, and is there opportunity for improvement?
- What is the level of evidence for the measure (e.g., that a change in the measure is likely to represent a true change in health outcomes)? Does the measure produce consistent (reliable) and credible (valid) results about the quality of care?
- Are the results meaningful and understandable and useful for informing quality improvement?
- Is the measure feasible? Can it be implemented without undue burden (e.g., captured with electronic data or electronic health records)?

Performance measures should consider the quality of the structure of services (e.g., the characteristics of the settings in which providers deliver health care, including material resources, human resources, and organizational structure), the process by which care is provided (whether services are provided correctly and completely, and how clients perceive the care they receive), and the outcomes of that care (e.g., client behaviors or health conditions that result) (*149*). They also may assess each dimension of quality services (*10*,*13*). Examples of measures that can be used for monitoring the quality of family planning services (*150*) and suggested measures that might help providers monitor quality of care have been listed (Table 6). However, other measures have been developed that also might be useful (*151–153*). Service sites that offer family planning services should select, measure, and assess at least one intermediate or outcome measure on an ongoing basis, for which the service site can be accountable. Structure- and process-based measures that assess the eight dimensions of quality services may be used to better determine how to improve quality (*154*).

Collecting Information

Once providers have determined what information is needed, the next steps are to collect and use that information to improve the quality of care. Commonly used methods of data collection include the following:

TABLE 2. Checklist of family planning and related preventive health services for women

Screening components	Family planning services (provide services in accordance with the appropriate clinical recommendation)					Related preventive health services
	Contraceptive services*	Pregnancy testing and counseling	Basic infertility services	Preconception health services	STD services†	
History						
Reproductive life plan§	Screen	Screen	Screen	Screen	Screen	
Medical history§,**	Screen	Screen	Screen	Screen	Screen	Screen
Current pregnancy status§	Screen					
Sexual health assessment§,**	Screen		Screen	Screen	Screen	
Intimate partner violence §,¶,**				Screen		
Alcohol and other drug use§,¶,**				Screen		
Tobacco use§,¶	Screen (combined hormonal methods for clients aged ≥35 years)			Screen		
Immunizations§				Screen	Screen for HPV & HBV§§	
Depression§,¶				Screen		
Folic acid§,¶				Screen		
Physical examamination						
Height, weight and BMI§,¶	Screen (hormonal methods)††		Screen	Screen		
Blood pressure§,¶	Screen (combined hormonal methods)			Screen§§		
Clinical breast exam**			Screen			Screen§§
Pelvic exam§,**	Screen (initiating diaphragm or IUD)	Screen (if clinically indicated)	Screen			
Signs of androgen excess**			Screen			
Thyroid exam**			Screen			
Laboratory testing						
Pregnancy test **	Screen (if clinically indicated)	Screen				
Chlamydia§, ¶	Screen¶¶				Screen§§	
Gonorrhea§, ¶	Screen¶¶				Screen§§	
Syphilis§,¶					Screen§§	
HIV/AIDS§,¶					Screen§§	
Hepatitis C§,¶					Screen§§	
Diabetes§,¶				Screen§§		
Cervical cytology¶						Screen§§
Mammography¶						Screen§§

Abbreviations: BMI = body mass index; HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus; IUD = intrauterine device; STD = sexually transmitted disease.

* This table presents highlights from CDC's recommendations on contraceptive use. However, providers should consult appropriate guidelines when treating individual patients to obtain more detailed information about specific medical conditions and characteristics (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010;59(No. RR-4).

† STD services also promote preconception health but are listed separately here to highlight their importance in the context of all types of family planning visits. The services listed in this column are for women without symptoms suggestive of an STD.

§ CDC recommendation.

¶ U.S. Preventive Services Task Force recommendation.

** Professional medical association recommendation.

†† Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. Medical Eligibility Criteria 1) or generally can be used (U.S. Medical Eligibility Criteria 2) among obese women (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. MMWR 2010;59[No. RR-4]). However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

§§ Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of an infection or condition.

¶¶ Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD treatment guidelines (Sources: CDC. STD treatment guidelines. Atlanta, GA: US Department of Health and Human Services, CDC; 2013. Available at http://www.cdc.gov/std/treatment. CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR 2010;59[No. RR-12]). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. Medical Eligibility Criteria 4) women who have a very high individual likelihood of STD exposure (e.g. those with a currently infected partner) generally should not undergo IUD insertion (U.S. Medical Eligibility Criteria 3) (Source: CDC. US medical eligibility criteria for contraceptive use 2010. MMWR 2010;59[No. RR-4]). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

- **Review of medical records.** All records that detail service delivery activities can be reviewed, including encounters and claims data, client medical records, facility logbooks, and others. It is important that records be carefully designed, sufficiently detailed, provide accurate information, and have access restricted to protect confidentiality. The use of electronic health records can facilitate some types of medical record review.
- **Exit interview with the client.** A patient is asked (through either a written or in-person survey) to describe what happened during the encounter or their assessment of their satisfaction with the visit. Both quantitative (close-ended questions) and qualitative (open-ended questions) methods can be used. Limitations include a bias toward clients reporting higher degrees of satisfaction, and the

TABLE 3. Checklist of family planning and related preventive health services for men

Screening components and source of recommendation	Family planning services (provide services in accordance with the appropriate clinical recommendation)				Related preventive health services
	Contraceptive services*	Basic infertility services	Preconception health services†	STD services§	
History					
Reproductive life plan¶	Screen	Screen	Screen	Screen	
Medical history¶,††	Screen	Screen	Screen	Screen	
Sexual health assessment¶,††	Screen	Screen	Screen	Screen	
Alcohol & other drug use ¶,**,††			Screen		
Tobacco use¶,**			Screen		
Immunizations¶			Screen	Screen for HPV & HBV§§	
Depression¶,**			Screen		
Physical examination					
Height, weight, and BMI¶,**			Screen		
Blood pressure**,††			Screen§§		
Genital exam††		Screen (if clinically indicated)		Screen (if clinically indicated)	Screen§§
Laboratory testing					
Chlamydia¶				Screen§§	
Gonorrhea¶				Screen§§	
Syphilis¶,**				Screen§§	
HIV/AIDS¶,**				Screen§§	
Hepatitis C¶,**				Screen§§	
Diabetes¶,**			Screen§§		

Abbreviations: HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus virus; STD = sexually transmitted disease.

* No special evaluation needs to be done prior to making condoms available to males. However, when a male client requests advice on pregnancy prevention, he should be provided contraceptive services as described in the section "Provide Contraceptive Services."

† The services listed here represent a sub-set of recommended preconception health services for men that were recommended and for which there was a direct link to fertility or infant health outcomes (Source: Frey K, Navarro S, Kotelchuck M, Lu M. The clinical content of preconception care: preconception care for men. Am J Obstet Gynecol 2008;199[6 Suppl 2]:S389–95).

§ STD services also promote preconception health, but are listed separately here to highlight their importance in the context of all types of family planning visit. The services listed in this column are for men without symptoms suggestive of an STD.

¶ CDC recommendation.

** U.S. Preventive Services Task Force recommendation.

†† Professional medical association recommendation.

§§ Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of infection or other condition.

provider's behavior might be influenced if she or he knows clients are being interviewed.

- **Facility audit.** Questions about a service site's structure (e.g., on-site availability of a broad range of FDA-approved methods) and processes (e.g., skills and technical competence of staff, referral mechanisms) can be used to determine the readiness of the facility to serve clients.
- **Direct observation.** A provider's behavior is observed during an actual encounter with a client. Evaluation of a full range of competencies, including communication skills, can be carried out. A main limitation is that the observer's presence might influence the provider's performance.
- **Interview with the health-care provider.** Providers are interviewed about how specific conditions are managed. Both closed- and open-ended questions can be used, although it is important to frame the question so that the 'correct' answer is not suggested. A limitation is that providers tend to over-report their performance.

Consideration and Use of the Findings

After data are collected, they should be tabulated, analyzed, and used to improve care. Staff whose performance was assessed should be involved in the development of the data collection tools and analysis of results. Analysis should address the following questions (*155*):

- What is the performance level of the facility?
- Is there a consistent pattern of performance among providers?
- What is the trend in performance?
- What are the causes of poor performance?
- How can performance gaps be minimized?

Given the findings, service site staff should use a systematic approach to identifying ways to improve the quality of care. One example of a systematic approach to improving the quality of care is the "Plan, Do, Study, and Act" (PDSA) model (*147*,*156*), in which staff first develop a plan for improving quality, then execute the plan on a small scale, evaluate feedback to confirm or adjust the plan, and finally, make the plan

TABLE 4. Suggested measures of the quality of family planning services

Type of measure and dimension of quality	Measure	Source
Health outcome	• Unintended pregnancy • Teen pregnancy • Birth spacing • Proportion of female users at risk for unintended pregnancy who adopt or continue use of an FDA-approved contraceptive method (measured for any method; highly effective methods; or long-acting reversible methods) [Intermediate outcome]	PIMS*
Safe (Structure)	• Proportion of providers that follow the most current CDC recommendations on contraceptive safety	
Effective (Structure, or the characteristics of the settings in which providers deliver health care, including material resources, human resources, and organizational structure)	• Site dispenses or provides on-site a full range of FDA-approved contraceptive methods to meet the diverse reproductive needs and goals of clients; short-term hormonal, long-acting reversible contraception (LARC), emergency contraception (EC). • Proportion of female users aged ≥24 years who are screened annually for chlamydial infection. • Proportion of female users aged ≥24 years who are screened annually for gonorrhea. • Proportion of users who were tested for HIV during the past 12 months. • Proportion of female users aged ≥21 years who have received a Pap smear within the past 3 years.	PIMS*
Client-centered (Process, or whether services are provided correctly and completely, and how clients perceive the care they receive)	• Proportion of clients who report the provider communicates well, shows respect, spends enough time with the client, and is informed about the client's medical history. • Proportion of clients who report that – Staff are helpful and treat clients with courtesy and respect. – His or her privacy is respected. – She or he receives contraceptive method that is acceptable to her or him.	CAHPS† RQIP§
Efficient (Structure)	• Site uses electronic health information technology or electronic health records to improve client reproductive health.	PIMS*
Timely (Structure and process)	• Average number of days to the next appointment. • Site offers routine contraceptive resupply on a walk-in basis. • Site offers on-site HIV testing (using rapid technology). • Site offers on-site HPV and hepatitis B vaccination.	PIMS*
Accessible (Structure and process)	• Site offers family planning services during expanded hours of operation. • Proportion of total family planning encounters that are encounters with ongoing or continuing users. • Proportion of clients who report that his or her care provider follows up to give test results, has up-to-date information about care from specialists, and discusses other prescriptions. • Site has written agreements (e.g., MOUs) with the key partner agencies for health care (especially prenatal care, primary care, HIV/AIDS) and social service (domestic violence, food stamps) referrals.	PIMS* CAHPS–PCMH item set on care coordination†
Equitable (Structure)	• Site offers language assistance at all points of contact for the most frequently encountered language(s).	PIMS*
Value	• Average cost per client.	CDC¶

Abbreviations: CAPHS = Agency for Healthcare Research and Quality's Consumer Assessment of Health Care Providers and Systems; FDA = Food and Drug Administration; HPV = human papillomavirus; MOU = memorandum of understanding; PIMS = Performance Information and Monitoring System; RQIP = Regional Quality Indicators Program.

* **Source:** Fowler C. Title X Family Planning Program Performance Information and Monitoring System (PIMS): Description of Proposed Performance Measures [DRAFT]. Washington, DC: Research Triangle Institute; 2012.

† **Source:** Agency for Healthcare Research and Quality. Consumer Assessment of Healthcare Providers and Systems (CAHPS). Available at https://www.cahps.ahrq.gov/default.asp.

§ **Source:** John Snow International. The Regional Quality Indicators Project (RQIP). Boston, MA: John Snow International; 2014. Available at http://www.jsi.com/JSIInternet/USHealth/project/display.cfm?ctid=na&cid=na&tid=40&id=2621.

¶ **Sources:** Haddix A, Corso P, Gorsky R. Costs. In: Haddix A, Teutsch S, Corso P, eds. Prevention effectiveness: a guide to decision analysis and economic evaluation. 2nd ed. Oxford, UK: Oxford University Press; 2003; Stiefel M, Nolan K. A guide to measuring the triple aim: population health, experience of care, and per capita cost. Cambridge, MA: Institute for Healthcare Improvements; 2012.

permanent. Examples of steps that may be taken to improve the quality of care include developing job aids, providing task-specific training for providers, conducting more patient education, or strengthening relationships with referral sites through formal memoranda of understanding (*146*).

Conclusion

The United States continues to face substantial challenges to improving the reproductive health of the U.S. population. The recommendations in this report can contribute to improved reproductive health by defining a core set of family planning

services for women and men, describing how to provide contraceptive and other family planning services to both adult and adolescent clients, and encouraging the use of the family planning visit to provide selected preventive health services for women and men. This guidance is intended to assist primary care providers to offer the family planning services that will help persons and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy.

Recommendations are updated periodically. The most recent versions are available at http://www.hhs.gov/opa.

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Appendix A

How the Recommendations Were Developed

The recommendations were developed jointly under the auspices of CDC's Division of Reproductive Health (DRH) and the Office of Population Affairs (OPA), in consultation with a wide range of experts and key stakeholders. A multistage process that drew on established procedures for developing clinical guidelines (*1,2*) was used to develop the recommendations. In April 2010, an Expert Work Group (EWG) comprising family planning clinical providers, program administrators, representatives from relevant federal agencies, and representatives from professional medical organizations was created to advise OPA and CDC on the structure and content of the revised recommendations and to help make the recommendations more feasible and relevant to the needs of the field. This group made two key initial recommendations: 1) to examine the scientific evidence for three priority areas of focus identified as key components of family planning service delivery, (i.e., counseling and education, serving adolescents, and quality improvement); and 2) to guide providers of family planning services in the use of various recommendations for how to provide clinical care to women and men.

Developing Recommendations on Counseling, Adolescent Services, and Quality Improvement

Systematic reviews of the published literature from January 1985 through December 2010 were conducted for each priority topic to identify evidence-based and evidence-informed approaches to family planning service delivery. Standard methods for conducting the reviews were used, including the development of key questions and analytic frameworks, the identification of the evidence base through a search of the published as well as "gray literature" (i.e., studies published somewhere other than in a peer-reviewed journal), and a synthesis of the evidence in which findings were summarized and the quality of individual studies was considered, using the methodology of the U.S. Preventive Services Task Force (USPSTF) (*3*). Eight databases were searched (i.e., MEDLINE, PsychInfo, PubMed, CINAHL, Cochrane, EMBASE, POPLINE, and the U.K. National Clearinghouse Service Economic Evaluation Database) and were restricted to literature from the United States and other developed countries. Summaries of the evidence used to prepare these recommendations will appear in background papers that will be published separately.

In May 2011, three technical panels (one for each priority topic) comprising subject matter experts were convened to consider the quality of the evidence and suggest what recommendations might be justified on the basis of the evidence. CDC and OPA used this feedback to develop core recommendations for counseling, serving adolescents, and quality improvement. EWG members subsequently reviewed these core recommendations; EWG members differed from the subject matter experts in that they were more familiar with the family planning service delivery context and could comment on the feasibility and appropriateness of the recommendations as well as on their scientific justification. EWG members met to consider the core recommendations using 1) the quality of the evidence; 2) the positive and negative consequences of implementing the recommendations on health outcomes, costs or cost-savings, and implementation challenges; and 3) the relative importance of these consequences (e.g., the ability of the recommendations to have a substantial effect on health outcomes may be weighed more than the logistical challenges of implementing them) (*1*). In certain cases, when the evidence was inconclusive or incomplete, recommendations were made on the basis of expert opinion (see Appendix B). Finally, CDC and OPA staff considered the feedback from EWG members when finalizing the core recommendations and writing this report.

Developing Recommendations on Clinical Services

DRH and OPA staff members synthesized recommendations for clinical care for women and for men that were developed by >35 federal and professional medical organizations. They were assisted in this effort by staff from OPA's Office of Family Planning Male Training Center and from CDC's Division of STD Prevention, Division of Violence Prevention, Division of Immunization Services, and Division of Cancer Prevention and Control. The synthesis was needed because clinical recommendations are sometimes inconsistent with each other and can vary by the extent to which they are evidence-based. The clinical recommendations addressed contraceptive services, achieving pregnancy, basic infertility services, preconception health services, sexually transmitted disease services, and related health-care services.

An attempt was made to apply the Institute of Medicine's criteria for clinical practice guidelines when deciding which professional medical organizations to include in the review (*2*). However, many organizations did not articulate the process used to develop the recommendations fully, and many did not

conduct comprehensive and systematic reviews of the literature. In the end, to be included in the synthesis, the recommending organization had to be a federal agency or major professional medical organization that represents established medical disciplines. In addition, a recommendation had to be made on the basis of an independent review of the evidence or expert opinion and be considered a primary source that was developed for the United States.

In July 2011, two technical panels comprising subject matter experts on clinical services for women and men were convened to review the synthesis of federal and professional medical recommendations, reconcile inconsistent recommendations, and provide individual feedback to CDC and OPA about the implications for family planning service delivery. CDC and OPA used this individual feedback to develop core recommendations for clinical services. The core recommendations were subsequently reviewed by EWG members, and feedback was used to finalize the core recommendations and write this report.

Members of the technical panels recommended that contraceptive services, pregnancy testing and counseling, services to achieve pregnancy, basic infertility care, STD services, and other preconception health services should be considered family planning services. This feedback considered federal statute and regulation, CDC and USPSTF recommendations for clinical care, and EWG members' opinion.

Because CDC's preconception health recommendations include many services, the panel narrowed the range of preconception services that were included by using the following criteria: 1) the Select Panel on Preconception Care (*4*) had assigned an A or B recommendation to that service for women, which means that there was either good or fair evidence to support the recommendation that the condition be considered in a preconception care evaluation (Table 1), or 2) the service was included among recommendations made by experts in preconception health for males (*5*). Services for men that addressed health conditions that affect reproductive capacity or pregnancy outcomes directly were included as preconception health; services that addressed men's health but that were not related directly to pregnancy outcomes were considered to be related preventive health services.

The Expert Work Group noted that more preventive services are recommended than can be offered feasibly in some settings. However, a primary purpose of this report is to set a broad framework within which individual clinics will tailor services to meet the specific needs of the populations that they serve. In addition, EWG members identified specific subgroups that should have the greatest priority for preconception health services (i.e., those trying to achieve pregnancy and those at high risk of unintended pregnancy). Future operational research should provide more information about how to deliver these services most efficiently during multiple visits to clients with diverse needs.

Determining How Clinical Services Should Be Provided

Various federal agencies and professional medical associations have made recommendations for how to provide family planning services. When considering these recommendations, the Expert Work Group used the following hierarchy:

- Highest priority was given to CDC guidelines because they are developed after a rigorous review of scientific evidence. CDC guidelines tailor recommendations for higher risk individuals, (whereas USPSTF focuses on average risk individuals), who are more representative of the clients seeking family planning services.
- When no CDC guideline existed to guide the recommendations, the relevant USPSTF A or B recommendations (which indicate a high or moderate certainty that the benefit is moderate to substantial) were used. USPSTF recommendations are made on the basis of a thorough review of the available evidence.
- If neither a CDC nor a USPSTF A or B recommendation existed, the recommendations of selected major professional medical associations were considered as resources. The American Academy of Pediatrics' (AAP) Bright Futures guidelines (*6*) were used as the primary source of recommendations for adolescents when no CDC or USPSTF recommendations existed.
- For a limited number of recommendations, there were no federal or major professional medical recommendations, but the service was recommended by EWG members on the basis of expert opinion for family planning clients.

In some cases, a service was graded as an I recommendation by USPSTF for the general population (an I recommendation means that the current evidence is insufficient to assess the balance of benefits and harms of the service, so if the service is offered, patients should be informed of this fact), but either CDC, EWG members, or another organization recommended the service for women or men seeking family planning services. The situations in which this occurred and the reasons why the service was recommended despite its receiving an I recommendation by USPSTF have been summarized (Table 2). The approach used to consider the evidence and make recommendations that are used by USPSTF have been summarized (Tables 3 and 4) (*7*).

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TABLE 1. Select Panel on Preconception Care grading system

Quality of the evidence*	
I-a	Evidence was obtained from at least one properly conducted, randomized, controlled trial that was performed with subjects who were not pregnant.
I-b	Evidence was obtained from at least one properly conducted, randomized, controlled trial that was done not necessarily before pregnancy.
II-1	Evidence was obtained from well-designed, controlled trials without randomization.
II-2	Evidence was obtained from well-designed cohort or case-control analytic studies, preferably conducted by more than one center or research group.
II-3	Evidence was obtained from multiple-time series with or without the intervention, or dramatic results in uncontrolled experiments.
III	Opinions were gathered from respected authorities on the basis of clinical experience, descriptive studies and case reports, or reports of expert committees.
Strength of the recommendation	
A	There is good evidence to support the recommendation that the condition be considered specifically in a preconception care evaluation.
B	There is fair evidence to support the recommendation that the condition be considered specifically in a preconception care evaluation.
C	There is insufficient evidence to recommend for or against the inclusion of the condition in a preconception care evaluation, but recommendation to include or exclude may be made on other grounds.
D	There is fair evidence to support the recommendation that the condition be excluded in a preconception care evaluation.
E	There is good evidence to support the recommendation that the condition be excluded in a preconception care evaluation.

Source: Jack B, Atrash H, Coonrod D, Moos M, O'Donnell J, Johnson K. The clinical content of preconception care: an overview and preparation of this supplement. Am J Obstet Gynecol 2008;199(6 Suppl 2):S266–79.

TABLE 2. Services included in these recommendations that received a U.S. Preventive Services Task Force (USPSTF) I recommendation

Service/screen	USPSTF recommendation	Why the service is recommended despite a USPSTF I recommendation
Alcohol	I for adolescents	The recommendations are consistent with CDC's recommendations on preconception health and AAP's Bright Futures* guidelines.
Other drugs	I for adolescents and adults	The recommendations are consistent with CDC's recommendations on preconception health and AAP's Bright Futures guidelines.
Clinical breast exam	I for all women	No CDC recommendation exists, but ACOG and ACS recommend conducting clinical breast exams, and the Expert Work Group endorsed the ACOG recommendation.
Chlamydia	I for all males	The recommendations are consistent with CDC's STD treatment guidelines.
Gonorrhea	I for all males	The recommendations are consistent with CDC's STD treatment guidelines.

Source: US Preventive Services Task Force. USPSTF recommendations. Available at http://www.uspreventiveservicestaskforce.org/recommendations.htm.
Abbreviations: AAP = American Academy of Pediatrics; ACS = American Cancer Society; ACOG = American Congress of Obstetricians and Gynecologists; STD = sexually transmitted disease.
* Source: Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup. 2014 recommendations for pediatric preventive health care. Pediatrics 2014;133;568.

TABLE 3. U.S. Preventive Services Task Force (USPSTF) grades, definitions, and suggestions for practice

Grade	Definition	Suggestions for practice
A	USPSTF recommends the service. There is high certainty that the net benefit is substantial.	This service should be offered or provided.
B	USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.	This service should be offered or provided.
C	Clinicians may provide this service to selected patients depending on individual circumstances. However, for a majority of persons without signs or symptoms there is likely to be only a limited benefit from this service.	This service should be offered or provided only if other considerations support the offering or providing the service in an individual patient.
D	USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Use of this service should be discouraged.
I Statement	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	The clinical considerations section of USPSTF recommendation statement should be consulted. If the service is offered, patients should be educated about the uncertainty of the balance of benefits and harms.

Source: US Preventive Services Task Force. USPSTF: methods and processes. Available at http://www.uspreventiveservicestaskforce.org/methods.htm.

TABLE 4. Levels of certainty regarding net benefit

Level of certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as • the number, size, or quality of individual studies; • inconsistency of findings across individual studies; • limited generalizability of findings to routine primary care practice; and • lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes is insufficient because of • the limited number or size of studies, • important flaws in study design or methods, • inconsistency of findings across individual studies, • gaps in the chain of evidence, • findings not generalizable to routine primary care practice, • lack of information on important health outcomes, or • more information required to allow estimation of effects on health outcomes.

Source: US Preventive Services Task Force. USPSTF: methods and processes. Available at http://www.uspreventiveservicestaskforce.org/methods.htm.

* The US Preventive Services Task Force (USPSTF) defines certainty as the likelihood that the USPSTF assessment of the net benefit of a preventive service is correct. The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

Appendix B

The Evidence, Potential Consequences, and Rationales for Core Recommendations

Sixteen core recommendations that were considered by the Expert Work Group (EWG) are presented below. Each recommendation is accompanied by a summary of the relevant evidence (full summaries of which will be published separately), a list of potential consequences of implementing the recommendation, and its rationale. When considering the recommendations, the Expert Work Group was divided into two groups (one comprising seven members and the other five members), and each group considered separate recommendations.

Definition of Family Planning Services

Recommendation: Primary care providers should offer the following family planning services: contraceptive services for women and men who want to prevent pregnancy and space births, pregnancy testing and counseling, help for clients who wish to achieve pregnancy, basic infertility services, sexually transmitted disease (STD) services and preconception health services to improve the health of women, men, and infants.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of federal statute and regulation (*1*,*2*), CDC clinical recommendations (*3*–*5*), and expert opinion.

Potential consequences: Adding preconception health services means that more women and men will receive preconception health services. The recommended services also will promote the health of women and men even if they do not have children. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered in some settings.

Rationale: Services to prevent and achieve pregnancy are core to the federal government's efforts to promote reproductive health. Adding preconception health as a family planning service is consistent with this mission; it emphasizes achieving a healthy pregnancy and also promotes adult health. Adding preconception health is also consistent with CDC recommendations to integrate preconception health services into primary care platforms (*3*). All seven EWG members agreed to this recommendation.

Preconception Health — Women

Recommendation: Preconception health services for women include the following screening services: reproductive life plan; medical history; sexual health assessment; intimate partner violence, alcohol, and other drug use; tobacco use; immunizations; depression; body mass index (BMI); blood pressure; chlamydia, gonorrhea, syphilis, and HIV/AIDS; and diabetes. All female clients also should be counseled about the need to take a daily supplement of folic acid. When screening results indicate the presence of a health condition, the provider should take steps either to provide or to refer the client for the appropriate further diagnostic testing and or treatment. Services should be provided in a manner that is consistent with established federal and professional medical associations' recommendations to enable clients who need services to receive them and to avoid over-screening.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of CDC's recommendations to improve preconception health and health care (*3*) and a review of preconception health services by an expert panel on preconception care for women (*6*).

Potential consequences: More women will receive specified preconception health services, which will improve the health of infants and women. The evidence base for preconception health is not fully established. There is a potential risk that a client with a positive screen will not be able to afford treatment if the client is uninsured and not eligible for public programs. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered.

Rationale: The potential benefits to the health of women and infants were thought by the panel to be greater than the costs, potential harms, and opportunity costs of providing these services. Implementation (e.g., training and monitoring of providers) can address the issues related to providers over-screening and not following the federal and professional medical recommendations. CDC will continue to monitor related research and modify these recommendations, as needed. Health-care reform might make follow-up care more available to low-income clients. All seven EWG members agreed to this recommendation.

Preconception Health — Men

Recommendation: Preconception health services for men include the following screening services: reproductive life plan; medical history; sexual health assessment; alcohol and other drug use; tobacco use; immunizations; depression; BMI; blood pressure; chlamydia, gonorrhea, syphilis, and HIV/AIDS; and diabetes. When screening results indicate the presence of a health condition, the provider should take

steps either to provide or to refer the client for the appropriate further diagnostic testing and or treatment. Services should be provided in a manner that is consistent with established federal and professional medical associations' recommendations to ensure that clients who need services receive them and to avoid over-screening.

Quality of evidence: A systematic review was not conducted; the recommendation was made on the basis of CDC's recommendations to improve preconception health and health care (*3*) and a review of preconception health services for men (*7*).

Potential consequences: More men will receive preconception health services, which might improve infant and men's health. The evidence base for preconception health is not well established and is less than that for women's preconception health. There is a risk of over-screening if recommendations are not followed. There is a potential risk that a client with a positive screen might not be able to afford treatment if the client is uninsured and not eligible for public programs. The human and financial cost of providing preconception health services might mean that fewer contraceptive and other services can be offered.

Rationale: The potential benefits to men and infant health were thought by the panel to be greater than the costs, potential harms, and opportunity costs of not providing these services. Implementation (e.g., training and monitoring of providers) can address the issues related to providers over-screening and not following the federal and professional medical recommendations. CDC will continue to monitor related research and modify these recommendations, as needed. Health-care reform might make follow-up care more available to low-income clients. All seven EWG members agreed to this recommendation.

Contraceptive Services — Contraceptive Counseling Steps

Recommendation: To help a client who is initiating or switching to a new method of contraception, providers should follow these steps, which are in accordance with the key principles for providing quality counseling: 1) establish and maintain rapport with the client; 2) obtain clinical and social information from the client; 3) work with the client interactively to select the most effective and appropriate contraceptive method for her or him; 4) provide a physical assessment related to contraceptive use, when warranted; and 5) provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow-up, and confirm understanding.

Quality of evidence: Twenty-two studies were identified that examined the impact of contraceptive counseling in clinical settings and met the inclusion criteria. Of the 16 studies that focused on adults or mixed populations (adolescents and adults) (*8–23*), 11 found a statistically significant positive impact of counseling interventions with low (*11*,*12*,*14–16*,*18–21*), moderate (*8*), or unrated (*22*) intensity on at least one outcome of interest; study designs included two cross-sectional surveys (*14*,*22*), one pre-post study (*21*), one prospective cohort study (*8*), one controlled trial (*15*), and six randomized controlled trials (RCTs) (*11*,*12*,*16*,*18–20*). Six studies examined the impact of contraceptive counseling among adolescents (*24–29*), with four finding a statistically significant positive impact of low-intensity (*27*) or moderate-intensity (*24*,*25*,*29*) counseling interventions on at least one outcome of interest; study designs included two pre-post studies (*24*,*30*), one controlled trial (*29*), and one RCT (*27*). In addition, five studies were identified that examined the impact of reminder system interventions in clinical settings on family planning outcomes and met the inclusion criteria (*31–35*); of these, two found a statistically significant positive impact of reminder systems on perfect oral contraceptive compliance, a retrospective historical nonrandomized controlled trial that examined daily reminder email messages (*31*) and a cohort study that examined use of a small reminder device that emitted a daily audible beep (*34*). In addition, two studies examined the impact of reminder systems among depot medroxyprogesterone acetate users (DMPA) (*33*,*35*) with one, a retrospective cohort study, finding a statistically significant positive impact of receiving a wallet-sized reminder card with the date of the next DMPA injection and a reminder postcard shortly before the next injection appointment on timely DMPA injections. Statements about safety and unnecessary medical examinations and tests are made on the basis of CDC guidelines on contraceptive use (*36*,*37*).

Potential consequences: Fewer clients will use methods that are not safe for them, there will be increased contraceptive use, increased use of more effective methods, increased continuation of method use, increased use of dual methods, increased knowledge, increased satisfaction with services, and increased use of repeat or follow-up services.

Rationale: Making sure that a contraceptive method is safe for an individual client is a fundamental responsibility of all providers of family planning services. Removing medical barriers to contraceptive use is key to increasing access to contraception and helping clients prevent unintended pregnancy. Consistent use of contraceptives is needed to prevent unintended pregnancies, so appropriate counseling is critical to ensure clients make the best possible choice of methods for their unique circumstances, and are supported in continued

use of the chosen method. The principles of quality counseling, from which the steps listed in the recommendations are based, are supported by a substantial body of evidence and expert opinion. Future research to evaluate the five principles will be monitored and the recommendations modified, as needed. All seven EWG members agreed to this recommendation.

Contraceptive Services — Tiered Approach to Counseling

Recommendation: For clients who might want to get pregnant in the future and prefer reversible methods of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods (including long-acting reversible contraception such as intrauterine devices and contraceptive implants), in which the most effective methods are presented before less effective methods.

Quality of evidence: National surveys have demonstrated low rates of LARC use overall (*38,39*). However, Project CHOICE has demonstrated high uptake of long-acting reversible contraception (approximately two thirds of clients when financial barriers are removed) and a very substantial reduction in rates of unintended pregnancy (*40*). Further, a recent study of postpartum contraceptive use shows that 50% of teen mothers with a recent live birth are using long-acting reversible contraception postpartum in Colorado, which demonstrates high levels of acceptance in the context of a statewide program to remove financial barriers (*41*).

Potential consequences: Use of long-acting reversible contraception has the potential to help many more persons prevent unintended pregnancy because of its ease of use, safety, and effectiveness. Several questions were raised about ethical issues in using a tiered approach to counseling. First, is it ethical to educate about long-acting reversible contraception when the methods are not all available on-site? Second, conversely, is it ethical not to inform clients about the most effective methods? In other health service areas, the standard of care is to inform the client about the most effective treatment (e.g., blood pressure medications), so the client can make a fully informed decision, and this standard should apply in this instance as well. On the basis of historic experiences, there is a need to ensure that methods always are offered on a completely voluntary and noncoercive basis. Health-care reform might make contraceptive services more available to the majority of clients.

Rationale: Providers have an obligation to inform clients about the most effective methods available, even if they cannot provide them. Further, health-care reform will reduce the financial barriers to long-acting reversible contraception for many persons. The potential increase in use of long-acting reversible contraception and other more effective methods is likely to help reduce rates of unintended pregnancy. All seven EWG members agreed to this recommendation.

Contraceptive Services — Broad Range of Methods

Recommendation: A broad range of methods should be available on-site or through referral.

Quality of evidence: Three descriptive studies from the review of quality improvement literature identified contraceptive choice as an important aspect of quality care (*42–44*).

Potential consequences: Clients will be more likely to select a method that they will use consistently and correctly.

Rationale: A central tenet of quality health care is that it be client-centered. Being able to provide a client with a method that best fits her or his unique circumstances is essential for that reason. All seven EWG members agreed to this recommendation.

Contraceptive Services — Education

Recommendation: The content, format, method, and medium for delivering education should be evidence-based.

Quality of evidence: Seventeen studies were identified that met the inclusion criteria for this systematic review. Of these, 15 studies looked at knowledge of correct method use or contraceptive risks and benefits, including side effects and method effectiveness (*45–59*). All but one study (*56*) found a statistically significant positive impact of educational interventions on increased knowledge. These studies included six randomized controlled trials with low risk for bias.

Potential consequences: Clients will make more informed decisions when choosing a contraceptive method. More clients will be satisfied with the process of selecting a contraceptive method.

Rationale: Knowledge obtained through educational activities, as integrated into the larger counseling model, is a critically important precondition for the client's ability to make informed decisions. The techniques described in the recommendations have a well-established evidence base for increasing knowledge and satisfaction with services. This knowledge lays the foundation for further counseling steps that will increase the likelihood of correct and consistent use, and increased satisfaction will increase return visits to the service site, as needed. Four of seven EWG members agreed to this recommendation; three members did not express an opinion.

Contraceptive Services — Confirm Understanding

Recommendation: A check box or written statement should be available in the medical record that can be used to document that the client expressed understanding of the most important information about her/his chosen contraceptive method. The teach-back method may be used to get clients to express the most important points by repeating back messages about risks and benefits and appropriate method use and follow-up. Documentation of understanding using the teach-back method and a check box or written statement can be used in place of a written method-specific informed consent.

Quality of evidence: Two studies from outside the family planning literature (one cohort study and one controlled trial with unclear randomization) (*60,61*) and a strong recommendation by members of the Technical Panel on Counseling and Education were considered.

Potential consequences: More clients will make informed decisions, adherence to contraceptive and treatment plans will improve, and reproductive and other health conditions will be better controlled.

Rationale: Asking providers to document in the record that the client is making an informed decision will increase providers' attention to this task. This recommendation will replace a previous requirement that providers obtain method-specific informed consent from each client (in addition to a general consent form). Six of seven EWG members agreed to this recommendation.

Adolescent Services — Comprehensive Information

Recommendation: Providers should provide comprehensive information to adolescent clients about how to prevent pregnancy and STDs. This should include information about contraception and that avoiding sex (abstinence) is an effective way to prevent pregnancy and STDs.

Quality of evidence: A systematic review was not conducted because other recent reviews were available that have shown a substantial impact of comprehensive sexual health education on reduced adolescent risk behavior (*62–66*). The evidence for abstinence-only education was more limited: CDC's Community Guide concluded that there was insufficient evidence (*67*), but the Department of Health and Human Services' Office of Adolescent Health has identified two abstinence-based programs as having evidence of effectiveness (*68*).

Potential consequences: Teens will make more informed decisions and will delay initiation of sexual intercourse. The absence of harmful effects from comprehensive sexual health education was noted.

Rationale: The benefits of informing adolescents about all ways to prevent pregnancy are substantial. Ultimately, each adolescent should make an informed decision that meets her or his unique circumstances, based on the counseling provided by the provider. Six of seven EWG members agreed to this recommendation.

Adolescent Services — Use of Long-Acting Reversible Contraception

Recommendation: Education about contraceptive methods should include an explanation that long-acting reversible contraception is safe and effective for nulliparous women (women who have not been pregnant or given birth), including adolescents.

Quality of evidence: CDC guidelines on contraceptive use (*37*) provide evidence that long-acting reversible contraception is safe and effective for adolescents and nulliparous women.

Potential consequences: More providers will encourage adolescents to consider long-acting reversible contraception; more adolescents will choose long-acting reversible contraception, resulting in reduced rates of teen pregnancy, including rapid repeat pregnancy.

Rationale: Long-acting reversible contraception is safe for adolescents (*37*). As noted above, providers should inform clients about the most effective methods available. The potential increase in use of long-acting reversible contraception and other more effective methods by adolescents is substantial and is likely to lead to further reductions in teen pregnancy. Three EWG members agreed to this recommendation; two EWG members abstained.

Adolescent Services — Confidential Services

Recommendation: Confidential family planning services should be made available to adolescents, while observing state laws and any legal obligations for reporting.

Quality of evidence: Six descriptive studies documented one or more of the following: that confidentiality is important to adolescents; that many adolescents reported they will not use reproductive health services if confidentiality cannot be assured; and that adolescents might not be honest in discussing reproductive health with providers if confidentiality cannot be assured (*69–74*). One RCT showed a slight reduction in use of services after receiving conditional confidentiality, compared with complete confidentiality (*75*). One study showed a

positive association between confidentiality and intention to use services (*73*).

Potential consequences: Consequences might include an increased intention to use services, increased use of services, and reduced rates of teen pregnancy. However, explaining the need to report under certain circumstances (rape, child abuse) might deter some adolescent clients from using services. Further, some parents/guardians might not agree that adolescents should have access to confidential services.

Rationale: Minors' rights to confidential reproductive health services are consistent with state and federal law. The risks of not providing confidential services to adolescents are great and likely to result in an increased rate of teen pregnancies. Finally, this recommendation is consistent with the recommendations of three professional medical associations that endorse provision of confidential services to adolescents (*76–78*). All seven EWG members agreed to this recommendation.

Adolescent Services — Family-Child Communication

Recommendation: Providers should encourage and promote family-child communication about sexual and reproductive health.

Quality of evidence: From the family planning literature, 16 parental involvement programs (most using an RCT study design) were found to be positively associated with at least one short-term (13 of 16 studies) or medium-term (four of seven studies) outcome (*79–94*). However, only one of these studies was linked to clinical services (*80*); others were implemented in community settings.

Potential consequences: Consequences might include increased parental/guardian involvement and communication, improved knowledge/awareness, increased intentions to use contraceptives, and the adoption of more pro-social norms that support parent-child communication about sexual health.

Rationale: The literature provides strong evidence that increased communication between a child and her/his parent/guardian will lead to safer sexual behavior among teens, and numerous community-based programs have created an evidence base for how to strengthen parents/guardians' ability to hold those conversations. Although less is known about how to do so in a clinical setting, providers can refer their clients to programs in the community, and principles from the community-based approaches can be used to help providers develop appropriate approaches in the clinical setting. Research in this area will be monitored, and the recommendations will be revised, as needed. Four of five EWG members who provided input agreed to this recommendation; one member abstained.

Adolescent Services — Repeat Teen Pregnancy

Recommendation: Providers should refer pregnant and parenting adolescents to home visiting and other programs that have been shown to provide needed support and reduce rates of repeat teen pregnancy.

Quality of evidence: Three of four studies of clinic-based programs (using retrospective case-control cohort, ecological evaluation, and prospective cohort study designs) showed that comprehensive teen pregnancy prevention programs (programs with clinical, school, case management, and community components) were associated with both medium- and long-term outcomes (*95–98*). In addition, several randomized trials of community-based home visiting programs, and an existing systematic review of the home visiting literature, demonstrated a protective impact of these programs on preventing repeat teen pregnancy and other relevant outcomes (*99–103*).

Potential consequences: Consequences might include decreased rapid repeat pregnancy and abortion rates, and increased use of contraceptives.

Rationale: There is sufficient evidence to recommend that providers link pregnant and parenting teens to community and social services that might reduce rates of rapid repeat pregnancy. Three of seven EWG members agreed to an earlier version of this recommendation. Other members wanted to remove a clause about prioritizing the contraceptive needs of pregnant/parenting teens because they felt that all clients should be treated as priority clients. This suggestion was adopted, but the EWG did not have a chance to vote again on the modified recommendation.

Contraceptive Method Availability

Recommendation: Family planning programs should stock and offer a broad a range of FDA-approved contraceptive methods so that the needs of individual clients can be met. These methods are optimally available on-site, but strong referrals can serve to make methods not available on-site real options for clients.

Quality of evidence: No research was identified that explicitly addressed the question of whether having a broad range of methods was associated with short-, medium-, or long-term reproductive health outcomes. However, as noted above, three descriptive studies from the review of quality improvement literature identified contraceptive choice as an important aspect of quality care (*42–44*).

Potential consequences: Consequences might include increased use of contraception and increased use of reproductive

health services. It also was noted that there are sometimes high costs to stocking certain methods (e.g., intrauterine devices and contraceptive implants).

Rationale: Having a broad range of contraceptive methods is central to client-centered care, a core aspect of providing quality services. Individual clients need to have a choice so they can select a method that best fits their particular circumstances. This is likely to result in more correct and consistent use of the chosen methods. The benefits of this recommendation were weighed more heavily than the negative outcomes (e.g., additional cost). All five EWG members agreed to this recommendation.

Youth-Friendly Services

Recommendation: Family planning programs should take steps to make services "youth-friendly."

Quality of evidence: Of 20 studies that were identified, six looked at short-, medium-, or long-term outcomes with mixed designs (one group time series, one cross-sectional, three prospective cohort, and one nonrandomized trial); protective effects were found on long-term (two of three studies), medium-term (three of three), and short-term (three of three) outcomes (*29*,*30*,*104–107*). One of these six studies (*29*), plus 13 other descriptive studies (for a total of 14 studies), presented adolescents' or providers' views on facilitators for adolescent clients in using youth-friendly family planning services. Key factors described were confidentiality (13 of 14), accessibility (11 of 14), peer involvement (three of 14), parental or familial involvement (four of 14), and quality of provider interaction (11 of 14) (*105–121*). Four of these studies (*111*,*112*,*114*,*121*) plus one other descriptive study (*108*) described barriers to clinics adopting and implementing youth-friendly family planning services.

Potential consequences: Consequences might include increased use of reproductive health services by adolescents, improved contraceptive use, use of more effective methods, more consistent use of contraception, and reduced rates of teen pregnancy. It is also likely to lead to improved satisfaction with services and greater knowledge about pregnancy prevention among adolescents. It is possible that there will be higher costs, and some uncertainty regarding the benefits due to a relatively weak evidence base.

Rationale: Existing evidence has demonstrated the importance of specific characteristics to adolescents' attitudes and use of clinical services. The potential benefits of providing youth-friendly services outweigh the potential costs and weak evidence base. All five EWG members agreed to this recommendation. Some thought that it should be cast as an example of comprehensively client-centered care, rather than an end of its own.

Quality Improvement

Recommendation: Family planning programs should have a system for quality improvement, which is designed to review and strengthen the quality of services on an ongoing basis. Family planning programs should select, measure, and assess at least one outcome measure on an ongoing basis, for which the service site can be accountable.

Quality of evidence: A recent systematic review (*122*) was supplemented with 10 articles that provided information related to client and/or provider perspectives regarding what constitutes quality family planning services (*42–44*,*113*,*123–128*). These studies used a qualitative (k = 4) or cross-sectional (k = 6) study design. Ten descriptive studies identified client and provider perspectives on what constitutes quality family planning services, which include stigma and embarrassment reduction (n = 9), client access and convenience (n = 8); confidentiality (n = 3); efficiency and tailoring of services (n = 6); client autonomy and confidence (n = 5); contraceptive access and choice (n = 4); increased time of patient-provider interaction (n = 3); communication and relationship (n = 3); structure and facilities (n = 2); continuity of care (n = 2). Well-established frameworks for guiding quality improvement efforts were referenced (*122*,*129–132*).

Potential consequences: Consequences might include increased use by clients of more effective contraceptive methods, clients might be more likely to return for care, client satisfaction might improve, and there might be reduced rates of teen and unintended pregnancy, and improved spacing of births.

Rationale: Research, albeit limited, has demonstrated that quality services are associated with improved client experience with care and adoption of more protective contraceptive behavior. Further, these recommendations on quality improvement are consistent with those made by national leaders in the quality improvement field. Research is either under way or planned to validate a core set of performance measures, and the recommendations will be updated as new findings emerge. All five EWG members agreed to these recommendations.

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Appendix C

Principles for Providing Quality Counseling

Counseling is a process that enables clients to make and follow through on decisions. Education is an integral component of the counseling process that helps clients to make informed decisions. Providing quality counseling is an essential component of client-centered care.

Key principles of providing quality counseling are listed below and may be used when providing family planning services. The model was developed in consultation with the Technical Panel on Contraceptive Counseling and Education and reviewed by the Expert Work Group. Although developed specifically for providing contraceptive counseling, the principles are broad and can be applied to health counseling on other topics. Although the principles are listed here in a particular sequence, counseling is an iterative process, and at every point in the client encounter it is necessary to determine whether it is important to readdress and emphasize a given principle.

Principles of Quality Counseling

Principle 1. Establish and Maintain Rapport with the Client

Establishing and maintaining rapport with a client is vital to the encounter and achieving positive outcomes (*1*). This can begin by creating a welcoming environment and should continue through every stage of the client encounter, including follow-up. The contraceptive counseling literature indicates that counseling models that emphasized the quality of the interaction between client and provider have been associated with decreased teen pregnancy, increased contraceptive use, increased use of more effective methods, increased use of repeat or follow-up services, increased knowledge, and enhanced psychosocial determinants of contraceptive use (*2–5*) .

Principle 2. Assess the Client's Needs and Personalize Discussions Accordingly

Each visit should be tailored to the client's individual circumstances and needs. Clients come to family planning providers for various services and with varying needs. Standardized questions and assessment tools can help providers determine what services are most appropriate for a given visit (*6*). Contraceptive counseling studies that have incorporated standardized assessment tools during the counseling process have resulted in increased contraceptive use, increased correct use of contraceptives, and increased use of more effective methods (*2,7,8*). Contraceptive counseling studies that have personalized discussions to meet the individual needs of clients have been associated with increased contraceptive use, increased correct use of contraceptives, increased use of more effective methods, increased use of dual-method contraceptives to prevent both sexually transmitted diseases (STDs) and pregnancy, increased quality and satisfaction with services, increased knowledge, and enhanced psychosocial determinants of contraceptive use *(4,7,9–12)*.

Principle 3. Work with the Client Interactively to Establish a Plan

Working with a client interactively to establish a plan, including a plan for follow-up, is important. Establishing a plan should include setting goals, discussing possible difficulties with achieving goals, and developing action plans to deal with potential difficulties. The amount of time spent establishing a plan will differ depending on the client's purpose for the visit and health-care needs. A client plan that requires behavioral change should be made on the basis of the client's own goals, interests, and readiness for change (*13–15*). Use of computerized decision aids before the appointment can facilitate this process by providing a structured yet interactive framework for clients to analyze their available options systematically and to consider the personal importance of perceived advantages and disadvantages *(16,17)*. The contraceptive counseling literature indicates that counseling models that incorporated goal setting and development of action plans have been associated with increased contraceptive use, increased correct use of contraceptives, increased use of more effective methods, and increased knowledge *(2,9,18–20)*. Furthermore, contraceptive counseling models that incorporated follow-up contacts resulted in decreased teen pregnancy, increased contraceptive use, increased correct use of contraceptives, increased use of more effective methods, increased continuation of method use, increased use of dual-method contraceptives to prevent both STDs and pregnancy, increased use of repeat or follow-up services, increased knowledge, and enhanced psychosocial determinants of contraceptive use *(2,3,7,11,21,22)* . From the family planning education literature, computerized decision aids have helped clients formulate questions and have been associated with increased knowledge, selection of more effective methods, and increased continuation and compliance (*23–25*).

Principle 4. Provide Information That Can Be Understood and Retained by the Client

Clients need information that is medically accurate, balanced, and nonjudgmental to make informed decisions and follow through on developed plans. When speaking with clients or providing educational materials through any medium (e.g., written, audio/visual, or computer/web-based), the provider must present information in a manner that can be readily understood and retained by the client. Strategies for making information accessible to clients are provided (see Appendix D).

Principle 5. Confirm Client Understanding

It is important to ensure that clients have processed the information provided and discussed. One technique for confirming understanding is to have the client restate the most important messages in her or his own words. This teach-back method can increase the likelihood of the client and provider reaching a shared understanding, and has improved compliance with treatment plans and health outcomes *(26,27)*. Using the teach-back method early in the decision-making process will help ensure that a client has the opportunity to understand her or his options and is making informed choices (*28*).

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Appendix D

Contraceptive Effectiveness

Providers should counsel clients about the effectiveness of different contraceptive methods. Method effectiveness is measured as the percentage of women experiencing an unintended pregnancy during the first year of use, and is estimated for both typical and perfect use (Table).

TABLE. Percentage of women experiencing an unintended pregnancy during the first year of typical use* and the first year of perfect use† of contraception and the percentage continuing use at the end of the first year — United States

Method	% of women experiencing an unintended pregnancy within the first year of use		% of women continuing use at 1 year§
	Typical use	Perfect use	
No method¶	85.0	85.0	
Spermicides**	28.0	18.0	42.0
Fertility awareness-based methods	24.0		47.0
Standard days method††		5.0	
2-day method††		4.0	
Ovulation method††		3.0	
Symptothermal method		0.4	
Withdrawal	22.0	4.0	46.0
Sponge			36.0
Parous women	24.0	20.0	
Nulliparous women	12.0	9.0	
Condom§§			
Female	21.0	5.0	41.0
Male	18.0	2.0	43.0
Diaphragm¶¶	12.0	6.0	57.0
Combined pill and progestin-only pill	9.0	0.3	67.0
Evra patch	9.0	0.3	67.0
NuvaRing	9.0	0.3	67.0
Depo-Provera	6.0	0.2	56.0
Intrauterine contraceptives			
ParaGard (copper T)	0.8	0.6	78.0
Mirena (LNG)	0.2	0.2	80.0
Implanon	0.05	0.05	84.0
Female sterilization	0.5	0.5	100.0
Male sterilization	0.15	0.1	100.0

Emergency Contraceptives: Emergency contraceptive pills or insertion of a copper intrauterine contraceptive after unprotected intercourse substantially reduces the risk of pregnancy.***
Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.†††
Source: Adapted from Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M, eds. Contraceptive technology: 20th revised ed. New York, NY: Ardent Media; 2011.

* Among typical couples who initiate use of a method (not necessarily for the first time), the percentage of couples who experience an accidental pregnancy during the first year if they do not stop use for any other reason. Estimates of the probability of pregnancy during the first year of typical use for spermicides and the diaphragm are taken from the 1995 National Survey of Family Growth corrected for underreporting of abortion; estimates for fertility awareness-based methods, withdrawal, the male condom, the pill, and Depo-Provera are taken from the 1995 and 2002 National Survey of Family Growth corrected for underreporting of abortion. See the text for the derivation of estimates for the other methods.

† Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), the percentage of couples who experience an accidental pregnancy during the first year if they do not stop use for any other reason. See the text for the derivation of the estimate for each method.

§ Among couples attempting to avoid pregnancy, the percentage of couples who continue to use a method for 1 year.

¶ The percentages becoming pregnant in columns labeled "typical use" and "perfect use" are based on data from populations in which contraception is not used and from women who cease using contraception to become pregnant. Among such populations, approximately 89% become pregnant within 1 year. This estimate was lowered slightly (to 85%) to represent the percentage of women who would become pregnant within 1 year among women now relying on reversible methods of contraception if they abandoned contraception altogether.

** Foams, creams, gels, vaginal suppositories, and vaginal film.

†† The Ovulation and 2-day methods are based on evaluation of cervical mucus. The Standard Days method avoids intercourse on cycle days 8 through 19. The Symptothermal method is a double-check method based on evaluation of cervical mucus to determine the first fertile day and evaluation of cervical mucus and temperature to determine the last fertile day.

§§ Without spermicides.

¶¶ With spermicidal cream or jelly.

*** Ella, Plan B One-Step, and Next Choice are the only dedicated products specifically marketed for emergency contraception. The label for Plan B One-Step (1 dose is 1 white pill) says to take the pill within 72 hours after unprotected intercourse. Research has indicated that all of the brands listed here are effective when used within 120 hours after unprotected intercourse. The label for Next Choice (1 dose is 1 peach pill) says to take one pill within 72 hours after unprotected intercourse and another pill 12 hours later. Research has indicated that that both pills can be taken at the same time with no decrease in efficacy or increase in side effects and that they are effective when used within 120 hours after unprotected intercourse. The Food and Drug Administration has in addition declared the following 19 brands of oral contraceptives to be safe and effective for emergency contraception: Ogestrel (1 dose is 2 white pills), Nordette (1 dose is 4 light-orange pills), Cryselle, Levora, Low-Ogestrel, Lo/Ovral, or Quasence (1 dose is 4 white pills), Jolessa, Portia, Seasonale or Trivora (1 dose is 4 pink pills), Seasonique (1 dose is 4 light-blue-green pills), Enpresse (1 dose is 4 orange pills), Lessina (1 dose is 5 pink pills), Aviane or LoSeasonique (one dose is 5 orange pills), Lutera or Sronyx (1 dose is 5 white pills), and Lybrel (1 dose is 6 yellow pills).

††† However, for effective protection against pregnancy to be maintained, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches age 6 months.

Appendix E

Strategies for Providing Information to Clients

The client should receive and understand the information she or he needs to make informed decisions and follow treatment plans. This requires careful attention to how information is communicated. The following strategies can make information more readily comprehensible to clients:

Strategies for Providing Information to Clients

Educational materials should be provided that are clear and easy to understand. Educational materials delivered through any one of a variety of media (for example, written, audio/visual, computer/web-based) need to be presented in a format that is clear and easy to interpret by clients with a 4th to 6th grade reading level (*1*–*3*). Many adults have only a basic ability to obtain, process, and understand health information necessary to make decisions about their health (*4*). Making easy-to-access materials enhances informed decision-making (*1*–*3*). Test all educational materials with the intended audiences for clarity and comprehension before wide-scale use.

The following evidence-based tools provide recommendations for increasing the accessibility of materials through careful consideration of content, organization, formatting, and writing style:

- Health Literacy Universal Precautions Toolkit, provided by the Agency for Healthcare Research and Quality (available at http://www.ahrq.gov/qual/literacy),
- Toolkit for Making Written Material Clear and Effective, provided by the Centers for Medicare and Medicaid Services (available at http://www.cms.gov/WrittenMaterialsToolkit), and
- Health Literacy Online, provided by the Office of Disease Prevention and Health Promotion (available at http://www.health.gov/healthliteracyonline).

Information should be delivered in a manner that is culturally and linguistically appropriate. In presenting information it is important to be sensitive to the client's cultural and linguistic preferences (*5*,*6*). Ideally information should be presented in the client's primary language, but translations and interpretation services should be available when necessary. Information presented must also be culturally appropriate, reflecting the client's beliefs, ethnic background, and cultural practices. Tools for addressing cultural and linguistic differences and preferences include

- Health Literacy Universal Precautions Toolkit, provided by the Agency for Healthcare Research and Quality (available at http://www.ahrq.gov/qual/literacy), and
- Toolkit for Making Written Material Clear and Effective, Part 11; Understanding and using the "Toolkit Guidelines for Culturally Appropriate Translation," provided by the Centers for Medicare and Medicaid Services (available at http://www.cms.gov/outreach-and-education/outreach/writtenmaterialstoolkit/downloads/toolkitpart11.pdf).

The amount of information presented should be limited and emphasize essential points. Providers should focus on needs and knowledge gaps identified during the assessment. Many clients immediately forget or remember incorrectly much of the information provided. This problem is exacerbated as more information is presented (*7*–*9*). Limiting the amount of information presented and highlighting important facts by presenting them first improves comprehension (*10*–*14*).

Numeric quantities should be communicated in a way that is easily understood. Whenever possible, providers should use natural frequencies and common denominators (for example, 85 of 100 sexually active women are likely to get pregnant within 1 year using no contraceptive, as compared with 1 in 100 using an IUD or implant), and display quantities in graphs and visuals. Providers also should avoid using verbal descriptors without numeric quantities (for example, sexually active women using an IUD or implant almost never become pregnant). Finally, they should quantify risk in absolute rather than relative terms (for example, "the chance of unintended pregnancy is reduced from 8 in 100 to 1 in 100 by switching from oral contraceptives to an IUD" versus the chance of unintended pregnancy is reduced by 87%). Numeracy is more highly correlated with health outcomes than the ability to read or listen effectively (*15*). The strategies listed above can help clients interpret numeric quantities correctly (*16*–*28*).

Balanced information on risks and benefits should be presented and messages framed positively. In addition to discussing risks, contraindications, and warnings, providers should discuss the advantages and benefits of contraception. In presenting this information, providers should express risks and benefits in a common format (for example, do not present risks in relative terms and benefits in absolute terms), and frame messages in positive terms (for example "99 out of 100 women find this a safe method with no side effects," versus "1 out of 100 women experience noticeable side effects"). Many clients prefer to receive a balance of information on risks and benefits (*29*), and using a common format avoids bias in presentation of information (*18*,*22*,*26*,*30*). Framing messages positively increases acceptance and comprehension (*18*,*22*,*31*,*32*).

Active client engagement should be encouraged. Providers should use educational materials that encourage active information processing (e.g., questions, quizzes, fill-in-the-blank, web-based games, and activities). In addition, they should be sure the client has an opportunity to discuss the information provided, and when speaking with a client, providers should engage her or him actively. Research has indicated that interactive materials improve knowledge of contraceptive risks, benefits, and correct method use (*33*–*35*). Clients also value spoken information (*29*,*36*); and educational materials, when delivered by a provider, more effectively increase knowledge (*10*,*37*). In particular, presenting information in a question and answer format is more effective than simply presenting the information (*10*,*15*,*37*–*41*).

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Appendix F

Screening Services For Which Evidence Does Not Support Screening

The following services have been given a D recommendation from the U.S. Preventive Services Task Force (USPSTF), which indicates that the potential harms of routine screening outweigh the benefits. Providers should not perform these screening services.

The USPSTF has recommended against offering the following services to women and men:

- **Asymptomatic bacteriuria:** USPSTF recommends against screening for asymptomatic bacteriuria in men and nonpregnant women (*1*).
- **Gonorrhea:** USPSTF recommends against routine screening for gonorrhea infection in men and women who are at low risk of infection (*2*).
- **Hepatitis B:** USPSTF recommends against routinely screening the general asymptomatic population for chronic hepatitis B virus infection (*3*).
- **Herpes simplex virus (HSV):** USPSTF recommends against routine serological screening for HSV in asymptomatic adolescents and adults (*4*).
- **Syphilis:** USPSTF recommends against screening of asymptomatic persons who are not at increased risk of syphilis infection (*5*).

The USPSTF has recommended against offering the following services to women:

- **BRCA mutation testing for breast and ovarian cancer susceptibility:** USPSTF recommends against routine referral for genetic counseling or routine breast cancer susceptibility gene (BRCA) testing for women whose family history is not associated with an increased risk of deleterious mutations in breast cancer susceptibility gene 1 (BRCA1) or breast cancer susceptibility gene 2 (BRCA2) (*6*). However, USPSTF continues to recommend that women whose family history is associated with an increased risk of deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.
- **Breast self-examination:** USPSTF recommends against teaching breast self-examination (*7*).
- **Cervical cytology:** USPSTF recommends against routine screening for cervical cancer with cytology (Pap smear) in the following groups: women aged <21 years, women aged >65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer, women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia grade 2 or 3) or cervical cancer. USPSTF recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology, in women aged <30 years (*8*).
- **Ovarian cancer:** USPSTF recommends against routine screening for ovarian cancer (*9*).

The USPSTF has recommended against offering the following services to men:

- **Prostate cancer:** USPSTF recommends against prostate-specific antigen (PSA)-based screening for prostate cancer (*10*).
- **Testicular cancer:** USPSTF recommends against screening for testicular cancer in adolescent or adult males (*11*).

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Lead Authors

Loretta Gavin, PhD, Division of Reproductive Health, CDC
Susan Moskosky, MS, Office of Population Affairs, CDC

Systematic Review Authors and Presenters

Anna Brittain, MHS, Division of Reproductive Health, CDC
Marion Carter, PhD, Division of Reproductive Health, CDC
Kathryn Curtis, PhD, Division of Reproductive Health, CDC
Emily Godfrey, MD, Division of Reproductive Health, CDC
Arik V. Marcell, MD, The Johns Hopkins University and the Male Training Center
Cassondra Marshall, MPH, Division of Reproductive Health, CDC
Karen Pazol, PhD, Division of Reproductive Health, CDC
Naomi Tepper, MD, Division of Reproductive Health, CDC
Marie Tiller, PhD, MANILA Consulting Group, Inc.
Stephen Tregear, DPhil, MANILA Consulting Group, Inc.
Michelle Tregear, PhD, MANILA Consulting Group, Inc.
Jessica Williams, MPH, MANILA Consulting Group, Inc.
Lauren Zapata, PhD, Division of Reproductive Health, CDC

Expert Work Group

Courtney Benedict, MSN, Marin Community Clinics
Jan Chapin, MPH, American College of Obstetricians and Gynecologists
Clare Coleman, President and CEO, National Family Planning and Reproductive Health Association
Vanessa Cullins, MD, Planned Parenthood Federation of America
Daryn Eikner, MS, Family Planning Council
Jule Hallerdin, MN, Advisor to the Office of Population Affairs
Mark Hathaway, MD, Unity Health Care and Washington Hospital Center
Seiji Hayashi, MD, Bureau of Primary Health Care, Health Resources and Services Administration
Beth Jordan, MD, Association of Reproductive Health Professionals
Ann Loeffler, MSPH, John Snow Research and Training Institute
Arik V. Marcell, MD, The Johns Hopkins University and the Male Training Center
Tom Miller, MD, Alabama Department of Health
Deborah Nucatola, MD, Planned Parenthood Federation of America
Michael Policar, MD, State of California and UCSF Bixby Center
Adrienne Stith-Butler, PhD, Keck Center of the National Academies
Denise Wheeler, ARNP, Iowa Department of Public Health
Gayla Winston, MPH, Indiana Family Health Council
Jacki Witt, MSN, Clinical Training Center for Family Planning, University of Missouri—Kansas City
Jamal Gwathney, MD, Bureau of Primary Health Care, Health Resources and Services Administration

Technical Panel on Women's Clinical Services

Courtney Benedict, MSN, Marin Community Clinics
Janet Chapin, MPH, American College of Obstetricians and Gynecologists
Elizabeth DeSantis, MSN, South Carolina Department of Health and Environmental Control
Linda Dominguez, CNP, Southwest Women's Health
Eileen Dunne, MD, Division of STD Prevention, CDC
Jamal K. Gwathney, MD, Bureau of Primary Health Care, Health Resources and Services Administration
Jule Hallerdin, Consultant Advisor
Mark Hathaway, MD, Washington Hospital Center
Arik V. Marcell, MD, Johns Hopkins University and the Male Training Center
Cheri Moran, University of Illinois Medical Center at Chicago
Deborah Nucatola, MD, Planned Parenthood Federation of America
Michael Policar, MD, Family PACT Program - California State Office of Family Planning
Pablo Rodriguez, MD, Women's Care Inc., Providence Office
Denise Wheeler, ARNP, Iowa Department of Public Health
Jacki Witt, MSN, Clinical Training Center for Family Planning, University of Missouri—Kansas City

Technical on Men's Clinical Services

Linda Creegan, FNP, California STD/HIV Prevention Training Center
Dennis Fortenberry, MD, Indiana University School of Medicine
Emily Godfrey, MD, University of Illinois at Chicago
Wendy Grube, PhD, University of Pennsylvania School of Nursing
Arik V. Marcell, MD, The Johns Hopkins University and the Male Training Center
Elissa Meites, MD, Division of STD Prevention, CDC
Anne Rompalo, MD, Johns Hopkins University
Thomas Walsh, MD, University of Washington Medical Center
Jacki Witt, MSN, Clinical Training Center for Family Planning, University of Missouri—Kansas City
Sandra Wolf, MD, Women's Care Center, Philadelphia

Technical Panel on Adolescents

Claire Brindis, DrPH, University of California, San Francisco
Gale Burstein, MD, SUNY at Buffalo School of Medicine and Biomedical Sciences, Department of Pediatrics
Laura Davis, MA, Advocates for Youth
Patricia J. Dittus, PhD, Division of STD Prevention, CDC
Paula Duncan, MD, University of Vermont College of Medicine
Carol Ford, MD, The Children's Hospital of Philadelphia
Melissa Gilliam, MD, The University of Chicago
Mark Hathaway, MD, Unity Health Care & Washington Hospital Center
Deborah Kaplan, PhD, New York City Department of Health and Mental Hygiene
Arik V. Marcell, MD, The Johns Hopkins University and the Male Training Center
Brent C. Miller, PhD, Utah State University
Elizabeth M. Ozer, PhD, Division of Adolescent Medicine, University of California, San Francisco
John Santelli, MD, Columbia University, Mailman School of Public Health

Technical Panel on Counseling and Education

Beth Barnet, MD, University of Maryland
Betty Chewning, PhD, University of Wisconsin School of Pharmacy
Christine Dehlendorf, MD, University of California, San Francisco
Linda Dominguez, CNP, Southwest Women's Health
Jillian Henderson, PhD, University of California, San Francisco
James Jaccard, PhD, New York University
Beth Jordan, MD, Association of Reproductive Health Professionals—East
David Kaplan, PhD, American Counseling Association
Alicia Luchowski, American Congress of Obstetricians and Gynecologists
Merry-K Moos, FNP, University of North Carolina at Chapel Hill
Patricia Murphy, DrPH, University of Utah College of Nursing
Elizabeth O'Connor, PhD, Kaiser Permanente Center for Health Research
Jeff Peipert, MD, Washington University in St. Louis

Technical Panel on Quality Improvement

Davida Becker, PhD, Bixby Center for Global Reproductive Health University of California, San Francisco
Peter Briss, MD, National Center for Chronic Disease Prevention and Health Promotion, CDC
Denise Dougherty, PhD, Agency for Healthcare Research and Quality
Daryn Eikner, MS, Family Planning Council
Christina I. Fowler, PhD, RTI International
Evelyn Glass, MSPH, Consultant Advisor
Yvonne Hamby, MPH, Regional Quality Improvement and Infertility Prevention Programs
A. Seiji Hayashi, MD, Bureau of Primary Health Care, Health Resources and Services Administration
Michael D. Kogan, PhD, Health Resources and Services Administration /Maternal and Child Health Bureau
Tom Miller, MD, Alabama Department of Health
Sam Posner, PhD, National Center for Chronic Disease Prevention and Health Promotion, CDC
Donna Strobino, PhD, Johns Hopkins University
Amy Tsui, PhD, Johns Hopkins Bloomberg School of Public Health
Reva Winkler, MD, National Quality Forum

Adivsors on Community Outreach and Participation*

Paula Baraitser, MBBS, Kings College Hospital NHS Foundation Trust/Health Protection Agency
Joy Baynes, MPH, Advocates for Youth
Diane Chamberlain, California Family Health Council
Clare Coleman, National Family Planning & Reproductive Health Association
Emily Godfrey, MD, University of North Carolina and Division of Reproductive Health, CDC
Rachel Gold, MPA, Guttmacher Institute
Rachel Kachur, MPH, Division of STD Prevention, CDC
Michelle Kegler, PhD, Rollins School of Public Health, Emory
Eleanor McLellan-Lemal, PhD, Division of HIV/AIDS Prevention, CDC
Paula Parker-Sawyers, National Campaign to Prevent Teen and Unplanned Pregnancy
Denise Wheeler, MS, Iowa Department of Public Health
Gayla Winston, MPH, Indiana Family Health Council, Inc.

CDC and Office of Population Affairs Reviewers

Wanda Barfield, MD, Division of Reproductive Health, CDC
Gail Bolan, MD, Division of STD Prevention, CDC
Linda Dahlberg, PhD, Division of Violence Prevention, CDC
Patricia Dietz, PhD, Division of Reproductive Health, CDC
Sherry Farr, PhD, Division of Reproductive Health, CDC
Evelyn Glass, MSPH, Office of Population Affairs
Tamara Haegerich, PhD, Division of Violence Prevention, CDC
David Johnson, MPH, Office of Population Affairs
Pamela Kania, MS, Office of Population Affairs
Marilyn Keefe, MPH, Deputy Assistant Secretary for Population Affairs
Dmitry Kissin, MD, Division of Reproductive Health, CDC
Nancy Mautone-Smith, MSW, Office of Population Affairs
Jacqueline Miller, MD, Division of Cancer Prevention and Control, CDC
Sam Posner, PhD, National Center for Chronic Disease and Health Promotion, CDC
Cheryl Robbins, PhD, Division of Reproductive Health, CDC
Lance Rodewald, MD, Division of Immunization Services, CDC
Mona Saraiya, MD, Division of Cancer Prevention and Control, CDC
Van Tong, MPH, Division of Reproductive Health, CDC
Lee Warner, PhD, Division of Reproductive Health, CDC
Kim Workowski, MD, Division of STD Prevention, CDC

External Reviewers

Paula Braverman, MD, Department of Pediatrics at the University of Cincinnati
Claire Brindis, DrPH, University of California–San Francisco
Sarah Brown, MPH, National Campaign to Prevent Teen and Unplanned Pregnancy
Marji Gold, MD, Albert Einstein School of Medicine
Milton Kotelchuck, PhD, Massachusetts General Hospital for Children and Harvard Medical School
David Levine, MD, Morehouse School of Medicine
Pamela Murray, MD, West Virginia University School of Medicine

Competing interests for the development of these guidelines were not assessed.

*These persons made important contributions to a discussion about community outreach and participation. A decision was made to narrow the focus of this report to clinical services, so recommendations informed by the input of these persons will be published separately.

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ISSN: 1057-5987