

**Providing Quality Family Planning Services:
Recommendations of the CDC and
The US Office of Population Affairs
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Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Welcome to today's webinar on the national launch of Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs. My name is Nancy Mautone-Smith, and I'm a public health advisor from the Office of Population Affairs, and I will be moderating today's webinar. As you can see on this slide, we have a distinguished panel of speakers here to talk about the new MMWR, Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. Today's webinar will start with opening remarks from Dr. Howard Koh, Assistant Secretary for Health at the U.S. Department of Health and Human Services, and then we will have comments from some key stakeholders. We will then have two speakers who will provide us with an overview of the QFP, and then we'll have some time to answer questions. So let's get started.

It's my great privilege to introduce our first speaker, Dr. Howard Koh. Dr. Koh serves at the 14th Assistant Secretary for Health for the U.S. Department of Health and Human Services. Dr. Koh was nominated by President Barack Obama and confirmed by the US Senate in 2009. He oversees 12 core public health offices including the Office of the Surgeon General and the US Public Health Service Commission Corps, 10 regional offices across the nation and 10 presidential and secretarial advisory committees. He also serves as the Senior Public Health Advisor to the Secretary. The office of the Assistant Secretary for health implements an array of interdisciplinary programs relating to disease prevention, health promotion, the reduction of health disparities, women's and minority health, adolescent health, HIV/AIDS and chronic infectious diseases, vaccine programs, fitness, sports and nutrition, bioethics, population affairs, blood supply, research integrity and human research protections.

As the Assistant Secretary for Health, Dr. Koh is dedicated to the mission of creating better public health systems for prevention and care so that all people can reach their highest attainable standard of health. Dr. Koh previously served as the Harvey V. Fineberg Professor of the Practice of Public Health, Associate Dean for Public Health Practice and Director of the Division of Public Health Practice at the Harvard School of Public Health. Dr. Koh served as Commissioner of Public Health for the Commonwealth of Massachusetts from 1997 to 2003, after being appointed by Governor William Weld. As Commissioner, Dr. Koh led the Massachusetts Department of Public Health, which included a wide range of health services four hospitals and a staff of more than 3,000 professionals. Welcome, Dr. Koh.

Howard K. Koh, MD, MPH – Assistant Secretary of Health – U.S. Department of Health & Human Services

Nancy, thank you so much and welcome everyone. I am absolutely delighted to be on this webinar and to thank all of you for joining and showing your interest in these new Quality Family Planning Services guidelines. So let me start by thanking our extraordinary Office of Population Affairs and Sue Moskosky and her wonderful team and also our great colleagues from the CDC, Dr. Wanda Barfield and her team. Welcome all of you and also thank our colleagues from HRSA and ACOG for being on this webinar.

Almost every individual will at one point have to address the issue of whether they want to have children and when. And ideally, those pregnancies will be planned, which will increase the chances that children will be healthy and have the support they need to thrive through childhood into adolescence. Now it is long known that access to family planning services leads to healthier birth outcomes for women, infants and families. But in the era of health reform, we're talking a lot about quality of care and quality of services, so now we're very pleased to share the release of new guidelines that address the quality of

family planning services delivery. These new family planning guidelines, QFP for short, are designed to help individuals and couples achieve the desired number and spacing of healthy children. And HHS, as you will hear, is committed, like you, to making family planning integrated as part of a quality healthcare in the era of health reform for millions of men and women of reproductive age.

And we also want to help providers of family planning services both within the Title X network and in the broader field of primary care learn about and implement these recommendations having to do with improving quality. So this is really a critical moment. This is the point where we celebrate many months, if not years, of work to get to this point. And I just want to thank everybody for being part of this very important release and I'll turn it back to Nancy. You're going to have a really fascinating webinar, and thank you so much everyone for being a part of this historic launch.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you so much, Dr. Koh, for your comments. Our next speaker is Dr. Michael Lu. Dr. Lu was named Associate Administrator of the Maternal and Child Health Bureau of Health Resources and Services Administration, HRSA, within the U.S. Department of Health and Human Services on November 3, 2011. Dr. Lu joined HRSA from the University of California Los Angeles School of Medicine and Public Health, where he was associate professor of obstetrics, gynecology and public health. He brings years of experience in maternal and child health research, practice, and policy to his post at HRSA.

Prior to his appointment, Dr. Lu chaired the Secretary's Advisory Committee on Infant Mortality. He has served on two Institute of Medicine committees, the Committee on Understanding Premature Birth and Assuring Health Outcomes and the Committee to Re-examine IOM Pregnancy Weight Guidelines and the Centers for Disease Control and Prevention select panel on Preconception Care. While at UCLA, Dr. Lu was a lead investigator for the National Children's Study and led a project to monitor and improve the quality of safety of maternity care in California. He was best known for his research on racial, ethnic disparities in birth outcomes and his leadership on life course.

Dr. Lu taught obstetrics and gynecology at the David Geffen School of Medicine at UCLA and Maternal and Child Health at UCLA School of Public Health. He has received numerous awards for his teaching including excellence in teaching awards from the Association of Professors of Gynecology and Obstetrics. As an obstetrician, Dr. Lu has attended over 1,000 births and has been voted one of the best doctors in America since 2005. Welcome, Dr. Lu.

Michael Lu, MD, MS, MPH – Associate Administrator, Maternal and Child Health Bureau – Human Resources and Services Administration

Thank you, Nancy. Let me start by thanking the CDC and the Office of Population Affairs for their tremendous leadership. And I want to give a special shout out to Wanda and Sue and all the co-authors and staff at CDC and OPA for this really important report. The recommendations contained in this report are going to raise the bar on the Quality for Family Planning Services and I'm grateful for the opportunity to provide input throughout the process and to provide a few remarks for this webinar.

Now, as Nancy mentioned, I run a bureau that's responsible for the health of all of America's mothers, children and families and I believe that these recommendations can be a game changer not only for family planning, but for maternal and child health for three reasons. First, quality family planning is critical to maternal and child health. Now, I don't need to tell this audience just how important family planning is to maternal and child health, about the negative impact of unintended pregnancies, teen pregnancies, sexually transmitted infections and so forth on birth outcomes and on long-term child and family health. This report can assist the 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.

Second, QFP takes an important step forward by defining family planning to include preconception and inter-conception health. Now, as you all know, a growing body of scientific evidence suggests that if we are to improve maternal and child health in the country, we have to start by improving men and women's health before pregnancy. The recommendations address important preconception health services such as reproductive life planning, medical history, intimate partner violence, tobacco, alcohol, drug use, depression, promotion of immunization, management of chronic conditions such as overweight and obesity, hypertension and diabetes.

The time when a woman and man is seeking to prevent or achieve pregnancy is the optimal time to reach them with these services. For those of you, you're providing family planning services either through the network of 4,000 Title X clinics around the nation or in public and private primary care practice, you are often in a better position to provide preconception care than most of our programs are. We often don't see our clients until they get pregnant, but you have a unique opportunity to improve men and women's health before pregnancy through quality family planning.

And, lastly, let me just say these recommendations really strengthen the connection between the world of family planning and maternal and child health service providers. There has traditionally been this divide between MCH and family planning, between Title V and Title X. I'm really here to say no more, it's time we bridge this divide. We need you to help improve maternal and child health in this country as much as you need us to help you promote family planning. It's time we normalize family planning in everything we do in maternal and child health. QFP is the first step in bridging the two worlds; these guidelines will be of great help to our programs such as Healthy Start and Home Visiting and promoting quality family planning and HRSA and the Maternal and Child Health Bureau is committed to support the widespread dissemination and uptake of QFF. So with that, let me turn it back to you, Nancy.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you very much, Dr. Lu. Next, I would like to introduce Dr. Laura Makaroff. Dr. Makaroff is the Senior Clinical Advisor for the Office of Quality and Data, Bureau of Primary Health Care at the Health Resources and Services Administration. In this role, she provides clinical leadership for the Bureau's Clinical Quality Strategy, including patient-centered medical home transformation, clinical quality measures and electronic health records implementation for the nation's community health centers.

Prior to coming to HRSA, Dr. Makaroff was the Robert L. Phillips Primary Care Health Policy Fellow at Georgetown University. She completed her residency in family medicine at the University of Colorado and spent five years in solo practice in a recognized medical home prior to her fellowship. Dr. Makaroff continues to practice clinical medicine at a federally qualified health center in the District of Columbia. Dr. Makaroff?

Laura Makaroff, DO – Senior Clinical Advisor, Office of Quality and Data, Bureau of Primary Health Care – Human Resources and Services Administration

Thank you. Thank you so much for being here today. On behalf of our Associate Administrator, Jim Macrea, and our Chief Medical Officer, Dr. Seiji Hayashi, welcome to this important webinar. It is really our pleasure to be with you today and join my federal colleagues in supporting this important initiative. I am a senior clinical advisor for the health center program and also a family physician. So I'm deeply thankful for these new guidelines and for the opportunity to improve our patient's experiences in accessing quality family planning services.

Community health centers and the primary care provider's work within them see more than 21 million patients a year. Many of whom need family planning services, whether that is their reason for visiting the health center or not. The mission of the health center program remains focused on improving access to

comprehensive, high quality primary care services for vulnerable and underserved populations. Quality Family Planning Services recognizes the need to address preventive care in a more holistic and comprehensive manner. QFP also recognizes that services need to be of high quality in order to have an impact on health outcomes and helps define what quality means in a family planning visit.

These guidelines will be great help to community health centers, their providers and patients. HRSA and the Bureau of Primary Health Care is delighted to support the widespread dissemination and uptake of QFP and we look forward to working with all you. Thank you again to the CDC and OPA for your leadership in this area and thank you all for joining us today and for your continued efforts in providing high quality comprehensive QFP.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you, Dr. Makaroff. Now we'll hear from Janet Chapin from the American Congress of Obstetricians and Gynecologists. Ms. Chapin is the Senior Director of the Office of Global Women's Health and Special Issues in Women's Health at the American College of Obstetricians and Gynecologists, ACOG. Her primary responsibilities include global women's health and other special issues and projects such as LARC, fetal and infant mortality review, American Indian, Alaskan native women's health, maternal mortality and morbidity and other public health activities.

Before coming to ACOG in 1986, she initiated and operated a community-based high blood pressure control program at a rural community health center and managed the primary care program of the West Virginia Department of Health. Miss Chapin also served as a member of the expert work group that advised OPA and CDC throughout the process of developing these recommendations. Miss Chapin?

Janet Chapin, RN, MPH – Director, Global Women's Health & Special Issues in Women's Health – American Congress of Obstetricians and Gynecologists

Hi. This is a really exciting event, I think, and on behalf of the American College and the American Congress, which are the same organization, and it's over 58,000 members in the US. I want to begin by not just supporting the release and the content of providing quality family planning services, but applauding the process that was used to develop it. This was a phenomenal effort done really exceedingly well. The process was rigorous, it was inclusive, and all points of view were examined and given respect. But in the end, it was the evidence for specific services and practices that was clearly identified and based – the guidelines were based on that.

There were a lot of individuals representing a lot of organizations who participated and ACOG was particularly pleased to be included both on the guidance panel as well as some of the other panels. And many of our members and some of our staff served on workgroups. And I want to add my congratulations and thanks to Susan and the folks at OPA, and Wanda and Lori and Kate at CDC, particularly because without their efforts none of this would have happened. The leadership they provided really, really made the recommendations happen and made – gave us a product that everybody can use and be proud of.

The main points I think that we would like to make in support of the guidelines is, first of all, that as other people have said, helping women and couples achieve the desired timing and spacing for pregnancies and birth, as well as the number of children they want to have, is a fundamental part of preventive care and a fundamental responsibility for healthcare providers, not just family planning clinics, not just obstetrician, gynecologists, but all healthcare providers. I like to put the importance of family planning services in the global women's health context because globally, at least one-third of the maternal deaths could be prevented if women had access to family planning.

In the last year, ACOG's President, Jeanne Conry, used the mantra, "every woman, every time." And for her, this meant that for every woman at every encounter in our healthcare delivery system, providers need

to provide the help that she needs to achieve optimal healthcare and wellness in the context of her reproductive choices. These new guidelines embody that concept. They place family planning services squarely or actually if you look at the diagram on page three roundly, in the context of preventative care. And the clinical pathway for family planning on page four of the document can apply to any primary care provider for women in any setting.

Secondly, at the same time the guidelines clearly specify the services that should be offered as family planning both for preventing pregnancy as well as for those women who are seeking to have a child. That delineation and that specification critical to Title X programs is also useful to other women's healthcare providers, including OB/GYNs. And by basing the clinical guidelines on the medical eligibility criteria, which is also endorsed by ACOG, we can really now say that in the US we have a widely approved, consistent set of clinical family planning guidelines that can be used by all providers.

ACOG, like Dr. Lu, is also pleased to see the inclusion of preconception and interconception counseling in the guidelines. Because we think this is an important part of preventative care, assisting a woman to achieve optimal healthcare before she is pregnant and it's applicable to women who wish to become pregnant or don't wish to become pregnant. This will improve, I think, the quality – the guidelines will improve the quality of reproductive health care. And the other very important point about them is they're going to be – they're designed so they can be rapidly updated to incorporate new evidence, which is going to really help all the providers of family planning stay current.

The third point I want to make is that the guidelines include very specific descriptions of how to provide effective services. And even again, as those are targeted to Title X providers, I think they're going to be useful to any provider in any busy practice. And to that note regarding all those three points, ACOG really will support the efforts to disseminate and implement the recommendations of the guidelines in any way we can. I've already, I think, indicated that there are sections of the document that we think will be useful to our fellows and we'll work to inform OB/GYNs about those. But perhaps more importantly, we'll be able to, because the clarity and precision, the consistency, the evidence-base practice included in the guidelines, we will be able to, and our members will be able to advocate for Title X programs – the Title X program in general and the clinics in their community.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you, Miss Chapin. Next Dr. Wanda Barfield and Miss Susan Moskosky will provide an overview of the QFP. Our first speaker will be Dr. Wanda Barfield. Dr. Barfield is a Captain in the U.S. Public Health Service and is the Director of the Division of Reproductive Health National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention. With a staff of over 180 members and a budget of approximately \$43 million dollars, she is responsible for promoting CDC's Safe Motherhood and Infant Health Initiative. The division's two priority areas include women's reproductive health, pregnancy health, infant health promotion and unintended pregnancy prevention. Dr. Barfield leads CDC's winnable battle on teen pregnancy prevention in collaboration with the President's Initiative on Teen Pregnancy Prevention under Health and Human Services Office of Adolescent Health and other federal partners.

Dr. Barfield received her medicine and public health degrees from Harvard University. She completed a pediatrics residency at Walter Reed Army Medical Center and a neonatal perinatal medicine fellowship at Harvard's joint program in neonatology. Prior to serving in the Public Health Service, she served in the U.S. Army as Director of the NICU at Madigan Army medical center in Tacoma, Washington. She is board certified in general pediatrics and neonatal/perinatal medicine and still provides care to critically ill newborns.

Our second speaker is Miss Susan Moskosky. Miss Moskosky serves as the Acting Director for the Office of Population Affairs, U.S. Department of Health and Human Services. She is responsible for management administrative operations of the Title X Family Planning Program as well as long-range planning, program and budget oversight and policy development. Ms. Moskosky joined the federal government as a regional program consultant for family planning in DHS Region 7, Kansas City, where she also served as the Region 7 Women's Health Coordinator.

Ms. Moskosky is a certified women's health nurse practitioner who spent the first 15 years of her professional career providing family planning, prenatal, and other preventative health services and educating nurse practitioner students for the Title X Family Planning Program. She was the Director of one of the five original Title X funded Women's Healthcare Advanced Nurse Practitioner programs at the University of Texas, Southwestern Medical Center at Dallas, Texas. Now I will turn things over to Dr. Barfield, who will begin the overview of QFP. Dr. Barfield?

Wanda D. Barfield, MD, MPH, FAAP – Director, Division of Reproductive Health – Centers for Disease Control and Prevention

Thank you. Preventing teen and unintended pregnancies are important public health priorities. More than 700,000 teens become pregnant every year, half of all pregnancies are unintended and only one-half of all pregnancies occur within the optimal spacing within 18 to 59 months of the previous birth. CDC has had a longstanding tradition of supporting the delivery of family planning services through the development of clinical guidelines, program evaluation and surveillance. And CDC will continue to support these efforts and are delighted to partner with OPA in the development of the QFP. I would just like to thank doctors Koh, Lu, Makaroff, Janet Chapin and their staff for their incredible support and collaboration in these efforts. These recommendations help family planning and primary care providers use the best evidence to provide the best care.

Now, the release of the QFP has occurred in the context of a renewed emphasis in the following areas. This includes increased access and this must be accompanied by improved quality, emphasis on accountability as health outcomes and an evidence-based approach, as well as standards that are needed on which to base performance measurements. We had the following – next slide, please. We had the following reasons for developing these recommendations. The intended audience is all providers of family planning services, including Title X grantees. And the key purposes are to define what services should be offered in a family planning visit and describe how to do so. Also, to support consistent application of quality care across settings and provider types and also to translate research into practice so that the most evidence-based approaches are used. Next slide, please.

This figure provides a visual image of how QFP is related to other guidelines, such as CDC's STD treatment guidelines, the medical eligibility criteria for contraception, as well as the selective practice recommendation. Now, QFP complements existing guidelines in two ways. First, it integrates existing guidelines that are appropriate for the use in the family planning setting. These guidelines are often used in a siloed, isolated manner, and we hope that integrating them into a combined set of guidelines appropriate for the family planning setting, will make them more accessible and useful to clinical providers.

QFP also goes one step further and fills gaps in existing guidelines. For example, QFP provides new recommendations about contraceptive counseling and shows how this can be integrated with any CNSPR. QFP also describes how to work with male clients about pregnancy prevention and how to address the special needs of adolescent clients. Other areas in which QFP makes unique contributions are in defining the range of services that should be offered in a family planning setting, emphasizing the role of helping clients achieve as well as prevent pregnancy, describing how to provide pregnancy testing and counseling

services, and highlighting the role that quality improvement can play in improving health outcomes. Next slide, please.

Both CDC and IOM are engaged in efforts to strengthen the process by which clinical guidelines are developed, and we tried our best to meet the standards published by the IOM in their 2011 report on trustworthy clinical guidelines. These efforts emphasized the use of evidence, to the extent possible, and complete transparency in the process of developing recommendations. Some of the things that are most noteworthy about the process we use are as follows. An expert workgroup with leaders in the field guided us through the entire process. Although CDC and OPA made final decisions, we relied heavily on the expert of the expert working group through all stages of development. They really helped us define the scope of guidelines, identify priority areas for systematic reviews in the literature, and helped interpret the evidence as well as provide feedback on draft recommendations. Their efforts were invaluable and I would like to really, truly thank them for their efforts.

We also conducted systematic literature reviews in four priority areas, counseling and education, adolescent services, quality improvement, and community education and outreach. There was also a comprehensive synthesis of existing clinical recommendations for medical professional associations as well as federal agencies that helped to identify numerous inconsistencies and then developed a process for reconciling these inconsistencies. Our goal was to draw on existing recommendations, whenever possible, but also to fill important gaps. With the input from the expert working group, recommendations were developed after consideration of both the evidence and the potential harms and benefits of implementing the recommendations. We have made tremendous efforts to be fully transparent in the process and rationale for all recommendations. There are sections in the recommendations document itself that lay these issues out, and currently we're publishing an entire supplement in the American Journal of Preventative Medicine that will include the systematic reviews used to develop the recommendations. Next slide, please.

A central premise underpinning the guidance is that improved quality of care will lead to improved reproductive health outcomes, such as lower rates of teen and unintended pregnancy. Next slide, please. This slide, which I really like, shows how we conceptualize family planning service. A few things are worth noting. First, our definition of family planning services includes contraceptive services, pregnancy testing and counseling, services to help clients achieve pregnancy, basic infertility services, preconception health and STD services. Preconception health was included because in 2006 the CDC recommended that preconception health services be integrated into all primary care settings. We think that family planning includes planning for a healthy pregnancy. The family planning visit is an excellent time to reach women of reproductive age with preconception and other preventative services that improve women and men's health, regardless of their pregnancy intention.

Second, we identified a second tier of related preventative services, which are considered beneficial to reproductive health and appropriate to deliver in a family planning setting, but do not directly contribute to achieving or preventing pregnancy. Breast and cervical cancer screening are the key services for women. Other preventative health services such as colorectal or skin cancer screening are noted, but they are not described as priority areas in a family planning setting. Next slide.

This figure takes another key point in QFP, which is that we're trying to address the FP needs of all individuals who need services related to preventing or achieving pregnancy. On the left side of this diagram is a flow chart of services to be offered to clients who come to the service by seeking services related to preventing or achieving pregnancy. Once their initial request is addressed, the diagram shows that their need for STD, preconception and relative preventative health services should be assessed and appropriate services offered.

The right side of the diagram makes a point that clients who seek services for a reason unrelated to preventing or achieving pregnancy, should also be asked about their need for these services. For example, we hope that clients who come into primary care settings for acute care, other preventative services or chronic care management will be screened to see if they need services related to preventing or achieving pregnancy. We know that screening for family planning needs will not always be possible in the latter situation, but in many cases, it will. Next slide.

So at this point, I would just like to hand things over to Sue Moskosky, the Acting Director of the Office of Population Affairs, and also thank her and her staff for the wonderful collaboration on this effort. Sue?

Susan Moskosky, MS, WHNP-BC – Acting Director, Office of Population Affairs – Department of Health and Human Services

Thank you, Dr. Barfield. I'm now going to provide a brief overview of some of the key QFP recommendations regarding clinical services. So contraceptive services is the first of the family planning services addressed in the recommendations, there were very few existing recommendations for how to provide contraceptive services, so we think that this section is a unique contribution to the field. And in developing this section, we drew heavily on the literature reviews we had conducted as well as existing recommendations, particularly the MEC and SPR, as well as expert opinion from our expert workgroup. And key points in this section include removing medical barriers as a prerequisite to contraceptive provision, many of these services are actually important in their own right, but they're not necessary to provide before providing contraception safely. So for instance, pelvic exams are not routinely needed unless you are inserting IUD or fitting a diaphragm. Cervical cytology, while it might be important to provide, is not necessary as a prerequisite to providing contraception, as well as routine HIV screening.

Also in the document, we're urging providers to offer a full range of FDA approved methods, optimally on site. And to use an evidence informed counseling process, which is client-centered and includes information about contraceptive effectiveness. Providing quality counseling is an essential component of client-centered care and counseling is defined as 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 these informed decisions. The QFP outlines 5 key principles of quality counseling, listed on this slide, and these include establishing and maintaining rapport with the client, assessing the client's needs, working with the client interactively to establish a plan, providing information that can be understood and retained by the client, and finally, confirming client understanding. Although initially developed specific to the provision of contraceptive counseling, these principles are broad and can be applied to a variety of different family planning services.

In alignment with the principles of quality counseling just presented, the QFP also outlines five key steps in providing contraceptive services. These include, one, establishing and maintaining rapport with the client, two, obtaining clinical and social information from the client. Three, working with the client interactively to select the most effective and appropriate contraceptive method for him or her, four, conducting a physical assessment related to the contraceptive use when warranted. And fifth is providing the contraceptive method along with instructions about consistent and correct use, helping the client to develop a plan for using that selected method and for follow up and documenting client understanding.

I want to draw your attention to one of the components of this last step, which addresses confirming the client's understanding. And in QFP, we've suggested using the "teach-back method," which is a method that includes repeating back messages about risks and benefits and appropriate method use and follow up to confirm that the client has understood the information and then documenting that in the chart. And if done correctly, this can be used in place of what formerly many providers included in terms of a method specific consent form.

This next slide shows a chart from QFP that shows a broad range of contraceptive methods organized from top to bottom by how effectively the methods prevent pregnancy. So you can see the top tier methods include things like the implant and the intrauterine device as well as sterilization. This chart is based on Jim Trussel's work on contraceptive failure and it's also an adaptation of figures that have previously been published in *Contraceptive Technology* and by the World Health Organization. And QFP providers are encouraged to use a client-centered approach to counseling and this includes providing information about the effectiveness of contraceptive methods, so that clients are aware of the effectiveness when making decisions about what method to choose for them.

There are specific sections throughout the QFP that address key points regarding services for adolescents, and this includes recognizing that adolescents have unique needs and characteristics. And that providers should offer confidential services to adolescents as well as to observe all relevant state laws and legal obligations such as reporting or notification of things like child abuse or child molestation or sexual abuse. Also, that providers should encourage and promote parent-child communication about sexual and reproductive health, and that providers should provide comprehensive information about pregnancy prevention, including contraception as well as abstinence as the best choice for being 100% sure that pregnancy doesn't – or STDs don't occur. Finally, it includes providing information on long acting reversible contraceptives as safe and effective for many sexually active adolescents and that condoms – the use of condoms should be used to encourage the decrease the risk of STDs.

Pregnancy testing is the second family planning service that's described in QFP. And these recommendations note that pregnancy testing is a key reason that many patients first seek family planning services. And the visit should include discussion of reproductive life plan or reproductive intentions, a medical history, the pregnancy test itself, confirmation of the result with the client and then counseling and referral as appropriate. Much of this section is based on expert opinion from our expert workgroup and supplemented by American Academy of Pediatrics and ACOG guidelines, which are consistent with Title X requirements about non-directive options counseling.

The recommendations also describe how to meet the needs of clients would want to become pregnant and this includes clients who have been trying to get pregnant for less than 12 months. And it includes screening including medical history, history of current partner or sexual violence, as well as alcohol and other drug use or tobacco use, counseling on fertility awareness and techniques to predict ovulation and lifestyle influence. In developing this section, our expert workgroup encouraged us to draw on the American Society for Reproductive Health Medicine recommendations, as well as ACOG recommendations.

In terms of basic infertility services, these are services for either clients who have failed to achieve pregnancy after 12 months or more after regular unprotected intercourse, although an earlier assessment may be needed for some clients, such as women who are trying to become pregnant or trying to become pregnant who are more than 35 years of age. Our expert workgroup encouraged us to draw on recommendation from ASRM again for recommendations about how to provide basic infertility services to female clients. So you can see on this slide that for female clients it includes medical history, alcohol and drug use history, a history of tobacco use, blood pressure, BMI, examination for thyroid enlargement, breast secretions, signs of androgen excess and a pelvic exam. And this slide also summarizes key aspects of how to provide basic infertility services to men, in accordance with recommendations from the American Urological Association, and I won't read off all of these, I think you can see them on the slide.

QFP also recommends providing several preconception health services to both female and male clients and preconception health services for women aimed to identify and modify biomedical, behavioral, and social risks to a women's or man's health by improving health before conception. And in turn, this can lead to a reduction in pregnancy related adverse outcomes such as low weight, preterm birth or infant

mortality. In addition, these are important for improving health, regardless of a pregnancy intention. And these services are especially important to consider for couples that are trying to achieve pregnancy and couples seeking infertility services. But given the high rates of unintended pregnancy in the US, women and men who are using contraception to prevent or delay pregnancy will also benefit from preconception health services, especially those who are at high risk of unintended pregnancy, such as those who might be using a lesser effective or no contraceptive method or women with a history of incorrect and/or inconsistent use of contraception.

The identified preconception health services for women include all of the services included on this list. So again, I'm not going to read through all of them, but I just want a particular note, screening and referral or treatment for IPV, alcohol or drug use, tobacco use, immunizations, depression, height, weight and BMI, blood pressure and diabetes. This list was developed by considering the 2006 CDC recommendations plus additional work done by a select committee on preconception health that was published in 2008. And in this section, the QFP cites both CDC and US Preventative Services Task Force for how to provide each of these services.

QFP also recommends offering the same preconception health services to men as to women with two exceptions and those include, intimate partner violence, screening of folic acid. The reason that IPV screening is not included is because the USPTF recommendations on which the QFP recommendation was based, was only applied to women at this point. There may be more evidence that accrues in the future and we'll be happy to change the recommendations if and when that evidence is available and is substantiated. Also, folic acid is not included for men for obvious reason and that is because it affects infant health through maternal stores of folic acid, not through the male.

QFP recommendations on STD services are consistent with CDC recommendations including the STD treatment guidelines, the HIV test recommendations, RH related vaccinations and hepatitis C recommendations, and this slide summarizes the female clients that should be screened for each STD. The next slide shows the QFP recommendations for providing STD services to male clients also rely – and these rely on existing CDC recommendations and this slide summarizes the male clients who should be screened.

Finally, as was noted previously, selected related preventative health services are recommended for delivery in family planning visit. And for women, the QFP recommends screening for cervical and breast cancer. For cervical cancer, the recommendations include no screening for women under the age of 21 and then a PAP every three years for women between the ages of 21 and 65 if a traditional PAP is being used. And then a PAP plus HPV testing every five years for women beginning at age 30 through age 65, if you're going to switch to that technology.

Breast cancer screening recommends – ACOG recommends annual examination through a clinical breast exam for women over the age of 19. And the American Cancer Society recommends screening every three years for women with a clinical breast exam, if you're between the ages of 20 and 39 and annually for women beginning at age 40. And then you can also see here on this slide the recommendations for mammography screening. For males, QFP recommends conducting an examination of adolescent male genitals to document normal growth and development and also to identify other conditions such as STDs.

Now I'll talk a little bit about the plans to support implementation of QFP. This next slide shows that we're developing several other products that are designed to support and enhance QFP and efforts to improve the quality of family planning services. First, we're developing training to help Title X providers develop the skills, knowledge, and have access to important tools needed to implement the recommendations. And we're developing them in a way that will make them easily adaptable for other organizations and healthcare systems to be able to use.

Second, we're taking steps to strengthen QFPs recommendations for quality improvement by developing and validating performance measures for contraceptive services. Third, a surveillance summary is under development that will document coverage of the services that are included in the recommendations. And, finally, the process of developing the recommendations has led to the identification of several important research priorities and future implementation of that research will strengthen the evidence base for future versions of the QFP.

We intend to take steps to make sure that QFP is updated on an ongoing basis and that it keeps pace with changes over time. So the current plans for doing this include a comprehensive review and update as needed every – what we're projecting at this point is probably every four to five years. In the next major revision in four to five years, we may identify additional priority areas for in-depth review and systematic reviews. In the meantime, we'll update QFP as the CDC and USPSTF recommendations are updated and we'll have a process in place to be able to make those changes on an ad hoc basis. We hope that QFP will be widely adopted by both the public and private organizations and Title X, of course, will be deeply invested in implementing the recommendations that are included in QFP. But we also are engaging a number of other federal partners, many of whom you've heard previously on this call such as the Bureau of Primary Health Care, the Maternal and Child Health Bureau, but we're also engaging a number of other professional medical associations such as the ones who are listed here and many others.

This is a screen shot of our family planning national training centers website that includes specific sections on the QFP, as well as training resources for implementing. I urge you to visit the FPNTC website that will also have this webinar archived there as well as on the Office of Population Affairs website.

So in summary, the new QFP recommendations should introduce a consistent set of evidence informed recommendations for all providers of family planning services. We hope that they will strengthen the delivery of contraceptive services and other family planning services. They support the use of the family planning platform to provide other essential preventative services for women and men and encourage more research to strengthen the evidence base for specific strategies and services. So, I want to thank you all for your time and attention this afternoon. And on the last slide, we'll be moving on to our question-and-answer session, so I'm going to turn it back over to Nancy to host that part of the webinar for us.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you, Ms. Moskosky. As we said, we're going to move on to our Q&A answer question. We will get started with some of the questions that were submitted in advance of this webinar.

Our first question is for Ms. Moskosky. Why do the new recommendations matter?

Susan Moskosky, MS, WHNP-BC – Acting Director, Office of Population Affairs – Department of Health and Human Services

I think, as has been pointed out a couple of different times on this webinar, I think the United States faces many reproductive challenges, not the least of which is that nearly half of all pregnancies in this country are unintended. And one-half of pregnancies are not spaced in an optimal way and more than 700,000 adolescents become pregnant each year. All of these reproductive health outcomes can lead to substantial health, social and economic consequences for the women who give birth as well as for the infant and families of these outcomes. And the QFP recommendations are designed to help reduce these negative health outcomes and to increase the number of women and men who are able to achieve their desired number and spacing of healthy children.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you. Our next question is for Dr. Barfield. How will these new recommendations impact the landscape of family planning services to adolescents?

Wanda D. Barfield, MD, MPH, FAAP – Director, Division of Reproductive Health – Centers for Disease Control and Prevention

Well, thank you. Given the importance of teen pregnancies, especially these of adolescent clients, are highlighted in the QFP. And it pulls together key recommendations about adolescents from other guidelines. It also – the MEC recommendation that LARC methods are safe and an effective option for healthy teens. It also expands on existing guidelines by addressing the need to provide adolescents with comprehensive information on birth control options, meeting their needs for confidential and friendly youth services. It also encourages parent-child communication about sexual health matters and it doesn't miss opportunities to work with pregnant and parenting teens to avoid repeat teen pregnancy.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

We have another question for Ms. Moskosky. Are these new recommendations supported and endorsed by ACOG and other organizations that influence family planning services?

Susan Moskosky, MS, WHNP-BC – Acting Director, Office of Population Affairs – Department of Health and Human Services

So the right now, as you all have heard from one of the early speakers, we had an ACOG representative, Jan Chapin, and when Jan wasn't able to be present we always had an ACOG representative who served on the expert workgroup as well as on many of the technical panels throughout this process. And we had representatives of several other major professional medical associations that reviewed and commented on the document as it was being prepared. And also, as we mentioned, when I was going through some of the clinical recommendations that we've incorporated, recommendations from a number of other major professional associations like the American Academy of Pediatrics and the ASRM and American Urological Association. So now that QFP has been released, we will be going to some of these organizations and seeking formal endorsement. We don't have that at this point, but we will be working with them to see whether we can get a formal endorsement from important partners such as ACOG.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you. This next question is for Dr. Barfield. The emphasis on preconception health services seems new. Can you explain why you recommend including these services as part of a family planning visit?

Wanda D. Barfield, MD, MPH, FAAP – Director, Division of Reproductive Health – Centers for Disease Control and Prevention

Well, we did this for several reasons. First, we think that women should be healthy, regardless of their pregnancy intention and preconception health services contribute to that goal. It also gives women an opportunity for a reproductive life plan, as recommended by preconception care experts. Given that a half of all pregnancies are unintended, it makes sense to offer these services to women of reproductive age during family planning visits.

Also, about one out of eight pregnancies in the US results in pre-term birth and infant mortality rates remain high relative to other developed countries. By using preconception – by using contraceptive services to space birth and offering preconception health services as part of a family planning visit, the health of the infant as well as the woman and man can be improved.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you, Dr. Barfield. We have time for one more question and we do have a question in the Q&A chat pod. And the question is, please address the decision not to discuss counseling in unplanned pregnancies in detail, specifically, why not mention abortion adoption? Ms. Moskosky, would you like to answer that?

Susan Moskosky, MS, WHNP-BC – Acting Director, Office of Population Affairs – Department of Health and Human Services

Sure, so in the document, in the QFP document, it does specifically state that options counseling should be provided in accordance with recommendations from professional medical associations such as ACOG and American Academy of Pediatrics. One of the things I wanted to point out, as we pointed out throughout the presentation, was that the guidelines were all – as much as possible; these recommendations were based on evidence and in most cases, were based on recommendations, evidence-based recommendations from either CDC or USPSTF.

Although non-directed options counseling is a Title X program requirement and remains a Title X program requirement, in terms of the evidence base or whether there's a strong scientific and evidence base, it's not part of these other major recommendations in terms of an evidence-based technique. But it is still a requirement and so we addressed it in the document. In the QFP document itself, for broad audiences that these should be provided in accordance with these major professional associations recommendations and so that's why it's referred to in that way, because there's not a CDC or USPSTF recommendations on options counseling.

Nancy Mautone-Smith – Public Health Advisor – Office of Population Affairs

Thank you. Unfortunately, that's all the time that we have for questions today. For more information, or to obtain a copy of QFP, please use the links on this slide. As mentioned, also this webinar will be archived on the Family Planning National Training Center's website and on the OPA website. And we thank you all for attending the webinar today.