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Availability of Confidential Services for Teens Declined After the 2011–2013 Changes to Publicly Funded Family Planning Programs in Texas

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A B S T R A C T

Purpose: Texas is one of 24 states that does not explicitly allow minors to consent to contraception. We explore changes in the provision of confidential reproductive health services after the implementation of state policies that cut and reorganized public family planning funding, including Title X.
Methods: We use data from 3 waves of in-depth interviews, conducted between February 2012 and February 2015, with program administrators at publicly funded family planning organizations in Texas about changes in service delivery. We conducted a thematic analysis of transcripts from 47 organizations with segments related to the provision of services to minor teens.
Results: Overall, 34 of the 47 organizations received Title X funding before 2013, and 79% lost this funding during the study period. Respondents at these organizations frequently reported a decrease in teen clients, which they attributed to loss of confidential services previously guaranteed under Title X. As the number of Title X–funded sites decreased, availability of confidential services became inconsistent. Most organizations offered confidential testing for pregnancy and sexually transmitted infections, but availability of confidential contraceptive services varied across and within organizations and often depended on insurance coverage. Respondents also reported challenges clarifying parental consent requirements after the changes in Title X and state funding.
Conclusions: Loss of Title X funding decreased availability of quality family planning services for teens and burdened organizations. As the new Title X regulations are implemented, family planning organizations' experiences in Texas foreshadow what might occur nationally, particularly in states that do not allow minors to consent for contraception.

IMPLICATIONS AND CONTRIBUTION

After multiple changes in public family planning in Texas, organization administrators perceived a decrease in access to and quality of services for their teen clients. These data could have national implications as the 2019 Title X regulations are litigated.

Confidential and low-cost sexual and reproductive health care (SRH) is essential for adolescents' access to and use of services. Adolescents who have concerns about confidentiality are less likely to use SRH services and have lower contraceptive use [1–3]. Indeed, the Society for Adolescent Health and Medicine,

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American Academy of Pediatrics, and American College of Obstetricians and Gynecologists recommend that all adolescents, including teens aged <18 years, receive confidential and low/no-cost SRH services [4,5].

The federal Title X family planning program, which supports nearly 4,000 health centers nationwide, historically has guaranteed confidential and low-cost SRH services for patients, including adolescents aged <18 years [6]. For minor teens living in any of the 24 states that do not explicitly allow them to consent for their own contraception [7], Title X–funded clinics offer a critical point of access for those needing confidential services because federal rules supersede state parental consent laws [8].

However, changes to the Title X program guidelines in 2019 may alter teens' abilities to get confidential services. Key among these are rules that impede organizations' abilities to provide comprehensive SRH care, including counseling and referral for abortion [9]. Although the new rules still allow confidential services, they now require providers to document attempts to encourage family participation in teens' health care. Unclear guidance around this rule could lead to provider confusion and misinterpretation. Policy analysts argue these regulations will reduce the network of participating organizations, and thus locations where minor teens can receive confidential services [10–13]. Indeed, 14 states have already lost more than half of their Title X network [14].

Earlier policy initiatives in Texas that aimed to exclude Planned Parenthood from public funding may provide some evidence about the potential impact of the 2019 Title X changes. Because Texas requires parental consent and does not cover contraception in the state Children's Health Insurance Program, Title X–funded clinics have been one of the few ways minor teens could receive confidential SRH, unless they are enrolled in Medicaid. However, the Title X–funded network changed following the 2011 legislative session when policymakers cut the biennial family planning budget by two thirds and directed the Department of State Health Services to allocate the remaining funds, almost exclusively Title X funds, through a system that favored Federally Qualified Health Centers (FQHCs), public health departments, and other primary care organizations over specialized family planning providers in an effort to exclude Planned Parenthood from public funding. Over a 2-year period, 25% of publicly funded family planning clinics closed or stopped providing contraceptive services, most of which were not Planned Parenthood affiliates [15]. In 2013, U.S. Department of Health and Human Services awarded Texas' Title X grant to a nonprofit association that could disburse funds to all qualified providers, and the legislature created 3 new state-funded family planning programs, only one of which covered minor teens. Organizations participating in the new programs, many of which were first-time family planning contractors, had to follow state parental consent requirements [16].

In this study, we explore how publicly funded family planning organizations served minor teens in Texas' changing state policy environment. Specifically, we assess the ways in which budget cuts or total loss of Title X funding and compliance with parental consent requirements affected organizations' abilities to provide confidential, low-cost, and quality SRH services. We draw on the Institute of Medicine's (now called The National Academy of Medicine) [17] domains of health care quality: safe (avoids harm), effective (grounded in science), patient-centered (incorporates patient preferences), timely (avoids delays), efficient (reduces waste of materials or human energy), and equitable (quality does not differ by factors, such as age, socioeconomic status, or geography).

Methods

For this study, we analyzed transcripts from 3 waves of in-depth interviews conducted as part of a mixed-methods study evaluating changes in Texas' family planning programs that occurred between 2011 and 2013. Procedures for these interviews have been described elsewhere [15,18–20] and are summarized here. In the first wave (February to July 2012), we invited respondents from 37 publicly funded family planning organizations distributed across Texas' 8 health service regions to take part in the interviews. In the second wave (May to September 2013), we recontacted organizations that were still providing family planning services (n = 32) and contacted the 2 additional organizations that began providing services through Title X or state-funded programs. For the third wave, conducted 1 year after implementation of Texas' new family planning programs (November 2014 to January 2015), we invited 45 organizations that were still providing family planning services, including 10 organizations that were new to the state family planning programs.

In all 3 waves, we mailed executive directors a letter explaining the study and then sent emails and made follow-up phone calls to arrange in-person or phone interviews with staff members who were knowledgeable about the organizations' family planning programs and services. Respondents included administrators, directors of clinical services or medical directors, and other clinicians involved in SRH. Two of the authors (K.W. and K.H.) conducted all interviews, which lasted approximately 1 hour. Respondents provided oral consent and were not compensated for their participation. Interviews were audio recorded and transcribed. The institutional review boards at the authors' universities approved the study.

This analysis focuses on changes in services for minor teens after the implementation of new policies and programs. In all waves, we asked respondents to describe any changes they had observed in the number of teens seeking care and the reasons they attributed to these changes. We also asked how organizations documented parental consent for teens at sites that never had or lost Title X funding and any challenges they experienced implementing these changes.

We conducted a thematic analysis of the interview transcripts and used NVivo 12 (QSR International, Doncaster, Australia) for data management. K.C.M. and K.W. reviewed all transcript segments pertaining to the delivery of teen services and created a preliminary coding scheme based on our research questions, organization funding status at the time of interview, and the Institute of Medicine's quality of care domains, while allowing themes to emerge in vivo. Next, they independently coded data from 11 organizations, reviewed coding consistency, and refined codes. K.C.M. coded the remaining interviews, and K.W. independently coded transcripts from 5 organizations (10% of the remaining sample) selected at random to compare coding; discrepancies were resolved through consensus. Finally, K.C.M and K.W. reviewed coded data and displayed data in written narratives and tables to identify broader themes and patterns within themes, including by organization type (e.g., specialized family planning, FQHC) and Title X funding status (e.g., lost Title X, never had Title X). We summarized the main themes and reported on any observed differences between groups.

Table 1
Distribution of publicly funded family planning organizations by Title X funding status (N = 47), Texas 2012–2015

	Title X funding status				Total
	Lost funding, 2012–2015, n (%)[a]	Funding throughout, 2012–2015 n (%)[a]	New grantee after 2013[b], n (%)[a]	Never funded[c], n (%)[a]	
All organizations	27 (57)	7 (15)	3 (6)	10 (21)	47
Type of organization					
Federally qualified health center	12 (67)	1 (6)	1 (6)	4 (22)	18
Women's health/family planning	8 (53)	3 (20)	1 (7)	3 (20)	15
Public health department/hospital	3 (33)	3 (33)	1 (11)	2 (22)	9
Other	4 (80)	0 (0)	0 (0)	1 (20)	5
State family planning program experience					
Established contractor, 2011 and before	26 (63)	7 (17)	2 (5)	6 (15)	41
New contractor, 2012 or after	1 (17)	0 (0)	1 (17)	4 (67)	6

[a] Row percentages.
[b] Funded after the Title X grant went to a private nonprofit.
[c] Did not have Title X funding during the study period.

Results

Twenty-seven organizations completed interviews in Wave 1 (73% response rate), 29 in Wave 2 (85% response), and 39 in Wave 3 (87% response). Forty-seven organizations had transcript segments pertaining to teen services and parental consent and were included in the subsequent analysis: 18 FQHCs, 15 women's health or specialized family planning organizations (henceforth referred to as the latter), 9 public health departments or hospital districts, and 5 other organizations (e.g., community action agencies).

Title X funding status during the study period varied by organization type and state family planning program experience. Of the 34 organizations that received Title X before 2013, 27 (79%) lost program funding during the study period. Fewer public health departments and hospital districts lost Title X funding, compared with other types of organizations (Table 1). Of the 6 new state family planning contractors, 4 did not receive Title X funding, and another lost funding after a 1-year contract.

Four main themes emerged: the importance of confidential and accessible services to minor teens, strategies organizations used to make those services available, variability in organizations' parental consent requirements, and the impact of funding changes on organizations.

Importance of confidential and accessible services

Many respondents described how teens were a priority population, and those at organizations that had ever received Title X funding, in particular, noted that their agency was committed to making services as accessible as possible. Although some respondents thought many parents were supportive of teens' contraceptive use and said it was not uncommon for teens to bring an adult to their visit, even without a parental consent requirement, many similarly recognized that not all teens could or wanted to involve a parent in their care. Title X–funded organizations valued their ability to offer teens confidential services, referring to the program as a "*safety net*" and "*protection*" that was essential for serving a teen population. A clinical director at a state-funded public health department that lost Title X during the study period stated, "*They don't want their parents to know they are having sex, and if they can do it on their own without anything, they would much rather do it that way.*" An administrator at a Title X–funded FQHC echoed this idea saying, "*The majority of the teens that we see do not want their parents to know, and the parents don't know that they're coming for family planning services.*"

Following the 2011 policy changes, which reduced organizations' budgets and the number of Title X–funded sites, administrators experienced difficulties providing equitable services to all teens. Most organizations that lost Title X funding during the study period reported that they observed a decrease in their total clients, including the number of teens. Respondents attributed this to fewer resources to conduct outreach and requiring all uninsured patients to pay for services (among other factors), but many felt the decrease was primarily related to their inability to provide care to teens without parental consent. A clinical director at a state-funded public health department described the following decrease in teen client volume after losing Title X funding:

> *"When that law first went into effect… we lost over 1,000 clients because we had hundreds of teenagers and they just disappeared. Because for us to be able to give them their birth control refills, we had to have their parents come in and sign for them, and they wouldn't do it." They said, "No way. We just won't get it anymore."*

An administrator at a state-funded FQHC summed up these changes by saying, "*Once you sort of eviscerate that [confidential services], you've eviscerated any adolescent health program in primary care. …If you can't offer confidentiality, you don't have an adolescent program.*"

Strategies to ensure confidential and affordable services were accessible

To ensure minor teens stayed connected to care, organizations that lost Title X adopted multiple strategies. Staff informed teens calling for appointments that parental consent may be required and "*encouraged them to bring Mom or Dad.*" Recognizing not all teens would be able to do so, many respondents mentioned their organization developed a referral system. For example, some organizations that retained Title X funding allocated their reduced funds to specific clinics in their network that served a larger number of teens; teens seeking confidential services were then referred to the specific Title X–funded locations.

To avoid turning away teens if they arrived without a parent, staff at one of these organizations discouraged walk-in appointments and informed callers where to go for care, "*If they call, we are going to send them to [another network clinic]. Do not show up*." At other organizations that did not have Title X funding, staff would refer teens to another Title X–funded clinic in the community, if possible. Specialized family planning organizations, compared with other types of organizations, seemed more aware of area clinics where they could refer teens for confidential services. Some respondents mentioned having a formalized process in which they confirmed the other clinic would accept the teen client, provided the teen with the number for the referral clinic, and followed up to see if the client attended their appointment. However, these strategies did not always prevent teens from "*getting lost in the shuffle*" and reduced access to timely care because of scheduling and transportation barriers. One administrator remarked, "*If they'd [teens] made all these arrangements just to get to your clinic, now you're telling them they need to go here, they may not be able to do that right then. They may have to make another arrangement on a different day to be able to get to that clinic.*"

Respondents also mentioned that their organization tried to mitigate cost barriers after losing funding. Several tried to raise funds from private donors and foundations that would be earmarked for teen services, and others relied more heavily on patient assistance funds for their teen clients. Many organizations, particularly specialized family planning organizations, also developed or expanded sliding-fee scales with prices that were within reach for teens. For example, sliding scales at a few organizations were based on age in addition to income, with teens having a lower co-pay than adults. In the face of significantly reduced funding, the executive director at a Title X–funded specialized family planning organization remained committed to serving teens and explained that if they "*don't have $20, we're telling the staff see them… The only reason we are asking for the $20 is to generate some income to see more teens, [and] put it back into the program.*"

Variability in parental consent requirements

Respondents frequently pointed out that teens could receive SRH services without parental consent, depending on the type of service requested (e.g., sexually transmitted infection screening) or health care coverage. Although minor teens with Medicaid had access to all confidential services, including contraception, determining whether parental consent was required for teens without Medicaid became more complicated as organizations lost Title X funding or participated in new state family planning programs with different consent rules. As an administrator at a state-funded FQHC explained, "*We have 3 or 4 different consent forms that we use—it depends on the age of the patient who comes in and what services they're getting, what program they're coming to.*" Respondents at 3 FQHCs commented that parents had to sign a general consent for their teen to receive care, with additional consent required for contraception, whereas respondents at other organizations stated that parental consent was required only to receive prescription contraception. For example, an administrator at a state-funded FQHC reported, "*For certain services they can be seen without a guardian's consent, especially for counseling for birth control… Once they require a prescriptive medication, like the birth control pills and Depo, the guardian has to be on-site… to sign off on the paperwork.*" A clinical director at a specialized family planning organization also highlighted the boundaries around which contraceptive and other SRH services could be provided without parental consent at clinics without Title X funding. She said if a teen desires pregnancy testing at a non–Title X site in their network, "*we do the pregnancy test without parental consent, and we hand them condoms and say, 'You need to go to this [Title X] clinic to get on birth control.'*"

Most respondents reported that they documented parental consent with a signed form, and the majority stated that a parent or legal guardian had to come to the visit with their teen and sign the form so staff could witness the signature. However, a minority of respondents stated that their organization did not require the parent or guardian to sign the form in person and instead allowed teens to pick up a consent form or print one from their website and return a signed copy to the clinic; these were primarily specialized family planning organizations. Because some organizations allocated their reduced Title X funding to a limited number of sites in their network, only some of their clinics offered the full range of SRH services without parental consent, whereas at other locations, staff had to document consent for some of the same services. This resulted in inequitable care for teen clients even within organizations.

Respondents at organizations that recently lost Title X funding or that were first-time state family planning program contractors commented that they were still working with their legal teams to clarify their parental consent protocols. For example, a clinical director at a specialized family planning organization that lost Title X funding stated that they had to "*be careful*" with the consent policy, "*Legal is reviewing what that consent needs to look like. 'Cause we learned at one of those [meetings] that there are clinics who just, 'Oh, we just do parental consent and she brings it back.' Is that enough? Or will that hold up?*" At a subsequent interview, a respondent for this organization noted in-person consent was now required as they still did not have Title X funding.

Impact of funding changes on organizations

Respondents commented that the required changes were abrupt and difficult for many front-line staff. For example, an administrator at a specialized family planning organization that lost Title X funding recalled,

> *"To look these patients in the face and know that we've been… giving them the birth control for the past 2 years, 'Sorry, we can't do it today.' Can you imagine being the one to tell them, and why? 'Because the state took away our funds. Call your congressman.' 'Well, I'm not old enough to vote.' 'I know, hun.' Every day, all day long, these were [the] conversations."*

Moreover, at several organizations, parental consent requirements changed several times over the study period following shifts in family planning programs and their administration. These changes reduced organizational efficiency because they necessitated retraining clinic and outreach staff to inform community partners and teen clients. For example, an FQHC received Title X funding during the 2012–2013 period, after which their family planning program was supported only by state funds. An administrator at that organization commented,

> *"The biggest impact will be the retraining because we were really driving it hard that you have to make this available to these*

minors, and, yes, this is a departure from what we were telling you a year ago, but this is the way it is now; you have to deliver this message. And now, we're going to come back and go, 'Oh! Stop. Don't say that anymore. Pull it down off the website. Pull the signs off the walls.'"

An executive director at a primary care organization recounted that changes were stressful for staff and the families they served during a 3-month interruption in their Title X funding,

"It was horrible. Nobody could remember anything, you know. We kept meeting in the hall saying: 'Okay now what were we going to do here?' I mean it just got awful. And the teens were furious and the mothers were furious that they had to come in with their teens, and all of this hostility went on for 3 months."

When their Title X funding was reinstated, she leveraged social media to disseminate the news more quickly to the community, "*On our Facebook page I was able to say: 'We can see all the teens now, no big deal.' And all the teens were responding: 'Yay, we're back.' You know, because otherwise they did not have any other place to go and they were very upset.*"

Discussion

In this study of publicly funded family planning organizations in Texas, we found that policy changes between 2011 and 2013 complicated an already complex service delivery environment for minor teens needing SRH services and adversely affected 3 of the 6 domains of quality care [17]. Specifically, access to care became less equitable. As the network of Title X–funded clinics shrank and new state-funded programs required organizations to comply with Texas parental consent laws, teens' ability to obtain confidential, low-cost services was increasingly dependent on the funding source for their care and services requested. Although teens could receive a wide array of SRH services at some organizations—including sexually transmitted infection screening and contraceptive counseling—without having to involve a parent in their care, confidential access to hormonal and long-acting contraception was limited to teens enrolled in Medicaid or who were able to reach a Title X clinic. Not only did the scope of confidential services vary across facilities but also it varied within some organizations that allocated reduced Title X funding to specific sites.

Although the 2011 policy changes, in particular, contributed to fewer overall clients served [15], respondents in our study reported notable decreases in teen clients, which they attributed to parental consent requirements. Although many organizations used creative strategies to ensure teens could continue to access low-cost services through referral systems and greater flexibility in required fees for services, discouraging walk-in visits or referring them elsewhere is a barrier to timely care—the second domain of quality health care [17,21–23]. The reported decrease in teen clients is consistent with changes in Texas teens served during this period [24,25] and other research on the importance of confidentiality in adolescents' access to SRH services [1–3]. In addition, the increase in teen pregnancy following the policy changes [26] is further evidence that minor teens were unable to obtain contraceptive services.

The changes in parental consent requirements that followed programmatic shifts affected a third domain of quality of care—efficiency [17]. Efforts to clarify and develop protocols for obtaining parental consent and train and retrain staff required extra time and resources for many organizations that lost Title X funding or were new participants in state programs. Administrators further noted tension between ensuring that they followed the law while also trying to facilitate teens' access to needed care.

Our findings point to the potentially complicated systems of access to SRH for teens living in states that require parental consent for contraception. They also foreshadow the changes that may occur after the implementation of the new Title X guidelines, which will likely vary across states and organizations, as 32 states have lost organizations in their Title X networks [14]. As demonstrated in Texas, reduced points of access to confidential, low-cost SRH services from Title X–funded clinics and specialized family planning organizations, which provide access to a wider range of contraception than other providers [27–29], may adversely affect teens by eliminating their access to SRH care or limiting where they can receive high-quality care. Moreover, the quality of care for teens may become inequitable, inefficient, and less timely as organizations determine how to comply with new Title X rules that require providers to encourage family participation in SRH care or, in the absence of funding, develop protocols to comply with their state's parental consent requirements. Finally, as seen with our Texas respondents, funding uncertainty may create confusion among providers about whether the new rules are in place and how and when to abide by them. This, and the inability to provide high-quality care to teens because of the new Title X regulations, may result in higher staff burnout and lower retention, which further burdens already strained organizations [30,31].

Our study is limited to a single state, and we did not include all publicly funded providers in Texas. However, our sample includes diverse organizations in terms of size, geography, and organization type that served the majority of Texas clients [15,18–20]; thus, we likely captured the service environment that many teens would have encountered. Although not reproducible, our data provide helpful context for other states. In addition, we likely did not capture some details as teens were not the only focus of the larger study. Respondents mostly discussed changes as they pertained to female teens, and although they account for the vast majority of people obtaining Title X–funded services and almost all people obtaining prescription contraceptive services [6], we do not know how these changes may have affected male or gender-nonconforming teens. Future research should assess whether the consequences we documented in Texas occur elsewhere.

Although the Texas case is unique, the experiences of family planning providers in that state illustrate an ominous picture of what might happen to providers and their teen clients elsewhere if the Title X rules remain in effect. Indeed, the potential harm is recognized through joint-ligation efforts of professional health associations, such as the American Medical Association, health care organizations, and individual health care providers. Health care quality for teens in Texas and nationwide would be improved with guaranteed access to a full range of confidential, affordable SRH services and the right to decide who to involve in their care.

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References

[1] Fuentes L, Ingerick M, Jones R, et al. Adolescents' and young adults' reports of barriers to confidential health care and receipt of contraceptive services. J Adolesc Health 2018;62:36–43.
[2] Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. J Am Med Assoc 1999;282:2227–34.
[3] Lehrer JA, Pantell R, Tebb K, et al. Forgone health care among U.S. Adolescents: Associations between risk characteristics and confidentiality concern. J Adolesc Health 2007;40:218–26.
[4] The Society for Adolescent Health and Medicine, American Academy of Pediatrics. Sexual and reproductive health care: A position paper of the Society for Adolescent Health and Medicine. J Adolesc Health 2014;54:491–6.
[5] Committee on Adolescent Health Care. Adolescent confidentiality and electronic health records. Washington, D.C.: American College of Obstetricians and Gynecologists; 2014.
[6] Fowler CI, Gable J, Wang J, et al. Family Planning Annual Report: 2017 national summary. Research Triangle Park, N.C.: RTI International; 2018.
[7] Guttmacher Institute. An overview of consent to reproductive health services by young people. Available at: https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law. Accessed June 30, 2019.
[8] English A. Adolescent confidentiality protections in Title X. Washington, D.C.: Center for Adolescent Health & the Law; National Family Planning & Reproductive Health Association; 2014.
[9] Compliance with statutory program integrity requirements 84 FR 7714. Washington, D.C.: Department of Health and Human Services; 2019.
[10] Sobel L, Rosenzweig C, Salganicoff A. Proposed changes to Title X: Implications for women and family planning providers. San Francisco, CA: Henry J. Kaiser Family Foundation; 2018:11.
[11] Sobel L, Salganicoff A, Frederiksen BN. New Title X regulations: Implications for women and family planning providers. San Francisco, CA: Henry J. Kaiser Family Foundation; 2019.
[12] Hasstedt K. What the Trump administration's final regulatory changes mean for Title X. Health Aff Blog 2019. https://doi.org/10.1377/hblog20190923.813004.
[13] Planned Parenthood Federation of America, Abortion Care Network, American Academy of HIV Nursing. Opposition to Title X changes. Oakbrook Terrace, IL: Society for Adolescent Health and Medicine Website; 2018. Available at: https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2018-Activity/Opposition-to-Title-X-Changes.aspx. Accessed June 30, 2019.
[14] Frederiksen B, Salganicoff A, Gomez I, et al. Data note: Is the supplemental Title X funding awarded by HHS filling in the gaps in the program? San Francisco, CA: Kaiser Family Foundation; 2019.
[15] White K, Hopkins K, Aiken ARA, et al. The impact of reproductive health legislation on family planning clinic services in Texas. Am J Public Health 2015;105:851–8.
[16] Tan T. State releases reduced list of women's health clinics. Tex Trib 2012.
[17] Institute of Medicine. Committee on quality of health care in America. Crossing the quality chasm: A new health system for the 21st century. Washington, D.C.: National Academies Press; 2001.
[18] White K, Hopkins K, Grossman D, et al. Providing family planning services at primary care organizations after the exclusion of Planned Parenthood from publicly funded programs in Texas: Early qualitative evidence. Health Serv Res 2018;53:2770–86.
[19] White K, Campbell A, Hopkins K, et al. Barriers to offering vasectomy at publicly funded family planning organizations in Texas. Am J Mens Health 2017;11:757–66.
[20] White K, Adams K, Hopkins K. Counseling and referrals for women with unplanned pregnancies at publicly funded family planning organizations in Texas. Contraception 2019;99:48–51.
[21] World Health Organization. Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services. Geneva, Switzerland: World Health Organization; 2012.
[22] AAP Committee on Adolescence. Achieving quality health services for adolescents. Pediatrics 2016;138:e20161347.
[23] Marcell AV, Burstein GR, Adolescence CO. Sexual and reproductive health care services in the pediatric setting. Pediatrics 2017;140:e20172858.
[24] Frost JJ, Zolna MR, Frohwirth L. Contraceptive needs and services, 2010. New York: Guttmacher Institute; 2013.
[25] Frost J, Frohwirth L, Zolna MR. Contraceptive needs and services: National and State Data, 2014 update. New York: Guttmacher Institute; 2016.
[26] Packham A. Family planning funding cuts and teen childbearing. J Health Econ 2017;55:168–85.
[27] Thiel de Bocanegra H, Cross Riedel J, Menz M, et al. Onsite provision of specialized contraceptive services: Does Title X funding enhance access? J Womens Health 2014;23:428–33.
[28] Frost JJ, Gold RB, Frohwirth L, et al. Variation in service delivery practices among clinics providing publicly funded family planning services in 2010. New York, NY: Guttmacher Institute; 2012.
[29] Hasstedt K. Why we cannot afford to undercut the Title X national family planning program. New York, NY: Guttmacher Institute; 2017.
[30] Garrett DKD, McDaniel AMD. A new look at nurse burnout: The effects of environmental uncertainty and social climate. J Nurs Adm 2001;31:91–6.
[31] Friedberg MW, Chen PG, Van Busum KR, et al. Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. Rand Health Q 2014;3:1.