WV Department of Health and Human Resources
Bureau for Public Health
Office of Maternal, Child and Family Health
Family Planning Program Guidelines

Introduction

The Title X Family Planning Program was enacted in 1970 as Title X of the Public Health Service Act (Public Law 91-572 Population Research and Voluntary Family Planning Programs). Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services.

For more than 40 years, Title X family planning clinics have played a critical role in ensuring access to a broad range of family planning and related preventive health services for millions of low-income or uninsured individuals and others.

Since 1970, the West Virginia Family Planning Program has been the sole grantee of Title X in WV and remains dedicated to providing access to quality health care to help women, men, and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy.

Following the direction of *Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Population Affairs* (QFP) and *Office of Population Affairs Program Requirements for Title X Funded Family Planning Projects*, these guidelines outline recommendations for how to provide quality family planning services, which include offering a full range of contraceptive methods for persons seeking to prevent pregnancy, pregnancy testing and counseling, helping achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services. This document also assists providers in identifying family planning clients (those seeking to prevent or achieve pregnancy), highlighting the special needs of adolescent clients and encouraging the use of the family planning visit to provide selected preventive health services for clients, in accordance with the recommendations issued by the Institute of Medicine and adopted by the U.S. Department of Health and Human Services.

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WV Family Planning Program Guidelines
All WV Family Planning Provider agencies must use these clinical protocols, plans for client counseling and education, facility management, and financial instructions, approved by the WV Family Planning Program and signed by the service site Medical Director who must be a licensed WV physician. The Chair of the Board of Directors must also sign, or when a clinic has no Board of Directors, the Clinic Administrator's signature must be present. These protocols outline specific procedures for the provision of each service offered and are in accordance with state and federal laws and consistent with Title X program requirements. Additional protocols and updates may be added by the WV Family Planning Program, as needed.

The Medical Director and Board Chair, or Clinic Administrator, must review current guidelines, new policy statements, and any content changes to the *WV Family Planning Program Guidelines* and update this signature page annually, to serve as verification of this review process.

Clinic Name:______________________________

Clinic ID #:______________________________

Medical Director (please print): ______________________________

Medical Director's Signature:______________________ **Date:**__________

Clinic Administrator or Board Chair (please print):______________________

Clinic Administrator or Board Chair Signature:______________ **Date:**__________

Medical Director (please print): ______________________________

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Clinic Administrator or Board Chair (please print):______________________

Clinic Administrator or Board Chair Signature:______________ **Date:**__________

1.0 GENERAL ADMINISTRATION

1.1 PROGRAM PRIORITIES

Each year the Office of Population Affairs (OPA) establishes program priorities that represent overarching goals for the Title X program. Program priorities derive from Healthy People 2020 Objectives and from the Department of Health and Human Services (HHS) priorities. The WV Family Planning Program will send out annual updates of these priorities to each provider and include information for any training necessary to address these goals.

1.2 PRIMARY AUDIENCE

The primary audience for these guidelines 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.

1.3 VOLUNTARY PARTICIPATION

Family planning services are to be provided solely on a voluntary basis. Clients cannot be coerced to accept services or to use or not use any particular method of family planning. A client's acceptance of family planning services must not be a prerequisite for eligibility or receipt of any other services, assistance from, or participation in any other program.

Any staff administering family planning services may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.

In order to meet these federal requirements, the WV Family Planning Program requires that a Client's Bill of Rights be shared with all clients; this can be posted or given to each individual.

1.4 PROHIBITION OF ABORTION

All service sites must be in full compliance with Section 1008 of the Title X statute and 42 CFR 59.5(a)(5), which prohibit abortion as a method of family planning. All providers must have written policies that clearly indicate that no Title X funds or supplies will be used in programs where abortion is a method of family planning.

1.5 CONFIDENTIALITY

Every provider site must have safeguards to ensure client confidentiality. Information obtained by staff about an individual receiving services may not be disclosed without the individual's documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual.

1.6 LIMITED ENGLISH PROFICIENCY (LEP)

Providers must have written policies that are consistent with the HHS Office for Civil Rights policy document, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (August 4, 2003) (HHS Grants Policy Statement 2007, II-23).

All provider agencies must:

- Ensure meaningful access to services for LEP clients;
- Develop and implement a written plan regarding the process for providing language assistance to LEP clients. Guidance can be found in Federal Register/Vol. 76, No 74/Monday, April 18, 2011/Notices. The plan must consider:
    - The size of the LEP population to be served or likely to be encountered; and
    - The frequency of contact with the LEP population.

All LEP plans must include:

- A statement of the agency's commitment to provide meaningful access for LEP persons;
- A statement that services will not be denied to a client because she or he is limited English proficient;
- A statement that clients will not be asked or required to provide their own interpreter. Because of the concerns for confidentiality and the sensitive nature of the information that clients may disclose during services, the use of family and friends as interpreters is strongly discouraged. If the client chooses to use family or friends, first inform the client of the right to receive free interpreter services and permit the use of family or friends only after the offer has been declined and documented.
    - The WV Department of Health and Human Resources, Bureau for Public Health has contracted with Interpreters Unlimited for translation services. This service is available to all WV Family Planning Program providers with no direct cost to the provider agency. Interpreters Unlimited provides language services in more than 200 different languages. Sign language is not a contracted service through Interpreters Unlimited. Contact the program directly for information on sign language interpretation. Interpreters Unlimited can be reached at (855) 620-6899, enter code# 11417 when prompted. Providers must notify the program when using interpreter services to ensure proper record keeping and program billing records.

At a minimum, provider agencies must include and address the following within their LEP plans:

- Identifying LEP individuals who need language assistance;
- Language assistance measures;
- Oral interpretation;

- Sign language interpretation;
- Written translation;
- Providing notice to LEP persons;
- Staff training; and
- Monitoring and updating the LEP plan.

When providing services to clients who are deaf or hard of hearing, providers have a duty to provide effective communication using auxiliary aids and services that ensure that communication with people who have a hearing loss is as effective as communication with others (ADA Title III at 28 CFR 36.303(c)).

The American with Disabilities Act does not require the provision of any auxiliary aid or service that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a health care provider. However, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in a fundamental alteration or undue burden.

Language and deaf or hard of hearing assistance activities utilized by provider agencies will be monitored on a periodic basis to measure compliance and effectiveness.

1.7 PERSONNEL POLICIES

Providers are obligated to establish and maintain personnel policies that comply with applicable Federal and State requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title I of the Americans with Disabilities Act, and the annual appropriations language. These policies should include, but are not to be limited to:

- staff recruitment;
- selection;
- performance evaluation;
- promotion;
- termination;
- compensation;
- benefits; and
- grievance procedures.

Provider staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population. Providers must also ensure that family planning medical services will be performed under the direction of a physician with special training or experience in family planning.

All clinics must name a staff member to be the liaison with the program. The contact person must provide a valid email which must be checked at least once per week. Clinic administration must report any changes to the contact person's information within 10 days of the date of the change.

1.8 EMERGENCIES

Emergency situations involving clients and/or staff may occur at any time. All provider agencies must have written plans for the management of on-site medical emergencies. At a minimum, written protocols must address vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties. Protocols must also be in place for emergencies requiring transport, after hours management of contraceptive emergencies, and clinic emergencies. All provider agency staff must be familiar with these plans. Appropriate training, including training in CPR, should be available to clinic staff.

Provider agencies must also have a written plan for the management of non-medical emergencies, and clinic facilities must meet applicable standards established by Federal, State, and local governments (e.g., local fire, building, and licensing codes). The basic requirements of these regulations include, but are not limited to:

- Disaster plans (e.g., fire, bomb, terrorism, earthquake, etc.) have been developed and are available to staff;
- Staff can identify emergency evacuation routes;
- Staff have completed training and understand their role in an emergency or natural disaster; and
- Exits are recognizable and free from barriers.

1.9 FACILITIES AND ACCESSIBILITY OF SERVICES

Title X service sites should be geographically accessible for the population being served. Providers should consider clients' access to transportation, clinic locations, hours of operation, and other factors that influence clients' abilities to access services.

Providers may not discriminate on the basis of disability and, when viewed in their entirety, facilities must be readily accessible to people with disabilities.

1.10 STRUCTURE AND MANAGEMENT

Where required services are provided by referral, the provider is expected to have written agreements for the provision of services and reimbursement of costs as appropriate.

- If a provider wishes to subcontract any of its responsibilities or services, a written agreement that is consistent with Title X Program Requirements and approved by the WV Family Planning Program Director or her/his designee, must be maintained by the provider;

- All services purchased must be authorized by the WV Family Planning Program Director or her/his designee; and
- Provider agencies will be given an opportunity to participate in the establishment of ongoing grantee policies and guidelines.

1.11 EQUIPMENT AND SUPPLIES

Equipment and supplies must be appropriate to the type of care offered by the provider. Provider agencies are expected to follow applicable Federal and State regulations regarding infection control. Pharmaceutical and clinical supplies received from the WV Family Planning Program are to be used for Title X clients only. Pharmaceuticals are to be kept in a locked area.

Providers are responsible for keeping an accurate physical count of all supplies and pharmaceuticals. To properly maintain these records, providers should utilize a perpetual inventory system. To establish a perpetual inventory system, first count all supplies and pharmaceuticals provided by the WV Family Planning Program and establish a baseline inventory. From this point forward, provider staff should record anything coming in or out of the inventory as a plus or minus, respectively. A monthly check of ordering records, current inventory, and on-going inventory lists should be compared and any discrepancy investigated and adjustments made, if necessary. Inventory records should be kept for at least three years.

1.11.1 ORDERING SUPPLIES

A. Provider agencies must order all WV Family Planning Program supplies and literature on order forms located on the WV Family Planning Program website at www.wvdhhr.org/fp. Orders should be faxed to:

WV Department of Health and Human Resources
Materials Management Office
900 Bullitt Street
Charleston, WV 25301
Phone: (304) 558-3417
FAX: (304) 558-1524

B. All supplies necessary for the collection and preparation of laboratory specimens (with the exception of Pap and Human Papillomavirus tests) are provided by the WV Office of Laboratory Services at no charge to the provider. To order laboratory supplies, please contact:

WV Office of Laboratory Services
167 – 11th Avenue
South Charleston, WV 25303
Phone: (304) 558-3530
FAX: (304) 558-2006

C. To order supplies necessary for the collection and processing of cytology screening services (Pap and Human Papillomavirus tests), please contact your preferred cytology vendor directly.

1.12 PHARMACEUTICALS

The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. It is essential that each facility maintain an adequate supply (based on patient count) and variety of drugs and devices to effectively manage the contraceptive needs of its clients.

Providers are responsible for rotation of the stock of all pharmaceuticals by following the steps below:

- Check and maintain a current inventory of all pharmaceuticals supplied by the WV Family Planning Program at least once per month;
- Note the expiration dates of all pharmaceuticals, when the expiration date is such that the medication cannot be used at your location prior to that date, contact Materials Management (above) for information about possible return for redistribution; and
- Move short-dated stock to front of your stock and use it first.

1.12.1 DRUG RECALL SYSTEM

The Patient Data Form field 23, requires documentation of lot numbers for each product or medication dispensed to WV Family Planning Program clients. In the event of a drug recall, the WV Family Planning Program creates a report, which lists the following:

- Clinic Name;
- Brand Name/Dosage;
- Lot Number; and
- Client Name(s).

All provider agencies will receive a notice regarding specific drug recall information, a printout listing clients who received the recalled products and a Drug Recall Notification/Tracking Form. Each provider agency has the responsibility to notify listed clients of the drug recall and to request return of any unused products containing the recalled lot numbers. The Drug Recall Notification/Tracking Form

must be completed and returned to the WV Family Planning Program by the date specified in the notice.

When clients return recalled products to the provider agency, clients must be provided replacement supplies from a different lot number. The exchange of supplies must be documented in the client's chart and on the Patient Data Form for the return visit. This visit should be invoiced to the WV Family Planning Program as an Interim/Continuing visit. All products with recalled lot numbers must be returned immediately to WVDHHR Materials Management for credit and/or exchange with the manufacturer.

1.12.2 PRESCRIPTION ORDERS AND RECORD KEEPING

All provider agencies are required to maintain accurate and adequate medical records pertaining to prescriptive medications.

1.12.3 PRESCRIPTION LABELING

The WV Family Planning Program requires that all prescriptive medications dispensed be labeled with the following:

- Client name;
- Date dispensed;
- Name of drug;
- Full directions for use; and
- Appropriate ancillary label(s), such as "Keep refrigerated", or "This drug may cause drowsiness", if indicated.

1.12.4 EXPIRED PHARMACEUTICALS

When pharmaceuticals have already expired, the following guidelines were developed by the U.S. Food and Drug Administration (FDA) to encourage the proper disposal of medicines and help reduce harm from accidental exposure or intentional misuse after they are no longer needed:

- Follow any specific disposal instructions on the prescription drug labeling that accompanies the medicine. Do not flush medicines down the sink or toilet unless this information specifically instructs you to do so;
- Take advantage of programs that allow unused drugs to be taken to a central location for proper disposal. Call your local law enforcement agencies to see if they sponsor medicine take-back programs in the community. Contact local trash and recycling service to learn about medication disposal options and guidelines; and
- Transfer unused medicines to collectors registered with the Drug Enforcement Administration (DEA). Authorized sites may be retail, hospital or clinic

pharmacies, and law enforcement locations. Some offer mail-back programs or collection receptacles ("drop-boxes"). Visit the DEA's website or call 1-800-882-9539 for more information and to find an authorized collector in your community.

If no disposal instructions are given on the drug labeling and no take-back program is available in the community, dispose of the the drugs in the trash following these steps:

- Remove them from their original containers and mix them with an undesirable substance, such as used coffee grounds, dirt or kitty litter (this makes the drug less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash seeking drugs); and
- Place the mixture in a sealable bag, empty can or other container to prevent the drug from leaking or breaking out of a garbage bag.

1.13 REPORTING

Provider agencies must submit required program statistical records which reflect number and financial status of eligible individuals served and the nature and outcome of services rendered. Provider agencies must also produce data on a stipulated periodic basis.

1.14 TITLE X FAMILY PLANNING ANNUAL REPORT (FPAR)

Clinics that participate in the WV Family Planning Program must provide information about those clients for reporting on the Title X Family Planning Annual Report (FPAR). Information which must be collected and reported by each individual service site includes, but is not limited to:

- Unduplicated number of family planning users by age and sex (Under 15, 15-17, 18-19, 20-24, 25-29, 30-34, 35-39, 40-44, Over 44);
- Unduplicated number of female family planning users by race and ethnicity;
- Unduplicated number of male family planning users by race and ethnicity;
- Unduplicated number of family planning users by income level;
- Unduplicated number of family planning users by principal health insurance coverage status;
- Unduplicated number of family planning users with limited English proficiency (LEP);
- Unduplicated number of female family planning users by primary method and age;
- Unduplicated number of male family planning users by primary method and age;
- Unduplicated number of users who obtained a pap test;
- Number of pap tests performed;
- Number of pap tests with an ASC or higher result;
- Number of pap tests with an HSIL or higher result;
- Unduplicated number of users who received a clinical breast exam (CBE);

- Unduplicated number of users referred for further evaluation based on their CBE;
- Unduplicated number of family planning users tested for Chlamydia by age and sex;
- Number of users tested for gonorrhea by sex;
- Number of users tested for syphilis by sex;
- Number of confidential HIV tests;
- Number of positive confidential HIV tests;
- Number of anonymous HIV tests; and
- Number of family planning encounters by type of provider (i.e., MD, DO, NP, etc.).

2.0 PROGRAM SERVICES

2.1 CLIENT ACCESS

All persons who want to obtain family planning care must have access to such services. All service sites must provide for comprehensive medical, informational, educational, social, and referral services related to family planning for clients who want such services. Services must:

- Be priority to persons from low-income families;
- Be provided in a manner which protects the dignity of the individual;
- Be provided without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, sexual orientation, gender identity, or marital status;
- Include a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents);
- Be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician;
- Include pregnancy diagnosis and counseling to all clients in need of this service;
- Offer pregnant women the opportunity to be provided information and counseling regarding prenatal care and delivery, infant care, foster care, adoption, and pregnancy termination;
- Provide neutral, factual information, and nondirective counseling on each of the pregnancy options, and referral upon request, except with respect to any options(s) about which the pregnant woman indicates she does not wish to receive such information and counseling;
- Provide for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance;
- Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs;
- Encourage family participation in the decision of minors to seek family planning services; and
- Provide counseling for minors on how to resist coercion into engaging in sexual activities.

Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

2.2 CLINICAL PROTOCOLS

The *WV Family Planning Program Guidelines* serve as clinical protocols and plans for client education, approved by the WV Family Planning Program, in accordance with State laws and signed by the service site Medical Director and Board Chair, or Clinic Administrator.

Providers who desire to use local clinical protocols and medical histories as an adjunct to these recommendations, must submit those to the WV Family Planning Program for approval by the director or her/his designee.

Complete information regarding clinical protocols is addressed in Section 3 of these guidelines and provides information about how to care for patients which may go beyond the level of care provided by most family planning services providers in primary care settings. However, family planning providers must be aware of these recommendations because they will assist in providing referrals to clients for additional continued care. While the WV Family Planning Program advises following QFP recommendations for client care, some services are not payable by the program. Services which are not will be clearly marked.

2.3 QUALITY FAMILY PLANNING (QFP) RECOMMENDATIONS

All providers should be familiar with and follow the "Providing Quality Family Planning Services" (QFP), a document that was created in 2014 by the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services, Office of Population Affairs (OPA) after a multi-stage process drawing on established procedures for developing clinical guidelines. The QFP defines what services to provide and how to do so. The recommendations are evidence-informed guidelines for all service delivery providers of family planning and reproductive health services. This clinical pathway can be used as a framework to help determine a client's need for services and then to transition from addressing a client's stated need to exploring the need for additional family planning and related preventive health services. It is intended for all providers and potential providers of family planning services, including primary care providers.

The QFP recommends a client-centered approach and delivering "high-quality care to all clients, including adolescents, lesbian, gay, bi-sexual, transgender, and questioning (LGBTQ) persons, racial and ethnic minorities, clients with limited English proficiency (LEP), and persons living with disabilities." At patient encounters, the QFP recommends that providers assess the primary reason for the client's visit, determine whether the client has another source of primary care, and then assess the client's reproductive life plan. For clients who are sexually active and do not want a child at this time, providers should offer contraceptive services

When providing contraceptive services, the QFP recommends that providers follow these five steps:

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

The last step involves educating the client, and the QFP suggests, "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)." Then, providers should help clients consider potential barriers to using the methods they are considering. When warranted, providers should conduct physical assessments such as blood pressure readings; however, the recommendations warn, "Unnecessary medical procedures and tests might create logistical, emotional, or economic barriers to contraceptive access for some women." Finally, the QFP advises providers to provide the selected method along with instructions, and "help the client develop a plan for using the selected method and for follow-up, and confirm client understanding."

2.4 STAFF TRAINING

The WV Family Planning Program will provide orientation and/or in-service training of all provider personnel, including the staff of service sites at least once per year. The program must be notified of any change in clinic staff. While training will be conducted or arranged by the WV Family Planning Program, providers are responsible for maintaining updated records for clinic staff to show completion (such as certificates, confirmation of completion emails, etc.) of the required training. Training information may include but is not limited to:

- Reporting requirements: staff must be aware of Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as on human trafficking;
- Cultural competency: staff must consider the educational and cultural backgrounds of the individuals to whom they provide services;
- LGBTQ: staff must consider the unique needs of persons representative of all communities;
- Adolescents: staff must understand the needs of this key population. Adolescents must be assured that services are confidential. Title X providers may neither require written consent of parents or guardians for the provision of services to minors, nor notify parents or guardians at any time when a minor has requested and/or received Title X family planning services. However, staff must be knowledgeable about encouraging and assisting adolescents in involving family members in the decision to seek family

planning services and on counseling for how to resist being coerced into engaging in sexual activities;

- Pregnancy options counseling;
- Confidentiality: staff must be informed about polices related to preserving client confidentiality and privacy, and exhibit that this information is safeguarded;
- LEP: staff must show competency in dealing with persons with limited English proficiency and in utilizing available resources;
- Disability: staff must be sensitive to the needs of disabled persons and must follow all state and federal laws regarding provision of care; and
- HIPAA: all staff must complete a Health Insurance Portability and Accountability Act (HIPAA) training each year.

2.5 REFERRALS AND FOLLOW-UP

Provider agencies must offer **all** family planning services either on-site or by referral. Provider agencies must have written policies/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients' concerns for confidentiality and privacy.

For services determined to be necessary but which are beyond the scope of the WV Family Planning Program, clients must be referred to other providers for care. When a client is referred for non-family planning or emergency clinical care, providers must:

- Make arrangements for the provision of pertinent client information to the referral provider. Providers must obtain client's consent to such arrangements, except as may be necessary to provide services to the client, or as required by law with appropriate safeguards for confidentiality;
- Advise client on their responsibility in complying with the referral; and
- Counsel client on the importance of such referral and the agreed upon method of follow-up.

Efforts may be made to aid the client in identifying potential resources for reimbursement of the referral provider, but neither the WV Family Planning Program nor providers, are responsible for the cost of this care.

Providers must make provisions for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance. Providers must coordinate the use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs.

In order to meet this federal program requirement, providers must have current (i.e., signed within the past 12 months) written (e.g., Memorandums of Understanding (MOUs), collaborative agreements with relevant referral agencies, which must have been approved by the WV Family Planning Program Director.

2.6 COMMUNITY EDUCATION

All providers are expected to provide for community participation and education and to promote the activities of the program.

- Providers must make available an opportunity for participation in the development, implementation, and evaluation of the program by persons broadly representative of all significant elements of the population to be served; and by persons in the community knowledgeable about the community's needs for family planning services.
- Providers must establish and implement planned activities, such as health fairs and expos, host teen awareness events, or collaborate with program staff to speak at area schools, to facilitate community awareness of and access to family planning services. Each community education program(s) should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.
- Community education should serve to enhance community understanding of the objectives of the program, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial.
- Providers must maintain current records to document all community participation and education.

2.7 CLIENT ENROLLMENT, PATIENT CHARTS, AND FORMS

To enroll a client in the WV Family Planning Program, the provider agency must:

- Obtain a consent for services (located on the Basic Data Form);
- Explain voluntary participation and confidentiality;
- Complete all program and billing forms; and
- Assemble the patient chart.

A patient chart should be assembled with the following forms prior to being seen by a clinician (forms and related requirements are subject to change):

- Basic Data Form (general consent);
- Reproductive Life Plan;
- Patient Data Form;
- Medical History Form;
- Client Education and Counseling Checklist; and
- Progress Notes and Order Sheet.

Forms are available for download and printing on the program website at www.wvdhhr.org/fp. A user name and password are obtained by contacting the WV Family Planning Program.

Please note, the WV Family Planning Program strongly encourages the use of electronic health records (EHR). While this section discusses the use of mandatory forms and assembly of patient charts, we do not assume the use of paper charts, only that the information on the mandatory forms must be present in the patient chart. Additionally, providers using EHR must be able to provide printed versions of the screens used for obtaining the mandatory data in order to assure all necessary information is being collected. If it is not possible to print those screens for review, WV Family Planning Program forms must be used and scanned into the EHR, or an approval to use altered forms must be obtained (see below, 2.7.2).

2.7.1 DOCUMENTATION

Providers must document the entire patient encounter on the appropriate corresponding form or EHR screen (e.g., demographic information should be recorded on the Basic Data Form, medical history on the Medical History Form, client counseling and education must be completed using the Client Education and Counseling Checklist). Additional information must also be documented on the Progress Notes and Order Sheet. The progress notes section of this form must be used to clearly document what specific services were provided. Examples of information which must be recorded in the progress notes section of this form include, but are not limited to:

- Documentation that adolescent clients seeking family planning services received counseling on how to resist coercive attempts to engage in sexual activities and encouragement regarding family involvement in their decision to seek family planning services;
- Documentation of gonorrhea and chlamydia testing as well as the result when it is received;
- Documentation of STD counseling; and
- Documentation of completion of the Reproductive Life Plan and subsequent discussions.

2.7.2 ALTERATION OF FORMS

Program billing forms cannot be altered or substituted. Billing forms received in an altered state will be returned without processing. Providers wishing to use altered or substituted clinical services forms, may submit the form to the WV Family Planning Program for approval, **but must continue using program forms until approval is received**. This also applies to providers utilizing Electronic Health Record (EHR).

Providers using EHR must be able to provide printed versions of those screens for approval. If it is not possible to submit those screens for approval, WV Family Planning Program forms must continue to be used and scanned into the EHR.

2.8 MEDICAL RECORDS

Provider agencies must establish a medical record for every client who obtains clinical services. These records must be maintained in accordance with accepted medical standards and State laws with regard to record retention. Electronic Health Records are highly recommended. Records must be:

- Complete, legible, and accurate, including documentation of telephone encounters of a clinical nature;
- Signed by the clinician or other appropriately trained health professionals making entries, including name, title, and date;
- Readily accessible;
- Systematically organized to facilitate prompt retrieval and compilation of information;
- Confidential;
- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use; and
- Available upon request to the client.

2.8.1 CONTENT OF CLIENT RECORD

The client's medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes:

- Personal data;
- Medical history, physical exam, laboratory test orders, results, and follow-up;
- Current medication list;
- Treatment and special instructions;
- Scheduled revisits;
- Consent for services; and
- Allergies and reactions to any drug(s) recorded in a prominent and specific location.

The record must also contain reports of clinical findings, diagnostic and therapeutic orders, and documentation of continuing care, referral, and follow-up. The record must allow for entries by the counseling and social service staff. Client financial information should be kept separate from the client medical record.

2.8.2 CONFIDENTIALITY AND RELEASE OF RECORDS

A confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client, or as required by law, with appropriate safeguards for confidentiality. When information is requested, provider agencies should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other forms which do not identify particular individuals.

2.8.3 RECORD RETENTION

The provider agency agrees to retain all records, documents and correspondence relative to medical services in accordance with all state and federal law, or for a period of not less than six years from date the file has been closed, terminated, expired or settled, whichever is later. Records for minors must be up for a minimum of six years after the minor turns 18 or becomes emancipated.

Reviews or audits of records and documents may be conducted at any time by State and/or Federal personnel and/or other persons duly authorized by the Office of Maternal, Child and Family Health (See Section 2.11, Monitoring).

2.9 PROCEDURAL OUTLINE

The services provided to family planning clients, and the sequence in which they are provided, will depend upon the type of visit and the nature of the service requested.

All exam components should be determined by the needs of the individual client. For example, a client who is eighteen (18) may not have the same comprehensive exam components as a client who is thirty (30). Additionally, patients who have been seen by another provider may not need any exam components; these clients must have records on file to determine what care is necessary. Because policies, procedures, and/or guidelines issued by the CDC, the American College of Obstetricians and Gynecologists (ACOG), and the American Society of Colposcopy and Cervical Pathology (ASCCP) may change before these guidelines can be updated, all exam components should be completed as indicated by the current recommendations of those agencies.

Initial exam: The client's first comprehensive medical examination during which all exam components recommended by the QFP are provided. **The initial exam does not necessarily occur during the client's first visit to the clinic.** For example, a client first may come to a clinic seeking a pregnancy test and then make an appointment to return later for an initial examination.

An initial exam may be billed once per client by a participating WV Family Planning Program clinic. If the client changes to a different clinic, the new clinic may provide and bill for one initial exam for the client.

For purposes of billing and quality control, the following must be present and/or completed during the initial exam:

- Required Staff: Staff present must be licensed/certified by applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form, Reproductive Life Plan, Client Education and Counseling Checklist, Medical History Form, Progress Notes and Order Sheet;
- Labs: as indicated in prescribing info or patient history;
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Annual exam: Comprehensive medical examination at which time an established WV Family Planning Program client receives all exam components recommended by the QFP. An annual exam can be provided and billed only once in a 366 day period. **An established WV Family Planning Program client is one who has a prior initial or annual visit at that facility.**

For purposes of billing and quality control, the following must be present and/or completed for all Annual exams:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (updated signature), Reproductive Life Plan, Client Education and Counseling Checklist, Medical History Form, Progress Notes and Order Sheet;
- Labs: as indicated in prescribing info or by client history; and
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Problem medical exam: Medical services provided to an established WV Family Planning Program client by a clinician to care for conditions associated with the prescribed contraceptive

method or resulting conditions that affect method compliance and continuation. Examples of covered problems include breakthrough bleeding, amenorrhea, headaches, repeat Pap smears (performed by licensed clinician), vaginal infections, and urinary tract infections.

For purposes of billing and quality control, the following must be present and/or completed for all Problem medical exams:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (check to be sure this is in the client file and updated within the last year, if not one must be completed), Patient Data Form, Progress Notes and Order Sheet;
- Labs: as indicated in prescribing info or by client history; and
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: Schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Interim continuing visit: This visit type is intended to provide nursing or medical support staff care. Interim continuing services must be documented in the medical record. Examples include non-invasive testing or screening (i.e., blood pressure check, urine-based pregnancy test), supply refills, Depo-Provera re-injections, etc.

For purposes of billing and quality control, the following must be present and/or completed for all Interim continuing visits:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (check to be sure this is in the client file and updated within the last year, if not one must be completed), Patient Data Form, Progress Notes and Order Sheet;
- Required Services: Complete services as indicated, (i.e., pregnancy testing, blood pressure evaluation, supply refill, hormonal injection);
- Client Education: Providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: Schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

2.10 QUALITY ASSURANCE

A quality assurance system must be in place that provides for ongoing evaluation of provider personnel and services. The quality assurance system should include:

- An established set of clinical, administrative, and programmatic standards by which conformity would be maintained. This requirement is accomplished through these *WV Family Planning Program Guidelines;*
- A tracking system to identify clients in need of follow-up and/or continuing care;
- Ongoing medical audits to determine conformity with WV Family Planning Program protocols;
- Peer review procedures to evaluate individual clinician performance, to provide feedback to providers, and to initiate corrective action when deficiencies are noted;
- Periodic review of medical protocols to ensure maintenance of current standards of care;
- A process to elicit consumer feedback; and
- Ongoing and systematic documentation of quality assurance activities.

2.11 MONITORING

Provider agencies will be reviewed periodically by the Office of Maternal, Child and Family Health Quality Assurance Monitoring Team (QAMT). Providers must agree to on-site reviews from the Office of Maternal, Child and Family Health Quality Assurance Monitoring Team and/or Federal personnel of all client records and program information. The Office of Maternal, Child and Family Health Quality Assurance Monitoring Team or Federal personnel must be given access to all information related to WV Family Planning Program services to ensure that client care is provided in accordance with current practice standards. QAMT and/or Federal reviews may also include observation of patient examinations. The observation of patient examination is an extremely important part of the monitoring process to verify service components rendered during the physical examination. Providers may not refuse to participate in QAMT and/or Federal review observations, however; no observation may occur without the patient's written consent. The monitor must communicate with the patient and determine the patient understands that she/he is agreeing to allow the monitor observe the provider staff rendering services. The original signed consent is kept by the monitor and will be filed with the field notes, a copy should be kept in the patient record.

The provider agency also agrees that reviews or audits of records, and/or documents, may be conducted at any time by State and/or Federal personnel and other persons duly authorized by the Office of Maternal, Child and Family Health. This review may include an audit of any reproductive health patients' records (regardless of payor), clinic financial records, policy/procedural issuances, staffing ratios, job descriptions, meetings with consumers, and meetings with any staff directly involved in the provision of reproductive health services.

After each QAMT review, the WV Family Planning Program staff will follow-up with clinic staff. These meetings, whether in-person or by telephone, must be attended by a member of the clinic staff that is authorized by clinic administration to commit to any plan of action determined necessary during the follow-up process.

3.0 CLIENT CARE

3.1 NEED FOR SERVICES

For clients seeking to prevent or achieve pregnancy, providers should assess whether the client needs other related services (Figure 1) and offer them to the client. 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.

Figure 1. Family Planning and related and other preventive health services

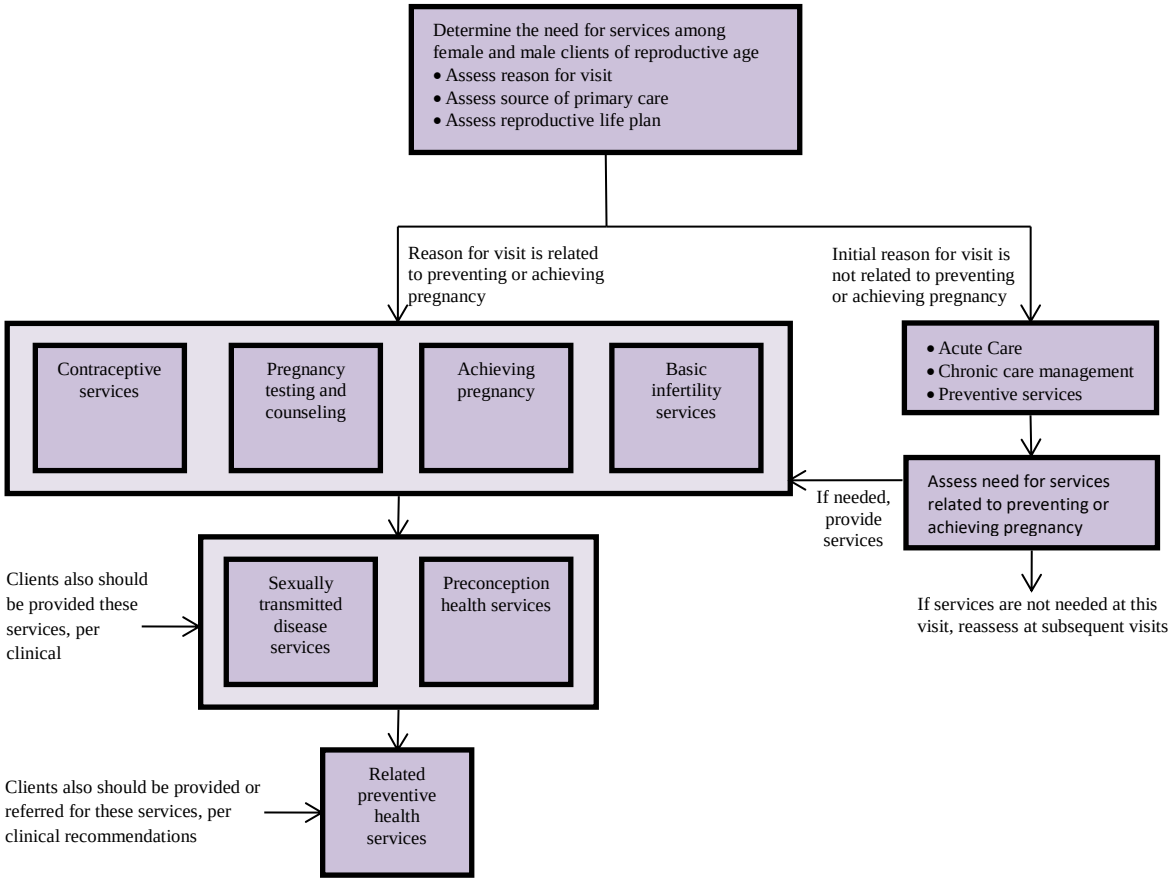
A clinical pathway of family planning services for women and men of reproductive age is provided, provided by the QFP, is illustrated in Figure 2. The following questions can help providers determine what family planning services are most appropriate for a given visit:

- **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 manual. 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. 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; and
- 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. 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 manual 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 manual (see Section 3.9) should be followed when determining which STD services a client might need. Aspects of managing symptomatic STDs are not addressed in these recommendations; and
- **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 the QFP should be followed when determining which related preventive health services a client might need.

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



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 or persons with disabilities, should be consulted and integrated into procedures, as appropriate. For example, 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 (WHO).

3.2 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.

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 birth weight, premature birth, and infant mortality. 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.

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. A woman is at lower risk of unintended pregnancy if she is using a highly effective method, such as an intrauterine device or implant, or has an established history of using methods of contraception, such as injections, pills, patch, or ring correctly and consistently. Clients who do not want to become pregnant should also be provided preconception health services, since they are recommended by the U.S. Preventive Services Task Force (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. These guidelines include 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 – See Section 7 – Definitions).

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

For billing purposes, these services may be included as part of a family planning visit, however, may not be billed to the WV Family Planning Program if the client is seen for one of these services outside the scope of a family planning visit. For example, if a patient makes an office visit strictly to have their blood pressure checked, but it is unrelated to reproductive health, it is not payable by the WV Family Planning Program. However, if the patient makes an office visit to have their blood pressure checked as a result of concern regarding contraceptive use, this visit is payable by the WV Family Planning Program.

3.2.1 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.

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).

3.2.2 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 – See Section 7 – Definitions) recommendations.

3.2.3 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 – See Section 7 – Definitions) for how to do so, and provide behavioral counseling interventions, as indicated. 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. 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.

3.2.4 TOBACCO USE

For female and male clients, providers should screen for tobacco use in accordance with the USPSTF recommendation for how to do so. Adults (Grade A – See Section 7 – Definitions) 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. Adolescents (Grade B – See Section 7 – Definitions) should be provided intervention to prevent initiation of tobacco use.

3.2.5 IMMUNIZATIONS

For female and male clients, providers should screen for immunization status in accordance with recommendations of CDC's Advisory Committee on Immunization Practices 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. (For vaccines for reproductive health-related conditions, i.e., human papillomavirus and hepatitis B, see "Sexually Transmitted Disease Services.")

3.2.6 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. 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 and American Academy of Child and Adolescent Psychiatry recommendations to assess risk for suicide among persons experiencing depression and other risk factors.

3.2.7 HEIGHT, WEIGHT, AND BODY MASS INDEX

For all clients, providers should screen adult (Grade B – See Section 7 – Definitions) and adolescent (Grade B – See Section 7 – Definitions) 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. 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

3.2.8 BLOOD PRESSURE

For female and male clients, providers should screen for hypertension in accordance with the USPSTF's recommendation (Grade A – See Section 7 – Definitions) that blood pressure be measured routinely among adults. Further recommendation is annual screening for persons at increased risk (i.e., African American, high normal blood pressure, obese or overweight, aged >40 years) and every three-five years in persons at low risk (adults aged 18-39 years with no risk factors).

It should also be noted, that the American Heart Association recommends blood pressure measurement at each regular health care visit or at least once every two years in adults with blood pressure less than 120/80 mm Hg. The American Academy of Family Physicians' recommendation is similar to that of the USPSTF. The American Congress of Obstetricians and Gynecologists recommends blood pressure screening as part of women's annual health care visits.

3.2.9 DIABETES

The USPSTF recommends screening for diabetes in adults aged 40–70 years who are overweight or obese, and referring patients with abnormal glucose levels to intensive behavioral counseling interventions to promote a healthful diet and physical activity (Grade B – See Section 7 – Definitions).

3.3 SEXUALLY TRANSMITTED DISEASES

Providers should offer STD services in accordance with CDC's STD treatment and HIV testing guidelines. 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. Vaccination for human papillomavirus (HPV) and hepatitis B are also important parts of STD services and preconception care.

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 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 and recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. Clients also should follow CDC's recommendations for testing for hepatitis C, and the Advisory Committee on Immunization Practice's recommendations on reproductive health-related immunizations. 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. 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.

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. 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. 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 three months.

- **GONORRHEA**

  For female clients, providers should screen clients for gonorrhea, in accordance with CDC's STD treatment guidelines. Routine screening for *N. gonorrhoeae* in all sexually active women at risk for infection is recommended annually. 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 gonorrhea 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.

  For male clients, providers should screen MSM for gonorrhea at anatomic sites of exposure, in accordance with CDC's STD treatment guidelines. 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 three months after treatment.

- **SYPHILIS**

  For female and male clients, providers should screen clients for syphilis, in accordance with CDC's STD treatment guidelines. 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. Pregnant women should be screened for syphilis at the time of their pregnancy test if there might be delays in obtaining prenatal care.

- **HIV/AIDS**

  For female and male clients, providers should screen clients for HIV/AIDS, in accordance with CDC HIV testing guidelines. Providers should follow CDC recommendations that all clients aged 13–64 years are screened routinely for HIV infection and that all persons likely to be at high risk for HIV are rescreened at least annually. 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. Transgender clients should be assessed for their STD and HIV-related risks on the basis of current anatomy and sexual behaviors. 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 – See Section 7 – Definitions). Clients with HIV infection should be tests at least annually for hepatitis C. The WV Family Planning Program does not pay for HIV/AIDS testing.

- **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. 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 – See Section 7 – Definitions). The WV Family Planning Program does not pay for Hepatitis C Testing.

- **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. 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 three 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. 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 – See Section 7 – Definitions). One high-intensity behavioral counseling model that is similar to the contraceptive counseling model is Project Respect, 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 non-monogamous 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: 1) 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, three to six 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 three 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.

3.3.1 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; 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

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Male clients aged 11–21 years (minimum age: nine 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. 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.

The WV Family Planning Program does not pay for immunizations.

3.4 CLIENT COUNSELING AND EDUCATION GUIDELINES

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.

3.4.1 COUNSELING

Key principles of providing quality counseling are listed below and may be used when providing family planning services. 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.

- **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. 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.
- **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. 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. 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 STDs and pregnancy, increased quality and satisfaction with services, increased knowledge, and enhanced psychosocial determinants of contraceptive use.
- **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. 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. 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. 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. 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.

- **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 QFP 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. 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.

3.4.2 EDUCATION

Informational and educational materials must be suitable for the population and community for which they are intended and consistent with the purposes of Title X. In order to meet this federal requirement, the WV Family Planning Program has established an Information and Education Advisory Committee (I&E Advisory Committee). When presented with information and educational materials, the I&E Advisory Committee will:

- Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
- Consider the standards of the population or community to be served with respect to such materials;

- Review the content of the material to assure that the information is factually correct;
- Determine whether the material is suitable for the population or community to which it is to be made available; and
- Establish a written record of its determinations.

All informational and educational materials provided at WV Family Planning Program clinics, regardless of the pay source of the patient encounter, must be approved by the I&E Advisory Committee prior to distribution.

3.5 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.

To help a client who is initiating or switching to a new method of contraception, providers should follow the following 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 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.

  Clients considering combined hormonal contraception should have blood pressure monitored and be asked about tobacco use, in accordance with CDC guidelines on contraceptive use.

  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);
- **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; and

- **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 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.

- **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. 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). 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. 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.

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. 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;
- **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;
- **Non-contraceptive benefits.** Many contraceptives have non-contraceptive benefits, in addition to preventing pregnancy, such as reducing heavy menstrual bleeding. Although the non-contraceptive 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; and
- **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.

When working with male clients, when appropriate, providers should discuss information about female-controlled 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. 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. 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);
- **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. 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; and
- **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. 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 few, if any, examinations or laboratory tests before starting a method of contraception. 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). Clinical evaluation of a client electing permanent sterilization should be guided by the clinician who performs the procedure. Recommendations for contraceptive use are available. 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, 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. 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):
        - 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.

      No physical examination needs to be performed before distributing condoms.

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 contracepti	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 and 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 assess 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 eligiblity 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 Elgibility 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 elgibility 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.

- **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. 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:

- 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; or
- 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 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 increases the likelihood of an unintended pregnancy. 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, so providers should discuss ways the client might deal with potential side effects to increase satisfaction with the method and improve continuation.

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.

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).

3.6 CONTRACEPTIVE METHODS

Because certification or licensure requirements may vary and/or change before this document can be updated, providers must follow all applicable state and federal laws in determining which clinical staff should be involved in the provision of contraceptive methods and supplies. Similarly, recommendations and requirements for administration or use of contraceptives and supplies may change before this document can be updated, providers should follow the recommendations for usage of contraceptives, found at: http://www.cdc.gov; http://www.acog.org; and http://www.asccp.org.

The following contraceptives are currently offered by the WV Family Planning Program; this list is subject to change:

- **REVERSIBLE CONTRACEPTION**
  - **Long acting reversible contraceptives (LARC)**
    - **Implants**: The hormonal contraceptive implant is a type of birth control for women. It is a flexible, plastic rod the size of a matchstick that is put under the skin of the arm. The hormonal contraceptive implant contains a hormone called etonogestrel and lasts up to three years.
    - **Intrauterine devices (IUDs)**: The Copper T intrauterine device is made of copper and releases a small amount of copper into the uterus. This can prevent the egg from being fertilized or attaching to the wall of the uterus. The copper also prevents sperm from going through the uterus into the fallopian tubes and reduces the sperm's ability to fertilize an egg. Copper T intrauterine device is indicated for use up to 10 years.

      Levonorgestrel intrauterine system, a hormonal IUD, releases a small amount of hormone progestin into the uterus. This thickens the cervical mucus, which decreases the chance that the sperm will enter the cervix. It makes the sperm less active and makes the sperm and the egg less likely to be able to live in the fallopian tube. It also thins the lining of the uterus. This keeps the fertilized egg from attaching and makes periods lighter. Levonorgestrel intrauterine system is indicated for use up to five years.

- **Short acting hormonal methods**
  - **Injectables:** Depo-Provera (Depo Medroxyprogesterone Acetate or DMPA) is a form of progestin which is used as an injectable method of contraception effective for 12 weeks.
  - **Oral contraceptives**: There are two major classifications of birth control pills: combination and progestin-only. Combination pills contain both estrogen and progestin compounds which suppress ovulation, change uterine lining, tubal transport, and cervical mucus thereby affecting the ability of sperm and egg to unite and implant. Progestin-only pills work by inhibiting ovulation, thickening cervical mucus, creating a thin endometrium, and destroying the corpus luteum.
  - **Intra-vaginal devices:** Intra-vaginal device is a non-biodegradable, flexible, transparent, colorless to almost colorless, combination contraceptive vaginal ring containing two active components, etonogestrel and ethinyl estradiol. When placed in the vagina, each device releases on average 0.120mg/day of etonogestrel and 0.015mg/day of ethinyl estradiol over a three week period of use.
- **Barrier methods**
  - **Male Condom**: A male condom keeps sperm from getting into a woman's body. Latex condoms, the most common type, help prevent pregnancy, HIV and other STDs, as do the newer synthetic condoms. "Natural" or "lambskin" condoms also help prevent pregnancy, but may not provide protection against STDs, including HIV. Condoms can only be used once and may be used with water-based lubricants. Oil-based lubricants such as massage oils, baby oil, lotions, or petroleum jelly should not be used with latex condoms. They will weaken the condom, causing it to tear or break.
  - **Female Condom**: The female condom helps keeps sperm from getting into the body. It is packaged with a lubricant and can be inserted up to eight hours before sexual intercourse.
  - **Diaphragm**: When properly fitted, diaphragms serve two purposes, to stop sperm from entering the cervical canal and to hold the spermicide.
  - **Cervical Cap:** The cervical cap is a small, bowl-shaped device that fits snugly over the cervix and has a strap for easy removal. Like the diaphragm, the cervical cap is designed for use with spermicide.
  - **Sponge**: The contraceptive sponge is a round piece of white plastic foam with a little dimple on one side and a nylon loop across the top that looks like shoelace material. It's pretty small—just two inches

across. It blocks your cervix to keep sperm from getting into your uterus, and is designed for use with spermicide.

- **Vaginal Contraceptive Film**: Vaginal Contraceptive Film (VCF) is an individually sealed semi-transparent square (two inch) of hormone-free soluble film containing nonoxynol-9. Inserted into the vagina, VCF dissolves quickly when it comes in contact with bodily fluids inside the vagina. Once dissolved, VCF creates a gel coating which contains highly effective spermicides that kill sperm on contact for up to three hours after insertion. Because VCF becomes a gel it doesn't become runny or messy. It won't stain. Over time the dissolved gel gets washed away with the natural body fluids. There's nothing to remove or dispose. This product used together with condoms, offers greater protection against pregnancy.
- **Foam**: Contraceptive foam, or spermicide, is a birth control method that contains chemicals that stop sperm from moving. Spermicide can be used alone, or it can be used with other birth control methods to make them more effective.

- **Fertility awareness methods (FAM)**:
  Fertility awareness (also called natural family planning or rhythm method) is a way to predict fertile and infertile times in your cycle. FAM is based on body signs, which change during each menstrual cycle in response to the hormones that cause ovulation (the release of an egg).
- **Emergency (post-coital) contraception (EC)**:
  Emergency contraception is a therapy for clients who experience an act of unprotected sexual intercourse. Emergency contraception is NOT a regular method of birth control.
  - The Copper T IUD can also be used as a type of EC if inserted within five days of unprotected sex.
  - Emergency Contraceptive Pills (ECPs) is a hormonal contraceptive taken up to 5 days after unprotected sex. It should be noted that the sooner the pills are taken, the more effective they will be.

- **STERILIZATION**

  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. Informed consent must be obtained prior to performing a sterilization procedure. To obtain informed consent, the federal Consent for Sterilization form, available on the WV Family Planning Program website, must be signed and dated by:
  - The individual to be sterilized;

- The interpreter, if one is provided;
- The person who obtains the consent; and
- The physician who will perform the sterilization procedure.

The person obtaining the consent and the physician performing the sterilization must certify by signing the consent form that:

- Before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized;
- He or she explained orally the requirements for informed consent as set forth on the consent form; and
- To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally, read the consent form and explained its contents, and to the best of the interpreter's knowledge and belief, the individual to be sterilized understood what the interpreter told him or her.

The counseling and consent process for clients requesting sterilization must assure that the client's decision to undergo sterilization is completely voluntary and made with the full knowledge of the permanence, risks, and benefits associated with female and male sterilization procedures. A person who obtains informed consent for a sterilization procedure must offer to answer any questions the individual to be sterilized may have concerning the procedure, provide a copy of the consent form, and provide orally all of the following information or advice to the individual who is to be sterilized:

- Advice that the individual is free to withhold or withdraw consent to the procedure any time before the sterilization without affecting his or her right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;
- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization; and

- Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after he or she gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The following booklets (links for these are available on the WV Family Planning Program website) as resources for counseling on sterilization:

- "Female Sterilization – The Facts"
- "Male Sterilization – The Facts"

Informed consent may not be obtained while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.

Any requirement of state and local law for obtaining consent, except one of spousal consent, must be followed.

Sterilization clients must meet the following criteria:

- At least twenty-one (21) years of age at the time consent is obtained;
- Mentally competent;
- Given his or her informed consent; and
- Waited at least 30 days, but not more than 180 days, between the date of consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after he or she gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The WV Family Planning Program must preauthorize all requests for sterilization. The following forms must be completed for approval:

- The Federal Sterilization Consent Form; and
- The Voluntary Sterilization In-Take Form. The in-take form must be signed and dated by the client and witnessed by staff.

Completed forms must be faxed to the WV Family Planning Program office at the number listed on the Voluntary Sterilization In-Take Form. A copy of the

approved/denied in-take form will be returned to the provider with an authorization period listed on approved forms (180 days from signature date).

The provider can make the referral appointment or request that the client schedule the appointment with the participating sterilization provider. However, providers shall not perform, or arrange for the performance of, a sterilization of any mentally incompetent individual or institutionalized individual. Copies of the approved Voluntary Sterilization In-Take Form and Sterilization Consent Form should be forwarded to the sterilization provider. If the client is unable to have the procedure performed during the authorization period, she/he must re-apply, complete new forms, and begin a new waiting period. In all instances, whether the provider performs the procedure or the client is referred for an appointment, adequate contraception should be provided during any period of waiting.

3.7 CONTRACEPTIVE SERVICES FOR ADOLESCENTS

Adolescents seeking contraceptive services should have appointments made available to them as soon as possible. They should be informed and counseled about all methods of contraception, including information that LARCs are safe and effective for nulliparous women (women who have not been pregnant or given birth), including adolescents. Abstinence and safe sex practice options to reduce risks for STD/HIV and pregnancy must also be discussed with all adolescents. It is important not to assume that adolescents are sexually active simply because they have come for family planning services. As the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

Adolescents must be assured that services are confidential. Title X providers may neither require written consent of parents or guardians for the provision of services to minors, nor notify parents or guardians at any time when a minor has requested and/or received Title X family planning services. However, counselors should encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts of coercion to engage in sexual activities.

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.

3.8 ADOLESCENT PREGNANCY PREVENTION INITIATIVE

The Adolescent Pregnancy Prevention Initiative (APPI) is a focus area within the WV Family Planning Program, whose goal is to reduce the number of pregnancies among adolescents through improved decision making, abstinence, or access to contraceptive services. This statewide initiative provides community outreach and education to increase public awareness of problems associated with early sexual activity. APPI collaborates with WV public schools

and community organizations to promote local activities for adolescent pregnancy prevention. Additionally, APPI has resources available for use at no cost, by request.

Contact Information:
Adolescent Pregnancy Prevention Initiative
350 Capitol Street, Room 427
Charleston, WV 25301-3714
Phone: (304) 558-5388 Fax: (304) 957-7505
Toll-Free: (800) 642-8522
Email: dhhromcfhapp@wv.gov
Website: www.wvdhhr.org/appi

3.9 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 ACOG and the American Academy of Pediatrics (AAP). 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. 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.

3.9.1 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. 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. 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.

3.9.2 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.

3.10 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).

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 six-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 one – two 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); and
- Smoking, consuming alcohol, using recreational drugs, and using most commercially available vaginal lubricants should be discouraged as these might reduce fertility.

3.10.1 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).

Infertility commonly is defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse. Earlier assessment (such as six 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 sub-fertile (the condition of being less than normally fertile though still capable of effecting fertilization). 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. 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. ASRM recommends that evaluation of both partners should begin at the same time.

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.

3.11 LABORATORY TESTING

- **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. 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 three 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.

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. 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. 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 three months.

- **Gonorrhea: For female clients**, providers should screen clients for gonorrhea, in accordance with CDC's STD treatment guidelines. Routine screening for *N. gonorrhoeae* in all sexually active women at risk for infection is recommended annually. 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 gonorrhea infection should be re-screened for re-infection at three 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.

  For male clients, providers should screen MSM for gonorrhea at anatomic sites of exposure, in accordance with CDC's STD treatment guidelines. 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 three months after treatment.
- **Syphilis: For female and male clients**, providers should screen clients for syphilis, in accordance with CDC's STD treatment guidelines. 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. Pregnant women should be screened for syphilis at the time of their pregnancy test if there might be delays in obtaining prenatal care.
- **Cervical Cytology:** Providers should follow USPSTF recommendations to screen women aged 21–29 years with cervical cytology (Pap smear) every three years, for women aged 30–65 years every three years with cervical cytology alone, every five years with high-risk hrHPV testing alone, or every five years with hrHPV testing in combination with cytology (cotesting). (Grade A – See Section 7 – Definitions).

Cervical cytology not recommended on an annual basis or for women aged <21 years (Grade D). Women with abnormal test results should be treated in accordance with professional standards of care, which may include colposcopy. The need for cervical cytology should not delay initiation or hinder continuation of a contraceptive method.

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.

3.11.1 NOTIFICATION OF LAB RESULTS

A procedure which addresses client confidentiality must be established to allow for client notification and adequate follow-up of laboratory results.

ABNORMAL LABORATORY RESULTS:

The following are minimum requirements for follow-up of abnormal lab results and referral for medical problems for WV Family Planning Program clients. **No attempt to contact client(s) may breach client confidentiality.**

- A minimum of three attempted client contacts is required. The first attempt to contact the client must be initiated within seven days of receipt of the results;
- The first attempt at contacting a client should be by telephone, unless the client specified otherwise;
- Telephone contact regarding medical test results and/or referrals should be made by a clinician, registered nurse, or licensed practical nurse;
- Each attempt to contact a client must be documented in the client's medical record, along with the results of a successful contact;
- After two unsuccessful attempts to reach the client by phone, a certified letter must be sent. The time period between the receipt of pap results and the mailing of the letter must not be more than six weeks. The letter should communicate that this will be the last effort made in contacting the client; and
- When attempts at contacting a client are terminated, this action must be documented in the client's medical record. Suggestions for writing letters to clients:
    - Write a letter that the client can understand. Keep it short and simple;
    - Use non-alarming language. Emphasize the importance that the client contact the health care facility for further information and follow-up; and
    - Give the client a specific contact person and time to call.

NORMAL LABORATORY RESULTS:

The Title X WV Family Planning Program does not require client notification of normal laboratory results. It is recommended, however, that provider agencies utilize a consistent procedure for handling and/or notification of normal laboratory results, (i.e., instruct clients to contact clinic for results or instruct clients they will be notified only in the event of abnormal results; send letter to clients for all lab results).

PAP TEST ACTIVITY LOG:

Title X Guidelines require that provider agencies utilize a tracking system to identify clients in need of follow-up and/or continuing care. For Pap test results, provider agencies may use the Family Planning Pap Test Activity Log available on website.

3.11.2 MANAGEMENT OF ABNORMAL RESULTS

Follow the current management guidelines and follow-up recommendations of the ASCCP, located at http://www.asccp.org, and the ACOG, located at http://www.acog.org.

The WV Family Planning Program does not reimburse for colposcopy or related diagnostic/treatment services. Refer to the WV Breast and Cervical Cancer Screening Program (BCCSP) for possible financial assistance.

3.11.3 COLPOLSCOPY REFERRAL

When a WV Family Planning Program client meets the Breast and Cervical Cancer Screening Program protocol for a colposcopy referral, the client must be enrolled in the BCCSP. Follow-up pap test, as recommended by the colposcopy provider, will be provided through the WV Family Planning Program as per liquid based Pap policy.

4.0 RELATED 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:

4.1 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 – See Section 7 – Definitions). The USPSTF also recommends that women at increased risk for breast cancer should be counseled about risk-reducing medications (Grade B – See Section 7 – Definitions).

4.2 CLINICAL BREAST EXAM

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. The American Cancer Society (ACS) recommends screening every three years for women aged 20–39 years, and annually for women aged ≥40 years. 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.

4.3 MAMMOGRAPHY

Providers should follow USPSTF recommendations (Grade B – See Section 7 – Definitions) 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.

The WV BCCSP may provide additional diagnostic services for patients. For more specific information, contact the WV BCCSP at (304) 558-5388 or http://www.wvdhhr.org/bccsp/.

4.4 GENITAL EXAM

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. Components of this examination include inspecting skin and hair, palpating inguinal nodes, scrotal contents and penis, and inspecting the perianal region, as indicated.

4.5 SUMMARY RECOMMENDATIONS

The QFP 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 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:

- The process of asking questions about a client's history, including a determination of whether risk factors for a disease or health condition exist;
- Performing a physical exam; and
- 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 three 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. 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.

TABLE 2. Checklist of family planning and related preventive health services for women

	Family planning services (provide services in accordance with the appropriate clinical recommendation)					
Screening components	**Contraceptive services #**	**Pregnancy testing and counseling**	**Basic infertility services**	**Preconception health services**	**STD services +**	**Related preventive health 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			Screen		
Immunizations §	for clients aged ≥35 years			Screen	Screen for HPV & HBV	
Depression §, ¶				Screen		
Folic acid §, ¶				Screen		
Physical examination						
Height, weight and BMI §, ¶	Screen (hormonal methods) ++		Screen	Screen		
Blood pressure §, ¶	Screen (combined hormonal methods)			Screen §§		
Clinical breast exam # #			Screen			
Pelvic exam §, # #	Screen (initiating diaphragm or IUD)	Screen (if clinically indicated)	Screen			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 = intrauterin 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 colum 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. 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.

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)				
	Contraceptive services #	Basic infertility services	Preconception health services+	STD services §	Related preventive health 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 tranmitted 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 out comes (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 colum 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.

5.0 FINANCIAL MANAGEMENT

Each provider site must submit an application to and be approved by the WV Family Planning Program Director or her/his designee, including service sites of existing providers. Approved clinics are issued a unique ID number for identification, ordering, and billing purposes. Clinics offering WV Family Planning Program services without approval will not be reimbursed.

5.1 CHARGES AND COLLECTIONS:

General charges and collection information:

- Reasonable efforts must be made to collect payment from clients who are responsible for paying a fee for services; these patients should be given bills directly to avoid jeopardizing confidentiality;
- Income verification is obtained by client statement;
- The WV Family Planning Program Sliding Fee Scale, provided annually, is required for individuals with family incomes between 101% and 250% of the Federal Poverty Level (FPL). The provider agency will be reimbursed the difference between the amount the client was charged and the WV Family Planning Program's maximum allowable charge for the service provided;
- When confidentiality of services is not a concern, the family's income must be considered in determining the appropriate charge(s);
- Clients whose documented income is at or below 100% of the FPL must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services;
- Eligibility for discounts for unemancipated minors who receive confidential services must be based on the income of the minor;
- Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the provider agency administrator, are unable to pay for family planning services, including those who are determined to be underinsured;
- For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services;
- Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third party payment without the application of any discounts; and
- Voluntary donations from clients are permissible; however, clients must not be pressured to make donations and donations must not be a prerequisite to the provision of services or supplies.

WV Family Planning Program clients should not be denied services, or be subjected to any variation in quality of services, because of an inability to pay. Determination of ability to pay is made by the clinic administration.

5.1.2 PROGRAM INCOME

The standards set forth in this section shall be used to account for program income related to projects financed in whole or in part with Federal funds. Program income shall be retained by the provider and, in accordance with the terms and conditions of the award, shall be used in one or more of the following ways:

- Added to funds committed to the project or program, and used to further eligible project or program objectives;
- Used to finance the non-Federal share of the project or program; or
- Deducted from the total project or program allowable cost in determining the net allowable costs on which the Federal share of costs is based (45 CFR §74.24).

Each provider must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements that will support effective control and accountability of funds. Documentation and records of all income and expenditures must be maintained as required. A specific budget and accounting records for Title X funds must be accurately maintained. To assist with this process, the WV Family Planning Program will provide a list of all pharmaceuticals and supplies provided to each clinical site. The clinical sites must include this information in their Title X budgets and make an "in-kind" adjustment to accounting records.

5.1.3 INSURANCE, HMO, MCO, and OTHER FEDERAL PROGRAMS:

Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third party payment without the application of any discounts. This includes all clients enrolled in the WV Medicaid Program, the WV Medicaid Managed Care initiative and clients seen in Federally Qualified Health Centers (FQHC). This does not apply to clients receiving confidential services through the WV Family Planning Program; these clients are enrolled in the WV Family Planning Program and no other funding source is billed.

Family income should be assessed before determining whether copayments or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% of the FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied (42 CFR 59.5(a)(9).

Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency must be in place.

5.1.4 REFERRAL FROM PRIVATE PRACTICE PHYICIANS

This policy is intended to address the concern of submitting clients to unnecessary, repeated examinations, while providing clarification that family planning provider agencies must not become "supply depots" for contraceptive supplies. Clients with a prescription from a private practice physician may be provided supplies if the following criteria have been met:

- Written prescription for contraceptive supplies;
- Documentation of medical services provided (medical history, physical assessment, appropriate labs completed); and
- Client referred from private physician for continuation in WV Family Planning Program clinic.

5.2 BILLING

Providers are required to bill for services at least once a month but may bill more frequently if desired. All claims for a calendar month must be invoiced by the 10th day of the following month. Deviation from established policy may result in the claim not being accepted.

5.2.1 FAMILY PLANNING ELECTRONIC DATA SYSTEM

The Family Planning Electronic Data System (FPEDS) is the system utilized by the WV Family Planning Program to replace the manual process of recording patient visits, creating invoices and sending documents to Family Planning to process for payment. Clinics/providers access FPEDS via the internet to enter patient visits and create invoices and will be responsible for approving the created invoice prior to it being processed for payment by Our Advanced Solution with Integrated Systems (WVOASIS). The clinic/provider can track the status of their invoices through the website using the Invoice Summary and Invoice Detail webpages.

The FPEDS website is located on the WV Family Planning Program webpage under the Family Planning Electronic Data System link. A list on the following page will display the link. When the FPEDS tab is clicked, it initiates the browser to link into FPEDS. A user ID and password is issued by contacting the WV Family Planning Program.

In cases where a provider is unable to access the FPEDS, invoices may be submitted to the WV Family Planning Program billing office for processing. The invoice is the total

amount of reimbursement due the clinic for all Patient Data Forms in the batch. Batches mailed in must contain claims for a single calendar month and cannot be combined (i.e., January and February claims in a single batch). The completed invoice is submitted with Patient Data Forms to the WV Family Planning Program for payment. The invoice must be completed neatly and accurately in blue ink to assure prompt processing time.

The top left section of the invoice contains the following clinic billing address information:

- **Provider Name**: The name of the provider agency as listed on the Memorandum of Understanding (MOU) with the WV Family Planning Program;
- **Address**: The address listed on the MOU with the WV Family Planning Program. This address may not necessarily be the physical address of the clinic;
- **Service Site Name**: The name of the individual clinic or service site;
- **WV Vendor Registration Number**: The Federal Employer Identification Number (FEIN) or state tax identification number. This is a different number than the 10 digit provider number assigned for the WV Family Planning Program;
- **Service Month**: The date(s) and month of services being billed. If billing for a two week period, the from/to field would reflect the particular date(s) of service (i.e., January 1-15, 2001). If billing for the entire month, the from/to field would reflect those dates (i.e., January 1-31, 2001); and
- **Invoice Number**: A number assigned by the provider agency to track the invoice for their records.

Each visit type is listed on the invoice with a breakdown of percentages. The total number of claims for each category must be listed, with the total calculated. A total of all visit types and dollar amounts due the provider agency must be recorded. The invoice must have an original signature (in blue ink), title of the individual completing the invoice as well as the date submitted. The invoice must be certified with this statement, "I certify this is the original invoice and payment has not been received." An authorized signature (in blue ink), title and date must accompany this statement.

5.2.2 PATIENT DATA FORM INSTRUCTIONS

All clients must have a Patient Data Form completed and maintained in the client medical record for every visit regardless of payor source. All Patient Data Forms or computer generated claims must be accurately completed with the required information. Avoid marking outside the designated blocks or lines. No information,

except that required for completion, is to be entered on the form. Avoid making strikeovers or crossing out errors. If the provider agency generates more than 150 Patient Data Forms per month, submission of at least two batches is required. Listed below are instructions for completion of each field of the Patient Data Form.

Field 1: Clinic Number

Each clinic is assigned a unique number by the WV Family Planning Program for the purposes of identification. Enter this number here.

Field 2: Patient Social Security Number

Enter the client's Social Security Number. If a client doesn't have, doesn't know or refuses to divulge his/her social security number, an alternate client ID number will be assigned by FPEDS. This alternate number must be used for the remainder of the calendar year.

Field 3: Visit Date (MM/DD/YYYY)

Enter the actual date the client received WV Family Planning Program services. Use the two digits for month and day and four digits for the year. Example: For services rendered January 6, 2016, the visit date should be entered as 01/06/2016.

Field 4: County of Residence Code

Enter the two digit code for the client's county of residence. Enter "00" if the client is not a WV Resident. A list of resident codes is available on the WV Family Planning website.

Field 5: Name

Enter the client's name: last, first, middle initial. If a client has no middle name, leave the middle section blank.

Field 6: Date of Birth

Use two digits for month and day, four digits for the year. Example: a birth date of February 2, 1980, should be entered as 02/02/1980.

Field 7: Sex

Check the applicable box.

Field 8: Ethnicity

Must check one (1) of the two (2) boxes to indicate client's self-reported ethnicity. Staff may assist the client in reporting his/her ethnicity by asking "Do you consider yourself Hispanic/Latino or Not Hispanic/Latino?"

- **Hispanic/Latino** – defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin. Persons of Hispanic/Latino origin may be of any race.
- **Not Hispanic/Latino** – defined as a person not Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Field 9: Race

Must check the box(es) for all races identified by the client. Clinic staff may ask "What is your race? You must select one or more." Federal definitions are provided:

- **White** – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Black/African American** – a person having origins in any of the black racial groups of Africa.
- **Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **American Indian/Alaska Native** – a person having origins in any of the original peoples of North or South American, including Central America and who maintains tribal affiliation or community attachment.
- **Native Hawaiian/Pacific Islander** – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Field 10: Additional Demographic Info

- **Person with disability –** Check box if client reports having a physical and/or mental disability.
- **Limited English proficiency –** A person with limited English proficiency is one who's native or dominant language is not English and whose skills in listening to, speaking, reading, or writing English are such that he/she would derive little benefit from family planning and related preventive health services provided in English. Check box if client required oral language assistance services to optimize his/her use of Title X services. Language assistance services include those provided by bilingual clinic staff, FP contracted interpreter, or the client's own interpreter.

Field 11: Principal Health Insurance Coverage

For individuals with coverage under more than one health plan, principle insurance is defined as the insurance plan that the agency would bill first (i.e., primary) if a claim were to be filed. Income eligible and insurance/Medicaid

status must be determined at each clinic visit. If a client requests confidential services, but their principal health insurance covers some or all Family Planning Services, record the client's coverage as private or public whenever the coverage type is known or can be asked, as this information is required for the Family Planning Annual Report.

- **Uninsured/Underinsured (Title X)** – Check when a client, who meets Program income eligibility guidelines, does not have other insurance or their insurance does not cover some or all of the services provided by the WV Family Planning Program.
- **Public Health Insurance (Medicaid ID#_____)** – Check if client has Medicaid coverage and enter the card number.
- **Private Health Insurance** – Check when a patient has private health insurance.

Field 11(a): Confidential

Check to indicate the client is seeking confidential services without the involvement or knowledge of family. If client has any other type of insurance, checking this box explains the reason for use of Title X funding and overrides rejection of the claim.

Field 12: Monthly Income

Document the gross monthly income supporting the client by using four digits. If income is 1, 2 or 3 digits, precede with leading zero(s) to make four digits. If the client and/or family have no income, enter four zeros. When a client requests confidential services, enter only the income of the individual client.

Field 13: Family Size

Enter the number of individuals who receive support from the monthly income. Precede single digits with a zero (i.e., a family of four is entered as 04). Clients requesting confidential services are considered a family of one, and only the individual client's income is considered.

Field 14: Patient Fee Percentage

Enter the applicable percentage of the visit fee the client should be charged based upon the current WV Family Planning Program Sliding Fee Scale.

Field 15: Patient Fee

Enter the applicable dollar amount the client should be charged for the visit based upon the current WV Family Planning Program Sliding Fee Scale.

Field 16: Purpose of Visit

The purpose of family planning visits in Title X clinics is to provide reproductive health services. In keeping with this federal definition, if a client is an ongoing family planning user who visits the clinic to obtain any type of family planning or related preventive health services, the encounter is considered a family planning encounter.

Federal regulations further specify that to qualify as a Title X family planning encounter, the visit must:

- Include face-to-face contact between the client and service provider;
- Be documented in the client's medical record;
- Include the provision of family planning counseling and education; and
- Take place in a Title X service site.

Exam Type

All exam components should be determined by the needs of the individual client. For example, a client who is eighteen (18) may not have the same comprehensive exam components as a client who is thirty (30). Additionally, patients who have been seen by another provider may not need any exam components; these clients must have records on file to determine what care is necessary. Because policies, procedures, and/or guidelines issued by the CDC, ACOG, and the ASCCP may change before these guidelines can be updated, all exam components should be completed as indicated by the current recommendations of those agencies.

Initial exam: The client's first comprehensive medical examination during which all exam components recommended by the QFP are provided. **The initial exam does not necessarily occur during the client's first visit to the clinic.** For example, a client first may come to a clinic seeking a pregnancy test and then make an appointment to return later for an initial examination.

An initial exam may be billed once per client by a participating WV Family Planning Program clinic. If the client changes to a different clinic, the new clinic may provide and bill for one initial exam for the client.

For purposes of billing and quality control, the following must be present and/or completed during the initial exam:

- Required Staff: Staff present must be licensed/certified by applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form, Reproductive Life Plan, Client Education and Counseling Checklist, Medical History Form, Progress Notes and Order

Sheet;

- Labs: as indicated in prescribing info or patient history;
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Annual exam: Comprehensive medical examination at which time an established WV Family Planning Program client receives all exam components recommended by the QFP. An annual exam can be provided and billed only once in a 366 day period. **An established WV Family Planning Program client is one who has a prior initial or annual visit at that facility.**

For purposes of billing and quality control, the following must be present and/or completed for all Annual exams:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (updated signature), Reproductive Life Plan, Client Education and Counseling Checklist, Medical History Form, Progress Notes and Order Sheet;
- Labs: as indicated in prescribing info or by client history; and
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Problem medical exam: Medical services provided to an established WV Family Planning Program client by a clinician to care for conditions associated with the prescribed contraceptive method or resulting conditions that affect method compliance and continuation. Examples of covered problems include breakthrough bleeding, amenorrhea, headaches, repeat Pap smears (performed by licensed clinician), vaginal infections, and urinary tract infections.

For purposes of billing and quality control, the following must be present and/or completed for all Problem medical exams:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (check to be sure this is in the client file and updated within the last year, if not one must be completed), Patient Data Form, Progress Notes and Order Sheet;
- Labs: as indicated in prescribing info or by client history; and
- Examination Components, as indicated;
- Client Education: providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: Schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Interim continuing visit: This visit type is intended to provide nursing or medical support staff care. Interim continuing services must be documented in the medical record. Examples include non-invasive testing or screening (i.e., blood pressure check, urine-based pregnancy test), supply refills, Depo-Provera re-injections, etc.

For purposes of billing and quality control, the following must be present and/or completed for all Interim continuing visits:

- Required Staff: Staff present must be licensed/certified within applicable state and/or federal law to perform the components necessary for the individual client's needs;
- Required Forms: Basic Data Form (check to be sure this is in the client file and updated within the last year, if not one must be completed), Patient Data Form, Progress Notes and Order Sheet;
- Required Services: Complete services as indicated, (i.e., pregnancy testing, blood pressure evaluation, supply refill, hormonal injection);
- Client Education: Providers should complete discussion on all aspects of the strategies of education and the key principles for counseling, STD/HIV prevention, emergency contact procedures; and
- Follow-up/Referral: Schedule next appointment for continuing family planning care and provide written referral(s) for any additional services, as indicated.

Field 17: Service Provider

Defined by Title X regulations as the provider with the highest level of training who assumes primary responsibility for client's health assessment, care and documentation of services in the client medical record and who exercises independent judgment

regarding which services the client needs. Only one service provider can be reported for the visit although two or more may have participated in the care of the client. For example, if a mid-level practitioner performed an examination and a nurse provided contraceptive counseling/education, the mid-level provider would be considered the higher trained of the two professionals and would be reported as the service provider. All providers must be licensed in the State of WV.

- **Physician** – check if the service provider was a licensed doctor of medicine or osteopathy (MD or DO).
- **Physician Assistant, Nurse Practitioner, Nurse Midwife** – check if the service provider was trained and permitted by state-specific regulations to perform all aspects of the client's physical assessment.
- **Registered Nurse, Licensed Practical Nurse** – check if the service provider was a RN or LPN licensed to perform the service(s) rendered.
- **Other (Medical Assistant, Health Educator, Social Worker, Clinic Aide, Lab Technician)** – check if the service provider was other than listed above (i.e., medical assistant, health educator, social worker, clinic aide or lab technician) trained/licensed to provide and document services such as obtaining samples for routine laboratory tests, performing routine aspects of the client's physical assessment (i.e., blood pressure, weight, temperature), providing client education and counseling, making referrals, and/or follow-up.

Field 18: Exam Components Provided

The service provider should complete this section of the Patient Data Form at the time the services are provided. Check the corresponding box for every medical examination component completed making certain that all exam components required by Title X are provided and documented. If no exam was provided (i.e., only pregnancy testing, counseling, and education were provided), check box #10.

Field 19: Laboratory Services Provided

Check the corresponding box(es) for every lab test provided during the clinic visit making certain that all Title X required tests are completed and documented. If lab testing was not required or indicated during the visit, check box #13.

Field 20: Referrals Made

Check the corresponding box(es) that apply for referral(s) made to another agency, clinician or program for additional services.

- **Sterilization** – check if client education/counseling about sterilization was provided by trained personnel, informed consent signed and in-take form for WV Family Planning Program – funded surgical sterilization and referral was made for sterilization services.
- **Gynecological** – check if client was referred for special gynecological services

beyond the scope of those provided by WV Family Planning Program.

- **Breast Evaluation** – check if client was referred for further breast evaluation based upon clinical breast examination findings.
- **Colposcopy** – check if client was referred for colposcopy as follow-up to abnormal cytology results.
- **STD/HIV services** – check if client was referred for STD/HIV testing and/or treatment not within the defined scope of WV Family Planning Program services.
- **Infertility evaluation** – check if client was referred to an infertility specialist for evaluation beyond the scope of Level I infertility services provided by the WV Family Planning Program.
- **Adoption services** – check if client requested and was provided information about adoption services during pregnancy options counseling.
- **Prenatal services** – check if client requested and was provided information about prenatal services during pregnancy options counseling.
- **Abortion services** – check if client requested and was provided information about abortion services during pregnancy options counseling.
- **Social services** – check if client was referred for needed social services (i.e., county DHHR office).
- **Laboratory services** – check if client was referred for laboratory services beyond the scope of those available through the WV Family Planning Program.
- **Alcohol/Drug services –** check if client was referred for needed services for alcohol and/or drug abuse services.
- **Intimate Partner Violence** – check if client was referred for services to help stop intimate partner violence.
- **Immunizations** – check if client was referred for assistance in receiving immunizations.
- **Mental Health services** – check if client was referred for mental health services such as depression.
- **BMI** – check if client was referred for services related to obtaining a healthy BMI.
- **Blood Pressure** – check if client was referred for services related to obtaining a healthy blood pressure.
- **Diabetes** – check if client was referred for services related to diabetes prevention or care.
- **WV Tobacco Quit Line** – check if client was referred to the WV Quit Line for tobacco cessation assistance.
- **Other Tobacco Cessation Program** – check if client was referred to another tobacco cessation program other than the WV Tobacco Quit Line.

- **No referrals** – check if no referrals were indicated or made.

Field 21 (a): Primary Contraceptive Method – Female

The primary method of contraception is the client's chosen method. If the client chooses more than one family planning method, check the most effective one as the primary method. The list of female methods includes some which are not available through the WV Family Planning Program. The primary method the client uses, from whatever source, should be indicated by checking the appropriate box.

- **Oral Contraceptives** – check if client uses an oral contraceptive, either combination or progestin-only, as her primary method of birth control.
- **IUD** – check if client uses an Intrauterine Device (i.e., ParaGard Copper T 380A) or Intrauterine System (i.e., Mirena).
- **Diaphragm/Cap** – check if client's primary method is a diaphragm or cervical cap.
- **Spermicide (used alone)** – check if client's primary method is the use of only spermicidal jelly, cream, foam, or film not in conjunction with another method of contraceptive.
- **Fertility Awareness or Lactational Amenorrhea Method** – check if the client relies on one or a combination of the following fertility awareness methods to identify potentially fertile days in each menstrual cycle when intercourse is most likely to result in a pregnancy: rhythm/calendar, basal body temperature, cervical mucus, and/or symptom-thermal. Post-partum women who are practicing the lactation amenorrhea method (LAM) should also be reported with users of fertility awareness methods.
- **Hormonal Implant** – check if client's primary contraceptive is a long-term, sub-dermal hormonal implant.
- **Contraceptive Sponge** – check if client's primary contraceptive method is a contraceptive sponge.
- **Hormonal Injection – three-month** – check if client uses a three-month injectable hormonal contraception as her primary family planning method.
- **Hormonal Contraceptive Patch** – check if client uses a trans-dermal hormonal contraceptive patch as her primary family planning method.
- **Vaginal Ring** – check if the client uses a hormonal vaginal ring (i.e., NuvaRing) as her primary family planning method.
- **Female Condom** – check if client uses female condoms with or without spermicides as her primary family planning method.
- **Female Sterilization** – individuals who have undergone sterilization procedures are eligible for annual exams.
- **Abstinence** – abstinence is defined as refraining from oral, vaginal, and anal

intercourse. Check if client relies on abstinence as her primary family planning method or is not currently sexually active and therefore not using contraception.

- **Rely on Male Method –** check if client relies on her partner's vasectomy or male condoms, with or without spermicide, as her primary method of contraception.
- **Withdrawal or Other Method** – check if client uses withdrawal or other methods not listed as her primary family planning method.
- **No Method: Reason** – check if client is not using any contraceptive method because she is pregnant or seeking to become pregnant, or if she is not using a contraception method to avoid pregnancy due to other reasons than seeking pregnancy or pregnancy prevention (i.e., she or her partner is sterile without having been sterilized surgically).

Field 21 (b): Primary Contraceptive Method – Male

The primary method of contraception is the client's chosen method. If the client chooses more than one family planning method, check the most effective one as the primary method.

- **Vasectomy** – individuals who have undergone sterilization procedures are eligible for WV Family Planning Program annual exams.
- **Male Condom** – check if client uses male condoms with or without spermicides as his primary family planning method.
- **Abstinence –** check if client relies on abstinence as his primary family planning method or is not currently sexually active and therefore not using contraceptive. For reporting purposes, abstinence is defined as refraining from oral, vaginal, and anal intercourse.
- **Fertility Awareness Method** – check if the client relies on one or a combination of the following fertility awareness methods to identify potentially fertile days in each menstrual cycle when intercourse is most likely to result in a pregnancy: rhythm/calendar, basal body temperature, cervical mucus, and/or symptom-thermal.
- **Withdrawal or Other Method** – check if client uses withdrawal or other methods not listed as his primary family planning method.
- **Rely on female method** – check if client relies solely on the contraceptive method used by his female partner to prevent pregnancy, including lactation amenorrhea method (LAM).
- **No Method: Reason** – check if client is not using any contraceptive method because his partner is pregnant or seeking to become pregnant, or if client is not using any contraceptive method to avoid causing pregnancy due to reasons other than partner is pregnant or seeking pregnancy, (i.e., he or his partner is sterile without having been sterilized surgically).

Field 22: Emergency Contraceptive (EC)

- **EC administration –** immediate need – check if emergency contraception was dispensed to the client as soon as possible within the first 72 hours, but within five days, after unprotected intercourse to reduce the risk of becoming pregnant.
- **EC follow-up –** check if client was seen for follow-up post-administration of emergency contraceptive.
- **EC advance supply –** check if client was provided an advance supply of emergency contraception for future use with instructions to use in the event of unprotected intercourse or birth control failure.

Field 23: Medical Products Dispensed

List warehouse item code, quantity, and lot number(s) of pharmaceutical products (contraceptive methods/supplies and treatment medications) dispensed during clinic visit.

Field 24: Reason for Pap

- **Routine** – check if Pap was performed as part of a regular procedure.
- **Clinically indicated** – check if Pap was performed outside the regular procedure schedule by clinician's determination of medical necessity, clinical indication must be included in the patient record.
- **Requested** – check if Pap was performed at the client's request. The WV Family Planning Program does not reimburse for patient requested services.

Field 25: By-pass Payment

Check if the client has a payor other than the WV Family Planning Program.

5.2.3 Bypass Payment

Providers can be reimbursed for collection of information on clients with a pay source other than the WV Family Planning Program by completing the following steps:

- Complete a Patient Data Form for each of these patients utilizing the same steps used when the client is a WV Family Planning Program payor client except you will mark Number 25: Bypass Payment. Complete a Data Collection Reimbursement Invoice and submit it to the WV Family Planning Program for payment. Invoices for these services are submitted using the same instructions as all other invoices except:
    - Invoices must be marked clearly with "BYPASS" on the form.
    - Bypass invoices must not be mixed with regular invoices.
    - Item Description must be present and must say, "Reimbursement for electronic data collection" or the invoice will be rejected and no

payment will be received.

Bypass invoicing can be verified in FPEDS by checking the patient information. Those entered with the "Bypass" selected will appear in red under "Private Insurance" and will not add any amount to the balance total.

6.0 LEGAL ISSUES

6.1 GENERAL

To enable persons who want to obtain family planning care to have access to services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572), which added Title X "Population Research and Voluntary Family Planning Programs," to the Public Health Service Act. Section 1001 of the Act (as amended) authorizes grants "to assist in the establishment and operation of family planning projects which offer a broad range of acceptable and effective family planning methods and services."

The mission of Title X is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children. The regulations governing Title X (42 CFR Part 59, Subpart A) set out the requirements of the Secretary, Department of Health and Human Services, for the provision of family planning services funded under Title X and implement the statute as authorized under Section 1001 of the Public Health Service Act.

WV Code §16-2B-2, authorizes the WV Department of Health and Human Resources to provide printed material, guidance, advice, financial assistance, appliances, devices, drugs, approved methods, and medicines for use in the operation of family planning clinics.

This document, the *WV Family Planning Program Guidelines,* interprets these laws and regulations in operational terms and provides a general orientation to the Federal and State perspective on family planning.

6.2 VOLUNTARY PARTICIPATION

Use of family planning services by any individual must be solely on a voluntary basis. Individuals must not be subjected to coercion to receive services or to use, or not to use, any particular method of family planning. Acceptance of family planning services must not be a prerequisite to eligibility or receipt of, any other service or assistance from or participation in any other programs.

Provider agency personnel must be informed they will be subject to prosecution under Federal law if they coerce, or endeavor to coerce, any person to undergo an abortion or sterilization procedure.

6.3 NON-DISCRIMINATION

No person shall be excluded from participation in, denied the benefits of, or subjected to, discrimination in any way from any service available through the WV Family Planning Program on the basis of race, color, ethnicity, gender, gender identity, gender expression,

religion, creed, political belief, age, national origin, citizenship, linguistic and language difference, sexual orientation, socio-economic status, height, weight, marital or familial status, disability, number of pregnancies, or any other characteristic protected by law. The WV Family Planning Program does not discriminate against any client for services on any of the above criteria and is committed to the promotion of diversity in all areas. All program providers **must** agree to uphold and further this policy.

6.4 PROGRAM ADMINISTRATION AND ETHICS

The WV Family Planning Program will never request an individual to violate their own code of ethics, morality, or religion. However, when a provider agrees to participate in the WV Family Planning Program, there must be at least one person on staff to provide all types of contraceptives and counseling (for which he/she is trained and legally able to distribute) offered by the WV Family Planning Program, including Emergency Contraceptives.

6.5 CONFIDENTIALITY

Every provider agency must assure client confidentiality and provide safeguards for individuals against the invasion of personal privacy, as required by the Privacy Act. No information obtained by the staff about individuals receiving services may be disclosed without the individual's written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual.

6.6 STANDARDS OF CONDUCT

Provider agencies must establish policies to prevent employees, consultants, or members of governing or advisory bodies from using their positions for purposes of private gain for themselves or for others.

6.7 HUMAN SUBJECTS CLEARANCE (RESEARCH)

Research conducted within Title X programs may be subject to Department of Health and Human Services regulations regarding the protection of human subjects (45 CFR Part 46). The provider must advise the WV Family Planning Program in writing of any research projects that involve Title X clients (HHS Grants Policy Statement 2007, II-9).

6.8 LIABILITY COVERAGE

Provider agencies should ensure the existence of adequate liability coverage for all segments of the program funded under the grant, including all individuals providing services. Governing boards should obtain liability coverage for their members.

6.9 COMPLIANCE WITH STATE REPORTING LAWS

WV Family Planning Program provider agencies must adhere to the state requirement for reporting of suspected child abuse of minor children. WV Code, **pertaining to health care professionals**, is listed below. For a complete listing of WV Code for all persons mandated to report, please visit http://www.legis.state.wv.us/wvcode/code.cfm.

§49-2-803. Persons mandated to report suspected abuse and neglect; requirements.
Any medical, dental, or mental health professional, Christian Science practitioner, religious healer, school teacher or other school personnel, social service worker, child care or foster care worker, emergency medical services personnel, peace officer or law-enforcement official, humane officer, member of the clergy, circuit court judge, family court judge, employee of the Division of Juvenile Services, magistrate, youth camp administrator or counselor, employee, coach or volunteer of an entity that provides organized activities for children, or commercial film or photographic print processor who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the WV Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the

Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(f) Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

§49-2-809. Reporting procedures.

(a) Reports of child abuse and neglect pursuant to this article shall be made immediately by telephone to the local department child protective service agency and shall be followed by a written report within forty-eight hours if so requested by the receiving agency. The state department shall establish and maintain a twenty-four hour, seven-day-a-week telephone number to receive those calls reporting suspected or known child abuse or neglect.

(b) A copy of any report of serious physical abuse, sexual abuse, or assault shall be forwarded by the department to the appropriate law-enforcement agency, prosecuting attorney, coroner, or medical examiner's office. All reports under this article are confidential. Reports of known or suspected institutional child abuse or neglect shall be made and received as all other reports made pursuant to this article.

§49-2-810. Immunity from liability.

Any person, official, or institution participating in good faith in any act permitted or required by this article are immune from any civil or criminal liability that otherwise might result by reason of those actions.

§49-2-812. Failure to report; penalty.

(a) Any person, official, or institution required by this article to report a case involving a child known or suspected to be abused or neglected, or required by section eight hundred nine of this article to forward a copy of a report of serious injury, who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction, shall be confined in jail not more than ninety days or fined not more than $5,000, or both fined and confined.

(b) Any person, official, or institution required by this article to report a case involving a child known or suspected to be sexually assaulted or sexually abused, or student known or suspected to have been a victim of any non-consensual sexual contact, sexual intercourse or sexual intrusion on school premises, who knowingly fails to do so or knowingly prevents

another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail not more than six months or fined not more than $10,000, or both.

Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

6.10 ADDITIONAL INFORMATION

Additional legal information, including Title X grant requirements, case law for adolescent confidential services, WV Code for family planning and child spacing, and public health sterilization regulation can be located on the WV Family Planning Program website at www.wvdhhr.org/fp. A user name and password are obtained by contacting the WV Family Planning Program.

7.0 DEFINITIONS

Can/May

Indicates suggestions for consideration by individual provider agencies.

Coercion

The practice of persuading someone to do something by using force or threats.

Confidentiality

One of the core duties of medical practice requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient. Confidentiality is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Confidential Services

Services provided to clients without the knowledge or involvement of any other person or entity.

Family Planning Encounter

An encounter between a user and a medical provider or other health provider, the primary purpose of which is to provide family planning services, (i.e., clinical or educational services related to contraception, infertility, or sterilization). All family planning encounters are either medical encounters or other health encounters that involve family planning services. Only face-to-face contacts documented in a medical or health record can be counted as encounters.

Family Planning Patient/Client

A person seeking to prevent or achieve pregnancy.

Family Planning Program

Under the WV Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health, the Family Planning Program is the entity that manages all components of the Title X grant.

Federal Poverty Level (FPL)

Income levels used for determination of financial eligibility for WV Family Planning Program services and reflected in the annual WV Family Planning Program sliding fee scale; updated annually based upon the last calendar year's increase in prices as measured by the Consumer Price Index.

Grantee

The entity that receives a federal grant and assumes legal and financial responsibility and accountability for awarded funds and for performance of activities approved for funding.

Memorandum of Understanding (MOU)

A formal agreement between two or more parties. Companies and organizations can use MOUs to establish official partnerships.

Must

Indicates mandatory program policy.

Provider Agency

The delegate/contact agency that provides clinical family planning services with Title X funds and/or supplies under a negotiated, written agreement with the WV Family Planning Program.

Referral

Defined by the U.S. Department of Health and Human Services, Public Health Service, Office Population Affairs as providing a client with the name, address, and/or telephone number of a provider, without further action to secure the services.

Service sites

Locations where clinical services are provided.

Should

Indicates *recommended* program policy relating to components of family planning and program management that the service provider is urged to utilize in order to fulfill the intent of Title X.

Title X

U.S. Public Health Service, Family Planning Program; authorizes grants to assist in the establishment and operation of family planning clinics.

Uninsured/Underinsured

Indicates a client's lack of principal health insurance, or principal health insurance that does not cover some or all of the services provided by the WV Family Planning Program.

U.S. Preventive Services Task Force (USPSTF) Recommendations/Grades

The U.S. Preventive Services Task Force (USPSTF) assigns one of five letter grades (A, B, C, D, or I) to describe the strength of their recommendation for specific practices. A complete list of full descriptions for each letter can be located at https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions.

8.0 SOURCES

Office of Population Affairs, Title X Family Planning
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