TITLE X POLICY AND PROCEDURE MANUAL

This manual was developed to guide the administrative, financial, and clinical services of family planning clinics receiving Title X funding through the Women’s Health and Family Planning Association of Texas.

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APPROVED BY:
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WHFPT Board of Trustees on February 11, 2015

UNDER THE DIRECTION OF:
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<td>American Society for Reproductive Medicine</td>
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<td>CBE</td>
<td>Clinical Breast Exam</td>
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<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
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<td>CLIA</td>
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<td>CLIENT</td>
<td>An individual receiving medical care, treatment, or education related to family planning</td>
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<td>Emergency Contraception</td>
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<td>EPHC</td>
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<td>HIPAA</td>
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<td>Intrauterine Contraception</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
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<td>JSI</td>
<td>John Snow, Inc.</td>
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<td>LARC</td>
<td>Long Acting Reversible Contraceptive</td>
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<td>LEP</td>
<td>Limited English Proficiency</td>
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<td>MMWR</td>
<td>Morbidity and Mortality Weekly Report</td>
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<td>MSM</td>
<td>Men Who Have Sex with Men</td>
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<td>NFPRHA</td>
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<td>OPA</td>
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<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
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<td>PHC</td>
<td>Primary Healthcare Grant</td>
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<td>PID</td>
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<td>QFP</td>
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<td>SHAC</td>
<td>Texas School Health Advisory Council</td>
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<td>WHFPT Title X funded agencies; delegate agency; contractor</td>
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<td>Texas Women's Health Program</td>
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<td>USPSTF</td>
<td>United States Preventive Services Task Force</td>
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<td>WHFPT</td>
<td>Women's Health and Family Planning Association of Texas</td>
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<tr>
<td>WIC</td>
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INTRODUCTION

Purpose of Manual

This document describes how to implement and operationalize the statutory and regulatory requirements of the Title X Family Planning Program as set out in applicable federal statutes, regulations, guidelines, requirements, and Women’s Health and Family Planning Association of Texas (WHFPT) policies. WHFPT, as the Title X grantee for the state of Texas, funds sub-recipients for projects that consist of the educational, medical, and social services necessary to aid individuals in determining the number and spacing of their children.

In 2014, the Office of Population Affairs (OPA) released updated Title X Family Planning Program guidelines, hereafter referred to as “The Guidelines.” The Guidelines consist of two parts: 1) The Title X Program Requirements, and 2) Providing Quality Family Planning Services (QFP). These documents can be found on the OPA website.

While this Manual is intended as a guide for Title X sub-recipients, agencies which participate in other federal and state family planning programs, such as Title XIX (Medicaid), and state-funded family planning programs (e.g., TWHP, EPHC, FP, etc.), should also follow the policies and procedures established by these programs.

Federal and state laws related to reporting of child abuse, operation of health facilities and pharmacies, professional practice, insurance coverage, and similar topics also impact family planning services. Title X-funded agencies are required to be aware of, and in compliance with, state and federal laws.

WHFPT Background and History

The Women’s Health and Family Planning Association of Texas is a 501(c)(3), nonprofit organization, founded in 1977 by a group of individuals dedicated to the proposition that every Texan should have equal access to high quality reproductive health services and control over the timing and spacing of their children. WHFPT is the only independent organization devoted exclusively to family planning in the state of Texas. The OPA awarded WHFPT with the Title X family planning grant on March 31, 2013 and WHFPT is the sole Title X grantee for the state of Texas.

WHFPT Priorities

• To provide Texans, through Reproductive Life Planning, with the ability to exercise personal choice in achieving their reproductive health goals.
• To ensure that quality family planning and related preventive health services are available to all individuals of reproductive age who want and need them, with a focus on access for individuals from low-income families and adolescents.
• To provide a broad range of acceptable and effective family planning methods, including Long Acting Reversible Contraceptives (LARCs) when medically appropriate. The broad range of services does not include abortion as a method of family planning.
• To ensure that all services are voluntary and provided confidentially.
To ensure that services are available to all who request them, regardless of ability to pay, residency, citizenship, limited English proficiency, gender, sexual orientation, marital status, disability, religion, age, race, ethnicity, or financial status.

To ensure that individuals who have incomes at or below 100% of the federal poverty level are never charged for services, although projects must bill third parties that are authorized or legally obligated to pay for services.

To incorporate the 2014 Title X Program Requirements and the OPA/CDC’s Providing Quality Family Planning Services (QFP) throughout the network.

To ensure the financial sustainability of family planning and preventive health agencies across the Texas Title X network.

To embrace innovation and technology, and to stay abreast of the best practices and medical advancements in reproductive healthcare.

To establish linkages and partnerships with comprehensive primary care providers, HIV care and treatment providers, and mental health, drug, and alcohol treatment providers.

**WHFPT Values**

As the Title X grantee, WHFPT strives to manage the Title X project to reduce administrative burdens, minimize reporting requirements, and, in every way possible, support its sub-recipients in their efforts to provide quality preventive and family planning healthcare to their clients. To this end, WHFPT pledges to:

- be open, transparent, and collaborative in its processes and decision making;
- involve sub-recipients in decision making at all levels of the organization’s structure;
- keep the needs of its sub-recipients and their clients at the forefront of all it does;
- be respectful, flexible, and responsive in all its dealings with sub-recipients; and
- partner with sub-recipients to meet the growing need for quality family planning and preventive health services in Texas.

**WHFPT’s Collaboration with Sub-Recipients**

Effective communication between WHFPT and all of its sub-recipients builds a strong foundation for collaboration. Each sub-recipient must designate a minimum of two individuals from its organization to act as liaisons with WHFPT. These point people will receive all communications from WHFPT and will be expected to direct those communications to the appropriate individuals within their organization. If communication between the two organizations is not effective, timely, and consistent, WHFPT may ask the sub-recipient to designate an alternate point person(s).

The Texas Title X project was created based on the ideals of partnership. As partners, it is important to WHFPT that its sub-recipients are given an opportunity to participate in the establishment and revision of ongoing grantee policies and guidelines. To ensure that sub-recipients play an active role in the administration of the Title X project, WHFPT has developed many opportunities for sub-recipients and WHFPT staff to work together to achieve shared goals.
These opportunities include:

**Board of Trustees**

To ensure that the collective voice of the sub-recipients is heard at the highest level of organizational governance, a minimum of three board members will be chosen from the pool of candidates nominated by, and from the communities of, the sub-recipients. In addition, both the Chair and Co-Chair of the Provider Committee and the Chair of the Medical Committee (both described below) are granted automatic voting membership on the Board.

**Committees, Workgroups, and Taskforce Structure**

As part of its governance structure, WHFPT has constructed a system of committees, workgroups, and taskforces to encourage collaboration between sub-recipients, board members, and staff. Each group differs in duration, scope, and level of authority.

- Committees are composed of members of the Board of Trustees and are a permanent part of the governance structure. Committees may have autonomous power and authority as granted by the Board.
- Workgroups are project focused and created to analyze and recommend action to the committee from which they are formed. Workgroups are composed of sub-recipients and WHFPT staff and are on-going or reconvene annually.
- Taskforces are formed as needed to focus on a single issue which can be analyzed in a few meetings to formulate a recommendation for consideration by the Board or the committee which formed the taskforce. Taskforces are composed of sub-recipient representatives and WHFPT staff and are disbanded once their objective(s) have been reached.

The following committees and workgroups are designed for sub-recipient involvement:

**The Medical Committee**

The Medical Committee is composed of physicians, mid-level practitioners, and other relevant support staff from WHFPT’s sub-recipients. The Committee is also open to other interested clinicians broadly representative of the communities they serve. The Committee shall perform such functions as delegated to it by the Board, including providing advice to the Board and staff on professional licensure, clinical, or regulatory compliance matters. The Chair of the Medical Committee, a physician with special training in family planning, shall serve as the Medical Director and a voting member of the Board. The Director of Program Quality and Performance serves as the staff liason to the Medical Committee.

**The Provider Committee**

The Provider Committee shall be composed of one designated representative from each of WHFPT’s sub-recipients. The Committee shall provide recommendations and guidance to the staff and Board from a sub-recipient perspective. The Provider Committee shall elect a Chair and a Co-Chair who shall each serve as voting members of WHFPT’s Board. The Committee shall select an alternate to attend Board meetings in the absence of either the Chair or Vice-Chair. The Director of Program Management will serve as the staff liason for the Provider Committee.
From time to time, based on the needs of the organization, WHFPT will establish workgroups and taskforces comprised of members from the Provider Committee. Currently, the following groups are actively working with WHFPT staff:

• **EDUCATION MATERIALS WORKGROUP**

  Sub-recipients are not required to maintain a family planning Informational and Educational (I&E) Committee to review informational and educational materials. This will be performed by WHFPT through a workgroup of the Provider Committee composed of a mix of clinical, education, counseling, and outreach staff. The workgroup shall perform those functions delegated to it by the Board of Trustees, including expediting the approval process for new materials, creating a list of approved materials to be used in Title X clinics, and assuring all materials are current, accurate, and appropriate for the populations and communities served.

• **ALLOCATIONS WORKGROUP**

  The Allocations Workgroup is made up of representatives from sub-recipient network. This group will work with WHFPT staff to research, analyze, and develop a funding allocation formula and process that will govern the annual allocation determinations. This committee will reconvene each year to critique the effectiveness of the allocation methodology and make changes to the process as needed. The Chief Executive Officer will serve as the staff liason for this workgroup.

• **DATA COLLECTION WORKGROUP**

  Comprised of data and billing staff from sub-recipient agencies, the Data Collection Workgroup collaborates with WHFPT staff to review data collection processes and recommend changes. The changes are incorporated into the Data Manual, which is made available to all sub-recipients. The Data Specialist will serve as the staff liason for this workgroup.

• **TRAINING WORKGROUP**

  The Training Workgroup is comprised of sub-recipient staff who are representative of clinical, educational, counseling, outreach, and training staff. This workgroup collaborates with WHFPT staff to create the annual training plan and helps to choose timely and relevant topics to be addressed during the Annual Title X Conference. The Training and Outreach Manager will serve as the staff liason for this workgroup.

**Sub-Recipient Reporting Requirements**

As part of our commitment to ease the administrative burden of sub-recipients, WHFPT strives to keep all sub-recipient reporting requirements to a minimum.

**Family Planning Annual Report (FPAR)**

The FPAR is the only source of annual, uniform reporting by all Title X family planning service grantees. It provides consistent, national-level data on the Title X Family Planning Program and its users.

Information from the FPAR is important to OPA for several reasons. First, OPA uses FPAR data to monitor compliance with statutory requirements, regulations, and operational guidance. Second, OPA uses FPAR data to comply with accountability and federal performance requirements for Title X family
planning funds. Finally, OPA relies on FPAR data to guide strategic and financial planning, monitor performance, and respond to inquiries from policymakers and Congress about the program.

As the Title X grantee, WHFPT utilizes our centralized data reporting system to collect encounter-level client data to complete the FPAR. The information needed, and not collected through the centralized data system, will be collected annually through an online survey.

Centralized Data Reporting System

WHFPT sub-recipients are required to participate in WHFPT’s Centralized Data Reporting System. Sub-recipients must submit encounter-level data for all of their family planning clients on a timely basis, as determined by WHFPT.

Financial Reporting

Sub-recipients are required to submit a copy of the organization’s annual independent audit report, including the management letter.

Additional Program Reporting

Sub-recipients must comply with all reporting requirements attached to participation in WHFPT’s special funding and mini-grant opportunities. From time to time, WHFPT will require sub-recipient input via surveys, questionnaires, etc., especially during the end-of-year reporting and competitive grant writing processes.

Sub-Recipient Administrative Requirements

Personnel Policy and Procedures

Sub-recipients must develop and maintain personnel policies and procedures to ensure that agency clinical and non-clinical staff are hired, trained, and evaluated appropriately for their job position. Employee personnel files must be maintained in a confidential manner and should include job descriptions; a written Title X orientation plan for new staff, to include skills evaluation and/or competencies appropriate for the position; and a performance evaluation process for all staff. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure, to include special privileging of clinical practitioners. Policies must stipulate that staff are broadly representative of the population served.

Sub-recipients must develop and maintain a written policy addressing non-discrimination in recruitment, selection, performance evaluation, discipline, promotion, and termination.

Sub-recipients should establish safeguards to prohibit employees, consultants, or members from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement. All sub-recipients must have a qualified medical director with experience or special training in family planning to supervise, direct, and assume responsibility for clinical services. The medical director must be a licensed Texas physician.
Training

Sub-recipients should have a documented plan for organized staff development. Staff development must include Title X orientation and continuing education for all personnel and volunteers. Employee orientation and continuing education must be documented in agency personnel files. All sub-recipients must provide Title X orientation for board members and advisory committees.

All staff should be trained in or have sufficient knowledge of the basics of reproductive health and requirements of the Title X program. For clinical staff who provide education and counseling, knowledge of reproductive health should be verified through staff evaluations and/or through a certification in the Family Planning National Training Center’s (FPNTC) Family Planning Basics.

Front-line staff must demonstrate knowledge of the Title X program during phone calls with clients. Best practices include setting appointments within the time appropriate for concerns, but no greater than two weeks from the date of initial request, with no mention of costs up front. Staff must be able to deal effectively with the cultural characteristics of the client population.

All staff must receive training, at least every two years, on:

- Title X orientation;
- mandatory reporting;
- human trafficking; and
- family participation with minors.

Annual Title X Conference

WHFPT hosts a mandatory Title X Annual Conference for sub-recipients to receive relevant education and training. At least two individuals from each sub-recipient must attend the conference; however, sub-recipients can send more staff if desired. Persons attending should include those individuals who have decision-making responsibility for Title X activities. Examples of attendees include: executive directors, program managers, senior clinical staff, and other appropriate sub-recipient staff. Funds are available to support travel for two individuals from each agency. See Appendix for Travel Policy.

Training Resources

- HHS/OPA
- Family Planning National Training Center
- NFPRHA
- AETC National Resource Center
- STD/HIV Prevention Training Center
- Cardea
- JSI
- California Family Health Council
- Oregon Health Authority
Protocols, Standing Delegation Orders, and Procedures

WHFPT sub-recipients must develop and maintain written clinical protocols and Standing Delegation Orders (SDOs) in compliance with statutes and rules governing medical and nursing practices and consistent with national evidence-based clinical guidelines as written in the Providing Quality Family Planning Services MMWR (QFP) and Title X Guidelines. The written clinical protocols and/or SDOs must be signed by the medical director or supervising physician on an annual basis, or more often if changes are required. When WHFPT revises a policy, sub-recipients need to incorporate the revised policy into their written protocols, SDOs, and procedures on a quarterly basis. The medical director and clinical staff will affirm by dated signature that each has read and approved the policies related to clinical services.

Protocols

Sub-recipients that employ advanced practice nurses or physician assistants must have written protocols to delegate authorization to initiate medical aspects of client care. The protocols must be agreed upon and signed by the supervising physician and the physician assistant and/or advanced practice nurse, reviewed and signed at least annually, and maintained on-site.

Standing Delegation Orders

Sub-recipients that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants whose duties include actions or procedures for a client population with specific diseases, disorders, health problems, or sets of symptoms, must have written SDOs in place. SDOs are instructions, orders, rules, regulations, or procedures that specify under what set of conditions and circumstances actions should be initiated. The SDOs delineate under what set of conditions and circumstances a registered nurse, licensed vocational nurse, or non-licensed healthcare provider’s (NLHP) actions or tasks may be initiated in the clinical setting. SDOs authorize care for clients when a physician or advanced practice provider is not on-site, and/or before the client has been examined or evaluated by a physician or advanced practice provider. Applicable SDOs when a physician is not present on-site may include, but are not limited to:

• obtaining a personal and medical history;
• performing an appropriate physical exam and the recording of physical findings, when appropriate;
• initiating/performing laboratory procedures;
• administering or providing drugs ordered by voice communication with the authorizing physician or clinician;
• providing pre-signed prescriptions for:
  • oral contraceptives,
  • diaphragms,
  • injectable contraceptives,
  • contraceptive creams and jellies,
  • topical anti-infective for vaginal use, and
  • antibiotic drugs for treatment of STI(s);
• handling medical emergencies to include on-site management as well as the possible transfer of a client;
• giving immunizations; and
• administering pregnancy testing.

SDOs are distinct from specific orders written for a particular client. The SDOs must be dated and signed by the physician who is responsible for the delivery of medical care covered by the orders. SDOs must be reviewed and signed at least annually.

**Client Education**

In addition to the above, sub-recipients must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. All educational materials provided during client education must be reviewed and approved by the Education Materials Workgroup to assure that the materials are suitable for the intended population and community and consistent with the purposes of Title X. All client education materials need to follow standards approved by the Education Materials Workgroup. Information presented must be culturally appropriate.

As outlined in the QFP, education is an integral component of the contraceptive counseling process that helps clients make informed decisions and use contraceptive methods correctly. The content, format, method, and medium for delivering education should be evidence-based. The provider must present information in a manner that can be readily understood and retained by the client. Clients must receive current and accurate reproductive health information according to a written client education process. The education must be based on a client-centered assessment to include a Reproductive Life Plan. Information must be reviewed with clients on subsequent visits, as needed.

**Resources**

Requirements addressing scope of practice and delegation of medical and nursing acts can be accessed at the following websites:

• [Texas Medical Board](#)
• [Board of Nurse Examiners for the State of Texas](#)

Rules that are most pertinent to this topic include:

• Texas Administrative Code, Title 22, Part 9, Chapter 193; Texas Administrative Code, Title 22, Part 11, Chapters 221 and 224
• Texas Administrative Code, Title 22, Part 9, Chapter 185 (Physician Assistant Scope of Practice)

**Separation of Family Planning and Abortion Services**

No funds provided by WHFPT can be used in abortion services and, if an agency funded by WHFPT provides abortion services, these services must be physically and financially separate from Title X-funded services. Sub-recipients must have a policy which states that no Title X funds will be used where abortion is a method of family planning. WHFPT requires all sub-recipients to be in compliance with these requirements as described in “Title X Program Instruction Series, Federal Register 7/3/2000, volume 65, Number 128.” This document can be found at the [OPA website](#).
Facilities and Equipment

All sub-recipients are required to maintain a safe environment at all times. Sub-recipients must have written policies and procedures that address the handling of hazardous materials, fire safety, emergencies/natural disasters, medical equipment, medications, and training.

- **Hazardous Materials** – Sub-recipients must have written policies and procedures that address the handling, storage, and disposal of hazardous materials and waste according to applicable laws and regulations; the handling, storage, and disposal of chemical and infectious waste; and an orientation and education program for personnel who manage or have contact with hazardous materials and waste. Training must be documented.

- **Fire Safety** – Sub-recipients must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

- **Emergencies/Natural Disaster** – Sub-recipients must have written policies and procedures that address emergency situations and natural disasters according to laws and regulations and an orientation and education program for personnel. Oral and written plans must address how staff are to respond to emergency situations (e.g., fires, flooding, power outages, bomb threats, etc.). The disaster plan must identify the procedures and processes that will be initiated during a disaster and the staff positions responsible for each activity. A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace for employees to review. For an employer with ten or fewer employees, the plan may be communicated orally to employees. Training must be documented.

- **Medical Equipment** – Sub-recipients must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including automated external defibrillators (AED). For additional resources on facilities and equipment, please visit the [OSHA](https://www.osha.gov) website.

- **Medications** – Sub-recipients must have written policies and procedures that address the handling, storage, and disposal of medications according to applicable laws and regulations.

In addition, sub-recipients must have documentation of the following:

- **Smoking Ban** – Sub-recipients must have written policies that prohibit smoking in any part of their indoor facilities.

- **CLIA Waiver** – If the sub-recipient conducts diagnostic testing, it must have a current CLIA waiver certified by the State.

- **Pharmacy License** – Sub-recipients with pharmacies must have a current pharmacy license.

**Emergency Responsiveness**

All sub-recipients must be adequately prepared to handle clinical emergency situations, as follows:

- There must be a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and hospital admission, and emergencies requiring evacuation of the premises;
• Each service site must have staff trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. At least one staff member trained in basic CPR must be present during all hours of service site operation;

• There must be written protocols to address vaso-vagal reactions/syncope, anaphylaxis, cardiac arrest/respiratory difficulties, shock/hemorrhage, emergencies requiring EMS transport, after-hours emergencies, and management of contraceptive emergencies;

• Each service site must maintain emergency resuscitative drugs, supplies, and equipment appropriate to the services provided at that service site and appropriately trained staff when clients are present; and

• Documentation must be maintained in personnel files that staff have been trained regarding these written plans or protocols.

Pharmacy

All sub-recipients must have at minimum a Class D pharmacy at each service site or have a pharmacy which operates under Texas laws.

Sub-recipient pharmacies must be operated in accordance with federal and state laws relating to security and record keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. Sub-recipients must have an inventory system to control the purchase, use, and reordering of pharmaceuticals and medical supplies.

It is essential that each facility maintain an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of its clients. Not all sub-recipients must provide all FDA-approved methods of contraception, but they must be able to refer to another agency if the method is not offered. Sub-recipients should also ensure access to other drugs or devices that are necessary for the provision of other medical services included within the scope of the family planning project.

Sub-Recipient Quality Improvement Program

Service sites that offer family planning services must have an internal system for conducting quality improvement which is designed to review and strengthen the quality of services on an ongoing basis. Three key steps should be taken when conducting quality improvement:

• determine which measures are needed to monitor quality;
• collect the information needed; and
• use the findings to make changes to improve quality.

WHFPT sub-recipients must have a Quality Improvement Program individualized to their organizational structure and based on the services provided. “Plan, Do, Study, Act” (PDSA) is one example of a systematic approach to improving the quality of care. The goals of the Quality Improvement Program should ensure availability and accessibility of services and quality and continuity of care.

A Quality Improvement Program must be developed and implemented in a way that provides for ongoing evaluation of services. Sub-recipients should have a comprehensive plan for the internal review,
measurement, and evaluation of services; the analysis of monitoring data; and the development of strategies for improvement and sustainability of the improvement. In addition, quality improvement systems must include evaluation of project personnel. For additional information about the quality improvement process, please read page 21 in the QFP.

Although each organization’s Quality Improvement Program is unique, the following activities must be included:

- administration of record reviews to assure compliance with program requirements and clinical standards of care;
- tracking and reporting of adverse outcomes;
- dissemination and review of client satisfaction surveys;
- annual review of facilities to maintain a safe environment, including an emergency safety plan;
- annual review of policies, clinical protocols, and standing delegation orders (SDOs) to ensure they are current; and
- evaluation of project personnel.

WHFPT staff is available to support each sub-recipient in the development and implementation of its Quality Improvement Program.

**Research (Human Subject Clearance)**

Sub-recipients considering research at service sites supported by Title X and using family planning clients as subjects must obtain prior approval from their own Institutional Review Board (IRB).

The IRB is responsible for the review of human subject research and requests for release of data, including Protected Health Information. Sub-recipients must adhere to the Title X federal requirements governing human subject research at 45 CFR Part 46, as applicable.

Sub-recipients must have a policy in place that indicates that approval will be obtained from the IRB prior to instituting any research activities. Documentation of approval must be submitted to WHFPT in writing prior to implementation of the research. Sub-recipients must also ensure that staff have been trained in this policy.

**ACCESS TO CARE**

WHFPT’s philosophy regarding access to care is to ensure that quality family planning and related preventive health services are available to all individuals of reproductive age who want and need them, removing social, cultural, geographic, and financial barriers to care.

Quality family planning services should encompass the following values:

- Safety
- Effectiveness
- Client-Centered Approach
- Timeliness
• Efficiency
• Accessibility
• Equity
• Affordability

Policies that Ensure Access

Confidentiality

All WHFPT-funded sub-recipients must be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy. Information can be found on the HIPAA website.

The client’s preferred method for follow-up of services (e.g., cell phone, home phone, work phone, or email) and preferred language must be documented in the client’s record.

Each client, regardless of age, must receive verbal assurance of confidentiality and an explanation of what confidentiality means (specifically, kept private and not shared without written permission), as well as any applicable exceptions (i.e. abuse reporting (see the Abuse and Neglect Reporting section of this Manual)).

Confidentiality must be maintained with health information management and release of information. Privacy and confidentiality must be maintained in the delivery of services, including the transfer of records, records retention, and proper disposal of client records.

Family planning visit records cannot be released without the client’s written consent. For example, if a minor requests confidential services, family planning records must not be released to the parent requesting medical records without the minor’s written consent.

Non-Discrimination

WHFPT sub-recipients must comply with state and federal anti-discrimination laws, including and not limited to:

• Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
• Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
• Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
• Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
• Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
• Food and Nutrition Act of 2008 (7 U.S.C. §2011 et seq.);
• Texas Health and Human Services Commission’s (HHSC) administrative rules, as set forth in the Texas Administrative Code, to the extent applicable;
• HHS Executive Order 13166, 45-CFR 80.3(b)(2).

To ensure compliance with non-discrimination policies, WHFPT sub-recipients must:
• have a written policy that states that the agency does not discriminate on the basis of ability to pay, residency, citizenship, Limited English Proficiency (LEP), gender, sexual orientation, marital status, disability, religion, race, ethnicity, or financial status;
• have a policy that addresses client rights and responsibilities and is applicable to all clients requesting family planning services;
• ensure that all agency staff are trained in the agency’s non-discrimination policies and complaint procedures;
• take reasonable steps to ensure that LEP persons have meaningful access to its programs and services and do not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client’s interpreter if requested, and the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality. Interpreter services are at no cost to the client.

More information about applicable laws and regulations can be obtained from the HHSC Civil Rights Office, executive order 13166.

Non-Coercion

Family planning clients are guaranteed the right to choose family planning providers and any contraceptive method without coercion or intimidation. Acceptance of family planning services must not be a prerequisite to eligibility for or receipt of any other service or assistance.

To ensure that all usage of project services by any patient, participant, client, or customer be solely on a voluntary basis, individuals must not be coerced into receiving services, or using/not using any particular method of family planning.

Employees must be informed that they may be subject to prosecution under federal law if they coerce, or endeavor to coerce, any patient, participant, client, or customer who comes to a site for services to undergo an abortion or sterilization (e.g., tubal ligation, Essure™, or vasectomy) procedure.

Eligibility

Title X has no eligibility requirements. All clients of reproductive age who receive services to prevent or achieve a pregnancy at a Title X service site are, for reporting purposes, considered Title X clients. For more details, see the Data Manual in the appendix. Individuals must have the freedom and choice to self-declare income and family size. More information is available in the financial sustainability section, on page 41.

Abuse and Neglect Reporting

WHFPT expects all sub-recipients to comply with state laws governing the reporting of abuse and neglect. Sub-recipients must be in full compliance with Chapter 261 of the Texas Family Code and the Rider to the law requiring child abuse reporting as well as the Texas Department of State Health Services child abuse screening, documentation, and reporting policy requirements. Sub-recipients must have an internal policy and procedure for how they will determine, document, and report instances of abuse, sexual or non-sexual.
To report abuse or neglect, sub-recipients can either call 800-252-5400 or use the Texas Abuse Hotline’s [secure website](#). They should call any local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

Sub-recipients must document that all staff have attended an orientation training on policies and procedures for reporting abuse and review this training at least every two years.

**Human Trafficking**

WHFPT requires that all sub-recipients comply with all federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000 (Pub.L.No. 106-386), as amended, and 19 U.S.C. 1591. Sub-recipients must develop relevant policies and procedures, including but not limited to staff training on human trafficking that complies with state and federal laws (i.e. the Trafficking Victims Protection Act of 2000).

Sub-recipients must document that all staff have attended an orientation training on policies and procedures for human trafficking and review this training at least every two years.

**Resolution of Complaints**

Sub-recipients must ensure that clients have the opportunity to express concerns about care received and that those complaints are handled in a consistent manner. Sub-recipients’ policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received, including client involvement in the resolution of conflicts concerning care decisions. Any client complaint and the action taken on the complaint must be documented in the client’s record.

**Access to Quality Client-Centered Family Planning Care**

**Timely Access to Services**

WHFPT has established the following mandatory timelines for ensuring that clients have ready access to new client services for birth control, pregnancy testing, and emergency contraception. Timely access to care is proven to reduce rates of unintended pregnancies, stem the spread of STIs, and support the achievement of healthy pregnancies.

Services for a new family planning client seeking birth control should be available within 14 calendar days of the day the client calls for the service unless the client requests an appointment for a later date. Be advised that we expect each sub-recipient to make a reasonable effort to see clients as soon as possible according to the need of the service they are seeking. Pregnancy testing and emergency contraception must be provided on-site; these services should be made available on a walk-in basis.

Every sub-recipient must have a policy that addresses the issue of capacity. If a sub-recipient’s family planning program is unable to accept new family planning patients because they are at capacity, WHFPT must be immediately notified in writing. WHFPT will work with each sub-recipient to develop an individualized plan of action.
General Informed Consent

Consent information must be effectively communicated to every client in a manner that is understandable by that client and allows the client to participate and make sound decisions regarding her/his own medical care in compliance with Limited English Proficiency regulations and addressing any disabilities that impair communication. Only the client may consent, and consent must never be obtained in a manner that is or could be perceived as coercive.

In addition, the agency must obtain the informed consent of the client for procedures as required by the Texas Medical Disclosure Panel. Consent forms, if applicable, must be completed and signed.

Consent for Services for Minors

Sub-recipients must not require consent of parents or guardians for the provision of family planning services to minors. For minors requesting confidentiality, sub-recipients must not notify parents or guardians before or after a minor has requested and received Title X family planning services. Sub-recipients must not release family planning records to the parent/guardian without written consent of the minor. Sub-recipients must encourage family (e.g., parents, guardians, or other adult family members) participation in the decision making process of minors seeking family planning services. To date, Title X is the only confidential program that minors can access in the state of Texas.

Consent for HIV Tests

Consent for HIV testing is described under Texas Health and Safety Code §81.105 and §81.106. HIV testing cannot be performed without first obtaining the informed consent of the person to be tested. If a client has signed a general consent form, there is no need to provide additional consent for HIV testing.

Follow this link to the Texas Health and Safety Code website.

Clinical Services for Clients of Reproductive Age

Reproductive Life Plan

The purpose of any family planning encounter is a Reproductive Life Plan, which outlines personal goals about pregnancy planning and pregnancy prevention. Providers must discuss a Reproductive Life Plan with clients receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted infection testing and/or treatment, and preconception health services in accordance with the CDC’s recommendation.

Providers should assess the client’s Reproductive Life Plan by asking questions such as:

• What are your life goals, plans for work, school, and education for the next five years and how would children fit in?
• Are you responsible for the care of any children now?
• Are you planning a pregnancy in the next year?

Depending on the client’s response to the above questions, next steps might include:

• If the client does not want a child at this time and is sexually active, offer contraceptive services. *Introduce methods from most effective to least effective.*
• If the client desires pregnancy testing, provide pregnancy testing and counseling appropriate to the test results.
• If the client wants to have a child now, provide services to help the client achieve a healthy pregnancy.

Steps to Providing Contraceptive Services

1. ESTABLISH AND MAINTAIN RAPPORT WITH THE CLIENT

   Strategies to achieve these goals include the following:
   • use open-ended questions;
   • demonstrate expertise, trustworthiness, and accessibility;
   • ensure privacy and confidentiality;
   • listen to and observe the client in a non-judgemental manner;
   • encourage and demonstrate empathy and acceptance.

   All clinical staff must introduce themselves to the client with their name and title and call the client by name while maintaining client confidentiality. Name tags are encouraged.

2. OBTAIN CLINICAL AND SOCIAL INFORMATION FROM THE CLIENT

   Medical history must be taken to ensure that methods of contraception being considered are safe for the client. For more information, reference: Reproductive Health Access Project.

   A medical history for females must include contraindications and review:
   • Reproductive Life Plan;
   • menstrual history (including last menstrual period, menstrual frequency, length and amount of bleeding, and other patterns of uterine/vaginal bleeding);
   • HIV status and sexually transmitted infection (STI) history, risk, and exposure;
   • smoking history (for clients considering combined hormonal methods of contraception);
   • relevant infectious or chronic health conditions and other characteristics and exposures (e.g., age, postpartum status, and breastfeeding status) that might affect the client’s medical eligibility criteria for contraceptive methods;
   • pertinent sexual behavior history, including family planning practices (e.g., past and current contraceptive use), number of partners, last sexual encounter, and whether the patient has been forced to have sex;
   • obstetrical history, including recent delivery, miscarriage, or termination;
   • gynecological and urologic conditions;
   • cervical cancer screening history (including the date and results of last Pap test or other cervical cancer screening test; note any abnormal results and treatment)
   • allergies; and
   • immunizations related to reproductive health, including:
     • human papillomavirus vaccine (HPV);
     • female clients aged 11-26 should be offered either HPV2 or HPV4 vaccines for the prevention of HPV and cervical cancer; and
hepatitis B vaccine – this should be offered to all unvaccinated adolescents under 19 years old and all adults who are unvaccinated and do not have any documented history of hepatitis B infection.

A medical history for males should include:

- Reproductive Life Plan;
- use of condoms;
- allergies to condoms;
- recent intercourse;
- information about current partners, including whether current partner is pregnant or has had a child, miscarriage, or termination;
- infectious or chronic health conditions;
- status as men who have sex with men (MSM).

**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 [see Reproductive Life Plan]).

**Sexual Assessment**

Performing a sexual assessment is a key component in assisting the client in selecting the contraceptive method that is most appropriate.

**Practices**: Explore the types of sexual activity in which the client engages (e.g., vaginal, anal, or oral sex).

**Pregnancy prevention**: Discuss contraceptive experiences and preferences, as described in more detail below. Ask about current and previous use of methods, use of contraception at last intercourse, difficulties with contraception, and whether the client has a particular method in mind.

**Partners**: Ask questions to determine the number, gender (men, women, or both), and concurrency of the client’s sex partners (if partner had sex with another partner while still in a sexual relationship with the client). It might be necessary to define the term “partner” to the client or use other relevant terminology.

**Protection from sexually transmitted diseases (STIs)**: Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. Topics such as monogamy and abstinence can also be discussed.

**Past STI history**: Ask about any history of STIs, including whether their partners have ever had an STI. Explain that the likelihood of an STI is higher with a past history of an STI.

**Contraceptive Experiences and Preferences**

Ask questions to establish previous experience and preferences with contraceptive methods, such as:
• What method(s) are you currently using, if any?
• What did you like about your previous method?
• What did you not like about your previous methods?
• What method would you like today?
• Have you had unprotected sex in the last week?
• What is important to you about your birth control method?

3. WORK WITH CLIENT INTERACTIVELY TO SELECT THE MOST EFFECTIVE AND APPROPRIATE CONTRACEPTIVE METHOD

• 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.
• Discuss a broad range of methods, including long-acting reversible contraception (i.e. intrauterine devices [IUDs] and implants), with all women and adolescents, if medically appropriate.
• Use a tiered approach to present reversible methods of contraception: start with most 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.
• Use a client-centered approach to ensure that the client is selecting the method that works best for her or him. Omitting information about methods that are not available on-site is not appropriate. Sub-recipients are responsible for referring clients to a location where they can obtain their method of choice.
• Discuss, if appropriate, permanent sterilization (male or female) with clients who have completed childbearing or do not plan to have children. Sterilizations are safe, highly effective, and can be performed in an office or out-patient surgery setting.

Important Things to Consider During Method Selection:

Method effectiveness: A contraceptive method’s rate of typical effectiveness—measured by the percentage of women experiencing an unintended pregnancy during the first year of typical use—is an important consideration. For more information, refer to page 47 in the QFP.

Correct use of the method: The mode of administration and a clear understanding of this mode of administration might be important considerations for the client when choosing a contraceptive method. Discuss the client’s lifestyle, whether taking a pill every day is realistic, or whether getting an injection every three months is acceptable to her lifestyle.

Non-contraceptive benefits: Explain to the client that some contraceptives have non-contraceptive benefits, such as reducing heavy menstrual bleeding. 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 must 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 should also be informed about warning signs for rare, but serious, adverse events with specific contraceptive methods, such as stroke and venous thromboembolism with use of combined hormonal methods.

**Protection from STIs including HIV:** *Abstinence and condoms are the only methods that offer protection from STIs and HIV.* When used correctly and consistently, condoms help reduce the risk of STIs, HIV, and pregnancy. It is optimal to pair condoms with a more effective method to prevent pregnancy while relying on condoms to reduce the risks of STIs and HIV.

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.

**Potential barriers to method selection:** Potential barriers include social-behavioral factors, intimate partner violence and sexual violence, mental health, and substance use behaviors. Clients experiencing any of these barriers should be given information on appropriate local resources for support.

**Social-behavioral factors:**

- 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)
- The client’s confidence in being able to use the method correctly and consistently (i.e. 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
- Methods that require no partner participation or that can be concealed

**Mental health and substance use behaviors:**

- History of depression, anxiety disorders, and other mental disorders
- History of alcohol use, prescription drug abuse, and illicit drug use

4. **CONDUCT A PHYSICAL ASSESSMENT RELATED TO CONTRACEPTIVE USE, WHEN WARRANTED**

The following section describes two different client-service provider scenarios. The first scenario explains how services are provided to a client with no primary care provider. The second scenario explains how services are provided to a client with access to primary care services. Assess the client’s circumstances at the beginning of each visit to determine which strategy is appropriate.
Begin by assessing whether the client has access to primary healthcare, either at the sub-recipient site or another location. See the infographic below for more information.

If the client **DOES have access to primary care**, conduct the following physical assessments:

- **Blood pressure** must be taken before initiating the use of combined hormonal contraception.

- **Current pregnancy status** must be determined for 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. However, measuring weight and calculating baseline BMI might be helpful for monitoring any weight changes and counseling women who might be concerned about weight change perceived to be associated with their hormonal contraceptive method.
Most women will not need examinations or laboratory tests before starting a method of contraception. Evidence indicates that unnecessary medical procedures and tests can create a barrier for contraceptive access for some women.

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).

- 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 risk for blood clots.

- Pelvic examinations, **unless inserting an intrauterine device (IUD) or fitting a diaphragm**, No physical examination needs to be performed before distributing condoms. Refer to Table 1 in the appendix for further guidance on necessary examinations and tests related to initiation of contraception.

**If the client DOES NOT have access to primary care, conduct the following physical assessments.**

**Females:**
- height measurement;
- weight measurement (to assess for diagnoses of underweight, overweight, or obese);
- blood pressure evaluation;
- cardiovascular assessment;
- clinical breast exam (CBE), as appropriate for age and history;
- pelvic exam;
- visual inspection of external genitalia and perianal area;
- visual inspection of vagina and cervix speculum exam in women age 21 years and older;
- visual inspection of vagina and cervix speculum exam in women less than 21 years, as indicated by history;
- bimanual exam in women 21 years and older;
- bimanual exam in women less than 21 years, as indicated by history; and
- assessment of other systems as indicated by history (e.g., evaluation of thyroid, lungs, abdomen).

**Males:**
- height measurement;
- weight measurement (to assess for diagnoses of underweight, overweight, or obese);
- blood pressure evaluation;
- cardiovascular assessment;
• visual inspection of external genitalia (penis, scrotum, and testicles) and perianal area;
• manual examination of penis, scrotum, and testicles;
• hernia assessment;
• palpation of prostate, as indicated by history and age; and
• assessment of other systems as indicated by history (e.g., evaluation of thyroid, lungs, abdomen).

5. PROVIDE THE CLIENT WITH THE CONTRACEPTIVE METHOD

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

A broad range of FDA-approved contraceptive methods should be available on-site. Referrals for methods not available on-site must 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 on-site 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.
  o 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 less than or equal to seven 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 less than or equal to seven days after spontaneous or induced abortion;
    - is within four weeks postpartum; or
    - is fully or nearly fully breastfeeding (i.e. exclusively breastfeeding or the vast majority [greater than or equal to 85%] of feeds are breastfeeds), amenorrheic, and less than six months postpartum.
• Provide or dispense multiple cycles of oral contraceptive pills, the patch, or the ring to minimize a barrier to continuing the method when a client cannot return to the service site.
• If client chooses a method that is not available on-site or same day, provide the client another method to use until he or she can start the chosen method.
• Make condoms easily available.
• Help the client develop a plan for using the selected method correctly, for example:
  • Develop a follow-up plan, which includes the best contact method for follow-up questions; and
  • Request that the client call before discontinuing the method.
• Discuss client’s risk for discontinuation and factors that might influence this.

6. CONFIRMING CLIENT’S UNDERSTANDING

Client understanding can be assessed by using the teach-back method. When providers assess the client’s understanding, a checkbox or written statement can be used in place of a written
method-specific informed consent form, which demonstrates that the client understand risks, benefits, warning signs, and when to return for follow-up if warning signs emerge. Have clients sign method-specific informed consent forms for IUD’s and hormonal implants.

**Adolescent Access to Services**

- Minors who require confidential services do not need written consent from parents or guardians; parents and guardians must not be notified of services.
- Access to clinical services for minors is a major component of providing quality family planning. Sub-recipients must ensure appointments for adolescents are provided as soon as possible (i.e. the same day or no later than two weeks after the initial request for services).
- Clinic hours should include after-school, evening, and/or weekend hours to accommodate availability for minors.
- Emergency contraception must be made available on a walk-in basis, given that effectiveness is limited to a time period within 72 to 120 hours of last sexual encounter, or by patient request.

**Counseling Adolescents**

Adolescents age 17 and younger must be provided individualized family planning counseling and family planning medical services that meet their specific needs. It is important not to assume that adolescents are sexually active simply because they have come for family planning services. 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](https://www.who.int).

Sub-recipients must address the following issues in age-appropriate counseling for adolescents:

- all methods of contraception, including abstinence;
- information about contraceptive options and safer sex practices that reduce risk for STI/HIV and pregnancy;
- information regarding the effective use of a variety of contraceptive methods, as contraceptive needs may frequently change;
- assurance that the counseling and medical care are confidential;
- encouragement of family participation in the decision of minors who request or receive services;
- information and skills in resisting attempts to be coerced into sexual activity;
- discussion about current partner, relationship and/or family violence, and available resources and assistance; and
- nutrition counseling and information on BMI and relevant referral(s), if needed.

**Positive Pregnancy Tests and Options Counseling:**

Sub-recipients must provide client-centered factual information and non-directive counseling on the client’s options. When requested, the sub-recipient must provide a referral for the service chosen. Based on a Reproductive Life Plan, clients with positive pregnancy test results must be offered options counseling, which includes:

- prenatal care and delivery;
• foster care or adoption; and
• pregnancy termination.

Clients with positive pregnancy test results who indicate a desire to remain pregnant should be given information about good health practices during early pregnancy and provided or referred for a confirmatory physical assessment and prenatal care as soon as possible, preferably within 15 days. If a referral is requested for foster care, adoption, or pregnancy termination, the agency must provide the name and contact information for the closest resource.

If ectopic pregnancy is suspected, the client must be referred for immediate diagnosis and treatment.

**Negative Pregnancy Tests and Methods Counseling**

A negative pregnancy test for a client who does not wish to become pregnant is one of the biggest missed opportunities to provide family planning services. Clients with negative pregnancy test results must be provided information about the availability of contraceptive and infertility services, as appropriate. Every effort should be made to provide same-day contraceptive access for those seeking pregnancy prevention. See information on working with clients to select a method on page 24. All clients with a negative pregnancy test should leave with a contraceptive method.

**Preconception Health Services**

Preconception health services are beneficial because of their positive effect on pregnancy and birth outcomes and their role in improving the health of women and men. For example, these services can reduce the rates of low birth weight, premature birth, and infant mortality. 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.

**Medical History**

The following information must be collected as part of preconception health services.

**Female Clients:**
• reproductive history;
• history of poor birth outcomes (e.g., preterm, cesarean delivery, miscarriage, and stillbirth);
• environmental exposures, hazards, and toxins (such as secondhand smoke);
• medications that are known teratogens;
• genetic conditions;
• family history;
• screening for intimate partner violence;
• alcohol/drug use;
• tobacco use;
• immunizations;
• depression;
• height, weight, and BMI;
• blood pressure; and
• diabetes.
Male Clients:

- past medical and surgical history that might impair the client’s reproductive health;
- genetic conditions;
- history of reproductive failures or conditions that can reduce sperm quality (e.g., obesity, diabetes mellitus, and varicocele) and environmental exposures, hazards, and toxins (e.g., smoking);
- alcohol/drug use;
- tobacco use; and
- screening for intimate partner violence.

Preconception Counseling

Preconception care is an integral part of a reproductive health plan. Counseling discussions should include a Reproductive Life Plan and provide preconception health services as a part of family planning services, when indicated. A daily dose of 0.4 mg of folic acid is optimal for all women both capable of becoming pregnant or planning a pregnancy, in accordance with the USPSTF recommendation.

Discussion of a Reproductive Life Plan and sexual health assessment services should be provided in accordance with the cited clinical recommendations, as well as any needed follow up (such as further diagnosis or treatment) should be provided either on-site or by referral. Preconception counseling should be provided to female clients who may become pregnant in the future. According to individual client circumstances, the following topics should be addressed:

- rubella status;
- folic acid supplements;
- nutrition;
- family history and genetic risk;
- tobacco and drug/alcohol use;
- pre-existing medical conditions that are associated with increased risks during pregnancy (such as diabetes); and
- current medications.

Achieving Pregnancy

For clients who wish to become pregnant, providers should advise 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 her partner may be counseled about how to maximize fertility.

Key points are as follows:

- The client should be educated about peak fertility 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 to 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 (i.e., more than five cups per day).

• Smoking, consuming alcohol, using recreational drugs, and using most commercially available
vaginal lubricants should be discouraged as these might reduce fertility.

Basic Infertility Services

Infertility is commonly defined as the failure of a couple to achieve pregnancy after 12 months or longer
of regular unprotected intercourse. Basic infertility information and counseling must be available on-
site. 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.

Earlier assessment (for example, after six months of regular unprotected intercourse) is justified for
women who fit one or more of the following criteria:

• over 35 years of age;
• history of oligo-amenorrhea (infrequent menstruation);
• known or suspected uterine or tubal disease or endometriosis; or
• a partner known to be sub-fertile (the condition of being less than normally fertile though still
capable of effecting fertilization).

INFERTILITY CARE FOR WOMEN

The following assessments should be made for women seeking infertility care:

Medical history, including:

• past surgeries, including indication(s) and outcome(s);
• previous hospitalization(s);
• serious illnesses or injuries;
• medical conditions associated with reproductive failure (e.g., thyroid disorders, hirsutism, or
other endocrine disorders);
• childhood disorders;
• results of cervical cancer screening and any follow-up treatment;
• current medication use;
• allergies; and
• family history of reproductive failure.
Reproductive history, including:

- number of partner’s children, if any;
- length of time the client has been trying to achieve pregnancy;
- coital frequency and timing;
- level of fertility awareness;
- results of any previous evaluation and treatment;
- gravidity, parity, pregnancy outcome(s), and associated complications;
- age at menarche, cycle length, and cycle characteristics;
- onset/severity of dysmenorrhea; and
- sexual history, including pelvic inflammatory disease, contraction of STIs, or exposure to STIs.

A review of systems should emphasize symptoms of thyroid disease, pelvic or abdominal pain, dyspareunia, galactorrhea, and hirsutism.

INFERTILITY CARE FOR MEN

The following assessments should be made for the male partner of an infertile couple:

Medical history, including:

- systemic medical illnesses (e.g., diabetes mellitus);
- prior surgeries and infections;
- medications (prescription and nonprescription);
- allergies; and
- lifestyle exposures.

Reproductive history, including:

- methods of contraception;
- coital frequency and timing;
- duration of infertility and prior fertility;
- sexual history;
- partner’s history of pelvic inflammatory disease, STIs, and sexual dysfunction; and
- gonadal toxin exposure, including heat.

Note: Physical examination should be conducted with particular focus given to: 1) examination of the penis, including the location of the urethral meatus; 2) palpation of the testes and measurement of their size; 3) presence and consistency of both the vas deferens and epididymis; 4) presence of a varicocele; 5) secondary sex characteristics; and 6) a digital rectal exam.

Additionally, male clients concerned about their fertility should have a semen analysis. If this test is abnormal, they should be referred for further diagnosis (e.g., second semen analysis, endocrine evaluation, post-ejaculate urinalysis, or others deemed necessary) and treatment.

NOTE: The semen analysis is the first and most simple screen for male fertility.
Related Preventive Health Services

For clients of reproductive age without a primary care provider, the following screening services must be provided, with appropriate follow-up and referral:

Cervical Cytology (Pap Smear)

- Cervical cytology is recommended every three years for women aged 21–65 years.
- A combination of cytology and HPV testing every five years is recommended for women aged 30–65 years.
- Cervical cytology is no longer recommended on an annual basis or for women under 21 years of age.
- Abnormal test results should be treated in accordance with professional standards of care, which may include colposcopy. See Screening Guidelines.
- ACOG and AAP recommend that a genital exam should accompany a cervical cancer screening to inspect for any suspicious lesions or other signs that might indicate an undiagnosed STI.
- The need for cervical cytology should not delay initiation or hinder continuation of a contraceptive method.

Clinical Breast Examination

Despite a lack of definitive data for or against their efficacy, clinical breast examination has the potential to detect palpable breast cancer and can be recommended.

- ACOG recommends annual examination for all women more than 19 years of age.
- ACS recommends screening every three years for women aged 20–39 years and annually for women aged 40 years or older.

Mammography

- Providers should screen every other year for women aged 50-74.
- Providers should only screen women less than 50 years of age if other conditions warrant.

Genital Examination for Males

- Providers should document normal growth and development and other common genital findings, including hydrocele, varicocele, and signs of STIs.
- Components of this examination include inspecting skin and hair; palpating inguinal nodes, scrotal contents, and penis; and inspecting the perianal region.

Laboratory Tests and Sexually Transmitted Infection Services

All initial and routine follow-up family planning clients must be provided appropriate laboratory and diagnostic tests as indicated by history, physical examination, and clinical assessment.

Policies and Procedures for Laboratory Testing and Follow-up

- Initial tests may be deferred until the initial physical exam is provided.
- Sub-recipients must have written plans to address laboratory and other diagnostic test orders, results, and follow-up, to include:
  - tracking and documentation of tests ordered and performed for each client;
• tracking test results and documentation in the client’s records; and
• mechanisms to notify clients of results in a manner to ensure confidentiality, privacy, and prompt, appropriate follow-up.
• Sub-recipients must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination, laboratory test findings, or clinical assessment.
• Before a sub-recipient can consider a client as “lost to follow-up,” the agency must have at least three separately documented attempts to contact the client.
• Provider must comply with state and local STI reporting requirements.
• Sub-recipients must have written policies and 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 and must be in compliance with state and federal requirements for transfer of health information.

Clinical Guidelines for Lab Testing

HIV TESTING

Providers should screen clients for HIV/AIDS in accordance with CDC HIV testing guidelines. Screening should be provided after the patient is notified that testing will be performed as part of general medical care. All clients aged 13-64 years should be screened routinely for HIV infection and all persons considered high risk be screened annually. High risk includes:

• injection drug users and their sex partners;
• persons who exchange sex for money or drugs;
• sex partners of HIV-infected persons;
• men having sex with men; and/or
• heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

Sub-recipients must offer on-site HIV testing as a routine component of medical care.

All female and male clients should be screened in accordance with the CDC HIV testing guidelines.

HIV COUNSELING

Test results must be provided by staff that are knowledgeable about HIV prevention and HIV testing.

NEGATIVE TEST RESULTS

Sub-recipients should provide negative HIV test results to clients in person, by telephone, through an online patient/client portal, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results must follow procedures that address client confidentiality, identification of the client, and prevention information.

POSITIVE TEST RESULTS

Sub-recipients must always provide positive HIV test results to clients in a face-to-face encounter and educate clients at the time of their diagnosis about the benefits of HIV medical care for improving personal health and preventing HIV transmission. Sub-recipients should actively assist newly HIV-diagnosed clients to enter medical care and follow up to ensure that clients keep their appointment with
the HIV medical care provider. Similarly, sub-recipients should assist clients who have dropped out of HIV medical care to re-engage in HIV medical care.

HERPES SIMPLEX VIRUS TESTING

Screening for Herpes Simplex Virus (HSV-1 or HSV-2) in the general population is not indicated. Type-specific serologic testing might be useful in the following cases:

- genital symptoms or atypical symptoms with negative HSV cultures;
- clinical diagnosis of genital herpes without laboratory confirmation; or
- having a partner with genital herpes.

HSV is frequently diagnosed through clinical evaluation of lesions; however, viral culture and serological testing methods are available. The CDC recommends isolation of HSV in cell culture for clients who present with genital ulcers or other mucocutaneous lesions.

The CDC’s recommendations for herpes testing can be found on their website.

SYPHILIS

Syphilis testing is recommended for all sexually active men and women at increased risk for syphilis infection. Providers should screen all clients at risk in accordance with CDC’s STI treatment guidelines.

Populations at risk:

- Men having sex with men (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 (who should be screened for syphilis at the time of their positive pregnancy test if there might be delays in obtaining prenatal care).

CHLAMYDIA TESTING

Chlamydia testing is recommended for:

- All sexually active females age 25 or younger at least annually;
- Women of any age if risk factors are present, including but not limited to:
  - a new sex partner during the past 60 days;
  - multiple sex partners;
  - cervicitis or signs and/or symptoms of other STIs;
  - pelvic inflammatory disease (PID) history;
  - exposure to an STI in the past 60 days;
  - pregnancy or currently planning pregnancy;
  - prior positive test for chlamydia or other STI within the past 12 months; and
  - previous chlamydia infection that has not been treated for three to four months, especially in adolescents (as follow-up for possible reinfection, not as a test of cure).

NOTE: There is currently insufficient evidence to recommend routine chlamydia testing in all sexually active men. Routine testing should be considered in clinical areas with a high prevalence of chlamydia, such as adolescent clinics and correctional facilities. Sexual risk assessment should be conducted to determine the appropriateness for testing, even if asymptomatic.
GONORRHEA TESTING

Gonorrhea testing is recommended for all sexually active men and women at increased risk for gonorrheal infection. Increased risk is defined as a history of prior gonorrheal or other sexually transmitted infections, new or multiple sexual partners, inconsistent condom use, sex work, and/or drug use.

The United States Preventive Services Task Force (USPSTF) does not recommend routine screening for gonorrhea in men and women who are at low risk for infection. More information can be found on the CDC’s website.

EXPEDITED PARTNER THERAPY

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of clients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the client to take to his/her partner without the healthcare provider first examining the partner.

Texas Administrative Code 22 TAC §190.8 was amended to allow Expedited Partner Therapy for STI treatment.

WHFPT strongly supports the CDC’s recommendations for the use of EPT. See clinical guidelines on the CDC’s website.

Service sites implementing EPT should develop appropriate policies, procedures, and SDOs to reflect the CDC guidelines.

Immunizations related to Reproductive Health

HUMAN PAPILLOMA VIRUS

Best practices for human papillomavirus vaccinations include:

• offer female clients aged 11-26 either the HPV2 or HPV4 vaccines for the prevention of HPV and cervical cancer;
• begin vaccinating female clients starting at 11–12 years of age or as early as nine years of age;
• offer the “catch up” vaccine among females aged 13–26 who have not been vaccinated previously or have not completed the three-dose series through age 26;
• offer males clients aged 11-21 the HPV4 vaccine if not vaccinated previously; and
• offer the “catch up” vaccine among males aged 13-21 who have not been previously vaccinated or have not completed the three-dose series through age 21.

HEPATITIS B

Routine hepatitis B vaccination should be offered to:

• all unvaccinated children and adolescents under 19 years of age; and
• all unvaccinated adults who do not have a documented history of hepatitis B infection.
Radiology Procedures
On occasion, a provider may need to locate a “lost” Intrauterine Contraception (IUC)/ Intrauterine Device (IUD) or non-palpable contraceptive implant. The provider has the choice of using traditional X-ray or pelvic ultrasound for locating the IUC and/or IUD.

Client Health Record (Medical Record)
All clinical encounters, including those by telephone, must be complete, legible, and accurately documented. Clinical records must also be:

- written in ink without erasures or deletions, or documented by an electronic medical record (EMR);
- signed (wet or electronic) by the provider making the entry, including name of provider, title of provider, and date for each entry (stamped signatures are not acceptable);
- readily accessible to assure continuity of care and availability to clients while assuring compliance with HIPAA and Title X confidentiality protections;
- systematically organized to allow easy documentation and prompt retrieval of information; and
- appropriate to the health literacy of the population served.

The client’s medical/health record must include:
- client identification and personal data, including financial eligibility;
- informed consent documentation;
- preferred language/method of communication;
- client contact information, including the best way to reach client that facilitates continuity of care, assures confidentiality, and adheres to HIPAA regulations;
- medical history;
- medication and allergic reactions recorded prominently in a specific location;
- physical examination, as indicated;
- problem list;
- assessment or clinical impression;
- plan of care, including education/counseling, treatment, special instructions, scheduled visits, and referrals;
- laboratory and other diagnostic tests orders, results, and follow-up;
- documentation of refusal of services;
- documentation of referrals; and
- documentation of follow-up.

Client Records Management
Sub-recipients must have an organized and secure client record system. Records must be readily accessible to appropriate staff and available to the client upon request with a signed release of information consistent with the client confidentiality policy. The record must be safeguarded against loss or use by unauthorized persons.

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. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable and encouraged as medical records.

Information collected for reporting purposes may be disclosed only in summary, statistical, or other non-identifiable forms.

HIV information should be handled according to law. Please refer to the DSHS website for more information.

**Methods of Fertility Regulation/Methods of Pregnancy Prevention**

All Federal Drug Administration (FDA)-approved methods of contraception are as follows:

- abstinence from sexual intercourse – client counseling;
- intrauterine device (IUD);
- contraceptive implant;
- female and male sterilization;
- contraceptive injections;
- oral contraceptive pills;
- vaginal hormonal contraceptive ring;
- transdermal hormonal contraceptive ("the patch");
- vaginal barriers (e.g., female condom, diaphragm, sponge, and cervical cap);
- male condoms;
- vaginal spermicides;
- fertility awareness;
- emergency contraceptive pills; and
- Natural Family Planning.

Long Acting Reversible Contraceptives (LARCs) are highly effective methods in preventing unintended pregnancies. Sub-recipients should offer these methods for consideration by appropriate clients, including adolescents. As with all methods, the client’s preference after receiving unbiased, factual education must be respected, if there are no clinical contraindications.

With the exception of sterilizations, sub-recipients must provide all FDA approved contraceptive methods on-site. If Sub-recipient cannot provide all methods of contraception on-site, Sub-recipient must notify WHFPT in writing.

**Referral and Linkage to Care**

For many women and men of reproductive age, a family planning visit can be their only source of healthcare; 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.
When services required as part of the Title X project are provided by referral, sub-recipients must establish a written agreement with a referral resource for the provision of services. This agreement must identify a reimbursement mechanism and assure that the client is charged no more than the appropriate fee, based on the client’s income and family size.

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 should also assess the client’s social support and refer her or him to appropriate counseling or other supportive services, as needed.

Sub-recipients must have written agreements with the referral agency for:

- sterilizations;
- LARCs;
- HIV treatment; and
- primary care.

Sub-recipients should provide referrals to community support services for clients needing services related to the following:

- intimate partner violence (IPV);
- sexual assault/sexual coercion;
- mental health; and
- drug and alcohol treatment.

Outreach and Education

Community Education, Program Promotion and Outreach

Each sub-recipient must develop and implement an annual plan to provide program promotion, community education, and outreach to inform the public of its purpose and services. This plan should disseminate basic family planning knowledge, enlist community support, and attract potential clients. The plan must be based on an assessment of the changing needs of the community and consider the education and cultural backgrounds of the population served. Plans must be reviewed annually and contain an implementation and evaluation strategy, which determines the effectiveness of the program. There must be a process for community participation in the development, implementation, and evaluation of the program. Sub-recipients should maintain documentation of outreach activities.

These strategies may include but are not limited to:

- making information about family planning services available to the public through various media;
- translating public awareness materials into appropriate languages;
- distributing information about Title X services to other organizations and sub-recipients that deal with potential clients;
- joining a School Health Advisory Council (SHAC);
- working with local WIC offices;
• making services known to school nurses, counselors, homeless shelters, and/or parents; and
• providing sexuality education to public and/or private schools.

Financial Sustainability

Title X is an infrastructure grant. As such, Title X funds are used to support the infrastructure of a family planning program rather than pay for direct client services. Every client that receives family planning services at a Title X service site is supported in some way by Title X funds and is a reportable Title X client, regardless of additional payor sources. There are no client eligibility requirements for Title X.

Title X works in tandem with other payor sources and is not meant to fully cover the cost of sub-recipients’ family planning programs. Therefore, sub-recipients must generate revenue through billing third party insurance, whenever possible, and collecting client fees. The following policies and procedures outline the requirements that promote financial sustainability for family planning programs.

Connecting Clients to Coverage

Where there is a legal obligation or authorization for third party reimbursement, all reasonable efforts must be made to obtain third party payment without the application of any discounts. These third party coverage sources include all public state programs (e.g., TWHP and EPHC) and federal programs (e.g., Medicaid) and private insurance providers (such as those available on the Health Insurance Marketplace). A client’s eligibility for coverage by any third party payor cannot be a prerequisite to scheduling an appointment or receiving care at the time of their visit.

Outreach and Enrollment

Sub-recipients should participate in outreach and enrollment activities related to health coverage options. Sub-recipients are encouraged to provide on-site enrollment assistance whenever possible. When not possible, sub-recipients should have a linkage partnership in place with those who are able to provide enrollment assistance in order to connect clients to enrollment and coverage.

Sub-recipients must report on enrollment activities to WHFPT at least once annually.

Contracting and Credentialing

All sub-recipients must establish contracts with third party payors and credentialed clinicians to receive reimbursement for services, when possible. Sub-recipients must also provide evidence of contracts with insurance such as Medicaid, Medicaid Managed Care plans, and private insurance plans.

Third-Party Confidentiality Issues

Some clients are covered by a family member’s public or private insurance policy. In those cases, billing the third party payor potentially jeopardizes client confidentiality, as services would appear on the insurance statement. If the client requires confidential services, and billing the third party payor jeopardizes client confidentiality, clients can waive the right to use their public or private insurance and instead be charged based on the schedule of discounts.
Client Fee Guidelines

WHFPT recognizes that sub-recipients are located in extremely under-resourced areas and that the clients who walk into Title X service sites often have no other place where they can receive reproductive health services. A variety of barriers can prevent clients from receiving the services they need. WHFPT also recognizes that sub-recipients must generate revenue to keep their doors open and continue serving clients. Thus, WHFPT’s policies have been written with the aim of removing potential barriers to services for clients while ensuring that sub-recipients can generate revenue when possible.

The following client fee guidelines must be followed:

- Sub-recipients must have policies that address charging, billing, and collecting funds for services, and methods for “aging” of outstanding accounts.
- Clients must never be charged a flat fee for family planning services. All fees for family planning services must be determined using the schedule of discounts.
- Medicaid-eligible clients must never be charged a fee for family planning services. TWHP-eligible clients must never be charged a fee for services covered by TWHP.
- Clients must never be denied services because of inability to pay current fees or any fees owed, or inability to participate in any other program (e.g., Medicaid or TWHP).
- Clients who accrue a balance must receive counseling to determine ability to pay.
- Sub-recipients must have a process for waiving fees for clients who are unable, for good cause, to pay for family planning services.
- Reasonable efforts to collect client charges must be made without jeopardizing client confidentiality. If a collection agency is used, client confidentiality must be maintained.
- Family planning clients are not required to provide documentation regarding income, family size, residency, or immigration status. Clients must be allowed to self-declare income and family size.
- During initial phone encounters, sub-recipient staff should communicate that clients will be able to receive family planning services regardless of ability to pay. For example, staff can say: “We want to provide you with services. There are many programs that you may qualify for to pay for your services, and we will figure all of it out when you come in. We will never allow costs to get in the way of your care.”

Schedule of Discounts

Sub-recipients must develop and implement a schedule of discounts, based on ability to pay, for individuals with family incomes between 101% and 250% of the federal poverty level (FPL).

- There must not be a separate schedule of discounts for minors or any other clients.
- Minors requesting confidential services must be assessed based on their own income.
- The schedule of discounts must be documented in the client’s financial records.
- The schedule of discounts and fee schedules must be updated annually when the revised Federal Poverty Income Guidelines are released.
- This updated schedule of discounts and fee schedules must be submitted to WHFPT for review and approval upon request.

All schedules must have at least a minimum of three slides between 101% and 250% FPL. All schedules must slide to $0 at 100% FPL or below. Slides must increase at reasonable increments. Clients at 101%
FPL should not be expected to pay 50% of the full fee (i.e. discounts should not increase from 0% to 50% within one slide).

Federally Qualified Health Centers (FQHCs) have the option of either using a separate schedule of discounts for family planning services or using their existing schedule of discounts. If FQHCs choose to use their existing schedule of discounts, fees for clients at 100% FPL or below must be waived and slides must extend to 250% FPL for family planning services.

**Co-Pays**

Based on the requirements of the Affordable Care Act, clients should never be charged a co-pay for preventive family planning services. In the rare case that a co-pay is required for a family planning service, the amount collected must never exceed what the client would have paid based on the schedule of discounts. If the co-pay amount exceeds the fee based on the schedule of discounts, Title X agencies should continue to bill the third party payor but collect the lesser of the two charges.

For example, if the insurance co-pay amounts to $20, but the fee according the schedule of discounts is $12, the Title X agency would bill the client’s insurance and waive the $8 difference for the client co-pay. This would result in the client only paying a $12 fee.

**Donations**

Voluntary donations from clients are permissible. However, clients must never be pressured to make donations and donations must not be a prerequisite to the provision of services or supplies. Donations are considered program income and must be reported annually to WHFPT. Sub-recipients must have a written policy on the collection of donations. Client donations collected must be utilized to support the delivery of family planning services. Any signage that advises clients of the acceptability of donations must clearly state that donations are optional and refrain from specifying an amount.
Resources

Adoption Options - https://www.depts.ttu.edu/sls/forms/Adoption-Options.pdf
AIDS Education and Training Center - www.aidsetc.org
American Academy of Pediatrics - www.aap.org
American Society for Colposcopy and Cervical Pathology - www.asccp.org
American Society for Reproductive Medicine - www.asrm.org
Board of Nurse Examiners for the State of Texas - www.bne.state.tx.us
California Family Health Council - www.cfhc.org
Cardea - www.cardeaservices.org
Center for Disease Control and Prevention - www.cdc.gov
Chapter 261 of the Texas Family Code - www.statutes.legis.state.tx.us/Docs/FA/htm/FA.261.htm
Family Planning National Training Center - www.fpntc.org
Institute for Healthcare Improvement - www.ihi.org
Jon Snow, Inc. - www.famplan.org
Mandatory Reporting Rider - www.dshs.state.tx.us/childabuserreporting
National Family Planning and Reproductive Health Association - www.nationalfamilyplanning.org
New York City Prevention Training Center - www.nycptc.org
Office of Population Affairs - www.hhs.gov/opa
Oregon Health Authority - www.public.health.oregon.gov
Reproductive Health Access Project - www.reproductiveaccess.org
Society for Assisted Reproductive Technology - www.sart.org
Texas Abuse Hotline’s secure website - www.txabusehotline.org
Texas Department of State Health Services - www.dshs.state.tx.us
Texas Health and Safety Code website - www.statutes.legis.state.tx.us
Texas Medical Board - www.tmb.state.tx.us
Women’s Health and Family Planning Association of Texas - www.whfpt.org
World Health Organization - www.who.int
The Women’s Health and Family Planning Association of Texas is dedicated to the proposition that every Texan should have equal access to high-quality reproductive health services and control over the timing and spacing of their children. WHFPT is the only private, non-profit organization devoted exclusively to family planning in the State of Texas.

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