



**RHODE ISLAND DEPARTMENT OF HEALTH
FAMILY PLANNING PROGRAM GUIDELINES
Updated July 1, 2011**

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TITLE X FAMILY PLANNING PROGRAM MISSION

In 1970, Congress passed the Family Planning Services and Population Research Act (Public Law 91-572), which added Title X to the Public Health Services Act. This legislation authorizes grants to public and non-profit organizations for the provision of a broad range of acceptable and effective medically approved family planning services for all who want and need them. The mission of the Region I Title X Program is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children. The Title X Program works collaboratively with federal, state, and local partners to maximize the provision of related clinical services as well as focused outreach and public awareness activities. The Title X Program makes data and science-based decisions taking into account accessibility, confidentiality, and response to targeted client and population needs. Among all clients served, the Title X Program emphasizes services to the under-served, especially low-income, at risk women and adolescents. The Rhode Island Department of Health (HEALTH) is the single Title X “grantee” for the state of Rhode Island. As the grantee, HEALTH is the entity that receives federal Title X grant funding and assumes legal and financial responsibility and accountability for the awarded funds and for the performance of activities approved for funding.

**RHODE ISLAND DEPARTMENT OF HEALTH
TITLE X FAMILY PLANNING PROGRAM**

See www.health.ri.gov/find/familyplanningagencies for an up-to-date list of Rhode Island Title X agencies.

CENTRAL FALLS

Blackstone Valley Health Center
9 Chestnut Street
Central Falls, Rhode Island 02863
724-7110

CRANSTON

Family Health Services
1090 Cranston Street
Cranston, Rhode Island 02910
943-1981

COVENTRY

Family Health Services of
191 McArthur Boulevard
Coventry, Rhode Island 02816
828-5335

EAST PROVIDENCE

East Bay Family Health Care
100 Bullocks Point Avenue
Riverside, Rhode Island 02915
437-1008

JOHNSTON

Tri-Town Health Center
1126 Hartford Avenue
Johnston, Rhode Island 02919
351-2750

NEWPORT

East Bay Family Health Care
100 Bullocks Point Avenue
Riverside, Rhode Island 02915

PASCOAG

WellOne (Northwest Health Center)
35 Bridgeway
Pascoag, Rhode Island 02829
568-7661

PAWTUCKET

Blackstone Valley Health Center
42 Park Place
Pawtucket, Rhode Island 02860
722-0081

PROVIDENCE

PCHC-Allenberry Health Center
202 Prairie Avenue
Providence, Rhode Island 02907
444-0570

PCHC-Capitol Hill Health Center

40 Candace Street
Providence, Rhode Island 02908
444-0550

PCHC-Central Health Center

239 Cranston Street
Providence, Rhode Island 02907
444-0580

PCHC-Chaffee Health Center

One Warren Way
Providence, Rhode Island 02905
444-0530

PCHC-Olneyville Health Center

100 Curtis Street
Providence, Rhode Island 02909
444-0540

Planned Parenthood of SNE Teen Clinic

111 Point Street
Providence, Rhode Island 02903
421-7820

WAKEFIELD

Thundermist of South County
1 River Street
Wakefield, Rhode Island 02879
783-0523

WOONSOCKET

Thundermist Health Center
450 Clinton Street
Woonsocket, Rhode Island, 02895
767-4100

WARWICK

Family Health Services
226 Buttonwoods Avenue
Warwick, Rhode Island 02886
732-9090

FACILITIES & ACCESSIBILITY OF SERVICES

Part I, section 6.4, page 9 of the 2001 federal Title X guidelines state that facilities in which project services are provided should be geographically accessible to the population served and should be available at times convenient to those seeking services (i.e. they should have evening and/or weekend hours in addition to daytime hours. The facilities should be adequate to provide the necessary services and should be designed to ensure comfort and privacy for clients and expedite the work of the staff.

Facilities must meet applicable standards established by the Federal, state and local governments. HEALTH's Family Planning Program will consider project facilities with JCAHO accreditation and those in compliance with state regulatory requirements to be in compliance with Title X standards regarding facilities. Emergency situations may occur at any time. Title X requires all projects to have written plans and procedures for the management of emergencies.

Title X further requires that projects comply with 45 CFR, Part 84 which prohibits discrimination on the basis of handicap in federally assisted programs and activities, and which among other things, that recipients of federal funds operate their federally assisted programs so that, when viewed in their entirety, they are readily accessible to people with disabilities. Projects must also comply with any applicable provisions of the American With Disabilities Act (Public Law 101-336).

PERSONNEL

Section 6.5 of the federal Title X guidelines requires all projects to establish and maintain personnel policies that comply with applicable federal and state requirements, including Title VI of the Civil rights Act, Section 504 of the Rehabilitation Act of 1973 and Title I of the Americans with Disabilities Act. These policies should include, but need not be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures. Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to and able to deal effectively with the cultural and other characteristics of the client population. Agencies must ensure that:

- Projects are administered by a qualified project director;
- The clinical care component of the project operates under the responsibility of a medical director who is licensed and qualified physician with special training or experience in family planning;
- Protocols exist that provide project personnel with guidelines for client care;
- Personnel records are kept confidential;
- Licenses of applicants for positions requiring licensure are verified prior to employment and that there is documentation that licenses are kept current; and
- Performance evaluations are conducted on staff who are supported with Title X funds on an annual basis.

MEDICAL RECORDS

Part II, section 10.3, page 28 of the 2001 federal Title X guidelines requires projects to establish a medical record for every client who obtains clinical services. These records must be maintained in accordance with accepted medical standards and state laws with regard to record retention. The only exception to this requirement involves clients who receive anonymous HIV testing, counseling, and referral (CTR) services. Records must be:

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

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

- Personal data;
- Medical history, physical exam, laboratory test orders, results, and follow-up;
- Treatment and special instructions;
- Scheduled revisits;
- Informed consents;
- Refusal of services; and
- Allergies and untoward reaction to drug(s), latex, food, etc. recorded in a prominent and specific location.

The record must also include reports of clinical findings, diagnostic and therapeutic orders, and documentation of continuing care, telephone conversations, referral, and follow-up. The record must allow for entries by counseling and social services staff. Agencies should maintain a problem list at the front of each chart listing identified problems to facilitate continuing evaluation and follow-up. Client information should be kept separate from the client medical chart. If included in the medical chart, client financial information should not be a barrier to client services.

Confidentiality and Release of Records: A confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law, and kept separate whenever possible. When information is requested, agencies should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form, which does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care.

Part II, section 8.7, page 25 of the 2001 federal Title X guidelines requires projects to assure that the counseling sessions for adolescents are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individuals. However, counselors must encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts to coerce them into engaging in sexual activities. Title X projects may not require written consent of parents or guardians for the provision of core required family planning services to minors. Nor can the project notify parents or guardians before or after a minor has requested and received Title X core required family planning services.

REQUIRED SERVICES, FOLLOW-UP & REFERRAL

Standard: The following components must be offered to and documented on all clients at the initial and return visits:

- Planned mechanism for client follow-up
- Performance of any necessary clinical procedures
- Provision of medication and/or supplies as needed
- Provision of referrals as needed

I. Required Services

Agencies funded under Title X must provide all family planning services listed below either on-site or by referral:

- The client's **written informed voluntary consent to receive services must be obtained** prior to the client receiving any clinical services.
- If a client chooses a prescription method of contraception, **a method-specific consent form must be obtained** and updated routinely at subsequent visits to reflect current information about that method.
- Counseling/Education (See section in guidelines for description)
- History, Physical Assessment, and Laboratory Testing (See section in guidelines for description)
- Fertility Regulation (See section in guidelines for description)
- Infertility Services (See section in guidelines for description)
- Adolescent Services (See section in guidelines for description)
- Identification of Estrogen-Exposed Offspring (See section in guidelines for description)

When required services are to be provided by referral, the grantee/agency **must establish formal arrangements with a referral agency** for the provision of services and reimbursement of costs, as appropriate.

II. Referrals

Agencies must have written policies/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test finding. These policies must be sensitive to client's concerns for confidentiality and privacy.

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

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

Efforts may be made to aid the client in identifying potential resources for reimbursement of the referral provider, but projects are not responsible of this care. Agencies must maintain a current list of health care

providers, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs to be used for referral purposes. Referral resources should be reviewed periodically for quality assurance. Whenever possible, clients should be given a choice of providers from which to select.

QUALITY ASSURANCE AND AUDIT

Section 10.4 of the federal Title X guidelines requires a quality assurance system to be in place that provides for ongoing evaluation of project personnel and services. The required written quality assurance plan must include:

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

INFECTION CONTROL

Standard: All clinics must have policies and procedures to identify and reduce the risk of acquiring or transmitting an infection.

Agencies must follow applicable Federal and state regulations regarding infection control.

Agencies should have a comprehensive process in place for surveillance, prevention and control of infections.

HEALTH will consider agencies with JCAHO accreditation and those in compliance with state ambulatory health care standards (if applicable) to be in compliance with this standard.

DELEGATE AGENCY SITE REVIEWS

INTRODUCTION

The Title X site review is a valuable management tool that provides planning information to the federal Title X Family Planning Program, the Rhode Island Department of Health (HEALTH) Title X Family Planning Program, and Rhode Island's eleven (11) Title X delegate agencies. The federal Title X Family Planning Program requires that all family planning projects funded under Title X of the Public Health Services Act of 1970 be monitored to ensure compliance with the provisions of the law. This monitoring, which is done through the annual site review process, is one of several components that collectively constitute an overall quality assurance system.

Rhode Island's Title X site reviews generate information that helps Title X delegate agencies by identifying program areas that require additional support to improve program activities through the implementation of corrective action. Moreover, the information collected can produce information about the needs of Rhode Island's Title X delegate agencies --- information necessary for developing and carrying out responsive technical assistance, consultation, and training activities.

SITE REVIEW OBJECTIVES

The primary objectives for the HEALTH's Title X site review are as follows:

1. To ensure delegate agencies' understanding of and compliance with Title X and other federal and state laws, regulations, policies, and guidelines.
2. To verify activities reported by each delegate agency, such as an agency's expenditure of funds and scope of services.
3. To determine each delegate agency's progress in implementing the project plan as stated in the approved Title X grant application and delegate agency work plans.
4. To determine whether appropriate systems are being implemented, are effective, and are ensuring program compliance with Title X.
5. To develop and present to each delegate agency a statement of findings and recommendations, including identified problem areas that require resolution and, if appropriate, on-site consultation and technical assistance.

6. To obtain from each delegate agency an appropriate plan of correction, based on the statement of findings and recommendations.
7. To provide each delegate agency with an opportunity to develop a plan of assistance to help improve delivery of Title X services as necessary. This includes providing each delegate agency with resources, as available, and follow-up to questions or problems identified during the site review.
8. To provide each delegate agency with the opportunity to identify trends and common issues in the delivery of Title X services and in the implementation of Title X requirements to assist in state program planning.

PROCEDURES FOR CONDUCTING SITE VISITS AND SUBSEQUENT FOLLOW-UP

1. On an annual basis, HEALTH will select three (3) or four (4) delegate agencies to be reviewed. By doing so, each delegate agency will be the subject of a comprehensive financial, administrative and clinical site review once every three years. All agencies will have a scheduled review visit on alternate years from the comprehensive site visit.
2. HEALTH will notify each delegate agency being reviewed, in writing, at least 30 days prior to the site visit. As a part of the notification, HEALTH will provide each delegate agency being reviewed with the names and positions of HEALTH staff that will be participating in the site review.
3. HEALTH will provide each delegate agency with a copy of the site review instrument at least 14 days prior to the site review. In addition, HEALTH will provide each delegate agency being reviewed with a written description of the site review process.
4. HEALTH will work with each delegate agency being reviewed to determine the date and time of the visit. Each site review is expected to take no longer than one half day.
5. One week prior to the site review, HEALTH will ask each delegate agency being reviewed, in writing, to have available for review 20-25 clinical and financial records on the date of the site review. The clinical and financial records will be randomly selected by the family planning computerized data system, and the numbers and types of clients to be reviewed will be determined by HEALTH staff prior to the review.
6. HEALTH will conduct the site review on the agreed-upon date and time. HEALTH staff will provide each delegate agency being reviewed with an opportunity to ask

questions and address concerns.

7. HEALTH will provide each delegate agency with a written report with findings and recommendations, no later than 30 days following the site review.

8. Each delegate agency reviewed is expected to provide a written response to the HEALTH's report with findings and recommendations, no later than 30 days following receipt of the report.

9. HEALTH will conduct a follow-up visit to each delegate agency reviewed no later than 6 months following 1 month after the date of its initial written report.

COMMUNITY OUTREACH & EDUCATION

Standard: Each agency must submit a community outreach and education plan to the Rhode Island Department of Health, in accordance with 2001 Federal Guidelines (Part I, Section 6.9, page 12). Title X requires that each family planning project plan to provide for community education. Efforts should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy. Community education should serve to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial. Community education can be directed toward identifying local agencies and institutions which are likely to serve significant numbers of individuals in need of family planning, such as schools and social services agencies.

To facilitate community awareness of and access to family planning services, agencies must establish and implement planned activities whereby their services are made known to the community. In planning for community outreach and education, agencies should review the range of possible strategies and assess the availability of existing resources and materials. Community outreach activities should be reviewed annually and be responsive to the needs of the community. Agency community outreach & education efforts should compliment statewide efforts. Any educational or promotional materials utilized as a part of community education efforts must be reviewed by the Information and Education (I & E) Committee prior to dissemination.

DEFINITION OF A FAMILY PLANNING CLIENT, FEE POLICY AND SLIDING FEE SCALES

I. Fee Policy

Fees charged to clients must reflect true costs to a delegate agency. Bills must be given directly to the client by a delegate agency or submitted to another payment source such as Title XIX, Medicaid/RIte Care, private insurers or other third party payers. Delegate agencies are required to bill all possible third party payers, including Medicaid to ensure that Title X funds will be used only on patients without any other sources of payments. Delegate agencies are encouraged to have written agreements with RIte Care Medicaid Plans, as appropriate, in order to bill (See 2001 Federal Guidelines: Part I, Section 6.3, page 7). Title X funds will be used only as the payer of last resort.

A schedule of discounts (sliding fee scale) must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. Agencies may use their community health center (CHC) cost analysis to determine charges for core required Title X services if the CHC cost analysis includes all core required Title X services. The sliding fee scale should be based on family size, income, and other specified economic considerations for individuals with family incomes between 101% and 250% of the Federal Poverty Level (FPL). An agency may begin the the full fee category at 200% of the FPL to align with its CHC sliding fee scale. A copy of the sliding fee scale must be submitted annually by each delegate agency to the Rhode Island Department of Health (HEALTH). Fees must be waived for individuals with family incomes above this amount who, as determined by the site director, are unable, for good cause, to pay for family planning services. **Clients must not be denied services or be subjected to any variation in quality of services because of the inability to pay.**

At the time of services, clients who are responsible for paying any fee for their services must be given bills directly. Client income and insurance status should be evaluated at the initial visit and be re-evaluated at least annually. Uninsured clients at or below 100% of the FPL may be charged for the office visit, in accordance with the CHC sliding fee scale, if a client has another non-core required Title X service on the day of the visit. If an uninsured client at or below 100% of the FPL has only core required family planning services on the day of the visit, then the client must not be charged for the visit. The agency must bill all third parties legally obligated to pay for the services. Bills to third parties may not be discounted. The schedule of discounts must include charges for a new patient, an established patient, counseling and education, supplies, and laboratory costs and must be submitted by each delegate agency annually to HEALTH as a part of the schedule of discounts. With respect to pregnancy tests, all third parties must be billed. However, all other patients should not be billed for pregnancy tests and HIV counseling, testing and referral (CTR) services since HEALTH reimburses Title X agencies separately for these services through other federal Title X funds (HIV CTR services) and Title V MCH funds (pregnancy tests).

Agencies should document in a client record, but **NOT** the client's medical record, eligibility for a discount. Whenever possible, there should be separate charts for client record and medical record. Documentation may include a copy of a pay stub, a copy of most recent federal tax filing, verification of Family Independence Program (FIP), formerly called Aid to Families with Dependent Children (AFDC), or other form of documentation of family income. Agencies that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than

re-verify income or rely solely on client's self report. Clients who cannot present documentation of income must not be denied services and are allowed to self-report income. Agencies have a large measure of discretion in determining the extent of income verification activity that they believe is appropriate for their client population. Bills to clients must show total charges minus any allowable discounts.

Voluntary donations from clients are permissible. If your agency chooses to ask for a donation, then donations must be requested from all clients, including private and Medicaid clients (not just no cost clients). In addition, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations from clients do not waive the billing/charging requirements set out above. An example of a patient donation policy can be found at the end of this section (Section 13).

A suggestion may be made to minor and adult clients to make a financial contribution based on their ability to pay; but they can not be denied services due to either their inability or refusal to make a contribution or because confidential services have been requested. Delegate agencies must inform all potentially eligible clients about the sliding fee scale and the fact that services will not be denied due to the inability to pay.

A minor is an individual under eighteen years of age. If a minor client is unemancipated and confidentiality is not a concern, the minor's family income must be considered in determining the service fee as with all other clients. Health insurance plans covering a minor under a parent/guardian's policy should be billed, if the minor does not need or request confidential services. In such a case, a written consent form permitting the billing of the health insurance plan, signed by the minor, must be included in the minor's client record. RIte Care insurance plans are an exception and a minor does not need to sign a written consent form permitting the billing of the health insurance plan.

If a minor client with RIte Care requests confidential services without involvement of a principal family member, RIte Care should be billed. If a minor client with private insurance requests confidential services, charges for services must be based on the minor client's income. Income actually available to a minor client, such as wages from part-time employment and allowances transferred directly to the minor, must be considered in determining a minor client's ability to pay for services. Basic provisions (e.g., food, shelter, transportation, tuition, etc.) supplied by the minor client's parents/guardians must not be included in the determination of a minor client's income.

Under certain conditions where confidentiality is restricted to limited members of a minor client's family (e.g., there is parental disagreement regarding the minor's use of family planning services), the charge must be based on the minor client's income, rather than family income, if the minor client's confidentiality could be breached in seeking the full charge. It is not allowable for delegate agencies to have a general policy of no fee or flat fees for the provision of services to minor clients. Nor is it allowable for delegate agencies to have a schedule of fees for minors that is different from other populations receiving services.

Agencies must inform clients about the existence of the sliding fee scale and the fact that services will not be denied due to inability to pay. Delegate agencies must make reasonable efforts to collect bills, but they must in no way jeopardize client confidentiality in the process. Delegate agencies must obtain a client's permission before sending bills or making phone calls to the clients home and/or place of employment. Clients must not be sent to the pharmacy to purchase any family planning supplies.

Agencies must offer by federal mandate a broad range of acceptable and effective medically approved

family planning methods and services either on-site or by referral (Federal Guidelines: Part II, Sec. 7.0, page 13).

II. Definition of A Family Planning Visit

According to the current (2001) Title X Family Planning Annual Report (FPAR), a family planning client is an individual who receives one or more family planning encounters during the reporting period (i.e. visits with a medical or other health care provider in which family planning services were provided). The Rhode Island Department of Health's Family Planning Program considers individuals ages 11 through 64 years to be potentially eligible for family planning services. However, visit definitions are needed to determine who is a family planning client.

Family Planning Visit: A visit between a client and a medical provider or other health care provider, the primary purpose of which is to provide family planning services (i.e. clinical or educational services related to contraception, infertility or sterilization). All family planning visits are either medical visits or other health care visits that involve family planning services. Only face-to-face contacts determined in a medical record can be counted as visits.

Medical Visits: Family Planning Visit With A Medical Provider

A visit between a medical provider and a client in which the client is provided (in association with the proposed or adopted method of contraception or treatment for infertility) one or more of the following medical services related to family planning:

- | | |
|---------------------------|-------------------------|
| *pap smear | *blood pressure reading |
| *pelvic examination | *HIV/STD testing |
| *rectal examination | *sterilization |
| *testicular examination | *infertility treatment |
| *hemoglobin or hematocrit | |

Other Health Care Visits: Family Planning Visit with Another Health Care Provider

A visit between an other health care provider (i.e. non-medical health educator) and a client in which family planning education or counseling services are provided in relation to contraception (proposed or adopted method), infertility or sterilization. The counseling should include a thorough discussion of the following:

- *Reproductive anatomy and physiology
- *Infertility, as appropriate
- *HIV/STDs
- *The variety of family planning methods available, including abstinence and NFP
- *The uses, health risks, and benefits associated with each family planning method
- *Detailed instructions regarding the adopted method
- *The need to return for evaluation on a regular basis and as problems are identified

Education and/or counseling related to contraception, infertility or sterilization, which may occur in a group setting on an individual basis, must be face-to-face and documented in the client's medical record in order to be counted as a family planning client.

Laboratory tests, in and of themselves, do not constitute visits of any type. If laboratory testing is performed and there is no other face-to-face contact between a provider and a client, then the visit cannot be counted. However, if the tests are accompanied by other medical services involving family planning related to contraception (proposed or adopted), infertility or sterilization **and/or** family planning counseling and/or education related to contraception (proposed or adopted), infertility or sterilization, an individual will have had a medical or an other health care provider visit by virtue of such medical services or counseling and/or education.

Pap smears and pelvic examinations in and of themselves constitute a medical visit but not a family planning medical visit. However, if a pap smear and pelvic examination are accompanied by other medical services involving family planning (related to contraception (proposed or adopted), infertility, or sterilization) **and/or** family planning counseling and/or education related to contraception (proposed or adopted), infertility or sterilization, an individual is considered to have had a family planning medical visit.

Once an individual has been determined to be a family planning client, there are a number of required services that must be provided to that client (See Section 13 of the state *Family Planning Guidelines*) in addition to specific reporting requirements (See Section 15 of the state *Family Planning Guidelines*). The state Family Planning Guidelines are based on the current federal *Program Guidelines For Project Grants for Family Planning Services* (January 2001).

Examples of Clients Who Are Family Planning Clients

In order to be counted as a family planning client, these visits must be face-to-face and documented in the client's medical record.

*An eleven-year old girl or boy who is not sexually active, but is provided with counseling and education regarding reproductive anatomy and physiology can be considered to be a family planning client. Counseling and education regarding birth control methods and HIV/STD counseling and education should also be provided to such clients if appropriate. According to the legislative mandates attached to Title X and conditioned in the notice of grant award, Title X providers must counsel minors on how to resist sexual coercion; encourage minors to include their family in the decision to seek family planning services, and follow all state reporting laws on child abuse, child molestation, sexual abuse, rape, or incest. As with all medical services and highlighted in Title X, discussions between the provider and the client are confidential and based on the provider's expertise in assessing what each patient's needs are as indicated in the notes in the client's medical chart.

*An adolescent male who comes in for birth control education and counseling with his adolescent girlfriend can be counted as a family planning client as long as he is encouraged to receive other documented Title X required services for males (i.e. sexual history, partner history, and HIV/STD education, TSE, etc.) in the future. According to the legislative mandates attached to Title X and conditioned in the notice of grant award, Title X providers must counsel minors on how to resist sexual coercion; encourage minors to include their family in the decision to seek family planning services, and follow all state reporting laws on child abuse, child molestation, sexual abuse, rape, or incest. As with all medical services and highlighted in Title X, discussions between the provider and the client are confidential and based on the provider's expertise in assessing what each patient's needs are as indicated in the notes in the client's medical chart.

*An adult man under 65 years old coming in for a comprehensive preventive health visit can be counted as

a family planning client if he receives birth control education and/or counseling (i.e. primarily condoms) and receives other documented Title X required services for males (i.e. sexual history, partner history, HIV/STD education, TSE, colon cancer screening if appropriate, etc.).

*An adult man under 65 years old coming in for an HIV/STD visit can be counted as a family planning client if he receives birth control counseling and/or education (condoms) and receives other documented Title X required services for males (i.e. sexual history, partner history, and HIV/STD education, etc.). Required TSE and colon cancer screening may not occur during the HIV/STD visit, but should be performed if the man comes back for other health care services in the future. As a part of the counseling and/or education, the message that condoms can prevent unintended pregnancy must be included in addition to the message that condoms can prevent HIV/STDs.

* A male who relies on his partner's method for birth control, and receives birth control counseling and education on the partner's method can be counted as a family planning patient.

*Sterilized individuals can be counted as family planning clients as long as they are under 65 years old and receive other Title X required services since such individuals have selected a method of birth control (sterilization).

*Individuals who are abstinent can be counted as family planning clients as long as they are under 65 years old and receive other Title X required services since such clients have selected a method of birth control (abstinence).

*A female under 65 years old can be counted as a family planning client if she receives birth control education or counseling and other documented Title X required services for females as appropriate (sexual history, partner history, HIV/STD education, etc.)

* Pregnant women or women who are seen for their late stage pregnancy or post-partum visit can be counted as a family planning client if she receives birth control education and counseling and/or HIV/STD testing as part of her care.

* Females who have a positive pregnancy test result can be counted as a family planning client as long as they receive pregnancy diagnosis and counseling services. Pregnant women must be provided with information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.

* Females with a negative pregnancy test can be counted as a family planning client if she receives birth control education and counseling. In addition, the cause of delayed menses should be investigated.

Example of Client Who Is Not A Family Planning Client

*An individual who receives anonymous HIV counseling, testing, and referral (CTR) services cannot be counted as a family planning client since he or she does not have a medical record and since the visit cannot be documented.

III. Core (Minimum) Family Planning Services

The following services must be charged for on a sliding fee scale, which includes a zero pay category for clients with incomes $\leq 100\%$ of the FPL and a schedule of discounts for clients with family incomes $>101\%$ and $\leq 250\%$ of the FPL.

1. Client education must provide all clients (male and female) with the information needed to: make informed decisions about family planning, use specific methods of contraception and identify adverse effects, perform breast/testicular self examination, reduce risk of HIV/STD transmission, understand the range of available services and the purpose and sequence of clinic procedures, and understand the importance of recommended screening tests and other procedures involved in the family planning visit. Client education must be documented in the client record. All clients should receive education as a part of an initial visit, an annual revisit, and any medically indicated revisits related to family planning. Education can occur in a group or individual setting.
2. Counseling to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services must be provided for all clients (male and female). In addition all clients must receive counseling on, at a minimum, education about HIV infection and STDs, information on risks and infection prevention, and referral services. Documentation of counseling must be included in the client's record. The client's written informed voluntary consent to receive services must be obtained prior to the client receiving any clinical services. In addition, if a client chooses a prescription method of contraception, a method-specific consent form must be obtained and updated routinely at subsequent visits to reflect current information about the method. The signed informed consent form must be a part of the client's record. All clients should receive counseling as a part of an initial visit, an annual revisit, and any medically indicated revisits related to family planning.
3. Comprehensive history for all clients (male and female) at initial visit, with updates at subsequent visits. Histories for all clients must include at least the following areas: significant illnesses, hospitalizations, surgery, blood transfusion or exposure to blood products, and acute or chronic medical conditions; allergies; current use of prescription and over-the counter medications; extent of use of tobacco, alcohol, and other drugs; immunization and rubella status; review of systems; pertinent history of immediate family members; and partner history (including injectable drug use, multiple partners, risk history for HIV/AIDs, and sexual orientation. Histories of reproductive functioning in female clients must include at least the following: contraceptive use (past and present); menstrual history; sexual history; obstetrical history; gynecological conditions; HIV & STDs (including HBV); pap smear history; and in utero exposure to DES for clients born between 1940 and 1970. Histories of reproductive function in male clients must include at least the following: sexual history; HIV & STDs (including HBV); and urological conditions.
4. Complete Physical Exam for all female clients. For female clients, the exam should include, but is not required, height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum. For female clients, the exam **must** include blood pressure evaluation, breast examination, pelvic examination including vulvar evaluation and bimanual exam, pap smear, digital colo-rectal cancer screening in individuals over 40, and HIV/STD screening, as indicated. All physical examination and laboratory test requirements stipulated in the prescribing information for specific methods of contraception must be followed. Physical examinations should be made available to male clients, however, they are not required. For male clients, the exam should include

but is not required, height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum. Examination should also include palpitation of the prostate, as appropriate, and instructions in self-examination of the testes. Clinics should stress the importance of blood pressure evaluation, colo-rectal cancer screening in individuals over 50, and HIV/STD screening, as indicated.

5. Laboratory Tests are required for the provision of specific methods of contraception. Pregnancy testing must be provided onsite and HIV, Chlamydia, Gonorrhea, and Syphilis testing must be provided for all clients as indicated (State law requires providers to offer HIV testing to all family planning and prenatal clients). The following laboratory procedures must be provided to clients if required in the provision of a contraceptive method: anemia assessment, vaginal wetmount, diabetes (blood sugar) testing, cholesterol or lipid testing, Hepatitis B testing, chlamydia, gonorrhea and syphilis testing, rubella titer and urinalysis, either on site or by referral.
7. Level I Infertility Services must be made available to female and male clients desiring such services. Level I Infertility services includes initial infertility interview, education, physical examination, counseling, and appropriate referral.
8. Revisit schedules must be individualized based on the client's need for education, counseling, and clinical care beyond that provided at the initial and annual visit. Clients selecting hormonal contraceptives, IUDs, cervical caps, or diaphragms for the first time should be scheduled for a revisit as appropriate after initiation of the method to reinforce its proper use, to check for possible side effects, and to provide additional information or clarification. A new or established client who chooses to continue a method already in use need not return for this early visit unless a need for reevaluation is determined on the basis of findings at the initial visit.
9. Under the federal Title X law, grants cannot be made to entities that offer only a single method or unduly limited number of family planning methods. Either directly or through referral, all reversible and permanent methods of contraception must be provided, which include barrier methods (female and male), IUDs, fertility awareness methods, natural family planning, hormonal methods (injectables, implants, and orals) and sterilization. Certain oral contraceptives have been found to be safe and effective for use as post coital emergency contraception. Methods not directly provided at the site should be referred first to another Title X site, if appropriate, and, secondly, elsewhere at an agency with which the site has a formal arrangement with for the provision of the service.

IV EXAMPLE SLIDING FEE SCALE*

The following example sliding fee scale can be used by agencies to help develop their own sliding fee scales (See next page). Non-core services do not have to appear on the Title X sliding fee scale.

**CORE REQUIRED FAMILY PLANNING SERVICES
EXAMPLE SLIDING FEE SCALE***

	≤100%	>250%
<u>Laboratory Tests</u>		
Pregnancy Test		Uninsured and Underinsured Clients = No Cost (Funded with Federal Title V MCH funds)
Pap Smear	\$0	Full Fee
Anemia Assessment**	\$0	Full Fee
Vaginal Wetmount**	\$0	Full Fee
Diabetes Testing**	\$0	Full Fee
Cholesterol & Lipids**	\$0	Full Fee
Hepatitis B Testing**	\$0	Full Fee
Rubella Titer**	\$0	Full Fee
Urinalysis**	\$0	Full Fee
HIV Testing		No Cost (Funded with federal Title X funds)
Chlamydia Testing	\$0	Full Fee
Gonorrhea Testing	\$0	Full Fee
Syphilis (VDRL, RPR) Testing	\$0	Full Fee
<u>Methods***</u>		
Oral Contraceptives	\$0	Full Fee
Emergency Contraception	\$0	Full Fee
Depo-Provera	\$0	Full Fee
Male Condoms	\$0	Full Fee
Female Condoms	\$0	Full Fee
IUD	\$0	Full Fee
Cervical Cap	\$0	Full Fee
Diaphragm	\$0	Full Fee
Patch	\$0	Full Fee
Ring	\$0	Full Fee
Sponge	\$0	Full Fee
Spermicides	\$0	Full Fee
<u>Other</u>		
Hepatitis B Vaccine (For Clients Under 19 YOA Only)		Uninsured and Underinsured Clients = No Cost (Funded with federal/state immunization funds)

*Visits must be a part of Title X sliding fee scales (Please include CPT codes).

**Must be provided to clients if required in the provision of a contraceptive method.

***Title X agencies must provide a broad range of contraceptive methods

CONFIDENTIALITY

Standard: Every project must assure client confidentiality and provide safeguards for individuals against the invasion of personal privacy, as required by the Privacy Act. No information obtained by the project staff about individuals receiving services may be disclosed without the individuals written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual (2001 Federal Guidelines: Part I Section 5.2, page 5).

Part II, section 8.7, page 25 of the 2001 federal Title X guidelines requires projects to assure that the counseling sessions for adolescents are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individuals. However, counselors must encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts to coerce them into engaging in sexual activities. Title X projects may not require written consent of parents or guardians for the provision of core required family planning services to minors. Nor can the project notify parents or guardians before or after a minor has requested and received Title X core required family planning services.

REPORTING REQUIREMENTS

I. Standard

Agencies must comply with the financial and other reporting requirements of 45CFR, Part 74 or 45 CFR, Part 92 as applicable and comply with other reporting requirements as required by DHHS and HEALTH. Delegate agencies must document all patient services in the client medical record. The agency must also complete and send to MSI, on a monthly basis, a completed Family Planning Encounter Record (FPER) for every family planning visit. No FPER may be submitted for pregnancy tests done without counseling services.

II. Contract Reporting Obligations

Each agency must submit to the Rhode Island Department of Health, in writing annually, documents that includes the following:

A description of the agency's catchment area and family planning population to be served
A workplan that includes the following:

- *name of the agency's designated family planning coordinator
- *an objective for increasing or maintaining client utilization
- *an objective for staff training (JSI trainings)
- *an objective for community outreach
- *an objective for and description of the agency's family planning quality assurance plan
- *an objective and plan for coordinating with RIte Care to assure that your agency makes every effort possible to charge RIte Care for teens with RIte Care
- *an objective for no cost pregnancy testing and administering of "Care Questionnaires, including education and follow-up"
- *an objective for HIV Counseling, Testing and Referral services
(an objective for serving teens
- * an objective for assuring that uninsured clients have on-site access to high cost contraceptives
- *a list of community and statewide agencies, organizations and specialty service providers used for referral and follow-up of clients
- *a list of Title X agencies who serve referrals from the agency for Title X services not provided by the agency

*An education plan that includes goals and content outlines to ensure consistency and accuracy of information provided. The plan should also include policies to assure that staff encourage

family participation in the decision of minors to seek family planning services and that they provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities; and staff adheres to state laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

A written, year-end, progress report on the previous fiscal year's objectives.

A Quality Assurance or Quality Improvement Plan

A copy of the agency's sliding fee scale

A list of staff who have completed basic and/or advanced reproductive health training

Other forms such as: Midlevel and Physician Provider forms, QA survey, Site Information form, the List of Services form, and Title X certification

III. Source of Payment on the Family Planning Encounter Record (FPER)

What you should be documenting on a FPER for every patient.

Medicaid

The agency must bill all health insurance plans, including **Medicaid (and Rite Care)**, that are legally obligated to pay for the services. Charges to health insurance plans may not be discounted. Agencies seeing minor clients with Medicaid or Rite Care who are receiving confidential services, since Medicaid law protects the confidentiality of minors receiving reproductive health services should bill Medicaid or Rite Care.

Private Insurance

The agency must bill all **private health insurance** plans, because they are legally obligated to pay for the services. The only exception is for confidential teens, in which the parent's insurance must not be billed because it could jeopardize confidentiality. Charges to third parties may not be discounted. Clients with private health insurance include the following:

- * A client who has private health insurance and who pays a co-payment.

- * A teen under 18 yrs of age who is covered by parent's private health insurance, and gives permission and understands that by billing the insurance plan, he/she may be inhibited from having a confidential visit.

- * A client 18 yrs. or older, who is either covered by his/her parent's private health

insurance or his/her spouse's private health insurance, and who gives permission and understands that by billing the insurance plan, he/she may be inhibited from having a confidential visit.

Self Pay –Partial

Uninsured, under-insured, and clients with family incomes between 100% and 250% of the Federal Poverty Level (FPL), based on family size, income, and other specified economic considerations should be placed on the Title X sliding fee scale. Specifically,

- An uninsured client with family incomes between 100% and 250% of the Federal Poverty Level (FPL), should be considered partial-fee clients and be charged based on the agency's sliding fee scale. **Self Pay -Partial Patients should be included in the Self Pay -Partial category under the source of payment on the FPER form, and not in the Title X category.** A Partial fee client can be either an uninsured adult or an uninsured teen whose income is between 100% and 250% of the FPL.

A client seeking a confidential visit is considered to have a family size of one.

Self Pay - Full

Uninsured, under-insured, and clients with family incomes above 250% of the FPL should be charged full fee by the agency. A client seeking a confidential visit is considered to have a family size of one.

100% Grant / No-Fee Patients

Clients whose family income are at or below 100% of the FPL, and do not have health insurance (or whose family incomes are at or below 100% of the FPL and are under-insured under their existing private health insurance plan) are considered to be 100%Grant/No-fee clients. 100% Grant/No-fee clients include the following:

- A teen under 18yrs. of age who is uninsured and who wants a confidential visit and whose income places him/her at or below 100% of the FPL.
- A teen under 18yrs. of age who is either uninsured or privately insured and who wants a confidential visit, whose income places him/her at or below 100% of the FPL, and who gives a donation.
- A teen under 18 who has private health insurance under his/her parent, whose individual income is at or below 100% of the FPL, who wants a confidential visit

- A teen under 18 who has private insurance under his/her parent, whose family income is at or below 100% of the FPL, who wants a confidential visit, and who gives a donation.
- A client who is 18 yrs. or older who is covered by parent's or spouse's health private insurance, whose family income is at or below 100% of the FPL, and who wants a confidential visit.
- A uninsured client who is 18 yrs. or older and whose income is at or below 100% of the FPL.
- * An under-insured client with a family income at or below 100% of the FPL.

An uninsured adult, an uninsured teen, and a teen who wants confidential services and who has coverage under his/her parent's health insurance plan and an adult who has coverage under his/her parent or spouse's plan should not be considered to be a 100%Grant/No-fee client unless his/her income is at or below 100% of the FPL. If any of these client's income is above 100% of the FPL, then he/she should be placed on the sliding fee scale (partial fee) or pay full fee, as appropriate. In determining income for either an adult or a teen who requests confidential services, only the income of that adult or teen can be considered. A client seeking a confidential visit is considered to have a family size of one.

State Funding/ DPH

The payment of source field for the FPER form, State Funding/DPH, **should only be utilized by Rhode Island delegate agencies for School Based Health Center clients since other sources of funding have been appropriated for SBHC services.** If it is utilized for other types of family planning patients, agencies will not be given appropriate credit. Confidential HIV testing clients fall into one of the other categories (Medicaid, Private Insurance, Self-pay partial, Self-pay full or 100% grant/No-fee).

Center Care

The payment of source field "Center Care" for the FPER form, should never be utilized. If it is utilized, agencies will not receive appropriate credit.

FC Pool

The payment of source field "FC Pool" for the FPER form, should never be utilized. If it is utilized, agencies will not receive appropriate credit.

NON-DISCRIMINATION

I. Non-Discrimination Statement

According to Public Health Service regulation, Part 59, § 59.5, agencies must provide services to all clients without regard to religion, race, color, national origin, creed, disability, sex, and number of pregnancies, marital status, age, and contraceptive preference (42 CFR Ch. 1 (10-1-00 Edition)). Services must also be provided in a manner that protects the dignity of the individuals. As much as possible, services should be culturally competent.

II. Coercion Prohibited

Individuals must not be subjected to coercion to receive services or to use or not to use any particular method of family planning. Acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other service or assistance from or participation in any other programs of the applicant. Delegate agency staff are subject to prosecution under Federal law if they coerce or endeavor any person to undergo an abortion or sterilization procedure.

III. Disabled Clients

Agencies must comply with 45 CFR Part 84, which prohibits discrimination on the basis of handicap in Federally assisted programs and activities, and which requires, among other things, that recipients of Federal funds operate their Federally assisted programs so that, when viewed in their entirety, they are readily accessible to people with disabilities. Agencies must also comply with any applicable provisions of the American With Disabilities Act (Public Law 101-336).

TRAINING & TECHNICAL ASSISTANCE

Section 6.6 of the federal Title X guidelines requires projects to provide for the orientation and in-service training of all project personnel. All project personnel should participate in continuing education related to their activities. Documentation of continuing education should be maintained and used in evaluating the scope and effectiveness of the staff training plan.

Training through HEALTH's Family Planning Program and through the regional training center (JSI) is available to all projects under the Title X Program. In addition to training, project staff may receive technical assistance from HEALTH's Family Planning Program for specific project activities.

FAMILY PLANNING ADVISORY COUNCIL

The Rhode Island Department of Health (HEALTH) is required to provide for an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of the significant elements of the population to be served, and by persons in the community knowledgeable about the community's needs for family planning services. HEALTH must also provide for the review of all informational and educational materials developed or made available under the program.

In response to these requirements and the need for agency and community input, the HEALTH has established a Family Planning Advisory Council (FPAC). Agencies are required to assign a staff person to serve as a Family planning Coordinator and to serve on the FPAC. Bylaws for the FPAC appear on the next pages.

RHODE ISLAND FAMILY PLANNING ADVISORY COUNCIL

BYLAWS

Article I
Title

This body is named the Rhode Island Family Planning Advisory Council.

Article II
Authority

The Advisory Council is established in conjunction with U.S. Department of Health and Human Services, Public Health Service Act, Title X regulations and program guidelines, as an advisory body to the Director of the Rhode Island Department of Health.

Article III
Purpose

The purpose of the Rhode Island Family Planning Advisory Council is to bring together family planning providers, administrators and other interested parties to:

- Advise the Director of the Rhode Island Department of Health on matters affecting the availability and quality of family planning services throughout Rhode Island,
- Identify, formulate and advocate to ensure all people of childbearing age have access to comprehensive, high quality family planning services that are affordable and culturally relevant,
- Identify consumer and community family planning problems and needs.

Article IV
Membership

- Sec. 1 The full membership of the Rhode Island Family Planning Advisory Council shall include representatives from family planning providers, administrators, and other interested parties, who shall participate on the Steering Committee or other Family Planning Advisory Council committees. Membership shall also include staff of the Rhode Island Department of Health Family Planning Program.
- Sec. 2 The Annual Meeting of the Family Planning Advisory Council may be held in the Spring of each year, at which time the Chairperson will report to the Director of the Rhode Island Department of Health and to the membership on the activities of the Council during the previous year. Election of officers and nominated Council members shall be held.
- Sec. 3 Resignations from the Family Planning Advisory Council shall be considered automatic for members who miss more than half of the meetings in one calendar year or three consecutive meetings without reasonable cause and prior notification of absence. Vacancies may be filled immediately.

Article V
Officers

- Sec. 1 The Family Planning Advisory Council shall have a Chairperson and Vice Chairperson elected by the membership at the Annual Meeting. The term of office shall be two years. No officer shall serve more than two consecutive terms, except than an officer who is first elected to fill a vacancy shall be eligible to serve for two additional years.
- Sec. 2 The Chairperson's responsibilities shall be to preside at

Steering Committee meetings, to select and appoint individual members to various committees, to create “as hoc” committees for special purposes when needed and to represent the Family Planning Advisory Council when necessary. The Vice-Chairman shall carry on the functions of the Chairperson in his/her absence and provide assistance to the Chairperson in accomplishing his/her responsibilities. If both officers are absent, responsibility for chairing the Steering Committee meeting shall be delegated to a staff member from the Rhode Island Department of Health Family Planning Program.

A. Nominating Committee

This committee shall consist of a minimum of three members of the Family Planning Advisory Council, chosen by the Chairperson of the Council in January of each year. The responsibility of the nominating committee shall be to submit a slate of officers for the Council to consider at its Annual Meeting. The nominating committee shall also submit a list of nominations of membership in the Council, at this time, with special attention to insuring representation from the community.

B. Information and Education Committee

This committee shall have the responsibility for reviewing and approving or appointing a subcommittee to review and approve all family planning informational and educational materials, to be used in Title X agencies, in accordance with Title X regulations and guidelines. The committee shall, also, participate in long-range Council planning; facilitate the provision of information and education on reproductive health care to the general public, as well as professional family planning providers; facilitate informing Rhode Islanders about the availability of family planning services throughout the state; provide training in coordination with the Medical Advisory Committee; and facilitate the acquisition of audio/visual and print materials, by the Department of Health, which will further Family Planning Program objectives.

C. Medical Advisory Committee

This committee shall monitor any aspect of Title X family planning programs and services for impact on the quality of care for Rhode Islanders; shall make recommendations for standards of

care; shall participate in long-range Council planning; and shall provide training in coordination with the Information and Education Committee.

D. Finance Committee

This committee shall monitor and assure that programs designed as Title X delegate agency sites continue to receive funding in amounts proportionate to their ability to meet Title X needs; shall monitor and advocate for Rhode Island's achieving parity among New England states in allocations of Title X and other available federal monies; shall participate in long-range Council planning; and shall make recommendations to the Rhode Island Department of Health regarding equitable and fair allocations to local delegate agencies.

Article VI
Committees

Sec. 1 Steering Committee

The Steering Committee shall function as the core of the Council. The Steering Committee shall conduct the business of the Council at regular meetings. This committee shall consist of not less than 9 nor more than 15 members, which number shall include officers of the Steering Committee. Each agency receiving Title X funds from the Rhode Island Department of Health is a member of the Steering Committee and shall have one vote on the committee. Title X family planning clients shall not exceed three voting members. Ex-officio (non-voting) members of the committee shall be the staff of the Rhode Island Department of Health, Division of Family Health, Family Planning Program.

Meeting of the Family Planning Advisory Council Steering Committee shall be held five times yearly, at a time and place to be determined by the Chairperson.

A simple majority of the current voting membership shall constitute a quorum. For a vote of the Council Steering Committee to be binding, a quorum must be present either directly or by proxy.

Sec.2 Standing Committees

In addition to the Steering Committee, there shall be four standing committees of the Rhode Island Family Planning Advisory Council, as outlined above. Committees shall have the responsibility to elect a chairperson, who is a voting member of the Steering Committee; set committee agendas; hold regular meetings; keep minutes of the meetings and report periodically to the Steering Committee. Any ad hoc committees, formed by the Chairman of the Steering Committee, shall report periodically to the Steering Committee membership.

Each Title X funded agency shall have a representative on at least one of the four standing committees. The Rhode Island Department of Health shall provide staff and technical assistance to each committee.

*Article VII
Technical Assistance*

Sec. 1 The Rhode Island Department of Health shall provide or make provision for technical assistance such as typing, copying and mailing, so that the Family Planning Advisory Council can fulfill its responsibilities.

*Article VIII
Amendments*

These bylaws may be amended at any meeting of the Family Planning Advisory Council, with advanced written notice of at least 30 days given to all members. Amendments to these bylaws shall require a two-thirds majority of the quorum.

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**REVIEW & APPROVAL OF CLIENT
INFORMATIONAL & EDUCATIONAL (I & E) MATERIALS**

Title X requires that “an advisory committee of five (5) to nine (9) members who are broadly representative of the community must review and approve all informational and educational materials, developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purpose of Title X.”

The federal guidelines further state that “this committee shall 1) consider the educational and cultural backgrounds of the individuals to whom the materials are addressed, 2) consider the standards of the population or community to be served with respect to such materials, 3) review the content of the material to assure that the information is factually correct, 4) determine whether the material is suitable for the population or community to which is to be made available, and 5) establish a written record of its determinations. The committee may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff, but final approval of informational and educational material rests with the committee.”

In response to this mandate, the Rhode Island Title X Family Planning Program established a five to nine member Informational and Education Subcommittee of the Family Planning Advisory Council (FPAC) to review and approve all information and education materials utilized by the Title X Family Planning Program. Agencies are required to submit any information and education materials utilized by the agency, including “agency-produced” materials, to the Rhode Island Department of Health for I & E Committee review and approval prior to their dissemination. A current list of approved materials begins on page A-39 and a current list of materials that were reviewed and not approved begins on page A-65. For a copy of the Family Planning Program’s materials order form, call Lauren Piluso at 222-5919.

SEXUAL COERCION POLICY

Standard: Decreasing the sexual coercion rate among minors must include knowledge of laws, definitions, reporting family involvement, counseling and referrals. The Rhode Island Department of Health's (HEALTH's) policy on sexual coercion was developed in collaboration with the HEALTH's Office of Domestic Violence.

The federal Title X program requires grantees and their delegate agencies to provide counseling to minors on how to resist coercive attempts to engage in sexual activities. Sexual coercion is a major issue that needs a critical amount of attention and consideration. Coercive situations involve the act of persuading or coercing a person specifically a minor into engaging in an unwanted sexual activity. These acts may be achieved through physical force, or emotional manipulation. Coercive situations involve threats, humiliation and anger as a person's means to convince a partner to consent in sexual activity.

According to the Emory University School of Medicine, the coercion occurrence rate is increasing as more young women date older men. This situation may lead to many other concerns including an earlier initiation to sexual behavior and an increase in pregnancy and STD rates. According to the American Bar Association (1997), there is increasing evidence of sexual relationships between girls aged ten- fifteen and adult men over the age of twenty. These relationships are a serious problem as the girls may be forced (coerced) into sexual relationships they are not ready for and which lead to the possibility of pregnancy and sexually transmitted diseases and emotional trauma.

The key elements of this policy are 1) the implementation of family participation, and 2) counseling services to minors on how to resist attempts to coerce minors into engaging in sexual activities. Federal grant requirements regarding Title X certification on coercion counseling and family planning must be fulfilled.

A. REPORTING REQUIREMENTS

It is important to note that not all forms of sexual coercion are illegal. Therefore, not all forms of sexual coercion are reportable. However, since the federal Title X requirements mandate counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities, counselors should provide counseling to minors on both illegal and non-criminal forms of coercion. In addition, counselors are mandated by statute to report illegal forms of all coercion (i.e. child abuse).

1. Any person who has reasonable cause to know or suspect that any child has been abused shall report within twenty-four hours, by transferring such information to

the Department of Children, Youth and Families who shall cause the report to be investigated immediately. All those who are guilty of such crimes will be prosecuted in the appropriate manner, according to the law.

2. Immunity from Liability – Any person participating in good faith in making a report, shall have Immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. There is no obligation to have personal information released for public information when reporting an abuse case to the police.

3. Penalty for failure to report – Any person, official physician or institution required to report known or suspected child abuse or who knowingly prevents any person acting reasonably from doing so, shall be guilty of a misdemeanor. Upon conviction they shall be subject to a fine of not more than five hundred dollars or imprisonment for not more than one year or both. Reporting of abuse is critical in the legal system.

4. A teen’s right under Title X to obtain confidential family planning services, however, does not supersede an individual’s reporting responsibilities.

B. FAMILY INVOLVEMENT

Family involvement should be recommended to family members to assist in the improvement of the adolescent’s health status. Family involvement includes, but is not limited to parental awareness of a minor’s decision to seek family planning services, discussions of family planning options, and encouragement toward responsible sexual decision making. The relationship between the family and the teen, if there are open lines of communication, is critical to establishing healthy behaviors. Parents raise their children to the best of their ability, and how sexuality is taught in the family will vary depending on religious and cultural beliefs, societal norms, previous experience and the comfort level of the parents with the material. In some situations, it is difficult for parents to feel knowledgeable enough to teach their adolescents about sex and sexuality because of the new information about disease and contraceptive technology.

Unfortunately, there is also the issue of family interference. Adolescents may feel that they cannot talk to their parents about a sexual decision because their parents would not support their decision. If the parent/parents does not approve of the relationship, or the teen’s choice to have sex, then the teen will be less apt to obtain birth control and pregnancy or STD contraction may occur.

C. WHAT TO INCLUDE IN THE COUNSELING SESSION

It is important for counseling to be implemented as a precaution and prevention tactic concerning sexual coercion. According to Emory University School of Medicine, when attempting to counsel an individual or individuals who are being coerced there are several tactics that should be utilized. Since there are no physical signs present on

an individual to expose sexual coercion, it must be determined through a thorough comprehensive evaluation. It is important to talk to the client about different types of coercive tactics including, persuasion, guilt trips, manipulation and/or put-downs. The clinician needs to examine the adolescent's statements, behaviors, and body language in light of any physical findings. It may be difficult to determine if an individual has been a victim of sexual coercion because each person responds differently to specific situations.

A COUNSELOR SHOULD:

1. Be open minded
2. Be specific and clear
3. Be nonjudgmental
4. Acknowledge the adolescents feelings
5. Set a priority list as to what is important with the teen
6. Interview the client alone
7. Use a list to ensure all topics are covered
8. Screening and counseling questions should be asked in an open ended format
9. Ask specific questions regarding anyone else, beside the partner, having pushed, coerced or forced sex.
10. Refer these questions to the adolescent:
 - Should I be having sex yet?
 - Am I the only one not having sex yet?
 - Have my boyfriend/girlfriend been together long enough to have sex?
 - Will he/she leave me if I do not have sex with him/her?
 - What will change if I do/do not have sex with him/her?

Attempts should be made to establish a comfortable atmosphere. The client should be aware that he/she might contact you at a later date for further counseling. The counselor should be "teen" friendly. Ignoring a situation or starting a conversation that cannot be finished are a disservice to the client. Phrasing and tone of voice are critical, if the teen feels the counselor disapproves, the client will stop sharing information. Where minors are involved, confidentiality is extremely important. Refer to your agency's confidentiality policies and procedures. Include information on legal options, skill building and referral to local agencies.

D. DEFINITIONS

1. Sexual Abuse – vaginal, anal or oral intercourse; vaginal or anal penetration; and other forms of inappropriate touching or exhibitionism for sexual gratification of a child.

2. Sexual Exploitation – the use of a child for prostitution, pornography, or other sexually exploitative activities. In Rhode Island, children under age fourteen are protected under child molestation statutes.
3. Third Degree Sexual Assault – vaginal or anal penetration of a person over the age of fourteen and under the age of sixteen by a person who is age eighteen or older.
4. First Degree Sexual Assault – forced or coerced sexual penetration of the vaginal, anus or mouth.
5. Second Degree Sexual Assault – forced or coerced sexual contact with a person’s genital area, inner thighs, buttocks or breasts.
6. Sexual Coercion – the act of persuading or coercing a person specifically a minor into engaging in an unwanted sexual activity. This differs from rape in that the minor is coerced into consent for any number of reasons.
7. Statutory Rape – vaginal or anal penetration of a person of the age of fifteen.
8. Rape – forced sexual intercourse
9. Sexual Assault – sexual crimes not involving penile – vaginal intercourse such as, forced sodomy, oral copulation, and vaginal penetration with objects.

ABORTION PROHIBITION POLICY

Section 1008 of the federal Title X statute, 42 USC 300a-6, states “None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning”. On July 3, 2000, the Federal Register (Volume 65 Number 128) issued a summary of the regulatory requirements and interpretations that relate to Section 1008. All Title X agencies are required to adhere to these requirements and interpretations. The summary is reproduced as follows:

1. General Principles: Section 1008 prohibits Title X Programs from engaging in activities which promote or encourage abortion as a method of family planning. However, Section 1008 does not prohibit the funding under Title X of activities which have only a possibility of encouraging or promoting abortion; rather, a more direct nexus is required. The general test is whether the immediate effect of the activity in question is to promote or encourage the use of abortion as a method of family planning. If the immediate effect of the activity in question is essentially neutral, then it is not prohibited by the statute. Thus, a Title X Project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating for an abortion within Title X Program activities, or failing to preserve sufficient separation between Title X Program activities and abortion-related activities.

2. Abortion Counseling and Referral: Under 42 CFR 59.5 (a) (5), a Title X Project must not provide abortion as a method of family planning. However, a project must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- (A) Prenatal care and delivery;
- (B) Infant care, foster care, or adoption;
- (C) Pregnancy termination.

If requested to provide such information and counseling, the project must provide neutral, factual information and non-directive counseling on each of the options, and referral on request, except with respect to any option(s) about which the pregnant woman indicates that she does not wish to receive such information and counseling.

However, there are limitations on what abortion counseling is permissible under the statute. A Title X Project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortions, although the project may provide patients with complete, factual information about all medical options and the accompanying risks and benefits. While a Title X Project may provide a referral for an abortion, which may include providing the patient with the name, address, telephone

number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient. Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition or the condition of the fetus (such as the woman's life would be in danger), such a referral by a Title X Project is not prohibited by Section 1008 and is required by 42 CFR 59.5 (b) (1). The limitations on referrals do not apply in cases in which a referral is made for medical indications.

3. **Advocacy Activities:** A Title X Project may not promote or encourage the use of Abortion as a method of family planning through advocacy activities such as providing speakers to debate in opposition to anti-abortion speakers, bringing legal action to liberalize statutes relating to abortion, or producing and/or showing films that encourage or promote a favorable attitude toward abortion as a method of family planning. Films that present only neutral, factual information about abortion are permissible. A Title X Project may be a dues paying participant in a national abortion advocacy organization, so long as there are other legitimate program-related reasons for the affiliation (such as access to certain information or data useful to the Title X Project. A Title X Project may also discuss abortion as an available alternative when a family planning method fails in a discussion of relative risks of various methods of contraception.

4. **Separation:** Non-Title X abortion activities must be separate and distinct from Title X project activities. Where an agency conducts abortion activities that are not part of the Title X Project and would not be permissible if they were, the agency must ensure that the Title X supported project is separate and distinguishable from those other activities. What must be looked at is whether the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program is to make it difficult or impossible to separate the eligible and non-eligible items of cost.

The Title X Project is the set of activities the agency agreed to perform in the relevant grant documents as a condition of receiving Title X funds. A grant applicant may include both project and non-project activities in its grant application, and, so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, no problem is created. Separation of Title X from abortion activities does not require separate agencies or even a separate health care facility, but separate bookkeeping entries alone will not satisfy the spirit of the law. Mere technical allocation of funds, attributing federal dollars to non-abortion activities, is not a legally supportable avoidance of Section 1008.

Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non Title X abortion-related activities: (A) a common waiting room is permissible, as long as the costs are properly pro-rated, (B) common staff is permissible, as long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely

separate from the Title X Project; (C) a hospital offering abortions for family planning purposes and also housing a Title X Project is permissible, as long as the abortion activities are sufficiently separate from the Title X Project; and (D) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Whether a violation of Section 1008 has occurred is determined by whether the prohibited activity is part of the funded project, not by whether it has been paid for by federal or non-federal funds. An agency may demonstrate that prohibited abortion-related activities are not part of the Title X Project by various means, including counseling and services protocols, intake and referral procedures, material review procedures, and other administrative procedures.

HUMAN SUBJECT CLEARANCE (RESEARCH)

Agencies considering clinical or sociological research using Title X clients as subjects must adhere to the legal requirements governing human subject research at 45 CFR Part 46, as applicable. A copy of these regulations can be obtained from the web site, www.access.gpo.gov/nara/cfr/waisidx_00/45cfr46_00.html. Agencies must advise HEALTH, Title X Family Planning Program in writing, who then will advise the Regional Office in writing of research projects involving Title X clients or resources in any segment of the project.

EDUCATION/COUNSELING

Standard: To assure that all clients receive quality education and counseling in accordance with federal Title X requirements.

The federal Title X Guidelines require the following:

I. Client Education

Title X agencies must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. Client education must be documented in the client record. The education provided should be appropriate to the client's age, level of knowledge, language, and socio-cultural background and is presented in an unbiased manner. A mechanism to determine that the information provided has been understood should be established.

Education services must provide clients with the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;
- Perform breast/testicular self examination;
- Reduce risk of transmission of sexually transmitted diseases and Human Immunodeficiency Virus (HIV);
- Understand the range of available services and the purpose and sequence of clinic procedures; and
- Understand the importance of recommended screening tests and other procedures involved in the family planning visit.

Clients should be offered information about basic female and male reproductive anatomy and physiology, and the value of fertility regulation in maintaining individual and family health. Additional education should include information on reproductive health and health promotion/disease prevention, including nutrition, exercise, smoking cessation, alcohol and drug abuse, domestic violence and sexual abuse.

A. Method-Specific Informed Consent

Written informed consent, specific to the contraceptive method, must be signed before a prescription contraception method is provided. Consent forms for prescriptive methods of birth control are available through the Family Planning Program at no cost. Prior to implementation, the service site Medical Director should approve informed consent forms.

The consent forms must be written in a language understood by the client or translated and witnessed by an interpreter. To provide informed consent for contraception, the client must receive information on the benefits and risks, effectiveness, potential side

effects, complications, discontinuation issues and danger signs of the contraceptive method chosen. Specific education and consent forms for the contraceptive method provided must be part of the agency service plan.

The signed informed consent form must be a part of the client's record. All consent forms should contain a statement that the client has been counseled, provided with the appropriate informational material, and understands the content of both. The method-specific consent form should be renewed and updated when there is a major change in the client's health status or a change to a different prescriptive contraceptive method.

Federal sterilization regulation (42 CFR part 50, Subpart B), which address informed consent requirements, must be complied with when a sterilization procedure is performed or arranged for by the project.

II. Counseling

The primary purpose of counseling in the family planning setting is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive issues and to enhance their capacity to arrive at a decision that reflects their considered self-interest.

The counseling process involves mutual sharing of information. Persons who provide counseling should be knowledgeable, objective, nonjudgmental, sensitive to the rights and differences of clients as individuals, culturally aware and able to create an environment in which the client feels comfortable discussing personal information. The counselor must be sufficiently knowledgeable to provide accurate information regarding the benefits and risk, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Additionally, the counselor should be knowledgeable about the other services offered by the agency. **Documentation of counseling must be included in the client's record.**

A. Method Counseling

Method counseling refers to an individual dialogue with a client that covers the following:

- Results of physical exam and lab studies (if indicated);
- Effective use of contraceptive methods, including natural family planning (NFP), and the benefit and efficacy of the methods;
- Possible side effects/complications;
- How to discontinue the method selected and information regarding back-up method use, including the use of postcoital emergency contraception;
- Planned return schedule;
- Emergency 24-hour telephone number;
- Location where emergency services can be obtained; and

- Appropriate referral for additional services as needed.

B. Sexually Transmitted Disease (STD) and HIV Counseling

All clients must receive thorough and accurate counseling on STDs and HIV.

STD/HIV counseling refers to an individualized dialogue with a client in which there is discussion of personal risks for STDs/HIV, and the steps to be taken by the individual to reduce risk, if necessary. Persons found to have behaviors which currently put them at risk for STD/HIV must be given advise regarding risk reduction and must be advised whether clinical evaluation is indicated. **All agencies must offer, at a minimum, education about HIV infection and AIDS, information on risks and infection prevention, and referral services.** On an optional basis, clinics may also provide HIV risk assessment, counseling and testing by specially trained staff. When the agency does not offer these optional services, the agency must provide the client with a list of health care providers who can provide these services.

III. Additional Information

In 2002, the California Family Health Council, Inc. developed a set of guidelines to help Title X agencies and client educators meet Title X requirements in the areas of informed consent, education, and counseling. Some of the major highlights of these guidelines have been included here as follows.

A. About Client Education and Counseling

When you provide quality education and counseling, you offer information in a way that helps your clients make well-informed decisions and choices. You can do this in two ways. You can teach basic information about reproductive health care issues in a group setting or one on one. A community health worker or medical assistant could conduct the education and counseling sessions. A clinician can discuss complex medical information and issues.

You can also offer your client information through video or audiotapes. For sight-impaired clients, you may use cassette tapes and materials written in large print and Braille. For hearing impaired clients, appropriate reading materials are used. It is also important to have someone available who can provide information in sign language.

No matter how your agency provides this education, a staff person will also meet with the client one on one so that he/she has an opportunity to ask questions and discuss personal issues. Counseling is then offered as needed. There is a major difference between education and counseling, even though they are often offered together. When you provide education, you are teaching clients specific information. You are giving facts. When you are counseling, you are discussing the client's feelings, concerns, and issues. Counseling offers a client a chance to talk about personal issues when it comes to his/her reproductive health, sexuality, and relationships.

One of the major purposes of client education and counseling is to help clients make informed decisions about their own reproductive health care. This means that clients must be given the quality of information and support they need to be able to freely choose the method of family planning they want to use.

Good education and counseling is a two-way process. When you ask questions and pay attention to the way clients communicate even when they are not speaking, you can better involve clients in the learning process. The more involved clients are, the more they learn and explore their feelings. This makes the education and counseling experience more meaningful to the clients.

Client education and counseling means more than giving fact through pamphlets or presentations. It means the sharing of information and experiences to help people discover and use new knowledge and skills in their lives. Personal contact, trust, and communication between the client educator and the client are important. The way that you provide client education and counseling is just as important as what you say. A warm welcome and a sincere smile always helps to create a special environment for a client education and counseling session. This is an environment where clients feel most able to question and learn new things. When clients feel you respect them and you care, a sense of trust can develop between you and the client.

B. Principles of Family Planning and Informed Consent

Family planning helps individuals freely choose the number of children they want. It also enables them to choose when they would like to have their children. The basis principles of family planning include the following:

1. The right to plan families: People should be able to choose how many children they want to have, and when to have them. People have the right to choose whether and when they want to have children. Family planning should be available to everyone, regardless of age, gender, race, ethnicity, sexual orientation, disability, religious belief, income, or marital status. All people should be allowed to decide whether to try to become pregnant or to prevent pregnancy.

A key part of this principle is that family planning decisions must be voluntary. People need to be able to make choices about childbearing freely, without pressure from friends, family members, client educators, or clinicians. All people have the right to make these choices for themselves. Occasionally, a court of law will make decisions. This only happens when people are legally unable to make decisions for themselves.

2. The right to informed consent: People should be able to get information and give informed consent. Family planning decisions can only be voluntary if people freely consent to receive these services. This is true for all medical services. Our legal system requires that client educators obtain informed consent from clients for a service or treatment before it is given. Clients also have the right to withhold their consent. They

can also change their minds at any time, without affecting the health care services that they receive.

Client education helps people give informed consent because they learn all about their options and the major risks and benefits of each choice. For family planning, this means a person must know about all of the birth control methods before choosing which one to choose. Client educators should also be careful to give correct information in an unbiased way. This means that the information is based on the facts, not on a client educator's personal opinion. Unbiased information helps clients better understand their options and choices. Clients can then make their own decisions about reproductive issues without pressure from others. If a client does not receive correct information, they can not freely make family planning decisions.

3. The right to confidentiality: People should receive services which are confidential. Family planning services should be provided in a way that respects the privacy and the dignity of each client. This means that discussions with clients and written records about the client are confidential (things that educators are required to report by law should be explained to the client before the educator begins taking a history). With the exception of information that is legally reportable, information can not be given to others without the client's consent. Client educators should talk with clients about their health care in a private setting. For this reason, hallways and waiting rooms are not acceptable places to talk with clients about family planning or anything personal.

4. The right to quality services. People should receive quality health care. Basic standards of quality should be met by all family planning programs which comply with Title X requirements. In order to do this; program staff should have proper training and skill. The program should also be accessible to clients and make it easy for them to receive services. Also, services should be provided in a language the client understands.

For some individuals, the only time they receive routine health services is when they go to a family planning clinic. Therefore, family planning services become the main source of health care for these individuals. The regular health screening they get at a family planning clinic can help identify many health problems. If health problems are identified early enough, they can be treated before they become serious. For health problems that can not be treated at the family planning clinic, clients should be referred to other medical programs and specialists.

C. How to Create A Special Environment for Learning

1. Introduce yourself and greet the client. Here are some steps to follow when you introduce yourself.

***Greet each client warmly and politely.** Ask the client what he/she prefers to be called. If you don't know how to say the client's name, ask him/her.

***Introduce yourself and offer the client a seat.** Your sessions should take place where other people can't hear the conversation. All clients should have a private place to talk with you.

***Tell clients what they share with you will be kept confidential.** Explain that you will not tell anyone, including his or her parents, partner, or friends. If there are any things that you are required to report (like sexual abuse of a minor) explain this to the client before you begin taking a history. Respond to any concerns they may have about privacy.

***Encourage clients to ask questions.** Give clients a chance to ask questions often. Invite them to ask their questions throughout the session. You can do this by asking, "What questions do you have?"

2. Pay attention to non-verbal messages. Here are some ways to pay attention to non verbal messages.

***Listen with more than your ears.** Watch the client's facial expressions and body language. For example, if a client looks anxious, do not assume she feels anxious. Instead, ask her how she is feeling. Remember that body language varies among people from culture to culture.

***Watch your own non-verbal messages.** Clients will have their own feelings about your body language and your facial expressions. You can often show warmth and caring by smiling and leaning slightly forward toward your clients as they talk.

3. Assessing the Client's Educational Needs

Assessing the client's educational needs means finding out what they need and want to know. This helps educators to be most effective with teaching and enables them to meet the client's needs. If it is not done, the educator will not know what the client wants and needs to learn. It also helps the educator use his/her time most effectively and efficiently.

At the beginning of a client education session, the educator should assess the reason for the client's visit and his/her knowledge about specific topics, such as contraception. The best way to do this is to ask questions.

Example:

Marisa is a new client at the clinic. After introducing yourself, you ask, "What brings you to the clinic today?" She says, "I don't want to get pregnant, and would like to get the shot." Her answer gives the reason for her visit and the method she wants. But before you start talking about Depo-Provera or Lunelle, you'll need to find out more information. You could ask Marisa these questions.

*What have you heard about the shot?

*Do you have any concerns about this method?

*Do you know anyone who has used the shot? What did they tell you about it?

*What are some of the reasons why you think it is the right method for you?

Based on Marisa's answers to your assessment questions, you will know what information you must teach her.

4. Set Clear Educational Objectives

Objectives are statements about what the client will be able to say or do by the end of the session. They describe the most important points the client will learn. Educational objectives focus on what the client will be able to do, not what the client educator says. Here are some sample objectives for an educational session about the male condom. Each objective describes something the client will be able to say or do.

Sample Objectives:

By the end of the educational session, the client will be able to:

- *Explain how the male condom works to prevent pregnancy, HIV, and STDs.
- *List the proper steps for using the condom.
- *Show how to correctly put on a condom and remove it using a penis model.
- *Describe the advantages and disadvantages to using the condom.
- *List any possible side effects of the condom.

5. Keep on Assessing

Ask what a client knows. Help him/her learn the appropriate information. By doing this, you may need to change some of the objectives you had originally planned to discuss. This is because some people already know much of the information. Therefore, there is no need to spend time discussing it. Others need to learn more about the topic. When you change your objectives to meet the specific needs of each client, you can teach them more effectively.

For example, you ask a client if he knows how to use the condom and he says, "Yes." You then ask him to explain how to use it. If the client is able to tell you exactly how the condom works, you do not need to teach the instructions because that objective has already been met. Instead, you can go on to the next objective. On the other hand, if the client's instructions are incorrect, you will need to take the time to correct the misinformation.

Sometimes, you need to add an objective and discuss information you had not originally planned. For example, let's say that a teenage client tells you she wants to talk with her mother about using the pill but doesn't know how to approach her. Hearing this, you can add an objective to address this specific need.

Example:

The client educator says,

"Let's practice how you might talk with your mother about using the pill. I'll pretend to be your mother and you can practice what you would say to her with me."

C. How to Share Information

Once you have created an environment for learning, you can begin to share information with the client about birth control and other topics.

1. **Share information about birth control methods.** Clients interested in family planning need to know basic information about all methods of birth control. They are then able to compare them and decide which method they would like to use. You can give this basic information about methods in writing or verbally.

However, as you educate clients about their chosen method of birth control, there are certain topics you must discuss. These topics are needed for informed consent. They include:

- *What it is
- *How it works
- *How effective it is
- *How to use it

In addition, you must inform clients about the method's advantages and disadvantages, side effects, complications as well as any warning signs, associated with the use of the method.

When you educate clients, you may wish to present these main points in a different order, depending upon the client's individual needs. Here are some examples of what you might say when talking to clients about their chosen method of birth control.

Example 1: Discuss the objectives.

For the female condom, you might begin by discussing the objective of the education and counseling session.

"Hello, my name is Eva. I'm a client educator at the clinic. Since you have chosen the female condom, let's talk about the method. It is important that by the time we have finished, you will know:

- *How the female condom works to prevent pregnancy, HIV, and STDs and how well it works.
- *How to use the female condom by using this pelvic model.
- *We'll also talk about the things you like about the female condom and anything you don't like about it.
- *Side effects you might have from using the female condom."

Example 2: Describe the method.

For the male condom, you might begin by describing what the method looks like and what it is made of. You should also show clients an actual sample of the method if possible.

"There are several types of condoms, as you can see here. They are all made of latex. I'll take this condom out of its package so you can see and touch it. Notice the expiration date on the package. It tells you when its too old to use anymore."

Example 3: Teach how the method works.

When explaining how the diaphragm keeps a woman from getting pregnant you might say:

"The diaphragm covers the cervix*. It is used with a spermicide*, which kills sperm. These two things prevent the sperm from meeting with an egg. If the egg and the sperm don't meet, you won't get pregnant."

*Find out if the client knows what a cervix is, where is located, and if she knows about spermicides.

Example 4: Explain how the method works.

When talking with clients about pregnancy rates for typical users and perfect users, explain what these rates mean for them. For example, for Depo-Provera, you might say:

"Depo-Provera is a very effective method. Let's say 100 women use this method for one year. 99 will not become pregnant and perhaps one will, even when the shots are taken as directed. This means it is 99% effective in preventing pregnancy."

Example 5: Teach how to use the method.

When teaching clients how to use a method, teach all of the steps clearly. Show them and tell them how to use a method. Then, have them show and tell you. For example, for contraceptive foam you might say:

"Let me show you how to use contraceptive foam. First, shake the foam can about 20 times. Then, press this applicator on top of the can and press down. You can watch the applicator fill up with foam. When it is filled completely with foam, lift the applicator away."

"Now, I'll use this plastic model of a woman's reproductive organs to show you how you will put the foam into your vagina."

Example 6: Discuss the advantages and disadvantages of the method.

Please remember, that what one person feels is an advantage may be a disadvantage to the next person. Ask clients what they like and don't like about the method they've chosen. Always ask clients if they have any concerns about the method. This can help determine if there are any disadvantages for the client. For example, for the pill you might ask:

"Do you see any advantages to taking the pill? How would you describe these advantages for you?"

"In your view, are there any disadvantages to taking the pill? Do you have any concerns about taking the pill?"

Example 7: Discuss possible side effects of the method.

Ask clients if they have heard of any side effects about the method. Correct any misinformation and discuss possible side effects. Tell clients whether the side effects are common or unusual. Determine how the client feels about the side effects. Explain what the client should or can do if a side effect is experienced. For Norplant you might say:

"A very common side effect of Norplant is changes in menstrual bleeding. Some women have no bleeding and others have irregular spotting. A few women bleed for many days or have heavy bleeding. How would you feel if you noticed changes in your menstrual bleeding after getting Norplant?"

For a spermicidal cream or jelly, you might say:

"an uncommon side effect is an allergic reaction. If this happens to you, you can try another spermicide. Sometimes by changing brands you can find one that doesn't give you an allergy."

Example 8: Discuss possible complications and warning signs.

Discuss possible complications and warning signs of complications. In addition, explain what should be done if the client experiences any warning signs. For the IUD you might say:

"Here is a list of the warning signs for the IUD. One way to think of these warning signs is to think of the word P-A-I-N-S. The P stands for "period late, abnormal spotting, or bleeding". The A stands for "abdominal pain or pain with intercourse." The I is for "infection." The N is for "not feeling well, fever, or chills." And the S stands for "string missing, shorter, or longer."

"What will you do if you experience one or more of these warning signs?"

2. Share content information on other topics.

All of the examples in this section describe topics that you should cover when you educate clients about methods of family planning. You will also provide information on a variety of other reproductive health and sexual issues. These may include breast and testicular self-examination, human sexuality, HIV and STDs, clinic procedures, and other topics. Regardless of the information you share, the process is much the same.

D. How to Help Clients Learn

Clients learn in many different ways. They have different learning styles and abilities.

1. Ask questions.

There are two main types of questions that you can use. These are open-ended questions and closed questions.

Open-ended questions

These kinds of questions encourage clients to give as much information as they would like. They are an excellent way to help you assess a client's needs.

Examples of open-ended questions are:

*"What brings you to the clinic?"

*"How do you feel about being examined today?"

*"What are some ways you can protect yourself from getting HIV/STDs?"

When clients answer open-ended questions, they can discuss whatever they think about the question. These types of questions encourage communication.

Closed questions

These questions can be answered with one or only a few words. They are often used in order to clarify information or get specific answers. The answers to these types of questions are often "Yes", "No", or "I don't know."

Examples of closed questions are:

*"Is this the first time you've had a pelvic exam?"

*"Are you using a method of family planning?"

*"When did you start your last menstrual period?"

If you need a fact from a client, such as the date of her last menstrual period, a closed question works well. But when you want clients to describe their thoughts, feelings, or what has happened to them, it is best to use open-ended questions.

Tips for asking questions.

Ask only one question at a time.

If you ask more than one question at the same time, the client won't know which one to answer. You also won't know which one was answered. For example, if you ask, "Have you decided to use the diaphragm? Do you know anything about it?" the client could answer "Yes" or "No". The answer does not tell you which question the client is answering,

Don't ask questions in a way that makes the client "think" you want a particular answer.

Sometimes client educators phrase questions in such a way that clients answer based on what they "think" the client educator wants to hear, instead of the truth. For example, if

you ask "you only have sex with your husband, don't you?" the client will probably answer, "Yes", even if she is also having sex with someone else. If you change your question to "how many partners have you had sex with in the last month?", you will be more likely to get a truthful response.

2. Use a variety of teaching methods.

In addition to asking questions and listening to answers, there are other teaching methods that you can use. These methods include demonstration, role-play, and short lecture. It is usually best to use a variety of teaching methods when educating clients.

Demonstration.

You show a client how to do something. For example, you fill an applicator with spermicidal foam while the client watches.

Question and Answer

You ask questions of the client, and the client asks questions which are answered by you. This is an excellent way to find out what a client knows about a certain topic.

Role Play

You give clients the chance to practice what they might say or do in a given situation. For example, you ask the client to practice what she would like to say to her boyfriend about condom use. You then play the role of her boyfriend.

Short Lecture.

You give information for a short period of time. If the lecture gets too long, clients can lose interest.

3. Encourage clients to learn new skills.

Each teaching method needs to be used correctly and in the right situation. It is important to actively involve clients in the learning process. Clients need more than just new information to use their birth control method well. They also need to learn new skills (i.e. how to use the method).

It's not always easy to learn new skills. Your clients need a chance to practice them. You can help clients practice skills by showing or demonstrating the skill to them first. Many of the ways to do this have already been described. After you have shown a new skill to a client, give the person a chance to try it. Allow the client to practice more than once. As he/she practices, give feedback and support.

4. Use different teaching materials.

Another way to involve clients is to use different teaching materials. Here are some of the most common teaching materials and ways to use them in family planning clinics.

Print materials

Print materials include brochures, pamphlets, information sheets, and wallet cards. Use print materials to:

- *Show clients the most important information you want them to know.
- *Draw circles around specific information to emphasize its importance.
- *Give to the client to take home.

Visual Aids

These include flip charts, posters, and diagrams of the human body and drawings. Use visual aids to:

- *Reinforce the most important information.
- *Help clients understand and learn.

Samples and models

Samples are actual objects that clients can see and touch. Models are copies of objects that clients can see and use to practice skills. Use samples and models to:

- *Help clients develop skills.
- *Help clients feel comfortable by allowing them to touch and hold the object.
- *Show clients how to do something.
- *Give them a chance to practice, with your support.

Other audiovisuals

These include videos, films, and slide shows. When using audiovisuals:

- *Always preview the audiovisual.
- *Introduce the audiovisual to the client and explain the reason for having him/her watch it.
- *Discuss the audiovisual with the client after it is shown.

5. Speak in ways that clients understand.

The words you choose and the ways you talk to clients is very important. To communicate effectively, it is important to speak in ways that clients understand. One way to do this is to listen to the words that your client uses and then use those words if you can. Another way is to use examples your client can relate to. Examples help connect new ideas with words and concepts the client already knows.

Use common language the client knows.

In order to learn, clients must need to be able to understand what you are saying. At the most basic level, client educators need to speak in the language used by the client. For example, if clients speak Chinese they need to talk with a client educator (or at least a trained interpreter) who speaks Chinese. When educating clients, minimize the use of technical medical terms. When you need to use unfamiliar terms, explain their meaning clearly. Never assume a client knows the term, even if it is one you would expect her to know, such as menstrual cycle and ovulation.

Relate new information to what the client already knows.

A good way to do this is to present information in a way that is based on what the client has just learned. For example, you should talk about the reproductive organs and what they do before you explain the menstrual cycle.

Demonstrate

Showing the client what you mean can clarify things. Remember that the way you educate clients is just as important as the content you teach. There are many effective teaching techniques, including the ones described in this section. When you use these techniques, clients actively participate in the learning process. This helps them remember and use information correctly.

E. How to Give Informed Consent

Informed consent is when a client freely chooses to use a birth control method or go through a medical procedure, knowing all the important facts. Informed consent is a very important part of family planning services. Clients must give their informed consent before they can obtain a prescriptive method of birth control.

Decisions people make about their own health care often depends upon their cultural values. Some clients may wish to consult a family member before they give their consent. Others look to the client educator; expecting him/her to make the decision for them. In this situation, client educators should explain their role at the clinic and why it is important for clients to make their own decision.

1. Importance of informed consent.

A client's informed consent to use a birth control method is important for many reasons. There are legal, ethical, and practical reasons.

Legal reasons.

In the United States, laws protect a person's right to make an informed choice about medical care. The laws state that health care providers must make sure that each client reaches an informed decision about their own health care. If a person is harmed by a service and was not fully informed of the risks, the provider might be held responsible. This kind of lawsuit can be very costly to a health care provider.

Ethical reasons.

Ethical reasons come from the moral standards of our society. This means that informed consent is a fair and just process which supports a person's basic rights. Family planning services are based on a person's right to freely choose whether and when to have children. People should always be able to make their own family planning choices. They also have a right to know all the facts that can help them make these choices.

Practical reasons

There are many practical reasons to make sure that clients make informed choices. First of all, people who freely choose a birth control method from many options and

understand how to use it are more likely to use their method well. If their chosen method does not work out, they are more likely to return to the clinic for a different method. Also, the informed consent process can help client feel that their views and values are respected. This can make people feel more satisfied with the clinic. When they are more satisfied, they are more likely to return for follow-up care as well as refer other clients.

2. Guidelines for informed consent

There are six basis guidelines that must be followed for clients to give their informed consent for a birth control method.

Clients must know about all birth control methods.

Before clients can make an informed choice to use a specific birth control method, they need to understand all of their options. Client educators must make sure that each client knows basis information about all of the birth control methods in order to compare them. This information can be provided verbally, or in writing. For example, clients may receive educational materials about the methods. To compare the methods, clients need to understand the following basis facts about each available method.

- *What they are and how they will work
- *How well they work and how long they last
- *advantages and disadvantages

Clients must fully understand their chosen method.

Each client must understand exactly how to use his or her chosen method. They need to know about any possible side effects or complications that could result from using it. They also need to know the benefits the method can provide as well as any risks involved in using it.

For certain methods, clients must know about fitting or insertion procedures that they need before they receive the method. For example, the diaphragm and the cervical cap are methods that need to be fitted by a clinician so the client gets the correct size. Other methods, like the IUD and Norplant, need to be inserted.

If a client gets a method like one of these, she needs to know if there are any health risks involved in the fitting or insertion procedure. She also needs to know if she might feel any discomfort when she gets her method.

Some methods have warning signs that are explained to the client. Warning signs are physical changes in the body which could mean the person is developing a serious health problems, or complication, as a result of using the method. Clients need to know what to do if they experience any of the warning signs.

The main points to include when helping clients fully understand their chosen method are:

- *What it is

- *How it works
- *How to use it
- *Possible side effects
- *Possible complications and warning signs
- *Precautions (If any)
- *Effectiveness
- *Advantages and disadvantages

Clients must receive information verbally and in writing.

Client educators need to talk with clients about the details of their chosen method and also give the information to them in writing. Clients need to receive written information about any warning signs of their chosen method. They need to know when, where, and how to get emergency care, if they need it. Clients should receive written materials in a language they understand. For clients who can not read well, you can read the printed information for them.

If a client is deaf or hard of hearing, you can use pictures and print information to share ideas. Also, you should use a sign language interpreter to translate the session. When a client is blind or can not see well, brochures or pictures may not be useful. You client may be able to use a magnifying glass or materials with large print. You can use audiotapes, read the information, or use models that can be touched. For clients who read Braille, use Braille materials. Talk to the client and find other ways to communicate.

Clients must be able to ask questions and receive answers about any of the methods or procedures.

Client educators should encourage clients to ask questions. All of the client's questions need to be answered correctly or referred to someone who knows the answer. A client educator can also research the answer and tell the client later.

Sometimes, new information about the benefits or risk of a method is discovered after a client is already using the method. If this happens, clients need to learn about it when they return to the clinic for their next visit. Client educators should keep themselves updated on any changes in information about birth control methods so that they can keep clients well informed.

Clients must know that they have the right to stop using a method at any time.

- *Clients have a right to withdraw their consent at any time
- *Clients may change their methods while learning how to use a chosen method.
- *They may sign a consent form for a method and then decide not to use it. Sometimes, a clinician may find medical reasons why a client should not use the chosen method.
- *Clients may use a method for a while and decide it isn't right for them. It is important for client educators to tell clients that they can change their minds about a method at any time. If a client changes her or his mind, the client should always get the same quality of health care as they did before.

When client educators provide good education about all birth control methods, clients are more likely to choose a method they will want to continue using for a while.

F. How to evaluate what clients have learned.

1. How to evaluate the session.

When you evaluate, you find out if clients have successfully accomplished the objectives. In order to evaluate the session, you need to observe clients as they describe and/or demonstrate the main points. If clients can tell you or show you they have learned them, you know the objectives of the session have been achieved. There are different ways to find out what clients are learning. You can:

- *Ask questions
- *Have the client show what they have learned
- *Give a written test.

Evaluation questions

When you ask questions and listen to a client's answers, you will know what they have learned from the session. When you ask evaluation questions, it is usually best to ask open-ended questions. Clients may then explain the answers in their own words.

Here are some questions you can use to evaluate what a client has learned about birth control pills.

- *What is one of the ways the pill works to keep you from getting pregnant?
- *What would you do if you forgot to take a pill?
- *What are the five warning signs of a serious side effect of the pill?
- *If you have any of these warning signs, what should you do?

Return demonstration

After you show a client how to do something, you can ask him/her to demonstrate it for you. This is called a return demonstration. For example, after you show a male client how to put a condom on a penis model, you can give the model and the condom to the client. Then, ask him to describe and show you all the steps for putting on the condom. For methods that need to be inserted into and removed from the vagina, have the client show you by using a model of the female reproductive system.

Written tests

For clients who read well, written tests can be used to evaluate an increase in their knowledge. Written tests are sometimes given to a group of clients. A pre-test and a post-test can be used.

2. When to evaluate the session

It is important to evaluate the client learning at various times throughout the education session. This means evaluating at the beginning, during, and at the end of the session. By evaluating often, you can find out if the client understands you and if a client needs extra help to learn the main points.

If a client does need extra help, review the point that is unclear before you go on to give new information. What you have just talked about, but in a different way. For example, use examples, or change your demonstration.

When you know the client understands the information well, go on to the next point. As you can see, by evaluating what clients have learned throughout the session, you may better address their learning needs. Some clients learn very quickly. They may already know some of the information or they may grasp new ideas easily. For these clients, you may need to change the education and counseling session. Instead of teaching a lot of information, you can ask the clients to provide you with much of the information through questioning and discussion. Correct any misinformation.

At the end of the education and counseling session, you may also ask for feedback from the clients. For example, you might ask, "How could this session have been better for you?" If you welcome and encourage feedback, you can learn new ways to improve your educational sessions directly from the people you are teaching.

Evaluate the session:

- *At the beginning
- *During
- *At the end

REFERENCE

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