

**FISCAL YEAR 2017**

**POLICY  
and  
PROCEDURE  
MANUAL**

**For**

**Healthy Texas Women (HTW)**

**2017**



Health and Human Services Commission  
Women's Health Services Division

## Table of Contents

### Introduction

Program Background .....	i
Purpose of the Manual .....	ii
Definitions .....	ii
Acronyms .....	vii

### Section I - Administrative Policies

Chapter 1- Client Access.....	I-1
Chapter 2- Abuse & Neglect Reporting .....	I-2
Human Trafficking .....	I-3
Intimate Partner Violence .....	I-3
Chapter 3- Client Rights .....	I-4
Confidentiality.....	I-4
Non-Discrimination .....	I-4
Termination of Services.....	I-6
Resolution of Complaints .....	I-6
Research (Human Subject Clearance).....	I-7
Chapter 4- Client Records Management.....	I-8
Chapter 5- Personnel .....	I-9
Chapter 6- Facilities and Equipment .....	I-10
Chapter 7- Quality Management .....	I-12
Chapter 8- Pharmacy .....	I-14

### Section II - Client Services and Community Activities

Chapter 1- Client Eligibility and Application Process.....	II-15
Eligibility Guidelines .....	II-15
Other Benefits .....	II-15
Presumptive Eligibility.....	II-17
Adjunctive Eligibility .....	II-18
Chapter 2- Consent.....	II-21
Procedure-Specific Informed Consents.....	II-21

## Table of Contents

Consent for HIV Test.....	II-24
Chapter 3- Clinical Policy .....	II-25
Client Health Record (Medical Record).....	II-27
Family Planning and Contraceptive Services .....	II-35
Preconception Services.....	II-42
Infertility Services .....	II-44
Cervical Cancer Screening.....	II-45
Breast Cancer Screening .....	II-47
STD/STI Screening and Treatment.....	II-50
Healthy Lifestyle Intervention .....	II-53
Diabetes Mellitus Screening, Prevention, and Treatment.....	II-56
Hypertension Screening and Treatment.....	II-66
High Cholesterol Screening and Treatment .....	II-69
Postpartum Depression Screening, and Treatment.....	II-72
Chapter 4- Program Promotion and Outreach.....	II-76
<b>Section III Reimbursement, Data Collection and Reporting</b>	
Chapter 1- Reimbursement.....	III-77
Medicaid Provider Enrollment.....	III-77
IUD and Contraceptive Implant Complications .....	III-80
Chapter 2- Data Collection & Reporting .....	III-82
<b>Section IV Appendices</b>	
Appendix A - HTW Income Worksheet	
Appendix B - HTW Screening Tool	
Appendix C - Promotion/Outreach Annual Report	
Appendix D - B-13H	

# **Introduction**

## General Information

## PROGRAM AUTHORIZATION AND SERVICES

### Program Background

In December 2014, the Sunset Commission issued the recommendation that the Texas Health and Human Services agencies consolidate the women's health care programs in order to improve service and efficiency for clients and providers. As a result, a transition plan was developed by the Health and Human Services Commission (HHSC) pursuant to Texas Government Code §531.0204 consolidating the HHSC Texas Women's Health Program and the Department of State Health Services' Expanded Primary Health Care Program. On July 1, 2016, a new and consolidated program launched as Healthy Texas Women under the direction of HHSC. The new HTW program is technically a successor to TWHP which was successor to the former Medicaid Women's Health Program, and is subject to Texas Human Resources Code §32.024(c-1).

### Reimbursement

The new HTW program includes a fee-for-service component as well as a cost reimbursement component. The HTW Fee-For-Service program is patterned after the current Texas Women's Health Program. Clients will be able to apply online or by mailing or faxing a paper copy of their application. Fee-for-service claims will be processed by the Texas Medicaid Healthcare Partnership (TMHP). Client benefits for the new HTW Fee-for-Service program include:

- Pelvic examinations
- Contraceptive services (pregnancy prevention and birth spacing)
- Pregnancy testing and counseling
- Sexually transmitted infection (STI) services
- Breast and cervical cancer screenings and diagnostic services
- Immunizations
- Cervical dysplasia treatment
- Other preventive services

The HTW Cost Reimbursement program provides funds to agencies that support the overall outcomes of clients provided services through the HTW Fee-for-Service program. These funds may be used for support services that enhance HTW Fee-for-Service client service delivery. Activities must include:

- Assisting clients with enrollment into the HTW Fee-for-Service program;
- Client and community based educational activities related to HTW;
- Staff development and training related to HTW service delivery;
- Direct clinical care for clients deemed presumptively eligible for the HTW Fee-for-Service program; or
- Upon approval by HHSC, other activities that will enhance HTW service delivery including the purchase of equipment and supplies to support the project.

## Rules

The state rules for HTW services can be found in the [Texas Administrative Code \(TAC\), Title 1, Part 15, Chapter 382, Subchapter A](#).

## PURPOSE OF THE MANUAL

The *Healthy Texas Women (HTW) Policy Manual* is a guide for contractors who deliver women's health and family planning services in Texas. The policy manual has been structured to provide contractor staff with information needed to comply with program legislation and rules. This policy manual only applies to HTW Cost Reimbursement contractors. Federal and state laws related to reporting abuse, operation of health facilities, professional practice, insurance coverage, and similar topics also impact women's health and family planning services. Contractors are required to be aware of and comply with existing laws.

## DEFINITIONS

The following words and terms, when used in this manual, have the following meanings:

**Applicant** – A female applying to receive services under HTW, including a current client who is applying to renew.

**Barrier to Care** – A factor that hinders a person from receiving health care (i.e., distance, lack of transportation, documentation requirements, co-payment amount, etc.).

**Case Management** – Case management services refer to an individualized approach for each client. Case management is a broad category that fits within the larger field of human services. Generally, case management involves coordination of care, advocacy and discharge planning. Case management aims to assist the individual to navigate social service systems and attain the highest quality of care; however, counseling and therapeutic support may also be offered.

**Class D (Clinic) Pharmacy License** – A pharmacy license issued to a pharmacy to dispense a limited type of drug or devices under a prescription drug order (e.g., XYZ Health Clinic). Information to apply for a Class D Pharmacy License may be found at: [http://www.tsbp.state.tx.us/files\\_pdf/INSTRUCTIONS\\_CLASS\\_D\\_PHY.pdf](http://www.tsbp.state.tx.us/files_pdf/INSTRUCTIONS_CLASS_D_PHY.pdf).

**Client** – A female who receives services through HTW.

**Community Assessment** – Tool used to identify factors that affect the health of a population and to determine the availability of resources within the community to impact these factors.

**Community Health Worker** – A person who, with or without compensation, is a liaison and provides cultural mediation between health care and social services, and the community. A Community Health Worker (CHW) is a trusted member of the community who: has a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community served; assists people with gaining access to needed services; and increases health

knowledge and self-sufficiency through a range of activities such as outreach, client navigation and follow-up to community health education and information, informal counseling, social support, advocacy, and participation in clinical research. A certified CHW is an individual with current certification as a community health worker issued by the Texas Department of State Health Services.

**Contraceptive methods** – A broad range of birth control options, approved by the United States Food and Drug Administration, with the exception of emergency contraception.

**Contractor** – An entity that the Health and Human Services Commission has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually provides the services.

**Co-payment (co-pay)** – Monies collected directly from clients for services.

**Core Tool** – A standardized instrument used to review contractors to ensure compliance with basic requirements for operating a clinic providing health services, as reflected in the DSHS Standards for Public Health Clinic Services.

**Department of State Health Services (DSHS)** – State agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

**Diagnosis** – The recognition of disease status determined by evaluating the history of the client and the disease process, and the signs and symptoms present. (Determining the diagnosis may require microscopic (i.e., culture), chemical (i.e., blood tests), and/or radiological examinations (i.e., x-rays).

**Diagnostic Services** – Activities related to the diagnosis made by a physician, advanced practice nurse or physician assistant, which may also be performed by nurses or other health professionals.

**Diagnostic Studies or Diagnostic Tests** – Tests ordered by the client’s health care practitioner(s) to evaluate an individual’s health status for diagnostic purposes.

**Documented Immigrant** – A non-U.S. citizen with a valid immigration document.

**Elective Abortion**- The intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means to terminate a pregnancy that resulted from an act of rape or incest; in a case in which a female suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the female in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

**Expanded Primary Health Care** – A state-funded health care program that provides primary, preventive and screening services to women, age 18 and older, that are at or below 200 percent of the Federal Poverty Level and are unable to access the same care through other programs. These services are made available at participating clinic sites throughout the state and are intended to increase the number of women receiving primary and preventive care services; increase early detection of breast and cervical cancers; avert unintended Medicaid births; reduce the number of preterm births; and reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes. This program will end on August 31, 2016 and transition to the Health Texas Women program.

**Family Composition/Household** – A person living alone or a group of two or more persons related by birth, marriage (including common law) or adoption, who reside together and who are legally responsible for the support of the other person.

**Family Planning Services** – Educational or comprehensive medical activities that enable individuals to determine freely the number and spacing of their children and to select the means by which this may be achieved.

**Federal Poverty Level (FPL)** – The household income guidelines issued annually and published in the Federal Register by the United States Department of Health and Human Services.

**Fee-for-service** – Payment mechanism for services that are reimbursed on a set rate per unit of service (also known as unit rate).

**Fiscal Year** – State fiscal year, September 1 – August 31.

**Health and Human Services Commission (HHSC)** – State agency with administration and oversight responsibilities for designated Health and Human Services agencies.

**Health Screening** – The provision of tests, (e.g., blood glucose, serum cholesterol, fecal occult blood) as a means of determining the need for intervention and perhaps more comprehensive evaluation.

**Health Service Region (HSR)** – Counties grouped within a specified geographic area throughout the state.

**Healthy Texas Women** – HTW is a state-funded program administered by HHSC to provide uninsured women with women's health and family planning services such as women's health exams, health screenings, and birth control. HTW providers must provide client services on a fee-for-service basis, and may also, but are not required to, contract with HHSC to provide support services that enhance the HTW fee-for-service client delivery on a cost reimbursement basis.

**Healthy Texas Women Cost Reimbursement** – The funding mechanism for qualified agencies that support the overall outcomes of clients provided services through the HTW Fee-for-Service program. These funds may be used for support services that enhance HTW Fee-for-Service client service delivery.

**Healthy Texas Women Fee-for-Service** – Women’s health and family planning client services provided through the Healthy Texas Women program on a fee-for-service basis through the TMHP system.

**HTW Provider** – A health care provider that performs covered services. An HTW provider may be contracted with HHSC to provide additional services.

**Informed Consent** – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options, and the benefits and risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the patient to participate and make sound decisions regarding his or her own medical care.

**Laboratory** – (informally, **lab**) Facility that measures or examines materials derived from the human body for the purpose of providing information on diagnosis, monitoring prevention or treatment of disease.

**Long-acting Reversible Contraceptives (LARC)** – Methods of birth control that provide effective contraception for an extended period without requiring user action. LARC include intrauterine devices (IUDs), and subdermal contraceptive implants.

**Medicaid** – The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32, and subject to Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

**Minor** – In accordance with the Texas Family Code, a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated).

**Nutritional Services** – The provision of services to identify the nutritional status of an individual, and instruction which includes appropriate dietary information based on the client’s needs, i.e. age, sex, health status, culture. Information may be provided on an individual, one-on-one basis, or to a group of individuals.

**Outreach** – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of clients.

**Patient** – An individual who is eligible to receive medical care, treatment, or services. “Client” and “patient” may be used interchangeably in this manual.

**Payor Source** – Programs, benefits, or insurance that pays for the service provided.

**Presumptive Eligibility** – Short-term availability and access to health care services (up to 90 days) when the client screens potentially eligible for services but has not completed the HTW application or the application has not been processed and approved yet by HHSC.

**Preventive Health Care Services** – Medical care that focuses on disease prevention and health maintenance, including early diagnosis of disease, discovery, and identification of people at risk

of development of specific problems, counseling, and other necessary intervention to avert a health problem. Included are screening tests, immunizations, risk assessments, health histories, and baseline physicals for early detection of disease and restoration to a previous state of health, and prevention of further deterioration and/or disability.

**Program Income** – Monies collected directly by the contractor/subcontractor/provider for services provided under the contract award and revenue from HTW Fee-for-Service.

**Readiness** – Respondent has the specified attributes to support a given service, the ability to meet program and contractual requirements, and the capacity to achieve service levels based on awarded funds.

**Referral** – The process of directing or redirecting (as a medical case or a client) to an appropriate specialist or agency for definitive treatment; or direct to a source for help or information.

**Referral Agency** – An agency that will provide a service for the client that the contractor or one of its sub-contractors does not provide.

**Reproductive Life Plan** – A plan that outlines a client’s personal goals regarding whether to have children, the desired number of children, and the optimal timing and spacing of children. Counseling should include the importance of developing a reproductive life plan and information about reproductive health, family planning methods and services, and obtaining preconception health services, as appropriate.

**Resident Alien** – A person who is not a U.S. citizen, and has an immigration document.

**Service** – Any client encounter at a facility that results in the client having a medical or health-related need met.

**Social Services** – The provision of counseling and guidance; assistance to client and family in locating, accessing, and utilizing appropriate community resources.

**Texas Medicaid and Healthcare Partnership (TMHP)** – The Texas Medicaid Claims and Primary Care Case Management (PCCM) administrator. HHSC contracts with TMHP to process claims for providers.

**Texas Resident** – An individual who resides within the geographic boundaries of the state.

**Title XIX Family Planning Program** – Family planning services provided under Title XIX (Medicaid) of the Social Security Act, 42 United States Code §1396 *et seq.*

**Undocumented Alien** – A person who is not a U.S. citizen and has no immigration documentation.

**Unduplicated Client** – Clients are counted only one time during the program’s fiscal year, regardless of the number of visits, encounters, or services they receive (e.g., one client seen four times during the year is counted as one unduplicated client.)

Acronym	Term
ADA	Americans with Disabilities Act
ADA	American Dental Association
AED	Automated External Defibrillator
AMA	American Medical Association
BCCS	Breast and Cervical Cancer Services
CAD	Computer Aided-Detection
CAM	Complementary and Alternative Medications
CAP	Corrective Action Plan
CBE	Clinical Breast Exam
CD	Cervical Dysplasia
CDC	Centers for Disease Control and Prevention
CDSB	Contract Development and Support Branch
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CIHCP	County Indigent Health Care Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedure Terminology
DES	Diethylstilbestrol
DHHS	U.S. Department of Health and Human Services
DSHS	Texas Department of State Health Services
ECC	Endocervical Curettage
EDI	Electronic Data Interchange
EHR	Electronic Health Record
E/M	Evaluation and Management Services
EMR	Electronic Medical Record
EOB	Explanation of Benefit
EPHC	Expanded Primary Health Care
EPT	Expedited Partner Therapy
FDA	Federal Drug Administration
FFS	Fee-for-Service
FP	Family Planning
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHSC	Texas Health and Human Services Commission
HPV	Human Papillomavirus
HSR	Health Service Region
HSV	Herpes simplex virus

HTW	Healthy Texas Women
IRB	Institutional Review Board
IUC	Intrauterine Contraception
IUD	Intrauterine Device
LARC	Long-acting Reversible Contraceptive
LEP	Limited English Proficiency
MBCC	Medicaid for Breast and Cervical Cancer
MCH	Maternal and Child Health Services
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast & Cervical Cancer Early Detection Program
NPI	National Provider Identifier
NPES	National Plan and Provider Numeration System
OTC	Over the Counter
PHC	Primary Health Care
QA	Quality Assurance
QM	Quality Management
RFP	Request for Proposal
RSDI	Retirement Survivors Disability Income
SDO	Standing Delegation Orders
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPI	Texas Provider Identifier
TWHP	Texas Women's Health Program
USPSTF	United States Preventive Services Task Force
WIC	Special Supplemental Nutrition Program for Women, Infants & Children

# Section I

## Administrative Policies

**Purpose:** Section I assists the contractor in conducting administrative activities such as assuring client access to services and managing client records.

**CLIENT ACCESS**

The contractor must ensure that clients are provided services in a timely and non-discriminatory manner. The contractor must:

- have a policy in place that delineates the timely provision of services,
- have policies in place to identify and eliminate possible barriers to client care,
- comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and ensure services are accessible to persons with Limited English Proficiency ([LEP](#)) and speech or sensory impairments,
- have a policy in place that requires qualified staff to assess and prioritize client needs,
- provide referral resources for individuals that cannot be served or cannot receive a specific needed service,
- manage funds to ensure that established clients continue to receive services throughout the budget year,
- continue to provide services to established clients after allocated funds are expended,
- ensure that family planning services are provided to clients in a timely manner, preferably within 30 days of the request for services (clients who request contraception but cannot be immediately provided a clinical appointment must be offered a nonprescription method), appointments for minors age 15 through 17 should be seen as soon as possible - with every effort made to provide an appointment within two weeks of the request.
- ensure clinic/reception room wait times are reasonable so as not to represent a barrier to service.

## ABUSE AND NEGLECT REPORTING

HHSC expects contractors to comply with state laws governing the reporting of abuse and neglect. It is mandatory to be familiar with and comply with adult and child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call the Texas Abuse Hotline **800-252-5400**, use the [secure website](#), or call any local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

Contractors must have an agency policy regarding abuse and neglect.

## CHILD ABUSE REPORTING

### Child Abuse Compliance and Monitoring

Chapter 261 of the Texas Family Code requires child abuse reporting. Contractors/providers are required to develop policies and procedures that comply with the child abuse reporting guidelines and requirements set forth in Chapter 261.

The following outlines the review process for contract compliance.

**Policy** – Contractors must develop an internal policy specific to how these reporting requirements will be implemented throughout their agency, how staff will be trained, and how internal monitoring will be done to ensure timely reporting.

**Procedures** – During site monitoring the following procedures will be utilized to evaluate compliance:

- 1) The contractor's process used to ensure that staff is reporting according to Chapter 261. To verify compliance with this item, monitors must review that the contractor:
  - a) has an internal policy which details how the contractor will determine, document, report, and track instances of abuse, sexual or non-sexual, for all clients under the age of 17 in compliance with the Texas Family Code, Chapter 261;
  - b) followed their internal policy; and
  - c) documented staff training on child abuse reporting requirements and procedures.
- 2) If it is found during routine record review that a report should have been made as evidenced by the age of the client and evidence of sexual activity, the failure to appropriately screen and report will be identified as lack of compliance. Failure to report will be brought to the attention of the staff person who should have made the report or the appropriate supervisor with a request to immediately report. This failure to report will also be discussed with the agency director and during the Exit Conference with the contractor.

3) The monitoring report that is sent to the contractor will indicate the number of applicable records reviewed in each clinic and the number of records that were found to be out of compliance. This report will be sent to the contractor approximately 4weeks from the date of the review, which is the usual process for Site Monitoring Reports.

4) The contractor will have a determined length of time to respond with written corrective actions to all findings. If the contractor does not provide corrective actions during the required time period, the contractor will be sent a past due letter with a time period of 10 days to submit the corrective actions. If the corrective actions are not submitted during the time period given, failure to submit the corrective action is considered a subsequent finding of noncompliance with Chapter 261.

If the contractor has other findings that warrant technical assistance or accelerated monitoring review, either regional or central office staff will make the necessary contacts. Records and/or policies will again be reviewed to ensure compliance with Chapter 261. If any subsequent finding of noncompliance is identified during a subsequent monitoring or technical assistance visit, the contractor will be referred for financial sanctioning.

5) If a contractor is found to have minimal findings overall but did have findings of noncompliance with Chapter 261, an additional accelerated monitoring visit solely to review child abuse reporting will not be conducted. For agencies that receive technical assistance visits as a result of a quality assurance review, the agency child abuse reporting processes will be reviewed again for compliance with the child abuse reporting requirements with which the agency did not comply. In all cases, the corrective actions submitted by the contractor will be reviewed to ensure that the issues have been addressed.

## **HUMAN TRAFFICKING**

HHSC expects contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, HTW contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000 (Pub.L.No. 106-386), as amended, and 19 U.S.C. 1591.

Contractors must have a written policy on human trafficking which includes the provision of annual staff training.

## **INTIMATE PARTNER VIOLENCE (IPV)**

[Intimate partner violence \(IPV\)](#) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Contractors must have a written policy related to assessment and prevention of IPV, including the provision of annual staff training.

## CONFIDENTIALITY

All contracting agencies must be in compliance with the [U.S. Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) established standards for protection of client privacy.

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties. All employees, volunteers, sub-contractors, and board members and/or advisory board must sign a confidentiality statement during orientation.

The client's preferred method of follow-up to clinic services (cell phone, email, work phone, and/or text.) and preferred language must be documented in the client's record. (See Client Health Record – Section II Chapter 3)

Each client must receive verbal assurance of confidentiality, an explanation of what confidentiality means (kept private and not shared without permission), and any applicable exceptions such as abuse reporting. (See Abuse Reporting, Section I Chapter 2)

## Minors and Confidentiality

Except as permitted by law, a provider is legally required to maintain the confidentiality of care provided to a minor. Confidential care does not apply when the law requires parental notification or consent or when the law requires the provider to report health information, such as in the cases of contagious disease or abuse. The definition of privacy is the ability of the individual to maintain information in a protected way. Confidentiality in health care is the obligation of the health care provider to not disclose protected information. While confidentiality is implicit in maintaining a patient's privacy, confidentiality between provider and patient is not an absolute right.

The HIPAA privacy rule requires a covered entity to treat a “personal representative” the same as the individual with respect to uses and disclosures of the individual's protected health information. In most cases, parents are the personal representatives for their minor children, and they can exercise individual rights, such as access to medical records, on behalf of their minor children. (Code of Federal Regulations [45CFR164.504]).

## NON-DISCRIMINATION

HHSC contractors must comply with state and federal anti-discrimination laws, including and without limitation:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*),
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794),
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*),
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107),
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681 *et seq.*),
- Administrative rules for HHS agencies, as set forth in the Texas Administrative Code.

More information about non-discrimination laws and regulations can be found on the [HHSC Civil Rights website](#).

### **Contract Terms and Conditions**

To ensure compliance with non-discrimination laws, regulations, and policies, contractors must:

- have a written policy that states the agency does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or sexual orientation,
- have a policy that addresses client rights and responsibilities that is applicable to all clients requesting health care services,
- sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations,
- notify all clients and applicants of the contractor’s non-discrimination policies, including LEP policies, and HHSC complaint procedures, and
  - ensure that all contractor staff is trained in the contractor’s non-discrimination policy including policies for serving clients with LEP, and HHSC complaint procedures, and
  - notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no more than ten (10) calendar days after receipt of the allegation or complaint.

Send notices to:

HHSC Civil Rights Office  
701 W. 51<sup>st</sup> Street, Mail Code W206  
Austin, Texas 78751  
Phone Toll Free: (888) 388-6332  
Phone: (512) 438-4313  
TTY Toll Free: (877) 432-7232  
Fax: (512) 438-5885

### **Limited English Proficiency**

To ensure compliance with civil rights requirements related to LEP, contractors must:

- take reasonable steps to ensure that LEP persons have meaningful access to its programs and services, and not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client’s interpreter, if requested, and the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality, and
- make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

**Civil Rights Posters**

The contractor must prominently display in client common areas, including lobbies and waiting rooms, front reception desk, and locations where clients apply for services, the following posters:

- [“Know Your Rights” \[English\] \[Spanish\]](#)  
Size: 8.5” x 11” (standard size sheet of paper).  
Posting Instructions: Post the English and Spanish versions of this poster next to each other.  
Questions: Contact the HHSC Civil Rights Office.
- [“Need an Interpreter” \[Language Translation\] \[American Sign Language\]](#)  
Size: 8.5” x 11” (standard size sheet of paper).  
Posting Instructions: Post the “Language Translation” version and “American Sign Language” version next to each other.  
Questions: Contact the HHSC Civil Rights Office.
- [Americans with Disabilities Act \[English A\] \[Spanish A\] \[English B\] \[Spanish B\]](#)  
Size: 8.5” x 11” and 11” x 13”  
Posting instructions: Post with other civil rights posters.  
Questions: Contact the HHSC Civil Rights Office.

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

**TERMINATION OF SERVICES**

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the contractor’s ability to provide services or if the client’s behavior jeopardizes her own safety, clinic staff, or other clients.

Any policy related to termination of services must be included in the contractor’s policy and procedures manual.

**RESOLUTION OF COMPLAINTS**

Contractors must ensure that clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors’ policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received. If an aggrieved client requests a hearing, a contractor shall not terminate services to the client until a final decision is rendered. Any client complaint must be documented in the client’s record.

### **PROMPT SERVICES**

Contractors are responsible for ensuring that HTW services are provided to clients in a timely manner, preferably within 30 days of the request for services.

Clients who request contraception but cannot be immediately provided a clinical appointment must be offered a nonprescription method.

HTW minors ages 15 through 17 must be provided family planning counseling and medical services as soon as possible of request - with every effort made to provide an appointment within two weeks of the request.

Clinic/reception room wait times should be reasonable so as not to represent a barrier to service.

### **FREEDOM OF CHOICE**

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

Medicaid clients are free to receive services from any Medicaid-enrolled HTW provider, even in managed care areas.

Personnel at contractors' clinics must be informed that they may be subject to prosecution under federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure. [Section 205 of Public Law 94-63]. Contractors must have a written policy to this effect. (See TAC § 56.11)

### **RESEARCH (HUMAN SUBJECT CLEARANCE)**

Any HHSC HTW contractor that wishes to participate in any proposed research that would involve the use of HHSC HTW clients as subjects, the use of HHSC HTW clients' records, or any data collection from HHSC HTW clients, must obtain prior approval from the HHSC HTW program and be approved by the Institutional Review Board #1 (IRB #1).

Contractors should first contact the HHSC HTW program ([womenshealth@hhsc.state.tx.us](mailto:womenshealth@hhsc.state.tx.us)) to initiate a research request. Next, the program will assist contractors to find the most current version of the IRB application to complete and submit to [womenshealth@hhsc.state.tx.us](mailto:womenshealth@hhsc.state.tx.us). The IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from the HHSC HTW program, as well as the IRB, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.

**CLIENT RECORDS MANAGEMENT**

HHSC contractors must have an organized and secure client record system. The contractor must ensure that records are organized, readily accessible, and available to clients upon request with a signed release of information. The records must be kept confidential and secure, as follows:

- safeguarded against loss and use by unauthorized persons,
- secured by lock when not in use or inaccessible to unauthorized persons, and
- maintained in a secure environment in the facility as well as during transfer between clinics and in between home and office visits.

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. If the client is 15 through 17 years of age, the client's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release. HIV information should be handled according to [law](#).

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistically, or in a form that 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. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by HHSC all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical Records). Contractors must follow contract provisions, maintain medical records for at least seven years after the close of the contract, and follow the retention standards of the appropriate licensing entity. All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.

## PERSONNEL POLICIES AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately to their job position. Contracted staff must also be trained and evaluated according to their responsibilities. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Personnel policies and procedures must include:

- job descriptions,
- a written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position, and
- performance evaluation process for all staff.

Contractors must show evidence that employees meet all required qualifications and are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The HTW program Medical Director must be a licensed Texas physician.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- training needs,
- quality assurance indicators, and
- changing regulations/requirements.

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). Employee orientation and continuing education must be documented in agency personnel files.

**FACILITIES AND EQUIPMENT**

HHSC contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address hazardous waste, fire safety, and medical equipment.

**Hazardous Materials** – Contractors must have written policies and procedures that address:

- the handling, storage, and disposing of hazardous materials and waste, according to applicable laws and regulations,
- the handling, storage, and disposing of chemical and infectious waste, including sharps, and
- an orientation and education program for personnel who manage or have contact with hazardous materials and waste.

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

**Medical Equipment** – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment including Automated External Defibrillator (AED). Documentation must include:

- assessments of the clinical and physical risks of equipment through inspection, testing and maintenance,
- reports of any equipment management problems, failures and use errors,
- an orientation and education program for personnel who use medical equipment, and
- manufacturer recommendations for care and use of medical equipment.

**Radiology Equipment and Standards** - All facilities providing radiology services must:

- possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program,
- have operating and safety procedures as required by Title 25 Texas, Administrative Code Chapter 289, Texas Regulations for Control of Radiation,
- post NOTICE TO EMPLOYEES, Texas Regulations for Control of Radiation.

For information on x-ray machine registration, see the [Texas Department of State Health Services, Radiation Control Program](#).

**Smoking Ban** – Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must also comply with this policy.

**Disaster Response Plan** – Contractors must have written and oral plans that address how staff is to respond to emergency situations (i.e., fires, flooding, power outage, bomb threats, etc.). A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with 10 or fewer employees, the

plan may be communicated orally to employees. For additional resources on facilities and equipment, see the [Occupational Safety and Health Administration](#) website.

## QUALITY MANAGEMENT

Organizations shall embrace Quality Management (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations. QM programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services, and the populations served.

Contractors are expected to develop quality processes based on the four core QM principles that focus on:

- the client,
- systems and processes,
- measurements, and
- teamwork.

Contractors must have a QM program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, and quality and continuity of care.

A QM program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability. Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with HHSC policies and basic standards will be assessed with the subcontracting entities.

The QM Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, and other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. (The HTW program Medical Director must be a licensed Texas physician.)

The Quality Management Committee must meet at least quarterly to:

- receive reports of monitoring activities,
- make decisions based on the analysis of data collected,
- determine quality improvement actions to be implemented, and
- reassess outcomes and goal achievement.

Minutes of the discussion and actions taken by the Committee and a list of the attendees must be maintained.

The quality work plan at a minimum must:

- include clinical and administrative standards by which services will be monitored,
- include process for credentialing and peer review of clinicians,
- identify individuals responsible for implementing, monitoring, evaluating and reporting,

- establish timelines for quality monitoring activities,
- identify tools/forms to be utilized, and
- outline reporting to the Quality Management Committee.

**Although each organization’s quality assurance program is unique, the following activities must be undertaken by all agencies providing client services:**

- on-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care,
- tracking and reporting of adverse outcomes,
- client satisfaction surveys,
- annual review of facilities to maintain a safe environment, including an emergency safety plan,
- annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current, and
- performance evaluations to include primary license verification, DEA and immunization status to ensure they are current.

HHSC Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities including:

- annual license verification (primary source verification),
- clinical record review,
- billing and eligibility review,
- facility on-site review,
- annual client satisfaction evaluation process.

Data from these activities must be presented to the QM Committee. Plans to improve quality should result from the data analysis and reports considered by the Committee and should be documented.

## PHARMACY

### Vendor Drug Program

HTW utilizes the Vendor Drug Program (VDP), which provides statewide access to covered outpatient drugs in an efficient and cost-effective manner. HTW clients may receive approved medications from an associated pharmacy at no cost to the client by providing a HTW benefits card. For further information on the VDP, what drug benefits are covered by HTW, and to locate local pharmacies visit:

<http://www.txvendordrug.com/providers/index.asp>

### Class D Pharmacy

In order to facilitate client access to and compliance with contraceptive methods and related medications, **it is highly recommended, however not required**, that all contractors have at least a Class D pharmacy at each HTW clinic site.

If a contractor chooses to have a Class D pharmacy, the pharmacy must be operated in accordance with federal and state laws relating to security and record keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. It is essential that each facility maintain an adequate supply and variety of contraceptive methods and other medications on-site to effectively manage clients' contraceptive needs.

# **Section II**

## **Eligibility, Client Services, Community Activities and Clinical Guidelines**

**Purpose:** Section II provides policy requirements for eligibility, client services, community activities and clinical guidelines.

## ELIGIBILITY GUIDELINES

A female is eligible to receive services through HTW if she meets the following qualifications:

- is 18-44 years of age (an applicant is considered 18 years of age on the day of her 18th birthday and 44 years of age through the last day of the month of her 45th birthday);
- is 15-17 years of age (an applicant is considered 15 years of age the first day of the month of her 15<sup>th</sup> birthday and 17 years of age through the day before her 18<sup>th</sup> birthday) and has a parent or legal guardian apply, renew, and report changes to her case on her behalf;
- is a U.S. citizen or eligible immigrant;
- resides in Texas;
- does not currently receive full Medicaid benefits, Children’s Health Insurance Program (CHIP), or Medicare Part A or B;
- is not pregnant;
- does not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person; and
- has a countable household income at or below 200 percent of the federal poverty level.

## OTHER BENEFITS

In general, individuals are not eligible for HTW services if they are enrolled in another third party payor such as private health insurance, Medicaid or Medicare, or other federal, state, or local public health care coverage that provides the same services. Individuals with third-party insurance may be eligible for services provided by HTW if client confidentiality is a concern.

## APPLYING FOR HTW

A female, or parent or legal guardian acting on her behalf if she is 15 through 17 years of age, may apply for HTW services by completing an application form and providing documentation as required by HHSC.

An applicant may obtain an application in the following ways:

- on [HealthyTexasWomen.org](http://HealthyTexasWomen.org)
- from a local benefits office of HHSC, an HTW provider’s office, or any other location that makes HTW applications available;
- on the HHSC website;
- by calling 2-1-1; or
- by any other means approved by HHSC.

HHSC accepts and processes every application received through the following means:

- in person at a local benefits office of HHSC;
- by fax;

- through the mail;
- electronically through HealthyTexasWomen.org;
- electronically through YourTexasBenefits.com (a woman can apply here beginning September 1, 2016); or
- by any other means approved by HHSC.

Forms can be submitted by mail or by fax to:

Healthy Texas Women  
PO Box 149021  
Austin, TX 78714-9021  
Fax (toll-free): 1-866-993-9971

HHSC processes an HTW application by the 45<sup>th</sup> day after the date HHSC receives the application. Program coverage begins on the first day of the month in which HHSC receives a valid application. A client is deemed eligible to receive covered services for 12 continuous months after her application is approved. Providers and community-based organizations can help women fill out and fax their applications to HHSC for processing.

**Renewal** – A female, or parent or legal guardian acting on her behalf if she is 15 through 17 years of age, inclusive, may renew HTW services by completing a renewal form and providing documentation as required by HHSC. An HTW client will be sent a renewal packet during the 10<sup>th</sup> month of her 12-month certification period for HTW.

HHSC accepts and processes every renewal form received through the following means:

- in person at a local benefits office of HHSC;
- by fax;
- through the mail;
- electronically through YourTexasBenefits.com (a woman can renew HTW services here beginning September 1, 2016); or
- by any other means approved by HHSC.

Forms can be submitted by mail or by fax to:

Healthy Texas Women  
PO Box 149021  
Austin, TX 78714-9021  
Fax (toll-free): 1-866-993-9971

### Verifying HTW Eligibility

To verify that a woman is enrolled in HTW:

- call the TMHP Contact Center at 1-800-925-9126
- check online the Texas Medicaid Provider section of [www.tmhp.com](http://www.tmhp.com)
- check online at [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com)

### Referral to Other Programs

A female who is determined to be ineligible for HTW may be eligible for Medicaid or Family Planning Program services. If a female is determined ineligible for HTW, the contractor should refer her to other state programs that she might be eligible for.

### DETERMINING HTW PRESUMPTIVE ELIGIBILITY

HTW emphasizes the importance of proper family planning, and women's health preventative care. The goal of HTW is for women to have access to women's health services and not rely upon episodic, acute care.

HTW Cost Reimbursement contractors must use a portion of their cost reimbursement funds to provide services for a limited time to an individual who is determined to be presumptively eligible for HTW and has either not filled out an HTW application yet, or who has submitted an HTW application but a final eligibility determination has not been made by HHSC yet. Presumptive eligibility is effective for 90 days from the date the individual is first seen by the medical provider. The individual shall be enrolled on a presumptive eligibility basis only once in a 12-month period.

HHSC has developed a screening tool and an income worksheet to help providers screen for eligibility and identify acceptable forms of proof of citizenship, identity, and income.

To verify citizenship:

- U.S. birth certificate
- U.S. citizen ID card
- Hospital record of birth
- Northern Mariana ID card
- American Indian card with classification code KIC
- Religious record of birth with date and place of birth, such as baptism record
- Affidavit from two adults establishing the date and place of birth in the United States

To verify identity:

- Current driver's license with photo
- DPS ID with photo (Texas ID card)
- Work or school ID card with photo

Documentation is not required for:

- Address
- Residency status
- Household information
- Social Security number
- Household expenses

\* Documentation is not required during the presumptive eligibility screening process, however documentation will be required once the client submits an HTW application.

Verification of household composition is self-declared. Household Budget Group is determined as follows:

- Adults - The budget group consist of the applicant, applicant’s spouse and mutual and non-mutual children under age 19 who are within the required degree of relationship.
- Minors – The budget group will consist of parent(s), minor applicant, minor’s children, and minor’s siblings. Exclude parents from the minor’s budget group if they are out of the household, other-released or non-related adults. The legal guardian’s income will not be included in the budget group.

**ADJUNCTIVE ELIGIBILITY**

An applicant is considered adjunctively (automatically) eligible for HTW program services at a presumptive eligibility screening, if:

- She is receiving Temporary Assistance for Needy Families (TANF) cash or is in a TANF budget group for someone receiving TANF cash,
- She is in a Children’s Medicaid budget group for someone receiving Medicaid;
- A member in her budget group receives benefits in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or
- She is a member of a certified Supplemental Nutrition Assistance Program (SNAP) household.

Acceptable eligibility verification documentation may include:

<b>PROGRAM</b>	<b>DOCUMENTATION</b>
WIC.....	<i>WIC verification of certification letter, printed WIC-approved shopping list, or recent WIC purchase receipt with remaining balance</i>
SNAP.....	<i>SNAP eligibility letter</i>
TANF.....	<i>TANF verification certification letter</i>

A woman may also prove income eligibility if someone in her household (such as a child) has Medicaid. Providers can verify Medicaid eligibility using TexMed Connect on the [TMHP website](#).

**CALCULATION OF APPLICANT’S FEDERAL POVERTY LEVEL PERCENTAGE**

The steps to determine the Federal Poverty Level (FPL) percentage are:

1. determine the applicant’s household size,
2. determine the applicant’s total monthly income amount,
3. divide the applicant’s **total monthly income** amount by the **maximum monthly income** amount at 100% FPL for the appropriate **household size**,
4. multiply by 100%.

The maximum monthly income amounts by household size are based on the Department of Health and Human Services [federal poverty guidelines](#). The guidelines are subject to change around the beginning of each calendar year.

*Example:*

Applicant has a total monthly income of \$2,093 and counts three (3) family members in the household.

$$\begin{array}{rclclcl}
 \text{Total Monthly} & & \text{Maximum Monthly} & & & & \text{Actual Household} \\
 \text{Income} & & \text{Income} & & & & \text{FPL\%} \\
 & & \text{(Household Size of 3)} & & & & \\
 \$2,093 & \div & \$1,674 & = & 1.25 & \times & 100\% & = & 125\% \text{ FPL}
 \end{array}$$

**Monthly Income Limits for Healthy Texas Women**

Household Size	Monthly Income
1	\$1980
2	\$2670
3	\$3360
4	\$4050
5	\$4740
6	\$5430
7	\$6122

**DATE ELIGIBILITY BEGINS**

Program coverage begins on the first day of the month in which HHSC receives a valid application. For applicants 18 through 44 years of age, inclusive, a valid application has, at a minimum, the applicant’s name, address, and signature. For applicants 15 through 17 years of age, inclusive, a valid application has, at a minimum, the applicant’s name, address, and the signature of a parent or legal guardian.

**CLIENT FEES/CO-PAYMENTS**

HTW contractors may not assess a co-payment (co-pay) for HTW services from HTW clients. No HTW client shall be denied services based on an inability to pay.

### **OTHER FEES**

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill clients for services outside the scope of HTW allowable services, if the service is provided at the client's request, and the client is made aware of her responsibility for paying for the charges.

### **CONTINUATION OF SERVICES**

**Contractors who have expended their awarded HTW funds are required to continue to serve their existing HTW clients.**

If other funding sources are used to provide HTW services, the funds must be reported as non-HHSC funds on the monthly State Purchase Voucher (Form B-13) and the quarterly Financial Status Report (FSR or Form 269a).

## GENERAL CONSENT

Contractors must obtain the client’s written, informed, and voluntary general consent to receive services prior to receiving any clinical services. A general consent explains the types of services provided and how client information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a client does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

Consent information must be effectively communicated to every client in a manner that is understandable. This communication must allow the client to participate, make sound decisions regarding her own medical care, and address any disabilities that impair communication [in compliance with Limited English Proficiency (LEP) regulations.] Only the client may consent, except when the client is legally unable to consent (e.g., an individual with development disability), a parent, legal guardian or caregiver must consent. Consent must never be obtained in a manner that could be perceived as coercive.

In addition, as described below, the contractor must obtain informed consent of the client for procedures as required by the Texas Medical Disclosure Panel.

HHSC contractors should consult a qualified attorney to determine the appropriateness of all consent forms used by their health care agency.

## PROCEDURE-SPECIFIC INFORMED CONSENTS

### Sterilization Procedures

There are two consent forms required for sterilization procedures:

- the Sterilization Consent Form, and
- the Texas Medical Disclosure Panel Consent.

### The Sterilization Consent Form

This sterilization consent form is a federally mandated consent form and is necessary for both abdominal and transcervical sterilization procedures in women. It is provided in the Texas Medicaid Provider Procedures Manual (TMPPM), and is the only acceptable consent form for sterilizations funded by regular Medicaid (Title XIX), the HTW and HHSC Family Planning programs. An electronic copy of the Sterilization Consent Forms (in English and Spanish) may be found on the [TMHP website](#). In brief, the individual to be sterilized must:

- be at least 21 years old at the time the consent is obtained,
- be mentally competent,
- voluntarily give her informed consent,
- sign the consent form **at least 30 days but not more than 180 days prior** to the sterilization procedure\*, and

- may choose a witness to be present when the consent is obtained.

*\*An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after she gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.*

The consent form must be signed and dated by the:

- individual to be sterilized,
- interpreter, if one is provided,
- person who obtains the consent, and
- physician who will perform the sterilization procedure.

Informed consent may **not** be obtained while the individual to be sterilized is:

- in labor or in the process of delivering an infant or infants,
- seeking to obtain or obtaining an abortion, or
- under the influence of alcohol or other substances that affect the individual's state of awareness.

### **Texas Medical Disclosure Panel Consent**

[The Texas Medical Disclosure Panel \(TMDDP\)](#) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their clients or persons authorized to consent for their clients, and 2) establish the general form and substance of such disclosure. TMDDP has developed a “List A” (informed consent requiring full and specific disclosure) for certain procedures, which can be found in the [Texas Administrative Code \(TAC\)](#).

Contractors that directly perform tubal sterilization (a List A procedures), must also complete the [TMDDP Disclosure and Consent Form](#). This consent is in addition to the Sterilization Consent Form noted on the previous page.

The required disclosures for Tubal Sterilization are:

- injury to the bowel and/or bladder,
- sterility,
- failure to obtain fertility (if applicable),
- failure to obtain sterility (if applicable), and
- loss of ovarian functions or hormone production from ovaries.

For all other procedures not listed on List A, the physician must disclose, through a procedure specific consent, all risks that a reasonable client would want to know. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself)

and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

### CONSENT FOR SERVICES TO MINORS

A parent or legal guardian must apply on the behalf of a minor ages 15-17 for HTW services and provide documentation as required by HHSC. Minors ages 15-17 are required to obtain consent from a parent, managing conservator, or guardian before receiving HTW services only as authorized by Texas Family Code, Chapter 32, or by federal law or regulations. Proof of consent must be included in the minor client's medical record.

Parental consent is **not** required for minors to receive pregnancy testing, HIV/STD testing, or treatment for a STD.

For information on health services and consent requirements for minors see: [Adolescent Health – A Guide for Providers](#) and [The Texas Family Code, Chapter 32](#), part of which is outlined below.

Texas Family Code Chapter 32 Sec. 32.003. CONSENT TO TREATMENT BY CHILD: There are instances in which a child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:

- (1) is on active duty with the armed services of the United States of America;
- (2) is:
  - (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
  - (B) managing the child's own financial affairs, regardless of the source of the income;
- (3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
- (4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
- (5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
- (6) is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or

- (7) is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052(a)(19), Occupations Code.

### CONSENT FOR HIV TESTS

[Texas Health and Safety Code](#) §81.105 and §81.106 are as follows:

#### §81.105. INFORMED CONSENT

- a) Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested.
- b) Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

#### §81.106 GENERAL CONSENT

- a) A person who has signed a general consent form for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical test or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect.
- b) Except as otherwise provided by the chapter, the result of a test or procedure to determine HIV infection, antibodies to HIV, or infection with any probable causative agent of AIDS performed under the authorization of a general consent form in accordance with this section may be used only for diagnostic or other purposes directly related to medical treatment.

## Clinical Policy

This chapter describes the requirements and recommendations for Healthy Texas Women program contractors pertaining to the delivery of direct clinical services to patients. In addition to the requirements and recommendations found within this section, contractors should develop protocols consistent with national evidence-based guidelines appropriate to the target population.

All providers must offer the following core family planning services:

- Contraceptive services (pregnancy prevention and birth spacing)
  - Intrauterine devices (IUDs), contraceptive implants, oral contraceptive pills, three-month (medroxyprogesterone) injections, sterilizations, etc.
- Pregnancy testing and counseling
- Health screenings
  - Cervical cancer screening (Pap smears, etc.)
  - Screening for hypertension, diabetes, and elevated cholesterol
- Preconception health (e.g., screening for obesity, smoking, and mental health)
- Sexually transmitted infection (STI) services
  - Chlamydia and gonorrhea screening and treatment
  - HIV screening

### Covered Services:

The Healthy Texas Women (HTW) program seeks to promote the general and reproductive health of Texas women by providing safe and effective family planning and certain primary care services to women 15 through 44 years of age who meet program eligibility requirements.

The following services are covered under the HTW program:

- Annual family planning and preventive healthcare visit
- Contraceptive services, all methods except elective abortion and emergency contraception, including necessary follow-up and surveillance
- Preconception care
- Basic infertility services
- Certain screening, diagnostic, and treatment services, as indicated:
  - Pregnancy testing
  - Screening and treatment of Cervical Intraepithelial Neoplasia, diagnosis of cervical cancer
  - Screening and outpatient treatment of sexually transmitted diseases and infections (STD/STI)
  - HIV testing
  - Breast cancer screening and diagnosis

- Recommended immunizations
- Screening and treatment of postpartum depression
- Diabetes screening and treatment
- Hypertension screening and treatment
- Screening and treatment of elevated cholesterol

**Requirement for documentation of reproductive health services:**

All patients must receive services related to reproductive health at least annually for covered services to remain reimbursable under the HTW program. Patients using long-acting reversible contraception (intrauterine device, implantable hormonal contraceptive agent) and patients who have undergone permanent sterilization may continue to receive services under the program if they meet eligibility requirements. Providers must document reproductive health-related services (e.g., contraceptive, family planning, preconception, infertility services) using appropriate CPT and ICD-10 codes to ensure continued reimbursement for covered services.

The guiding principle of the HTW program is to improve the reproductive health of women to ensure that every pregnancy and every baby are healthy. At each patient encounter, including encounters for treatment of other conditions (eg, diabetes, follow up of abnormal Pap smear), the provider must educate the patient on how the service being provided relates to reproductive health or contraception, and this must be documented in the patient record. Providers are encouraged to take the opportunity provided by each subsequent encounter to reinforce or build on the counseling provided in previous encounters. The following examples are provided for illustration purposes only:

- If the patient is being seen for treatment of a covered chronic health condition such as hypertension or diabetes, the provider might explain briefly that control of a chronic disease such as hypertension prior to becoming pregnant can substantially reduce the risk of complications if a pregnancy occurs, and that this is important even for women who are using contraception or not actually trying to become pregnant because many pregnancies are unplanned and all contraceptive methods carry some risk of pregnancy.
- At a subsequent encounter for treatment of the same chronic condition, the provider might discuss how pregnancy might affect the course of the condition (eg, how medication requirements might change or what complications she might be at risk for).
- If the patient is being seen for another diagnostic or preventive health service (eg, influenza immunization, follow-up of an abnormal Pap smear), the provider might explain briefly why it is important to prevent influenza in a possible pregnancy or how prevention of cervical cancer relates to overall reproductive health.
- If the patient is being seen for contraceptive surveillance, no additional documentation is required beyond that for the contraceptive service.
- For a patient who has undergone sterilization, this counseling and documentation are not required when receiving covered services. The provider is required to submit the

appropriate service code annually for the patient to remain eligible for services under the HTW program, however.

### **Client Health Record and Documentation of Patient Encounters**

Providers must ensure that a patient health record (medical record) is created for every client who obtains clinical services (also see Section 1, Chapter 4 – Client Records Management).

All patient health records must be:

- A complete, legible, and accurate documentation of all clinical encounters, including those that take place by telephone
- Written in ink without erasures or deletions; or documented in the Electronic Health Record (EHR) or Electronic Medical Record (EMR)
- Signed by the provider making the entry, including name of the provider, provider title, and date for each entry
  - Electronic signatures are allowable to document provider review of care.
  - Stamped signatures are not allowable.
- Readily accessible to ensure continuity of care and availability to patients
- Systematically organized to allow easy documentation and prompt retrieval of information

The client health record must include:

- Client identification and personal data, including financial eligibility
- The client's preferred language and method of communication
- Client contact information, including the best way and alternate ways to reach the client, to ensure continuity of care, confidentiality, and compliance with HIPAA regulations
- A patient problem list, updated as needed at each encounter, indicating significant illnesses and medical conditions
- A complete medication list, including prescription and nonprescription medications, as well as dietary supplements, updated at each encounter
- A complete listing of all medication allergies and adverse reactions, and other allergic reactions, displayed in a prominent place, and confirmed or updated at each encounter; if the patient has no known allergies, this must be properly noted
- Documentation of the client's past medical history to include all serious illnesses, hospitalizations, surgical procedures, pertinent biopsies, accidents, exposures to blood products, and mental health history
- A record or history of immunizations, including immunity to rubella based on a history of vaccine or documented serology testing
- A patient health risk survey and assessment, including past and current tobacco and substance use/abuse, domestic and/or intimate partner violence and/or abuse (for any positive result, the client must be offered referral to a family violence shelter in compliance with [Texas Family Code, Chapter 91](#)), occupational and environmental

hazard exposure, environmental safety (e.g., seat belt use, car seat use, bicycle helmets, etc.), nutritional and physical activity assessment, and living arrangements (eg, homelessness or risk of homelessness), updated as appropriate at each encounter

- At each encounter, an encounter-relevant history and physical examination pertinent to the patient’s reason for presentation, with appropriate laboratory and other studies as indicated
- A plan of care, updated as appropriate, consistent with diagnoses and assessments, which in turn are consistent with clinical findings
- Documentation of recommended follow-up care, scheduled return visit dates, and follow-up for missed appointments
- Documentation of informed consent or refusal of services, to include at a minimum:
  - A general consent for treatment
  - Verbal or written consent for HIV testing, or patient refusal of testing
  - Sterilization consent form, if applicable
  - A completed Texas Medical Disclosure Panel Consent form for any surgical services provided, if applicable
  - For required or recommended services refused or declined by the patient, documentation of the service offered, counseling provided, and the patient’s decision to decline
  - Note the following special considerations for adolescent (17 years of age and younger) consent requirements, as required by the [Texas Family Code, Chapter 32](#):
    - Adolescents are required to have consent from a parent or guardian prior to receiving certain medical services; proof of parental consent must be included in the minor patient’s medical record.
    - Adolescents are not required to have parental consent in order to receive pregnancy-related services (including pregnancy testing), sexually transmitted disease/infection (STD/STI) and HIV testing, or STD/STI treatment.
- Documentation of client counseling and education, with attention to risks identified in the health risk assessment
- At every client visit, the record should be updated as appropriate, and the reason for the visit and current health status documented.

### Initial Clinical Visit

At the initial clinical visit or an early subsequent visit, a comprehensive health history must be taken, to include the following (in addition to the elements required for the Client Health Record above):

- Reason for the visit and current health status
-

- Review of systems with documentation of pertinent positives and negatives
- A reproductive health history, to include menstrual history, complete obstetrical history, sexual behavior history (including number and gender of partners, contraceptive practices, sexually transmitted infection/ sexually transmitted disease [STI/STD] and HIV history and risk factors, whether currently sexually active), and reproductive life plan
- Cervical and breast cancer screening history, noting any abnormal results and treatment, and dates of most recent testing
- Other history of gynecological, genital, and/or urological conditions
- Family health and genetic history

At every subsequent visit, including the annual primary health care and problem visits, the record must be updated as appropriate, and the reason for the visit and current health status documented.

### **Annual comprehensive family planning visit physical examination and testing**

The annual family planning visit offers an excellent opportunity for providers to address issues of wellness and health risk reduction as well as addressing any current findings or patient concerns. The annual visit must include an update of the person's health record as described in the Client Health Record section above, as well as appropriate screening, assessment, counseling, and immunizations based on the individual's age, risk factors, preferences, and concerns.

All clients must undergo a physical examination annually as part of the family planning visit. This can be deferred to a later date if the patient's current history and health status do not suggest issues requiring more urgent examination. However, the annual physical examination should not be deferred longer than 6 months, unless the clinician identifies a compelling reason for extended deferral. Such reason must be documented in the client record. Any breast or pelvic examination should be performed only with the consent of the patient. Clients must be offered a suitable method of contraception, such as oral contraceptives, without delay even if the physical examination is put off temporarily or an otherwise asymptomatic individual declines any or all components of the examination.

It is recommended that the family planning visit include all of the following components, at least annually, in addition to any other appropriate elements as suggested by history and presenting signs and symptoms (all findings, including tests, results, and patient notification, should be documented in the medical record, as well as patient refusal or other reason for not testing or performing a specified part of the examination):

- Measurement of height, weight, and blood pressure (BP); screening for hypertension
- Calculation of body mass index (BMI) with assessment for underweight, overweight, or obesity, with counseling (if indicated) on achieving and maintaining a healthy body weight (A [BMI calculator](#) is available from the Centers for Disease Control and Prevention.)
- Clinical breast examination, breast cancer risk assessment, and breast cancer screening as appropriate based on patient's age, risk, and preferences

- Counseling on breast awareness and advice to report any symptom or sign that is concerning to the patient
- Screening for cervical cancer beginning at 21 years of age, regardless of sexual history, and continuing as indicated based on the individual's age, prior test results, and treatment history
- Pelvic examination (for all consenting patients 21 years and older; only if indicated by the medical history in consenting patients less than 21 years of age) to include the following elements:
  - Visual examination of the external genitalia, vaginal introitus, urethral meatus, and perianal area
  - Speculum examination of the cervix and vagina
  - Bimanual examination of the cervix, uterus, and adnexa; and when indicated, rectovaginal examination
- Other examination as indicated by history, signs and symptoms, and patient concerns (e.g., thyroid, heart, lungs, abdomen, etc.)
- Diabetes screening as appropriate for age and risk factors
- Other appropriate screening or testing as indicated by age, risk factors, history, physical findings, and patient concerns:
  - Sexually transmitted infections
  - Pregnancy testing, available on-site (If the pregnancy test is positive, the patient must be given information on good health practices during pregnancy and given or referred for appropriate physical evaluation and initiation of prenatal care, preferably within 15 days.)
  - Rubella immunity testing in women of reproductive age if the status cannot be determined by history or previous testing
  - Cholesterol and/or serum lipid testing
  - Thyroid stimulating hormone
  - Other testing if indicated
- Appropriate family planning counseling and services
- Preconception care and/or basic infertility services as appropriate
- \*[Immunizations](#) as indicated
- Healthy lifestyle interventions and counseling as indicated based on age, risk factors, and client interest and receptiveness

\* Healthcare providers can voluntarily participate in the Texas Department of State Health Services (DSHS) [Adult Safety Net \(ASN\) vaccine program](#), which provides vaccines at no cost.

### **Counseling and Education**

All clients must receive accurate patient-centered education and counseling in their preferred language, presented in a way they are able to understand and to demonstrate their understanding,

and documented in the medical record. The intent of patient education is to enable the client to understand the range of available services and how to access them, to make informed decisions about family planning, to reduce personal health risk, and to understand the importance of recommended tests, health promotion, and disease prevention strategies.

Specific clinical policies must be in place to address counseling and other services provided to adolescents 17 years of age and younger, to include the following, at a minimum:

- Counseling of adolescents must include the following topics, and comply with the requirements of the [Texas Family Code, Chapter 261](#):
  - All medically approved methods of contraception, including abstinence
  - Prevention of STD/STIs and HIV
  - Domestic, partner, dating, and family violence and the offer of assistance as needed
  - Recognition and avoidance of sexual coercion
- Counseling and clinical services to adolescents must be expedited so that appointments are made available as soon as possible.
- Adolescents must be assured that their privacy and confidentiality will be protected within the parameters of applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), [Texas Family Code, Chapter 32](#), and the Texas Department of State Health Services (DSHS) family planning policy manual.

Details of appropriate educational interventions are included in each section of this clinical policy manual. In addition, links are provided to information of use to patients and educators at the end of most sections.

### **Requirements for policies to ensure appropriate follow-up and continuity of care**

Providers must develop and maintain policies and procedures to ensure proper timely follow-up and continuity of care, to include, at a minimum:

- Tracking pending tests until results are reviewed by provider and patient is notified of results and recommended follow-up
- Documentation of all tests and results in the client health record
- A mechanism to inform clients promptly of test results that protects the patient's privacy and confidentiality while supporting and promoting timely, appropriate follow-up
- A mechanism to track patient compliance with recommended follow-up care, schedule return visits, and follow up on missed appointments
- A process to ensure compliance with all applicable state and local laws for disease reporting

### **Problem Visits**

For all problem visits, the following elements must be documented in the medical record:

- Reason for the visit
- Appropriate interval medical history and focused history relevant to the problem reported
- Relevant physical examination and testing as indicated, as well as an assessment and treatment prescribed

### **Referrals**

When a client is referred to another provider of services for consultation or continuation of care, the chart must reflect a record of the purpose for the referral, the name of the provider consulted or referred to, counseling of the patient regarding the purpose of the referral, and answering any questions the patient has about the referral. Pertinent patient information and appropriate portions of the medical record must be provided to the referral clinician, and this must also be documented in the medical record. The results of the consultation or referral must be followed up on and documented in the medical record.

When services required as part of the Healthy Texas Women contract are to be provided by referral, the contractor must establish a written agreement with a referral resource for the provision of services and reimbursement of costs, and ensure that the patient is charged no more than the appropriately assessed fee.

Contractors must maintain a written policy reflecting these requirements for referral activities.

### **PRESCRIPTIVE AUTHORITY AGREEMENTS, STANDING DELEGATION ORDERS, AND PROCEDURES**

Contractors that provide clinical services must develop and maintain written clinical protocols and standing delegation orders (SDOs) in compliance with statutes and rules governing medical and nursing practice and consistent with national evidence-based clinical guidelines. When DSHS revises a policy, contractors need to incorporate the revised policy into their written protocols, SDOs, and procedures.

#### **Prescriptive Authority Agreements**

Contractors who delegate the act of prescribing or ordering a drug or device to Advanced Practice Registered Nurse(s) and/or Physician Assistant(s) must have in place a prescriptive authority agreement (PAA), as required by [Texas Administrative Code Title 22, Part 9, Chapter 193](#). The PAA must meet all the requirements delineated in the [Texas Medical Practice Act, Chapter 157](#), including, but not limited to, the following minimum criteria:

- Be in writing and signed and dated by the parties to the agreement;
- Include the name, address, and all professional license numbers of all parties to the agreement;
- State the nature of the practice, practice locations, or practice settings;
- Identify the types or categories of drugs or devices that may be prescribed, or the types or

- categories of drugs or devices that may not be prescribed;
- Provide a general plan for addressing consultation and referral;
- Provide a plan for addressing patient emergencies;
- Describe the general process for communication and sharing of information between the physician and the advanced practice registered nurse or physician assistant to whom the physician has delegated prescriptive authority related to the care and treatment of patients;
- If alternate physician supervision is to be utilized, designate one or more alternate physicians who may:
  - Provide appropriate supervision on a temporary basis in accordance with the requirements established by the prescriptive authority agreement and the requirements of this subchapter; and
  - Participate in the prescriptive authority quality assurance and improvement plan meetings required under this section; and
- Describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following:
  - Chart review, with the number of charts to be reviewed determined by the physician and advanced practice registered nurse or physician assistant; and
  - Periodic face-to-face meetings between the advanced practice registered nurse or physician assistant and the physician at a location determined by the physician and the advanced practice registered nurse or physician assistant.

The PAA need not describe the exact steps that an advanced practice registered nurse or physician assistant must take with respect to each specific condition, disease, or symptom. The PAA and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. A copy of the current PAA must be maintained on-site.

### **Standing Delegation Orders**

Contractors that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a patient population with specific diseases, disorders, health problems or sets of symptoms, must have written SDOs in place. SDOs are distinct from specific orders written for a particular patient. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, or non-licensed healthcare provider (NLHP) actions or tasks may be initiated in the clinical setting, and provide authority for use with patients when a physician or advance practice provider is not on the premises, and or prior to being examined or evaluated by a physician or advanced practice provider. Example: SDO for assessment of Blood Pressure/Blood Sugar which includes an RN, LVN or NLHP that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values. Other applicable SDOs when a physician is not present on-site may include, but are not limited to:

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

**The SDOs must be reviewed, signed, and dated by the supervising physician who is responsible for the delivery of medical care covered by the orders and other appropriate staff, at least annually and maintained on- site.**

## References

American Academy of Family Physicians (2016). Summary of recommendations for clinical preventive services. AAFP Policy Action Order No. 1968. Available at [http://www.aafp.org/dam/AAFP/documents/patient\\_care/clinical\\_recommendations/February%2016%202016%20SCPS.pdf](http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/February%2016%202016%20SCPS.pdf)

American College of Obstetricians and Gynecologists (2012). Committee opinion 534: Well-woman visit. *Obstet Gynecol* 120: 421-424. Available at [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Gynecologic\\_Practice/Well-Woman\\_Visit](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Well-Woman_Visit)

Centers for Disease Control and Prevention. Clinical care for women website. Available at <http://www.cdc.gov/preconception/careforwomen/index.html>

Centers for Disease Control and Prevention (2014). Providing quality family planning services. *MMWR* 63(4). Available at <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>

Centers for Disease Control and Prevention. Immunization schedules website. Available at <http://www.cdc.gov/vaccines/schedules/>

## Family Planning and Contraceptive Services

### Reproductive Life Plan

Providers should encourage all clients to develop a reproductive life plan, which is an outline of each person's immediate and future plans for having children. Questions such as the following can be useful in helping clients to develop the plan:

- Do you have children now?
- Do you desire to have (more) children?
- How many children would you like to have and when?

Of course, providers and clients should understand that such plans can change with time. Providers should take the client's stated plan into account in counseling on contraceptive and family planning services.

- If the client is sexually active and does not desire pregnancy, offer contraceptive services.
- Provide pregnancy testing and counseling to any woman who may be pregnant or who requests such testing. Initiate or provide referral for prenatal services if positive.
- If pregnancy is currently desired and the woman is not pregnant, offer services to help her and her partner to achieve a safe and healthy pregnancy, including basic infertility services if appropriate.

### Contraceptive Counseling and Education

At each encounter for services, clients must receive patient-centered counseling and education to enable them to make informed decisions about family planning, including information on preventing STD/STIs and HIV, the results of the physical examination and other testing, method-specific counseling as described below, and other counseling as indicated by the history and clinical evaluation.

Providers must offer clients a wide array of contraceptive options appropriate for the person's health status and reproductive plan. A 6-step approach that seeks to engage the client in the decision-making process while addressing individual personal and cultural preferences will improve client satisfaction and the likelihood that the selected method will be used correctly and consistently.

1. Establish and maintain rapport with the client. Some ways to do this include:
  - a. Ask open-ended questions.
  - b. Ensure confidentiality and privacy, and explain how confidential information may be used.
  - c. Listen to and observe the client.
  - d. Encourage questions, and provide culturally sensitive answers that demonstrate knowledge of the subject matter in language the client understands.

2. Obtain social and clinical information from the client to include the following:
  - a. Health history
  - b. Current reproductive life plan
  - c. Contraceptive experience and possible preferences
  - d. Assessment of sexual health:
    - i. Current and past practices (e.g., vaginal, oral, anal sex)
    - ii. Past and current contraceptive practices
    - iii. Partner history (e.g., number, sex, whether concurrently monogamous)
    - iv. Current and past STD/STI prevention (e.g., limiting partners, use of condoms, barriers to condom use, consistency of use)
    - v. Prior treatment for and possible exposure to STD/STIs
3. Work interactively with the client to choose the most appropriate contraceptive method for the individual.
  - a. Educate the client about all contraceptive methods that are safe and appropriate for her. An online [patient decision support tool](#) is available from the Association of Reproductive Health Professionals.
  - b. Providers should counsel patients on the [relative effectiveness of methods](#), correct use of methods, potential non-contraceptive benefits (e.g., reduced risk of iron-deficiency anemia with combination hormonal contraceptives), and method side effects, working with the individual or couple to select the method that best meets their needs and wishes.
  - c. Clients should be informed that contraceptive methods other than condoms provide no protection from STD/STIs, including HIV; and that condoms used correctly and consistently do help to reduce the risk of STD/STIs, including HIV.
  - d. Help the client to identify barriers to correct contraceptive method use and develop solutions to overcome barriers.
4. Perform a physical evaluation appropriate to the method chosen, when warranted. In most cases, no physical examination or laboratory testing is necessary prior to initiating a contraceptive method.
  - a. Blood pressure should be recorded prior to starting combination hormonal contraception.
  - b. Current pregnancy status should be determined at the time of service for any woman receiving contraceptive services, but routine pregnancy testing is not necessary if it is possible to be reasonably certain that she is not pregnant. A provider may be reasonably certain that a woman is not currently pregnant if she has no signs or symptoms of pregnancy (either intrauterine or ectopic) and meets

at least one of the following criteria:

- i.  $\leq 7$  days since the start of a normal menses
  - ii. No sexual intercourse since the beginning of the last normal menses
  - iii. Has been using a reliable method of contraception correctly and consistently
  - iv.  $\leq 7$  days since a spontaneous or induced abortion
  - v.  $\leq 4$  weeks postpartum
  - vi.  $< 6$  months postpartum, amenorrheic since delivery, and exclusively or almost exclusively breast feeding (at least 85% of infant feedings are breast feedings)
- c. Weight assessment is not necessary before initiating a contraceptive method because obesity alone is not a contraindication to any method. However, a baseline weight measurement may aid in assessing the possible effect of a chosen method on weight change.
- d. Certain tests and components of the physical examination may provide logistical, economic or emotional barriers to contraceptive access or acceptance for some women. In most cases, many of these interventions can be safely delayed, or avoided altogether if necessary, to enable a healthy individual to initiate an appropriate and preferred method (although there may be other healthcare-related indications for the interventions). The following tests and examinations are not necessary prior to initiating a contraceptive method:
- i. Pelvic examination, except when fitting a diaphragm or inserting an IUD
  - ii. Cervical, breast, or other cancer screening
  - iii. HIV screening
  - iv. Laboratory testing for hemoglobin, glucose, lipid, or liver enzyme levels; or for thrombogenic mutations
  - v. Any physical examination prior to distributing condoms
5. Once a method of contraception is selected, the provider should provide counseling on correct and consistent use, assist the client to develop a plan for correct use and follow-up, and confirm the client's understanding. Certain considerations may increase the likelihood of correct and consistent use.
- a. Ideally, the method should be dispensed on-site and started at the time of the visit (rather than waiting for the next menses), if the provider can be reasonably certain the woman is not pregnant (see item 4.b above for criteria to determine with reasonable certainty that a woman is not currently pregnant).
  - b. Multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring should be prescribed or provided to reduce the number of return visits necessary.

- c. Make condoms available easily and inexpensively.
  - d. If the client's chosen method is not available on-site or immediately, provide another method on the day of the visit to be used until the chosen method can be started.
6. Finally, help the client develop a plan for correct and consistent use of the chosen method and provide a plan for follow-up.
- a. Explore possible reasons for incorrect or inconsistent use and help develop strategies to deal with these. For example:
    - i. Suggest a daily text message or a sign on the bathroom mirror to routinize daily pill taking.
    - ii. Discuss ways to ensure timely return for injections.
    - iii. Discuss side effects, a common reason for method discontinuation, and ways to deal with these.
  - b. Create a follow-up plan with the client, taking into account the client's individual needs and perceived risk of method lapse or discontinuation.
  - c. Confirm the client's understanding of the information given and document this in the medical record.
    - i. The teach-back method, in which the client demonstrates understanding of the information by repeating back her understanding of the messages received, is a good way to confirm understanding and to increase retention of the information received.
    - ii. Provide counseling with teach-back of the following topics, at a minimum:
      - 1. Real-world method effectiveness
      - 2. Correct method use and common side effects
      - 3. Back-up contraceptive methods, including issues related to discontinuation of the chosen method
      - 4. Whether or not the method protects against STD/STIs
      - 5. Signs of rare, but serious, complications, and what to do if any of these signs occurs
      - 6. How to seek urgent or emergency care, including a 24-hour emergency telephone number
      - 7. When to return for follow-up

**Relative Method Effectiveness**

The following contraceptive methods and services necessary to provide them are approved for reimbursement under the Healthy Texas Women (HTW) Program. Providers must make each method available either on-site or by referral. Relative method effectiveness is indicated in parentheses, if reported values are available. Actual effectiveness depends on correctness and consistency of use.

- Extremely effective (~99%):
  - Total sexual abstinence
  - Lactational amenorrhea (< 6 months postpartum, amenorrheic, and providing at least 85% of infant feedings as breast feedings)
  - \*Contraceptive implant
  - \*Intrauterine device
  - Male or female sterilization
  
- Very effective (~91-99%):
  - Hormonal contraceptive pills
  - Hormonal contraceptive patch
  - Progestin injection (i.e., Depo-Provera)
  - Vaginal ring
  
- Effective (~80-99%)
  - Diaphragm
  - Female condom
  - Male condom
  - Withdrawal (“pulling out”)
  
- Moderately effective
  - Cervical cap
  - Fertility awareness (“rhythm”) (~76-99%)
  - Spermicide (~72-82%)
  - Sponge

**\*Long-Acting Reversible Contraceptive (LARC) Methods**

Because of their safety, reversibility, ease of use, and very high real-world effectiveness, providers are encouraged to make long-acting reversible contraceptive (LARC) agents and devices (i.e., the intrauterine device and the subdermal contraceptive implant) available to all clients who are candidates for their use. See the web page [Long-Acting Reversible Contraception](#)

[Program](#) from the American Congress of Obstetricians and Gynecologists for information and resources on the use of LARCs.

For more information on implementing a program to provide LARCs, see the Texas LARC Toolkit on the [Healthy Texas Women](#) website.

### Consent for Sterilization

For clients who choose sterilization, 2 consent forms are required to be signed by the patient after counseling on method-specific risks and benefits is provided and all the patient's questions have been answered:

- The [Sterilization Consent Form](#) must be signed by the patient at least 30 days and not more than 180 days prior to the procedure. An exception is made if the patient undergoes emergency abdominal surgery or preterm birth, in which case, the form must be signed at least 72 hours before the sterilization procedure (and at least 30 days prior to the expected date of delivery if preterm birth is the reason for the exception).
- A [Texas Medical Disclosure Panel Consent](#) for the surgical procedure by which sterilization will be performed must be signed by the patient after full disclosure of the risks and possible benefits is provided and all the patient's questions are answered.

### Note:

- Abortion is not considered a method of family planning and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors.
- Emergency contraceptive pills (EC or ECP) and related provider services are not reimbursable under the HTW program.

### References

Centers for Disease Control and Prevention (2014). Providing quality family planning services. *MMWR* 63(4). Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm> (web) <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf> (PDF)

Centers for Disease Control and Prevention. Selected practice recommendations for contraceptive use 2013. *MMWR* 62(No.RR-5). Available at [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s\\_cid=rr6205a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w) (web) <http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf> (PDF)

### Resources for patients and educators

Association of Reproductive Health Professionals. Method Match. Online decision support tool to help patients compare and select from different methods of contraception; includes information on relative effectiveness of methods. Available at <http://www.arhp.org/methodmatch/>

**Resources for providers**

American Congress of Obstetricians and Gynecologists. Long-acting reversible contraception program web page. Provides information, clinical guidance, and educational materials on Long-acting reversible contraceptives [LARCs]. Available at [https://www.acog.org/About\\_ACOG/ACOG\\_Departments/Long\\_Acting\\_Reversible\\_Contraception](https://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception)

**Further reading**

O'neil-Callahan M, et al. Twenty-four-month continuation of reversible contraception. *Obstet Gynecol.* (2013) 122(5):1083-91. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012225/> (web); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012225/pdf/nihms570115.pdf> (PDF)

Peipert JF, et al. Continuation and satisfaction of reversible contraception. *Obstet Gynecol.* (2011) 117(5):1105-13. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3548669/> (web); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3548669/pdf/nihms430088.pdf> (PDF)

### Preconception Services

The goal of preconception care is optimizing the health of every woman to lay the foundation for the best possible outcome of every pregnancy. Because almost half of all pregnancies in the United States are unplanned, and most pregnancies occur in women who did not have a specific preconception care visit prior to becoming pregnant, providers should keep preconception care in mind at every encounter with a woman of childbearing potential.

Good preconception care incorporates all components of general health care as described elsewhere in this manual. Attention should be paid to the following components:

- Optimization of known chronic medical conditions, such as diabetes, hypertension, thyroid disease, epilepsy, asthma, etc. For example:
  - A normal hemoglobin A1c prior to and early in pregnancy can substantially reduce the risk of birth defects in the offspring of mothers with Type 1 and Type 2 diabetes.
  - Women with hyperthyroidism or hypothyroidism should be treated as necessary to ensure that they are euthyroid prior to and during pregnancy to reduce the risk of miscarriage and preterm birth.
  - Women with a history of phenylketonuria should be counseled on the need to follow a low-phenylalanine diet before and during pregnancy to reduce the risk of birth defects and serious developmental delay in the offspring.
  
- Screening as indicated for any conditions that may be undiagnosed
- Confirming that immunizations are current
- Medications (prescription and nonprescription) and potential radiation exposure in early pregnancy
  - In general, the lowest effective dose of necessary medications is preferred, but patients should be cautioned against discontinuing or changing medications without first consulting their doctor, because an untreated or incompletely treated medical condition may pose greater risk to the fetus and mother than the medication prescribed.
  - Some known teratogenic medications include warfarin, valproic acid, carbamazepine, isotretinoin, and angiotensin-converting enzyme inhibitors.
  - For more patient and provider information on risk associated with specific exposures to medications and other environmental factors, consult the web site of the [Organization of Teratology Information Specialists](#).
  
- Prevention of STD/STIs
- Nutrition and food insecurity
- Occupational and environmental exposures to health risks and teratogens
- Tobacco and substance use, other high-risk behaviors
- Family medical history and genetic risk
- Domestic, intimate, and partner violence

- Social issues, such as homelessness
- Mental health

### References

American Academy of Pediatrics/American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care 7<sup>th</sup> Ed.* (2012). Ch. 5, pp. 95-106.

American College of Obstetricians and Gynecologists. Committee opinion 313: The importance of preconception care in the continuum of women's health care. *Obstet Gynecol* (2005). 106: 665-666. Available at

[http://www.acog.org/Resources\\_And\\_Publications/~/\\_link.aspx?id=75AD1BF47A76489F8E719EA5E3F22797&\\_z=z](http://www.acog.org/Resources_And_Publications/~/_link.aspx?id=75AD1BF47A76489F8E719EA5E3F22797&_z=z)

Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care – United States. *MMWR* (2006). 55(RR06): 1-23. Available at

<http://www.cdc.gov/mmWR/PDF/rr/rr5506.pdf>

Organization of Teratology Information Specialists. MotherToBaby: Medications & more during pregnancy & breastfeeding. Available at <http://mothertobaby.org/fact-sheets-parent/> (provides information for patients and health care providers on teratogenic risk of drugs and other exposures in pregnancy)

### Resources for patients and providers

Centers for Disease Control and Prevention. Clinical care for women website. Available at <http://www.cdc.gov/preconception/careforwomen/index.html>

Centers for Disease Control and Prevention. Preconception health and health care web site. Contains links to resources for patients, providers, and patient educators on planning for a healthy pregnancy. Available at <http://www.cdc.gov/preconception/index.html>

### Infertility Services

Healthy Texas Women contractors must offer basic infertility services to include, at a minimum, an initial infertility interview, related counseling and education, an appropriate physical examination, and referral for further services as indicated. A complete discussion of the evaluation and treatment of infertility is beyond the scope of this manual, and many related services are not covered under this program. The reader is referred to the references section for more information.

### Optimizing Natural Fertility

For information on counseling a patient or couple facing difficulty attempting to conceive, see [Optimizing natural fertility: a committee opinion](#) from the American Society for Reproductive Medicine.

### References

American Society for Reproductive Medicine (2015). Diagnostic evaluation of the infertile female: A committee opinion. *Fertil Steril* 103: e44-e50. Available at [https://www.asrm.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Committee\\_Opinions/Diagnostic\\_eval\\_infertile\\_female\\_inpress-noprint.pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/Diagnostic_eval_infertile_female_inpress-noprint.pdf)

Centers for Disease Control and Prevention (2014). Providing quality family planning services. *MMWR* 63(4). Available at <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>

### Patient and provider information

American Society for Reproductive Medicine (2013). Optimizing natural fertility: A committee opinion. *Fertil Steril* 100: 631-637. Available at [https://www.asrm.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Committee\\_Opinions/optimizing\\_natural\\_fertility\(1\).pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/optimizing_natural_fertility(1).pdf)

American Society for Reproductive Medicine. [ReproductiveFacts.org](http://ReproductiveFacts.org) (information for patients on a variety of topics related to fertility and infertility)

Organization of Teratology Information Specialists. MotherToBaby: Medications & more during pregnancy & breastfeeding. Available at <http://mothertobaby.org/fact-sheets-parent/> (provides information for patients and health care providers on teratogenic risk of drugs and other exposures in pregnancy)

### **Cervical Cancer Screening**

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Healthy Texas Women program, and do not include guideline recommendations for patients outside this range.

The majority of cases of cervical cancer occur in women who have never had screening or have had inadequate screening. It is estimated that half of women who receive a diagnosis of cervical cancer have never had cervical cytology testing, and an additional 10% have not had screening in the 5 years prior to the diagnosis of cancer. Providers are encouraged to implement and participate in programs aimed at increasing the percentage of women in their communities who receive indicated cervical cancer screening.

#### **General considerations**

- Cervical cancer screening should begin at age 21 for all sexually active women who are not infected with HIV or receiving immunosuppressive drugs due to a solid organ transplant. (See References section below for information on managing HIV-infected patients. It is reasonable to extrapolate the guidelines for screening of HIV-infected patients to solid organ transplant recipients.)
- Women with a history of in utero exposure to diethylstilbestrol or personal history of cervical intraepithelial neoplasia (CIN) 2 or 3 are at higher risk and should have more frequent screening than described in this policy manual, which is intended for women of average risk.
- Either liquid-based or conventional (PAP smear) methods of cervical cytology are acceptable.

#### **Screening frequency and response to abnormal findings**

- Women 21-29 years of age should undergo screening every 3 years by cervical cytology testing alone, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS).
- Women 30-44 years of age should have cotesting with cervical cytology and HPV testing every 5 years (preferred), or cervical cytology testing alone (with reflex HPV testing for ASCUS) every 3 years.
- It is reasonable to perform annual cervical cytology testing in women with in utero exposure to diethylstilbestrol.
- For any patient with an abnormal result, further testing and follow-up should be dictated by findings, diagnosis, and current evidence-based guidelines.
- 

#### **Discontinuation of screening**

- Screening should be discontinued after a hysterectomy with removal of the cervix in patients with no prior history of CIN 2 or greater.

**References**

Practice Bulletin No. 157: Cervical Cancer Screening and Prevention. *Obstet Gynecol.* 2016 Jan;127(1):e1-e20

Panel on opportunistic infections in HIV-infected adults and adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at [https://aidsinfo.nih.gov/contentfiles/lvguidelines/adult\\_oi.pdf](https://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf)

## Breast Cancer Screening

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Healthy Texas Women program, and do not include guideline recommendations for patients outside this range.

### Risk screening and patient counseling

All patients must have an assessment of their risk for breast cancer, updated periodically, to include the patient's age and ethnicity, personal and family history of breast cancer, other relevant genetic predisposition to breast cancer, and any history of chest radiation (particularly before age 30). A [risk calculator](#) for the individual 5-year risk of developing breast cancer for women 35 years of age and older is available from the National Cancer Institute.

All patients should be counseled on breast awareness, and advised to be familiar with their breasts and to report any changes (such as a mass, lump, thickening, or nipple discharge) promptly.

### Screening frequency

The following considerations\* apply to women 40 years of age and older who do not have a preexisting breast cancer or other high-risk breast lesion and who do not have a known underlying genetic mutation (such as a BRCA1 or 2 mutation, or other familial breast cancer syndrome) or a history of chest radiation at an early age.

Note that the age ranges included in the statements below reflect the age ranges covered by the Healthy Texas Women program, and may not include the full age ranges included in the guideline statements used as reference.

- The decision for screening mammography in women 40-44 years of age should be individualized:
  - While screening mammography may reduce cancer-related deaths in this population, the number of deaths prevented is less than in older populations and the number of false-positive mammography results and negative biopsies is higher.
  - Women who place a higher value on the potential benefits of screening than on the potential harms may choose, and should be allowed, to undergo biennial screening beginning sometime during her 40s.
  - Women with a first-degree relative (parent, sibling, or child) with breast cancer are at increased risk and may benefit more from screening in their 40s than average-risk women.
  
- There is insufficient evidence to assess the balance of benefits and harms for the following:
  - The use of digital breast tomosynthesis (DBT) as a primary breast cancer screening modality

- The use of breast ultrasonography, DBT, magnetic resonance imaging, or other methods of adjunctive screening in women with dense breasts identified on an otherwise negative screening mammogram

More frequent or earlier screening mammography may be considered in women with increased or uncertain individual breast cancer risk and in other circumstances where the balance of potential benefits and harms of screening is felt to justify it.

\*Note that the recommendations for frequency of mammography screening described above come from the US Preventive Services Task Force Recommendation Statement on Screening for Breast Cancer (Sui, 2016). The National Comprehensive Cancer Network recommends annual screening mammography be offered to all asymptomatic women 40 years of age and older. Links to both guidelines are provided in the References section immediately below.

### **Follow-up and referral for treatment**

Any patient with an abnormality identified on screening or a specific breast complaint (including, but not limited to, a mass, lump, thickening, or nipple discharge) must be evaluated as indicated in a timely manner. Providers should have procedures in place to ensure appropriate patient education and counseling, referral for further evaluation (including additional testing and biopsy) when indicated, communication and coordination with the patient and other providers, and proper follow-up through the conclusion of the case.

Patients who have abnormal clinical breast exam (CBE) or cervical cytology findings may be scheduled to return for repeat exams if this is considered to be appropriate follow up by the clinician. For patients whose cervical cytology test or CBE results in an abnormal finding that requires referral for services beyond those available through family planning, contractors are encouraged, whenever possible, to refer to a HHSC Breast and Cervical Cancer Services (BCCS) contractor. In order to promote the most effective use of limited resources, family planning contractors' clinicians should be familiar with nationally recognized guidelines and algorithms describing recommended practice regarding abnormal cervical cytology and CBE results.

Eligible patients in need of treatment for biopsy-proven breast cancer may apply for coverage under the Medicaid for Breast and Cervical Cancer Program. Information is available at <http://www.dshs.state.tx.us/bcccs/treatment-info.shtm>.

### **References**

Siu, AL. Screening for breast cancer: US Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2016;164(4):279-296. Available at <http://annals.org/article.aspx?articleid=2480757> (web); <file:///C:/Users/jingram680.DSHS/Downloads/AIME201602160-M152886.pdf> (PDF)

National Comprehensive Cancer Network. (2015). NCCN clinical practice guidelines in oncology: Breast cancer screening and diagnosis. Version 1.2015. Available at [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines\\_nojava.asp#detection](http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection)

**Additional reading**

National Comprehensive Cancer Network. (2015). NCCN clinical practice guidelines in oncology: Breast cancer risk reduction. Version 2.2015. Available at

[http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines\\_nojava.asp#detection](http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection)

National Comprehensive Cancer Network. (2016). NCCN clinical practice guidelines in oncology: Genetic/familial high-risk assessment: Breast and ovarian. Version 1.2016. Available at

[http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines\\_nojava.asp#detection](http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection)

**Information for patients**

National Cancer Institute. Mammograms patient information page. Available at

<http://www.cancer.gov/types/breast/mammograms-fact-sheet>

National Cancer Institute. Breast Cancer – Patient Version. Available at

<http://www.cancer.gov/types/breast>

**Online provider resources**

National Cancer Institute. Breast Cancer Risk Assessment Tool. Available at

<http://www.cancer.gov/bcrisktool/Default.aspx>

### **Sexually Transmitted Disease/Infection (STD/STI) Screening and Treatment**

Screening and treatment of STD/STIs must follow the current guidelines for [screening](#) and [treatment](#) from the Centers for Disease Control and Prevention (CDC). A risk assessment should be done for all clients to determine what testing is indicated, and documented in the medical record. Following is a brief overview of STD/STI screening recommendations (for more detailed information, go to the CDC screening link above):

- **HIV screening:**
  - Contractors must provide on-site HIV testing.
  - If HIV testing is done, verbal or written consent, should be documented in the medical record. If testing is indicated and the client declines, this should be documented.
  - All clients 15 to 44 years of age should be screened at least once for [HIV](#), using a policy that provides HIV education and allows patients to opt out of screening (i.e., prior to testing, patients are informed that HIV testing will be done as part of the general consent for care and they are free to decline testing if they choose to do so) as desired.
  - Clients who engage in risky sexual practices or share injection drug paraphernalia should be tested annually.
  - Clients who seek testing or treatment of STD/STIs should be tested for HIV at the same time.
  - HIV Counseling: Contractors may provide negative HIV test results to patients in person, by telephone, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results by telephone must follow procedures that address patient confidentiality, identification of the client, and prevention counseling. Contractors must always provide positive HIV test results to patients in a face-to-face encounter with an immediate opportunity for counseling and referral to community support services. Test results must be provided by staff knowledgeable about HIV prevention and HIV testing. Clients whose risk assessment reveals high-risk behaviors should be provided directly or referred for, more extensive risk reduction counseling by a DSHS HIV/STD Program trained risk reduction specialist. To find a DSHS HIV/STD Program contractor, visit the [DSHS HIV/STD](#) website.
- **Chlamydia and gonorrhea testing:**
  - Annual chlamydia and gonorrhea screening should be provided for all sexually active women under 25 years of age. If a pelvic examination will not be performed, as in asymptomatic women under 21 years of age and other women who decline a pelvic examination, screening can be performed using a nucleic

acid amplification technique on a urine sample or a patient self-obtained vaginal swab.

- Testing should also be done in older asymptomatic women with increased risk and in all symptomatic women. Indications include, but are not limited to:
  - New or multiple sex partners
  - A partner who has other partner(s)
  - Exposure to an STD/STI
  - Symptoms or signs of cervicitis or an STD/STI
  - History of pelvic inflammatory disease
  - A positive test for an STD/STI in the prior 12 months
  - Sex work or drug use
- Treated patients should be retested approximately 3 to 4 months after treatment to assess evidence of reinfection.
- All women who are pregnant or attempting pregnancy should be tested.
- Routine screening of male patients for chlamydia and gonorrhea is not recommended, but should be considered in settings where the prevalence of infection is high such as correctional facilities and adolescent clinics.
- **Herpes simplex virus (HSV) screening:**
  - Routine screening of asymptomatic patients for genital herpes simplex virus (HSV) infection is not recommended in the general or pregnant population.
  - Testing, counseling, and treatment of symptomatic patients (ie, presence of genital lesions), as well as management of affected pregnant patients, should follow current [CDC guidelines](#).
  - The preferred tests for confirmation of the diagnosis in patients with active genital ulcers or mucocutaneous lesions are cell culture and polymerase chain reaction (PCR) assay.
  - Type-specific serologic testing may be appropriate in some circumstances:
    - When the diagnosis is suspected, but no lesions are present (a culture or PCR assay is not indicated if no lesions are present)
    - When the diagnosis is uncertain and virologic tests (ie, culture and PCR) are negative in a symptomatic patient
    - For counseling patients regarding the risk of infection by a partner with known infection.
- Screening for other infections and more frequent screening should be considered as appropriate based on the patient's condition, risk factors, and concerns.
  - Patients under 25 years of age, and women at increased risk should also have chlamydia and gonorrhea testing.

### Patient-delivered partner therapy

Patient-delivered partner therapy (PDPT) is the practice of providing therapy to the sexual partner(s) of a person being treated for chlamydia or gonorrhea without first developing a patient-clinician relationship with the partner(s). An amendment to the [Texas Administrative Code, Chapter 22, Section 190.8](#) [Texas Secretary of State], adopted in June, 2009 by the Texas Medical Board, expressly allows PDPT. The exception created by this amendment acknowledges the serious impact of sexually transmitted diseases and the contribution of untreated partners to the reinfection of treated patients and exposure of others to infection. Providers are encouraged to implement PDPT by providing patients who are being treated for either chlamydia or gonorrhea with medications or prescriptions the partner(s) can use to be treated as well.

Providers may not receive reimbursement for providing partner treatment under this policy to persons who have not been seen as patients.

### References

American College of Obstetricians and Gynecologists. Committee Opinion No. 598: The initial reproductive health visit. *Obstet Gynecol* (2014) 123: 1143-1147. Available at [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Adolescent\\_Health\\_Care/The\\_Initial\\_Reproductive\\_Health\\_Visit](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Adolescent_Health_Care/The_Initial_Reproductive_Health_Visit)

Branson, BM., et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR* (2006) 55(RR14): 1-17. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

Centers for Disease Control and Prevention. Genital herpes. Available at <http://www.cdc.gov/std/Herpes/default.htm>

Centers for Disease Control and Prevention. Pregnant women, infants, and children: An opt-out approach to HIV screening. Available at <http://www.cdc.gov/hiv/group/gender/pregnantwomen/opt-out.html>

Centers for Disease Control and Prevention. Sexually transmitted diseases: Treatment. Available at <http://www.cdc.gov/std/treatment/default.htm>

Centers for Disease Control and Prevention. STD & HIV Screening Recommendations. Available at <http://www.cdc.gov/std/prevention/screeningreccs.htm>

Expedited partner therapy (information for patients and providers):

Centers for Disease Control and Prevention. Expedited partner therapy website. Available at <http://www.cdc.gov/std/ept/>

Texas Dept. of State Health Services. Expedited partner therapy website. Available at <http://www.dshs.state.tx.us/hivstd/ept/default.shtm>

### Healthy Lifestyle Intervention

All clients should receive a health risk survey at least annually, to determine areas where lifestyle modifications might reduce the risk of future disease and improve health outcomes and quality of life.

#### Counseling on healthy lifestyle choices

- All clients should be advised not to smoke or to use tobacco products, and to avoid exposure to second-hand smoke as much as possible. Those who use tobacco products should be advised to quit and assessed for their readiness to do so at each encounter.
- Clients should be counseled on healthy eating patterns and offered access to relevant information.
- Clients should be advised to limit their salt intake.
- Clients should be advised to engage in at least 30 minutes of physical activity or resistance training, tailored to their individual health condition and risks, at least 3 days per week, with no more than 2 consecutive inactive days. More frequent and longer duration (e.g., 60 minutes/day) activity is better.
- See the following section details on why and how to achieve some of these goals.

### Diet and Nutrition

There is strong evidence that nutrition plays an important role in our risk of disease. Dietary patterns that emphasize a lower percentage of total calories from fat, reduced amounts of saturated fats, and reduced sodium intake while achieving and maintaining a healthy body weight, have been shown to reduce the risk of cardiovascular disease, the most common cause of death in both men and women in the United States. No single diet has been shown to be the best, and providers should counsel clients on a variety of healthy eating patterns tailored to their particular health condition and cultural background, while preserving the pleasure of meals and eating.

#### Healthy Dietary Patterns

Two dietary patterns that have been shown to improve some measures of cardiovascular risk are the Dietary Approaches to Stop Hypertension (DASH) and Mediterranean (MED) diets. Both dietary patterns emphasize reduced saturated fat and red meat; and increased fiber, vegetables, fruits, fish, oils, and nuts, while allowing wide freedom of food choices to accommodate eating preferences and cultural differences among individuals.

The MED diet emphasizes

- Increased servings of fruits (particularly fresh fruits), vegetables (particularly green and root vegetables), whole grains (such as whole-grain breads, rice, pasta, and cereals), and fatty fish (which are rich in omega-3 fatty acids);
- Reduced amounts of red meat (emphasizing lean meats when meat is eaten);
- Substituting lower fat or fat-free dairy products for higher fat options; and

- Using oils (such as olive or canola), nuts (such as walnuts, almonds, or hazelnuts), or margarines containing flaxseed or rapeseed oil, in place of butter and other saturated fats.

The DASH diet is

- High in vegetables, fruits, low-fat or fat-free dairy products, whole grains, poultry, fish, legumes, and nuts; and
- Low in sweets, sugar-sweetened beverages, and red meats; and
- Lower in total fat and saturated fat than a typical American diet.

Dietary counseling on healthy eating patterns, such as those described above, provided as a routine part of a client encounter, has been shown to reduce blood pressure in those with type 2 diabetes or risk factors for cardiovascular disease, including those with mild untreated hypertension. For individuals with normal or modestly elevated cholesterol, regardless of gender or ethnicity, following a DASH dietary pattern can reduce low-density-lipoprotein cholesterol (LDL-cholesterol) and high-density-lipoprotein cholesterol (HDL-cholesterol). Following a DASH dietary pattern can reduce blood pressure in all individuals, regardless of age, gender, and ethnicity, including those with mild untreated hypertension.

### **Salt Intake**

There is strong evidence that reducing sodium (salt) intake reduces blood pressure in individuals with normal blood pressure as well as those with mild to moderate hypertension, regardless of gender, ethnicity, and age. This holds true even if no other dietary changes are made. Therefore, some individuals who consider the dietary patterns described above too drastic a change can reduce their blood pressure just by lowering their salt intake. Those who adopt a DASH dietary pattern and reduce their salt intake can lower their blood pressure even more. All clients should receive advice to limit their salt intake and counseled on ways to do so.

### **Cholesterol**

In spite of much public attention given to cholesterol in the diet as a cause of poor health, there has been very little research on the effect of reducing dietary cholesterol on the risk of future disease; therefore, no recommendation can be made to counsel clients on dietary cholesterol intake specifically.

### **Physical Activity**

Regular aerobic physical activity (e.g., walking, jogging, dancing, swimming, water-walking, gardening, climbing stairs, even house cleaning) and resistance training (e.g., working with light weights or elastic bands) can reduce the risk of serious disease by lowering LDL-cholesterol and blood pressure. Clients should be encouraged to engage in at least 30 minutes of an activity they enjoy, suitable to their current health status and risk, at least 3 times a week, with no more than two consecutive inactive days. More intensive physical activity (e.g., up to 60 minutes at a setting, more sessions per week), for those whose health status permits, offer more benefit.

**Reference**

National Heart, Lung, and Blood Institute. Lifestyle interventions to reduce cardiovascular risk: Systematic Evidence Review from the Lifestyle Work Group (2013). Available at <http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/cardiovascular-risk-reduction/lifestyle>

**Information for patients and educators**

American Heart Association. Healthy Eating. Provides information on food choices, recipes, how to eat healthy when dining out, and how to shop for groceries with a focus on healthy eating. Available at [http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/HealthyEating\\_UCM\\_001188\\_SubHomePage.jsp](http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/HealthyEating_UCM_001188_SubHomePage.jsp)

American Heart Association. Get moving! Easy tips to get active. Provides information on physical activity and fitness. Available at [http://www.heart.org/HEARTORG/HealthyLiving/PhysicalActivity/PhysicalActivity\\_UCM\\_001080\\_SubHomePage.jsp](http://www.heart.org/HEARTORG/HealthyLiving/PhysicalActivity/PhysicalActivity_UCM_001080_SubHomePage.jsp)

American Heart Association. Sodium and Salt. Provides information on ways to reduce dietary salt intake. Available at [http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/Sodium-and-Salt\\_UCM\\_303290\\_Article.jsp#.VtcjvPkrKM8](http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/Sodium-and-Salt_UCM_303290_Article.jsp#.VtcjvPkrKM8)

Mayo Clinic. Healthy diets. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/basics/healthy-diets/hlv-20049477>

Mayo Clinic. DASH diet: Healthy eating to lower your blood pressure. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/dash-diet/art-20048456>

Mayo Clinic. DASH diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/recipes/dash-diet-recipes/rcs-20077146>

Mayo Clinic. Mediterranean diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/mediterranean-diet-recipes/art-20046682>

## Diabetes Mellitus Screening, Prevention, and Treatment

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Healthy Texas Women Program, and do not include guideline recommendations for patients outside this eligibility range.

### Who should be screened for diabetes

The screening criteria below apply to nonpregnant patients only.

1. Screen adults < 45 years of age who are overweight or obese (BMI  $\geq$  25 kg/m<sup>2</sup> [BMI  $\geq$  23 kg/m<sup>2</sup> for Asian Americans]) with 1 or more risk factor. An [adult BMI calculator](#) is available from the Centers for Disease Control and Prevention (CDC).
2. Screen overweight or obese children or adolescents (19 years of age or younger) with 2 or more additional risk factors. To determine whether the client is overweight or obese, see the CDC web page [Defining Childhood Obesity](#) and the [child and teen BMI Calculator](#) provided by the CDC.
3. If test results are normal, retest at least every 3 years. Consider more frequent testing in patients with risk factors.
4. \*Patients with prediabetes (IFG or IGT) should be retested every year.
  - IFG and IGT refer to laboratory values that are above the normal range but do not meet the diagnostic criteria for diabetes.
  - Persons with these results are said to have “prediabetes.”
5. All women with a diagnosis of gestational diabetes in a recent pregnancy should have diabetes screening with a 2-hour oral glucose tolerance test at 6-12 weeks postpartum, regardless of other risk factors.
6. All women with any history of gestational diabetes should have testing for diabetes and prediabetes at least every 3 years, regardless of other risk factors.

### Risk factors for diabetes

- High-risk race or ethnicity (e.g., Latino, African American, Asian American, Native American, Pacific Islander)
- Diabetes in a first-degree relative
- Physical inactivity
- Women who ever had gestational diabetes or delivered a baby weighing > 9 pounds.
- \*History of prediabetes: hemoglobin A1C > 5.7% (39 mmol/mol), impaired fasting glucose (IFG), or impaired glucose tolerance (IGT) in previous testing
- HDL cholesterol < 35 mg/dL (0.90 mmol/L) and/or serum triglyceride level > 250 mg/dL (2.82 mmol/L)

- A history of polycystic ovary syndrome
- A diagnosis of hypertension
- A history of cardiovascular disease
- Any other condition in which insulin resistance is common, such as severe obesity or acanthosis nigricans

**Diagnostic criteria**

Any one or more of the following results, confirmed on repeat testing, meets the criteria for a diagnosis of diabetes (repeat testing for confirmation is not required in the presence of unequivocal clinical hyperglycemia):

1. Fasting plasma glucose (after no caloric intake for a minimum of 8 hours)  $\geq 126$  mg/dL (7.0 mmol/L)
2. Oral glucose tolerance test (OGTT) with a 2-hour postprandial glucose level  $\geq 200$  mg/dL (11.1. mmol/L) following a 75-g glucose load
3. Hemoglobin A1C  $\geq 6.5\%$  (48 mmol/mol) (For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred.)
4. Random plasma glucose  $\geq 200$  mg/dL (11.1. mmol/L) in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia (Confirmation by repeat testing is not required in this setting.)

The following table summarizes the diagnostic criteria for diabetes mellitus.

Test	Criteria to Diagnose Diabetes Mellitus	Comments
<b>Fasting plasma glucose</b>	> 126 mg/dL (7.0 mmol/L)	After no caloric intake for a minimum of 8 hours
<b>Oral glucose tolerance test (with a 75-g glucose load)</b>	2-hour glucose > 200 mg/dL (11.1. mmol/L)	
<b>Hemoglobin A1C</b>	> 6.5% (48 mmol/mol)	For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred
<b>Random plasma glucose</b>	> 200 mg/dL (11.1. mmol/L)	If this occurs in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia, confirmation by repeat testing is not required

**Table.** Diagnostic criteria for diabetes. Unless stated otherwise, all initial results should be confirmed with repeat testing.

### Treatment considerations

A thorough review of the management of Type 1 and Type 2 diabetes mellitus is beyond the scope of this policy manual. The reader is referred to the references at the end of this section and relevant textbooks for a more detailed discussion.

Diabetes care should be patient-centered, team-oriented, and individualized, and should take the patient's social and cultural background and preferences into account. The foundations of diabetes care include

- Diabetes self-management education (DSME), diabetes self-management support (DSMS), medical nutrition therapy (MNT), and physical activity
- Tobacco use cessation as indicated
- Immunizations
- Psychosocial care

- Medications as needed

### **Evaluation of the Diabetic Patient**

A comprehensive evaluation of the patient with diabetes should include a thorough medical and psychosocial history, updated as appropriate at periodic intervals and when changes occur in the patient's health.

A comprehensive physical examination should include all of the following items:

- Height, weight, and BMI
- For children and adolescent patients, evaluation of growth and pubertal development
- BP measurement
- Fundoscopic examination
- Palpation of the thyroid
- Examination of the skin
- Foot examination
  - Inspection
  - Posterior tibial and dorsalis pedis pulses
  - Patellar and Achilles reflexes
  - Assessment of proprioception, monofilament sensation, and vibration

Laboratory evaluation at the time of comprehensive workup should include:

- Hemoglobin A1C if not done in the previous 3 months
- Annual fasting lipid profile, liver function tests, and spot urinary albumin-to-creatinine ratio
- Annual serum creatinine with estimation of glomerular filtration rate
- Annual thyroid-stimulating hormone for patients with dyslipidemia or Type 1 diabetes

### **Diabetes self-management education (DSME) and support (DSMS)**

DSME and DSMS are essential components of diabetes care. All patients with diabetes should receive DSME aimed at developing and maintaining the knowledge and skills necessary for optimal self-care and self-management. Four critical time points for delivery of DSME and DSMS have been identified:

1. At the time of initial diagnosis of diabetes
2. Annually for the reassessment of education, nutrition, and emotional needs
3. At the time of changes in the patient's condition that influence self-management
4. Whenever a transition of care occurs

### **Medical Nutrition Therapy**

All patients with diabetes should receive individualized medical nutrition therapy (MNT), developed in a collaborative process involving the patient and the healthcare team, preferably guided by a registered dietitian, and tailored to the individual's needs, preferences, and cultural background. MNT should promote healthy eating habits, preserve the enjoyment of food, and provide the practical tools necessary to maintain a healthy eating pattern throughout life.

Nutrition counselors and educators should become aware of, and take into account, issues that may influence or impair a particular individual's ability to understand or comply with MNT, such as food insecurity, low educational level, poor literacy (and/or poor numeracy – inability to work with numbers), and homelessness. Where needs are identified, clients should be referred to appropriate resources in the community for assistance.

For individuals who are overweight or obese, modest weight loss (sustained loss of 5-7% of body weight) may improve blood glucose control and reduce the need for medication in those with type 2 diabetes, and may delay the progression to type 2 diabetes in those with prediabetes.

### **Physical Activity**

Regular exercise has been shown to improve blood glucose control, support weight loss, reduce the risk of cardiovascular disease, and improve well-being in persons with diabetes. Furthermore, it may help to prevent or delay the development of type 2 diabetes in individuals at high risk. All individuals with diabetes should be advised to engage in at least 150 minutes/week of moderate-intensity physical activity, divided over at least 3 days each week, with no more than 2 consecutive days without exercise. If no contraindications exist, those with type 2 diabetes should engage in resistance training (e. g., working with light hand or leg weights) at least twice weekly.

### **Tobacco Use Cessation**

All patients should have a thorough assessment of tobacco use and exposure, including the use of cigarettes, other tobacco products, and e-cigarettes, and exposure to second-hand smoke, updated at periodic intervals. Users should be assessed regularly for their readiness to quit and receive cessation counseling and information on other forms of cessation treatment.

### **Immunization**

- Persons with diabetes should receive routine vaccinations based on age-related recommendations for the general population, including but not limited to influenza and pneumococcal vaccines.
- In addition, unvaccinated adults 19-44 years of age with diabetes should receive the hepatitis B vaccine.

### Psychosocial Issues

Because psychosocial issues can substantially impair a person's ability to optimally self-manage diabetes and adversely affect outcomes, providers should routinely address each person's psychological and social situation, including such things as

- Attitudes toward diabetes and expectations of treatment and outcomes
- Quality of life, both general and diabetes-related
- Availability of resources (financial, logistical, social, and emotional)
- Psychiatric history

Patients should receive periodic routine screening for psychosocial problems such as depression, diabetes-related distress, anxiety, eating disorders, and cognitive impairment. A team approach to care is encouraged, with consideration of referral to a mental health specialist as indicated.

### Glucose Monitoring and Glycemic Targets

Self-monitoring of blood glucose (SMBG) is appropriate for some patients, especially those on intensive insulin therapy (multiple-dose or insulin pump), and may be useful in patients on less intensive insulin therapy and non-insulin therapies, to help guide treatment. For patients with type 2 diabetes on non-insulin regimens, SMBG may not be clinically beneficial or cost-effective, and the decision should be individualized based on whether the information obtained will influence patient management. A detailed review of SMBG and its use in management of diabetes is out of scope for this clinical policy manual. The reader is referred to the [Standards of medical care in diabetes](#) by the American Diabetes Association (see Reference section below) for a more detailed discussion.

All patients with diabetes should undergo periodic testing of hemoglobin A1C according to the following schedule:

- At least twice a year in patients who are meeting their treatment goals
- Quarterly in patients whose therapy has recently changed or who have not been meeting their glycemic goals
- More frequent testing should be considered based on individual criteria.

Targets for hemoglobin A1C should be individualized according to the patient's circumstances:

- For most nonpregnant adults, a target value < 7% (53 mmol/mol) is reasonable.
- A more stringent goal (< 6.5% [48 mmol/mol]) may be reasonable for some patients (e.g., diabetes of short duration, type 2 diabetes controlled by lifestyle or metformin alone, absence of significant cardiovascular disease, or long life expectancy) if it can be achieved without substantial hypoglycemia or other adverse effects.
- A less stringent goal (< 8% [64 mmol/mol]) may be appropriate for patients with a history of severe hypoglycemia, advanced micro- or macrovascular complications, limited life expectancy, extensive comorbid conditions, or long-standing diabetes where

the more stringent target has proven difficult to achieve despite optimal management efforts.

### Hypoglycemia

A thorough review of the treatment and prevention of hypoglycemia in diabetic patients is out of scope for this clinical policy manual. The reader is referred to the [Standards of medical care in diabetes](#) by the American Diabetes Association (see Reference section below) for a more detailed discussion.

All patients should be evaluated for their risk of hypoglycemia, and questioned for any history of hypoglycemic episodes, severe hypoglycemia, and hypoglycemia unawareness. Patients with increased risk or a positive history of hypoglycemia may benefit from SMBG to guide treatment so as to reduce hypoglycemia risk. Patients should be counseled on situations of increased risk (e.g., fasting for laboratory tests or procedures, during or after intense exercise, while sleeping, when unable to eat normally due to illness, or with changes in diet as with calorie restriction for weight loss). They should be advised on measures to take, such as ingesting glucose-containing foods, when they experience or suspect hypoglycemia.

Consideration should be given to referral of patients at increased risk of hypoglycemia to a diabetes specialist for their care.

### Management of Obesity in Prediabetes and Type 2 Diabetes

There is clear evidence that management of obesity can delay the progression to type 2 diabetes in individuals with prediabetes, and can be beneficial in persons with type 2 diabetes.

Sustained weight loss can be achieved with dietary calorie restriction and regular moderate-intensity physical activity, and requires the commitment of the patient and the support and encouragement of the healthcare team. Patient education is an essential element of a program aimed at bringing about the lifestyle changes necessary to achieve and maintain a healthier body weight.

Following is a list of recommended practices for providers who care for patients with type 2 diabetes to promote weight management:

- Calculate BMI at each patient encounter and document in the medical record. A [BMI calculator](#) is available from the Centers for Disease Control and Prevention.
- Determine if the person is overweight or obese (these are values for non-Asian Americans):
  - BMI < 18.5 kg/m<sup>2</sup>: Underweight
  - BMI 18.5 – 24.9 kg/m<sup>2</sup>: Normal
  - BMI 25.0 – 29.9 kg/m<sup>2</sup>: Overweight
  - BMI ≥ 30.0 kg/m<sup>2</sup>: Obese

- Use the following criteria to assess overweight and obesity for Asian Americans:
  - BMI < 23 kg/m<sup>2</sup>: Normal
  - BMI 23.0 – 27.4 kg/m<sup>2</sup>: Overweight
  - BMI 27.5 – 37.4 kg/m<sup>2</sup>: Obese
  - BMI ≥ 37.5 kg/m<sup>2</sup>: Extremely Obese
- Prescribe interventions aimed at achieving a 5% weight reduction in patients who are overweight or obese; and evaluate and document the person’s readiness to lose weight.
- During the early phase of a weight-loss program, weight loss interventions (eg, group education sessions, interaction with provider, etc.) should occur at least 16 times over a 6 month period and focus on diet, physical activity, and behavioral strategies designed to achieve a daily energy deficit of 500-750 kilocalories. This high frequency of interventions in the early phase of the program is important for providing patient support for early compliance and program success. Diets should provide approximately 1,200-1,500 kcal/day for women or 1,500-1,800 kcal/day for men.
- If weight loss is achieved over the short term, prescribe a longer term weight maintenance program that includes continuation of a reduced calorie diet, at least monthly contact with the provider, monitoring of body weight at least weekly, and 200-300 minutes of physical activity every week.
- Diets that differ in the distribution of carbohydrate, fat, and protein are equally effective in achieving weight loss as long as the total calorie consumption is the same.
- Frequent contact between the patient and the care team is important for patient engagement and the success of a sustained weight loss program. Providers are encouraged to develop creative local patient education and engagement programs that make use of group sessions, resources available in the community, and patient and educator resources available from organizations like the American Diabetes Association and the National Diabetes Education Initiative (see links below in the “Resources for patients and educators” section). Frequent interventions (2-3 times per week) are particularly helpful in the beginning, while the patient is learning new lifestyle habits and is receptive to change. As initial success with weight loss is achieved, less frequent intervention (monthly) is needed to reinforce healthy habits and learning.

### Medical Therapy

Note: A thorough treatment of the pharmaceutical management of type 1 and type 2 diabetes is out of scope for this manual. The reader is referred to the [Standards of medical care in diabetes](#) by the American Diabetes Association and relevant textbooks for further information. For patients with multiple comorbid conditions, those who present with marked symptomatology or markedly elevated laboratory values, those who fail initial therapy, and those whose diabetes proves difficult to manage, consideration may be given to referring the patient to a specialist in the treatment of diabetes.

**Type 1 diabetes**

Most persons with type 1 diabetes will require multiple-dose insulin injections or continuous subcutaneous insulin infusion. The reader is referred to the [Standards of medical care in diabetes](#) by the American Diabetes Association and relevant textbooks for further information. Consideration may be given to referring the patient to a specialist in the treatment of diabetes.

**Type 2 diabetes**

- For most individuals with type 2 diabetes who require pharmaceutical therapy, metformin is the preferred initial agent if no contraindications exist.
- Consider insulin therapy (with or without other agents) for patients who are very symptomatic and/or demonstrate markedly elevated glucose or hemoglobin A1c levels at the time of diagnosis.
- For patients who do not achieve or maintain target hemoglobin A1c values after 3 months of noninsulin single-drug therapy at the maximum tolerated dose, add a second oral agent or basal insulin.
- If glycemic goals cannot be achieved on oral agents, insulin therapy should not be delayed.
- Apply a patient-centered approach to selection of pharmaceutical therapy, taking into consideration such things as efficacy, side effects, cost, and patient considerations such as weight, comorbidities, risk of hypoglycemia, and personal preferences.

For a more detailed discussion of pharmaceutical therapy in patients with type 2 diabetes, the reader is referred to the section “Approaches to Glycemic Treatment” in the [Standards of medical care in diabetes](#) by the American Diabetes Association and relevant textbooks.

**References**

American College of Obstetricians and Gynecologists (2013). Practice Bulletin No. 137: Gestational diabetes mellitus. *Obstet Gynecol.* 122 406-416.

American Diabetes Association. Standards of medical care in diabetes – 2016. *Diabetes Care* (2016); 39(Suppl. 1). Available at <http://care.diabetesjournals.org/site/misc/2016-Standards-of-Care.pdf>

**Resources for patients and educators**

American Diabetes Association home page: <http://www.diabetes.org>

American Diabetes Association DiabetesPro website (information for providers of care) <http://professional.diabetes.org>

American Diabetes Association Diabetes Educators (information and resources for both patients and educators) <http://professional.diabetes.org/diabetes-education>

Centers for Disease Control and Prevention. Adult BMI calculator. Available at [http://www.cdc.gov/healthyweight/assessing/bmi/adult\\_bmi/english\\_bmi\\_calculator/bmi\\_calculator.html](http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html)

Centers for Disease Control and Prevention. BMI calculator for child and teen. Available at <http://nccd.cdc.gov/dnpabmi/Calculator.aspx>

Centers for Disease Control and Prevention. Defining childhood obesity web page (provides definition of overweight and obesity in children and adolescents 2 to 19 years of age, and link to BMI calculator for children and teens) Available at <http://www.cdc.gov/obesity/childhood/defining.html>

National Diabetes Education Initiative (patient education handouts and links to professional resources): <http://www.ndei.org>

National Institute of Diabetes and Digestive Diseases. National Diabetes Education Program (resources for patients and educators). Available at <http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/pages/index.aspx>

National Heart, Lung, and Blood Institute Aim for a Healthy Weight website: [https://www.nhlbi.nih.gov/health/educational/lose\\_wt](https://www.nhlbi.nih.gov/health/educational/lose_wt)

### Hypertension Screening and Treatment

This section is intended to serve as a guide for the diagnosis and management of hypertension by primary care providers. A detailed treatment of the management of hypertension, particularly in patients with multiple coexisting health conditions and those whose blood pressure is difficult to control, is out of scope for this clinical policy manual. Readers are referred to the References and Resources for Providers sections below as well as relevant textbooks for a more thorough discussion of the topic. Providers are encouraged to seek consultation from a specialist in the relevant area of medicine for management of complex patients and those whose blood pressure is difficult to control.

All clients, including those with hypertension, should be advised to adhere to a healthy lifestyle as described in the Healthy Lifestyle Intervention section of this clinical policy manual.

#### **Blood pressure thresholds for initiating treatment of hypertension in adults:**

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Healthy Texas Women program and do not reflect guideline recommendations for patients outside this eligibility range.

- All clients should undergo blood pressure assessment at least annually. Patients being treated for hypertension should be evaluated at least twice yearly, and more often if blood pressure is not adequately controlled or when changes are made to the treatment regimen.
- At all patient encounters, providers should reinforce the importance of adherence to healthy lifestyle habits and the hypertensive medication regimen.
- For patients who are < 60 years of age:
  - Start pharmacologic therapy to reduce blood pressure for systolic blood pressure  $\geq 140$  mm Hg or diastolic blood pressure  $\geq 90$  mm Hg.
  - Treat to a target systolic blood pressure < 140 mm Hg and target diastolic blood pressure < 90 mm Hg.
- For all patients 18 years of age or older with chronic kidney disease or diabetes:
  - Start pharmacologic therapy to reduce blood pressure for systolic blood pressure  $\geq 140$  mm Hg or diastolic blood pressure  $\geq 90$  mm Hg.
  - Treat to a target systolic blood pressure < 140 mm Hg and target diastolic blood pressure < 90 mm Hg.

Patient Population	BP Threshold to Start Therapy	Blood Pressure Target Values
< 60 years of age	SBP $\geq$ 140 DBP $\geq$ 90	SBP < 140 DBP < 90
18 years or older with chronic kidney disease or diabetes	SBP $\geq$ 140 DBP $\geq$ 90	SBP < 140 DBP < 90

**Table.** Thresholds for treatment initiation and target blood pressures.

### Pharmacologic Management

- For the general non-Black/African American population of patients, including those with diabetes, initial drug therapy should include a thiazide-type diuretic, a calcium-channel blocker, an angiotensin-converting enzyme inhibitor, or an angiotensin receptor blocker.
- For the general Black/African American population of patients, including those with diabetes, initial drug therapy should include a thiazide-type diuretic or a calcium-channel blocker.
- For patients 18 years of age and older with chronic kidney disease, including those with diabetes and regardless of ethnicity, initial antihypertensive treatment should include an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker to improve kidney outcomes. If the patient is already being treated with another antihypertensive agent, an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker should be added to the regimen.
- Three strategies for initial dosing of antihypertensive medications have been described (there is insufficient evidence to recommend one strategy over any other):
  - Start with a single drug and titrate the dose to achieve the target blood pressure. If the goal is not achieved at the maximum dose for that drug, add a second drug.
  - Start with a single drug and then add a second drug (if target blood pressure not achieved) before maximizing the dose of the first drug.
  - Initiate therapy with 2 drugs, either as separate pills or as a combination pill.
- The primary objective of treatment is to achieve and maintain the target blood pressure.
  - If the patient has not reached the blood pressure goal after a month of treatment, either increase the dose of the initial drug or add a second drug from the list of choices (i.e., calcium channel blocker, thiazide-type diuretic, angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker). Continue to monitor the blood pressure and adjust the regimen until the goal is reached.
  - If the blood pressure goal cannot be achieved with two drugs, add a third drug from the list and titrate to achieve the goal.
  - Do not use both an angiotensin receptor blocker and an angiotensin-converting enzyme inhibitor together in the same patient.
  - If goal blood pressure cannot be achieved with 3 drugs or because the patient has a contraindication to one or more of the listed drug classes, antihypertensive drugs from

other classes may be used.

- If a patient whose blood pressure was previously controlled begins to have blood pressure above the target, reenter the treatment algorithm above at the point where pressure was previously controlled.
- Consultation from or referral to a hypertension specialist should be considered for patients whose blood pressure cannot be controlled with the foregoing strategy or whose medical condition is otherwise more complicated.

### References

James, PA, et al. 2014 Evidence-based guideline for the management of high blood pressure in adults: Report from the panel members appointed to the eighth joint national committee (JNC 8). *JAMA* (2014); 311(5): 507-520. Available at <http://jama.jamanetwork.com/article.aspx?articleid=1791497> (web) <http://jama.jamanetwork.com/article.aspx?articleid=1791497> (PDF)

AFP Editors. JNC 8 Guidelines for the management of hypertension in Adults. *Am Fam Physician* (2014); 90(7): 503-504. Available at <http://www.aafp.org/afp/2014/1001/p503.html>

### Resources for patients and educators

American Heart Association. High blood pressure. Provides information on the meaning and importance of high blood pressure, risks for and prevention of high blood pressure, blood pressure monitoring, and treatment of high blood pressure. Available at [http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure\\_UCM\\_002020\\_SubHomePage.jsp](http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure_UCM_002020_SubHomePage.jsp)

National Heart, Lung, and Blood Institute. Description of high blood pressure. Provides a plain-language discussion of the prevention, diagnosis, and treatment of high blood pressure. Available at <http://www.nhlbi.nih.gov/health/health-topics/topics/hbp>

### Resources for providers

American Society of Hypertension. Hypertension Guidelines website: <http://www.ash-us.org/About-Hypertension/Hypertension-Guidelines.aspx>

### High Cholesterol Screening and Treatment

Note that the summary of cited guideline recommendations provided in this section address only women and reflect the ages of eligibility for the Healthy Texas Women program, and do not include guideline recommendations for men or for women outside this eligibility range.

The diagnosis and treatment of elevated blood cholesterol is a complex subject and a complete discussion is beyond the scope of this clinical policy manual. For more information, providers are referred to the reference section below and relevant textbooks.

#### Rationale for cholesterol screening

Evidence shows that a healthy lifestyle (following a heart healthy diet, maintaining a healthy weight, regular exercise, and avoidance of tobacco products) reduces the risk of cardiovascular disease. In certain persons with specific risk factors, cholesterol-lowering medications (ie, statins) can further reduce the risk of an adverse health event. Measurement of blood cholesterol is a component of the individual risk assessment in some patients.

#### Who should be screened for high cholesterol

- Women 20 years of age and older with increased risk for coronary heart disease (CHD)
- No recommendation is made regarding routine screening in women 20 years of age or older without increased risk of CHD

#### Risk Factors

Increased risk of CHD is defined by the presence of any 1 of the risk factors below. Greater risk results from the presence of multiple risk factors.

- Diabetes
- Personal history of previous CHD or non-coronary atherosclerosis
- Family history of cardiovascular disease in men before age 50 and in women before age 60
- Tobacco Use
- Hypertension
- Obesity (body mass index  $\geq 30$  kg/m<sup>2</sup>)

#### Screening Frequency

The optimal interval for screening is uncertain. Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.

### Screening Method

The preferred screening test for elevated cholesterol is the serum lipid panel (total cholesterol, high-density lipoprotein [HDL] cholesterol, and low-density lipoprotein [LDL] cholesterol) in the fasting or non-fasting state. If non-fasting results are used, only the total cholesterol and HDL-cholesterol are reliable. Abnormal screening results should be confirmed by a repeat sample on a separate occasion, and the average of both results should be used for risk assessment.

### Evaluation of Screening Results

Results of the lipid profile should be interpreted in the context of the individual's risk factors and 10-year estimated risk of atherosclerotic cardiovascular disease (ASCVD; defined as acute coronary syndrome, myocardial infarction, stable or unstable angina, stroke, transient ischemic attack, coronary or other arterial revascularization procedure, or atherosclerotic peripheral arterial disease). A [risk calculator](#) for 10-year ASCVD risk is available from the American College of Cardiology and American Heart Association.

Studies have shown a benefit of statin therapy in patients with the following risk profiles:

- All patients with clinical ASCVD, regardless of lipid profile results
- Any patient with LDL-cholesterol  $\geq$  190 mg/dL
- Patients 40-75 years of age with diabetes and LDL-cholesterol  $\geq$  70-189 mg/dL and no clinical ASCVD
- Patients 40-75 years of age with diabetes and LDL-cholesterol 70-189 mg/dL and no clinical ASCVD
- Patients of any age without diabetes or clinical ASCVD, with LDL-cholesterol 70-189 mg/dL and 10-year ASCVD risk  $\geq$  7.5%

### Treatment Considerations

Consider statin therapy for patients whose risk profile and screening results suggest a possible benefit as described above. See the References section below for links to guidelines for treatment of cholesterol to reduce cardiovascular risk.

### References

Stone NJ, et al. 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *Circulation* (2014). 129(25 Suppl 2): S1-S45 Available at <https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a>

National Heart, Lung, and Blood Institute. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Cholesterol in Adults (Adult Treatment Panel III). NIH Publication No. 01-3670, May 2001. Available at <http://www.nhlbi.nih.gov/files/docs/guidelines/atp3xsum.pdf>

U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services, “Lipid Disorders in Adults” (2014). Page 45. Available at <http://www.ahrq.gov/sites/default/files/publications/files/cpsguide.pdf>

**Further reading**

Pursnani A, et al. Guideline-based statin eligibility, coronary artery calcification, and cardiovascular events. *JAMA* (2015) 314:134-141 Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4754085/>

**Resources for providers**

ASCVD Risk Estimator from the American College of Cardiology. Provides an estimate of the 10-year risk of developing ASCVD. Available at <http://tools.acc.org/ASCVD-Risk-Estimator/>

## Postpartum Depression Screening and Treatment

### Prevalence and risk factors for postpartum depression

As many as 80% of new mothers experience a brief episode of the “baby blues” which may last up to about 2 weeks. Approximately 5-25% of new mothers will experience postpartum depression that warrants intervention. It typically begins in the first 4 to 6 weeks after birth of the infant, but may develop any time in the first year. Risk factors for postpartum depression include all of the following:

- Lack of social support
- Symptoms of depression (especially in the third trimester) or anxiety during the pregnancy
- Prior psychiatric illness or poor mental health, especially prior postpartum depression
- Family history of depression, anxiety, or bipolar disorder
- Low socio-economic status or low educational level
- Poor income or unemployment
- Poor relationship with the partner or father of the baby
- A negative attitude toward the pregnancy
- A recent stressful life event or perceived stress
- Intention to return to work
- A history of bothersome premenstrual syndrome
- A history of physical, sexual, or psychological abuse; domestic violence
- Stress related to child care issues
- Medical illness or prematurity in the infant
- A temperamentally difficult infant
- Immigrant from another country

Common signs and symptoms of postpartum depression include the following (note that some or none of these symptoms may be apparent):

- Difficulty sleeping even when the baby is sleeping
- Tearfulness, prone to crying
- Excessive worrying about the baby
- Excessive anxiety
- Feelings of guilt, such as the feeling that she is not a good mother
- Flat affect
- Poor appetite

### Screening for postpartum depression

Because postpartum depression can be a serious, and sometimes life-threatening condition, all new mothers must have screening for postpartum depression at the postpartum visit. For those who screen negative, repeat screening should be considered at a later visit or when the mother takes her baby in for a checkup.

A standardized self-administered screening tool with review and follow-up questions in a face-to-face interview with the provider will ensure consistency and efficiency in the screening process. The following postpartum depression screening tools are available on-line, and have been validated for use in postpartum patients:

- [Edinburgh Postnatal Depression Scale](#) (EPDS; Cox, Holden, & Sagovsky, 1987)
- [Patient Health Questionnaire-9](#) (PHQ-9; Spitzer, Kroenke, & Williams, 1999)
- [Postpartum Depression Screening Scale](#) (PDSS; Beck & Gable, 2001)

To ensure that all patients are screened without undue interruption of clinic workflow, a convenient approach to screening is the following:

- Give each postpartum patient a screening tool to complete while she waits for her visit with the provider.
- Score the tool and assess whether the screen is positive or negative:
  - EPDS: A score of 10 or more suggests depressive symptoms, a score of 13 or more indicates a high likelihood of major depression; a score of 1 or more on question #10 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
  - PHQ-9: A score of 10 or more indicates a high risk of having or developing depression; a score of 2 or more on question #9 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
  - PDSS Full form: A score of 60 or more suggests depressive symptoms, a score of 81 or more indicates a high likelihood of major depression; a score of 6 or more on the SUI (suicidal thoughts) subscale is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
  - PDSS Short form: A score of 14 or more indicates a high risk of major depression; a score of 2 or more on question #7 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
- The provider should review the screen and discuss it with the woman and ask follow-up questions to evaluate her risk of postpartum depression.

### **Screening for suicide risk**

Any patient with a positive screen based on responses to questions related to suicide risk, and any patient who expresses suicidal thoughts or ideation must be evaluated immediately for suicide risk. If the patient is felt to be acutely at risk of suicide, she must be referred for emergent evaluation and/or hospitalization as indicated.

### Nonpharmacologic treatment

Milder degrees of postpartum depression may respond well to cognitive behavioral interventions (eg, stress management, problem solving, goal setting), provided in individual or group settings. The provider might work with the patient to develop a [Postpartum Depression Action Plan](#) and see her again in a week to assess response to the intervention. Response can be assessed by repeating the screening tool to see if the score improves over time. If no improvement is seen, or if symptoms worsen, consideration should be given to initiating pharmaceutical therapy.

### Pharmacologic treatment

For patients with more severe symptoms and those who do not respond to nonpharmacologic therapy, selective serotonin reuptake inhibitors are commonly used to treat postpartum depression. There is no evidence that one agent is superior to any other. If the patient has taken an antidepressant in the past with good result, that agent would be a logical choice to initiate therapy.

It is generally prudent to start with a low dose and increase as needed, since the side effects of antidepressants can be a barrier to compliance, and because the lowest effective dose is preferred in the breastfeeding mother. The response to treatment can be assessed by repeating the screening tool used to diagnose postpartum depression. When remission of symptoms is achieved, treatment is generally continued for a period of time (eg, 6 to 9 months) and then discontinued. To minimize the side effects of suddenly discontinuing therapy, the dose can be tapered over a period of two weeks.

### Referral for additional treatment

Patients in need of more intensive treatment for postpartum depression should be referred to a provider of behavioral health services. Providers must have arrangements in place for appropriate referral of patients to behavioral health providers in their area. For information on local behavioral health care providers, refer to the website of the [Office of Mental Health Coordination](#) of the Texas Health and Human Services Commission, or call 211.

### References

- American College of Obstetricians and Gynecologists Committee Opinion no. 630. Screening for perinatal depression. *Obstet Gynecol* (2015). 125: 1268-1271. Available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>
- Hirst KP and Moutier CY. Postpartum major depression. *American Family Physician* (2010). 82: 926-933. Available at <http://www.aafp.org/afp/2010/1015/p926.html>
- Norhayati MN, et al. Magnitude and risk factors for postpartum symptoms: A literature review. *J Affect Disord* (2015). 175: 34-52.

O'Connor E, et al. Primary care screening for and treatment of depression in pregnant and postpartum women: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA* (2016). 315: 388-406.

Treece, CA. An overview of postpartum mood disorders (Conference presentation). Presented at Texas Department of State Health Services Grand Rounds: Postpartum Depression Screening and Management, March 30, 2016.

### **Resources for patients and providers**

American Academy of Family Physicians. Postpartum Depression web page. Information for patients and providers on postpartum depression. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.html>

American Academy of Family Physicians. Postpartum Depression Action Plan. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression/treatment/postpartum-depression-action-plan.html>

American Psychological Association. Postpartum Depression web page. Includes patient education brochures in English, Spanish, French, and Chinese as well as links to resources on postpartum depression for new mothers and new fathers. Available at <http://www.apa.org/pi/women/resources/reports/postpartum-dep.aspx>

Office of Mental Health Coordination website, Texas Health and Human Services Commission. Provides links to information for providers and patients in Texas on a variety of behavioral health topics, and a link to the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment services locator. Available at <http://mentalhealthtx.org/>

## PROGRAM PROMOTION AND OUTREACH

Contractors must develop and implement an annual plan to provide community education and program promotion to:

- inform the public of the purpose of the program and available services,
- enhance community understanding of its objectives,
- disseminate basic family planning and women's health care knowledge,
- enlist community support, and
- recruit potential clients for HTW.

The plan should be based on an assessment of the needs of the community and contain an evaluation strategy. Contractors should consider a variety of program promotion and client outreach strategies in accordance with organizational capacity, availability of existing resources and materials, and the needs and culture of the local community. In order to gauge the efficacy of program promotion and client outreach activities, contractors must:

- develop an annual women's health program promotion and client outreach plan that includes outreach/promotion activities for the year,
- regularly monitor plan implementation,
- evaluate the plan on an annual basis, and
- modify program promotion and outreach activities, as needed.

**Contractors must submit a one-page Healthy Texas Women Promotion Plan for the contract period within forty-five (45) days of the contract start date.** The plan should describe the agency's outreach and marketing strategy, and include a description of planned activities to reach potential Healthy Texas Women clients. Contractors must submit a Healthy Texas Women Promotion/Outreach Annual Report (found in Appendix C) to: [womenshealth@hhsc.state.tx.us](mailto:womenshealth@hhsc.state.tx.us)

# **Section III**

## **Reimbursement, Data Collection and Reporting**

**Purpose:** Section III provides policy requirements for submitting reimbursement, data collection and required reports

**Provider Reimbursement Criteria**

In order to be reimbursed for HTW, the following eligibility requirements must be met:

- Must be a Medicaid (Title XIX) provider in accordance with [1 TAC Chapter 352](#).
- Must have completed the HTW certification process through the TMHP portal attesting that they do not perform or promote elective abortions and are not affiliated with an entity that performs or promotes elective abortions.

Providers can complete the certification in one of the following ways:

- Existing Medicaid providers can complete the certification process through their TMHP portal account.
- Providers that are not already enrolled in Texas Medicaid can complete the HTW certification process as part of the provider enrollment process or as part of the paper Texas Medicaid Provider Enrollment Application.
- Annual recertification is required for all HTW providers.

Providers must not perform or promote elective abortions outside the scope of HTW and must not be an affiliate of an entity that performs or promotes elective abortions. In offering or performing an HTW service, the respondent must not promote elective abortion within the scope of HTW and must maintain physical and financial separation between its HTW activities and any elective abortion-performing or abortion-promoting activity, as evidenced by the following:

- Physical separation of HTW services from any elective abortion activities, no matter what entity is responsible for the activities
- A governing board or other body that controls the HTW health care provider has no board members who are also members of the governing board of an entity that performs or promotes elective abortions
- Accounting records that confirm that none of the funds used to pay for HTW services directly or indirectly support the performance or promotion of elective abortions by an affiliate
- Display of signs and other media that identify HTW and the absence of signs or materials promoting elective abortion in the provider's location or in the provider's public electronic communications
- Does not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

The term "promote" used here means advancing, furthering, advocating, or popularizing elective abortion by, for example:

- Taking affirmative action to secure elective abortion services for an HTW client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging

or scheduling an elective abortion procedure); however, the term does not include providing upon the patient's request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider

- Furnishing or displaying to an HTW client information that publicizes or advertises an elective abortion service or provider
- Using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

\* When enrolling as a Title XIX provider, Clinical Laboratory Improvement Amendments (CLIA) information must be provided. For public health agencies that provide limited numbers of tests, one CLIA certificate is all that is required for all clinics.

Failure to comply with these requirements will result in contract termination.

### **Provider Identifiers**

When a contractor's Medicaid application is approved, TMHP assigns the contractor a nine-digit Texas Provider Identifier (TPI). **Contractors must have a unique TPI for each clinical service site.**

Contractors must submit claims to TMHP using the billing TPI where clinical services are rendered. Contractors must not provide women's health and family planning services at one clinic site and bill those services to TMHP using the TPI of a different clinic site. If an additional TPI clinic site is required, providers must contact TMHP and complete the enrollment process.

The TPI is used in conjunction with a National Provider Identifier (NPI) to identify the provider for claims processing. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Numeration System (NPPES). Contractors may apply for a NPI at the [NPPES](#) website.

When a provider obtains their NPI they are required to attest to NPI data for each of their current TPI. For more information on NPI and the attestation process please visit the [TMHP](#) website.

### **Texas Medicaid Provider & Procedures Manual**

The *Texas Medicaid Provider & Procedure Manual* (TMPPM) includes information related to HHSC HTW Fee-for-Service program claims submission. In addition, Medicaid bulletins and R&S banner messages provide up-to-date claims filing and payment information. The R&S banner messages, and the TMPPM are all available on the [TMHP website](#).

### **REIMBURSEMENT FOR HEALTHY TEXAS WOMEN SERVICES**

HTW contractors may seek reimbursement for project costs by submitting monthly vouchers for expenses outlined in a categorical budget approved by HHSC, as required for the categorical cost reimbursement method.

**Categorical**

HHSC HTW Cost-Reimbursement program funding is used for support services that enhance services provided by the contractor to a client under the HTW Fee-for-Service program. Support services include, but are not limited to:

1. Assisting eligible women with enrollment into the HTW Fee-for-Service program;
2. Direct clinical care for women deemed presumptively eligible for the HTW Fee-for-Service program;
3. Staff development and training related to HTW Fee-for-Service program service delivery; and
4. Client and community based educational activities related to the HTW program. Costs may be assessed against any of the following categories the contractor identifies during their budget development process:
  - personnel,
  - fringe benefits,
  - travel,
  - equipment and supplies,
  - contractual,
  - other, and
  - indirect costs.

NOTE: Indirect costs are costs incurred for a common or joint purpose benefiting more than one project or cost objective of respondent's organization and not readily identified with a particular project or cost objective. Typical examples of Indirect Costs may include general administration and general expenses such as salaries and expenses of executive officers, personnel administration and accounting; depreciation or use allowances on buildings and equipment; and costs of operating and maintaining facilities.

Reimbursement is requested by using a purchase voucher and supporting schedule. Vouchers and supporting documentation must be submitted monthly within 30 days following the end of the month in which the costs were incurred. Program income from the HTW Fee-for-Service claims payment must be expended before HTW Categorical funds are requested through the voucher process. Contractors must submit vouchers monthly even if program income equals or exceeds program expenses. When program expenses exceed program income, the monthly voucher will result in a payment. Program income includes all monies collected directly by the contractor for services provided under the contract award and revenue from HTW Fee-for-Service.

To request reimbursement for the categorical contract, the following forms must be submitted monthly within **30 days following the end of the month in which the costs were incurred**:

- State of Texas Purchase Voucher (HHSC Form B-13),
- Supporting Schedule for HTW Voucher (Form B-13).

The following forms must be submitted within **45 days following the end of the contract term**:

- Final State of Texas Purchase Voucher (HHSC Form B-13),
- Final Supporting Schedule for HTW Voucher (Form B-13).

The [Client Services Contracting Unit \(CSCU\) website](#) provides necessary financial forms.

### **HTW Claims Pending Eligibility Determination**

Contractors must hold claims up to 45 calendar days for clients who were screened as presumptively eligible and have applied to HTW. If a client's HTW eligibility has not been determined after 45 calendar days, the contractor may bill the service to the HHSC HTW Cost-Reimbursement program if the client has a current eligibility form on file. If the contractor files a HHSC HTW Cost-Reimbursement program claim for a potentially HTW-eligible client before the end of the 45 day waiting period, the contractor should include a copy of the client's HTW denial letter in the client record before filing the claim or encounter.

### **IUD and Contraceptive Implant Complications**

Contractors may request reimbursement for costs associated with patient complications related to IUD or Contraceptive Implant insertions or removals. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement contractors should provide the HHSC HTW program with the following information:

- A copy of the R&S report showing that a IUD or Contraceptive Implant insertion or removal procedure was performed on the client in question;
- A narrative summary detailing the procedure performed and any related complications,
- All surgical and progress notes for the client related to the complication of the IUD or Contraceptive Implant insertion or removal procedure, and
- A completed CMS 1500 Claim Form or a 2017 Family Planning Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the HHSC HTW program).

### **Family Planning History Check**

HTW clients must receive family planning services annually, but no later than the third visit as an established client. These services must include family planning counseling and education, including natural family planning and abstinence. In order to receive reimbursement, all existing HTW clients must have received family planning services and/or counseling within the past rolling year.

The following HTW clients do not require a family planning history check:

- New clients
- Women who are sterilized
- Women who have a LARC

**RETROACTIVE ELIGIBILITY**

**Title XIX Retroactive Eligibility**

Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service. Individuals who are eligible for Title XIX (Medicaid) medical assistance receive three months prior eligibility to cover any medical expenses incurred during that period.

**REQUIRED REPORTS**

Financial Reporting

**VOUCHER AND REPORT SUBMISSION**

**PROGRAM INFORMATION:**

**Program Name:** HHSC Healthy Texas Women

**Contract Type:** Categorical

**Contract Term:** July 1, 2016 thru August 31, 2017

**VOUCHER: Voucher 1**

**Voucher Name:** State of Texas Purchase Voucher-Form B-13

**Submission Date:** By the last business day of the following month. Final voucher due within 45 days after end of the contract term.

**Submit Copy to:**

Name of Unit/Branch	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services		X	Email (preferred), or Fax	1

**Instructions:** Attach B-13H to voucher form B-13.

**NOTE:** Vouchers must be submitted each month even if there are zero expenditures. Vouchers must still be submitted each month for actual expenditures of the program even if the contract limit has been reached.

**VOUCHER: Report 1--Supporting**

**Report Name:** Supporting Schedule for Healthy Texas Women Reimbursement Vouchers Form B-13H in Excel format

**Submission Date:** By the last business day of the following month. Final B-13H due within 45 days after end of the contract term.

**Submit Copy to:**

Name of Unit/Branch	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services		X	Email (preferred), or Fax	1

**Instructions:** Attach B-13H to voucher form B-13.

**REPORT: Report 1**

**Report Name:** Financial Status Report Form 269A

**Submission Date:** For FY17, reports are due as follows: Quarter 1: July – August 2016; Quarter 2: September – November 2016; Quarter 3: December 2016 – February 2017; Quarter 4: March – May 2017; Quarter 5: June – August 2017. Submit 30 days after the end of each quarter. The final quarterly FSR is due 45 days after the end of the contract term. The final quarter report includes all final charges and expenses associated with the program contract. Mark it as "Final".

**Submit Copy to:**

Name of Unit/Branch	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services	X		Email (preferred), or Fax	1

**Instructions:** Form 269A must have an original signature (scanned email or fax accepted).

**Financial Status Reports (FSRs) for Categorical Family Planning Contracts**

The HHSC Healthy Texas Women operates using the FFS award, and categorical award. All revenue directly generated by FFS reimbursement are considered program income on the quarterly FSRs. Healthy Texas Women contractors are required to identify and report receipt and expenditure of FFS payments quarterly and annually on the FSR form 269a. See quarters for categorical FSR submission below. Program income (FFS payments), must be expended prior to receiving reimbursement for program costs.

The quarterly reports are due 30 days following the end of each quarter of the contract term. The final FSR, 269A, is due within 45 days after the end of the contract term, unless stipulated differently in the contract attachment following the end of the contract term. HHSC reserves the right to base funding levels, in part, upon the contractor’s proficiency in identifying, billing, collecting, and reporting income, and in utilizing it for the delivery of family planning services.

**Quarters for Categorical FSR submission:**

- Quarter 1: July – August 2016
- Quarter 2: September – November 2016
- Quarter 3: December 2016 – February 2017
- Quarter 4: March – May 2017
- Quarter 5: June – August 2017

**Healthy Texas Women Categorical Budget Revisions** – Contractors may shift up to 25% of their total Healthy Texas Women categorical direct budget between categories,

except equipment, without prior approval. However, if the amount being shifted is greater than 25% of the contractor's total budget, the contractor must receive prior approval from HHSC. In such a case, contractors are required to submit a revised budget for review.

**Programmatic Reporting**

Contractors must complete requested reports in accordance with the contract.

Last Updated/Reviewed: 6/29/2016

# **Section IV**

## Appendices

### Healthy Texas Women Income Worksheet

<b>Total Gross Earned Income</b>	\$
<b>Earned Income Deduction(s)</b>	-
<b>Adjusted Gross Earned Income</b>	=
<b>Total Unearned Income</b>	+
	=
<b>Other Deductions</b>	-
<b>*Countable Monthly Income</b>	=

*Convert earned/unearned income and deductions to monthly using the following conversion factors:  
If paid or received weekly multiply by 4.33, Bi-weekly multiply by 2.17, or Semi-monthly multiply by 2*

**Earned Income**

Earned income is related to funds received for work-related activities; entitling a household to certain allowable deductions.

**Earned Income Deduction(s)**

- The earned income deduction is the work-related expense of \$120 per employed person.
- The costs for care of a child or incapacitated adult (even when the child or incapacitated adult is not included in the certified group); or
- Transportation of a child to and/or from day care or school.
- Dependent Care Maximum Deductions –
  - \$200 per month for each child under age two, and
  - \$175 per month for each dependent age two or older.

**Note:** Enter zero adjusted earned income if deductions exceed earnings.

**Unearned Income**

Unearned income is income received without performing work-related activities.

Examples: SSI, RSDI, VA, Worker’s Compensation, Unemployment, Child Support, Alimony, Savings/Checking Account Interest, Retirement Benefits, and TANF.

**Other Deductions**

- Child Support –
  - Paid Out - Deduct child support payments made by a member of the budget group.
  - Received - Deduct up to \$75 per month of total child support received by members of the budget group.
- Alimony, and
- Payments to dependents living outside the home.

**Monthly Countable Income**

Compare this amount to the Federal Poverty Limit chart for the appropriate household size.

## Healthy Texas Women Hoja de cálculo de ingresos

<b>Total de ingresos brutos del trabajo</b>	\$
<b>Deducciones de ingresos del trabajo</b>	-
<b>Ingresos brutos del trabajo ajustados</b>	=
<b>Ingresos totales no derivados del trabajo</b>	+
	=
<b>Otras deducciones</b>	-
<b>*Ingresos mensuales contables</b>	=

*Convierta los ingresos del trabajo y no derivados del trabajo y las deducciones a unidades mensuales usando los siguientes factores de conversión: Si se pagó o recibió semanalmente, multiplique por 4.33; cada dos semanas, multiplique por 2.17, o dos veces al mes, multiplique por 2.*

### **Ingresos del trabajo**

Los ingresos del trabajo son los fondos recibidos por actividades relacionadas con el empleo. Esto le da al hogar el derecho a ciertas deducciones permitidas.

### **Deducciones de ingresos del trabajo**

- La deducción de ingresos del trabajo es cualquier gasto hasta \$120 relacionado con el trabajo por persona empleada.
- Los costos del cuidado de un niño o un adulto incapacitado (aun cuando el niño o adulto incapacitado no forma parte del grupo certificado); o
- Transporte de un niño de ida o vuelta del centro de cuidado de niños o escuela.
- Máximo de deducciones por el cuidado de dependientes:
  - \$200 por mes por cada niño menor de 2 años, y
  - \$175 por mes por cada dependiente de 2 años o más.

**Aviso:** Escriba cero para ingresos del trabajo ajustados si las deducciones sobrepasan las ganancias.

### **Ingresos no derivados del trabajo**

Los ingresos no derivados del trabajo son los ingresos recibidos sin realizar actividades relacionadas con el empleo.

Ejemplos: SSI, RSDI, VA, indemnización laboral, desempleo, manutención de niños, pensión alimenticia, intereses de cuentas de ahorros o de cheques, beneficios de jubilación y TANF.

### **Otras deducciones**

- Manutención de niños:
  - Pagada - Reste los pagos de manutención de niños hechos por un miembro del grupo presupuestario.
  - Recibida - Reste hasta \$75 al mes de la manutención de niños total recibida por los miembros del grupo presupuestario.
- Pensión alimenticia
- Pagos a los dependientes que viven fuera del hogar.

### **Ingresos contables mensuales**

Compare esta cantidad a la de la tabla del Límite Federal de Pobreza que corresponde al tamaño del hogar.

APPENDIX B

Healthy Texas Women (HTW) Screening Tool		
NAME:		DATE:
Step	Question	Yes / No
<b>Current recipients of Medicaid, Medicare (A or B), or CHIP cannot receive HTW benefits. *</b>		
1.	Does the female applicant live in Texas?	<input type="checkbox"/> Yes: Continue to next step
		<input type="checkbox"/> No: Applicant is screened ineligible for HTW *
2.	Is the female applicant between the ages of 18 through 44? <i>Applicants are considered 18 the day of their 18<sup>th</sup> birthday and 44 until the end of the month of their 45<sup>th</sup> birthday</i>	<input type="checkbox"/> Yes: Continue to Step 4
		<input type="checkbox"/> No: Continue to next step
3.	Is the female applicant age 15 through 17 and her parent or legal guardian is applying for her? <i>Applicants are considered 15 the month of their 15<sup>th</sup> birthday.</i>	<input type="checkbox"/> Yes: Continue to next step
		<input type="checkbox"/> No: Applicant is screened ineligible for HTW *
4.	Is the female applicant pregnant?	<input type="checkbox"/> Yes: Applicant is screened ineligible for HTW *
		<input type="checkbox"/> No: Continue to next step
5.	Is the female applicant a U.S. Citizen?	<input type="checkbox"/> Yes: Attach a copy of the U.S. citizenship verification with the application and continue to Step 7
		<input type="checkbox"/> No: Continue to next step
6.	Is the female applicant a legal immigrant?	<input type="checkbox"/> Yes: Attach a copy of the legal immigrant verification with the application and continue to next step
		<input type="checkbox"/> No: Applicant is screened ineligible for HTW *
7.	Does the female applicant have a child who currently receives Medicaid?	<input type="checkbox"/> Yes: Attach a copy of the Medicaid ID verification with the application and continue to Step 10
		<input type="checkbox"/> No: Continue to next step
8.	Does anyone in the household currently receive WIC? <i>Acceptable forms of verification are WIC Verification of Certification or Active WIC Voucher/EBT Shopping List.</i>	<input type="checkbox"/> Yes: Attach a copy of the WIC verification with the application and continue to Step 10
		<input type="checkbox"/> No: Continue to next step
9.	What is the household countable monthly income? \$ _____ How many are in the household? _____  Use 200% FPL income chart located at: <a href="https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf">https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf</a>  Is the countable monthly income less than or equal to 200% FPL for the household size?	<input type="checkbox"/> Yes: Attach a copy of the income verification with the application and continue to the next step
		<input type="checkbox"/> No: Applicant is screened ineligible for HTW *
10.	Does the female applicant have existing health insurance that covers family planning?	<input type="checkbox"/> Yes, Keep confidential, provide application**
		<input type="checkbox"/> Yes, Not confidential, Applicant is screened ineligible for HTW *
		<input type="checkbox"/> No: Provide application

## APPENDIX B

Applicants are required to verify eligibility utilizing the below listed resources.

\*Should an applicant be determined ineligible through this pre-screening tool, the applicant may still be eligible for services.

Those applicants are encouraged to visit [HealthyTexasWomen.org](http://HealthyTexasWomen.org) or [YourTexasBenefits.com](http://YourTexasBenefits.com) for more information.

Program applications can be submitted electronically or through their local HHSC office. Contact 211 to help find your nearest office.

***\*\*All documents must be kept confidential if a claim on the applicant's insurance will cause her physical, emotional, or other harm from spouse, parents, or other person.***

Common sources of acceptable verification as listed in Tables 1-3. There may be other documents we can accept to prove citizenship and/or identity. Please contact your local HHSC benefits office to discuss other possibilities.

### Acceptable Verification for Step 2

If the applicant cannot provide one of the combined forms of verification found in Table 1, the applicant must provide one form of citizenship from Table 2 and one form of identity from Table 3. Note: Current Medicare or SSI recipients are exempt from this verification requirement.

### Table 1 (Primary Evidence of Combined Citizenship and Identity)

- U.S. passport
- Certificate of Naturalization
- Certificate of U.S. citizenship

### Table 2 Evidence of Citizenship (Use only when primary evidence from Table 1 is not available.)

Examples of documents that can be accepted as proof of **citizenship** but not of identity are:

- A U.S. Birth Certificate from one of the 50 States, D.C., and in some cases other U.S. territories.
- For a birth out of state, individuals may obtain a birth certificate through <http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm>
- Report of Birth Abroad of a U.S. Citizen (FS-240), Certification of Birth Abroad (FS 545 or DS-1350) or U.S. Citizen Identification Card (Form I-179 or I-197)

For women born in Texas, HHSC advisors can access Bureau of Vital Statistics (BVS) as a verification source. Required entries include the woman's first and last name, and the mother's maiden name.

### Table 3 Evidence of Identity (Use only when primary evidence from Table 1 is not available.)

Documents that can be accepted as proof of **identity**:

- One of the following is acceptable, if the document has a photograph or other identifying information such as but not limited to name, age, sex, race, height, weight, eye color, or address:
  - Driver license issued by a state or territory
  - School identification card
  - U.S. military card or draft record
  - Identification card issued by the federal, state, or local government with the same information included on driver licenses
  - U.S. Coast Guard Merchant Mariner card
  - Military dependent's identification card
- Native American Tribal document
- Certificate of Degree of Indian Blood or other U.S. American Indian/Alaskan Native and Tribal document with a photograph or other personal identifying information
- Two or more corroborating documents (examples include, but are not limited to, marriage licenses, divorce decrees, or high school diplomas)
- For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care

## APPENDIX B

### Acceptable Verification for Step 3: Legal Immigrant

Documents that can be accepted as proof of legal immigrant status

- Form I-94, I-151, I-551, I-688-B (with special annotations),
- I-766 (with special annotations), or other valid Immigration and Naturalization Service records
- 

### Acceptable Verification for Step 4: Income

<p><b>EARNED INCOME</b>            HHSC Form H1028 –Employment Verification completed by employer            Earning statements or check stubs            Employer's written statement</p>	<p><b>VETERANS ADMINISTRATION (VA) BENEFITS</b>            Current award notice, letter, or written statement from VA            Check (or copy of check)</p>
<p><b>RSDI (Social Security)</b>            Current award notice, letter, or written statement from Social Security Administration            Check (or copy of check)            Direct deposit slip</p>	<p><b>OTHER INCOME</b>            Check (or copy of check)            Statement from bank paying dividends and interest            Written statement from company or union providing pensions or union benefits</p>
<p><b>SUPPLEMENTAL SECURITY INCOME (SSI)</b>            Current award notice, letter, or written statement from, Social Security Administration            Check (or copy of check)            Direct deposit slip</p>	<p><b>WORKER'S COMPENSATION</b>            Current award notice, letter, or written statement from,           <ul style="list-style-type: none"> <li>• Claims Adjuster</li> <li>• Attorney</li> <li>• Insurance company</li> </ul>           Check (or copy of check)</p>
<p><b>SELF EMPLOYMENT</b>            Most recent IRS tax return (annual or seasonal)            Business records and receipts            Statement from bank paying dividends and interest            Tax Guide for Small Business            Receipts for goods/services provided</p>	<p><b>CHILD SUPPORT</b>            Current court records, such as a court order, court support agreement, or divorce or separation papers            Written statement from parent providing support            Check (or copy of check)            Wage-withholding statement            County Clerk records            Attorney General collection and distribution records            Withholding statement from unemployment compensation            Cancelled checks (3 months, if possible)</p>
<p><b>UNEMPLOYMENT COMPENSATION</b>            Check (or copy of check)            Current award notice, letter, or written statement from Texas Workforce Commission            Written statement from former employer</p>	<p><b>CONTRIBUTIONS</b>            Written statement from person or agency providing the money or making payment for you            Contribution check (or copy of check)            Cancelled check of person making contribution</p>
<p><b>OTHER GOVERNMENT BENEFITS</b>            Current award notice, letter, or official written statement            Check (or copy of check)</p>	

**APPENDIX B**

<b>Evaluación para determinar elegibilidad de Healthy Texas Women (HTW)</b>		
<b>NOMBRE:</b>		<b>FECHA:</b>
Paso	Pregunta	Sí / No
<b>Los clientes actuales de Medicaid, Medicare (A o B) o CHIP no pueden recibir beneficios de HTW. *</b>		
<b>1.</b>	¿Vive la solicitante en Texas?	<input type="checkbox"/> Sí: Siga con el próximo paso <input type="checkbox"/> No: La evaluación de la solicitante indicó que no califica para HTW *
<b>2.</b>	¿Tiene la solicitante entre 18 y 44 años? <i>Se considera que una solicitante tiene 18 años el día que cumple 18 años y tiene 44 años hasta el último día del mes en que cumple 45 años.</i>	<input type="checkbox"/> Sí: Vaya al paso 4 <input type="checkbox"/> No: Siga con el próximo paso
<b>3.</b>	¿Tiene la solicitante entre 15 y 17 años y está solicitando por ella su madre, padre o tutor legal? <i>Se considera que una solicitante tiene 15 años el mes en que cumple 15 años.</i>	<input type="checkbox"/> Sí: Siga con el próximo paso <input type="checkbox"/> No: La evaluación de la solicitante indicó que no califica para HTW *
<b>4.</b>	¿Está la solicitante embarazada?	<input type="checkbox"/> Sí: La evaluación de la solicitante indicó que no califica para HTW * <input type="checkbox"/> No: Siga con el próximo paso
<b>5.</b>	¿Es la solicitante ciudadana estadounidense?	<input type="checkbox"/> Sí: Adjunte una copia de la verificación de ciudadanía estadounidense a la solicitud y siga con el paso 7 <input type="checkbox"/> No: Siga con el próximo paso
<b>6.</b>	¿Es la solicitante inmigrante legal?	<input type="checkbox"/> Sí: Adjunte una copia de la verificación de inmigrante legal a la solicitud y siga con el próximo paso <input type="checkbox"/> No: La evaluación de la solicitante indicó que no califica para HTW *
<b>7.</b>	¿Tiene la solicitante algún hijo que actualmente recibe Medicaid?	<input type="checkbox"/> Sí: Adjunte una copia de la identificación de Medicaid a la solicitud y siga con el paso 10 <input type="checkbox"/> No: Siga con el próximo paso
<b>8.</b>	¿Recibe WIC actualmente alguien del hogar? <i>Las formas aceptables de verificación son la Verificación de certificación de WIC o una lista de compras de EBT o cupón de WIC vigente.</i>	<input type="checkbox"/> Sí: Adjunte una copia de la verificación de WIC a la solicitud y siga con el paso 10 <input type="checkbox"/> No: Siga con el próximo paso
<b>9.</b>	¿Cuáles son los ingresos mensuales contables del hogar? \$ _____  ¿Cuántas personas hay en el hogar? _____  <i>Use la Tabla del 200% del FPL que encontrará en:  <a href="https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf">https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf</a></i>  ¿Son los ingresos mensuales contables iguales o menores al 200% del FPL para el tamaño del hogar?	<input type="checkbox"/> Sí: Adjunte una copia de la verificación de ingresos a la solicitud y siga con el próximo paso  <input type="checkbox"/> No: La evaluación de la solicitante indicó que no califica para HTW *
<b>10.</b>	¿Tiene la solicitante actualmente un seguro médico que cubre la planificación familiar?	<input type="checkbox"/> Sí, Mantener confidencial, proporcionar solicitud** <input type="checkbox"/> Sí, No confidencial, Se determinó que la solicitante no califica para HTW * <input type="checkbox"/> No: Proporcionar solicitud

## APPENDIX B

**Es necesario que las solicitantes verifiquen la elegibilidad por medio de los documentos indicados a continuación.**

**\*Si por medio de esta herramienta de preevaluación se determina que una solicitante no califica, todavía podría calificar para recibir servicios.**

**Se les recomienda a esas solicitantes que busquen más información en [HealthyTexasWomen.org](http://HealthyTexasWomen.org) o [YourTexasBenefits.com](http://YourTexasBenefits.com).**

**Las solicitudes del programa pueden enviarse electrónicamente o por medio de la oficina local de la HHSC. Llame al 211 para encontrar la oficina más cercana.**

***\*\*Todos los documentos se tienen que mantener confidenciales si una solicitud de pago al seguro de la solicitante le causará daño físico, emocional o de otro tipo por parte del esposo, los padres u otra persona.***

Los documentos comunes de verificación que se aceptan aparecen en las Tablas 1-3. Puede haber otros documentos que se acepten para demostrar la ciudadanía o la identidad. Por favor, llame a la oficina local de la HHSC para hablar sobre otras posibilidades.

### **Verificación aceptable para el paso 2**

Si la solicitante no puede presentar una de las formas combinadas de verificación que aparecen en la Tabla 1, la solicitante tiene que dar una prueba de ciudadanía de la Tabla 2 y una prueba de identidad de la Tabla 3. Nota: Las personas que actualmente reciben Medicare y SSI están exentos de este requisito de verificación.

### **Tabla 1 (Prueba principal de ciudadanía e identidad combinadas)**

- Pasaporte de Estados Unidos
- Certificado de naturalización
- Certificado de ciudadanía de Estados Unidos

### **Tabla 2 Prueba de ciudadanía (solo se usa cuando la prueba principal de la Tabla 1 no está disponible).**

Ejemplos de documentos que se pueden aceptar como prueba de **ciudadanía** pero no de identidad son:

- Un acta de nacimiento de uno de los 50 estados, o de Washington, D.C. y en algunos casos, otros territorios de Estados Unidos.
- Una persona que nació fuera del estado puede obtener un acta de nacimiento a través de <http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm>
- Reporte de nacimiento en el extranjero de un ciudadano estadounidense (FS-240), Certificación de nacimiento en el extranjero (FS 545 o DS-1350) o Tarjeta de identificación de ciudadano estadounidense (Formulario I-179 o I-197)

Para mujeres nacidas en Texas, los asesores de la HHSC pueden acceder a la Oficina de Estadísticas Vitales (BVS) como una fuente de verificación. La información requerida incluye el primer nombre y apellido de la mujer y el nombre de soltera de la madre.

### **Tabla 3 Prueba de identidad (solo se usa cuando la prueba principal de la Tabla 1 no está disponible).**

Documentos que pueden ser aceptados como prueba de **identidad**:

- Uno de los siguientes es aceptable, si el documento tiene una fotografía u otra información de identificación como nombre, edad, sexo, raza, estatura, peso, color de ojos o dirección:
  - Licencia de manejar emitida por un estado o territorio
  - Tarjeta de identificación escolar
  - Tarjeta militar de Estados Unidos o registro de reclutamiento
  - Tarjeta de identificación emitida por el gobierno federal, estatal o local con la misma información que aparece en la licencia de manejar
  - Tarjeta de marinero mercante del Guardacostas de Estados Unidos
  - Tarjeta de identificación de dependiente de militar
- Documento tribal de indio americano
- Certificado de grado de sangre indio americana u otro documento de indio americano o nativo de Alaska y de tribu con una fotografía u otra información de identificación personal
- Dos o más documentos corroborantes (por ejemplo, licencia de matrimonio, auto de divorcio o diploma de la preparatoria)
- Para los niños y jóvenes menores de 19 años, el expediente de una clínica, doctor, hospital o escuela, incluso un centro preescolar o de cuidado de niños

## APPENDIX B

### Verificación aceptable para el paso 3: Inmigrante legal

Documentos que se pueden aceptar como prueba de calidad de inmigrante legal

- Formulario I-94, I-151, I-551, I-688-B (con anotaciones especiales),
- I-766 (con anotaciones especiales), u otros documentos válidos del Servicio de Inmigración y Naturalización

### Verificación aceptable para el paso 4: Ingresos

<b>INGRESOS DEL TRABAJO</b> Forma H1028 de la HHSC – Verificación de empleo, completada por el empleador Declaraciones de ingresos o talones de cheque de pago Declaración por escrito del empleador	<b>BENEFICIOS DE LA ADMINISTRACIÓN DE VETERANOS (VA)</b> Aviso de concesión, carta o declaración por escrito reciente de la VA Cheque (o copia de cheque)
<b>RSDI (Seguro Social)</b> Aviso de concesión, carta o declaración por escrito reciente de la Administración de Seguro Social Cheque (o copia de cheque) Recibo de depósito directo	<b>OTROS INGRESOS</b> Cheque (o copia de cheque) Estado de cuenta del banco que paga dividendos e intereses Declaración por escrito de la compañía o el sindicato que proporciona las pensiones o beneficios sindicales
<b>SEGURIDAD DE INGRESO SUPLEMENTARIO (SSI)</b> Aviso de concesión, carta o declaración por escrito reciente de la Administración de Seguro Social Cheque (o copia de cheque) Recibo de depósito directo	<b>INDEMNIZACIÓN LABORAL</b> Aviso de concesión, carta o declaración por escrito reciente de <ul style="list-style-type: none"><li>• un tasador de reclamaciones</li><li>• un abogado</li><li>• una compañía de seguros</li></ul> Cheque (o copia de cheque)
<b>EMPLEO POR SU CUENTA</b> Última declaración de impuestos del IRS (anual o de temporada) Recibos y registros del negocio Estado de cuenta del banco que paga dividendos e intereses Guía fiscal para pequeñas empresas Recibos de bienes y servicios proporcionados	<b>MANUTENCIÓN DE NIÑOS</b> Documentos de la corte vigentes, como una orden judicial, acuerdo de manutención de la corte, divorcio o separación Declaración por escrito del padre que paga manutención de niños Cheque (o copia de cheque) Declaración de retención de salario Registros del secretario del condado Registros de cobro y distribución del Procurador General Declaración de retención de la compensación por desempleo Cheques cobrados (3 meses, si es posible)
<b>COMPENSACIÓN POR DESEMPLEO</b> Cheque (o copia del cheque) Aviso de concesión, carta o declaración por escrito reciente de la Comisión de la Fuerza Laboral de Texas Declaración por escrito del empleador anterior	<b>CONTRIBUCIONES</b> Declaración por escrito de la persona o agencia que le proporciona dinero o hace pagos por usted Cheque de contribución (o copia del cheque) Cheque cobrado de la persona que hace la contribución
<b>OTROS BENEFICIOS DEL GOBIERNO</b> Aviso de concesión, carta o declaración oficial por escrito reciente Cheque (o copia del cheque)	

APPENDIX C

HEALTHY TEXAS WOMEN PROMOTION / OUTREACH ANNUAL REPORT

Agency Name				Person(s) completing report	Phone number	Email		
Activity	Date of activity	Number of agency staff monitoring	Estimated number of potential clients reached	Community partners / Collaborating organizations	MARKETING OUTLET(S)			
					Small media (i.e. brochures, posters)	Mass media (i.e. TV/radio, newspaper/magazine)	Social media* (i.e. active Facebook account, active twitter account)	Community Event (yes or no)
<i>Example activity 1 – Health Fair</i>	<i>1/1/2016</i>	<i>2</i>	<i>34</i>	<i>none</i>	<i>posters</i>	<i>none</i>	<i>none</i>	<i>yes</i>
<i>Example activity 2 – Started Facebook page with weekly posts</i>	<i>3/31/2016</i>	<i>1</i>	<i>167</i>	<i>none</i>	<i>none</i>	<i>none</i>	<i>Facebook</i>	<i>no</i>

**Successes**

**Challenges/Barriers**

**Instructions**  
 Complete and submit to [womenshealth@hhsc.state.tx.us](mailto:womenshealth@hhsc.state.tx.us) within forty-five (45) days of the contract start date.

\*Each social media outlet (i.e. Facebook, Twitter) may only count once a quarter.

**Texas Health and Human Services Commission  
Form B-13H**

Agency Name:

<b>Supporting Schedule for Healthy Texas Women Reimbursement Vouchers</b>			
	Column A	Column B	Column C
1	<b>Total Allowable HTW Cumulative Expenses Incurred:</b> "B"=Date-Month and year expenses incurred through "C"=Amount of cumulative HTW eligible client services expenses (Value of in-kind contributions should only be reported on line 15)		
2	<b>Program Income (Cumulative):</b>		
3	<b>HTW Fee-For-Service Reimbursements from TMHP</b>		
4*	<b>Sub Total - Program Income</b> →→→→		0.00
5*	<b>Gross Cumulative HTW Reimbursable Expenses</b>		0.00
6	<b>Total Award Amount of the HTW Categorical Contract</b>		
7*	<b>Non HHSC Funding Expended</b> – If Column C Line 5 is greater than Column B Line 6, then C5 - B6 = C7. Otherwise, Column C Line 7 will be zero.		0.00
8*	<b>Net Cumulative HTW Reimbursable Expenses</b>	→→→→	0.00
9	<b>Less: Gross Reimbursements Requests Previously Submitted to HHSC (Cumulative)</b>		
10*	<b>Gross Reimbursement Requested this Voucher</b>		0.00
11	<b>Less: Refunds or Other Adjustments (if any)</b>		
12*	<b>Net Reimbursement Requested this Voucher</b> (Negative amount at end of contract term indicates a refund to HHSC)		\$0.00
13*	<b>Total Cumulative Non HHSC Funding Expended</b> (This amount must be the same as the Cumulative Non-HHSC Funding on the Quarterly FSR).		0.00

\* = Indicates a built in calculation. Do not change formulas.

I certify that to the best of my knowledge and belief that the information contained in this report is correct and complete.

Signature of Authorized Certifying Official (signature not necessary for HTW program)	Date Submitted
Typed or Printed Name and Title of Certifying Official	Telephone (     )

***This completed form must be submitted with each reimbursement voucher (Form B-13) and Quarterly Financial Status Report***