**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Reproductive Health Well Visit | **No.** |
| **Approved by:**  |  | **Effective Date:**  |
| **Revised Date:** January 2018, January 2019, January 2021,October 2022, **January 2024** |
| **References:** U.S. Preventive Services Task Force (USPSTF); Providing Quality Family Planning Services (CDC QFP), 2014 |

POLICY: This Clinical Practice Standard follows the recommendations of the USPSTF, CDC QFP, ACOG, and ACP.

PURPOSE: This Clinical Practice Standard provides guidance to reproductive health prescribing providers on the provision of an annual reproductive health well visit. The Reproductive Health Well Visit provides an opportunity for Nurse Practitioners (NPs), Physician Assistants (PAs), Doctor of Osteopathic medicine (DO), Naturopathic Doctors, or Medical Doctors (MDs) to offer associated reproductive health services in addition to contraceptive management.

A Reproductive Health Well Visit includes a client-centered interview, comprehensive family and personal health history, examination or laboratory tests as indicated by history and following national standards of care, and client-centered counseling to improve health and reduce risks to health.

A Reproductive Health Well Visit is not required in order to prescribe contraception, but a current written prescription is and this requirement creates the opportunity to offer age-appropriate screenings, examinations, and laboratory services. If a client is current on recommended exam and laboratory services or refuses the Reproductive Health Well Visit and is in need of contraceptive services, refer to the [*Prescription Visit Clinical Practice Standard*.](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Prescription_Visit.docx)

**STANDARD:**

(**insert AGENCY name**) NPs, PAs, DOs, NDs, and MDs will perform a Reproductive Health Well Visit following national standards of care as outlined below, though certain components may be delegated to assistive staff.

**PROCEDURE:**

1. Follow [*Core Reproductive Health Services Clinical Practice Standard*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx)***.***
2. Assess and document a Review of Systems (ROS) based on the reason for visit and Health History Form. Issues identified that are beyond the scope of the program will be referred to primary or specialty care and referral assistance will be provided.
3. Screen for BRCA risk.
	1. Assess clients with a personal or family history of breast, ovarian, tubal, or peritoneal cancer, or who have an ancestry associated with BRCA 1/2 gene mutations with an appropriate brief familial risk assessment tool. *USPSTF (August 2019)*
* Clients with a positive result on the risk assessment tool should be referred for genetic counseling and, if indicated after counseling, genetic testing.
1. The following tools have been validated and accurately estimate the likelihood of carrying a harmful BRCA 1/2 mutation: (**See Attachment 1**)
* Ontario Family History Assessment Tool
* Manchester Scoring System
* Referral Screening Tool
* Pedigree Assessment Tool
* 7-Question Family History Screening Tool
* International Breast Cancer Intervention Study instrument (Tyrer-Cuzick)
* Brief versions of BRCAPRO
	1. The USPSTF (August 2019) recommends against routine risk assessment, genetic counseling, or genetic testing for clients whose personal or family history or ancestry is not associated with potentially harmful BRCA*1/2* gene mutation. *USPSTF* *Grade D Recommendation (August 2019)*

Exam and Laboratory Services:

1. Perform individualized physical exams. See below. There is no evidence to support the evaluation of heart, lungs, thyroid, abdomen, or genitals in the asymptomatic client with no history of a medical problem relating to these systems. The physical exam will be individualized and based on the client’s clinical presentation and medical history. If another program requires a certain exam component (for example, the Breast and Cervical Cancer Program requires a clinical breast exam), perform the exam component as directed by that program.
2. Breast Cancer Screening for clients at average risk:
* Clinical Breast Exam (CBE): The USPSTF concludes that there is insufficient evidence to assess the balance of benefits and harms for clinical breast exam beyond mammography (*Grade I Recommendation*). Per ACOG guidelines, clinical breast examination *may be offered* to asymptomatic clients in the context of an informed, shared decision-making approach that recognizes the uncertainty of additional benefits and the possibility of adverse consequences of clinical breast examination (i.e., false positives).
	1. If performed for screening, intervals of every 1–3 years for clients aged 25–39 years and annually for clients aged 40 years and older are reasonable.
	2. The clinical breast examination continues to be a recommended part of evaluation of high-risk clients and clients with symptoms.
	+ Mammography:
	1. Biennial screening mammography is recommended for clients ages 40-74 years old. (*USPSTSF Grade B Recommendation*) There is insuffiecient evidence to assess the balance of benefits and harms of screening mammography for clients aged 75 years or older.
1. Cervical Cancer Screening:
	* The below USPSTF recommendations apply to clients who have a cervix, regardless of sexual history or HPV vaccination status. These recommendations do not apply to clients who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, clients with in utero exposure to diethylstilbestrol, or those who have a compromised immune system (such as clients living with HIV).
2. The USPSTF recommends screening for cervical cancer:
	* Ages 21 to 29 years with cytology alone (Pap smear) every 3 years
	* Ages 30 to 65 years:
* Screening every 3 years with cytology alone, or
* Every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or
* Every 5 years with hrHPV testing in combination with cytology (co-testing). *Grade A Recommendation* (*August 2018)*
1. The USPSTF recommends against screening for cervical cancer in clients:
	* Younger than age 21 years. *Grade D Recommendation*
	* Older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. *Grade D Recommendation*
	* Who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. *Grade D Recommendation*
2. Management of Abnormal Cervical Cytology: Refer to the [*ASCCP App and Guidelines*](https://www.asccp.org/guidelines)forPap screening/testing within the context of a history of a prior abnormal result and/or for follow-up of a recent abnormal result.
3. Clients should be offered or referred for additional preventative screenings (e.g., diabetes screening, lipid screening, and colorectal cancer screening) when indicated; however, these screenings are beyond the scope of RH Program services. See the [USPSTF screenings with A and B recommendations](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations) for a comprehensive list of recommended screenings.
4. Exam/lab testingwhen clinically indicated:
* Urinalysis/urine dipstick if symptomatic;
* Hgb/Hct for those reporting heavy menses; frequent vaginal bleeding, symptomatic, or with a prior history of anemia;
* Wet mount if symptomatic;
* Pregnancy test if symptomatic or history of unprotected intercourse;
* Rubella titer if never vaccinated or if vaccination status unknown; and/or
* Pelvic exam if obtaining a Pap test or as clinically indicated.

Do not routinely perform**:**

1. Self-Breast Exam (SBE) Instructions: The USPSTF recommends against teaching breast self-examination. (*Grade D Recommendation*) Average-risk clients may be counseled about breast self-awareness and encouraged to notify their health care provider if they experience a change. Breast self-awareness is defined as a person’s awareness of the normal appearance and feel of their breasts.
2. Pelvic Exam: The ACP (July 2014) recommends against performing screening pelvic examination (inspection of the external genitalia; speculum examination of the vagina and cervix; bimanual examination of the adnexa, uterus, ovaries, and bladder; and rectal or rectovaginal examination) in asymptomatic, nonpregnant, adult clients (*strong recommendation*, moderate-quality evidence).
3. Testicular Cancer Screening: The USPSTF (April 2011) recommends against screening for testicular cancer, by self-examination or clinical examination, in adolescents or adults. *Grade D Recommendation*
4. Ovarian Cancer Screening: The USPSTF (February 2018) recommends against screening for ovarian cancer in asymptomatic clients. (*Grade D Recommendation)* This recommendation does not apply to clients who are known to have a high-risk hereditary cancer syndrome.
5. Herpes Simplex Virus (HSV) screening: The USPSTF (November 2016) recommends against routine serological screening for HSV in asymptomatic adolescents and adults. *Grade D Recommendation*
6. Prostate Cancer Screening: The USPSTF (May 2018) recommends for clients aged 55 to 69, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, clients should have the opportunity to discuss the potential benefits and harms with their clinician; *Grade C Recommendation.*

**ASSESMENT/SUMMARY OF FINDINGS:**

1. Document a summary of all findings from the exams above, even if the finding is beyond the scope of services provided in the RH program.

**PLAN:**

1. Review assessment findings and develop and document a plan to address each finding.
2. Discuss how the client will be notified of laboratory test results or how to obtain results. Answer questions.
3. If client is interested in contraception, provide with method of their choice and related counseling and education. Refer to the method specific *Clinical Practice Standards* for guidance on method provision.
4. Inform client of the timing of the next assessment (e.g., 1 year) and document. Recommend timing of screening interval per national standards listed above.
5. Refer clients in need of follow-up or management that is beyond the scope of the program or not provided within the RH Program to their Primary Care Provider or local Federally Qualified Health Center.

CLIENT EDUCATION:

1. If client is not planning pregnancy at this time, provide information about all available methods of contraception. Refer to the method specific *Clinical Practice Standards* for guidance on method provision. Advise client of availability of emergency contraception, the formulations available, and the most appropriate formulation for the individual client based on their weight and BMI, and how to access it.
2. Provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents per *USPSTF Grade B Recommendation (August 2013).*
3. Provide preconception information if pregnancy is planned in the near future.
4. Explain the range of clinic services available, how they can be accessed, and the expected sequence of clinic visits.
5. Explain how to access services in case of an emergency.
6. Offer information on health promotion and disease prevention including nutrition, exercise, tobacco cessation, alcohol and drug abuse, domestic violence, and sexual abuse.

REFERRAL:

1. Refer for follow up of abnormal physical examination or laboratory findings that are beyond the scope of the agency’s services.
2. Discuss the importance of follow-up with the client and advise regarding the responsibility for complying with the referral.
3. Whenever possible, give a choice of referral providers.
4. Obtain consent to transfer information if needed.
5. Provide pertinent information to the referral provider.
6. Follow agency procedures for recall/follow-up visits and contacts.

**REFERENCES:**

# American College of Physicians. 2014. Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline. <https://www.acpjournals.org/doi/full/10.7326/M14-0701>

# American College of Obstetricians and Gynecologists. Breast Cancer Risk Assessment and Screening in Average-Risk Women. Practice Bulletin Number 179. July 2017. <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/07/breast-cancer-risk-assessment-and-screening-in-average-risk-women>

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

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**ATTACHMENT 1: BRCA Assessment Tools**

* + 1. **Ontario Family History Assessment Tool**

|  |  |
| --- | --- |
| Risk Factor | Points |
| **Breast and ovarian cancer** |
| Mother | 10 |
| Sibling | 7 |
| Second/third-degree relative | 5 |
| **Breast cancer relatives** |
| Parent | 4 |
| Sibling | 3 |
| Second/third-degree relative | 2 |
| Male relative (add to above) | 2 |
| **Breast cancer characteristics** |
|  Onset age, y |
|  20-29 | 6 |
|  30-39 | 4 |
|  40-49 | 2 |
|  Premenopausal/perimenopausal | 2 |
|  Bilateral/multifocal | 3 |
| **Ovarian cancer relatives** |
|  Mother | 7 |
|  Sibling | 4 |
|  Second/third-degree relative | 3 |
| **Ovarian cancer onset age, y** |
|  <40 | 6 |
|  40-60 | 4 |
|  >60 | 2 |
| **Prostate cancer onset** |
|  Age <50 y | 1 |
| **Colon cancer onset** |
|  Age <50 y | 1 |
| **Family total** |
|  Referral b | ≥10 |

b Referral with score of 10 or greater corresponds to doubling of lifetime risk for breast cancer (22%)

1. **Manchester Scoring System a**

|  |  |  |
| --- | --- | --- |
| Risk Factor (Age at Onset for Relative in Direct Lineage) | BRCA1`Score | BRCA2 Score |
| **Female breast cancer, y** |
|  <30 | 6 | 5 |
|  30-39 | 4 | 4 |
|  40-49 | 3 | 3 |
|  50-59 | 2 | 2 |
|  ≥30 | 1 | 1 |
| **Male breast cancer, y** |
|  <60 | 5b | 8c |
|  >60 | 5b | 5c |
| **Ovarian cancer, y** |
|  <60 | 8 | 5 |
|  >60 | 5 | 5 |
| **Pancreatic cancer** |
| Any age | 0 | 1 |
| **Prostate cancer, y** |
|  <60 | 0 | 2 |
|  ≥60 | 0 | 1 |
| **Total individual genes** | 10 | 10 |
| **Total for combined =15** |  |  |

Abbreviation: BRCA, breast cancer susceptibility gene

aA score of 10 in either column or a combined score of 15 for both columns would be equivalent to a 10% chance of identifying a BRCA1 or BRCA2 mutation.

bIf testing for BRCA2

cIf testing for BRCA1

1. **Referral Screening Toola**

|  |
| --- |
| History of Breast or Ovarian Cancer in the Family? If yes, Complete checklist |
| Risk Factors | **Breast Cancer at age ≤50 y** | **Ovarian Cancer at any age** |
| Yourself |  |  |
| Mother |  |  |
| Sister |  |  |
| Daughter |  |  |
| Mother’s side |
|  Grandmother |  |  |
|  Aunt |  |  |
| Father’s side |
|  Grandmother |  |  |
|  Aunt |  |  |
| ≥2 cases of breast cancer after age 50 y on same side of family  |  |
| Male breast cancer at any age in any relative |  |
| Jewish ancestry |  |

 aReferral if 2 or more checks in table.

1. **Pedigree Assessment Toola**

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| --- | --- |
| Risk Factor | Score for every Family Member with Breast or Ovarian Cancer Diagnosis, Including Second/Third Degree Relatives |
| Breast cancer at age ≥50 y | 3 |  |
| Breast cancer at age >50 y | 4 |  |
| Ovarian cancer at any age | 5 |  |
| Male breast cancer at any age | 8 |  |
| Ashkenazi Jewish heritage | 4 |  |
|  Total  |  |

bScore 8 or greater is the optimal referral threshold

1. **Seven-Question Family History Screeninga**

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| **No. Questions Yes/No** |
| 1 | Did any of your first-degree relatives have breast or ovarian cancer? |  |
| 2. | Did any of your relatives have bilateral breast cancer? |  |
| 3. | Did any man in your family have breast cancer? |  |
| 4. | Did any woman in your family have breast ***and*** ovarian cancer? |  |
| 5. | Did any woman in your family have breast cancer before age 50 y? |  |
| 6. | Do you have 2 or more relatives with breast ***and/or*** ovarian cancer? |  |
| 7. | Do you have 2 or more relatives with breast ***and/or*** bowel cancer? |  |

aOne positive response initiates referral.

1. **International Breast Cancer Intervention Study Modela**

|  |  |
| --- | --- |
| **No.** | **Risk Factor** |
| 1. | Personal history: current age, age at menopause, age at menarche, childbirth history menopausal status, use of menopausal hormone therapy |
| 2. | Personal breast history, breast density (optional), prior breast biopsy, history of cancer (breast or ovarian), genetic testing. |
| 3. | Ashkenazi Jewish inheritance |
| 4. | Family history (genetic risk) – relatives with breast or ovarian cancer, age at diagnosis, genetic testing |

aReferral for genetic testing if the personal risk level for mutation in breast cancer susceptibility gene 1 or 2 is 10% or greater.