RHCare
Reproductive Health Care

RHCare Certification Packet

Version 3.0

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Oregon Health Authority

RHCare Certification Packet

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The Reproductive Health (RH) Program is dedicated to ensuring all people in Oregon have access to high-quality reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. By using funding from multiple sources, the RH Program supports clinics across the state, and works to ensure all people with reproductive capacity have access provide high-quality, culturally responsive reproductive health services.

RH Program Vision: All people in Oregon have reproductive autonomy.[1]

The RH Program commits to working towards racial equity by addressing racism and implicit bias and reducing systemic barriers to care. We acknowledge the past and present role of government in creating inequities and doing harm to communities of color and tribal and indigenous communities in Oregon, leading to historical and ongoing trauma. We envision an Oregon where all community members thrive, and racial inequities are eliminated. The RH Program's full statement on racial equity can be found here.

Chapter 1. RHCare Introduction

RHCare is a public health program administered by the Oregon Reproductive Health (RH) Program. Health care agencies and their clinics can become certified RHCare sites and receive reimbursement for services provided to clients enrolled in the RH Access Fund. The RH Access Fund is a coverage source, also administered by the RH Program, into which clients may enroll to cover many of their reproductive health needs.

Although RHCare does provide reimbursement, it is not just a coverage source. The RH Program believes that all people are entitled to high-quality, culturally-responsive reproductive health services. Therefore, RHCare clinics are required to provide the same high-quality, culturally-responsive reproductive health services to all clients with reproductive capacity, regardless of ability to pay. The RHCare Certification Requirements are based on:

- Nationally Recognized Standards (e.g., US Preventive Services Task Force, US Medical Eligibility Criteria for Contraceptive Use),
- Providing Quality Family Planning Services (QFP) – Recommendations from the Centers for Disease Control and Prevention (CDC), and the Office of Population Affairs (OPA), and
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

[1] Reproductive autonomy is having the power to decide and control contraceptive use, pregnancy, and childbearing. For example, women with reproductive autonomy can control whether and when to become pregnant, whether and when to use contraception, which method to use, and whether and when to continue a pregnancy. *From The Bixby Center for Global Reproductive Health, University of California, San Francisco.*

All RH services supported under RHCare must be delivered in compliance with the requirements of the Federal Title X Program as detailed in statutes and regulations, including but not limited to 42 USC 300 et.seq., 42 CFR Part 50 subsection 301 et seq., and 42 CFR Part 59 et seq., the Title X Program Requirements, and OPA Program Policy Notices (PPN).

This document outlines the minimum requirements that health care clinics must meet to be a certified RHCare clinic per OAR 333-004-3000 through 333-004-3240. Clinics may provide services beyond these minimum requirements.

Chapter 2. RHCare Certification Process

a. To be eligible to become a RHCare clinic, the clinic's parent agency must:
    1. Meet applicable licensing or regulatory requirements set forth by federal and state statutes, regulations, and rules.
    2. Have a valid business license if such a license is a requirement of federal, state, or local government to operate a business or to provide services.
    3. Have a current CLIA certification, if applicable.
    4. Have a current Board of Pharmacy license, if applicable.
    5. Be enrolled as an OHP Provider.
    6. If an applicant agency is located out of the state of Oregon, it may enroll under the following conditions:
        A. The applicant agency is appropriately licensed or certified and meets standards established within the provider's state for participation in Medicaid; and
        B. The applicant agency is located in a state contiguous to Oregon and is within 75 miles of the Oregon border.
    7. Meet with RH Program staff to discuss program requirements and clinic staff capacity. Applicant agency/clinic staff who must attend the meeting may include:
        A. Authorizing official(s);
        B. Clinical supervisor(s);
        C. Billing supervisor(s); and
        D. Front desk manager(s).
    8. An applicant agency or any of its providers that are currently subject to sanctions by the Authority or the federal government are not eligible for enrollment as an agency.
b. An agency must submit a RHCare Certification Application and all supporting documents to the RH Program. (Contact the RH Program to request an application: rh.program@oha.oregon.gov).

c. The RH Program will determine if the application is complete and notify the agency of its determination within seven calendar days of receipt of the application.
    1. If the RH Program determines that the application is not complete, the RH Program will notify the agency and the agency will have 30 calendar days to complete their application.
        A. If the agency does not complete their application within 30 calendar days, their application will be denied.
        B. The agency may then re-apply or appeal the decision per OAR 333-004-3220.

d. Once an application is determined to be complete, the RH Program will review the applicable documents and determine if the agency meets the certification requirements.

e. If the RH Program determines that the agency meets the RHCare Certification Requirements , the RH Program will inform the agency in writing that the application has been approved and that the agency is certified. This notification will occur no more than 30 calendar days after the RH Program has determined the application to be complete.

f. Once an application for certification has been approved, the RH Program will provide a RHCare Medical Services Agreement (MSA) to be signed by both the Oregon Health Authority and the certified agency.

g. If the agency does not meet all the RHCare Certification Requirements in its application, the RH Program may deny certification.
    1. The RH Program will respond to the agency with a letter of denial providing a clear description of reasons for denial, based on the certification requirements.
    2. An agency may request that the program reconsider the denial of RHCare certification. A request for reconsideration must be submitted in writing to the RH Program within 90 calendar days of the date of the denial letter and must include a detailed explanation of why the applicant believes the Program's decision is an error along with any supporting documentation.
    3. The RH Program shall inform the agency in writing, within 30 calendar days of receipt of the request, whether it has changed its decision.
    4. The agency may appeal this decision per OAR 333-004-3220.

h. A certified agency must renew its certification every odd year.

Chapter 3. RHCare Program Monitoring and Compliance Process

a. The RH Program may conduct an onsite verification review to provide technical assistance and determine compliance with certification requirements of each approved agency that

has not been previously certified with the RH Program to administer RHCare within one year of application approval.

b. After the initial on-site verification review, the RH Program will conduct regular compliance reviews for all agencies, based on a schedule developed by the RH Program.
    1. RH Program staff will work with the agency to schedule onsite reviews every three years at a mutually agreed upon time. The agency will be notified, in writing, a minimum of 60 calendar days before its scheduled on-site verification review.
        A. Onsite reviews include, but are not limited to:
            i. Review of documents, policies, and procedures;
            ii. Discussions/interviews with staff;
            iii. Review of medical charts;
            iv. Assessment of client experience; and
            v. Observation of clinic environment and practices.
        B. Onsite reviews may be postponed or conducted remotely during a public health emergency.
    2. The RH Program will perform regular billing, enrollment, medical chart, and other reviews as needed.

e. The RH Program may conduct a review of the agency without notice of any or all certification requirements for compliance and perform a verification on-site review if the RH Program is made aware of issues of compliance or complaints from any source.

f. At any time, the agency may request an administrative review of compliance, which includes an onsite visit. The review will be considered a "no-penalty" review with the exception of gross violation or negligence that may result in agency decertification.

g. An agency that has been terminated due to OAR 333-004-3050(2)(a)(A) or (C) may not apply for certification for two years after termination.

If you have questions, please contact us:

Oregon Reproductive Health Program
800 NE Oregon St.
Portland, OR 97222
rh.program@oha.oregon.gov
www.healthoregon.org/rh

RHCare Certification Requirements, Version 3.0

Please note: For the purposes of these requirements, client means any person who has reproductive capacity and is seeking reproductive health services at a RHCare clinic.

Section A. Facility, Operations, and Staffing

A.1 Clinic Space

a. Clinics must make efforts to create a welcoming and inclusive environment whereby the clinic space and signage are reflective of all clients including but not limited to communities of color, teens, LGBTQ+ individuals, and people with disabilities.
b. The agency's clinic facility(s) must be compliant with ADA requirements.

A.2 Infection Control

a. Clinics must utilize Standard Precautions for infection control, following CDC guidelines.

A.3 Laboratory

a. Clinics must maintain the appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification, and must have written policies that align with CLIA rules and regulations. Staff competency assessment must be included in the policies.
b. Clinics must have the ability to collect specimens and samples. Specimens and samples may be sent off-site to a CLIA-certified laboratory.

A.4 Pharmacy and Dispensing Medications and Contraceptive Methods

a. Medications and contraceptive methods included under RHCare must be dispensed on-site following Oregon Board of Pharmacy rules and per appropriate licensure (OAR 855-043).
b. Clinics may offer clients the option of receiving their contraceptive methods by mail at no additional cost to the client.
    1. Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive contraceptive methods.
    2. Clinics must package and mail supplies in a manner that ensures the integrity and confidentiality of the contraceptive packaging and effectiveness of the method upon delivery.

A.5 Emergencies

a. Clinics must maintain a written plan for medical emergencies, including:
    1. Anaphylaxis/Shock;
    2. Vaso-vagal reaction/Syncope;
    3. Cardiac Arrest/Respiratory Difficulty (if the clinic has an automated external defibrillator (AED) include protocol on how to use); and
    4. Hemorrhage.
b. Clinics must maintain a written after-hours emergency policy management plan.
c. Clinics must meet applicable fire, building, and licensing codes and standards and maintain Exit Routes, Emergency Action Plans, and Fire Prevention Plans in accordance with OSHA.

A.6 Reproductive Health Coordinator

a. The agency must designate a staff person as a Reproductive Health Coordinator (RHC) to be the key point of contact in accordance with OAR 333-004-3040. The RHC is responsible for all the items listed in the RH Coordinator Competencies, including, but not limited to:
   1. Ensuring program compliance at all clinic sites;
   2. Being the agency's subject matter expert on all aspects of the RHCare certification requirements and how they are operationalized within clinic sites;
   3. Acting as the primary contact with the Oregon RH Program; and
   4. Managing the implementation and operationalization of RHCare certification requirements in all participating clinics.

b. If the agency's designated RHC does not comply with these responsibilities, the RH Program may require the agency to designate a different agency staff person.

c. When an RHC is designated, the designated RHC and a higher-ranking staff member (e.g. agency administrator, the RHC's supervisor) who understands the RHC's workload and job duties must sign the RH Coordinator Competencies.

d. The agency must notify the RH Program within 10 business days of when the designated RHC leaves the agency, takes a leave of absence longer than one month, or if a different staff member is being assigned the role of RHC.
   1. In the case of a leave of absence longer than one month, an interim RHC must be assigned.

A.7 Staff Training Requirements

a. Upon RHCare clinic certification or new hire, clinic staff must receive training on the following topics:
   1. RHCare certification requirements, policies, and processes (as applicable to staff roles);
   2. Title X orientation (all staff working in reproductive health);
   3. Client-centered, nondirective pregnancy options counseling (staff who provide pregnancy options counseling); and
   4. Reproductive Justice in the clinical setting (all staff working in reproductive health).

b. Annually, clinic staff must receive training on the following topics:
   1. Healthy relationships and adult engagement, including how to document the provider/client discussion (direct service providers);
   2. Identifying and reporting suspected abuse (i.e., mandatory reporting), including human trafficking (all staff designated as mandatory reporters); and

3. Equity, including topics related to racism, health equity, cultural-responsiveness[1], and/or trauma-informed[2] care in providing sexual and reproductive health clinical services (all staff working in reproductive health).

c. On an ongoing basis, clinic staff who interact with clients must be offered training opportunities on topics related to reproductive health, as appropriate to their staff roles.

A.8 Quality Assurance and Quality Improvement

a. Agencies must follow a documented process to address quality assurance and quality improvement efforts related to reproductive health care services within their clinic(s).

b. Agencies must ensure that end-user engagement, feedback, and data is used to inform and improve the provision of client-driven, trauma-informed, culturally-responsive services. This must include:
   1. Using a client advisory panel or other structured means for clients to provide input.
   2. Using client demographic data to inform and improve the provision of trauma-informed, culturally-responsive services.

A.9 Compliance with Financial Oversight

a. The agency must comply with the applicable financial oversight, audit requirements, and responsibilities set forth in the Oregon Revised Statutes, use of general funds under ORS 293.590 – 293.660, and ORS 297

b. The agency must adhere to proper fiscal oversight and stewardship of all public funds. This includes but is not limited to, proper accounting and documentation of all funds received, financial reporting completed as requested, and review of all documentation and submissions to ensure proper recordkeeping of all funds.

Section B. Equitable Access

B.1 Access to Care

a. Reproductive health services must be provided to any individual of reproductive capacity who is seeking them.

b. Clinics must offer the same scope and quality of services regardless of:

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[1] Culturally-Responsive means paying particular attention to social and cultural factors in managing medical encounters with patients from different social and cultural backgrounds. The word “responsiveness” places emphasis on the capacity to respond. In practice this boils down to utilizing a set of tools – questions and skills for negotiation based on cultural knowledge – which they can incorporate into their interactions with patients from diverse cultural backgrounds. Examples include finding out about the patient’s history of present illness, their health beliefs and use of alternative treatments, expectations of care, linguistic challenges, and culturally-based family dynamics that guide decision-making processes. (Culturally Responsive Care by Marcia Carteret, M.Ed. https://www.dimensionsofculture.com/2010/10/576/)

[2] Trauma-informed means an approach, based on knowledge of the impact of trauma, aimed at ensuring that environments and services are welcoming and engaging for recipients and staff. (Trauma Informed Oregon: traumainformedoregon.org)

1. Race, skin color, national origin, religion, immigration status, sex, sex characteristics, sexual orientation, gender identity, age, number of pregnancies, marital status, or disability, in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, section 1557 of the ACA, the Americans with Disabilities Act (ADA) of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A.
2. Ability to pay or insurance coverage.
3. Location of residence.

c. All reproductive health services must be provided without a referral requirement.

d. Clients who cannot be provided services within two weeks must be offered information about other reproductive health providers in the area, including whether or not they are RHCare providers.

B.2 Cultural Responsiveness

a. Agencies must implement a written, ongoing comprehensive strategy to provide equitable, trauma-informed, culturally-responsive services. The strategy should include an assessment, action plan, and evaluation.

b. Clinics must ensure that clinical services are provided in a way that makes it easy and comfortable for youth to seek and receive the services they need.

c. Clients must be treated in a trauma-informed manner that is responsive to their identities, beliefs, communication styles, attitudes, languages, and behavior.

B.3 Linguistic Responsiveness

a. Clinics must communicate with clients in their preferred language and provide interpretation services in the client's preferred language, at no cost to the client.
   1. Clinics must inform all individuals, in their preferred language, both verbally and in writing, that language services are readily available at no cost to them, in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA).
   2. All persons providing interpretation services must adhere to confidentiality guidelines.
   3. Family and friends may not be used to provide interpretation services, unless requested by the client.
   4. Individuals under age 18 should never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance.

b. Clinics must have materials and signage that are easily understandable and in languages commonly used by the populations in the service area.
   1. Medically accurate, culturally and linguistically appropriate, inclusive, and trauma-informed health educational materials must be available for clients needing them.

2. All print, electronic, and audiovisual materials must use plain language[3] and be easy to understand. A client's need for alternate formats must be accommodated.

B.4 Information & Education Committee (I & E Committee)

a. Health education materials[4] must be reviewed by an Information and Education (I & E) committee. Agencies can develop and maintain their own I & E committee, or they can have materials reviewed and approved by the state I & E committee. In addition to the I & E committee your agency may also choose to have additional groups review materials that are issue or identity specific and require expertise the I & E Committee may not hold.
    1. If an agency chooses to maintain their own I & E Advisory Committee, the agency must assure that it broadly represents the population and community for whom the materials are intended.
    2. The I & E committee must maintain a minimum of five members.
    3. In reviewing materials, the I & E committee must:
        i. Consider the educational, cultural, and diverse backgrounds of individuals to whom the materials are addressed;
        ii. Consider the standards of the population or community to be served with respect to such materials;
        iii. Review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, inclusive, and trauma informed;
        iv. Determine whether the material is suitable for the population or community to which is to be made available; and
        v. Establish a written record of its determinations.

B.5 Fiscal Requirements

a. Clients may not be denied any reproductive health services or be subjected to any variation in the quality of services based on their inability to pay or insurance coverage.
b. Prior to the visit and in a confidential manner, clients receiving services for which they do not have coverage (e.g., OHP, RH Access Fund) must be informed that they may be expected to pay.
c. Clinics must use a sliding fee schedule up to 250% of the Federal Poverty Level for reproductive health services provided to clients without coverage, unless federal regulations say otherwise.
    1. Clients whose self-reported income is at or below 100% of the Federal Poverty Level must not be charged.

[3] A communication is in plain language if its wording, structure, and design are so clear that the intended readers can easily find what they need, understand what they find, and use that information. (Plain Language Association International: https://plainlanguagenetwork.org/)

[4] Health education materials are any brochures, posters, videos, or other materials, printed or electronic, that your agency uses to help inform or educate clients about reproductive health.

2. The sliding fee schedule must be based on an analysis of the costs of all services offered in the clinic.
3. When assessing a client's fees based on the sliding fee schedule, clinics must use the client's household size and only the client's own income.
4. Income is self-reported, and proof of income may not be required.
5. The agency's fee schedule must be available upon request.
6. Clinics may not charge a flat fee (e.g. minimum fee, nominal fee, no-show fee, etc.).
7. If a client has private insurance, their Federal Poverty Level must be assessed before copays or additional fees are charged. The client should not pay more in copays or additional fees than what they would otherwise pay when the sliding fee scale is applied.

d. Clients with insurance must be informed of any potential for disclosure of their confidential health information to the policyholder(s) of their insurance.
e. Priority may not be given to clients with sources of insurance coverage or with incomes above 250% of the Federal Poverty Level.
f. Clinics must make reasonable efforts to collect charges without jeopardizing client confidentiality. Clients may not be sent to collection agencies.
g. A clinic may accept voluntary donations.

Section C. Clients' Rights and Safety

C.1 Confidentiality

a. Safeguards must be in place to ensure confidentiality, and to protect clients' privacy and dignity throughout the clinic space, during clinic interactions, and in record keeping.
b. Information obtained by staff may not be disclosed without written consent, except as required by law or as may be necessary to provide services to the individual.
c. All aspects of service provision must be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.
d. For services provided via telehealth, staff must comply with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority/OHA) Confidentiality and Privacy Rules and security protections for the client in connection with telemedicine technology, communication, and related records.
e. A copy of a patients' bill of rights must be posted in a public area of the clinic in the languages most commonly used by clients.

f. Minors (under 18 years)[5] & Confidentiality
   1. Clinic staff are prohibited from requiring written consent from parents or guardians for the provision of reproductive health services to minors.
   2. Clinic staff may not notify a parent or guardian before or after a minor has requested and/or received reproductive health services.
   3. Services must, however, comply with legislative mandates to encourage family participation in the decision of minors to seek reproductive health services, and as such, staff will encourage, but not require, the inclusion of parents/guardians/responsible adults in their decision to access reproductive health services.

C.2 Noncoercion

a. All services must be voluntary
   1. Clients may not be coerced to accept services or to use a particular method of birth control.
      i. Clinic staff must be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.
   2. Receipt of reproductive health services may not be a prerequisite for eligibility for, or receipt of services, assistance, or participation in any other program.

C.3 Informed Consent

a. Upon establishing care, clients must sign an informed consent form for reproductive health services.
   1. Informed consent for reproductive health services may be incorporated into the clinic's general consent for services.
b. The informed consent process, provided verbally and supplemented with written materials by the clinic, must be presented in plain language.
c. Telehealth
   1. Clinics must obtain informed consent from the client for the use of telehealth as an acceptable mode of delivering reproductive health services. The consent must be documented in the client's health record or in each telehealth visit note.

C.4 Mandatory Reporting

a. Agencies must maintain a written policy that requires clinic staff to follow state and federal laws regarding mandatory reporting and assists staff to recognize and acknowledge their responsibility to report suspected abuse or neglect of a protected person pursuant to Federal and State law. The policy must:
   1. Address mandatory reporting obligations regarding sexual abuse, and
   2. Be updated when applicable laws change.

[5] Under Oregon law, anyone under the age of 18 is considered a minor (ORS 419B.550 [definition of minor] and ORS 109.510 [age of majority]).

Section D. Services

D.1 Service Delivery

a. Services must be provided using a trauma-informed, inclusive[6], culturally-responsive, and client-driven[7] approach that helps the client clarify their needs and wants, promotes personal choice and risk reduction, and takes into account the cultural and socioeconomic factors of the client and psychosocial aspects of reproductive health.

D.2 Clinical Practice Standards

a. Clinics must adopt and follow the RHCare Clinical Practice Standards (CPSs) that are based on national standards of care and best practices to ensure all clients receive the same quality and scope of reproductive health services.
    1. The RH Program must approve any modification to CPSs made by clinics.
b. The agency's Health Officer, Medical Director, or medical designee[8] must review and sign all RHCare CPSs attesting that certified RHCare clinics will follow them in all RHCare visits. The agency must then submit the RHCare Clinical Practice Standards Attestation Form (see Appendix B).
    1. A RHCare Clinical Practice Standards Re-Attestation Form must be submitted:
        i. When the agency's Health Officer, Medical Director, or medical designee who originally signed the RHCare CPSs changes. The agency's new Health Officer, Medical Director, or medical designee must review and sign all RHCare CPSs attesting that certified RHCare clinics will follow them in all RHCare visits within three months.
        ii. When the RH Program updates a CPS. Agencies' CPSs must align with the CPSs posted on the RH Program's website, therefore, agencies must update their corresponding CPS within three months of the change.
c. If a clinic does not offer a method for which there is a CPS, the clinic does not need to adopt that method's CPS.
d. Agencies must notify the RH Program within 10 business days when the agency's Health Officer, Medical Director, or medical designee changes.

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[6] Inclusive means all people are included and can actively participate in reproductive health decision making, including, but not limited to people who belong to communities that have been historically marginalized such Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)

[7] Client-driven means the client's preferences and needs are prioritized, and their values guide all decision-making.

[8] Medical designee means a clinician who is trained and permitted by state-specific regulations to perform all aspects of the physical assessments recommended for contraceptive, related preventive health, basic infertility care. They must work at the agency on a regular basis, have prescribing and medical decision-making authority, and be familiar with RHCare requirements and the agency's staffing and clinical practices.

D.3 Clinical Services

a. Clinics must offer the full scope of services as defined by RHCare to all clients regardless of their ability to pay or insurance coverage. See Appendix A for the detailed list of services. The full scope of services includes:
   1. A broad range of contraceptive methods, including device insertion and removals;
   2. Core reproductive health services;
   3. Contraceptive services;
   4. Counseling and education services;
   5. Pregnancy testing and counseling on all pregnancy options, including parenting, abortion, and adoption;
   6. Preconception health services;
   7. Basic infertility services;
   8. Sexually transmitted infection (STI) screening and treatment, within the context of a family planning visit; and
   9. Breast and cervical cancer screening, within the context of a family planning visit.

b. Clinics must notify the RH Program within 10 business days if they are unable to provide the full scope of services (e.g. loss of clinical provider) for one month or longer.

c. Clients must be able to get their first choice of contraceptive method unless there are specific contraindications.

d. Limited exceptions to the clinical services and contraceptive supply requirements as described in D.3.a may be considered. Please see Appendix C for more information.

D.4 Counseling and Education Services

a. Clinics must offer the list of counseling and education topics as detailed in Appendix A.

b. Pregnant people must be offered information and counseling regarding each of the options in a neutral, factual, and non-directive manner: parenting, abortion, and adoption.

c. Clinics must offer/provide written information about all pregnancy options. It must be written in a factual and non-directive manner and include contact information for agencies that give medically-accurate, unbiased information about the option(s) for which they are being listed.

D.5 Referrals and Information Sharing

a. Clients must be offered information about:
   1. Where to access free or low-cost primary care services,
   2. How to obtain full-benefit health insurance enrollment assistance, public or private, as needed, and
   3. Resources available in the community to address barriers that might exist for clients, including but not limited to transportation, childcare, housing, and food insecurity, as appropriate.

b. Clinics must provide closed-loop referrals[9] for clinical services within the scope of RHCare that require follow-up to ensure continuity of care.

D.6 Telehealth Services

a. Clients must be given the option to have an in-person visit and informed of the scheduling options, services available, and restrictions of both types of visits.[10]

Section E. Data Collection and Reporting

E.1 Collection and Submission of Encounter Data

a. Clinics must collect all required visit/encounter data variables as indicated on the RH Program Clinic Visit Record (CVR) for:
    1. Visits in which the primary purpose is to prevent or achieve pregnancy,
    2. Annual visits that include services related to preventing or achieving pregnancy,
    3. Repeat cervical cancer screening visits,
    4. Follow-up visits for treatment and rescreening of GC/CT, pursuant to a visit as described in 1. or 2. above, and
    5. Visits in which the primary purpose is STI screening and the clients meets the RHEA eligibility requirements.

b. Clinics must submit CVR data to the RH Program or its data collection vendor, as directed.

E.2 Other Data and Reporting Requirements

a. Agencies must submit annual updates on agency, clinic, and staff contact information to the RH Program.
    1. If any of this information changes, agencies must update the RH Program within 30 calendar days of when the change occurs.

b. Agencies must provide additional information as requested by the RH Program.

Section F. Reproductive Health Access Fund

F.1 Client Enrollment

a. Clients must not be required to enroll in the RH Access Fund to receive services.
    1. Clinics must provide reproductive health services to clients with reproductive capacity who decline to enroll in the RH Access Fund.

b. Clinic staff must emphasize that alternative programs may be available for clients ineligible for the Reproductive Health (RH) Access Fund.

c. Clinic staff must support clients in completing the RH Access Fund Enrollment Form accurately and to the best of the client's knowledge.

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[9] Closed-loop referral means a referral process in which the referring clinic or provider receives information from the entity to which a client was referred about the services they received. This excludes abortion care, as it is considered a self-referral.

[10] Exceptions to this requirement are permitted during a public health emergency.

d. Clinic staff must ensure that all required client enrollment data is collected using the RH Access Fund Enrollment Form, that all fields are completed, and that it is signed and dated appropriately, unless they receive written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database. Enrollment Forms may not be backdated.
    1. If the Enrollment Form is completed remotely, either over the telephone or during a video visit, clinic staff must write the client's name on the signature line and the day's date with a note that consent was obtained verbally, unless the clinic receives written approval from the RH Program to enter client enrollment data directly into the RH Access Fund Eligibility Database.

e. All required client enrollment data must be entered into the web-based RH Access Fund Eligibility Database.

f. As part of the client enrollment process, clinics must comply with all relevant National Voter Registration Act (NVRA) rules. (OARs 165-005-0060 through 165-005-0070).

F.2 Billing and Payment

a. RH Access Fund enrollees may not be charged for services covered by the RH Access Fund. See OARs 333-004-3070 and 333-004-3090 for RH Access Fund-covered services and client eligibility, respectively.

b. Enrollees may not be billed for services that would normally be covered by the RH Access Fund if not for an error on the part of clinic staff.

c. Enrollees may be billed for services that are outside of the RHCare scope of services as defined in OAR 333-004-3070.

d. Prior to the visit and in a confidential manner, enrollees receiving services not covered by the RH Access Fund must be informed that they may be expected to pay.

e. Clinics may not request a deposit from the enrollee in advance of services covered by the RH Access Fund.

f. Clinics must submit claims to the RH Program or its claims processing vendor, as directed.

g. Clinics have a legal obligation to seek third party reimbursement, if applicable, prior to billing the RH Access Fund. The clinic:
    1. Must be enrolled with and bill the Oregon Health Plan (OHP);
    2. Must be credentialed with and bill private insurance companies; and
    3. Must assure confidentiality, when indicated.
        i. Including not seeking third party reimbursement if the client requested confidentiality.

h. For services billed to the RH Access Fund, the clinic must accept RH Access Fund reimbursement as payment in full and may not charge the enrollee additional fees for those services.

i. Clinics must register and maintain 340B and Apexus Prime Vendor certification, if eligible. Reimbursement for supplies will be based on 340B drug program pricing or actual acquisition cost.

Appendix A. RHCare Scope of Services

1. A broad range of contraceptive methods, as defined below:

Available onsite (i.e. stock onsite)	Offer (must be available at clinic within 7 business days)	Refer for
Hormonal and nonhormonal IUDs	Internal condoms	Sterilization, both tubal and vasectomy
Subdermal implant	Either diaphragm or cervical cap	
Hormonal injection	Ring, if not available onsite	
Combination oral contraceptives	Patch, if not available onsite	
Progestin-only pill		
At least one non-oral combination contraception (ring or patch)		
Vaginal pH modulators		
Fertility Awareness Method (FAM)		
Information about abstinence and withdrawal		
Emergency contraception (Ella and Plan B)		
Latex and non-latex external condoms		
Spermicide		

2. Core reproductive health services:

- Obtaining a medical history;
- Clarifying the client's reproductive needs and preferences;
- Performing a sexual health assessment;
- Screening for depression;
- Screening for Intimate Partner Violence (IPV)/contraceptive coercion, counseling, and referring for additional assistance when indicated;
- Screening for tobacco/illicit substance use, counseling, and referring for cessation assistance when indicated;
- Screening for immunization status and recommending/offering vaccination when indicated; and
- Screening for sexually transmitted infections (STIs) per national standards, and offering individualized risk reduction counseling;

Appendix A. RHCare Scope of Services

3. **Contraceptive services:**
    - Identifying the client's contraceptive experiences and preferences;
    - Working with the client to select the most appropriate contraceptive method;
    - Conducting a physical assessment related to contraceptive use and per national standards when warranted;
    - Offering a broad range of contraceptive options and the ability to provide them;
    - Providing a contraceptive method with instructions, plan for using the method, follow-up schedule, and confirmation of client's understanding;
    - Follow-up and additional counseling as needed.

4. **Counseling and Education services:**
    - Contraception
    - Sterilization, vasectomy and tubal
    - Infertility
    - Preconception
    - STI risk reduction
    - Adult engagement
    - Healthy relationships, including relationship safety and consent
    - Pregnancy options, including parenting, abortion, and adoption

5. **Pregnancy testing and counseling services:**
    - Performing a pregnancy test.
        - If the test if positive:
            - Counseling on all pregnancy options, including parenting, abortion, and adoption;
            - Assessing for symptoms of and information regarding ectopic pregnancy;
            - Providing general information on pregnancy; and
            - Referring for services requested.
        - If the test is negative:
            - Contraceptive services if client doesn't wish to be pregnant; and
            - Preconception and/or infertility services and information if seeking pregnancy.

6. **Preconception health services:**
    - Providing individualized care to improve outcomes if a pregnancy occurs (e.g. reduce tobacco use, start taking folic acid, etc.).

7. **Basic infertility services:**
   - Medical exam, as indicated;
   - Counseling on achieving pregnancy; and
   - Referring for additional infertility services when indicated.

8. **Sexually transmitted infection (STI) services, within the context of a family planning visit:**
   - Screening for STIs per national standards, testing for STIs within the context of a RH visit based on individualized risk, and providing individualized risk reduction counseling;
   - Treatment and rescreening for gonorrhea/chlamydia pursuant to family planning visit

9. **Breast and cervical cancer screening, within the context of a family planning visit:**
   - Cervical Cytology services include:
     - Cervical cytology screening, per national standards;
     - Repeat cervical cytology pursuant to a family planning visit per national standards; and
     - Referral for additional procedures outside of scope (e.g. colposcopy).
   - Breast Cancer services include:
     - Providing a clinical breast exam when indicated per national standards;
     - Screening for BRCA risk by medical and family history; and
     - Referral for abnormal exam results or positive results on risk assessment tool, per national standards.
   - Mammography referrals include:
     - Recommending mammography per national standards; and
     - Referral for mammography.

Appendix A. RHCare Scope of Services

REFERENCES:

Oregon Administrative Rules (OARs) 333-004-3000 through and 333-004-3240

Oregon Reproductive Health Program Certification Requirements for RHCare Clinics, Version 2.

Centers for Disease Control and Prevention, 2013. U.S. Selected Practice Recommendations for Contraceptive Use. Retrieved from: http://www.cdc.gov/MMWr/preview/mmwrhtml/rr6205a1.htm

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Centers for Disease Control and Prevention, 2015. Update: Providing Quality Family Planning Services – Recommendations from CDC and the U.S. Office of Population Affairs. Retrieved from: https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm

Centers for Disease Control and Prevention, 2016. U.S. Medical Eligibility Criteria for Contraceptive Use. Retrieved from: https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm?s_cid=rr6503a1_w

Appendix B. RHCare Clinical Practice Standards Attestation

The Clinical Practice Standards (CPSs) ensure that all clients receiving reproductive health services are provided the same quality and scope of reproductive health services. To become an RHCare agency, the agency's Health Officer, Medical Director, or their medical designee[8] must review and sign the RHCare Clinical Practice Standards. By signing the CPSs, the Health Officer, Medical Director, or medical designee[8] is attesting that certified RHCare clinics will follow them in all RHCare visits. The agency must then complete the CPS Attestation Form.

All the Clinical Practice Standards are listed in the table below, and can be found on our Clinical Practice Standards webpage.

RHCare Clinical Practice Standards	
Basic Infertility Services	Pharmacy – Dispensing Medications
Coitus Interruptus (Withdrawal)	Preconception Health Visit
Combination Oral Contraceptives	Pregnancy Test Visit
Core Reproductive Health Services	Prescription Visit
Depo Provera	Progestin-Only Pills
Diaphragm and Cervical Cap	Reproductive Health Well Visit
Emergency Contraception	STI Screening, Testing, and Treatment
External Condoms	Subdermal Implant
Fertility Awareness-Based Methods	Tubal Sterilization – Counseling & Referral
Hormonal Contraceptive Patch	Vaginal Contraceptive Ring
Internal Condoms	Vaginal Spermicides and pH Modulators
Intrauterine Contraception	Vasectomy – Counseling & Referral
Lactational Amenorrhea Method (LAM)	

To complete the Clinical Practice Standards Attestation form go to:
https://app.smartsheet.com/b/form/e76e2f50964549349794e6c3f6af1627

Appendix C. RHCare Clinic Exceptions

In limited circumstances, the Reproductive Health Program may grant clinics exceptions to the following certification requirements:

- D.3.a Clinics must offer the full scope of clinical services and contraceptive supply requirements as defined by the RH Program.

For an exception to be considered, the site must meet the minimum criteria below:

- Services provided must follow national standards of care and be culturally-responsive and client-driven.
- Have a dedicated, private area for services to be conducted.
- Offer clinical services that meet the minimum scope of practice of an RN.
- Provide a referral for the clinical services and contraceptive supplies not available at the site.
- Offer written and verbal pregnancy options information and counseling about parenting, abortion, and adoption in a neutral, factual, and non-directive manner.

The RH Program will consider each request on a case-by-case basis.

To view and complete the RHCare Exception Clinic Request Form go to:
https://app.smartsheet.com/b/form/cf051bd83a8f431a91536d1c34ebbd51