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# Where are we going? RH Program 2.0

Reproductive Health Coordinators' Meeting  
Wednesday, October 23rd



PUBLIC HEALTH DIVISION  
Reproductive Health Program

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# RH Program Certification Requirements, Version 1

Drafted January 2018,  
updated July 2019



**Oregon Reproductive Health Program**  
**Certification Requirements for Reproductive Health Services**  
**Version 1.2**

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**Introduction**

The Oregon Reproductive Health (RH) Program oversees a statewide network of certified health care providers to ensure access to a suite of reproductive health services (preventive reproductive health care, preconception, and contraception). These services are provided to all individuals regardless of race, color, national origin, immigration status, sex, sexual orientation, gender identity, age, or disability.

This document outlines the minimum requirements service providers must meet in order to be certified by the Oregon Health Authority (OHA) RH Program and receive funding per OAR 333-004-2000 through 333-004-2190.

The Certification Requirements provide the foundation for high-quality services based on national standards of care and align with best practices and recommendations for comprehensive client-centered, culturally-responsive preventive care. The Certification Requirements are based on the following:

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

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**Background**

In 1999, Oregon applied for and received a Medicaid 1115 waiver for family planning which allowed for an expansion of Medicaid coverage to include more people. This program eventually became Oregon ContraceptiveCare or CCare. As a Medicaid program, clients must be either a U.S. citizen or hold eligible immigration status to receive services under CCare.

In 2017, the Oregon Legislature passed the Reproductive Health Equity Act (HB 3391) in response to community partners advocating for the necessity for all women to receive the full array of reproductive health services without cost sharing.

The Reproductive Health Program also receives state general funds to support the provision of high-quality reproductive health services.

# Rooted in Title X

## 8.6 Staff Training and Project Technical Assistance

Title X grantees are responsible for the training of all project staff. Technical assistance may be provided by OPA or the Regional Office.

- 8.6.1 Projects must provide for the orientation and in-service training of all project personnel, including the staff of sub-recipient agencies and service sites (42 CFR 59.5(b)(4)).
- 8.6.2 The project's training plan should provide for routine training of staff on Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as on human trafficking
- 8.6.3 The project's training plan should provide for routine training on involving family members in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities.

## B.7 Required Training

- a. Orientation to the RH Program is provided to all new agencies by state Program staff within three months of becoming a certified provider of reproductive health services.
- b. The designated RHC at each agency is responsible for coordinating subsequent staff orientation and training.
- c. At minimum, the agency/RHC is responsible for providing annual training to staff on the following:
  - 1. Encouraging family involvement,
  - 2. Relationship safety – counseling on resisting sexual coercion,
  - 3. HIPAA compliance,
  - 4. Mandatory reporting,
  - 5. Cultural responsiveness,
  - 6. Blood borne pathogen prevention, and

# Summer 2019

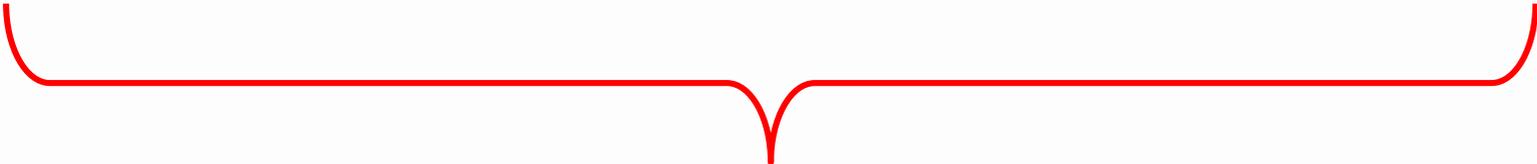
- Termination of Title X grant
- Use of general funds to ensure ongoing provision of and access to full scope of services
- Begin process to identify RH Program hallmarks/foundations and evaluate current requirements

# What did you identify as hallmarks of the program?

- Emphasis on education, equity, access
- RH services for all
- Quality RH care to all clients
- Providing many options of birth control
- Medically accurate sexual health education
- Enrollment at time of service, without income documents
- Providing reproductive care to people who may be underserved or for whom it is difficult to obtain
- Ability to provide a full year of a contraceptive method
- Funding to provide RH services for our community

# Identifying core foundations

## What are the foundations of the RH Program?

- Comprehensive preventive reproductive health services
  - Equity
  - Client's rights and safety
  - Quality assurance and improvement
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- Agency administration, including staff competency

# Examples of alignment of your hallmarks and core foundations

- Comprehensive preventive reproductive health services
  - Providing many options of birth control
  - Medically accurate sexual health education
  - Ability to provide a full year of a contraceptive method
- Equity
  - RH services for all
  - Providing reproductive care to people who may be underserved or for whom it is difficult to obtain
  - Enrollment at time of service, without income documents

# How to make foundations more understandable: values

- **Foundation: Equity**
- **Underlying values of equity:**
  - Parity
  - Client-centered care
  - Accessible
  - Culturally appropriate

# Back to our process: first question

What RH Program requirements are specific to federal Title X requirements?

A	B
RH Program requirements that come SOLELY from Title X	
<b>Topic Area</b>	<b>Requirement</b>
Agency	I & E Committee
Agency	Policies: civil rights/ADA
Agency	Education and projection promotion
Agency	Certified clinical provider QI plans
Agency	Training - Mandatory Reporting,
Agency	Training - Family Involvement
Agency	Training - Relationship Safety
Agency	Emergency Management
Agency	Policies: Standards of Conduct
Agency	Personnel Policies
Agency	Fiscal agency review (part of triennial review)
Agency	New clinic staff have to have orientation to Title X program
Agency	Community participation
Care/services	Clinical protocols
Care/services	Services started under Title X must continue under Title X (e.g., CT treatment/rescreening)

# Second question

What about other RH Program requirements?

Topic Area	Title X	Cert Reqs	OARs	CCare Req	Requirement
Care/services	8.1				Voluntary participation (no coercion)
Care/services	10	B.3			Confidentiality
Agency	13.1	B.11	2130		Facility must comply with ADA
Agency		B.7			Training: Cultural responsiveness
Care/services		B.4			Linguistic and Cultural Responsiveness
Claims/Data		D.3	2080	X	Reimbursement from RHP accepted as pymt in full - not charge client
Client eligibility			2080		If agency misrepresented client eligibility, agency must assume responsibility for full cost of services provided
Client eligibility		D.2	2080	X	Not request deposit from client in advance of services
Care/services	8.5.4	C.3			Services under physician
Agency			2060		Current CLIA Certification
Care/services		B.10	2080		Testing on-site following CLIA
Agency	9.12		2130		Must report suspected child abuse
Care/services	9.12	C.7			Counseling: Family engagement

# More questions

1. What is the requirement?
2. What is the value behind, or underlying, the requirement?
3. Under which core foundation(s) does the value/requirement fall?
4. How is the value/requirement currently operationalized?
5. Is there a new or different way of operationalizing the value/requirement? What is the rationale for doing so?
6. How should the value/requirement be monitored/reviewed for compliance?

# Structure

Core Foundations	Values	Requirements	Operationalize – Current			
Comprehensive preventive RH services						
Equity						
Client’s rights and safety						
QA/QI						

# Structure

Core Foundations			Operationalize – Proposed	Rationale	Monitor
Comprehensive preventive RH services					
Equity					
Client’s rights and safety					
QA/QI					

# Example: Materials

**Current Requirement:** Outreach materials are informed by community feedback and are culturally responsive to community.

**How it is operationalized:** All educational materials must be reviewed by an Information and Education (I & E) committee – comprised of 5-9 members.

# Example: Materials

<b>Core Foundation</b>	<b>Value</b>
Comprehensive Preventive RH Services	
Equity	Materials are culturally responsive
Clients' Rights & Safety	
QA/QI	

# Example: Materials

<b>Core Foundation</b>	<b>Value</b>	<b>Proposed Requirement</b> <i>(remaining the same or changing?)</i>
Comprehensive Preventive RH Services		
Equity	Materials are culturally responsive	Outreach materials are informed by community feedback and are culturally responsive to community <i>(remaining the same)</i>
Clients' Rights & Safety		
QA/QI		

# Example: Materials

Core Foundation	Value	Proposed Requirement <i>(remaining the same or changing?)</i>	How will it be operationalized? <i>(remaining the same or changing?)</i>
Comprehensive Preventive RH Services			
Equity	Materials are culturally responsive	Outreach materials are informed by community feedback and are culturally responsive to community <i>(remaining the same)</i>	All educational materials must be reviewed by an Information and Education (I&E) committee <i>(removed required # of members)</i>
Clients' Rights & Safety			
QA/QI			

# Topic Areas

- Some of the topic areas you identified over the last two days:
  - Training
  - CVR Data
  - Clinical protocols



# Training

- Annual trainings. These are trainings that yearly is excessive. Providers already have other compliance trainings that are required.
- Annual trainings are too frequent for medical providers. Every 2 years would be more manageable (like CPR) and easier to get provider compliance.
- Onboarding all staff into program and annual trainings.

# CVR Data

- Please review/evaluate categories. And we need to as a group agree on the definitions and all use the same or the data is junk. Data is good if it is good data.
- Data collection is cumbersome and expensive. Limits community provider participation.
- Any data we no longer need to gather?
- Data reporting – what is meaningful and to whom?
- Duplication of documentation (patient's record and CVR) which also impacts accuracy of data.

# Exercise



## CVR Data:

1. Identify the foundation behind the current requirement.
2. What is the value behind the current requirement?
  - Why is it important?
  - What would happen if it was no longer required?
3. Create a new requirement to meet the value.
4. Discuss how the requirement could be operationalized.
5. Discuss how the RH Program can monitor operationalization of the requirement.

# Clinical Protocols

- P&P are very detailed. Is that necessary? Don't providers already know how to do these procedures?
- Do P&P need to be updated annually?
- Too many policy and procedures – can we simplify?
- Independent licensed practitioner needing to work under standing orders.
- Policies being approved annually is too frequent. HRSA requires every 3 years. SBHC requires every 2 years. Can RHP choose 2 or 3 years or whenever there is a change?

# Exercise



## Clinical Protocols:

1. Identify the foundation behind the current requirement.
2. What is the value behind the current requirement?
  - a. Why is it important?
  - b. What would happen if it was no longer required?
3. Create a new requirement to meet the value.
4. Discuss how the requirement could be operationalized.
5. Discuss how the RH Program can monitor operationalization of the requirement.

# Additional Topics Identified

- A lot of paperwork at check-in. Make demographics separate and optional (after other paperwork while waiting). Enter into database as a collective not tied to individuals.
- Requiring clinical data as part of enrollment form creates workflow challenges between clinical and operational staff and is confusing to clients.
- Integrating the RH Program into primary care
- Under Title X we had some pharmacy restrictions...Can these be more flexible? We ended up buying/stocking/wasting types of pills never used.
- Coverage limited to birth control – let's add symptomatic visits and STI testing!
- Enrollment and coverage rules
- Can we build a SFS with a equity lens?
- High barrier to entry when considering training, documentation, and monitoring required (for full RH Program)