Michigan Title X

Family Planning Program Standards & Guidelines Manual 2024

Michigan Department of Health and Human Services

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TABLE OF CONTENTS

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Introduction

The Michigan Department of Health and Human Services (MDHHS) Family Planning Program philosophy is consistent with the Title X Family Planning Program. Family Planning assists individuals and couples in achieving their desired number and spacing of children by providing a broad range of voluntary, confidential, high-quality and client-centered family planning and related preventive health services. Services are provided to all individuals seeking care regardless of ability to pay. By assisting the establishment and operation of family planning projects throughout Michigan, the program positively impacts the health and well-being of individuals and families. Services provided through family planning clinics help individuals and couples to make well-informed reproductive health choices. MDHHS-funded family planning clinics are designed to prioritize family planning services to persons from low-income families and provide access to populations with special needs.

MDHHS has primary responsibility in Michigan to administer state and federal funds for family planning. The provision of voluntary family planning services is authorized under the Michigan Public Health Code, Section 333.9131-9133. Local health departments may provide services under supervision of MDHHS and must publicize the availability of services. The MDHHS Title X Family Planning Program Standards and Guidelines provides policy and guidance for sub-recipients to provide family planning services. The manual forms the basis for monitoring MDHHS Title X projects.

The MDHHS Title X Family Planning Program Standards and Guidelines is modeled on the Office of Population Affairs (OPA) Program Requirements for Title X Projects, 2014 (pdf), the Title X Program Handbook, Title X Program Handbook published July 2022 to align program expectations with the 2021 Title X Final Rule, and on Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs, 2014 (QFP) and Quality Family Planning (QFP) updates which serve as clinical guidance for Title X Family Planning programs.

1. The Title X Program Handbook (pdf), published July 2022, is based on the Title X Statute (42 U.S.C. § 300 *et seq.*); the implementing regulations of 2021 "Ensuring Access to Equitable, Affordable, Client-Centered Quality Family Planning Services," 42 CFR Part 59, subpart A; federal legislative mandates, federal laws applying to Title X; and additional OPA program guidance;
2. The Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (pdf) *(QFP)* document, developed jointly by the Centers for Disease Control and Prevention (CDC) and OPA, was based on nationally recognized standards of care and the best available scientific evidence. The QFP was published as a *CDC MMWR Recommendations and Report* and is available with multiple updates on the CDC website. The QFP was intended for providers across all practice settings and serves as the clinical guidance for Title X projects. This document is currently undergoing revisions to reflect current evidence and nationally recognized standards of care.

The MDHHS Standards and Guidelines has five sections: (Section I) Federal and State Laws and Resources, (Section II) Administrative Program Requirements, (Section III) Clinical Services, (Section IV) Program Monitoring, and (Section V) Training. Section II follows OPA Title X program requirements. Section III follows updated clinical recommendations and the QFP document.

SECTION I

Federal and State Legislation, Regulations and Resources

A. Federal Legislation, Regulations, and Resources

The Federal Title X Family Planning Program

The United States Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) to assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services. Section 1001 of the Public Health Service (PHS) Act authorized grants "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services to adolescents)."

The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. It is designed to provide contraceptive services and information to all clients who want to prevent pregnancy and space births, with priority given to persons from low-income families. Title X-funded projects are required to offer a broad range of medically approved family planning services, which includes all Food and Drug Administration (FDA) approved contraceptive products and natural family planning methods; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; preconception health services; sexually transmitted infection (STI) services; and other preventive health services on a voluntary and confidential basis. Title X services include patient education, counseling and referral for other needed services. By law, Title X funds may not be used in programs where abortion is a method of family planning.

The Title X Family Planning Program is administered by the Office of Population Affairs (OPA), Office of the Assistant Secretary for Health (OASH), within the U.S. Department of Health and Human Services (HHS). OASH facilitates the application process and funds a network of family Planning Services grantees across the United States under 42 CFR 59.7(a). Services are provided through state, county, and local public health departments; community health centers; and hospital-based, school-linked, faith-based, and other private nonprofit centers. OPA monitors program operation and performance of Title X grantees.

Title X Statute

TITLE X - Population Research and Voluntary Family Planning Programs

Statutory requirements for the provision of Title X family planning services are in Title X of the Public Health Services Act, 42 USC 300 et seq, which authorizes the Secretary of HHS to award grants for Title X family planning services projects. A copy of the entire Title X statute can be found by clicking on the link above. The sections of the statute summarized below are ones that apply directly to Family Planning Services grants funded under Title X.

Section 1001 [300] PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES
Section 1001 authorizes grants to public or nonprofit private entities "to assist in the establishment and operation of voluntary family planning projects which offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practicable, entities must encourage family participation". Section 1001 stipulates grant funding take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of the funds. Local and regional entities are assured the right to apply directly for Title X grant funds.

Section 1002 [300a] FORMULA GRANTS TO STATES FOR FAMILY PLANNING SERVICES
Section 1002 authorizes grants to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. Grants to States are allocated based on populations and need of the respective States.

Section 1006 [300a-4] REGULATIONS AND PAYMENTS
Section 1006 stipulates that grants under sections 1001 or 1002 for family planning service projects assure that:

1) Priority is given to the provision of services to persons from low-income families; and
2) No charge will be made for services provided to any person from a low-income family except to the extent that payment is made by a third party (including a government agency) authorized or under legal obligation to pay.
3) The term ''low-income family'' is defined by the Secretary using criteria to insure that economic status is not a deterrent to participation in Title X programs.
4) Informational and educational materials developed or made available under Title X grants must be suitable for the population or community to which they are made available, taking into account the educational and cultural background of the individuals for which they are intended, and the standards of the populations or community served.
5) Title X services projects must provide for a review and approval of informational and educational materials, prior to distribution, by an advisory committee including individuals broadly representative of the population or community to which the materials are to be made available.

Section 1007 [300a-5] VOLUNTARY PARTICIPATION
Section 1007 stipulates that Title X services and information "shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information."

Section 1008 [300a-6] PROHIBITION OF ABORTION
Section 1008 stipulates that none of the funds appropriated under Title X shall be used in programs where abortion is a method of family planning.

Title X Regulations

42 CFR PART 59 – Subpart A -- Project Grants for Family Planning Services

Authority: 42 U.S.C. 300a-4. [FR Doc. 2021-21542 Filed: 10/4/2021; Published: 10/7/2021. Requirements for providing Title X family planning services are set out in the implementing regulations which govern grants for family planning services. Revised regulations were published in the 2021 Final Rule (86 Fed. Reg. 56144) on October 7, 2021. They readopted the 2000 Regulations, with several updates to ensure "access to equitable, affordable, client-centered, quality family Planning services."

The 2021 Title X Regulations (42 CFR Part 59, Subpart A) include the following: Description of the program they apply to (§ 59.1), Definitions (§ 59.2), Who can apply for family planning services grants (§ 59.3), How to apply (§ 59.4), Requirements that must be met by a family planning project (§ 59.5), Procedures to assure suitability of informational and educational materials (§ 59.6), Criteria HHS uses to decided what projects to fund (§ 59.7), How grants are awarded (§ 59.8), Use of grant funds (§ 59.9), Confidentiality (§ 59.10), and Additional conditions (§ 59.11). The full Title X Regulations are available here. Below is a copy of the sections that apply directly to providing family planning services under Title X funded grants.

§ 59.1 To what programs do these regulations apply?

The regulations of this subpart are applicable to the award of grants under section 1001 of the Public Health Service Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects. These projects shall consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children.

§ 59.2 Definitions.

As used in this subpart:

Act means the Public Health Service Act, as amended.

Adolescent-friendly health services are services that are accessible, acceptable, equitable, appropriate and effective for adolescents.

Clinical services provider includes physicians, physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform all aspects of the user (male and female) physical assessments recommended for contraceptive, related preventive health, and basic infertility care.

Client-centered care is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions.

Culturally and linguistically *appropriate services* are respectful of and responsive to the health beliefs, practices and needs of diverse patients.

Family means a social unit composed of one person, or two or more persons living together, as a household.

Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.

Health equity is when all persons have the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Inclusive is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as 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.

Low-income family means a family whose total annual income does not exceed 100 percent of the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources.

Nonprofit, as applied to any private agency, institution, or organization, means that no part of the entity's net earnings benefit, or may lawfully benefit, any private shareholder or individual.

Quality healthcare is safe, effective, client-centered, timely, efficient, and equitable.

Secretary means the Secretary of Health and Human Services (HHS) and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

Service site is a clinic or other location where Title X services are provided to clients. Title X recipients and/or their subrecipients may have service sites.

State includes, in addition to the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlaying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia, and the Republic of Palau.

Trauma-informed means a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

§ 59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, preconception health services, and adolescent-friendly health services). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of acceptable and effective medically approved family planning methods and services. Title X service sites that are unable to provide clients with access to a broad range of acceptable and effective medically approved family planning methods and services, must be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested.

(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant [1] .

(3) Provide services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care.

(4) Provide services in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

(5) Not provide abortion as a method of family planning. [2] A project must:

(i) Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery,

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling.

(6) Provide that priority in the provision of services will be given to clients from low-income families.

(7) Provide that no charge will be made for services provided to any clients from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

(8) Provide that charges will be made for services to clients other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

(i) Family income should be assessed before determining whether copayments or additional fees are charged.

(ii) With regard to insured clients, clients whose family income is at or below 250 percent of the FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

(9) Take reasonable measures to verify client income, without burdening clients from low-income families. Recipients that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients' self-report. If a client's income cannot be verified after reasonable attempts to do so, charges are to be based on the client's self-reported income.

(10) If a third party (including a government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title XIX, XX, or XXI agency is required.

(11)(i) Provide that if an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential subrecipients which have previously provided or propose to provide family planning services to the area proposed to be served by the applicant.

(ii) Provide an opportunity for maximum participation by existing or potential subrecipients in the ongoing policy decision making of the project.

(b) In addition to the requirements of paragraph (a) of this section, each project must meet each of the following requirements unless the Secretary determines that the project has established good cause for its omission. Each project must:

(1) Provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referral to other medical facilities when medically indicated and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for opportunities for community education, participation, and engagement to:

(i) Achieve community understanding of the objectives of the program.

(ii) Inform the community of the availability of services; and

(iii) Promote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services.

(4) Provide for orientation and in-service training for all project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

(6) Provide that family planning medical services will be performed under the direction of a clinical services provider, with services offered within their scope of practice and allowable under state law, and with special training or experience in family planning.

(7) Provide that all services purchased for project participants will be authorized by the project director or their designee on the project staff.

(8) Provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the recipient. The recipient must be prepared to substantiate that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

§ 59.6 What procedures apply to assure the suitability of informational and educational material (print and electronic)?

(a) A grant under this section may be made only upon assurance satisfactory to the Secretary that the project shall provide for the review and approval of informational and educational materials (print and electronic) developed or made available under the project by an Advisory Committee prior to their distribution, to assure that the materials are suitable for the population or community to which they are to be made available and the purposes of Title X of the Act. The project shall not disseminate any such materials which are not approved by the Advisory Committee.

(b) The Advisory Committee referred to in paragraph (a) of this section shall be established as follows:

(1) *Size.* The committee shall consist of no fewer than five members and up to as many members the recipient determines, except that this provision may be waived by the Secretary for good cause shown.

(2) *Composition.* The committee shall include individuals broadly representative of the population or community for which the materials are intended (in terms of demographic factors such as race, ethnicity, color, national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including but not limited to individuals who belong to underserved communities, such as 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).

(3) *Function.* In reviewing materials, the Advisory Committee shall:

(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.

§ 59.9 For what purpose may grant funds be used?

Any funds granted under this subpart shall be expended solely for the purpose for which the funds were granted in accordance with the approved application and budget, the regulations of this subpart, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR Part 75.

§59.10 Confidentiality.

(a) All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made. Recipient must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client.

(b) To the extent practical, Title X projects shall encourage family participation.[3] However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.

§59.11 Additional conditions.

The Secretary may, with respect to any grant, impose additional conditions prior to, at the time of, or during any award, when in the Department's judgment these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds.

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[1] 42 U.S.C. 300a-8 provides that any officer or employee of the United States, officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

[2] Providers may be covered by federal statutes protecting conscience and/or civil rights.

[3] 42 U.S.C. 300(a).

42 CFR PART 50, Subpart B—Sterilization of Persons in Federally Funded Family Planning Programs

Authority: Sec. 215, Public Health Service Act, 58 Stat.690 (42 U.S.C. 216) Sec. 1006, Public Health Service Act, 84 Stat. 1506 (42 USC 300a-4)

Title X projects that provide sterilization services must comply with 42 CFR Part 50, Subpart B. This rule defines requirements for sterilization procedures using Federal financial assistance including informed consent requirements for sterilization of a mentally competent individual aged 21 or older (§50.204), consent form requirements(§50.205), prohibition of sterilization of a mentally incompetent individual or of an institutionalized individual, prohibition of sterilization by hysterectomy solely for sterilization purposes. Required consent form language is appended to the regulation and links to the consent form in English and Spanish are available on the OPA website. MDHHS maintains a version of this approved consent form for use by Michigan Providers. See below under **Title X Federal Program Guidelines, Guidance and Resources** (Page 18) and **Michigan laws Regarding Consent for Sterilization** (Page 28).

Legislative Mandates

The following legislative mandates have been part of the Title X appropriations language for a number of years. Title X family planning services projects must ensure adherence to these requirements.

- None of the funds appropriated in this Act may be made available to any entity under Title X of the PHS Act unless the applicant for the award certifies to the Secretary of Health and Human Services that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.
- Notwithstanding any other provision of law, no provider of services under Title X of the PHS Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.
- That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

Additional Program Guidance

OPA Program Policy Notices (PPN)

OPA periodically issues Program Policy Notices (PPN) designed to clarify or provide guidance on specific policy issues relevant to Title X recipients and projects:

Program Policy Notice 2016-11 –Integrating with Primary Care Providers

The purpose of OPA Program Policy Notice 2016-11—Integrating with Primary Care Providers was to clarify how Title X grantees and subrecipients can remain in compliance with Title X Program requirements while integrating services with Health Resources & Services Administration (HRSA) Health Center Program grantees and look-alikes (i.e., health centers that receive funding under Section 330 of the Public Health Service Act).

Other Program-Related Notices

Provision of Abortion-Related Services in Family Planning Services Projects

Provision of Abortion-Related Services in Family Planning Services (65 FR 41281-01, July 3, 2000)

This notice provides guidance on compliance with Section 1008 prohibition on use of Title X funds related to abortion. The notice was issued in conjunction with The Title X 2000 final rule (65 Fed. Reg. 41270, July 3, 2000) and was reinstated with the Title X 2021 final rule which readopted the 2000 regulations with some updates and revisions.

OPA Program Priorities

OPA program priorities represent the overarching goals for Title X projects. OPA Program Priorities for 2022 were identified in the Notice of Funding Opportunities and become priorities for funded projects. They support the Title X regulations, ensuring that services are client-centered and provided in a culturally and linguistically appropriate, inclusive, and trauma-informed manner that protects the

dignity of each individual and provides equitable, quality services consistent with nationally recognized standards of care.

- **Advance Health Equity:** Advancing equity means including all people from low-income families, people of color, and others who have been historically underserved, marginalized and adversely affected by poverty and inequality have the opportunity to obtain full access to services. Key strategies include ensuring access to the same quality care, full medical information and referral services that higher-income and privately insured persons can access by working to remove barriers, improve quality and ensure services are client-centered.

- **Expand Access:** Expanding access means making services as accessible as possible for all clients through expanding location and hours of services; exploring possible modalities of service such as in-person, telehealth, drive-through, mobile clinics and other expansions of services; ancillary services, referral linkages and broadening community education and outreach to expand access.

- **Provide High-Quality Care:** Title X services are the gold standard for contraceptive and reproductive health care. This means providing high-quality services consistent with nationally recognized standards of care (see page 19) that are safe, effective, efficient, timely, equitable, and client centered. Client-centered care means providing care that is respectful and responsive to individual client preferences, needs, and values; and means the client goals guide the clinical decisions.

FPAR: Family Planning Annual Reporting

Requirements and Instructions

Annual submission of the Family Planning Annual Report (FPAR) is required of all Title X family planning services grantees for purposes of monitoring and reporting program performance. FPAR data are presented in summary form, protecting confidentiality of individuals who receive Title X-funded services.

The FPAR is the source of uniform reporting by Title X family planning services grantees, providing national-level data on the Title X Family Planning Program and its users. FPAR data are used to monitor compliance with statutory, regulatory and operational guidance including:

- Monitoring compliance with legislative mandates, such as priority to low-income persons
- Ensuring Title X projects provide a broad range of family planning methods and services.

OPA uses FPAR data to comply with federal accountability and performance requirements for Title X funding and to guide strategic and financial planning, monitor performance, and respond to inquiries from policymakers and Congress about the program.

FPAR 2.0

FPAR 2.0 is the next iteration of FPAR data reporting that requires reporting of encounter-level data for Title X family planning services grantees. FPAR 2.0 intends to improve data collection, reporting, and analysis to allow for opportunities to improve service delivery.

The MDHHS Title X Family Planning Program transitions to FPAR 2.0 data submission for calendar year 2024 following a waiver period working with subrecipients and their electronic medical records (EMRs) systems to develop encounter-level FPAR 2.0 compliant data reporting systems.

Links to Title X Program Guidelines, Guidance and Resources

The Office of Population Affairs website provides access to program guidance, program resources, grantee contacts, clinic locations, and Compliance Standards for Family Planning Services Projects. The links below are available on the website: Office of Population Affairs website

Statutory Requirements:
Title X Statute, Regulations and Legislative Mandates

Program Guidelines:
Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services (42 CFR Part 59 -- Subpart A, October 2021)
Title X Program Handbook, July 2022
Providing Quality Family Planning Services (QFP): Recommendations of CDC and the U.S. Office of Population Affairs

Regulations for Sterilizations in Federally Funded Family Planning Programs:
Sterilization of Persons in Federally Assisted Family Planning Projects (42 CFR Part 50 Subpart B)

Sterilization Consent Forms:
Sterilization Consent Form-English Sterilization Consent Form-Spanish
MDHHS Sterilization Consent Form-English

Provision of Abortion-Related Services in Family Planning Services Projects
Provision of Abortion-Related Services in Family Planning Services (65 FR 41281-01, July 3, 2000)

Program Resources:
The Reproductive Health National Training Center (rhntc.org) provides resources, materials, and training packages to assist with compliance with Title X guidelines.
The National Clinical Training Center for Family Planning (ctcfp.org) provides training and clinical resources for Title X clinical providers.

Information on the Family Planning Annual Report (FPAR) is available on the OPA website:
Family Planning Annual Report | HHS Office of Population Affairs

Title X Family Planning Clinic Locator:
Title X Family Planning Clinic Locator found on the OPA website and MDHHS Family Planning website

Title X Family Planning and Federally Qualified Health Centers:
Advancing Quality Family Planning Practices: A Guide for Community Health Centers (NACHC.ORG)

Title X Resources and Links

Department of Health and Human Services Websites		
Office of Population Affairs	National Vaccine Program Office	Healthy People 2030
Clinical Training Center for Sexual & Reproductive Health (CTC SRH)	Reproductive Health National Training Center (RHNTC)	Office on Smoking and Health CDC
Office of HIV/AIDS	Office of Teen Pregnancy Prevention (TPP)	OPA Research & Evaluation-Publications
Office of Minority Health	Division of Reproductive Health CDC	OSHA Regulations
Office of Pharmacy Affairs-340B Program	President's Council on Physical Fitness & Sports	Office of Research Integrity
Office on Women's Health	Substance Abuse and Mental Health Services Administration	Division of STI Prevention CDC
Reproductive Health Office of Population Affairs (OPA publications)		Office of the Surgeon General

Nationally Recognized Standards of Care

Title X Regulations and the OPA Program Priorities in 2022 funding grants require Title X recipients to provide quality family planning services using national standards of care. These include Providing Quality Family Planning Services Recommendations of CDC and OPA (QFP) and other national standards from the Centers for Disease Control and Prevention (CDC) and national medical associations:

Centers for Disease and Prevention (CDC)

US Medical Eligibility Criteria for Contraceptive Use, 2016 (MEC)

US Selected Practice Recommendations for Contraceptive Use, 2016 (SPR)

STI Treatment Guidelines, 2021 Guide to Taking a Sexual History

Advisory Committee on Immunization Practices (ACIP)

United States Preventive Services Taskforce (USPSTF)

Cervical Cancer Screening Recommendations Breast Cancer Screening Recommendations

American Society for Colposcopy and Cervical Pathology (ASCCP)

Cervical Cancer Screening Guidelines Cervical Cancer Screening Management

American College of Obstetricians and Gynecologists (ACOG)

Cervical Cancer Screening Guidelines Breast Cancer Screening Guidelines

Contraception

American Cancer Society (ACS)

Early Detection of Cervical Cancer Early Detection of Breast Cancer

American Society for Reproductive Medicine (ASRM)

Achieving Pregnancy Infertility-Biological Female Infertility-Biological Male

American Urological Association (AUA)

Guidelines for Early Diagnosis of Testicular Cancer and Prostate Cancer Screening

Federal Laws and Regulations that apply to Title X Grants

HHS and Other Federal Regulations that apply to Title X Grants:

- HHS Grants Policy Statement 2007: The Department of Health and Human Services Grants Policy Statement summarizes the general terms and conditions of HHS grant awards which apply to Title X grants.
- 2 CFR Chapter I, Chapter II, Part 200 (PDF): Uniform administrative requirements, Cost Principles, and Audit Requirements for Federal Awards; Final Rule. Federal Register December 26, 2013. This guidance streamlined requirements and superseded administrative requirements (A-110 and A-102), cost principles (A-21, A-87, and A-122), audit requirements (A-50, A-89, and A-133), and HHS regulations (45 CFR Parts 74 and 92).
- 45 CFR Part 75: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards to non-federal entities and is available as an electronic document:
- 45 CFR Part 80: Nondiscrimination under programs receiving Federal assistance through HHS effectuation of Title VI of the Civil Rights Act of 1964
- 45 CFR Part 81: Practice and procedure for hearings under Part 80 of this Title
- 45 CFR Part 84: Nondiscrimination on the basis of disability in programs and activities receiving or benefitting from Federal financial assistance
- 45 CFR Part 91: Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance.

Federal Laws that apply to Title X Grants

Civil Rights Act of 1964

The Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, religion, sex or national origin. Provisions of this civil rights act forbids discrimination on the basis of sex, as well as race in hiring, promoting, and firing. The Act prohibited discrimination in public accommodations and federally funded programs. It also strengthened the enforcement of voting rights and the desegregation of schools.

The Civil Rights Act of 1964 is the benchmark civil rights legislation, and continues to resonate in the U.S. Passage of the Act ended the application of "Jim Crow" laws, which had been upheld by the Supreme Court in the 1896 case *Plessy v. Ferguson*, in which the Court held that racial segregation purported to be "separate but equal" was constitutional. The Civil Rights Act made racial discrimination illegal in hotels, motels, restaurants and other places of accommodation. It forbade discrimination in employment on the basis of race, color, national origin, religion or gender. It was expanded by Congress to strengthen enforcement of these fundamental civil rights.
The Civil Rights Act of 1964: Eleven Titles at a Glance

Privacy Act of 1974

The Privacy Act of 1974 established a code of fair practices governing the collection, maintenance, use and dissemination of information about individuals maintained in the record systems of federal agencies. The Privacy Act prohibits the disclosure of records without written consent of the individual unless the disclosure is required by statuary law. The Act also provides individuals access and means to seek amendment to their records and establishes record-keeping requirements.

The purpose of the Privacy Act was to balance government's need to collect and maintain information with the rights of individuals to be protected against invasion of their privacy. The Act aims to protect individuals from illegal surveillance, investigation and potential abuses presented by storage of personal data using a universal identifier – such as social security numbers. The Act focuses on four basic policy objectives:

1. Restrict disclosure of identifiable personal records.
2. Grant individuals rights of access to records maintained on them.
3. Grant individuals rights to seek amendment of records upon finding records to be inaccurate, irrelevant, untimely, or incomplete.
4. Establish fair practices for collection, maintenance, and disclosure of personal records.

https://www.justice.gov/opcl/privacy-act-1974

Non-Discrimination on the Basis of Disability in Programs Receiving Federal Financial Assistance (45CFR Part 84)

The purpose of 45 CFR Part 84 is to assure implementation of section 504 of the Rehabilitation Act of 1973, designed to eliminate discrimination on the basis of disability in any program or activity receiving Federal financial assistance. It applies to each recipient of Federal financial assistance from the Department of Health and Human Services and to the program or activity that receives such assistance, including Title X projects. It is intended to assure that no qualified disabled person is excluded from participation in, denied the benefits, or otherwise subjected to discrimination under any program or activity which receives Federal financial assistance, on the basis of disability. Facilities and services must be available to accommodate persons with disabilities.

Disability Laws, Regulations, and Guidance | HHS.gov

Occupational Safety and Health Standards (29 CFR Part 1910 Subpart E)

The Occupational Safety & Health Administration (OSHA) defines standards for the health and safety of employees. 29 CFR Part 1910, Subpart E provides and updates guidance for employers regarding emergency planning.

https://www.osha.gov/healthcare

Exit Routes, Emergency Action Plans, and Fire Prevention Plans-Occupational Safety and Health Administration (osha.gov)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Many aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) impact MDHHS and its sub-recipients. HIPAA was intended to protect the privacy and security of patient

personal health information and health care transactions and standardize and streamline business processes across the health care system. Below are key elements of HIPAA implementation:

Administrative Simplification
To improve efficiency and effectiveness of the health care system, HIPAA included Administrative Simplification provisions that require HHS to adopt national standards for electronic health care transactions, code sets, unique health identifiers, and security. Recognizing that increased electronic technology could erode privacy of health information, the act included provisions to protect privacy of individually identifiable health information.

The Privacy Rule
The HIPAA Privacy Rule established national standards to protect individual medical records and other personal health information and applied these to health plans, health care clearinghouses, and health care providers that conduct health care transactions electronically. The Rule requires safeguards to protect the privacy of personal health information and sets limits on the use and disclosure of information without patient authorization. The Rule also provides patient rights over their health information, rights to examine, obtain a copy of their health records, and request corrections.

The Security Rule
The HIPAA Security Rule establishes national standards to protect individual electronic personal health information that is created, received, used, or maintained by a covered entity. It requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

Transactions and Code Sets Standards
Standard Health Care Transactions are electronic exchanges involving the transfer of information between two parties for specific purposes: provider claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals authorizations, and premium payment. Under HIPAA, transactions must follow standard content and format requirements. HIPAA also adopted specific Code Sets to define diagnoses, procedures and drugs to be used in all healthcare transactions. These are the common codes systems: International Classification of Diseases (ICD-10), Current Procedure Terminology (CPT), Health Care Procedure Coding System (HCPCS), and National Drug Codes (NDC) used in health care transactions.

Employer Identifier Standard
HIPAA requires that employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The Unique Employer Identify Standard is described on the CMS website.

National Provider Identifier Standard
The NPI is a unique identification number for covered health care providers. Health care providers, health plans and health care clearinghouses **must** use the NPIs in administrative and financial transactions under HIPAA. The NPI is a 10-digit number that does not carry other information about

the individual healthcare provider. The NPI must be used in HIPAA standards transactions. Under HIPPA, covered providers must share their NPI with other providers, health plans, clearinghouses, and entities that need it for billing purposes. The National Provider Identifier (NPI) Standard is described on the CMS website.
HIPAA Basics for Providers: Privacy, Security & Breach Notification Rules Booklet (cms.gov)

U.S. Laws and Legislations on Human Trafficking

Federal Anti-Trafficking Laws:

Prohibitions against human trafficking in the United States have their roots in the 13th Amendment to the U.S. Constitution, which barred slavery and involuntary servitude in 1865. However, the first federal law to address trafficking in persons is the Trafficking Victims Protection Act (TVPA) of 2000. It provided a three-pronged approach: prevention, protection, and prosecution. The TVPA has been amended several times, most recently in 2023. It provides for both criminal and civil penalties for human trafficking offenses and includes provisions for victim protection and assistance. Under U.S. federal law, "severe forms of trafficking in persons" include sex trafficking and labor trafficking:

- **Sex trafficking** is the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act, in which commercial sex acts are induced by force, fraud, or coercion, or in which the person induced to perform sex acts is under the age 18. (22 USC § 7102; 8 CFR § 214.11(a)).
- **Labor trafficking** is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery, (22 USC § 7102).
- **Sex Trafficking of Children or by Force, Fraud, or Coercion Act** criminalizes sex trafficking, which is defined as causing a person to engage in a commercial sex act under statutorily defined conditions of force fraud, coercion or conduct involving persons under the age of 18. (18 USC § 1591)

Involuntary Servitude, Forced Labor, And Sex Trafficking Statutes Enforced (justice.gov)

Human Trafficking Resources:

Polaris | We Fight to End Human Trafficking (polarisproject.org)
National Human Trafficking Resource Center: **1-888-373-7888**

Patient Protection and Affordable Care Act of 2010 (ACA)

The Patient Protection and Affordable Care Act, referred to as the Affordable Care Act (ACA) or "Obamacare", is the comprehensive health care reform law of 2010. The law enacts health insurance reforms, including patient rights and protections, expanded coverage, and cost savings. The law makes preventive care, including contraceptives and services for pregnant people, more accessible and affordable. The information and resources provided here are intended to assist Title X-funded family planning centers and other safety net providers implement the ACA.

About the Affordable Care Act

About the Affordable Care Act | HHS.gov

Affordable Care Act and Preventive Health Services for Reproductive Age Women
Preventive care benefits for women | HealthCare.gov

Affordable Care Act Enrollment Resources
Apply for Health Insurance | HealthCare.gov

B. Michigan Information Legislation, Resources, Program Requirements

Michigan Public Health Code And Family Planning

Michigan Department of Health and Human Services (MDHHS) has primary responsibility in Michigan to receive and administer state and federal funds for family planning services. Family planning services are authorized under the State of Michigan's Public Health Code, Section 333.9131. Guidelines for MDHHS administration of the federal program are based on the Title X Statute, Title X Family Planning Program Requirements and on federal and state laws and directives that apply to Title X.

The program guidance found in this document interprets the laws and requirements in the form of standards to provide orientation and perspective on family planning. The manual is written to define minimum standards (requirements) and give recommendations (guidelines) for quality care, following nationally accepted standards of practice.

The philosophy of the MDHHS Family Planning Program, consistent with that of the Title X Program, is a preventive health measure which positively impacts on the health and well-being of individuals and families. Effective family planning programs are essential health care interventions that impact decreased pregnancy risks and decreased maternal and infant mortality and morbidity. Services provided through family planning clinics allow clients to make informed reproductive health choices. MDHHS funded family planning clinics prioritize addressing the unmet family planning needs of people from low-income families and provide access to those with special needs. No one is denied services or subject to any variation of services due to inability to pay.

Public Health Laws Important To Title X Implementation

333.9131 Family planning services; publicity; request by medically indigent individual; clinical abortions (Excerpt)

Sec. 9131.
(1) The department, and under its supervision a local health department, shall publicize the places where family planning services are available. The publicity shall state that receipt of public health services is not dependent on a request or non-request for family planning services.
(2) An effort shall not be made to coerce a medically indigent individual to request or not request family planning services. The department, and under its supervision a local health department, shall provide family planning services to a medically indigent individual upon the individual's request in

accordance with standards established under section 9133. Clinical abortions shall not be considered a method of family planning.
History: 1978, Act 368, Eff. Sept. 30, 1978 **Popular Name:** Act 368

Appropriations
Michigan Legislature-Appropriation Bills

Michigan Public Health Code:
Michigan Public Health Code (mi.gov)

Mental Health & Substance Use Disorder:
Michigan Mental Health Laws (mi.gov)
Confidentiality Relating to Mental Health Services (mcl 330.1748)
Your Rights when Receiving Mental Health Services in Michigan (mi.gov)
Drug & Alcohol Resources in Michigan

Michigan HIV/STI Laws:
Michigan HIV/STI laws (mi.gov)
Summary Michigan HIV STD Law FAQ.pdf
MDHHS HIV/STI Minor Consent Guidance Document

Michigan Minor Consent Laws:
Network for Public Health Law Issue Brief on Michigan Minor Consent Laws
Adolescent Health Initiative Spark Handout: Michigan Confidentiality/Minor Consent Laws.pdf
MDHHS HIV/STI Minor Consent Guidance Document

Adoption:
Michigan Adoption Laws (mi.gov)
Michigan Adoption Resource (mare.org)

Michigan Laws that Apply to Title X Programs

Drug Control License & Dispensing of Pharmaceuticals
Michigan Pharmacy law requires that **all prescribing providers** (physicians, physician assistants, nurse practitioners, nurse midwives, and clinical nurse specialists) who wish to dispense pharmaceuticals obtain a **drug control license** for **each location** in which the storing and dispensing of prescription drugs occur, with the exception of an emergency department, emergency room, or trauma center in a hospital or if the dispensing only involves complementary starter dose drugs. With the exception of drugs dispensed under Michigan's Expedited Partner Therapy law, pharmaceuticals may only be dispensed to the prescriber's own patients. The law describes requirements for drug storage, labeling, and delegatory authority when dispensing pharmaceuticals in a clinic site that does not have an on-site pharmacy.

Michigan Drug Control Law (mcl 333.17745) -- Drug Control license
Public Health Programs Without On-site Pharmacy (mcl 333.17745a) – Dispensing of Contraceptives
LARA Michigan Drug Control Licensing Guide
Licensing for Health Care Professionals LARA Website

Expedited Partner Therapy Legislation

Public Act 525 of 2014 (MCL 333.5110) authorized the use of expedited partner therapy (EPT) in Michigan for certain sexually transmitted infections as designated by MDHHS. In 2020, MDHHS designated chlamydia, gonorrhea and trichomoniasis as appropriate for the use of EPT.
Michigan's Expedited Partner Therapy Legislation
MDHHS Guidance for Health Care Providers using EPT
MDHHS Information for Patients and Partners Offered Expedited Partner Therapy (EPT)

Michigan Child Protection & Mandated Reporting Legislation

Michigan's Child Protection Law requires certain professionals to report suspected cases of child abuse and neglect to the Department of Health and Human Services. The following professionals are considered mandatory reporters:

- Physicians; coroners; dentists; registered dental hygienists; medical examiners; nurses; persons licensed to provide emergency medical care; audiologists.
- School administrators; school counselors; schoolteachers; regulated childcare providers.
- Psychologists; marriage and family therapists; licensed professional counselors; certified social workers; social workers; social work technicians.
- Law enforcement officers.
- Members of the clergy

Michigan Child Protection Law (Act 238 Of 1975)
Resources for Mandated Reporters (mi.gov)

Michigan Human Trafficking Laws & Resources

The Michigan law banning human trafficking took effect in 2006 and has been strengthened in subsequent years to include enhanced restitution for victims; safe harbor provisions for victims including minors; stronger punishments for traffickers; lengthened statute of limitations; mandated reporting for trafficking of minors; inclusion of trafficking through control of an individual's access to a controlled substance; creation of a Human Trafficking Commission within the Attorney General's office and a Human Trafficking Health Advisory Board within MDHHS.
Michigan human trafficking laws
Michigan Human Trafficking Resources and Michigan **Hotline: 1-888-373-7888**
University of Michigan Human Trafficking Clinic
MDHHS Human Trafficking of Children Protocol
Fact Sheet on Human Trafficking

Vulnerable Adult Protection & Reporting Legislation

Michigan law defines and provides for protection and mandated reporting of abuse, neglect and exploitation of vulnerable adults (MCL 400.11(a-f) of the Social Welfare Act). The law defines vulnerable adults as individuals 18 and older who are unable to protect themselves from abuse, neglect or exploitation because of mental or physical impairment or because of advanced age. The law also mandates certain professionals to report suspected abuse, neglect or exploitation of a vulnerable adult. As with reporting for child abuse and neglect, mandated reporters are required to report by calling the MDHHS Centralized Intake for Abuse and Neglect hotline at **1-855-444-3911.** Mandated reporters include health care professionals including physicians, nurses and aids, as well as professionals in education, social welfare, mental health, law enforcement and the county medical examiners. Vulnerable adults, including those with cognitive limitations, retain rights to make their own choices and decisions unless or until determined mentally incapacitated by a court of law.

Michigan Vulnerable Adult Reporting Law (Public Act 280 of 1939 MCH 400.11a)
The Michigan Model Vulnerable Adult Protocol.pdf
MDHHS Adult Protective Services

Michigan Abortion Laws that Apply to Title X Programs

The MDHHS Family Planning Program follows Title X Regulations and Michigan law regarding abortion-related services and pregnancy testing, counseling and referral.

- The Title X statute (sec. 1008), regulations (42 CFR § 59.5(a)(5)) and legislative mandates prohibit funding, advocacy, or provision of abortion as a method of family planning.
- Title X guidance, "Provision of Abortion-Related Services in Family Planning Services Projects" (65 FR 41281-01) and Title X Regulations (42 CFR § 59.5(a)(5)(i)) require providing pregnant clients the opportunity for information and counseling regarding all pregnancy options, including termination of pregnancy. Pregnant clients are provided neutral, factual, nondirective counseling on each option about which they desire information and are provided referrals upon request. This guidance describes limitations on abortion counseling, referral, advocacy and separation of non-Title X abortion activities under section 1008 of the Title X statute. (See: Pages 16,18)

The U.S. Supreme Court decision in Dobbs v. Jackson Women's Health Organization of June 24, 2022, overturned the 1973 decision, Roe v. Wade, that protected a national right to legal abortion and returned the right to legal abortion to individual states. This decision led to confusion in many states about the legal status of abortion. Abortion remained legal in Michigan initially while judicial and constitutional decisions were pending. On November 8, 2022, the people of Michigan approved a constitutional amendment to explicitly enshrine the right to reproductive freedom in the Michigan Constitution (Article I § 28) ensuring abortion remains legal.

A number Michigan laws pertaining to regulation of abortion services have been repealed to comply with Article I of Michigan's constitution. As of December 2023, the following law remains in effect and applies to Title X services related to abortion referral information:

Public Act 133 of 1993: Requires a Michigan Informed Consent for Abortion process with a 24 hour wait period for abortion procedures. The act requires MDHHS maintain an Informed Consent for Abortion Website for patients to access required materials and Informed Consent Confirmation form to be printed and presented to the abortion provider. Michigan Title X staff providing options counseling should inform pregnant clients seeking referral for abortion of this Michigan law and may direct them to the website. Public Act 133 of 1993 (mi.gov)

Sexual Assault and Sexual Violence Legislation

In Michigan, the law regarding sexual assault is called the Criminal Sexual Conduct Act (mi.gov). Sexual assault is gender neutral and includes marital, stranger, date, acquaintance, and child sexual assault.
Michigan Coalition to End Domestic & Sexual Violence

Michigan Domestic and Sexual Violence Prevention and Treatment Board
MDHHS - Domestic & Sexual Violence (michigan.gov)

Domestic and Sexual violence Professional Training and Resources
MDHHS - Professional Training and Resources (michigan.gov)

Michigan Sexual Assault Hotline: 1-855-VOICES4 (864-2374)
National Domestic Violence Hotline: 1-800-799-7233

Michigan laws on Consent for Sterilization

The 2022 Michigan constitutional amendment established the right to reproductive freedom including the right to make decisions about sterilization. Michigan Administrative Codes on Informed Consent for Sterilization follow federal laws requiring informed consent for sterilization procedures.

In 1998 the Michigan Supreme Court upheld the right for a guardian to petition a probate court for authorization to consent to an extraordinary procedure, including sterilizations, if the procedure is in the ward's best interest. (Sec. 330.1629)
MDHHS Consent For Sterilization MSA-1959
Sterilization Consent Form-Spanish
MDHHS Provider Relations Consent for Sterilization

Additional Michigan and Medicaid Resources

Immunizations:

Recommended Adult Immunization schedule 2022
Pre-Teens/Teens and Their Parents
Pregnancy and Vaccination

HIV Testing Counseling and Referral Services:

Division of HIV and STI Programs website

Genetics:
MI Genetics Resource Center (migrc.org)

Michigan Medicaid Policy Information:
The Medicaid Provider Manual contains chapters on: Family Planning Clinics, Healthy Michigan Plan, Medicaid Health Plans, and Pharmacy which are relevant to Title X clinics. Medicaid Policy Bulletins update providers on Medicaid policy. Medicaid Provider Manual and Medicaid Policy Bulletins (mi.gov)

Medicaid Billing and Reimbursement Information:
Procedure codes and fee screens for Family Planning are found on MDHHS Provider Specific Information page. Specific billing questions or concerns can be directed to the Medicaid Provider Helpline, either by phone 1-800-292-2550 or e-mail ProviderSupport@michigan.gov.

MDHHS Title X Family Planning Program Resources

MDHHS Family Planning Minimum Program Requirements (MPRs)

ELEMENT DEFINITION:

Title X Family Planning programs assist individuals and couples in achieving their desired number and spacing of children through the provision of quality, affordable, voluntary family planning services. These include provision of a broad range of acceptable, effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility, STI, preconception health and adolescent-friendly health services). Services are provided based on ability to pay. Family Planning services include the delivery of related preventive health services including patient education and counseling; cervical and breast cancer screening; and human immunodeficiency virus (HIV) prevention education, testing, and referral. The program is designed to provide contraceptive supplies, information and services to all who want and need them, with priority given to persons from low-income families.

MINIMUM PROGRAM REQUIREMENTS:

1. Provide Family Planning services following Title X Requirements for provision of services: Services must be voluntary, provided without any coercion, provided in a client-centered manner that protects the dignity of the individual, provided without discrimination, with priority to individuals from low-income families, without residency or referral criteria, with safeguards for the privacy and confidentiality of individuals being served.
   References: *42 CFR (10-2021 edition) §59.5 (a)(2)-(6); 42 CFR §59.5 (b)(5); 42 CFR §59.10; Health Insurance Portability and Accountability Act of 1996 (HIPAA); The Privacy Act of 1974, 5 U.S.C. § 552a; Elliott-Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2101 to 37.2804, Executive Directive 2019-09*

2. Provide for orientation and in-service training for all project personnel.
   Reference: *42 CFR §59.5 (b)(4); MDHHS Michigan Title X Family Planning Standards & Guidelines; CFR Part 84; 29 CFR Part 1910 Subpart E.*

3. Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services. Projects must provide for an advisory committee.
   Reference: *42 CFR §59.5 (b)(10); 42 CFR CH. 1§59.5 (a) (11)(i, ii); MDHHS Michigan title X Family Planning Standards & Guidelines.*

4. Provide for opportunities for community education, participation, and engagement to achieve community understanding of the objectives of the program; inform the community of the availability of services; and promote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services.
   Reference: *42 CFR §59.5 (b)(3)(i-iii).*

5. Provide for billing and collecting client fees to include the following: Clients with family income at or below 100% of the Federal Poverty Level (FPL) are not charged, except where payment will be made by an authorized third party. Charges for services to clients with family income between 101-250% of FPL are charged in accordance with a schedule of discounts based on ability to pay. Charges to clients with family income that exceeds 250% of FPL will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.
   References: *42 CFR §59.5 (a)(7)-(9).*

6. Provide that where there is a third party (including a government agency) authorized or legally obligated to pay for services, all reasonable efforts are made to obtain the third-party payment without application of any discounts. Where the cost of services is reimbursed under title XIX, XX, or XXI of the Social Security Act, an agreement is required.
   Reference: *42 CFR §59.5 (a)(10)*

7. Provide that all services purchased for project participants will be authorized by the project director or their designee on the project staff. And Provide that any family planning services provided by contract or other similar arrangements with other service providers are provided in accordance with a plan which establishes rates and method of payment for care. These payments must be made under agreements with a schedule of rates and payments procedures maintained by the agency. The agency must be prepared to substantiate that these rates are reasonable and necessary.
   Reference: *42 CFR §59.5 (b)(7,9).*

8. Provide all core family planning services as outlined in *Providing Quality Family Planning Services (QFP): Recommendations of the CDC and U.S. Office of Population Affairs.* These include a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and

counseling; assistance to achieve pregnancy; basic infertility services; STI services; preconception health services; and adolescent-friendly health services); and related preventive health services.
References: *42 CFR §59.5(a)(1); 42 CFR CH. 1 §59.5 (b)(1); 42 CFR §59.5 (a)(5); MMWR/ April 25, 2014/Vol 63 /No. 4. Providing Quality Family Planning Services; Recommendations of CDC and the US OPA; MMWR/ July 29, 2016/Vol.65/No.4. US Selected Practice Recommendations for Contraceptive Use, 2016; MMWR/ Centers for Disease Control and Prevention (CDC) Selective Practice Recommendations (SPR); MMWR/July 29, 2016/Vol 65/No.3 US Medical Eligibility Criteria for Contraceptive Use, 2016; MMWR/Vol.70/No.4 Sexually Transmitted Infection Treatment Guidelines, 2021. Michigan Title X Family Planning Standards & Guidelines*

9. Provide family planning and related preventive health services to minors in an adolescent-friendly manner consistent with Title X legislative mandates.
Reference: *42 CFR CH.1 § 59.5 (a)(1); 42 CFR §59.10 (a)-(b); Legislative Mandates in Title X appropriations related to services to minors.*

10. Provide family planning medical services under the direction of a clinical services provider with special training or experience in family planning.
Reference: *42 CFR §59.5 (b)(6)*

11. Provide for emergency medical management to address emergency situations.
Reference: *29 CFR 1910, subpart E; 42 CFR §59.5 (b)(1)*

12. Projects must operate in accordance with federal and state law regarding the provision of pharmaceuticals including, security and record keeping for drugs and devices.
Reference: *42 CFR §59.5 (b)(1); PA 368 Sec. 333.17745, 333.17745a, 333.1774.*

13. Projects must operate in accordance with federal and state law and guidelines regarding the provision of laboratory services related to family planning and preventive health.
Reference: *42 CFR §59.5 (b)(1); 29 CFR 1910.1030; 42 CFR 493*

14. Projects must establish a medical record for all clients who receive clinical services, including pregnancy testing, counseling and emergency contraception. Medical records must comply with Health Insurance Portability & Accountability Act (HIPAA) privacy and security standards and document quality care standards.
Reference: *42 CFR §59.5 (b)(1); Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

15. Provide for coordination and use of referrals and linkages with primary healthcare providers and other providers of healthcare services, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other federal programs. And provide for social services related to family planning, including counseling, referral to other social and medical services agencies, and ancillary services which may be necessary to facilitate clinic attendance. Provide that referral services are as convenient as

feasible to promote access to services.
References: *42 CFR §59.5 (b)(8); 42 CFR §59.5 (b)(2)* Revised: December 2021

These Minimum Program Requirements (MPR's) are used as indicators for MDHHS program reviews. They are based on the MDHHS Title X Family Planning Program Standards and Guidelines. The Family Planning Indicator tool can be found on the MDHHS Family Planning website at: https://www.michigan.gov/familyplanning.

MDHHS Family Planning Minimum Reporting Requirements (MRRs)

Title X minimum reporting requirements are identified in the sub-recipient contracting process and required forms are provided to sub-recipients with instructions prior to their due dates. Reporting documents must be submitted to MDHHS accurately and timely. Reporting requirements are subject to change based on legislative, fiduciary, and other program changes.
Required reporting documents include:

- The Family Planning Annual Report (FPAR) Reports
- Family Planning Annual Health Care Plan
- Medicaid Cost-Based Reimbursement Tracking Form (Required for participating Local Public Health Agencies)

Reported information is used for essential activities including legislative reporting, federal reporting requirements for the State, budgeting, funding allocations, and other aspects of program management. This data provides information needed for program evaluation, assessment of need, and other activities required of Title X Family Planning Projects. Local Public Health Departments receiving Medicaid Cost-Based Reimbursement are required to report through EGrAMS with their year-end final status report. The following table summarizes the required Title X reports, data sources and due dates:

MDHHS Family Planning Program Minimum Reporting Requirements

Report	Time Period	Due Date to Department	Submit To
FPAR 2.0 Data Reports Encounter-Level (Calendar Year 2024)	**Jan. 1 – Mar. 31 Jan. 1 – June 30 Jan. 1 – Sept.30 Jan. 1 – Dec. 31**	**April 12 July 12 October 11 Jan. 10, 2025**	**MILogin via Family Planning Transfer Area**
FPAR 2.0 Family Planning Encounters (Table 13) & Family Planning Revenue Report (Table 14) (Calendar Year 2024)	**Jan.1 – June 30 Jan. 1 – Dec. 31**	**July 12 Jan. 10, 2025**	**MDHHS Family Planning Inbox mdhhs-reproductivehealthunit@michigan.gov**
Annual Health Care Plan*	**Oct. 1 – Sept.30**	**September 13**	**MDHHS Family Planning Inbox mdhhs-reproductivehealthunit@michigan.gov**

Teen/Adult Consumer Survey	**Oct. 1 – Mar. 31**	**April 19**	**MDHHS Family Planning Inbox mdhhs-reproductivehealthunit@michigan.gov**
Medicaid Cost-Based Reimbursement Tracking Form	**Oct. 1 – Sept. 30**	**November 30**	**EGrAMS with Final Financial Status Report**

***** Annual Health Care and Work Plans serve as continuation plans and are not required in years when a competitive bid application is required.

Each grantee shall indicate the following project outputs:

Target Measure	Total Performance Expectation	MDHHS State Agreement Minimum Performance Expected	
Unduplicated Number of Title X Clinic Users for FY24 Original Agreement Funding Amount		**Percent**	**Number**
		95%	
Unduplicated Number of Title X Clinic Users for FY24 Additional Geographic Service Area Funding Amount		**25%**	

MDHHS Family Planning Program Annual Health Care Plan Guidance

Sample Guidance from FY 2024 Guidance
Specific guidance is sent in July for September submission in non-competing contract years.

The Annual Health Care Plan highlights a local Family Planning agency's program accomplishments and challenges during this past fiscal year, and upcoming fiscal year priority populations, clinic operations, services provided, and program work plan. This document provides guidance on the submission requirements for the Annual Health Care Plan narrative and associated attachments.

I. Program Description
   A. Highlight significant program achievements, milestones, or other notable accomplishments during fiscal year (FY) 2023. Include a brief summary of telehealth activities, if applicable, and highlight any innovative strategies implemented to maintain or increase access to family planning services during and/or after the public health emergency.
   B. Highlight program and community changes (e.g., staffing changes, local policy/community issues) that occurred during FY 2023, including public health emergency impacts, focusing on service delivery and priority population(s) affects, and potential solutions.

II. Priority Population(s) and Service Area(s)

A. Provide a brief description of the agency's priority population(s) and service area(s). Low-income individuals must be an identified priority population.

B. Insert the below table into this narrative section and indicate the total number of unduplicated Family Planning users projected to be served during 2023-2024 by your agency for each service delivery category. Projections need to be based on actual service delivery capacity for identified priority population(s) and service area(s). For more information on service delivery categories, refer to Family Planning Annual Report (FPAR) Forms and Instructions.

Table 1. Projection of Unduplicated Family Planning Users Served, 2023-2024	
Client Sex & Age	Projected Unduplicated Users Served 2023-2024
Clients Assigned Male at Birth	
Clients Assigned Female at Birth	
Adolescent Clients (i.e., ≤19 years old)	
Client Income Level	Projected Unduplicated Users Served 2023-2024
At or below 100% of poverty	
Above 100% but no more than 150%	
Above 150% but not more than 200%	
Above 200% but not more than 250% of poverty	
Above 250% of poverty	
Visit Type	Projected Unduplicated Users Served 2023-2024
Face-to-Face	
Telehealth, if applicable	

III. Agency Capacity & Staffing Structure

A. Attach an organizational chart that demonstrates the position of the proposed program, including sponsoring agency, medical director, program coordinator, advisory committee, and all related program personnel (with project allocations, FTEs, clearly displayed).

B. Identify and report all clinical services to be provided to clients under the Family Planning scope by completing the *FY 2024 Services Provided Worksheet* (See Family Planning website, 'Information for Providers').

C. Attach a completed *FY 2024 Agency Clinic Schedule* (See Family Planning website, 'Information for Providers'), which includes program coordinator contact information, agency clinic location(s), main office hours, and Family Planning clinic hours for each week within a month.

IV. Program Work Plan

A. Develop program goal(s) and objectives for FY 2024 that are specific, measurable, attainable, realistic, and time bound (S.M.A.R.T.), and address program priorities.

Goals and objectives should reflect regional needs and engage priority populations. Submit the required work plan format, *FY 2024 Work Plan (*See Family Planning website, 'Information for Providers') as an attachment. At minimum, FY 2024 work plans **must** include an objective for each of the following:

1. Clinical Service Delivery
2. Community Education/Community Promotion
3. Health Equity, Health Disparities, or Social Determinants of Health
4. Quality Assurance/Quality Improvement

V. Family Planning Advisory Committee

A. Provide a brief description of the Advisory Committee's purpose or by-laws.
B. Include the following Advisory Committee documents as attachments: FY 2024 meeting schedule, current member roster, and minutes from the ***last*** held Committee meeting.

VI. Information and Education (I&E) Committee

A. Provide a brief description of the I&E Committee's function or by-laws.
B. Include the following I&E Committee documents as attachments: FY 2024 meeting schedule, current member roster, minutes from the *last* held Committee meeting, and I&E master list. The roster should indicate how members are broadly representative of the populations served by identifying communities, populations, groups the member represents (e.g., agency or professional organization name, or teen, male, client, or parent).
C. Provide a brief description of how the member composition of the I&E Committee represents populations served in terms of demographic factors (e.g., race, ethnicity, immigrant status, gender identity, sexual orientation, disability).

VII. Electronic Health Records/Electronic Medical Record (EHR/EMR)

A. Provide the name and version of the EHR/EMR system utilized for Family Planning, including whether this system is used to manage program inventory and if it is used by the medical director during the quality assurance process.

MDHHS Family Planning Financial Management Audit Requirements

The following audits are required of all Family Planning Title X sub-recipients.

1. Single Audit or Exemption Notice

   Title X subrecipients must submit a Single Audit or Exemption Notice to MDHHS. If submitting a Single Audit, Grantees must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs and management letter (if issued) with a response.

   A. Single Audit Providers designated as subrecipients that expend $750,000 or more in federal awards during the provider's fiscal year must submit a Single Audit to MDHHS. The Single Audit must comply with requirements of 2 CFR 200 Subpart F.

   B. Audit Exemption Notice Providers exempt from the Single Audit submission must submit an Audit Exemption notice that certifies the exemption. An Audit Exemption Notice form is available at: MDHHS Bureau of Audit Website under Audit Requirements.

2. Audit submission information
   The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response), or Audit Exemption Notice must be submitted to the Department within nine months after the end of the subrecipient's fiscal year by e-mail to the Department at MDHHS-AuditReports@michigan.gov.
3. Management Decisions
   MDHHS issues a management decision on findings or questioned costs contained in a subrecipient's Single Audit within six months of receipt of a completed final audit report. The management decision addresses whether the audit finding is sustained; reasons for the decision; and required subrecipient action.
4. MDHHS Title X Program Audits
   MDHHS conducts additional program audits to meet Title X monitoring needs. These audits are In addition to the Title X comprehensive program site reviews conducted every two to three years. The MDHHS program audits consist of detailed fiscal reviews and may be conducted in conjunction with another federal program audit (e.g., joint Title X and WIC audit). If concerns are noted, a corrective action plan is required.

SECTION II

Administrative Program Requirements for Title X Family Planning

A. Overview of Title X Program Requirements

The MDHHS Title X Family Planning Program administrative requirements are modeled after the OPA Title X Family Planning guidelines published in April 2014 revised by the 2021 Title X Final Rule, "Ensuring Access to Equitable, Affordable, Client-Centered Quality Family Planning Services" and the Title X Program Handbook published in July 2022. Clinical guidance is modeled after the Providing Quality Family Planning Services (QFP) published in April 2014, updates to that document, and current nationally recognized standards of care. OPA is currently working with the CDC to revise the QFP and revisions will be reflected in this manual as they are developed.

1. The Title X Program Handbook (pdf) is based on the Title X Statute, implementing regulations, and other requirements and guidance applying to Title X. The document represents current OPA guidance for Title X grantees and projects.

2. Providing Quality Family Planning Services (QFP) (pdf) The QFP was developed jointly by the Centers for Disease Control and Prevention (CDC) and OPA and published as a *CDC MMWR Recommendations and Reports*. Updates in 2015 and 2017 have been added. The QFP was intended for providers across all practice settings and serves as clinical guidelines for Title X projects. This document is currently undergoing revisions to reflect scientific evidence and nationally recognized standards of care.

B. Eligibility, Application and Grant Process

1. APPLICABILITY

The requirements set forth in this document apply to the award of grants to MDHHS Title X sub-recipients under the MDHHS grant awarded under section 1001 of the PHS Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects in Michigan. These projects consist of the educational, comprehensive medical, and social services necessary to assist individuals to freely determine the number and spacing of their children.

2. DEFINITIONS

Terms as used throughout this document include:

TERM	DEFINITIONS
The Act	**The Act** is Title X of the Public Health Service Act, as amended
Adolescent-Friendly Health Services	**Adolescent-Friendly Health Services** are services that are accessible, acceptable, equitable, appropriate and effective for adolescents.

Annual Requirements	Where this manual requires activities to be carried out annually, they must be conducted within a 12 month period.
Client-Centered Care	**Client-Centered Care** is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions.
Clinical Services Provider	A **Clinical Services Provider** is a physician, physician assistant, nurse practitioner, or certified midwife who performs all aspects of client physical assessments recommended for contraceptive, related preventive health and basic infertility
Culturally and Linguistically Appropriate Services	**Culturally and Linguistically Appropriate Services** are respectful of and responsive to the health beliefs, practices and needs of diverse clients.
Family	A **Family** is a social unit composed of one person, or two or more persons living together, as a household.
Family Planning Client or User	A **Family Planning Client** is an individual of reproductive age who needs family planning and related preventive health services. For purposes of FPAR, a **Family Planning User** is an individual who has at least one family planning encounter with a Title X family planning service provider during the reporting period.
Family Planning Encounter	A **Family Planning Encounter** is a documented contact between a client and a family planning provider either face-to-face in a Title X service site or virtual using telehealth technology. The purpose of a family planning encounter is to provide family planning and related preventive health services to clients who want to avoid unintended pregnancies or achieve intended pregnancies. To be counted for the FPAR, a written record of services provided during a family planning encounter must be documented in the client record. Family planning encounters may be: (1) encounters with a Clinical Services Provider or (2) encounters with an Other Services Provider.
Family Planning Services	**Family Planning Services** include a broad range of medically approved services, which includes U.S. Food and Drug Administration (FDA) approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services and other preconception health services.

Family Planning Service Site	The term **Service Site** refers to a clinic or other location where Title X family planning services are provided to clients. Title X recipients and/or subrecipients may have services sites.
Grantee	MDHHS is the **Grantee** that receives Title X funding for the state of Michigan and assumes legal and financial responsibility and is accountable for performance of approved grant activities.
Health Equity	**Health Equity** is when all persons have the opportunity to attain their full heath potential, and no one is disadvantaged from achieving their potential because of social position or other socially determined circumstances.
Inclusive	**Inclusive** means all people are fully included and can actively participate in and benefit from family planning, including, individuals who belong to underserved communities, Black, Latino, Indigenous and Native American persons, Asian Americans, 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.
Low-income family	A family whose total annual income does not exceed 100% of the most recent Federal Poverty Guidelines issued under 42 U.S.C. 9902(2). **Low-income Family** also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. Un-emancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources.
MCIR	The **Michigan Care Improvement Registry (MCIR)** is Michigan's online immunization registry.
Minors	The term **Minors** refers to clients under the age of 18 and is used with reference to legal/statutory mandates regarding provision of services, confidentiality, required counseling, protections, and requirements for mandatory reporting of suspected abuse of minors.
'Must' **'Should'** **'May'**	In this document, the word ***must*** indicates a required program requirement. The word ***should*** indicates recommended guidance or policies that reflect good practice and are strongly recommended to fulfill the intent of Title X. The word ***may*** indicate practices that projects may consider.

Nonprofit	**Nonprofit** as applied to any private agency, institution, or organization, means that no part of the entity's net earnings benefit, or may lawfully benefit, any private shareholder or individual.
Other Service Providers	**Other Services Providers** include licensed nurses, nurse assistants, laboratory assistants, health educators, social workers, or clinic aids providing family planning services.
Other Preventive Health Services	**Other Preventive Health Services** include preventive health services not linked to reproductive health (e.g., screening for lipid disorders, skin cancer, colorectal cancer or osteoporosis). These services are beyond the scope of family planning but should be available either on-site or by referral to appropriate providers. Family Planning programs **must** have appropriate unpaid referral sources for these services.
Project	Activities described in the grant and supported under the approved budget. The "scope of the project" is defined in the funded application and consists of activities the approved Title X family planning project budget supports.
Quality Healthcare	**Quality Healthcare** is safe, effective, client-centered, timely, efficient, equitable care that is consistent with national standards of healthcare.
Related Preventive Health Services	**Related Preventive Health Services** include services that are considered beneficial to reproductive health, linked to family planning services, and appropriate to deliver within a family planning visit (e.g., breast and cervical cancer screening). They are requirements for family planning programs.
Risk Assessment	The term **Risk Assessment** as used in this document, means an objective identification of risk behaviors and situations that may lead to recognized adverse health conditions. Risk assessment leads to screening recommendations, appropriate interventions, or treatments.
Screening	The term **Screening**, as used in this document, means **testing** to identify an unrecognized disease or health condition to enable early intervention and management. Screening initiatives help lead to earlier diagnosis to reduce mortality and suffering from diseases.
Sub-recipients	**Sub-recipients** are entities that provide family planning services with Title X funds under a written agreement with a grantee. They may also be referred to as delegates or contract agencies.

Trauma-informed	**Trauma-informed** means a program, organization, or system that is informed and recognizes the widespread impact of trauma and understands potential paths for recovery; recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.
Virtual (Telehealth) Family Planning Encounter	OPA FPAR Instructions define a **Virtual Family Planning Encounter** as one that uses telecommunications and information technology to provide access to Title X family planning and related preventive health services, including assessment, diagnosis, intervention, consultation, education and counseling, and supervision, at a distance. Telehealth technologies include telephone, facsimile machines, electronic mail systems, videoconferencing, store and forward imaging, streaming media, remote monitoring devices, and terrestrial and wireless communications.

3. ELIGIBILITY

Any public or nonprofit private entity located in Michigan is eligible to apply for a Title X family planning services project grant through MDHHS as the Title X Grantee for Michigan.

A. Eligible applicants **must** demonstrate past experience delivering primary care, adolescent health, reproductive health or family planning services. Potential applicants include:
   1. Public and private non-profit health agencies
   2. Local health departments
   3. Community health centers
   4. Federally Qualified Health Centers
   5. Rural and Urban Health Centers
   6. Tribal Indian health centers
   7. Faith based organizations.

B. Entities **must** furnish evidence of non-profit status in accordance with instructions accompanying the project grant application.

C. Applicants **must** have providers who are or can become Medicaid enrolled providers as well as bill private third-party payers.

D. Eligible applicants providing services beyond the Title X family planning program **must** ensure that Title X funds will be expended solely for the Title X program under the terms and conditions of the grant.

E. Eligible applicants **must** demonstrate and assure ability to meet program requirements set forth by the Title X statute, OPA Title X regulations and MDHHS Family Planning Minimum Program Requirements.

F. Applicants **must** have the capacity to provide a broad range of family planning methods and services. Grants cannot be made to entities that propose to offer only a single method or unduly limited number of family planning methods. If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project

offers a broad range of medically approved family planning methods and services. Service sites that are unable to provide clients a broad range of approved family planning methods and services, **must** be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested.

G. The organization **must** have a governing board that is representative of the community or have a program specific family planning advisory council representative of the community.
H. Local health departments have the primary responsibility to meet the health needs of vulnerable populations may elect, but are not required, to provide family planning services directly. (Public Health Code, 2000: Section 333.2473).

4. APPLICATION

MDHHS receives funds from the Department of Health and Human Services' Office of Population Affairs (OPA) to administer the Title X Family Planning Program in Michigan. MDHHS conducts a competitive bid process available to any public or nonprofit entity interested in providing Title X family planning services in Michigan. Applicants **must** submit a competitive bid application as set forth by MDHHS. Applicants **must** follow the format and content as detailed in the competitive bid guidance. The application and technical assistance are available from the MDHHS. The grant application covers at least a three-year period.

Annually, agencies awarded Title X funding in the competitive bid process **must** apply for continuing grantee sub-recipient status which includes a needs assessment and an annual health care plan. These annual plans **must** be submitted to MDHHS and follow the guidance provided by MDHHS (See the Michigan Family Planning Information in Section I of this document for details). Technical assistance is available. The plan **must not** include activities that cannot be funded under Title X, such as providing or promoting abortion, lobbying or promoting candidates for public office.

5. FUNDING

Funding support for the Michigan Title X Family Planning Program include the Title X Federal grant, State of Michigan appropriations, revenue from first- and third-party collections and donations. Annually, the Federal grant award and State appropriations are determined, and funds are distributed to sub-recipients based on a funding formula.

Title X funds support local infrastructures to deliver family planning services with a priority focus on the low-income population with the greatest need. The proxy for the population in need is women 15-44 years old at or below 100% of the Federal Poverty Level. Each county has 1) an estimated caseload of Title X users (clients) for which a $261 per user is allocated; and 2) the total amount of funding available.

Awardees are selected for a minimum three-year funding cycle (with the potential to extend one or more additional cycles). The initial annual agreement covers the Fiscal Year of the funding cycle, Michigan Department of Health and Human Services contract year. Awardees in good standing and who meet all minimum requirements will maintain sub-recipient status at least through the three-year funding cycle, depending on the availability of funds.

In subsequent years, sub-recipients **must** submit a non-competitive annual plan. Each year continuing funding is contingent upon the availability of funds; timely, accurate submission of reports; an approved annual plan; satisfactory progress toward completion of the current year's contract objectives and meeting family planning's Minimum Program Requirements and Reporting Requirements.

In addition to the grant awards, sub-recipients receive separate supplemental support in the form of bulk purchase condoms and laboratory testing services for Chlamydia and Gonorrhea via the MDHHS Laboratory. Pap and Colposcopy services are provided for eligible clients through MDHHS's Breast and Cervical Cancer Control Navigation Program (B3CNP).

Due to funding dependent upon Federal and State appropriations, allocations may vary and are subject to change.

Any change in scope of services provided by the sub-recipient, including expanding or reducing services or the service area, **must** be approved by MDHHS prior to implementation.

6. NOTICE OF AWARD

The notice of funding award will inform the MDHHS Title X sub-recipient of the initial year allocation based on the annual appropriation and minimum caseload supported by the allocation. Notices will identify the Michigan county/counties for which funding is appropriated and will identify any conditions of funding not addressed in the application. The project period between competitive bids is at least three years. The project is funded in budget periods, normally twelve months, based on the legislative appropriation process.

7. USE OF GRANT FUNDS

All funds granted for Title X family planning services projects **must** be expended only for the purpose for which the funds were awarded and in accordance with the approved application and budget. Funds may not be used for prohibited activities, such as providing abortion as a method of family planning or lobbying. Funds **must** be used in accordance with the Title X family planning services projects regulations, MDHHS annual contract, and HHS grants administration regulations. HHS grants administration regulations can be accessed in the HHS Grants Policy Statement, 2007

C. Project Management and Administration

8. PROJECT MANAGEMENT AND ADMINISTRATION

All sub-recipient agencies receiving Title X finds **must** provide high quality family planning services which are competently and efficiently administered.

A. Sub-recipient agencies **must** have written policies and operating procedures in place to meet the standards of the legal issues described in Section 8.1 through 8.7.

8.1 VOLUNTARY PARTICIPATION

Family planning services **must** be provided solely on a voluntary basis (Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a) (2)).

A. Clients **must not** be coerced to accept services or to use or not use any particular method of family planning (42 CFR 59.5 (a) (2)).
B. A client's acceptance of family planning services **must not** be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by the grantee or sub-recipient (Section 1007, PHS Act; 42 CFR 59.5 (a)(2)).
C. Personnel working within the family planning project **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 (42 U.S.C. 300a-8, as set out in 42 CFR 59.5(a)(2).
D. Sub-recipients **must** assure in their general consent for services that family planning services are provided on a voluntary basis, without coercion to accept services or any particular method of family planning and without prerequisite to accept any other service.

8.2 PROHIBITION OF ABORTION

Title X grantees and sub-recipients **must** be in full compliance with Section 1008 of the Title X statute and 42 CFR 59.5(a)(5), which prohibit abortion as a method of family planning.

A. Sub-recipients **must** have written policies that clearly indicate that no Title X funds will be used to provide or promote abortion as a method of family planning.
B. Sub-recipients **must** follow Title X guidance regarding abortion-related services in Title X projects. (Section I, page 16)

8.3 STRUCTURE AND MANAGEMENT

Family planning services under the MDHHS Title X grant are provided by sub-recipient agencies operating under the MDHHS Title X Family Planning Program. As the grantee, MDHHS is accountable for the quality, cost, accessibility, acceptability, reporting, and performance of the grant-funded activities provided by sub-recipients.

8.3.1 As the grantee, MDHHS **must** have a written contract with each sub-recipient and **must** maintain and provide updated MDHHS Title X Family Planning Standards and Guidelines Manual for sub-recipient agencies consistent with Title X Program Requirements and other applicable requirements (2 CFR Chapter I, Chapter II, Part 200).

Sub-recipients **must** have an updated copy of the MDHHS Standards and Guidelines available to each service site.

MDHHS **must** perform a comprehensive program review of each sub-recipient a minimum of every three years and is responsible for providing technical assistance and consultation as needed to ensure compliance.

8.3.2 Where a sub-recipient wishes to subcontract any of its responsibilities or services, a written agreement that is consistent with Title X Program Requirements **must** be in place and **must** be

approved by MDHHS. Sub-recipients **must** identify subcontracted responsibilities or services in their annual plan (2 CFR Part 200).

8.3.3 All services purchased for project participants **must** be authorized by the project director or their designee on the project staff (42 CFR 59.5(b) (7)).

8.3.4 Where required services are provided by referral, the sub-recipient **must** have written agreements for the provision of services and reimbursement of costs as appropriate. Services provided through a contract/arrangement **must** be paid for under agreements that include a reasonable schedule of rates. (42 CFR 59.5(b) (9)).

8.3.5 Sub-recipients **must** be given an opportunity to participate in the establishment of MDHHS policies and guidelines (42 CFR 59.5 (a) (11)).

8.3.6. Sub-recipients **must** maintain a financial management system that meets Federal standards, as applicable, requirements in the contract, and which complies with Federal standards that support effective control and accountability of funds. Documentation and records of all income and expenditures **must** be maintained. (2 CFR Chapter I, Chapter II, Part 200)

8.3.7. Sub-recipients **must** adhere to MDHHS Title X reporting requirements (MRR). (Section I, pages 32,33)

A. Calendar year 2024 is the MDHHS Title X Program's transition year for FPAR 2.0 reporting and include the following reporting requirements:
   1. Quarterly FPAR 2.0 Data Reports Encounter-Level (Calendar Year 2024)
   2. Mid-year and Year-end FPAR 2.0 Family Planning Encounters (Table 13) & Family Planning Revenue Report (Table 14) (Calendar Year 2024)
B. Family Planning Needs Assessment and Health Care Plan (Annual Plan) (Section I, page 33-35)
C. Sub-recipients **must** have written policies and procedures for mandatory reporting of child abuse and neglect; vulnerable adult abuse and neglect; and compliance with human trafficking laws.
D. Local Health Department sub-recipients **must** comply with Medicaid cost-based reimbursement reporting requirements.

8.4 CHARGES, BILLING, AND COLLECTIONS

The sub-recipient **must** have written policies and procedures for charging, billing, and collecting funds for the services provided by the project that meet Title X requirements:

Clients **must not** be denied services or be subjected to any variation in quality of services because of inability to pay.

Sub-recipients **must** develop a schedule of discounts to assure that clients are charged based on ability to pay (42 CFR 59.5(a) (8)). Ability to pay is determined by assessing family income using the most current Federal Poverty Level (FPL) guidelines.

A. Individual eligibility for a discount **must** be documented in the client's record/file. Client income should be re-evaluated at least annually.
B. Projects **must** rely on client self-report when assessing client income directly. However, Title X regulations allow grantees discretion to use income verification data provided by clients because of participation in other programs operated by the organization. Projects that have access to income verification data because of a client's participation in another program may use that data rather than rely solely on client self-report. (42 CFR 59.5 (a)(9))
C. MDHHS policy requires that the schedule of discounts **must** be developed with sufficient proportional increments to assure services are billed based on ability to pay. Sub-recipients **must** use the mandated quartile proportional increments that MDHHS distributes each year in developing their schedule of discounts unless sub-recipients have requested and received an MDHHS approved waiver to use other proportional increments.

8.4.1 Clients whose documented income is at or below 100% of FPL **must not** be charged, although projects **must** bill all third parties authorized or legally obligated to pay for services (Section 1006(c)(2), PHS Act; 42 CFR 59.5(a)(7)).

8.4.2 Clients whose family income falls between 101% and 250% of the FPL **must** be charged based on the schedule of discounts developed to assure that services are billed based on ability to pay (42 CFR 59.5(a) (8)).

8.4.3 Fees **must** be waived for all individuals with family incomes above 100% of the FPL who are unable, for good cause, to pay for family planning services, as determined by the service site project director (42 CFR 59.2). Approval of waived fees for good cause **must** be documented in the client record.

8.4.4 Clients whose family income exceeds 250% of the FPL **must** be charged based on a fee schedule designed to recover the reasonable cost of providing services (42 CFR 59.5(a) (8)). Sub-recipients **must** document their process for developing the fee schedule to indicate how they determined reasonable costs to be recovered. The documented process **must** include an analysis of the costs of providing services and identification of other factors used to determine the fee schedule. Sub-recipients may elect to set their fee schedule below what would recover the actual cost of providing services, based on their specific community needs and circumstances. Sub-recipients **must** review their program costs and reassess their fee schedule at least every two years and are encouraged to do so annually. Sub-recipients **must** use the cost analysis tool developed by MDHHS Family Planning Program unless they request and receive a waiver to use another methodology to assess program costs.

8.4.5 Eligibility for discounts for minors who receive confidential services **must** be based on the income of the minor (42 CFR 59.2).

A. Minors receiving confidential services **must** receive the required counseling for minors identified by legislative mandates that apply to Title X (Section I, page 16).
B. Sub-recipients **must not** have a fee schedule for minors that is different from the fee schedule for other populations receiving family planning services.

8.4.6 Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts **must** be made to obtain third party payment without the application of any discounts (42 CFR 59.5(a)(10)).

A. With regard to insured clients, family income **must** be considered before determining whether copayments or additional fees are charged. Clients whose family income is at or below 250% FPL **must not** pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied. (42 CFR 59.5(a)(8) (i, ii))
B. Clients **must** be informed of any potential for disclosure of their confidentiality to a policyholder where the policyholder is someone other than the client. (42 CFR § 59.10(a))
    a. This information **must** be included in the general consent for services.

8.4.7 Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement or registration with the Title XIX or the Title XX state agency at either the grantee or sub-recipient level is required (42 CFR 59.5(a)(9)].

8.4.8 Reasonable efforts to collect charges without jeopardizing client confidentiality **must** be made.

A. At the time of services, clients who are responsible for paying any fee for their services should be offered bills directly. Bills to clients should show total charges less any allowable discounts. Sub-recipients **must** have the capacity to provide a bill to clients who request a bill.
B. Sub-recipients **must** have a method for the "aging" of outstanding accounts. Written policies on billing and collections **must** include a policy on aging accounts and writing off outstanding accounts.

8.4.9 Voluntary donations from clients are permissible; however, clients **must not** be pressured to make donations, and donations **must not** be a prerequisite to the provision of services or supplies.

8.5 PROJECT PERSONNEL

Title X projects **must** have approved personnel policies and procedures.

8.5.1 Sub-recipients **must** establish and maintain personnel policies that comply with applicable Federal and State requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title I of the Americans with Disabilities Act, and the annual appropriations language. These policies should include, but are not to be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures.

A. Personnel records **must** be kept confidential.

B. Performance evaluations of program staff **must** be conducted according to the agency personnel policy.
C. Organizational chart and personnel policies **must** be available to all personnel.
D. Job descriptions **must** be available for all positions and updated as needed.

8.5.2 Family Planning staff should be broadly representative of significant elements of the population to be served by the project, and **must** be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population (42 CFR 59.5 (b)(10)).

8.5.3 Family Planning projects **must** be administered by a qualified project director/family planning coordinator. Family Planning directors/coordinators **must** be familiar with the MDHHS Family Planning Standards and Review Manual, the Title X statute and regulations. Sub-recipients **must** notify MDHHS of change or extended absence of the project director/family planning coordinator, or significant change in project personnel to assure ongoing communication and coordination of the Family Planning Program.

8.5.4 Family Planning projects **must** provide medical services under the direction of a clinical services provider with special training or experience in family planning (42 CFR 59.5 (b) (6).
A. Michigan's pharmacy law Act 368 of 1978 sec 333.17745 and 333.17745a. (Sec. I, pp. 25,26, Sec. III pp. 83-35) requires that all providers with responsibility for writing prescriptions and dispensing or delegating dispensing of prescription medications at a service site **must** maintain a Michigan Drug Control License for the location in which the storage and dispensing of prescription drugs occur. The dispensing license is in addition to the Michigan medical practice license required for writing prescriptions.

8.5.5 All Family Planning medical services **must** be performed utilizing protocols and/or standing orders approved by the project's medical director annually.
A. Physical assessment, diagnosis, treatment, and provision of medication and devices **must** be performed by a licensed clinical services provider (physician, physician assistant, nurse practitioner or certified nurse mid-wife).
B. All clinical services providers **must** maintain current licensure and certification by the standards defined by Public Act 368 of 1978 as amended, Part 4, R338.10406, as defined by the Michigan Department of Licensing and Regulation, Board of Nursing, in the General Rules, or by the Council of Allied Health Education (for the Certification of Physician Assistants); and other health professionals and para-professionals may be utilized to perform non-medical responsibilities, or assist in medical functions as approved by the medical director.

8.5.6 Appropriate salary limits apply as required by law. Salary limitations are identified in the Title X Notice of Award, reflecting the current federal appropriations law.

8.6 STAFF TRAINING AND PROJECT TECHNICAL ASSISTANCE

Title X grantees are responsible for the training of all project staff.

8.6.1 Sub-recipients **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)) and should provide periodic staff meetings to review program activities.

A. All staff working in the Title X program **must** be provided an initial orientation to the program that includes an understanding of the basic tenets of the Title X program. MDHHS requires use of Reproductive Health National Training Centers (RHNTC)'s Title X orientation and recommends use the additional resources in staff training on Title X.

B. Sub-recipients **must** maintain documentation and attendance for required trainings for all staff and volunteers. See the Staff Training Job Aid and sample Training Log on the FP website Information for Providers page.

C. Sub-recipients should maintain documentation and attendance for continuing education programs for all staff.

D. All staff should be offered the opportunity to attend/access training programs, including RHNTC programs, MDHHS training programs, and the annual Family Planning Update at least once per year.

E. Funds for training and continuing education should be included in each year's Title X operating budget.

F. Registered nurses and mid-level practitioners should be offered appropriate educational opportunities to comply with requirements of the licensure/certification process.

G. Sub-recipients should participate in annual Family Planning Coordinator Meetings where needs for future training programs are discussed.

H. Sub-recipients should have appropriate clinical resources available for staff such as: CDC Providing Quality Family Planning Services Recommendations of CDC and OPA; CDC U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (SPR); CDC, United States Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2016; and most recent edition of Contraceptive Technology (22nd edition).

8.6.2 All new staff **must** receive orientation to the Title X Family Planning Program including these basic tenets of Title X:

A. Services include a broad range of medically approved family planning methods and services including related preventive health care.

B. Services are voluntary, provided without any coercion or prerequisites.

C. Services are confidential except when disclosure is required by law.

D. Services are client-centered, culturally, and linguistically appropriate, inclusive, and trauma-informed, respecting the dignity of the individual client with their values driving their care.

E. Services are equitable, high quality and consistent with national standards of care; and no one is denied services regardless of ability to pay.

F. Services do not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

G. Title X programs prioritize services to low-income and under-served populations.

H. Services are adolescent-friendly and provided to minors without parental consent or disclosure and comply with Title X Legislative Mandates.

I. Title X programs **must** comply with state laws on mandated reporting.

J. Services **must** not include abortion as a method of family planning. However, pregnant clients **must** be offered information and counseling regarding all pregnancy options and referrals provided upon request including:

   a. Prenatal care and delivery,
   b. Infant care, foster care, or adoption
   c. Pregnancy termination

K. Orientation **must** also include staff review of the implementation procedures of the project, including agency Title X policies and procedures.

8.6.3 Staff **must** be trained on Title X Legislative Mandates (p. 16) on encouraging family involvement in the decision of minors to seek family planning services and on counseling of minors on how to resist being coerced into engaging in sexual activities **annually**.

8.6.4 Staff **must** be trained regarding prevention, transmission and infection control in the health care setting of sexually transmitted infections including HIV as required by OSHA regulations.

8.6.5 Staff **must** be trained and understand their role in an emergency or natural disaster as required by OSHA regulations.

8. 6.6 Staff **must** be trained in health equity, inclusive access to care and the unique social practices, customs and beliefs of under-served populations of their service area at least every **two years**.

8.6.7 Staff **must** be trained on content related to mandated reporting and human trafficking **annually,** including identifying situations in a Title X clinic setting and **must** include information on agency policies and procedures on mandatory reporting under Michigan's Child Protection, Vulnerable Adult Protection and human trafficking laws regarding minors.

8.6.8 Clinical staff involved in dispensing medications **must** be trained on required legal and safety procedures regarding the dispensing pharmaceuticals within the clinic setting at least every **two years**. (See Pharmaceuticals pages 83-85)

8.6.9 Medical Directors without OB-GYN special training or experience providing family planning **must** have a minimum of 4 hours in Family Planning or reproductive health care every **2 years**. (Trainings through RHNTC or CTC-SRH meet this requirement)

8.7 PLANNING AND EVALUATION

MDHHS **must** ensure that the project is competently and efficiently administered (42 CFR 59.5 (b) (6) and (7)). In order to adequately plan and evaluate program activities, MDHHS develops written goals

and objectives for the year, project period, that are specific, measurable, achievable, realistic, time-framed, consistent with Title X Program Requirements, and based on a needs assessment.

A. Sub-recipients **must** submit written goals and objectives (Family Planning Work Plan) for the year with their annual plans that are specific, measurable, achievable, time-framed and consistent with Title X Program requirements as part of their annual plan. Objectives **must** include an evaluation component. Instructions for the annual plan and work plan are available in the Michigan Information in Section I of this document and are emailed to Family Planning Coordinators annually. Templates for the Family Planning Program Work Plan are available on the MDHHS Family Planning website.

9. PROJECT SERVICES AND CLIENTS

Projects funded under Title X are intended to enable all persons who want family planning care to have access to such services. Projects **must** provide for comprehensive medical, informational, educational, social, and referral services related to family planning for clients who want such services. Sub-recipients **must** have written policies and procedures in place to assure the following:

9.1 Priority for project services **must** be to persons from low-income families (Section 1006(c) (1), PHS Act; 42 CFR 59.5(a) (6)).

9.2 Services **must** be provided in a manner that is client centered, culturally and linguistically appropriate, inclusive and trauma-informed; protects the dignity of the individual and ensures equitable and quality service delivery (42 CFR 59.5 (a) (3)).

A. **Client-centered care** is respectful of, and responsive to, individual client preferences,needs, and values; client values guide all clinical decisions. (42 CFR § 59.2)

B. **Culturally and linguistically appropriate services** are respectful of and responsive to the health beliefs, practices and needs of diverse patients. (42 CFR § 59.2)

C. **Inclusive** is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, AsianAmericans 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)

D. **Trauma-informed** means a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma intopolicies, procedures, and practices, and seeks to actively resist re-traumatization. (42 CFR § 59.2)

9.3 Services **must** be provided in a manner that does not discriminate against any client based on religion, race, color, national origin, age, height, weight, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status, partisan considerations, disability or genetic information. (42 CFR 59.5 (a) (4); MCL 37.2101 to 37.2804; MI Executive Directive 2019-09).

9.4 Projects **must** provide for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance (42 CFR 59.5 (b)(2)).

A. Projects **must** have policies and procedures in place to identify and address intimate partner violence.

B. Projects **must** have policies and procedures in place to identify and address victims of human trafficking.

9.5 Projects **must** provide for coordination and use of referrals and linkages with primary health care providers, other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close proximity to the Title X clinic where feasible. (42 CFR 59.5 (b)(8).

9.6 All family planning services **must** be provided using written clinical protocols that are in accordance with nationally recognized standards of care, signed by the medical director (clinical services provider responsible for program medical services) annually. MDHHS will review protocols at the comprehensive program review.

9.7 All projects **must** provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referrals to other medical facilities when medically indicated and provide for the effective usage of contraceptive devices and practices. (42 CFR 59.5(b)(1)).

A. Necessary referrals include but are not limited to emergencies that require referral. Efforts may be made to aid the client in finding potential resources for reimbursing the referral provider, but projects are not responsible for the cost of this care. Referrals should be made to facilities as convenient to the client as feasible. (43 CFR 59.5 (b)(8))

9.8 All projects **must** provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, preconception health services and adolescent-friendly health services). A service site that offers only a single or very limited number of family planning methods may participate only as part of a project where the entire project offers a broad range of family planning services. MDHHS **must** be informed of these arrangements (42 CFR 59.5(a) (1)).

9.9 Services **must** be provided without the imposition of any residency requirement or requirement that the client be referred by a physician (42 CFR 59.5(b) (5)).

9.10 Projects **must not** provide abortion as a method of family planning. Projects **must**

A. Provide pregnancy testing and counseling to all clients in need or requesting this service
B. Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options:
    a. Prenatal care and delivery
    b. Infant care, foster care, or adoption; and
    c. Pregnancy termination
C. If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and provide referral upon request, except with respect to any option(s) which the pregnant client does not wish to receive information and counseling. (42 CFR 59.5(a) (5)) Clients choosing to receive information about pregnancy termination are also provided information on the legal status of abortion in Michigan. (See page 27-28, 75)

9.11 Sub-recipients **must** comply with applicable legislative mandates set out in the HHS appropriations act. Grantees **must** have written policies in place that address these legislative mandates:

A. Projects **must** encourage family participation in the decision of minors to seek family planning services and **must** provide counseling to minors on how to resist efforts to coerce the minor into engaging in sexual activities.
B. Projects **must** comply with state laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest. No provider of services under Title X is exempt from laws requiring mandatory reporting.

10. CONFIDENTIALITY

Every project **must** have policies, procedures, and safeguards in place to ensure client confidentiality.

10.1 Safeguards to ensure confidentiality **must** include:

A. Assurance of confidentiality included in agency policies and procedures.
B. A confidentiality assurance statement in the medical record, e.g., in the general consent for services.
C. A confidentiality assurance statement signed by all family planning project personnel.
D. Title X projects **must not** require written consent of parents of guardians for the provision of services to minors; nor can Title X staff notify a parent or guardian before or after a minor has requested and/or received title X family planning services.
E. Reasonable efforts to collect charges without jeopardizing confidentiality are made, including information regarding potential disclosure to a policyholder. (See page 47)

10.2 Information obtained by the project staff about an individual receiving service **must not** be disclosed without the individual's documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality.

A. Clients **must** be informed of any potential for disclosure of confidential health information to policyholders where the policyholder is someone other than the client. (43 CFR 59.10 (a))

10.3 Information regarding clients and services **must** otherwise be disclosed only in summary, statistical, or other form that does not identify the individual (42 CFR 59.11).

10.4 Confidentiality under Title X **must** not be invoked to circumvent mandated reporting requirements for child abuse and neglect.

10.5. Efforts should be made to assure that written and verbal exchanges between clients and clinic/clerical staff kept private, so that other clients in the site do not know client identity or reason for the visit.

11. COMMUNITY PARTICIPATION, EDUCATION, AND PROJECT PROMOTION

Title X grantees are expected to provide for community participation and education and to promote the activities of the project.

11.1 Title X grantees and sub-recipient agencies **must** provide an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by persons in the community knowledgeable about the community's needs for family planning services (42 CFR 59.5(b)(10)).

A. Sub-recipients **must** fulfill this requirement using a governing board, program specific family planning advisory committee (FPAC), or other appropriate advisory group which reviews general program/policy issues and make recommendations to the agency on organization, management and operation of the Family Planning Program.
   1. The composition of the board or advisory committee **must** be broadly representative of the population served in the community and include persons knowledgeable about family planning.
   2. Each group **must** meet at least once a year to:
      a. Review the program plan, assess accomplishments, and suggest future program goals and objectives.
      b. Review the progress toward meeting the needs population in the service area and maintaining services and policies responsive to the needs of the community.
      c. The FPAC or advisory group, or a subcommittee of the FPAC or advisory group, may also serve the function of the Information and Education (I. & E.) Advisory Committee, so long as requirements of sections 12.1-12.7 are met.
   3. Minutes **must** be kept of all meetings.
   4. Meetings may be conducted utilizing electronic technology.

B. Other recommendations for community participation include the following:
   1. Use of client satisfaction surveys.
   2. Inclusion of teens and low-income clients on the Advisory Council.
   3. Asking for client input on educational and informational materials.

4. Use of client surveys or focus groups designed to elicit what services may be seen as needed by clients but not available.

11.2 Projects **must** establish and implement planned activities to facilitate community awareness of and access to family planning services (42 CFR 59.5(b) (3)). Each family planning project **must** provide for community education programs (42 CFR 59.5(b) (3)). Community education program(s) should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.

11.3 Projects **must** provide community education to enhance community understanding of the objectives of the project, make known the availability of services to potential clients and encourage continued participation by diverse persons to whom family planning may be beneficial to ensure access to quality family planning care. (42 CFR 59.5 (b)(3).

12. APPROVAL OF INFORMATION AND EDUCATION MATERIALS

Sub-recipients are responsible to maintain an Information and Education (I. & E.) Advisory Committee that follows Title X requirements for the review and approval of educational materials. The requirements of the I. & E. committee are as follows:

12.1 Every sub-recipient **must** have a review and approval process of all informational and educational (I. & E.) materials (print or electronic) developed or made available under the project prior to their distribution to assure that materials are suitable for the population or community for which they are made available and the purposes of Title X (Section 1006(d) (1), PHS Act; 42 CFR 59.6(a)).

The I. & E. Committee may also serve the community participation functions of a family planning advisory committee (FPAC) or advisory group described above in section 11.1.A, as long as it meets the requirements of both groups.

12.2 I. & E. Committee membership **must** include individuals broadly representative (in terms of demographic factors such as race, ethnicity, color , national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including individuals belonging to underserved communities of the population or community for which the materials are intended (42 CFR 59.6 (b) (2)).

A. Family Planning Program staff may provide administrative and clinical support to the committee but may not be voting members of the advisory committee.
B. The committee may include professionals who work directly with population groups for which materials are intended, but the priority should be to include client and community members where possible.
C. The agency **must** demonstrate efforts to recruit client and community members to assure broad representation the populations served. “Information & Education Committee Member Recruitment Tips and Resources” is available on the MDHHS Family Planning website.

D. The description of I. &. E. Committee composition submitted to MDHHS with the Annual Plan **must** include how the composition represents client populations served in terms of demographic factors.
E. The I. & E. Committee roster submitted to MDHHS with the Annual Plan **must** identify what communities/populations/groups the member represents (e.g., agency or professional organization name, or teen, male, client, parent, LGBTQ).

12.3 The sub-recipient I. & E. Committee **must** be made up of at least five members and up to as many members as the sub-recipient determines. (42 CFR 59.6(b)(1)).

12.4 MDHHS delegates the I. & E. materials review and approval process to the sub-recipients; however, the oversight responsibility of the I. & E. review process rests with MDHHS as the grantee. MDHHS monitors this committee and review process with the Annual Plan review and on-site comprehensive program reviews.
Each sub-recipient's I. & E. committee **must** have a process for the review and approval of materials prior to their distribution that includes the following:

A. A written description of the I. & E. Committee review and approval process **must** be included in a policy statement, by-laws, or other committee documents made available to members.
B. All new information or education materials are distributed to committee members, along with a clinic brochure review form for each item, prior to the committee meeting. Sub-recipients should allow at least two weeks for members to review materials prior to a meeting.
    a. The I. & E. Committee may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate staff; however, final responsibility for approval of the materials rests with the committee.
C. The I. & E. Committee **must** use an MDHHS approved clinic brochure review form to document their review and individual determinations regarding approval for each educational material.
    a. An approved clinic brochure review form is located on the MDHHS Family Planning website.
    b. Sub-recipients wishing to modify or use a different form **must** submit it to their MDHHS program consultant for approval.
D. At the I. & E. Committee meeting, members discuss their comments and recommendations and determine if the materials are appropriate for the intended community or target audience.
    a. In their review of materials, the committee **must** consider the following:
        i. The educational, cultural, and diverse backgrounds of the individuals the materials are intended to serve
        ii. The standards of the population or community materials are intended to serve
        iii. Review the content to assure that the information is medically accurate, culturally/linguistically appropriate, inclusive, and trauma informed.
        iv. Determine whether the materials are suitable for the population or community they are intended to serve

E. Committee approval of materials requires, at least one half of voting members.
F. The I. & E. Committee **must** meet at least once a year; and should meet as often as is needed to review and approve new materials prior to their use. Meetings may be conducted using electronic technology.
G. A written record of the determinations and approval process **must** be established and maintained (Section 1006(d), PHS Act; 42 CFR59.6 (b)) including:
    a. Minutes **must** be kept of all meetings and **must** reflect the determination for each item reviewed.
    b. Completed review forms or a compiled summary of individual review forms **must** be maintained to document member determinations.
    c. A master listing of materials that have been reviewed and approved by the committee with dates the items were approved/reapproved **must** be maintained.
H. Staff overseeing the I. & E. Committee are responsible to bring existing, previously approved materials for review or update to assure continued accuracy and appropriateness. Approved materials **must** be reviewed at least every three years.

12.5 Any publication or other media developed by the grantee or sub-recipient using Title X funds **must** acknowledge federal grant support (45CFR 74.36; Notice of Grant Award).
A. Acknowledgement **must** include the following language: "This [publication/ program/website, etc.] was supported by the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS) as part of a Title X financial award totaling [$XX with $ XX funded by OPA/OASH/HHS and $XX funded by other source(s)]. This [publication/program/website] is supported as part of this award. The contents are those of the author(s) and do not necessarily represent the views of, nor endorsement, by OPA/OASH/HHS, or the U.S. Government. For more information, visit: https://opa.hhs.gov/.
B. Sub-recipients wishing to use alternate language for this acknowledgement **must** request and receive a waiver from MDHHS.

13. ADDITIONAL ADMINISTRATIVE REQUIREMENTS

13.1 FACILITIES AND ACCESSIBILITY OF SERVICES

Title X service sites should be geographically accessible for the population being served. Sub-recipients are strongly encouraged to consider clients' access to transportation, clinic locations, hours of operation, and other factors that influence clients' ability to access services.

Title X clinics **must** have written policies that are consistent with the HHS Office for Civil Rights policy document, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (August 4, 2003) (HHS Grants Policy Statement 2007, II-23). (Section I, page 20)

A. Sub-recipients **must** ensure meaningful access to services for persons with limited English proficiency (LEP).

B. Sub-recipients **must** have a written plan regarding the process for providing language assistance to LEP clients.
C. The scope and complexity of the plan should consider the size of LEP populations likely to be encountered and frequency of contact with the LEP populations.
D. LEP plans **must** include:
    1. Statement of the agency's commitment to provide meaningful access for LEP persons.
    2 Statement that services will not be denied to a client because s/he is limited English proficient.
    3. Statement that clients will not be asked or required to provide their own interpreter. The use of family and friends as interpreters is discouraged. If the client chooses to use family or friends, the client is informed of the right to free interpreter services and use of family or friends occurs only after the offer is declined and documented.
    4. LEP plans **must** include following:
        a. Identify LEP individuals who need language assistance.
        b. Language assistance, oral interpretation, and/or written translation
        c. Staff training
        d. Providing notice to LEP persons
        e. Routine updating of the LEP plan

Sub-recipients **must not** discriminate on the basis of disability and, when viewed in their entirety, facilities **must** be readily accessible to people with disabilities (45 CFR part 84). (Section I, page 21)

13.2 EMERGENCY MANAGEMENT

Grantees, sub-recipients, and Title X clinics **must** have written plans for the management of emergencies (29 CFR 1910, subpart E), and clinic facilities **must** meet applicable standards established by Federal, State, and local governments (e.g., local fire, building, and licensing codes). (Section I, page 21)

Health and safety issues within the facility fall under the authority of the Occupational Safety and Health Administration (OSHA). Disaster plans and emergency exits are addressed under 29 CFR 1910, subpart E. The basic requirements of these regulations include:

A. Disaster plans (e.g., fire, bomb, terrorism, earthquake, etc.) have been developed and are available to staff.
B. Staff can identify emergency evacuation routes.
C. Staff has completed training and understands their role in an emergency or natural disaster.
D. Exits are recognizable and free from barriers.

13.3 STANDARDS OF CONDUCT

Sub-recipients **must** establish policies to prevent employees, consultants, or members of governing/advisory bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial gain for themselves or others (HHS Grants Policy Statement 2007, II-7). (Section I, page 20)

13.4 HUMAN SUBJECTS CLEARANCE (RESEARCH)

Research conducted within Title X projects may be subject to Department of Health and Human Services regulations regarding the protection of human subjects (45 CFR Part 46). Sub-recipients **must** advise the MDHHS in writing of research projects involving Title X clients or resources in any segment of the project.

A. MDHHS **must** approve human subject research through submission to the MDHHS Institutional Research Board (IRB) process.
B. MDHHS will advise the OPA Regional Office in writing of any approved research project that involves Title X clients (HHS Grants Policy Statement 2007, II-9). (Section I, page 20)

13.5 FINANCIAL AND REPORTING REQUIREMENTS

Sub-recipients **must** comply with MDHHS minimum reporting requirements, including the Family Planning Annual Report (FPAR). In addition, sub-recipients **must** file an annual health care plan and **must** have policies and procedures in place to follow Michigan mandatory reporting requirements under the Michigan Child Protection Act, Michigan's Human Trafficking law, and Vulnerable Adult Protection. (Section I, pages 17, 33 and 26,27).

A. MDHHS is transitioning from FPAR 1.0 Reporting to FPAR 2.0 reporting for Calendar year 2024, requiring:
    1. Quarterly FPAR 2.0 encounter level data submissions (calendar year 2024)
    2. Mid-year and Year-end FPAR 2.0 Family Planning Encounters (Table 13) & Family Planning Revenue Report (Table 14) (Calendar Year 2024)
    3. Sub-recipients **must** have a system in place to collect required data elements for the FPAR.
    4. Sub-recipients **must** have a system in place for validating the data reported on the FPAR.
B. MDHHS requires agencies file an annual needs assessment and health care plan (Annual Plan) following MDHHS instructions.
C. MDHHS requires agencies to have policies and procedures in place for mandatory reporting requirements under Michigan's Child Protection Act and training on Michigan's Human Trafficking Law. (9.11)

Sub-recipients **must** have program data reporting systems which accurately collect and organize data for program reporting and which support management decision making and act in accordance with other reporting requirements as required by HHS.

Sub-recipients **must** demonstrate continued institutional, managerial, and financial capacity (including funds sufficient to pay the non-Federal share of the project cost) to ensure proper planning, management, and completion of the project as described in the award (42 CFR 59.7(a)).

Sub-recipients **must** reconcile reports, ensuring that disbursements equal obligations and drawdowns. HHS is not liable should the recipient expenditures exceed the actual amount available for the grant.

14. ADDITIONAL CONDITIONS

With respect to any grant, HHS may impose additional conditions prior to or at the time of any award, when, in the judgment of HHS, these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds (42 CFR 59.12). MDHHS assures compliance with HHS grant conditions.

15. CLOSEOUT

Upon the end of grant support sub-recipients **must** submit the following in compliance with their MDHHS contract:

A. Final Financial Status Report (FSR)
B. Final Family Planning Annual Report (FPAR) report
C. Final progress report regarding:
    1. Accounting for any remaining inventory, contraceptive supplies and materials purchased with Title X funds.
    2. Notification and transfer, where appropriate, of Title X clients, including arrangements for clients to obtain copies of their medical records and a list of alternative family planning services providers where transfer of clients is not available.
    3. Identification of any equipment purchased with Title X funds with acquisition cost more than $5,000 for appropriate transfer or retention.

Following closeout, the sub-recipient remains obligated to return funds due as a result of any later refunds, corrections, or transactions, and MDHHS may recover amounts based on the results of an audit covering any part of the period of grant support (HHS Grants Policy Statement).

16. OTHER APPLICABLE HHS REGULATIONS AND STATUTES

The following HHS Department-wide regulations that apply to Title X grants: (Section I, pages 20,21)

A. 37 CFR Part 401: Rights to inventions made by nonprofit organizations and small business firms under government grants, contracts, and cooperative agreements
B. 42 CFR Part 50, Subpart D: Public Health Service grant appeals procedure
C. 45 CFR Part 16: Procedures of the Departmental Grant Appeals Board
D. 2 CFR Chapter I, Chapter II, Part 200: Uniform administrative requirements, Cost Principles, and Audit Requirements for Federal Awards; Final Rule. Federal Register December 26, 2013. This guidance streamlined requirements and superseded HHS regulations (45 CFR Parts 74 and 92) and administrative requirements (A-110 and A-102), cost principles (A-21, A-87, and A-122), audit requirements (A-50, A-89, and A-133).
E. 45 CFR Part 80: Nondiscrimination under programs receiving Federal assistance through HHS effectuation of Title VI of the Civil Rights Act of 1964
F. 45 CFR Part 81: Practice and procedure for hearings under Part 80 of this Title
G. 45 CFR Part 84: Nondiscrimination on the basis of disability in programs and activities receiving or benefitting from Federal financial assistance

H. 45 CFR Part 91: Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance
I. 45 CFR Part 100: Intergovernmental Review of Department of Health and Human Services Programs and Activities

The following statutes apply to grants under Title X: (Section I, pages 21-23)

A. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)
B. The Trafficking Victims Protection Act of 2000, as amended (Public Law 106-386)
C. Sex Trafficking of Children or by Force, Fraud, or Coercion (18 USC 1591)
D. The Patient Protection and Affordable Care Act (Public Law 111-148)

SECTION III

Clinical Services

17. INTRODUCTION

The MDHHS Title X Family Planning clinical guidelines are adapted from the Providing Quality Family Planning Services (QFP), recommendations developed by CDC and OPA. The QFP defines the provision of quality family planning services for people of reproductive age. The goal of family planning services is to assist individuals to achieve the desired number and spacing of children and increase the chances that children will be born healthy. Quality family planning services include these attributes: confidentiality, safety, effectiveness, client-centered approach to care, timeliness, efficiency, accessibility, equity and cost effectiveness. A client-centered approach to care means that services are client led, culturally and linguistically appropriate, inclusive and trauma-informed. Quality Family Planning Services include the following core services:

- Contraceptive services
- Pregnancy testing and counseling
- Achieving desired pregnancy
- Basic infertility services
- Preconception health services
- Sexually transmitted infection (STI) services

Michigan Title X providers **must** offer all core family planning services listed above, related preventive health services (see pages. 81-82) and referral for specialty care, as needed. Other preventive health services that are beyond the scope of Title X may be offered either on-site or by referral. Information on preventive health services recommendations is available from the U.S. Preventive Services Task Force.

All Title X projects **must** offer family planning services and related preventive health services to all clients, including minors. All projects **must** provide for medical services related to family planning including clinical services provider consultation, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies, in person or by telehealth, and necessary referrals to other medical facilities when medically indicated and provide for the effective use of contraceptive devices and practices (42 CFR 59.5(b)(1)). (See referrals page 82) Efforts may be made to aid the client in finding potential resources for reimbursement of the referral provider, but projects are not responsible for the cost of this care.

18. SERVICE PLANS AND PROTOCOLS

The service plan is the component of a sub-recipient's annual health care plan which identifies the services to be provided to clients under Title X.

A. All sub-recipients **must** offer a broad range of acceptable and effective and medically (FDA) approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, preconception health services) either on-site or by referral [59.5(a)(1)]. All

sub-recipient agencies **must** have written clinical protocols signed annually by the agency's medical director/ directing clinical services provider and approved by MDHHS, which outline procedures for the provision of each service offered. Subrecipients **must** have written protocols available at each clinical site. The clinic staff **must** use approved protocols for the provision of all family planning services.

B. Clinical protocols **must** be written in accordance with the QFP document, Michigan Title X Family Planning Program Standards and Guidelines, Michigan laws and nationally recognized standards for medical care (See Section I page 19,20). Clinical Protocols **must** be current (i.e., updated annually) and signed annually by the medical director/directing clinical services provider. The current Michigan Title X Family Planning Standards and Guidelines Manual **must** be available at each clinical site.

19. PROCEDURAL OUTLINE

The services provided to family planning clients, and the sequence, in which they are provided, will depend upon the type of visit and nature of the service requested. All the QFP services identified in the introduction **must** be offered to clients and documented in the medical record.

A. Services to all clients **must** include the following:
   1. Assure services are provided in a client-centered manner that protects the dignity of each individual, is culturally and linguistically appropriate, inclusive, trauma-informed and ensures equitable care for each client. (discussed on page 51)
   2. Assure services are respectful and responsive to the needs of diverse clients, (such as lesbian, gay, bi-sexual, transgender, questioning (LGBTQ) clients and clients with disabilities) and are responsive to the health beliefs and practices of diverse clients. Providers should avoid making assumptions about a client's sex, sexual orientation, gender identity, and sex characteristics, race, ethnicity or religious beliefs; all requests for services should be treated without regard to these characteristics.
   3. Assure client confidentiality and the provision of privacy.
   4. Assure the client has the opportunity to participate in planning their medical treatment.
      a. Individual client preferences, needs and values guide clinical decisions
   5. Encourage clients to voice any questions or concerns they may have.
   6. Assure all procedures, range of available services, and agency fees and financial arrangements are explained to the client.

B. **SERVICES TO MINORS**

Services to minors **must** be offered and provided in an adolescent-friendly manner, making services accessible, equitable, comprehensive, and effective for youth. Counseling for minors **must** include the following:

1. Title X providers **must** offer confidential services to minors and **must** observe relevant state laws related to mandatory reporting of child abuse and neglect, human trafficking and vulnerable adults. (Section I pages 26,27)

a. Title X providers **must not** require consent of parents or guardians for provision of services, nor notify a parent or guardian before or after a minor receives services, without consent of the minor.
b. Minors **must** be informed that services are confidential, except in special cases (e.g., child abuse or human trafficking of a minor) where reporting is required
c. Minors **must** be informed of potential disclosure of confidential health information to policyholders where the policyholder is someone other than the client. (42 CFR 59.5 (b) (1))
    i. By policy, Michigan Medicaid suppresses disclosure of Family Planning, STI, and mental health beneficiary services.
    ii. Most private insurers routinely disclose services as Explanation of Benefits (EOB) reporting to policyholders but have procedures for requesting suppression of disclosure.

2. Title X providers **must** encourage family involvement (communication between the minor and their parents, guardians, or a trusted adult) about their decision to seek family planning services.
3. Title X providers **must** provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.
4. Title X required counseling for minor clients **must** be documented in the medical record.
    a. If sub-recipients use checkboxes to document required counseling in the health record, there **must** be associated counseling policies/protocols for each of these topics to clearly indicate the content covered.
5. Minors seeking contraceptive services **must** be provided comprehensive information about how to prevent pregnancy, including abstinence.

C. Individual client education **must** be offered.
1. Materials and/or interpreter **must** be available for those with limited ability to read or understand English and for those with vision or hearing impediments.

D. Individual counseling (a client-centered, interactive process to assist the client in making an informed choice) **must** be offered and/or provided prior to the client making an informed choice of family planning services.

E. Counseling for all clients **must** address the client's pregnancy intention or reproductive goals.

F. The client's general consent for services **must** be obtained prior to receiving any clinical services. (Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a) (2))
1. The general consent for services **must** include that services are voluntary; provided without coercion to accept services or any particular method of family planning and provided without prerequisite to accept any other service.
2. The general consent for services **must** include that services are confidential, including information regarding potential disclosure as required by law and information about the potential for disclosure of health information to a policy holder of insurance where the policy holder is someone other than the client.
3. The general consent for services **must** be language appropriate or obtained through an interpreter.
4. If the encounter is a face-to-face visit, a written consent is required. If the encounter is a virtual or telehealth visit, a verbal consent for services **must** be documented in the client record.

G. Subrecipients are encouraged to consider adding availability of telehealth services as an option.
H. A medical history **must** be obtained that is appropriate to the type of service provided.
I. A physical examination, including necessary clinical procedures, **must** be provided, as indicated.
J. Laboratory testing **must** be provided, as indicated.
K. Medications and/or supplies **must** be provided, as indicated/requested.
    1. Written specific instructions **must** be provided on how to use medications, if dispensed.
    2. Instructions **must** be provided on danger signs and when, where, and how to obtain emergency care, return schedule and follow-up
L. Follow-up and Referral **must** be provided, as indicated.
    1. Provision of referrals as needed
    2. Planned mechanism for client follow-up
        a. Suggested return visit date
        b. Contact information for emergencies after hours
        c. Discuss access to primary care services.
L. Emergency arrangements **must** be available for after hours and weekend care and should be posted, given to, and/or explained to clients.
M. Return visits should assess the on-going plan of care and needed family planning related services.

20. CLIENT ENCOUNTERS

A. The client's general consent for services **must** be obtained prior to receiving any clinical services. (Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a) (2))
    1. If the encounter is a face-to-face visit, a written consent is required. If the encounter is a virtual or telehealth visit, a verbal consent for services **must** be documented in the client record.
B. Encounters with reproductive age clients may require different services (i.e., contraceptive services, pregnancy testing and counseling, achieving pregnancy, STI services, preconception health and related preventive health services). For all clients, questions to address the following issues **must** be asked and documented to determine what family planning services are most appropriate for the visit:
    1. **What is the client's reason for today's visit?**
    2. **Does the client have another source of primary health care?**
    3. **Does the client have reproductive goals or desire pregnancy in the next year?**
        a. Providers should assess the client's reproductive goals and/or pregnancy intention by asking questions like: "Do you think you might like to have (more) children at some point?", "When do you think that might be?", "How important is it to you to prevent pregnancy (until then)?" or "Are you considering getting pregnant in the next year?", or "Can I help you with reproductive health services today, such as birth control or preparing for a future pregnancy?" For guidance on client-centered reproductive goals counseling: PATH Framework: Client-Centered Reproductive Goals Counseling; Efficient Questions for Client-Centered Contraceptive Counseling or One Key Question guidance
        b. Providers should ask about partner participation in reproductive goals and family planning decisions where appropriate.

Virtual family planning encounters providing access to family planning and related preventive health services, may include assessment, diagnosis, intervention, consultation, education,

counseling, and supervision. 2021 Title X Regulations allow telehealth services in Title X projects going forward (42 CFR CH. 1 §59.5 (b)(1)). Policies and medical record documentation **must** reflect when services are provided via telehealth.

21. CONTRACEPTIVE SERVICES

Written protocols and operating procedures **must** be current and in place for contraceptive services. Sub-recipient agencies **must** offer contraceptive services to clients who wish to delay or prevent pregnancy. The delivery of preconception, STI, and related preventive health services **must** not be a barrier to a client's ability to receive services related to preventing or achieving pregnancy. Receiving services related to preventing or achieving pregnancy is the priority; if other family planning services cannot be delivered at the initial visit, follow-up visits should be scheduled.

A. **Contraceptive services must** include:

1. A Broad Range of FDA-approved Contraceptive products and natural family planning methods. All methods of contraception **must** have written protocols in place.
   a. Current CDC Medical Eligibility Criteria (MEC) **must** be followed when prescribing contraceptives.
   b. More than one method may be used simultaneously by the client (for example, a hormonal method and condoms or FABM and barrier method during the fertile period). Clients with high-risk sexual behavior patterns should be encouraged to use condoms correctly and consistently in addition to any other chosen method to reduce the risks of STIs/HIV and pregnancy.

B. **Broad Range of Contraceptives must** at least include the following:

1. Hormonal Contraceptives
   a. At least two delivery methods of combined hormonal contraceptives **must** be available on site.
   b. At least one delivery method of progestin-only contraceptives **must** be available on site.
   c. At least a second type of progestin-only method **must** be made available on site within two weeks of client request.
2. Condoms
   a. At least male external condoms **must** be available on site.
3. At least one type of long-acting reversible contraceptive (LARC) method **must** be provided, either on site or by paid referral.
4. At least one type of natural family planning method **must** be provided.
5. Education materials and information regarding all methods including, hormonal contraceptives, abstinence, fertility awareness-based methods, barrier methods, intrauterine devices, sterilization, and emergency contraception.
6. The agency formulary **must** indicate:
   a. Methods maintained and available on site
   b. Methods available on site within two weeks of client request
   c. Methods available by paid referral.
   d. Methods available by unpaid referral (i.e., sterilization)
7. Agencies **must** maintain a formal referral agreement for any required broad range method not provided on site.

8. A service site that is unable to provide a broad range of family planning methods and services **must** be able to provide a prescription or referral resource for a client's chosen method contraceptives.
9. Agencies are encouraged to review current practice and the needs and preferences of their client population and maintain the most frequently requested contraceptive methods.
10. Agencies are strongly encouraged to provide emergency contraception and maintain supplies on site.
11. Prescriptions may be written for contraceptives for a client's method of choice when unavailable at the service site. Accepting a prescription should not pose a barrier for the client. Clients should be made aware they are responsible for out of pocket costs at a pharmacy.

C**. Emergency Contraception**

The provision of emergency contraception is strongly encouraged but not required for subrecipients. Emergency Contraception education and referral **must** be offered to clients when not provided on site. When subrecipients provide emergency contraception, the following **must** occur:

1. Written protocol **must** be in place.
2. If indicated by the client's history, a negative, highly sensitive pregnancy test is necessary to exclude a pre-existing pregnancy.
3. Birth control counseling should accompany or follow any method used for emergency contraception.
4. Chlamydia testing **must** be offered to females <25 years of age and to females > 25 years with risk factors.

D. **Permanent Contraception (Sterilization)**

1. Education and information regarding sterilization **must** be provided to clients, if indicated.
2. Sub-recipient agencies **must** have a list of community providers where clients can be referred for sterilization. Paid referrals for sterilization are not required.
3. Sub-recipient agencies performing sterilization procedures **must** meet Federal regulations for sterilization informed consent.

E. **The clinic visit:** A medical history **must** be taken prior to prescribing contraception to ensure that methods of contraception are safe for the client.

1. The **medical history** for contraceptive care **must** include:
    a. Reproductive goals -
    b. Allergies
    c. Medications
    d. Immunization (MI. Care Improvement Registry "MCIR" review is strongly recommended)
    e. Menstrual history
    f. Gynecologic and Obstetrical history
    g. Recent intercourse
    h. Recent delivery, miscarriage or termination
    i. Contraceptive use
        i. Contraceptive experiences and preferences

ii. Partner history (use of contraception, pregnant, has children, miscarriage or termination)
iii. Condom use, allergies to condoms
iv. Interest in Sterilization if age appropriate (≥ 21 per federal law requirement)

j. Current Infectious or chronic health condition (e.g., hypertension)
k. Characteristics and exposures that might affect the client's medical eligibility criteria (MEC) for contraceptive methods. (e.g., age, postpartum, breastfeeding, smoking)
l. Social history/risk behaviors
m. Sexual history and risk assessment
n. Mental health
o. Intimate partner violence

NOTE: Taking of a medical history **must** not be a barrier to making condoms available in the clinical setting (i.e., a formal visit **must** not be a prerequisite for a client to obtain condoms).

F. **Physical and Laboratory Assessment**

1. For clients seeking combined hormonal method and needing screening for hypertension, the following **must** be provided:
   a. BP
      i. All clients—screen yearly
      ii. If BP <120/80---screen yearly, continue yearly
      iii. If BP 120-139/80-89 (treated or untreated), recheck BP again in same visit if average BP >140/90 recheck at next visit or in 1 week and refer if sustained BP >140/90.
2. For clients seeking IUD insertion, fitting diaphragm or cervical cap, bimanual exam and cervical inspection **must** be provided.
   a. CT and GC testing **must** be available for clients requesting IUD insertion, if indicated.
3. Cervical Cancer screening and clinical breast exam **must** be provided based on current recommendations for timing and testing components. (See Related Preventive Health Services section.)
4. Chlamydia testing **must** be offered annually for all females < 25 years, sexually active females ≥25 years with risk factors (infected partner, partner with other concurrent partners, symptoms, history of STI or multiple partners in the last year) (See pages 78,79 in the STI section referencing pre-paid CT/GC requisition forms.)
5. For male clients, laboratory tests are not required unless indicated by history.

G. **Client-Centered Education and Counseling**

Contraceptive counseling is to help a client choose a method of contraception and understand how to use it correctly and consistently. Clients (adults and minors) who are undecided on a contraceptive method **must** be informed about all methods that can be used safely based on the CDC's U.S. Medical Eligibility Criteria for Contraceptive Use,2016. When educating clients about the broad range of contraceptive methods, information **must** be medically accurate, balanced, and provided in a nonjudgmental manner. To assist clients in making informed decisions, providers should educate clients in a manner that is readily understood and retained. Documentation of education/counseling **must** be in the client's medical record.

1. Educating clients about contraceptive methods they can use safely includes:
    a. Method effectiveness
    b. Correct and consistent use of the method
    c. Benefits and Risks
    d. Potential Side effects
    e. Protection from STIs, including HIV
    f. Starting the method
    g. Danger signs
    h. Availability of emergency contraception (provide on-site or by prescription)
    i. Follow-up visit (as needed to obtain or maintain the selected method)
2. Quality client-centered contraceptive counseling includes the following:
    a. Establish and maintain rapport
    b. Assess the client's needs with a personalized discussion
    c. Work with the client to establish a plan
    d. Provide information in a manner understood by the client
    e. Confirm the client's understanding
    a. The teach-back method may be used to confirm the client's understanding by asking the client to repeat back messages about effectiveness, risks, benefits, method use, protection from STIs and follow-up (QFP pages 45-46).
3. Contraceptive counseling **must** be documented in the client record (i.e., checkbox or written statement).
4. Contraceptive counseling should include information about partner controlled methods where appropriate.
5. Clients should be reminded that condoms should be used correctly and consistently to reduce risk of STIs, including HIV.
6. Encourage partner communication about contraception, including understanding partner barriers, any misperceptions and support for using a chosen method.
7. Provide information about how partners can access contraceptive services as needed.
8. Client information sheets may be used for education.
9. A procedure consent form **must** be signed by the client prior to insertion/removal of an IUD or implant.
10. Clinical evaluation of a client electing permanent sterilization should be guided by the provider who performs the procedure.

H. **Contraceptive Counseling for Minor Clients**

Comprehensive information **must** be provided to minor clients about how to prevent pregnancy.

1. It should not be assumed that minor clients seeking family planning services are sexually active. Abstinence is an effective way to prevent pregnancy and STIs and can be chosen as a method at any time in life.
2. If minor clients indicate they will be sexually active, provide information about contraception and help them choose a method that best meets their individual needs, including the use of condoms to reduce the risk of STIs/HIV. Long-acting reversible contraception (LARCs) are a safe and effective option for many minors, including those who have not been pregnant or given birth.

3. Title X providers **must** offer confidential services to minors and **must** observe state mandated reporting laws related to child abuse, neglect and human trafficking (Section I, pages 26,27).
    a. Title X providers **must not** require consent of parents or guardians for provision of services, nor notify a parent or guardian before or after a minor receives services, without consent of the minor.
    b. Minors **must** be informed that services are confidential, except in special cases (e.g., child abuse or human trafficking of a minor) where reporting is required.
    c. Minors **must** be informed of a potential for disclosure of confidential health information to policyholders where the policyholder is someone other than the client. (42 CFR 59.5 (b) (1))
        i. By policy, Michigan Medicaid suppresses disclosure of Family Planning, STI, and mental health beneficiary services.
        ii. Most private insurers routinely disclose services as Explanation of Benefits (EOB) reporting to policyholders but have procedures for requesting suppression of disclosure.
4. Title X providers **must** encourage communication between the minor and parents, guardians or trusted adult about sexual and reproductive health and their decision to seek services.
5. Title X providers **must** provide counseling to minors on how to resist attempts to coerce them into engaging in sexual activities.

I. **Counseling Returning Clients**

When providing contraceptives for returning clients, an assessment should include the following:

1. Method concerns
2. Method use (consistent, correct)
3. Any changes in client's history (i.e., risk factors, medications)
4. Review of reproductive goals
5. If appropriate, provide additional contraceptives and discuss a follow-up plan.

J. **Preventive Health Promotion and Referral**

1. Title X providers should refer pregnant, parenting and postpartum minors to home visiting and other programs (MIHP, Nurse Partnership) that have been demonstrated to provide needed support and reduce rates of repeat teen pregnancy.
2. Title X providers should provide referral resources for mental health, domestic or intimate partner violence, impacts of traumatic adverse experiences, and behavioral health including ETOH, tobacco, substance use as indicated.
3. Title X providers should provide a referral resource for immunizations as indicated.

22. PRECONCEPTION HEALTH SERVICES

A written protocol and procedure **must** be current, available and consistent with national standards of care. Agencies **must** offer preconception health services to clients as part of core family planning services. Preconception health services promote health before conception thereby reducing pregnancy-related adverse outcomes (low birth weight, premature birth, and infant mortality), promote positive birth outcomes and improve the health of clients.

The clinic visit includes:

A. **Medical history must** include:

1. Reproductive goals
2. Sexual health/risk assessment
3. Reproductive history
    a. History of prior pregnancy/birth outcomes (e.g., preterm, cesarean delivery, miscarriage, or stillbirth)
    b. Past medical/surgical history that might impair reproductive health (e.g., conditions that could reduce sperm quality, varicocele)
4. Environmental exposures, hazards and toxins (smoking, alcohol, other drugs, Zika risk)
5. Medications
6. Genetic conditions
7. Family history
8. Social history/risk behaviors
9. Intimate partner violence
10. Immunizations (MCIR review is strongly recommended)
11. Depression

B. **Physical Examination**:
    1. Height, weight, BMI (screen for obesity)
    2. BP (screen for hypertension- based on American Heart Assn. recommendations)
        a. All clients—screen yearly
        b. If BP <120/80---screen yearly, continue yearly
        c. If BP 120-139/80-89 (either treated or untreated), recheck BP again in same visit and if average BP >140/90 recheck at next visit or in 1 week and refer if sustained BP >140/90.

C. Laboratory testing
    1. STI/HIV testing as indicated.
    2. Chlamydia testing **must** be offered annually for all females < 25 years, sexually active females ≥25 years with risk factors (infected partner, partner with other concurrent partners, symptoms, history of STI or multiple partners in the last year)
    3. Laboratory testing **must** be recommended based on risk assessment:
        a. Diabetes screening (for type 2 diabetes in asymptomatic adults) with sustained BP (either treated or untreated) >139/80 (USPSTF)

E. **Client Plan/Education**
    1. Some medications may be contraindicated in pregnancy, and current medications taken during pregnancy will need to be reviewed by a prenatal care provider
    2. Encourage a daily supplement containing (400-800 mcg) of folic acid (or a prenatal vitamin)
    3. Avoid smoking, alcohol and other drugs
    4. Avoid eating fish that might have high levels of mercury (e.g., King Mackerel, Shark, Sword fish, Tile fish)
    5. Offer for any needed STI screening (including HIV)
    6. Refer for vaccinations, if indicated
    7. Counseling **must** be documented in client record

F. **Referral**

1. If client desires, refer for further diagnosis and treatment
2. Refer clients for additional services if screening results indicate presence of health condition or as indicated (i.e., tobacco cessation, obesity, diabetes, depression, immunizations).

23. ACHIEVING PREGNANCY SERVICES

Agencies **must** offer services to assist clients in achieving pregnancy as a component of their core family planning services. A written protocol and procedure **must** be current and consistent with national standards of care.

Achieving pregnancy services are offered to clients who desire a pregnancy. Achieving pregnancy services include identifying and addressing the needs of clients who desire pregnancy, providing counseling and education, including fertility awareness and key messages on achieving pregnancy, and addressing any misperceptions regarding fertility and infertility. Clients who have been trying to achieve pregnancy for 12 months or longer with regular unprotected intercourse should be offered basic infertility services.

A. **Client Assessment** includes:

1. Reproductive goals
2. When pregnancy is desired
3. Length of time they have been attempting pregnancy.
    a. If less than 1 year, provide counseling on maximizing fertility success
4. History of pregnancies or infertility
5. Partner engagement and support system issues
    a. Support system issues may include family and community support, LGBTQ considerations, single parent considerations, cultural/familial considerations, and awareness of other concerns or influences.

B. **Medical history** includes:

1. Immunizations
2. Medications
3. Present infectious or chronic health conditions
4. Genetic conditions
5. Environmental exposures or risks for both partners, (e.g., smoking, alcohol, Zika risk)
6. Social history/risk behaviors
7. Sexual health risk assessment
8. Mental health
9. Reproductive history
    a. History of prior pregnancy/birth outcomes (preterm, cesarean delivery, miscarriage, or stillbirth)
    b. Past medical/surgical history that might impair reproductive health
    c. Medical conditions associated with reproductive failure that could reduce sperm quality
10. Family history
11. Intimate partner violence

C. **Physical Assessment** includes:
   1. Height, weight, BMI (screen for obesity)
   2. BP (screen for hypertension)
      a. All clients—screen yearly
      b. If BP <120/80---screen yearly, continue yearly
      c. If BP 120-139/80-89 (either treated or untreated), recheck BP again in same visit and if average BP >140/90 recheck at next visit or in 1 week and refer if sustained BP >140/90.
   3. Physical exam may be needed to evaluate problems raised by review of systems or concerns raised by the client.
   4. Assessment and updating the client's physical, sexual and medical history may reveal additional issues that need to be addressed. Results may indicate the need for information on fertility awareness or other health services: STI screening, preconception care, infertility services, and other preventive health services.

D. **Laboratory testing** as indicated based on client medical and sexual history
   1. STI testing, including chlamydia testing offered for female clients $\leq$ 25 years.
   2. Diabetic screening

E. **Client education and counseling** includes:
   1. Importance of regular preventive health and chronic disease management
   2. Some medications might be contraindicated in pregnancy and current medications will need to be reviewed by the prenatal care provider
   3. Encourage daily supplement containing (400-800 mcg) of folic acid or a prenatal vitamin
   4. Avoid smoking, alcohol and other drugs.
   5. Avoid eating fish that might have high levels of mercury (e.g., King Mackerel, Shark, Sword fish, Tile fish)
   6. Offer any needed STI screening, including HIV
   7. Offer or refer for vaccinations, as indicated
   8. Nutritional counseling and recommend weight management if indicated
   9. Counseling **must** be documented in the medical record

F. **Education on maximizing fertility awareness** and pregnancy success includes:
   1. Fertility awareness/ Techniques to predict ovulation
      a. Education about peak days and signs of fertility (including the 6-day interval ending on the day of ovulation that is characterized by slippery, stretchy cervical mucus and other possible signs of ovulation)
      b. Education on methods or devices designed to determine or predict the time of ovulation (e.g., over-the-counter ovulation kits, digital phone apps, or cycle beads) should be discussed
   2. Lifestyle influences
      a. Advise that vaginal intercourse every 1-2 days beginning soon after the menstrual period ends can increase the likelihood of becoming pregnant (clients with regular menstrual cycles)

b. Information that fertility rates are lower among clients who are very thin or obese, and those who consume high levels of caffeine (e.g., more than five cups a day)
c. Discourage smoking, alcohol, recreational drugs, and use of commercially available vaginal lubricants as they may reduce fertility
d. Education on Environmental risks and exposures
e. Encourage a daily supplement containing folic acid or prenatal vitamin
f. Encourage males to avoid hot tubs

G. Referral

1. If desired, clients should be provided a current referral listing for further diagnosis and treatment.

24. PREGNANCY TESTING AND COUNSELING

Agencies **must** provide pregnancy diagnosis and counseling to all clients in need of this service (42 CFR 59.5(a) (5)). Pregnancy testing is one of the most common reasons for a first visit to a family planning agency. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning services. A written protocol and procedure **must** be current, available, and consistent with national standards of care.

A. **Pregnancy testing services** include:
   1. General Consent for Services
   2. Reproductive Goals Discussion
   3. Medical history (including chronic medical illnesses, physical disability, psychiatric illness)
   4. Pregnancy testing (qualitative urine with high sensitivity)
   5. Pregnancy test results **must** be given to the client
   6. Counseling and referral resource list as appropriate
   7. Chlamydia testing **must** be offered to females < 25 years of age and to females $\underline{\geq}$ 25 years with risk factors.

B. If the **pregnancy test is positive**, the clinical visit should include:
   1. An estimation of gestational age so that appropriate counseling can be provided
      a. If a client is uncertain about the last normal menstrual period date, a pelvic examination may be needed to help assess gestational age.
   2. Information on the normal signs and symptoms of early pregnancy
   3. Instructions on when to report any concerns to a provider for further evaluation
   4. If ectopic pregnancy or other pregnancy abnormalities or emergency situations are suspected, the client **must** be referred for immediate diagnosis and management.

C. If the **pregnancy test is positive**, all of the following counseling options to manage the pregnancy **must** be offered, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling.
   1. Prenatal care and delivery
   2. Infant care, foster care, or adoption
   3. Pregnancy termination

D. **Pregnancy options counseling must** be provided in a non-directive, unbiased manner. When requested to provide such information and counseling, agencies **must** provide neutral, factual information and nondirective counseling on each of the options and referrals upon request, except with respect to any options about which the pregnant woman indicates she does not wish to receive information and counseling. [59.5(a) (5)].

E. **Referral** to appropriate providers of follow-up care **must** be made at the request of the client, as needed. For example, providers **must** provide a resource listing or directory of providers to help the client identify options for care.

F. Providers also should assess the client's social support and refer her to appropriate counseling or other supportive services, as needed.

G. For clients who are considering or choose to continue the pregnancy, a prenatal care referral **must** be provided, and initial prenatal counseling **must** be provided that includes:
   1. Pregnant women with risk factors should be tested for STIs (including HIV) at the time of their positive pregnancy test if there will be delays in obtaining prenatal care (more than 2 months).
   2. Advise that some medications might be contraindicated in pregnancy, and any current medications taken during pregnancy need to be reviewed by a prenatal care provider.
   3. Encourage to take a daily supplement containing (400-800 mcg) of folic acid (or a prenatal vitamin).
   4. Avoid smoking, alcohol, and other drugs.
   5. Avoid eating fish that might have high levels of mercury (e.g., King Mackerel, Shark, Sword fish, Tile fish).
   6. Refer for vaccinations if indicated.

H. For clients who are considering or choose to terminate the pregnancy, a referral **must** be provided upon request and information about the legal status of abortion in Michigan **must** be offered including:
   1. Abortion is legal in Michigan.
   2. Clients requesting referral for abortion should be informed of Michigan's Informed Consent for Abortion law (Public Act 133 of 1993) which requires viewing mandated materials on the MDHHS Informed Consent for Abortion website and printing the consent form at least 24 hours prior to an abortion and not more than 2 weeks prior to the procedure. Clients who do not have access to the internet or printer can secure the mandated materials from their abortion provider.
   3. Title X funds **may not** be used to make or facilitate abortion appointments, facilitate transportation, negotiate fees or used to assist clients to complete the informed consent law requirements. (65 FR 41281-01) (See Section I, Pages 16,27)

I. Clients with a **negative pregnancy test** who wish to avoid pregnancy or are unsure **must** be offered information about:
   1. Counseling to explore the client's reasons for seeking pregnancy testing services

2. The value of setting reproductive goals
3. Contraceptive services (or schedule an appointment)
4. Assess for difficulties using their current method of contraception, if indicated.

J. Clients with a **negative pregnancy test** who are seeking pregnancy **must** be offered information about:
   1. Services to help achieve pregnancy or basic infertility services
   2. Preconception health services
   3. STI services
   4. Reproductive goals
   5. Potential environmental or exposure risks, (e.g., smoking, alcohol, travel risks)

K. Counseling provided **must** be documented in the client record.

25. BASIC INFERTILITY SERVICES

A written protocol and procedure **must** be current, available, and consistent with national standards of care. Agencies **must** offer basic infertility care as part of core family planning services. Infertility is defined as the inability to achieve pregnancy after 12 months or longer of regular unprotected intercourse.

A. Infertility visit to a family planning clinic focuses on determining potential causes of the inability to achieve pregnancy and making any needed referrals for specialist care. Evaluation of both partners should begin at the same time.

B. Earlier evaluation (6 months of regular unprotected intercourse) is justified for:
   1. Females aged > 35 years.
   2. Those with a history of oligo-amenorrhea (infrequent menstruation)
   3. Those with known or suspected uterine or tubal disease or endometriosis
   4. Those with a partner known to be sub-fertile (the condition of being less than normally fertile though still capable of effecting fertilization)
   5. If risk factors of male infertility are known to be present or if there are questions regarding male infertility potential.

C. Basic Infertility Care should focus on:
   1. Understanding the clients' reproductive goals and difficulty achieving pregnancy.
   2. The **medical history** for both clients includes:
      a. Reproductive history (methods of contraception, coital frequency and timing, duration of infertility, prior infertility, gonadal toxin exposure, including heat)
      b. Past surgeries
      c. Previous hospitalizations
      d. Serious illnesses or injuries
      e. Past infections
      f. Medical conditions associated with reproductive failure (e.g., thyroid disorders, hirsutism, diabetes mellites, or other endocrine disorders)

g. Childhood disorders
h. Cervical cancer screening results and any follow-up treatment
i. Medications (prescription and nonprescription)
j. Allergies
k. Social history/risk behaviors
l. Family history of reproductive failures
m. Level of fertility awareness
n. Previous evaluation and treatment results; gravidity, parity, pregnancy outcome(s), and associated complications; age at menarche, cycle length and characteristics, and onset/severity of dysmenorrhea
o. Sexual history (pelvic inflammatory disease, history of/exposure to STIs both partners, problems with sexual dysfunction)
p. Review of systems (symptoms of thyroid disease, pelvic or abdominal pain, dyspareunia, galactorrhea, and hirsutism)

3. A physical examination **must** be offered for both clients if clinically indicated:
   a. Female physical examination:
      i. Height, weight, and body mass index (BMI) calculation
      ii. Thyroid examination (i.e., enlargement, nodule, or tenderness)
      iii. Clinical breast examination (CBE)
      iv. Signs of androgen excess
      v. A pelvic examination (i.e., pelvic or abdominal tenderness, organ enlargement/mass; vaginal or cervical abnormality, secretions, discharge; uterine size, shape, position, and mobility; adnexal mass or tenderness; and cul-de-sac mass, tenderness, or nodularity)
      vi. STI/HIV testing, as indicated
         i. Chlamydia testing **must** be offered for females < 25 and females $\geq$ 25 with risk factors.
   b. Male physical examination:
      i. Examination of the penis (including location of the urethral meatus)
      ii. Palpation of the tests and measurement of their size
      iii. Presence and consistency of both the vas deferens and epididymis
      iv. Presence of a varicocele
      v. Secondary sex characteristics
      vi. STI/HIV testing, as indicated
4. Semen analysis via unpaid laboratory requisition should be offered based on the client's concern. If the semen analysis is abnormal, the client should be referred for further diagnosis (i.e., second semen analysis, endocrine evaluation, post-ejaculate urinalysis, or others deemed necessary) and treatment. Semen analysis is the first and most simple screen for male fertility.

D. Infertility Counseling
   1. Counseling provided during the clinic visit is guided by information elicited from the client during the medical and reproductive history and findings from physical examination.
   2. Counseling provided **must** be documented in the client record.

E. Referral:
   1. Clients (both partners) **must** be referred for further diagnosis and treatment if indicated or requested.

26. SEXUALLY TRANSMITTED INFECTION SERVICES

Written protocols and operating procedures for sexually transmitted infections **must** be in place when STI/HIV services are provided. Screening and treatment **must** follow current Centers for Disease Control (CDC) STI Treatment and HIV testing guidelines.

A. Assess client's reproductive goals

B. Medical history
   1. Allergies
   2. Medications
   3. Medical conditions
   4. Sexual health assessment, based on gender identify, current anatomy and sexual behavior (partners, practices, protection, past history of STIs, pregnancy prevention)
   5. Intimate Partner Violence
   6. Immunizations (Hep.B, HPV)

C. Physical Exam as indicated (based on history or symptoms)

D. Laboratory testing including the following:
   1. Chlamydia:
      a. Testing **must** be offered annually for all females < 25 years. Sexually active females ≥25 years with risk factors (infected partner, partner with other concurrent partners, symptoms, history of STI or multiple partners in the last year) should be offered testing.
      b. Clients who test positive for Chlamydia should be re-tested 3 months following treatment for early detection of re-infection. Clients who do not present at 3 months for re-test should be re-tested the next time they present for services in the 12 months following treatment of the initial infection.
      c. Chlamydia screening for males can be considered at sites with high prevalence (adolescent clinics, correctional facilities, STI clinics) or males who have sex with males (MSM). Males with Chlamydia should be re-tested 3 months following treatment.
      d. The MDHHS family planning program partners with the MDHHS STI Program by allocating pre-paid test requisition forms for CT/GC to each sub-recipient agency. These forms are intended for clients who are uninsured, underinsured or request confidential testing services. Use these pre-paid forms based on the following criteria:
         i. Priority goes to females under 25
         ii. Based on historic positivity, males presenting in our publicly funded sites are eligible for testing with a pre-paid form
         iii. Anyone needing a 90-day re-test is eligible for a pre-paid form.

iv. Females ≥30 may be tested using a pre-paid form only if:
   a) Symptoms,
   b) Infected partner,
   c) History of STI (<3 years), or
   d) Partner risk (new partner since last test, 3 or more partners in last year, partner with 3 or more current partners)

2. Gonorrhea
   a. Testing **must** be offered annually to sexually active females <25 with high risks (previous gonorrhea, presence of other STIs, new or multiple sex partners, inconsistent condom use, commercial sex work, drug use) and those who reside in high prevalence areas. Other risk factors that place clients at increased risk include infected partner, symptoms, history of STI or multiple partners in past year.
   b. All males with symptoms suggestive of gonorrhea (urethral discharge or dysuria or whose partner has gonorrhea) should be tested and empirically treated.
   c. Males who have sex with males (MSM) should be tested at sites of exposure. Clients with gonorrhea infection should be re-tested for re-infection 3 months after treatment. Clients who do not present at 3 months for re-test should be re-tested the next time they present for services in the 12 months following treatment of the initial infection.
   d. Pre-paid IPP forms may be used for testing based on guidance provided above in 1.d.

3. Syphilis
   a. Testing is strongly encouraged and should be offered to all clients at high risk:
      i. MSM,
      ii. Commercial sex workers,
      iii. Persons who exchange sex for drugs,
      iv. Those in adult correctional facilities,
      v. Living in high prevalence areas)

4. HIV/AIDS
   a. Testing should be routinely recommended for all clients 13-64 years of age.
   b. Annual testing is recommended for high-risk individuals:
      i. injection drug users and their partners
      ii. persons who exchange sex for money or drugs
      iii. sex partners of HIV infected persons
      iv. MSM or heterosexual persons who themselves or whose sex partner have had more than one sex partner since their most recent HIV test
   c. Opt-out screening can be provided if included in the general medical consent.

5. Hepatitis C
   a. Testing should be recommended once for clients without risks (if born between 1945-1965). If testing is positive, refer for additional care and management of HCV infection and related conditions. Assess for alcohol use and refer for intervention if indicated.

b. Clients with high-risk behaviors /conditions (e.g., past or current injection of illegal drugs, HIV infected) should be recommended to have annual testing.

6. Hepatitis B
   a. Screening is not recommended for the general population.
   b. Testing should be recommended for high-risk populations (persons from high prevalence areas, HIV positive, IV drug users, MSM, Hep.B household contacts.)

7. HPV
   a. HPV testing is not recommended as general STI screening.
   b. Clients should receive regular cervical cancer screening as recommended regardless of HPV vaccination status. (See Preventive Health, page 81)
   c. HPV Vaccination should be encouraged to prevent high risk HPV infections which cause the majority of cervical, penile, vulvar, vaginal, anal, and oropharyngeal cancers and genital warts.
      i. HPV Vaccination is recommended for all clients aged 11-26.
      ii. Shared decision-making regarding HPV vaccination is recommended for clients aged 27–45 and previously unvaccinated.
      iii. Clients should be advised that HPV vaccination will not treat a current HPV infection or genital warts but is recommended to prevent future infections.
      iv. Clinics may but are not required to offer HPV vaccination on site.

E. **STI treatment** should be provided on-site. When treatment for any STIs provided on-site, the sub-recipient protocols **must** follow current Centers for Disease Control and Prevention STI Treatment Guidelines ensure all clients are treated in a timely manner and appropriate follow-up measures are provided.

F. Expedited Partner Therapy (EPT) should be offered as indicated for clients testing positive for chlamydia and gonorrhea.
   1. Michigan's Public Act 525 of 2014 (MCL 333.5110) authorized the use of expedited partner therapy (EPT) for certain sexually transmitted infections as designated by MDHHS. The department has designated chlamydia, gonorrhea, and trichomonas as infections for which the use of EPT is appropriate. Guidance for Providers and Information for Patients and Partners are available on the MDHHS HIV and STI Program website or Section I, page 26.

G. Counseling
   1. Educate on risk reduction and available testing or referral for testing.
   2. Encourage vaccination for HPV and Hepatitis B if indicated
   3. Encourage condom use to prevent STI/HIV infection
   4. Encourage clients with STIs to:
      a. Notify their sex partners and urge them to seek medical evaluation and treatment
      b. Refrain from unprotected sexual intercourse during the period of STI treatment

c. Return for re-testing in 3 months if indicated.

5. Counseling provided **must** be documented in the client record.

H. Referral
1. Clients with Hepatitis C and HIV infection should be linked to medical care and treatment.
2. Clients should be referred for immunizations as needed.

I. Mandatory Reporting
1. Sub-recipient agencies **must** comply with state and local STI reporting requirements.
Reportable Diseases in Michigan: Guide for Physicians, Health Care Providers,2022

27. GYNECOLOGIC SERVICES

Family planning agencies should provide for the diagnosis and treatment of minor gynecologic problems to avoid fragmentation or lack of health care for clients with these conditions. Written protocols and operating procedures **must** be available, current, and consistent with national standards of care. Problems such as vaginitis or urinary tract infection may be amenable to on-the-spot diagnosis and treatment, following microscopic examination of vaginal secretions or urine dip stick testing.

28. RELATED PREVENTIVE HEALTH SERVICES

Written protocols and operating procedures **must** be available, current, and consistent with national standards of care. All sub-recipient agencies **must** comply with the current MDHHS Family Planning Breast and Cervical Cancer Screening Protocols and **must** participate in the Family Planning/Breast and Cervical Cancer Control Navigation Program (FP/BC3NP) Joint Project for diagnostic services (i.e., breast ultrasound, mammogram, and colposcopy) for uninsured or underinsured clients. Coordination of care **must** go through the BC3NP Coordinator unless other referral/payment arrangements are in place. Family Planning projects are encouraged to refer eligible clients to the BC3NP program for cervical screening where appropriate.

A. Clinics **must** offer and/or provide and stress the importance of the following to all clients:
1. Clinical Breast Exam (CBE) performed at least every three years for average-risk asymptomatic clients beginning at age 25 through age 39, and annually for females ≥ 40 years of age.
2. Cervical Cancer screening as indicated following protocols based on national standards of care:
a. MDHHS Family Planning Program recommends programs follow Breast and Cervical Cancer Control and Navigation Program (BC3NP) the Breast and Cervical Cance Screening Protocols as posted on the BC3NP website under "BC3NP LCA Program Manuals and Policies." The BC3NP Breast and Cervical Cancer protocol is also posted on the Family Planning website Information for Providers page. MDHHS Family Planning program no longer requires use of these screening protocols, so long as agency protocols follow a nationally recognized standard of care. Agencies using a protocol with an alternate national standard of care for screening should be aware that the BC3NP program is currently unable to pay for cervical screening using HPV only for clients

under age 30. However, BC3NP can assist with needed follow up care for eligible clients regardless of the screening that indicated need for follow up care.

b. BC3NP Protocol recommends:
   1. Age 21 to 64, every 3 years if Pap test is negative, OR
   2. Age 30 to 64, every 5 years if using co-testing (pap and HPV) and both are negative
   3. Age 30 to 64, every 5 years if using HPV-HR test alone.

c. Cervical follow-up care provided for clients according to the 2019 ASCCP Cervical Risk-Based Management Guidelines. Mobile App - ASCCP

3. Pelvic examination (including vulvar evaluation and bimanual exam) should be performed with routine cervical cancer screening and **must** be provided if medically indicated.

B. Clinics **must** stress the importance of mammography screening:
   1. Clients 40-64 years at average risk for breast cancer on an annual basis.
   2. Screening for clients 25-64 at high-risk for breast cancer should be based on the client's risk factors. (NCCN 2018 screening recommendations for clients at increased risk)

C. Clinics should educate clients on HPV and encourage HPV vaccination if indicated:
   1. Clients 11-26 should be encouraged to receive the HPV vaccine series to protect against the majority of cervical, penile, vulvar, vaginal, anal, and oropharyngeal cancers and genital warts.
   2. HPV vaccination is also approved for clients aged 27–45 who are previously unvaccinated.
   3. Clients should be advised that HPV vaccination does not treat a current HPV infection or genital warts but is recommended to prevent future infections.
   4. Clinics may but are not required to offer HPV vaccination on site.

D. Clinics should conduct a genital examination for minor males and document:
   1. Skin and hair distribution (observation)
   2. Hydrocele, varicocele, (observation and palpation)
   3. Signs of STI (observation and/or palpation)

29. QUALITY MANAGEMENT

A. Referrals and Follow-up

Written protocols and operating procedures for referrals and follow-up **must** be in place for the following: referrals that are made as result of abnormal physical exam or laboratory findings, referrals for required services, and referrals for services determined to be necessary but beyond the scope of family planning.

1. Referral procedures **must** be sensitive to clients' concerns for confidentiality, privacy and to the extent possible, conveniently located.
2. Client consent for release of information to providers **must** be obtained, except as may be necessary to provide care or as required by law
3. Protocols and operating procedures for referrals and follow-up made as a result of abnormal physical examination or laboratory test findings within the scope of Title X that impact contraceptive management **must** include the following:

a. A system to document referrals and follow up procedures **must** be in place.
b. Follow-up procedures **must** include the following:
    1) A method to identify clients needing follow-up
    2) A method to track follow-up results on necessary referrals (such as, Pap and breast follow-up)
    3) Documentation in the client record of contact and follow-up.
    4) Documentation of reasons, actions and follow-up where recommendations were not followed and/or protocols not acted upon.
c. Referral procedures should include that the client receive explanation of the referral and need for follow-up including:
    1) Reason and importance of the referral
    2) Services to be received from the referral provider
    3) Address of the referral provider
    4) Instructions needed to follow through with the referral
    5) When to return to the family planning clinic

4. Sub-recipient agencies **must** provide all Quality Family Planning Service components either on-site or by referral. When required services are provided by referral, the agency **must** have in place formal arrangements with a referral provider that includes a description of the services provided and includes cost reimbursement information.
5. For services determined to be necessary but which are beyond the scope of the project (such as thyroid abnormalities), clients **must** be referred to other providers for care. When a client is referred for non-family planning or emergency clinical care, agencies **must**:
    a. Document that the client was advised of the referral and the importance of follow-up.
    b. Document that the client was advised of their responsibility to comply with the referral.
6. Sub-recipients **must** maintain a current referral list that includes health care providers, local health and human service departments, hospitals, voluntary agencies, and health service projects supported by other federal programs.
    a. Referral lists **must** be current and updated annually.
    b. When possible, clients should be given a choice of providers.

B. **Pharmaceuticals**

Agencies **must** operate 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 laws, federal regulations and professional practice regulations.

It is essential that each service site maintain an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of its clients. Projects should also ensure access to other drugs or devices that are necessary for the provision of other medical services included within the scope of the Title X project.

Subrecipients may write prescriptions for clients who choose and can conveniently obtain their method of choice and medications from a pharmacy. Subrecipients **must** provide a prescription

or provide a referral for clients whose method of choice is not available at the service site. (42 CFR §59.5(1)(a)) Accepting a prescription should not pose a barrier for the client. Clients should be made aware they are responsible for out of pocket costs at a pharmacy.

1. The medical director of the family planning program is responsible for all policies and procedures pertaining to the general handling of pharmaceuticals. Written protocols and operating procedures for the distribution, security and record keeping of pharmaceuticals and supplies **must** be in place.
2. Prescription of pharmaceuticals is done by a clinical services provider under the direction of the program's medical director. All prescribing providers **must** have a drug control license for each location in which the storage and the dispensing of prescription drugs occur. The prescribing provider may dispense indirectly under their delegated authority to an R.N. or other appropriately trained service provider. Pre-labeled, pre-packaged oral contraceptives may be distributed if delegated by a dispensing prescriber.
    a. All medications dispensed in Title X clinics **must** be pre-packaged.
    b. Prescription medications dispensed (including samples) **must** be labeled and labels **must** contain the following information:
        1) Name and address of location from which the prescription drug is dispensed
        2) Name of the client, unless prescription is authorized for EPT
        3) Date the prescription drug is dispensed
        4) Name, strength, and quantity of drug dispensed
        5) Directions for use, including frequency of use
        6) Prescriber's name
        7) Expiration date of prescription drug
        8) Client record number
    c. All clients **must** receive verbal and written instructions for each drug. Medication education sheets should be kept current annually reviewed and revised as needed. The nature of drug education should be documented in the medical records.
    d. There **must** be documentation that in-service training pertaining to the nature and safety aspects of pharmaceuticals is provided at least every two years to staff involved in the provision of medications to clients (i.e., new staff orientation, staff meeting, and quiz).
3. Under Public Health Code Act 368 of 1978, a dispensing prescriber may only dispense drugs to his/her clients, with the exception of dispensing prescriptions for expedited partner therapy (EPT) as authorized in section 5110 or section 17744a/17744b under Pharmacy Practice and Drug Control (333.17745) Michigan Legislature - Section 333.17745
4. The inventory, supply and provision of pharmaceuticals may be delegated to appropriate qualified health professionals.
    a. Family planning health professionals delegated to deliver prescriptions drugs **must** be trained in all aspects of pharmaceutical and supply distribution.
    b. Sub-recipients **must** have proper segregation between requisition, procuring, receiving and payment functions for pharmaceuticals and supplies.

c. Sub-recipients **must** have an inventory system to control purchase, use, reordering of pharmaceuticals and supplies.
d. Sub-recipients **must** have adequate controls over access to medications and supplies including:
    1) Contraceptive and therapeutic pharmaceuticals **must** be kept in a secure place, either under direct observation or locked.
    2) Access to pharmaceuticals **must** be limited to health care professionals responsible for distributing these items.
e. A system **must** be in place to monitor the expiration date on drugs and ensure disposal of all expired drugs.
f. A system for silent notification in case of drug recall **must** be in place.
g. Inventory levels should not exceed a six-month supply.

5. Sub-recipients participating in the 340B Program **must** have policies and procedures in place to assure program compliance including:
    a. Safeguards **must** be in place to assure that supplies purchased through 340B are provided only to clients of the family planning program.
    b. Medicaid billing procedures **must** be in place to guard against duplicate discounts.
    c. Sub-recipient maintains purchasing and inventory control records that document compliance with 340B requirements.
    d. Sub-recipient maintains current certification through the annual 340B recertification process.
6. A current formulary, listing all drugs available for Title X clients, **must** be maintained and reviewed at least annually. Formularies should be retained for three years.
7. An adequate supply and variety of drugs and devices **must** be available to meet their client's contraceptive needs.
    a. Purchase and use of generic drugs based on therapeutic equivalence as published by the FDA or in the Formularies of Therapeutic Equivalence accepted by the State Board of Pharmacy is acceptable.
    b. Sub-recipient agencies may elect to identify certain supplies on the formulary, such as more expensive or infrequently used methods, that will be ordered upon client request and be available within two weeks of the request.
8. At a minimum, each site that provides medical services **must** have the following:
    a. Emergency drugs and supplies for treatment of vaso-vagal reaction.
    b. Emergency drugs and supplies for treatment of anaphylactic shock.
9. Prescriptive Methods for Transfer Clients
    a. An informed (general) consent form **must** be obtained, and a client history **must** be completed/reviewed. A BP **must** be taken if the client desires to continue on a combined hormonal contraceptive. The provider will review the transfer records and decide if current prescription can be continued. The provider **must** document the prescription in the client's record.

C. Medical Emergencies

Emergency situations involving clients and/or staff may occur any time; therefore, all agencies **must** have written plans and protocols/ operating procedures for the management of on-site medical and non-medical emergencies.

1. At a minimum, written protocols **must** address:
   a. Vaso-vagal reactions/Syncope (fainting)
   b. Anaphylaxis
   c. Cardiac arrest
   d. Shock
   e. Hemorrhage
   f. Respiratory difficulties
2. Protocols **must** also be in place for emergencies requiring EMS transport, after hour's management of contraceptive emergencies and clinic emergencies.
3. All staff **must** be trained in emergency procedures and **must** be familiar with the plans. Licensed medical staff providing direct patient care services **must** be trained in CPR and hold current certification.
4. There **must** be a procedure in place for maintenance of emergency resuscitative drugs, supplies, and equipment.

D. Medical Records

1. General Policy
   a. A medical record **must** be established for each client who receives clinical services, including pregnancy testing/counseling clients and emergency contraception clients.
   b. Medical records are maintained in accordance with the accepted medical standards and state laws with regard to record retention. Records **must** be**:**
      1) Complete, legible, and accurate
      2) Signed and dated by the clinician/health professional making each entry
         a) Each entry includes date, name and title of the clinician/health professional.
         b) Each entry is a permanent part of the record.
      3) Readily accessible
      4) Confidential
         a) Safeguarded against loss or use by unauthorized persons
      5) Available upon request to the client
   c. HIPAA regulations regarding personal health information **must** be followed.
   d. Guidance regarding records management is available from the Michigan Department of Technology, Management and Budget, Records Management Services. DTMB - Records Management (michigan.gov)
2. Record Contents

   The client's medical record **must** contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical diagnosis, and warrant the treatment and end results. Records **must** include the following:
   a. Personal data:
      1) Name
      2) Address, phone number(s), and how to contact

3) Age
4) Sex
5) Income Assessment
6) Unique client number
7) Race and ethnicity (as required for FPAR)
8) Medical history
9) Allergies recorded in a prominent, consistent location

b. A general consent for services **must** be signed prior to providing services.
   1) General consent statement **must** contain a confidentiality assurance statement.
   2) An informed consent related to procedures **must** also be signed prior to providing the service.
c. Physical exam
d. Documentation of clinical findings, diagnostic/therapeutic orders
   1) Laboratory test results and follow-up done for abnormal results
   2) Treatments and special instructions
   3) Documentation of continuing care, referral and follow-up
   4) Documentation of scheduled revisits
e. Contraceptive method chosen by the client
f. Documentation of all counseling, education, and social services given
g. Documentation of deferrals, reason for deferral, and refusal of services
h. Date and signature of clinician or health professional for each entry, including documentation of telephone encounters of a clinical nature.
   1) Signature includes name and title of provider
   2) A signature log if full name and title are not used in medical record
i. A list of identified problems should be maintained to facilitate continuing management and follow-up.

3. A System **must** be in place to maintain confidentiality and consent for release of records.
   a. HIV, mental health, and substance use information **must** be handled according to state law.
   b. 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.
      1) Only the specific information requested may be released.
   c. Information collected for reporting purposes **must** be disclosed only in summary, statistical, or other form which does not identify individuals.
   d. Upon request, clients transferring to other providers **must** be provided with a copy or summary of their record to expedite continuity of care.
   e. Upon request, clients **must** be given access to their medical record

E. Quality Improvement

Sub-recipient agencies **must** have a system in place that provides for the ongoing evaluation for conducting quality improvement.

1. The quality improvement system should include the selection and measurement of activities of at least one quality measure such as suggested measures on table 4 in the QFP on page 24.
2. The quality improvement system **must** include the following elements:

a. A tracking system that identifies clients in need of follow up and/or continuing care **must** be in place. (Referrals and Follow-up)
b. A system to assure that professional licenses and CPR certifications are current **must** be in place. (Personnel & Emergencies)
c. **Medical Audits** to determine conformity with agency protocols, current standards, and acceptable medical practices **must** be conducted quarterly by the program's medical director.
    1) Minimum of two to three charts per clinician **must** be reviewed by the medical director quarterly.
d. **Chart Audits/ Record Monitoring** to determine completeness and accuracy of the medical record **must** be conducted at least quarterly by the quality assurance committee or identified personnel.
    1) Chart audits **must** represent a minimum of three percent (3%) of the agency's quarterly caseload, randomly selected and reviewed by staff.
    2) All clinical sites should be represented in the sampling.
    3) Topic audits are strongly suggested.
    4) QI/QA activity based on audit findings is encouraged.
e. Clinical protocols and procedures **must** be reviewed and signed annually by the medical director.
f. Infection control policies and procedures reflecting current CDC recommendations and OSHA regulations **must** be in place.
g. Laboratory audits to assure quality and CLIA compliance **must** be in place.
h. Equipment maintenance and calibration **must** be documented. (Equipment and Supplies)
i. A process to implement corrective actions when deficiencies are noted **must** be in place.

3. Sub-recipient agency quality improvement systems should include:
    a. Annual review of all clinician/providers should be conducted.
    b. Regularly scheduled staff meetings to update and/or review medical or service delivery topics. Minutes should be kept of these meetings.
    c. Routine check of emergency drugs and supplies
    d. A process to elicit consumer feedback should be in place.
    e. Periodic review of forms used by the agency for completeness and applicability.
    f. Routine monitoring of critical incident/occurrence reports
    g. Periodic review of credentials of contracted laboratories
    h. Periodic patient flow analysis
    i. Periodic review of provider liability insurance coverage.
    j. Periodic monitoring of reliability and accuracy of the client data system to assure program performance, reporting, quality care, and generation of revenues. Components that should be monitored include missing data elements, coding errors and outcome data.
4. A Quality Improvement Committee should be in place. Committees should meet monthly to discuss quality assurance issues and recommend corrective actions when deficiencies have been noted.
    a. Minutes should be kept of all committee meetings.
    b. Quality Improvement Committee functions may be assumed by an in-house nursing or medical advisory committee with ongoing documentation of quality improvement activities.

SECTION IV

Program Monitoring

A. ACCREDITATION AND SITE REVIEWS FOR TITLE X FAMILY PLANNING PROGRAMS

Title X subrecipients have a comprehensive program review every three years to assure that MDHHS supported family planning service sites are in compliance with Title X regulations and are managed effectively. The MDHHS Title X Family Planning Program contracts with several types of providers for provision of Family Planning Title X grant services, including local public health departments, Planned Parenthood, and hospital-based providers. For contracting and accreditation purposes, these providers are divided into two categories: local public health departments and private non-profit sub-recipients. Both categories of sub-recipients are reviewed using the Minimum Program Requirements (MPRs), regulatory requirements, and OPA Title X Program Guidelines.

The MDHHS Title X Family Planning Program Standards and Guidelines is the primary resource that outlines what is needed to meet Title X program requirements. The following resources are the basis of these program expectations: The Federal Register Title X [42 CFR Part 59, Subpart A], the Family Planning Statute which defines legislative requirements for the program. The OPA Title X Program Handbook outlines program expectations based on the 2021 Title X Rule (86 Fed. Reg. 56144) "Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," and Providing Quality Family Planning Services (QFP). They are available on the OPA website and in Section I, Federal Resource Section of this manual. The MDHHS Title X Family Planning Standards and Guidelines provides the most detailed specific expectations, including Michigan laws and Michigan specific requirements.

Accreditation Reviews for Local Public Health Department Family Planning Programs

MDHHS has contracted with Michigan Public Health Institute (MPHI) for the Michigan Local Public Health Accreditation Program to coordinate comprehensive accreditation site reviews for all local public health departments on a three-year cycle since 1997. For local public health departments that provide family planning services, the required Title X program site reviews have been incorporated into the Michigan Local Public Health Accreditation process. Family planning program areas including administration, clinical services, community outreach and education, and some aspects of financial management are reviewed.

The MDHHS Family Planning Program also works with the MDHHS Audit Bureau to conduct a more detailed financial audit every two to three years. MDHHS Financial Audit staff contacts subrecipients directly to schedule onsite review dates and arrangements for materials to be reviewed.

Program Site Reviews for Private Non-Profit Title X Family Planning Programs

Private non-profit Title X sub-recipients undergo a comprehensive program review conducted by the MDHHS Family Planning Program staff every three years. The program site review is conducted to assure that MDHHS supported family planning service sites are managed effectively and are following

federal Title X regulations. All program areas are reviewed: administration, clinical services, community outreach and education, and some aspects of financial management.
The MDHHS Family Planning Program works with the MDHHS Audit Division to conduct a more detailed financial management audit every two to three years. The MDHHS Financial Audit Division contacts subrecipients directly to schedule onsite review dates and arrangements for materials to be reviewed.

COVID-19 Public Health Emergency Exception--Pause and Resumption of Reviews
In response to the COVID-19 Public Health Emergency, both the MDHHS Family Planning Program and the Michigan Local Public Health Accreditation Program paused onsite reviews in March of 2020. In response to Federal requirements, the MDHHS Family Planning Program resumed Title X Comprehensive program reviews in December of 2022. The MDHHS Family Planning Program developed a three year schedule for resuming onsite reviews based on program needs, such as staff turnover during the COVID-19 Pandemic and indicators based on the abbreviated reviews conducted during the public health emergency. In April of 2023 the Michigan Local Public Health Accreditation Program (MLPHAP) resumed a Technical Assistance (TA) focused review process for Cycle 8 Local Public Health reviews. The MDHHS Family Planning Program conducts TA visits in conjunction with the MLPHAP Cycle 8 Accreditation schedule, providing TA as needed for the MDHHS Title X Comprehensive Review process. The MDHHS Family review process may consist of one of the following three processes: 1) “Pre-Comprehensive Review TA visit” 2) “Follow-up TA visit” 3) “Combined Comprehensive/TA visit”. The Local Public Health Accreditation Program intends to return to full comprehensive program reviews for Cycle 9. At that time MDHHS Family Planning Program intends to return to providing Title X Comprehensive Reviews within the Michigan Local Public Health Accreditation Program review schedule for local public health subrecipients.

What Title X Comprehensive Program Reviews are Like
Both local health departments and private non-profit programs are reviewed by the same standards of performance, compliance with the Minimum Program Requirements (MPRs). All programs are reviewed using the same tool and indicator guide. (See MPRs, Indicator tool, and pre-materials list on MDHHS Family Planning website, Information for Provides page and on the Michigan Local Public Health Accreditation website.

Reviews of private non-profit sub-recipients are coordinated by the MDHHS Family Planning Program staff. Local public health department sub-recipient program reviews are coordinated through MPHI and MDHHS Family Planning staff. All sub-recipients submit their required pre-materials directly to the MDHHS Family Planning Program at least two weeks prior to the site review. Multiple services sites operated by a sub-recipient program may be visited during the process.

The MDHHS Family Planning Program review team consists of an administrative reviewer and a clinical reviewer. The clinical reviewer is responsible for reviewing the clinic services portion of the program including clinic protocols, contraceptive supplies, clinic observation and medical review; and the administrative reviewer, assesses the administrative portions of the program including, policy review, observation, community outreach and education, staff training, billing and collections, and data collection processes.

Process

The following are steps in the site review process:

1. *Pre-Materials* are to be submitted to the MDHHS Family Planning program at least two weeks prior to the scheduled review. The materials should be submitted electronically.
2. Unless otherwise requested by the program, the family planning coordinator serves as the contact with MDHHS for the review process.
3. Subrecipients have the option to request a *pre-accreditation conference* call or meeting to ask questions as they prepare for the site review.
4. The *on-site program review* is a two-day process. Programs **must** have at least one clinic session scheduled during the visit to facilitate the evaluation of administrative and clinical components of the program. Programs are requested to schedule clinic sessions on the first day of the site review if there are not clinics on both days.
    a. A brief *entrance meeting* is scheduled to begin the review. This meeting occurs immediately at the beginning of the review to enable reviewers and program staff to meet prior to the review. The meeting may include any staff person who will be able to provide information regarding clinical, administrative, education or financial aspects of the program. This is an opportunity for the reviewers to meet program personnel and get acquainted with the building, schedules, etc. It is a time for program staff to meet and make reviewers aware of individual characteristics of the program and organization and clarify the review process.
    b. The *exit conference* is an opportunity for the reviewers and the program staff to discuss general findings of the review.
    c. Completed *program review reports* are received from MDHHS approximately 30 days after the on-site review. Any indicator that was **not met** is identified in the report with recommendations for correction. The report may also include commendations and recommendations for program improvement. Corrective plans of action **must** be submitted and accepted for all unmet indicators.
    5. *Corrective plans of action* (CPA) subrecipients submit their corrective action plans and any required documentation directly to the MDHHS Family Planning program using the Reproductive Health unit email during Cycle 8. Technical assistance is available to assist with developing the plans from MDHHS Family Planning reviewers.
        a. CPAs are due within 30 days following receipt of the report.
        b. Plan may be approved with no further action needed, with conditions such as subsequent site visit or submission of support materials to MDHHS or may be rejected with revisions required.
        c. Implementation of CPA **must** be completed within one year of the review to continue accreditation.

B. TECHNICAL ASSISTANCE AND MONITORING VISITS

Subrecipients are visited approximately one year following the accreditation/site review. These visits are intended to provide technical assistance and to monitor progress in areas needing improvement identified during the previous accreditation/site review. This is done to assure that those areas have been corrected to confirm Title X compliance.

In addition, program issues and changes are discussed at these visits and any technical assistance requested by the agency is provided.

During Cycle 8, Technical Assistance and Monitoring visits for Local Public Health Family Planning programs are being scheduled during the Michigan Local Public Health Accreditation review schedule and reports of those Technical Assistance visits are submitted through the MPHI web module process.

C. MDHHS FINANCIAL PROGRAM AUDITS

The Bureau of Audit is responsible for conducting financial audits of one-third of sub recipient agencies each year and managing Single Audit information sent in by third party auditors for agencies expending over $750,000 in Federal grant funding. (Section I, page 35)

There is one full time audit position assigned to the Reproductive Health unit to conduct fiscal audits and to ensure Title X fiscal policies are being followed. The audits verify that Title X activities are separate and distinct from non-Title X activities and proper financial reporting in accordance with contractual and regulatory requirements.

The audit staff uses a comprehensive procedural checklist to test various financial areas of the grantee. The audit results are compiled into a preliminary report for grantee review and a response on corrective action measures. Once the reply is reviewed, a final report is issued with recommendations. The audits are entered into an audit tracking system for future reference and monitoring. Program consultants review sub-recipient agency financial audits and exceptions as part of the comprehensive program review conducted every three years.

SECTION V

MDHHS and National Title X Training Programs

A. MDHHS COORDINATORS MEETING

Two regional Family Planning Coordinators Meetings are held annually to update all family planning coordinators throughout the State. These face-to-face meetings provide a venue for sharing pertinent information related to program and policy issues or changes. In addition, essential information is presented from the Michigan Department of Health and Human Services management, administrative and clinical consulting staff regarding clinical and management issues pertinent to Title X Family Planning clinics. The Family Planning Coordinators Meetings are also used to assess ongoing and future training needs for the network.

These two regional meetings are coordinated by the Michigan Public Health Institute (MPHI) and the Michigan Department of Health and Human Services. The regional meeting format replaced a single webinar format to allow for broader Family Planning Coordinator participation and networking among programs.

B. MICHIGAN ANNUAL FAMILY PLANNING UPDATE

The Michigan Department of Health and Human Services (MDHHS) Title X Family Planning Program sponsors a training workshop for anyone involved with family planning services. The scope of the audience is wider than the Annual Coordinator's Meetings. The conference follows a workshop format and is scheduled for two days, with a pre-conference option.

This annual conference is called the Michigan Family Planning Update. The conference location is rotated geographically to provide access to all areas in Michigan. Expert presenters are invited to address a variety of topics in both general session and workshop formats. Continuing education and contact hours are available where possible. In addition, MDHHS administrative, clinical and management staff are available to provide pertinent program information. This conference also provides an important venue for family planning providers, administrators and staff to network. Selected sessions, reflecting OPA training priorities, may be videotaped and archived on the MPHI Family Planning Training website for family planning providers and staff unable to attend the conference. Family Planning Program – Empowering Reproductive Health (mifamilyplanning.com)

C. ADDITIONAL MDHHS STAFF AND SUB-RECIPIENT TRAININGS

In addition to the coordinator meetings and the Annual Update conference, MDHHS in cooperation with MPHI, provides other training opportunities related to family planning through the year. These trainings are provided through a combination of face-to-face workshops and webinar offerings. Continuing education and contact hours are available where possible.

MPHI publishes a calendar online with all the educational offerings for the year. This calendar is available on the MPHI website. Visit the MPHI website for more information and registration: Family Planning Program – Empowering Reproductive Health (mifamilyplanning.com)

Participant evaluations are collected after each workshop and training to provide information from the previous year for planning future meetings and trainings. Trends in requests for information, suggestions for improvement and for future trainers, as well as other information obtained through these evaluations are considered in the planning.

D. NATIONAL MEETINGS, CONFERENCE AND NATIONAL TRAINING CENTERS (NTCS)

The National Family Planning Program authorized in 1970 as Title X of the Public Health Service Act (P.L.910572). The nationally funded Title X program is administered by the Office of Family Planning in the Office of Population Affairs within the Department of Health and Human Services. Information about the Family Planning program is available on the OPA Website at: https://opa.hhs.gov/grant-programs/title-x-service-grants

The Title X program, under Section 1003, provides training grants for personnel working in family planning services projects, with the purpose of promoting and improving the delivery of family planning services. OPA funds two training centers:

1. The Reproductive Health National Training Center (RHNTC) works in collaboration with OPA and the Office on Women's Health (OWH) to address the needs of Title X family planning service grantees and providers and Teen Pregnancy Prevention (TPP) grantees and program staff. Welcome to the Reproductive Health National Training Center | Reproductive Health National Training Center (rhntc.org)

2. The Clinical Training Center for Sexual & Reproductive Health (CTC SRH) provides clinical training for nurse practitioners, certified nurse midwives, physicians, and physician assistants. The CTC develops annual national family planning training symposiums, a national biennial reproductive health conference, and clinical webinars including "virtual coffee breaks." Clinical Training Center for Sexual and Reproductive Health-CTCSRH

MDHHS maintains a health system membership to the National Family Planning and Reproductive Health Association (NFPRHA) that includes member privileges for the FP Coordinator of each Title X sub-recipient. Member privileges include access to NFPHRA webinars, conferences, member calls and many resources on practice and program issues of importance to Title X providers. NFPRHA promotes and supports the work of family planning providers and administrators such as Title X. National Family Planning & Reproductive Health Association - National Family Planning & Reproductive Health Association

E. THE MICHIGAN FAMILY PLANNING ADVISORY COUNCIL (FPAC)

Overview

The Michigan Family Planning Advisory Council (FPAC) is a group of diverse individuals committed to improving access to family planning and reproductive health services for the people of Michigan. Having the skills and resources to plan the timing and size of families improves birth outcomes, protects the health of parents, and improves the well-being of individuals and families. Towards that end, individuals representing the state government, local health departments, Planned Parenthoods,

hospitals, adolescent health centers, advocacy agencies, and community members have joined together to enhance access to family planning services.

History

MDHHS has received Title X Family Planning funding for the state of Michigan since 1972. The Title X Program is the only federal program devoted solely to the provision of family planning and reproductive health care. Title X Grantees are required to have community participation in the program by persons broadly representative of significant elements of the population served and by persons knowledgeable about the community's needs for family planning services. Since 1972, Michigan has met this requirement through the statewide FPAC. During much of this time, Title X providers were among few sources of family planning care for low-income people in Michigan. Today, federally qualified health centers throughout Michigan provide low-cost health services including family planning. In 2006, Michigan Medicaid was approved to provide expanded family planning coverage to low-income females through a Medicaid waiver program, called Plan First! expanding access for many. In 2014, Michigan implemented the Affordable Care Act's (ACA) Medicaid Expansion, called the Healthy Michigan Plan. Under this plan, Medicaid coverage, including family planning, is available to adults with income up to 138% of the federal poverty level. After the successful rollout of the Healthy Michigan Plan, the Plan First! Waiver program was phased out in 2016. As of April 12, 2021, there were more than 900,000 people enrolled in the Healthy Michigan Plan. FPAC has consistently supported these efforts to expand access to care in Michigan. As of July 1, 2023, enrollment began for a new expanded Plan First! Family Planning program which provides a broad range of family planning services to Michigan residents at or below 195% of the Federal Poverty level.

During the summer of 2020, the FPAC completed a strategic planning process to define a clear vision for family planning in Michigan, the role of FPAC in achieving that vision, and identify specific actions to work toward the vision. While Title X programs remain the cornerstone of family planning services, the FPAC continues to focus on all providers of family planning and reproductive health care for low-income Michiganders. FPAC members identified three major themes in its vision for Michigan:

- **Contraceptive Availability:** Work towards Increase availability of condoms and comprehensive contraceptive access through distribution, affordability, insurance coverage, and over the counter options
- **Access and utilization of care:** Address the need for dependable, affordable, and accessible reproductive health care.
- **Awareness of Reproductive Health Services:** Provide the general public a greater awareness of family planning, its services and programs through public health messaging and campaigns that can be understood by all.

Shared Vision:

The vision of FPAC is that all Michigan communities have equitable access to comprehensive, affordable, inclusive, and affirming sexual and reproductive health services with a focus on quality and innovation.

Selected FPAC Roles:

- Promote the need for policy changes to increase available services and make them easier to access, including contraceptive availability in schools.
- Expand innovative, accessible sexual and reproductive health care through the promotion of telehealth services and "Contraceptive Access Best Practices."
- Raising community awareness of sexual and reproductive health services by providing resources and information to organizations serving Michiganders (schools, community orgs, consumers, providers, and those who link consumers with providers).

Participants

Membership includes individuals representing the state government, local health departments, Planned Parenthoods, hospitals, adolescent health centers, advocacy agencies, social workers, and community members.

Structure

The FPAC meets three times per year. The FPAC agenda is carried forward through the work of the following sub-committees.

- Policy and Advocacy: Promote the need for policy changes to increase available services and make them easier to access.
- Promotion and Education: Promote and provide the general public a greater awareness of family planning services and programs through public health messaging and campaigns that can be understood by all.
- Service Delivery: Expand innovative, accessible sexual and reproductive health care through the promotion of telehealth services and contraceptive access best practices.