Massachusetts Department of Public Health

SEXUAL AND REPRODUCTIVE HEALTH CORE VALUES AND PROGRAM STANDARDS

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Boston, MA 02108

The purpose of this document is to delineate minimum standards for MDPH-funded Sexual and Reproductive Health (SRH) agencies. This document, together with the RFR, the SRH Logic Model and the MDPH Sexual and Reproductive Health Program (SRHP) Billing and Reporting Manual, outlines contract expectations and represents criteria for evaluation by the MDPH Sexual and Reproductive Health Program (SRHP).

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Sexual and Reproductive Health Program Core Values

The MDPH SRHP is committed to the following core values. All services and activities funded under this program should support these ideals. For definitions of these and related key terms, please see **Appendix II: MDPH Sexual & Reproductive Health Program Definitions**.

Administrative Requirements

Program Design and Implementation Principles

All aspects of SRH programming, activities, and service delivery must be:

1) focused on the elimination of health inequities and promotion of health equity.
2) cognizant that individual health occurs in the context of individual, interpersonal, institutional, community, and public policy-related factors, and that the intersectionality of race, ethnicity, gender, class, sexual orientation, age and disability contribute further to health inequities.
3) evidence-based and medically accurate, client-centered,[1] trauma-informed, culturally and developmentally appropriate.
4) centered on the needs of those with the greatest barriers to access.
5) inclusive of meaningful, compensated community engagement of those most marginalized by various forms of oppression in the design of policies and programs.[2]
6) provided in a manner that assures client privacy.
7) inclusive of positive messages about health, wellness, and sexuality.
8) structured to facilitate and increase access and remove barriers to care.
9) collaborative with relevant MDPH-funded programs and other community-based programs.

Administrative Policies and Procedures

1) Agencies should maintain a current demographic, cultural, and epidemiological profile of the communities served based on a needs assessment or other collected evidence that enables the agency to effectively respond to the needs of priority populations within the service area who are in need of SRH services.
2) Agencies must have written policies and procedures. Policies should be reviewed regularly and updated as needed. Topics covered by administrative policies should include at a minimum:
    a) quality improvement/quality assurance activities.
    b) client confidentiality throughout service provision and any associated billing or communication, with particular attention to ensuring awareness of and access to protections for adolescents and others with confidentiality needs.
    c) client grievance policy and client bill of rights.

[1] While we utilize the terms "client" and "client-centered" throughout this document, we acknowledge the whole personhood of those receiving SRH services—including their unique preferences, values and needs—and not only their status as "client" relative to the health care system.

[2] Person-Centered Contraceptive Care Framework (UCSF) https://media.thewomensfoundation.org/wp-content/uploads/2019/11/14112841/UCSF-Person-Centered-Contraceptive-Care-Framework.pdf

d) safety plans and procedures, including medical emergencies and violence prevention and response.[3]

e) key requirements for SRH clinical care, including:

i) SRH services are accessible to all people,[4] including low-income persons.

ii) SRH services are provided on a voluntary basis.

iii) accepting SRH services is not a prerequisite to the receipt of any other services.

iv) structures are in place to increase access and timeliness to services and reduce barriers to care.

v) service delivery and maintenance of medical record privacy is in accordance with agency HIPAA guidelines.

vi) staff must not coerce or try to coerce any person to accept a contraceptive they do not want, or to undergo an abortion or sterilization procedure.

3) Where services are subcontracted to other entities, formal written contracts should govern the relationship between the contracted vendor and the subcontract, including the contracted vendor's responsibility for providing oversight of subcontracted entities' compliance with SRH standards, data reporting and billing requirements.

Fiscal and Data Reporting Policies and Procedures

1) Financial policies and procedures exist to document reasonable and necessary billing policies

2) Agencies can substantiate that their rates for services are reasonable and necessary. This includes demonstrating the process and/or rationale used to determine the cost of services

3) Agencies have the following written revenue cycle management policies and procedures:

a) No person is denied care for lack of financial resources.

b) Verifying client income does not present a barrier to receipt of services.

c) Assurance that clients at or below 100% FPL are not charged for services.

d) Credentialing of providers and contracting with third-party payers including MassHealth and Health Safety Net are pursued and kept current.

e) Clients that are eligible for but not enrolled in health insurance will be connected to resources to assist them with enrollment.

f) Third-party payers are billed for services where contractually possible.

[3] 101 CMR 19.00: Workplace Violence Prevention and Crisis Response Plan

[4] There is no discrimination in SRH service delivery based on race, age, sex, national origin, religious creed, parity, marital status, gender identity, sexual orientation, immigration status, disability, or ability to pay.

g) When a minor is seeking confidential services, the charges are based solely on the minor's income.

h) Client income is assessed at least annually (or as needed), insurance status is assessed at each visit, and discounts are appropriately applied to the cost of services.

i) Agencies have a policy and procedure to permit the review of an individual client's charges and allow designated staff to waive charges in case of financial hardship.

j) Client confidentiality is maintained during the revenue cycle management process.

4) A sliding fee scale and schedule of discounts are created, updated at least annually, and applied to SRH services for clients with family incomes between 101%-300% FPL or is in keeping with other fee scales utilized by the agency, such as a HRSA 330 compliant fee scale.

5) Agencies may request and/or accept donations. Agencies must never pressure clients to donate or require donations as a prerequisite to the provision of services or supplies.

6) On a monthly basis, agencies are required to submit an encrypted data strip/extraction or web entry of de-identified demographic and service provision data into the MDPH SRHP designated data reporting system.

Quality Assurance and Quality Improvement

Quality Assurance (QA) activities measure compliance against standards or the fulfillment of requirements. Quality Improvement (QI) activities focus on processes and systems in order to achieve measurable improvements in identified indicators of quality of care.[5,6] The results of QA monitoring activities are used to inform QI activities.

1) Agencies must have a system for conducting quality improvement designed to ensure that SRH programs are safe, effective, client-centered, timely, efficient, equitable,[7] accessible, and valuable (cost-effective).

2) QI activities are developed, monitored and documented by a team that includes, at a minimum, the program director and medical director of the SRH program, and staff who have direct SRH client interaction (i.e., medical and nursing staff, medical assistants, counselors, educators, outreach staff as applicable). This team:

a) meets regularly (at least 3 times per year) and is charged with overseeing quality improvement of all SRH activities.

b) develops an annual quality improvement plan which considers the establishment, monitoring and analysis of evaluation indicators, goals, and performance measures

[5] https://www.fpntc.org/resources/introduction-quality-improvement-family-planning-elearning-module-1

[6] Gavin L, Moskosky S, Carter M et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR* 2014;63(RR4):21.

[7] Committee on Quality Health Care in America, Institute of Medicine (2001). *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press.

related to SRH, including those set through internal SRH program monitoring and improvement processes as well as annual priorities of the MDPH SRH program.

c) develops quality improvement goals and interventions to address deficiencies noted in QA activities. Interventions may include staff training and/or changes to workflows and monitoring the effect on the desired outcome.

3) QA activities monitor whether all services are client-centered, safe, accessible, evidence-based, and medically accurate, and include:

a) regular (at least annual) assessment of client satisfaction, including formal and informal mechanisms for feedback from consumers. Both feedback and client grievance procedures are culturally and linguistically accessible.

b) regular review of clinical protocols and administrative policies and procedures at least every two years, with updates more frequently as needed.

c) review of adverse outcomes and development and implementation of corrective action plans.

d) review of clinical care sites for safety, comfort, accessibility, and client flow at least annually.

e) clinician peer review, including periodic medical record review.

f) monitoring of standardized training programs for on-boarding and updating staff on all relevant knowledge and skills required for SRH service delivery (see **Management, Training, and Supervision**).

g) monitoring provider use of designated clinical policies and protocols during onboarding and when guidelines are updated, or when national practice standards change.

h) monitoring additional data on various aspects of quality care (e.g., productivity, access, STI screening and treatment rates, HPV vaccination completion rates, program efficiency).

Human Subjects Clearance (Research)

Research involving clients served by the SRH program conforms to regulations on the protection of human subjects (on the federal level, 45 CFR Part 46). This includes approval by a health center or affiliated Institutional Review Board (IRB), appropriate notification to clients, and documentation available to MDPH.

Human Resources

Staff who provide SRH clinical, counseling, education, administration, registration, and/or outreach services must demonstrate professionalism, empathy, respect, commitment to the MDPH SRHP Core Values, and, ideally, reflect the Priority Populations in their communities.[8]

Personnel Policies

There is to be no discrimination in personnel administration. All personnel policies must comply with federal and state requirements, including, but not limited to, Title VII of the Civil Rights Act;[9] Title I of the Americans with Disabilities Act;[10] Commonwealth of Massachusetts Executive Order No. 491: Establishing a Policy of Zero Tolerance for Sexual Assault and Domestic Violence.[11] Policies should cover:

1) recruitment, hiring, promotion, and termination, including standardized hiring processes for staff expected to provide services in languages other than English.
2) community representation in hiring: a proactive approach to addressing and dismantling hiring practices that disadvantage people of color and hiring those who are representative of the local communities served by the health center, in particular those communities who experience health inequities.
3) compensation and benefits.
4) training, supervision, and performance evaluations.
5) staff grievance procedures.
6) sexual harassment and violence prevention and response in the workplace.

Leadership

1) SRH Programs must be administered by a qualified program director who is designated to oversee the SRH program. Hiring preference should be given to people who have experience in the following areas: public health, healthcare administration, grants management, safety net health service provision, SRH services, and clinical service delivery. This person should have authority to implement, manage, and monitor the SRH program at their agency.
2) The clinical program must be under the direction of a medical director who is a physician with training and experience in SRH services. A physician may delegate a nurse practitioner or certified nurse midwife to be the medical director of the program, only if they operate in that capacity under the direction of the physician. The medical director maintains licensure and clinical competencies as noted below. Responsibilities include (but are not limited to):

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[8] U.S. Department of Health and Human Services, Office of Minority Health (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Rockville, MD: IQ Solutions, Inc.

[9] Civil Rights Act of 1964, **42 U.S.C § 2000d (1964).**

[10] Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2, 104 Stat. 328 (2008).

[11] https://www.mass.gov/executive-orders/no-491-establishing-a-policy-of-zero-tolerance-for-sexual-assault-and-domestic

a) oversight of clinicians,

b) review and final approval of clinical protocols,

c) participation on the quality improvement committee(s), and

d) availability for clinical consultation during hours of operation.

3) The clinical program receives input and oversight through an involved, internal clinical committee or clinical advisory team. The medical director must be involved in the process.

4) Changes in senior program staff are provided to MDPH in writing within 60 days.

Clinical Staff Competencies

1) Clinical staff who provide SRH services must possess the knowledge and skills necessary to provide the comprehensive SRH services listed in the **Clinical Services** section below.

2) All clinical staff must possess a current license from the Board of Registration relevant to their role and maintain all professional certifications.

3) Both staff providing clinic-based clinical and counseling services and support staff must utilize the following principles when working with clients:

   a) A client-centered, trauma-informed approach[12] to all interactions, including:

      i) creating a safe, accepting and respectful environment.

      ii) exercising cultural humility.[13,14]

      iii) being aware of and managing personal biases and assumptions without projecting these values onto clients.

      iv) supporting client autonomy, preferences, values and choices in all services.

      v) addressing the client's expressed needs and reason for visit.

      vi) engaging the client's participation by building rapport, using open-ended questions, active listening skills, fostering mutual learning, normalizing the client's experience, encouraging questions, respecting boundaries, and confirming the client's understanding of key information.

      vii) assessing, recognizing, and building on client's strengths, social supports, and resources.

[12] https://www.integration.samhsa.gov/clinical-practice/trauma-informed#Providers

[13] https://www.aafp.org/news/blogs/leadervoices/entry/20190418lv-humility.html; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3834043/

[14] Terminology has evolved from "cultural competence" to "cultural humility" and most recently to "structural competency," described as acknowledgement and understanding of the impact of multiple oppressions on health and interactions within the health care system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4269606/; https://structuralcompetency.org/about-2/; https://journalofethics.ama-assn.org/article/structural-competency-and-reproductive-health/2018-03

b) Facilitation of opportunities for clients to meet privately (one-on-one) with staff, regardless of age or accompaniment by family member, friend, or partner.[15]

c) Assessment of barriers to access to SRH services or information (e.g., financial, cultural, linguistic, logistical, geographic, immigration, social, emotional) and provision of strategies to address them.

d) Proactive assurance of client confidentiality throughout service delivery, follow-up, and payment and billing (if appropriate), especially for minors who by law[16] may consent to their own care.

Management, Training, and Supervision

1) The program director directly manages or delegates all aspects of the SRHP program. These responsibilities include but are not limited to: attendance at all relevant provider meetings, coordination of accurate and timely billing, communication with MDPH, communicating MDPH policy to other agency staff, ensuring appropriate orientation and training of all staff, submission of required data, and creation and management of the annual workplan and other required periodic reports.

2) Programs are responsible for the training of their staff, including onboarding of new staff, updating staff knowledge and skills, and monitoring staff for competency. Technical assistance may be provided by MDPH SRHP staff or MDPH staff may refer to additional training opportunities.

3) Staff training is guided by a written policy, with annual training goals and activities documented and monitored in the work plan. Training is provided to all staff, including physicians, advanced practice providers, nurses, counselors, medical assistants, billing staff, front desk staff, and any other staff who work within the SRH program.

4) Individual trainings are designed with measurable learning objectives for staff participants, including improvement in knowledge, attitudes, health beliefs, skills and behaviors.

5) Specialized training in basic SRH competencies and MDPH SRHP Core Values must be completed by all staff who interact with clients within their first year, unless they have previous experience or training. Such training must be offered to all staff regularly and as needed to ensure fluency.

6) All staff provide SRH services within their scope of employment and licensure. Individualized training plans address responsibilities, knowledge and skills required by each role within the SRH program according to the relevant MDPH SRHP Standards.

[15] Gavin L, Moskosky S, Carter M et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR* 2014;63(RR4):1-54.
[16] MGL c112, §12F

7) Clinical and administrative SRH program staff receive training[17] annually on health inequities of priority populations, racial equity[18] and reproductive justice,[19] and how services are structured to address needs of priority populations.

8) Staff who provide interpretation services have access to interpreter training.

9) Programs assess the quality and efficacy of staff training through formal evaluation processes that:
   a) determine to what extent predetermined learning objectives have been achieved and
   b) assess the impact of educational activities on overarching SRHP goals and objectives.

10) Staff receive regular supervision that is designed to assess their competence and need for additional training in basic SRH competencies and MDPH SRHP Core Values and other relevant emerging topics. Opportunities for supervision may be formal and/or informal and occur on an individual and/or group level as needed to maximize learning opportunities for staff.

11) Daily and overall clinical supervision by a licensed clinical provider must be available for staff who function as SRH nurse/medical assistant/counselor/educator in the clinical setting.

12) Programs must develop and implement equitable plans to evaluate the quality of service delivery for staff providing services in languages other than English.

13) Volunteers, peer educators, and other non-employees are selectively recruited, adequately trained, supervised, and supported. Policies must exist to describe volunteer programs.

Clinical Standards

Clinical Guidelines for SRH Services

1) Clinical providers must provide SRH services according to guidelines, policies, and procedures. All guidelines, policies, and procedures must:

   a) reflect current, evidence-based standards of clinical SRH care published by nationally recognized organizations. Key guidance includes the most updated CDC U.S. Medical Eligibility Criteria for Contraceptive Use,[20] CDC U.S. Selected Practice Recommendations for Contraceptive Use,[21] CDC Providing Quality Sexual and Reproductive Health

[17] The requirement for clinical and administrative program staff training on health inequities of priority populations, racial equity, and reproductive justice means a proactive process of understanding the history of racism and reproductive coercion in health care and identifying how personal implicit and unconscious biases, historic health care practices, and structural racism perpetuate health inequities in the clinical setting.

[18] https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity/

[19] https://www.sistersong.net/reproductive-justice

[20] Curtis, K.M. (2010). U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR,* 59(RR5):1-6.

[21] Curtis, K.M. (2013). U.S. Selected Practice Recommendations for Contraceptive Use, 2013. *MMWR,* 62(RR5):1-46.

Services,[22] CDC STD Treatment Guidelines,[23] CDC Recommendations for Providing Quality Sexually Transmitted Disease Clinical Services, [24] CDC Guidelines for Preconception Care,[25] CDC HIV Testing Guidelines,[26] and CDC PrEP Clinical Practice Guidelines.[27] Other relevant SRH guidelines include, but are not limited to, those that are regularly updated and published by the American College of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), American Cancer Society (ACS), Centers for Disease Control and Prevention (CDC), United States Preventive Services Task Force (USPSTF), American Society for Colposcopy and Cervical Pathology (ASCCP), American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), UpToDate, Society for Family Planning, The National LGBT Health Education Center, National Abortion Federation, WHO/UNFPA and Women Enabled International Guidance on SRH for persons with disabilities,[28,29] Reproductive Health Access Project, Nurse Practitioners in Women's Health (NPWH), Alliance for Innovation on Maternal Health Patient Safety Bundles,[30] and Contraceptive Technology.

b) be available for each of the services listed in the **Clinical Services** section below and offered by the agency. A list of required clinical protocols is included in **Appendix I: List of Required Guidelines for Clinical SRH Services** and will be updated periodically.

c) delineate scope of care provided by each type of health professional involved, consistent with state regulations, including standing orders for any SRH services provided by nurses, such as emergency contraception, pregnancy testing, and STI and/or HIV screening, that clearly designate procedures as well as the limits, based on professional licensure, of clinical decision-making and other responsibilities.

d) include information on when to refer the client for more extensive assessment and treatment.

e) include relevant client counseling and education messages.

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[22] Gavin L, Moskosky S, Carter M et al., Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR* 2014;63(RR4):1-54.
[23] Warkowsky, K, Bolan, G, Sexually Transmitted Diseases Guidelines 2015. MMWR Recomm Rep 2015;64(RR3): 1-137.
[24] Barrow, Y, Ahmed, F, Bolan, G, Recommendations for Providing Quality Sexually Transmitted Disease Clinical Services. MMWR Recomm Rep 2020;68(RR5):1-24.
[25] Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care — United States: a report of the CDC/ ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55(No. RR6):1-22.
[26] https://www.cdc.gov/hiv/guidelines/testing.html
[27] Centers for Disease Control and Prevention: US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 Update: a clinical practice guideline. https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf. Published March 2018.
[29] https://www.unfpa.org/publications/promoting-sexual-and-reproductive-health-persons-disabilities
[28] https://www.womenenabled.org/wei-unfpa-guidelines.html
[29] https://www.unfpa.org/publications/promoting-sexual-and-reproductive-health-persons-disabilities
[30] https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/

f) procedures for notifying all providers whenever protocols are implemented, updated, or when national practice standards change.

2) Agencies that develop and/or adapt guidelines, policies, and procedures, should:

   a) use a collaborative, inclusive, and multidisciplinary process, with integration of input from staff who are subject to the protocol, including administrative, medical, nursing, client advocate, and other staff members.[31]

   b) implement a regular review process (and least annually and more frequently with changes in practice guidelines) under the supervision, review, and approval of the medical director.

   c) ensure that all guidelines include the date of last review, and reference sources.

3) When guidelines are externally accessed via app or web-based systems, agencies must develop:

   a) a general policy that defines:

      i) the process for how external guidelines is chosen, how frequently their use is reviewed and by whom.

      ii) procedures for notifying all providers whenever protocols are implemented, updated, or when national practice standards change.

   b) local practice policies that are adapted on a regular basis under the supervision of the medical director and include:

      i) when care needs fall outside of scope of practice, where to refer for additional care and how quickly.

      ii) delineation of scope of care provided by each type of involved health professional, consistent with state regulations.

      iii) client education and counseling messages, if not included in external protocol.

[31] ACOG Committee Opinion No. 792, *Clinical Guidelines and Standardization of Practice to Improve Outcomes.* Committee on Patient Safety and Quality Improvement. ACOG, Obstetrics and Gynecology 10/2019; 134: e122-125. Accessed at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Clinical-Guidelines-and-Standardization-of-Practice-to-Improve-Outcomes

Clinical Services

1) All SRH visits should include:[32]
    a) assessment of reproductive intention (pregnancy or paternity) and provision of services as indicated.[33]
    b) updated sexual history.[34]
    c) medical history appropriate to reason for visit.
    d) assessment for reproductive coercion.[35]
    e) documentation of contraceptive method used at the end of the visit, or if no method, the reason.
2) Clients receiving SRH services are assessed initially for the following, with updates at least annually or more frequently as indicated:
    a) sexual orientation and gender identity (SOGI)
    b) medical history, including medications and allergies
    c) sexual history
    d) history of intimate partner violence, sexual assault, and reproductive coercion,[36] with education and facilitated referrals as appropriate.
    e) assessments for social determinants of health[37] which have an impact on health outcomes, including access to health care, transportation, food security, housing security, educational opportunity, type of employment, and social supports, with in-house or community-based referrals for assistance, as appropriate.
    f) mental health, with in-house or community-based behavioral health referrals as appropriate.

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[32] Evidence-based standards for topic, content, and frequency of SRH screening assessments is evolving. This section contains the current expectations and is subject to change.

[33] There are many ways to assess reproductive intention. We recommend a standardized, person-centered approach that elevates the client's need at that visit and guards against subtle coercion and biases in provider response. One such approach is the Self-Identified Need for Contraception (SINC): The Electronic Clinical Quality Measure of Contraceptive Provision | UCSF; SINC_new data element for eCQMs_5.20.21.pdf (ucsf.edu); Pregnancy Intention and Contraceptive Needs Interventions for Clinics (PICNIC) - Partners in Contraceptive Choice and Knowledge (picck.org). Another approach focuses on pregnancy/paternity attitude: About PATH | envisionsrh

[34] Updated sexual history should be assessed no more often than every three months and should include indications for offering PrEP education and services.

[35] Note on human trafficking: While SRH staff may be trained to recognize red flags that might indicate human trafficking, screening for human trafficking should be limited to those staff who have been specifically trained and designated to provide appropriate screening and response, within the context of robust referral capacity for needed services.

[36] See previous footnote on human trafficking.

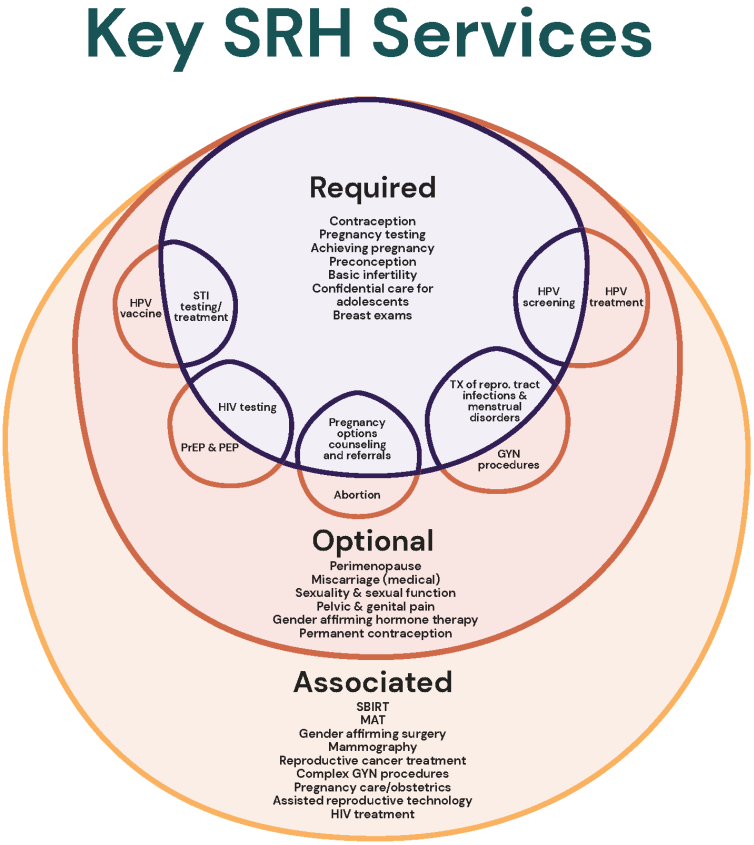
[37] According to *CDC Healthy People 2030,* social determinants of health (SDoH) are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks…(and) also contribute to wide health disparities and inequities." https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

g) substance use, with in-house or community-based treatment referrals as appropriate.

h) source of primary care if the health center is not the primary care provider.

3) All SRH visits must include clinical counseling and education, which may be provided in written, verbal, audio and other electronic formats. It should be client-centered, non-biased, factual, age appropriate, culturally and linguistically appropriate, and timely. The specific components and method of clinical counseling and education provided depend on the service provided and the client's needs, for example, providing contraceptive counseling within a shared decision-making framework.[38] Providers of clinical SRH services should be prepared to provide counseling and education to clients on all topics listed under required clinical services per national guidelines, continuously updating their knowledge as information and standards of care change.

The circles in the following diagram depict three levels of SRH services: Required SRH services (in blue), Optional SRH services (in red), and SRH-Associated Services (in grey). Services will be updated as national, state, and local SRH priorities emerge, and as evidence-based standards of practice evolve. All SRH services listed must be provided according to the principles outlined in **Clinical Staff Competencies** above, as well as guidelines and protocols that reflect current, national standards of care, and should be available in a timeframe commensurate with the urgency of the type of service requested.



[38] Dehlendorf C, Grumbach K, Schmittdiel JA, Steinauer J, *Shared Decision Making in Contraceptive Counseling.* Contraception. 2017 May;95(5):452-455. doi: 10.1016/j.contraception.2016.12.010. Epub 2017 Jan 6.

4) **REQUIRED**: Required services must be provided by all SRH programs. All services should be delivered on site and a majority of/all clinicians in the SRHP are expected to provide all of these services, which include:

   a) Contraceptive provision and management, including history, physical exam and lab testing as indicated by current guidelines. All FDA-approved categories of contraception, including emergency contraception, should be available on site or by prescription. Every effort should be made to provide same day access to the client's method choice. Services should include facilitated method switching and barrier-free LARC removal, when requested.

   b) Pregnancy testing and comprehensive, non-directive counseling for all pregnancy options provided by program staff who have received appropriate training. Facilitated referrals for prenatal care, abortion services, and adoption resources as requested by the client. Additional lab tests, exam, and referrals for care as indicated by medical and sexual history. Ideally, pregnancy testing should be available on a walk-in basis.

   c) Achieving pregnancy, including client education regarding maximizing fertility and assessment whether to provide or refer for basic infertility care.

   d) Basic infertility care including appropriate client and partner (as appropriate) history, exam and lab testing, and referral for additional services not available on site.

   e) Preconception care, including folic acid supplements, education, genetic history, and appropriate medical, sexual and social history, exam, and lab testing to identify infectious disease, chronic conditions, and toxic exposures. Referral for additional services outside of those available on site.

   f) STI risk assessment, physical exam, prevention including Hepatitis B and HPV vaccination on site or by referral, screening, partner services including expedited partner therapy for chlamydia and referral for partner notification as appropriate, evaluation of STD-related conditions, laboratory diagnosis, treatment, and referral to specialists for complex STD or STD-related conditions.[39]

   g) HIV risk assessment, testing, prevention, and risk reduction counseling, including education about PrEP and nPEP and related referrals, external or internal referral for HIV treatment.

   h) Age- and developmentally-appropriate confidential services for adolescents, including those under age 18—see **Adolescent Sexual and Reproductive Health Care** Standards below.

   i) Screening for HPV-related cancers.

   j) Breast cancer screening exams.

[39] Barrow, Y, Ahmed, F, Bolan, G, Recommendations for Providing Quality Sexually Transmitted Disease Clinical Services. MMWR Recomm Rep 2020;68(RR5):1-24

k) Diagnosis and treatment of common reproductive tract infections and menstrual disorders (such as urinary tract infections, vaginal infections, dysmenorrhea).

5) **OPTIONAL**: Optional services are encouraged and supported, but not required. If not provided on site, clients should be able to access these services through a warm referral. These services include:

   a) treatment for HPV-related reproductive cancer and precursors,

   b) GYN procedures such as endometrial and vulvar biopsy,

   c) abortion services,

   d) provision of PrEP/PEP for HIV prevention, including offering access to eligible clients through the Massachusetts Drug Assistance Program for PEP[40] and PrEP,[41]

   e) provision of HPV vaccine,

   f) perimenopause management,

   g) miscarriage management,

   h) sexual function issues,

   i) permanent contraception—tubal ligation and vasectomy,

   j) pelvic and genital pain syndromes, and

   k) gender-affirming hormone therapy.

6) **ASSOCIATED**: SRH-Associated services are important services for clients receiving SRH services, but may or may not be available in your agency. If not provided on site, clients should be able to access these services through a warm referral. Associated services include:

   a) SBIRT (screening, behavioral intervention, referral to treatment) for substance misuse disorder,

   b) Medication Assisted Treatment for substance use disorder,

   c) gender affirming surgery services,

   d) diagnostic or screening mammography,

   e) reproductive cancer treatment,

   f) prenatal and postpartum care and obstetrics services,

   g) gynecology services not available on site, and

   h) HIV treatment.

[40] https://crine.org/npep
[41] https://crine.org/prepdap

Medication Dispensing

Prescriptive medications, including contraception, are ordered by licensed clinical providers with prescriptive authority and dispensed by licensed clinical providers.[42] The medication order and dispensing information is documented in the medical record.

Referrals

Agencies must facilitate continuity of care by maintaining a referral network and providing care coordination through supported referrals.

1) Agencies maintain current and accurate referral relationships and lists.
2) Referral sources must be accessible to and accessed by SRH staff.
3) Referral partnerships must be with organizations that share SRHP core values, and that provide medically accurate information and evidence-based care. For example, referral partners may not include organizations that do not provide complete and medically accurate information about pregnancy and pregnancy options, such as crisis pregnancy centers.[43,44]
4) Referral partnerships include (at a minimum):
    a) SRH optional and associated services not available on site.
    b) primary care (pediatric and adult).
    c) dental care.
    d) programs that address food and housing insecurity (WIC, SNAP, mutual assistance programs, fuel assistance, housing assistance, and shelters).
    e) disability and special health care needs programs.
    f) behavioral health services, including mental health and substance use treatment services.
    g) violence prevention and response programs including rape crisis centers, domestic violence programs, emergency rooms that host the Sexual Assault Nurse Examiner (SANE) program, and intimate partner abuse education program services.
    h) health and prevention services programs for human trafficking survivors.
    i) positive youth development programs, including those funded by the MDPH Office of Sexual Health and Youth Development.
    j) programs for LGBTQ+ clients, including youth-specific programs.

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[42] https://malegislature.gov/Laws/GeneralLaws/Parti/TitleXV/Chapter94C

[43] NARAL Pro-Choice Mass "Crisis Pregnancy Lie: The Insidious Threat to Reproductive Freedom." Accessed online at https://www.prochoiceamerica.org/wp-content/uploads/2017/04/cpc-report-2015.pdf on November 7, 2019.

[44] Joint Position Statement of the Society of Adolescent Health and Medicine and the North American Society for Pediatric and Adolescent Gynecology. "Crisis Pregnancy Centers in the US: Lack of Adherence to Medical and Ethical Practice Standards." Journal of Adolescent Health, December 1, 2019. Accessed online at https://www.jahonline.org/article/S1054-139X(19)30413-6/fulltext

k) health insurance enrollment assistance.

l) community based job training and education programs.

m) relevant MDPH-funded programs (for example, those funded by the Office of HIV/AIDS and Division of Sexually Transmitted Disease Prevention within the Bureau of Infectious Disease and Laboratory Sciences, Bureau of Substance Addiction Services, Sexual and Domestic Violence Prevention and Services, and other programs within Child/Adolescent Health and Youth Development).

4) Referral information for a particular service should include, but is not limited to, the accurate location/address, telephone number, web site, hours of operation, service description and type, availability of interpreters or bilingual staff, and cost or insurance accepted.

5) When possible, staff assist clients with making appointments, arranging transportation, and addressing other access barriers.

6) Agencies have mechanisms in place to track outcomes of clinical referrals and to evaluate satisfaction with referral services.

7) Referrals should be documented in the medical record.

8) Agencies confirm referral resources at least annually to enhance collaboration, foster mutual understanding of services provided, and improve partnerships.

Medical Records

1) Agencies must establish and maintain electronic medical records which include documentation of both in-person and virtual clinical encounters.[45] Virtual encounters may include telehealth visits, telephone consultations, follow-up calls, texts, and emails. Documentation shall include:

a) client identifying information, including demographics and collection of SOGI (sexual orientation and gender identity) data,

b) consent for services,

c) source of primary care if not on-site,

d) medical, social, sexual history, including all assessments listed in the **Clinical Services** section above,

e) counseling/education provided,

f) physical exam findings and communication with client,

g) laboratory tests and results, with plan for follow-up as appropriate and prompt communication with client,

h) medications dispensed and prescribed,

[45] Records of hospitals or clinics; custody; inspection; copies; fees. MGL Part I Title XVI Chapter 111 Section 70

i) documentation of the contraceptive method selected by the client (also known as ending contraceptive method),

j) referrals, and

k) follow-up.

2) Clients are entitled to a copy of their medical records.[46]

Adolescent Sexual and Reproductive Health Care

1) The following MDPH SRHP principles on providing SRH services for adolescents are guided by published position statements and guidelines from the American Academy of Pediatrics (AAP),[47] American College of Obstetricians and Gynecologists (ACOG),[48] Society for Adolescent Health and Medicine (SAM),[49] American Academy of Family Physicians (AAFP),[50] Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN),[51] and CDC.[52]

   a) All adolescents, including those under age 18, must be offered the opportunity to receive comprehensive, confidential SRH services. Concerns about costs or confidentiality must not be barriers for adolescents, including minors, to accessing comprehensive SRH clinical, educational, and counseling services.

   b) All adolescents who request confidential SRH services, including minors, must be able to:

      i) self-consent for SRH care.[53]

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[46] Ibid.

[47] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Confidential-Services-and-Private-Time.aspx
Alderman EM, Breuner, CC, AAP COMMITTEE ON ADOLESCENCE. Unique Needs of the Adolescent. *Pediatrics.* 2019; 144(6):e20193150 https://pediatrics.aappublications.org/content/early/2019/11/14/peds.2019-3150

[48] https://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations/Evaluation-and-Counseling-Ages-13-18-Years

[49] Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine, approved by the Society for Adolescent Health and Medicine's Board of Directors, January 2014. Journal of Adolescent Health 54 (2014) 491e496

[50] https://www.aafp.org/about/policies/all/adolescent-confidentiality.html

[51] https://www.jognn.org/article/S0884-2175(17)30409-4/fulltext?utm_source=awhonn.org&utm_medium=page%2520link&utm_campaign=AWHONN_Positions&utm_content=Confidentiality%2520in%2520Adolescent%2520Health%2520Care

[52] CDC 2015 Sexually Transmitted Disease Treatment Guidelines 2015 https://www.cdc.gov/std/tg2015/tg-2015-print.pdf

[53] Confidentiality Issues and Use of Sexually Transmitted Disease Services Among Sexually Experienced Persons Aged 15–25 Years — United States, 2013–2015 MMWR *Weekly* / March 10, 2017 / 66(9);237–241 https://www.cdc.gov/mmwr/volumes/66/wr/mm6609a1.htm?s_cid=mm6609a1_w

[53] Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine, approved by the Society for Adolescent Health and Medicine's Board of Directors, January 2014. Journal of Adolescent Health 54 (2014) 491e496

[53] https://www.adolescenthealth.org/Resources/Clinical-Care-Resources/Confidentiality/Confidentiality/Policy-Statements-of-Professional-Organizations.aspx

ii) access the judicial bypass system for abortion procedures as requested and applicable.[54]

iii) receive education about confidentiality and the limits of confidentiality at their initial and subsequent visits.

iv) be assessed on a sliding fee scale or schedule of discounts based on their own income, not that of a parent of other family member. However, with the minor client's consent, family income is assessed and third-party insurance is pursued.

c) Parents or guardians must not be notified before or after the client has received SRH services to which they have self-consented.

d) The record of SRH services to which the adolescent has self-consented cannot be discussed with, or released to, anyone outside of the health center treatment team without the client's permission. Exceptions to this include mandatory reporting of:

i) certain infectious diseases to the Massachusetts Department of Public Health.[55]

ii) known or suspected abuse, neglect, commercial sexual exploitation or human trafficking of a minor, in accordance with Massachusetts Department of Children and Families guidelines.[56]

iii) client statement that represents a risk of serious harm to self or other.

e) Health centers must have an adolescent confidentiality policy that outlines how adolescent confidentiality is implemented in every level of the encounter, including registration, billing (including provisions of the PATCH Act),[57,58] medical records, lab services, follow-up, and referrals.

2) In addition to access to all services described above in the **Clinical Services** section above, visits with adolescents should include:

a) discussion and anticipatory guidance and counseling concerning:

i) sexual development, including gender identity and sexual orientation.

ii) whether there is a trusted adult they can involve in their SRH decision making.

iii) healthy peer and sexual relationships, consent, reproductive coercion.

iv) developmentally appropriate messages around sexual decision-making and consent, including delaying initiation of sexual activity.

b) identification of protective social factors and supports that may affect sexual behavior (i.e., family members and peers, school achievement, community involvement).

[54] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section12s
[55] https://www.mass.gov/infectious-disease-surveillance-reporting-and-control
[56] https://www.mass.gov/child-abuse-and-neglect
[57] https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter63
[58] https://www.hcfama.org/confidentiality

c) referrals to community based positive youth development programs, as appropriate.

3) Education for adolescents should include positive messages about health, wellness, and sexuality.

Community Collaboration, Outreach, and Community Education

Community Collaborations

1) Agencies should develop participatory, collaborative partnerships with community members and organizations, and utilize a variety of formal and informal mechanisms to facilitate ongoing community involvement.

2) Members of priority populations are included in the design, implementation, and evaluation of programming that targets them through formal or informal focus testing, committee review, and/or other strategies.

Outreach

Outreach efforts communicate information about the availability and scope of SRH services as well as the program's core values and competencies. Activities should promote program participation and client retention within all MDPH-funded SRH program components, and be in support of the MDPH SRHP Goals and Objectives and Core Values. Activities should raise awareness about available services and the right to high quality care. Outreach activities can include inviting potential clients to access services (outreach) and/or reaching clients that utilize other areas of the health center but are not currently receiving SRH services (inreach).

1) Agencies should produce a written plan for outreach.

    a) The outreach plan should include an analysis of the scope, purpose, desired outcomes, and cost.

    b) The outreach plan should describe processes for identifying effective outreach strategies, typical outreach activities, priority populations, staff expectations and responsibilities, provisions for staff safety, documentation expectations, and evaluation plans.

    c) Outreach plans should be driven by and linked to an analysis of clinical patterns or a quality improvement (QI) project.

    d) The outreach plan must identify relevant past and current statewide and national strategies in order to identify gaps or conflicts, avoid duplication of efforts, optimize timing and allow for mutually reinforcing, collaborative efforts. Outreach strategies may incorporate or adapt but may not duplicate current state or federal initiatives.

    e) The outreach plan must be reviewed annually to assess if current outreach practices effective and are still relevant or if they should be revised in part or entirely.

2) All modes of outreach are employed following an evaluation of risk to the agency and potential harms for clients and staff, demonstration of a justified business need, and analysis of anticipated benefits, including behavioral outcomes in Priority Populations. MDPH reserves the right to approve or modify the model.

3) Agencies must provide culturally appropriate, medically accurate, and linguistically accessible health information to the community, in general, and Priority Populations

specifically, in community-based settings, such as schools, clinics, shelters, substance abuse facilities, youth serving agencies, faith-based organizations and houses of worship, social service agencies, and community centers. When possible, agencies utilize trained Community Health Workers to conduct outreach programming.

4) Outreach may consist of one to two individual or group sessions aimed at informing potential clients of services. These people may have never utilized SRH services, or may have been out of care for a number of years. These activities should include clear information about how to access SRH services.

5) Outreach may consist of traditional public health activities, such as attending health fairs, running peer groups, "barbershop" programs, and distributing non-prescriptive contraceptives in the community. These activities are permissible as long as they are accompanied by a rigorous analysis of their effectiveness for the program.

6) Outreach activities should foster relationships between the SRH program and other community-based organizations or healthcare providers.

7) Digital and social media should be used to optimize outreach efforts. Agencies who employ digital and media must develop and publicize policies that:

   a) describe how frequently content will be produced, maintained to ensure accuracy, and moderated.

   b) include grievance procedures for removing or adding additional content.

   c) consider the potential legal implications of providing the information, such as confidentiality and copyright issues.

Community Education Program

Community education is an optional SRH program offering and consists of three to five education sessions using evidence-based or evidence-informed curricula.

1) Community education sessions should include one or more of the following topics: discussion of human sexuality throughout the lifespan; communication skills with partners, peers and providers; sexual health and wellness; gender identity, expression and sexual orientation; healthy relationships and sexuality; peer pressure and refusal skills, health promotion and risk reduction strategies, including proactively addressing health care access barriers, especially those applicable to other Priority Populations, as appropriate for the audience and venue.

2) To reduce duplication with other DPH-funded programs, SRH community education participants should be age 18 or older and sessions should occur in community-based settings, excluding secondary schools. Acceptable settings include but are not limited to: substance abuse treatment programs, sober living houses, jails and prisons, faith-based institutions, outreach centers, community-based health centers, and any other community-based setting that serves Priority Populations.

3) Community education must incorporate referrals, informal counseling, and other relevant follow-up requested in response to education provided.

4) Community education should be provided by community health workers (CHWs) that have completed CHW certification or will complete training within one year of hire. Where possible, certification is paid for by the hiring organization.

5) Community health education sessions utilize approved evidence-based or evidence-informed curricula. Approved curricula include:

   a) sexual health lessons from the Our Whole Lives Sexuality Education for Adults curriculum, with the exception of the faith sessions.

   b) HIV/AIDS lessons from VOICES/VOCES[59] or Community PROMISE.[60] Healthy Relationships[61] can be used for groups that occur with HIV-positive individuals.

   c) community education sessions can be supplemented by using MDPH-created workshops, in addition to an approved curriculum.

6) Adaptations to evidence-based/evidence-informed curricula or alternate curricula are approved by MDPH prior to implementation.

7) Community education programs assess quality and efficacy by:

   a) setting and measuring progress towards learning objectives for participants, and are designed to improve Priority Populations' knowledge, attitudes, health beliefs, skills and behaviors.

   b) including formal evaluation processes to determine to what extent predetermined learning objectives have been achieved, as well as to assess the impact of educational activities on overarching SRH program goals and objectives.

8) Education includes opportunities for active learning and accommodates different learning styles by engaging a minimum of two intelligences[62] to promote engagement in the learning process.

9) Procedures exist to ensure that the classroom environment is safe and flexible enough to accommodate participants' ongoing needs and must include:

   a) assessment of group and/or individual needs prior to and/or during an education or outreach session.

   b) establishment and/or review of ground rules, including mutual assurances of confidentiality, with exceptions for addressing abuse and neglect; respect; appropriate boundaries; sensitivity to the diverse life experiences of participants; and an affirming and non-judgmental approach.

[59] https://effectiveinterventions.cdc.gov/files/VOICES_Procedural_Guide_8-09.pdf?q=voices
[60] https://effectiveinterventions.cdc.gov/Files/promiseoverview.pdf
[61] https://effectiveinterventions.cdc.gov/en/persons-with-hiv/group-2/healthy-relationships
[62] https://www.niu.edu/facdev/_pdf/guide/learning/howard_gardner_theory_multiple_intelligences.pdf

c) the option to speak privately with staff on site about the lesson content, and/or related referrals to ensure participant safety and well-being.

d) opportunities to seek additional resources and/or connect with others to share the information provided.

10) Any over-the-counter medical supplies that are provided to participants are relevant to the education session and accompanied by instructions for use and linkage to SRH clinical services.

Education and Outreach Materials

1) All educational and promotional materials, campaigns, and communication developed by the agency (including but not limited to client information materials, brochures, instruction sheets, consent forms, educational handouts, educational curricula, social media, websites, marketing campaigns, and advertising) must meet the following guidelines. Educational materials developed by other entities in use at the agency should also reflect these guidelines to the greatest extent possible. Materials should:

   a) be consistent with MDPH SRHP Core Values.

   b) meet or exceed Culturally and Linguistically Appropriate Services (CLAS) standards.[63]

   c) meet or exceed applicable Americans with Disabilities Act (ADA) requirements[64] and MDPH Contractor Guidelines for Required ADA Compliance.[65]

   d) meet or exceed standards in the MDPH Office on Health and Disability Formatting Guidelines on Accessible Print Materials.[66]

   e) communicate information in a variety of formats (written, verbal, audio-visual, symbols and signs etc.) as appropriate.

   f) allow for meaningful access by low English proficiency/non-English speaking populations by using low literacy text at the 4th–6th grade reading level and images when possible.

   g) be linguistically and culturally accessible, including translation into languages commonly spoken among the target population and be identified by the name of the non-English language.

   h) provide sufficient information to connect clients and potential clients with key SRH services, including clinical services.

2) Processes should be developed to ensure that materials are periodically reviewed and updated as needed.

   a) Review processes should include input from Priority Populations, when appropriate.

   b) All materials should include the date of last review.

[63] https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
[64] https://www.ada.gov/ta-pubs-pg2.htm
[65] https://www.mass.gov/service-details/accessibility-requirements-for-state-facilities
[66] https://www.mass.gov/files/documents/2016/07/qi/accessible-print-materials.pdf

Additional Standards

1) In addition to this document, there are several additional requirements that govern the expectations of contracted providers. These include:

   a) Compliance with the MDPH SRHP Billing and Reporting Manual: This document, updated annually, describes the rules regarding grant reporting, program data submission, and the billing procedures for contracts.

   b) Compliance with relevant Commonwealth of Massachusetts laws and regulations: Contracted agencies are expected to comply with all relevant state laws and regulations, including, but not limited to:

      i) 808 CMR 1.03(5), Reimbursement as full payment.

      ii) MGL c. 94C, § 9, Administering and dispensing of controlled substances.

      iii) 105 CMR 340.100, Reporting of infectious diseases.

      iv) MGL c. 119C, § 51A, Mandated reporting of abuse or neglect of a minor.

      v) MGL c. 112, § 12F, Minors' consent to care.

   c) Licensure: Contracted agencies providing clinical care that are categorically required to be licensed by MDPH must be licensed by the Massachusetts Division of Health Care Facility Licensure and Certification.

   d) Agencies that purchase drugs and devices through the HRSA Office of Pharmacy Affairs 340B Program must develop and implement policies and procedures for enrollment, dispensing, and record keeping that comply with all 340B Program requirements.[67]

[67] https://www.hrsa.gov/opa/program-requirements/index.html

Appendix I: List of Required Guidelines for Clinical SRH Services

Agencies may develop their own guidelines for all offered services or use app- or web-based guidelines. Whichever guidelines are used, they must be chosen and/or developed, reviewed, and updated based the **Clinical Guidelines for SRH Services** Standards 1-3.

Contraceptive Method Guidelines

Contraception protocols should describe each of the following prescriptive or over the counter methods. Separate protocols are not required for each method within the general categories listed below, but must clarify where there are significant differences between methods within a category (i.e., a single IUD protocol is acceptable, if differences between all types of IUDs are described).

Contraceptive protocols should contain information about method provision and management, algorithms for method initiation which include same-day start, and easy access to the current CDC U.S. Medical Eligibility Criteria for Contraceptive Use[68] and CDC U.S. Selected Practice Recommendations for Contraceptive Use.[69] Guidelines for contraceptive counseling should be included, as well as client educational messages, including method effectiveness, side effects, correct use, discontinuation, signs that require immediate follow-up, and how client can access the method with the precise referral pathway, if appropriate.

- Abstinence
- Combined Oral Contraceptives
- Contraceptive Implant
- Contraceptive Patch
- Copper T IUD
- DMPA (Three-Month Hormonal Injection)
- Diaphragm
- Emergency Contraception
- Fertility Awareness-based Methods, including Standard Days Method
- Hormonal IUDs
- Internal and External Condoms
- Permanent Contraceptive Methods, including Tubal Ligation and Vasectomy
- Progestin-Only Oral Contraceptives
- Spermicide
- Vaginal Contraceptive Ring
- Vaginal Contraceptive Sponge
- Withdrawal

[68] Curtis, K.M. (2010). U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR,* 59(RR5):1-6.
[69] Curtis, K.M. (2013). U.S. Selected Practice Recommendations for Contraceptive Use, 2013. *MMWR,* 62(RR5):1-46.

Additional Required Clinical SRH Services Guidelines

- STD services including sexual history and physical exam, prevention, screening, partner services, (including expedited partner therapy and partner notification services), evaluation of STD-related conditions, laboratory testing, treatment, and referral for complex STD or STD-related conditions HIV risk assessment and prevention, including education about nPEP and PrEP, testing, referrals.
- PID diagnosis and treatment
- Vaginitis diagnosis and treatment
- Urethritis diagnosis and treatment
- Menstrual disorders diagnosis and treatment
- Cervical cancer screening and follow-up
- Breast cancer screening, including mammogram referral policy
- Pregnancy testing, comprehensive options counseling, and policy regarding provision of or referrals for all options
- Assessing reproductive intention (pregnancy or paternity)
- Preconception care
- Achieving pregnancy, including basic infertility care
- Adolescent SRH Care
- Social Determinants of Health screening
- Intimate partner violence and reproductive coercion screening, education, and referrals
- Sexual assault screening, education, referrals
- Human trafficking screening, education, referrals
- All Optional SRH Services offered on site.

Additional Required Clinical SRH Services Policies and Procedures

- Adolescent confidentiality
- Lab tracking, abnormal lab follow-up, and client notification process
- Referral process, including tracking outcomes of referrals
- Medical emergencies
- Mandatory reporting
- Medication dispensing

Appendix II: MDPH Sexual & Reproductive Health Program Definitions

Leading with Racial Justice

Sexual and Reproductive Health is one program within the Office of Sexual Health and Youth Development, which is part of the MDPH Bureau of Community Health and Prevention. This is our Bureau's *Racial Equity Why Statement*:

Leading with Race & Racism to Achieve Our Public Health Mission

"The history of structural racism – the public policies, institutional practices, and social norms that together maintain racial hierarchies – and its impact across the country and within the Commonwealth is often overlooked or unacknowledged, yet it is pervasive and unmistakably harmful to everyone. The social marginalization and inequities that racism cultivates in housing, education, employment, the built and social environments, and health care are felt across generations, most acutely in communities of color. The Bureau of Community Health and Prevention (BCHAP) recognizes that systems of cultural oppression need to be acknowledged and repaired by entities that helped create them. BCHAP is committed to improving the quality of life for all Commonwealth residents, while working towards eliminating the marginalization and inequities that threaten the lives of communities of color."

Our Core Values

Sexual and Reproductive Health Program (SRHP) Core Values recognize that **structural racism is embedded in the history and practices of the health care system**, that coercive and oppressive practices by the health care system extend into sexual and reproductive health care, and that racism embedded in these historical practices has engendered inequities in health outcomes for and a distrust of health care systems by people of color. This includes health care systems that provide sexual and reproductive health (SRH) services.

We acknowledge that historical oppression is the root cause of health disparities and inequities, specifically systemic racism, sexism, misogyny, homophobia, ageism, xenophobia, and ableism. **We emphasize that oppression (racism) and not circumstance (race) is the risk factor.**

The SRHP Core Values are incorporated in every expectation throughout the standards. This appendix contains definitions of the values.

Definitions

Racial Justice

"Racial justice is the systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice — or racial equity — goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures."[70,71]

[70] https://neaedjustice.org/wp-content/uploads/2018/11/Racial-Justice-in-Education.pdf;
[71] https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf

Racial Justice in Practice: **The Sexual and Reproductive Health Program acknowledges that racism is a public health crisis.** Therefore, we as a program are committed to dismantling White Supremacy Culture (WSC) and achieving racial justice in all aspects of sexual and reproductive health care. As described in *White Supremacy Culture—Dismantling Racism,*[72] "one of the purposes of listing characteristics of white supremacy culture is to point out how organizations which unconsciously use these characteristics as their norms and standards make it difficult, if not impossible, to open the door to other cultural norms and standards. As a result, many of our organizations, while saying we want to be multi-cultural, actually only allow other people and cultures to come in if they adapt or conform to already existing cultural norms. Being able to identify and name the cultural norms and standards you want is a first step to making room for a truly multi-cultural organization."

"Diversity without structural transformation simply brings those who were previously excluded into a system as racist, misogynist, as it was before." – Angela Davis

Reproductive Justice

Reproductive Justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities. It is a political movement that brings together reproductive rights with social justice.[73]

From *Introduction to Reproductive Justice*, by Loretta Ross and Rickie Solinger:
"Once more drawing from the histories of their peoples, their families, and their communities, reproductive justice activists maintained that reproductive safety and dignity depended on having the resources to get good medical care and decent housing, to have a job that paid a living wage, to live without police harassment, to live free of racism in a physically healthy environment – all of these (and other) conditions of life were fundamental conditions for reproductive dignity and safety – reproductive justice – along with legal contraception and abortion. ***The first reproductive justice activists explained that the right to reproduce and the right not to – the right to bodily self-determination – is a basic human right, perhaps the most foundational human right****."*[74]

The Reproductive Justice framework was created by Black feminists in the 1990s, but the advocacy and ideas it came from have existed for much longer. Reproductive Health and Reproductive Rights organizations historically were led by white women and did not center how racism impacts women of color's experiences in trying to maintain and support their reproductive health.

[72] Microsoft Word - Okun - white sup culture.doc (whitesupremacyculture.info)
[73] Reproductive Justice, SisterSong. SisterSong.net
[74] Ross, Loretta and Rickie Solinger. Reproductive Justice: An Introduction, University of California Press, 2017, p. 56.

- The Pillars of Reproductive Justice:
  - The right not to have a child[75]
  - The right to have a child[76]
  - The right to parent children in safe and healthy environments[77]
  - The right to disassociate sex from reproduction and that health sexuality and pleasure are essential components to whole and full human life,[78] which is inclusive of LGBTQ+ folks and upholds sexual autonomy and gender freedom for every human being.[79]

Health Equity

Health Equity is the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[80]

- **Health equality** means that everyone is given the same health intervention without consideration of underlying needs.
- **Health disparities** are significant differences in health outcomes between populations.
- **Health inequalities** are the unjust distribution of resources and power between populations which manifests in disparities.
- **Health equity** means that everyone has what they need to attain their highest level of health.

Data-Driven and Evidence-Based

Data-driven refers to programming determined by or dependent on the collection or analysis of data.[81]

- It is important to note that while we believe in data-driven programs, we must interrogate how the data is collected/what is being asked in the first place. Research that is not inclusive will not generate useful results for a wide variety of populations. For example, racial and reproductive justice research by people of color, about people of color, is often excluded from the quantitative and qualitative literature. In our evaluation of community need and client satisfaction, SRH programs have the

[75] Ross, Loretta and Rickie Solinger. Reproductive Justice: An Introduction, University of California Press, 2017, p.9.
[76] Ibid
[77] Ibid
[78] https://www.ansirh.org/staff-members/monica-mclemore
[79] Ross, Loretta and Rickie Solinger. Reproductive Justice: An Introduction, University of California Press, 2017, p.9
[80] U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010 [Internet]. Chapter 1: Introduction. Available from: http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34
[81] Oxford English Dictionary definition of "Data-driven," accessed 7 December 2020.

opportunity to center racial and reproductive justice by supporting community-based participatory research, qualitative methods, and storytelling.

A primary reason for data collection should be for the purpose of identifying the drivers of inequity in health outcomes and intervening to eliminate them.

Evidence-based means that SRH clinical and counseling services are provided in accordance with current, continuously updated, research-informed practice recommendations published by nationally recognized professional organizations. A list of current evidence-based care recommendations and community education curricula are provided in the main body of this document.

Sustainability

Sustainability, in the context of SRH, refers to an organization's ability to provide services now and into the future. It is a state of organizational health that allows one to meet one's strategic and operational goals, maintain long-term fiscal health, and be accessible for both clients and staff. Sustainability is achieved by including these principles into service provision and by developing strategies to:

- Include multiple mechanisms for significant, meaningful, compensated community input on all aspects of the program
- Assess the environment and adapt to change
- Increase capacity both within and outside their organizations
- Maintain and expand partnerships
- Create new strategic cross-sectoral partnerships
- Explore diverse funding opportunities

On-going sustainability for sexual and reproductive health programs also includes:

- Adequate budgeting and distribution of funds to meet program goals
- Functional and adaptable EMR, data, and reporting systems
- Timely revenue cycle management systems
- Sound and achievable operational goals
- Clinical care responsive to the needs of the community
- A commitment to staff training

Trauma-Informed Care

The trauma-informed[82] program realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families,

[82] https://www.thenationalcouncil.org/wp-content/uploads/2020/04/Trauma-Informed-Approaches-Practical-Strategies-for-Integrated-Care-Settings-11.30.17.pdf?daf=375ateTbd56

staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.

- Principles in the trauma-informed approach include:
  - Centering safety
  - Maintaining trustworthiness and transparency
  - Opportunities for peer support
  - Valuing collaboration and mutuality
  - Upholding empowerment, voice, and choice
  - Having an awareness of historical, cultural, and gender issues

Confidential, Youth-Friendly Care

All adolescents, including minors, are able to consent for and receive confidential, comprehensive sexual and reproductive health clinical and counseling services in a welcoming, non-judgmental environment. See **Adolescent Sexual and Reproductive Health Care** and **Clinical Staff Competencies.**