GEORGIA’S
TITLE X
FAMILY PLANNING
SERVICES MANUAL

Georgia Department of Human Resources
Division of Public Health
Family Health Branch
Office of Women’s Health Services

November 2006
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FAMILY PLANNING

SERVICES MANUAL


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INTRODUCTION

The Georgia Department of Human Resources (DHR) is the single grantee for Title X funds in Georgia. The Georgia Family Planning Program, located in the Division of Public Health’s Family Health Branch (FHB), provides high-quality family planning services and related preventive health care to improve the health of women and infants and to enable families to plan and space their children. While the target population for the program is low-income or uninsured individuals, the program serves all who want and need services. The State Program serves as the umbrella organization for the provision of services through Georgia’s 159 county health departments under the supervision of eighteen district health offices.

This manual is intended for use as a reference for delegate agencies of DHR to assure that family planning services are provided to clients in accordance with the Program Guidelines for Project Grants for Family Planning Services developed by the Office of Population Affairs, U.S. Department of Health and Human Services, Title X law and implementing regulations.
Chapter 1

GEORGIA FAMILY PLANNING HEALTH PROGRAM

PROGRAM OVERVIEW

The mission of the Georgia Family Planning Program is to assure that all women and men in Georgia will have knowledge of and access to opportunities for optimal health including the opportunity to plan and space their children to improve the health of individuals and families.

Family planning is essential to the well-being of women, men, adolescents, and the community at large. It offers individuals opportunities to plan and space their pregnancies in order to achieve personal goals and self-sufficiency.

In keeping with its mission, the Georgia Family Planning Program has developed strategies and implemented services directed toward the reduction of unintended pregnancies and improvement of birth outcomes.

Goals

The following goals have been developed to accomplish the mission of the Family Planning Program:

- To reduce unintended pregnancies in order to avoid the poor outcomes (health, social, and economic) related to unintended pregnancies.
- To improve birth outcomes through preconception health promotion.
- To promote the health of mothers by providing basic reproductive health care to women in need.

The Georgia Family Planning Program is often the main source of health information and clinical service for many Georgia women and represents a critical point of entry into the public health system. The Georgia Statewide Family Planning Program was first approved for funding in 1972. Georgia Department of Human Resources (DHR) is the single grantee in the State of Georgia for Title X funds. District and County Health Departments are the primary implementation units of the public health system in the State.
State Health Office

Program funds are distributed to the 18 District Health Offices and other delegate agencies in Georgia to provide Family Planning services to the local community. The state Family Planning staff provides the following services for the District Health offices and County Health Departments:

► Monitors and provides technical assistance
► Develops manuals, policies and protocol
► Provides or arranges for staff training related to family planning
► Conducts quality assurance activities utilizing standardized procedures

District Health Office

The eighteen district health offices serve as a liaison between the state Family Planning Office and the county health departments. They provide the following services:

► Interpret policies and procedures
► Coordinate training and assure training opportunities
► Manage funding for supplies and patient benefits
► Conduct quality assurance activities utilizing standardized procedures
► Provide staff to assist in the provision of family planning services

County Health Departments and Other Grantees

The 159 county health departments and 260 service delivery sites within the counties provide comprehensive family planning program services for low income men, women and adolescents. Family planning services are well integrated with numerous other health department services (e.g., immunizations, prenatal services and/or referrals, sexually transmitted infection services and HIV testing) to improve the comprehensiveness of the health care provided.

Family planning service providers in Georgia include the following:

► Expanded role nurses – registered nurses (RN) who have received additional training that prepares them to safely provide family planning services
► Advanced practice registered nurses (APRNs) including nurse practitioners and nurse midwives
All required Title X family planning services are available at service delivery sites. In sites where certain family planning methods, such as IUDs are not available, a referral system is in place to assure that the client receives the desired family planning services.

No client is denied services based on inability to pay. The target population for subsidized family planning services includes all female adolescents at risk of unintended pregnancy regardless of their income and women (ages 20-44) at or below 150 percent of the Federal poverty level.

Additional information about the Georgia Family Planning Program can be found at:

http://health.state.ga.us/programs/familyplanning/index.asp

- **Georgia's Family Planning Program Facts at a Glance, Fiscal Year 2005**
  Presents an overview of the Georgia Family Planning Program's services and clients and is based on data submitted by a network of 276 clinic sites across the state.

- **Family Planning Program Fact Sheet**
Overview

Program Guidelines for Project Grants for Family Planning Services have been developed by the Office of Population Affairs (OPA), U.S. Department of Health and Human Services (DHHS), to assist current and prospective grantees in understanding and utilizing the family planning services grants authorized by Title X of the Public Health Service Act, 42 U.S.C. 300, et seq. The Office of Population Affairs also provides more detailed guidance, updated clinical information and clarification of specific program issues in the form of periodic Program Instructions to the Regional Offices.

To enable persons who want to obtain family planning care to have access to such services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572), which added Title X, "Population Research and Voluntary Family Planning Programs," to the Public Health Service Act. Section 1001 of the Act (as amended) authorizes 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 for adolescents). The mission of Title X is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children.

The document, Program Guidelines for Project Grants for Family Planning Services (January 2001), interprets the law and regulations in operational terms and provides a general orientation to the Federal perspective on family planning. The hyperlinks below are an official part of this Family Planning Manual. Districts and clinics should have them available locally by internet or download and incorporate into this manual. Districts and clinics are responsible for being able to locate this material easily for reference or quality assurance audits.

A copy of the Program Guidelines is located at:

The Office of Population Affairs home page is:
http://opa.osophs.dhhs.gov/titlex/ofp.html
2006 Family Planning Program Priorities and Legislative Mandates, Key Issues:  

The Office of Population Affairs also provides more detailed guidance, updated clinical information and clarification of specific program issues in the form of periodic Program Instructions to the Regional Offices. These Program Instructions can be accessed at:  
Chapter 3

GEORGIA FAMILY PLANNING PROGRAM

FINANCIAL MANAGEMENT

Districts are responsible for the implementation of policies and procedures for charging, billing and collecting funds for the services provided by the program. The policies and procedures should be approved by the State office.

Definition of Terms

The following definitions are set forth to insure that there is not any misunderstanding of commonly used terms or concepts and to provide definitions of key components of the family planning fee system.

Client: Any person who is receiving or requesting family planning services provided by the county Boards of Health and contract agencies

Department: The Georgia Department of Human Resources

Self-declaration: Allowing clients to attest to their income instead of submitting documents such as pay stubs or tax statements to prove their income.

Ability to Pay: Determined by assessment of current Federal poverty level using annual gross income and family size.

Family:

(1) One or more adults and children, if any, related by blood or law, and residing in the same household

Where adults, other than spouses, reside together, each may be considered a separate family. Minors seeking family planning services without parental consent shall be considered one-person families.

(2) Emancipated minor: adolescent is self supporting and income determination would be the same as an adult.

Annual Gross Income: The sum of income available to an individual or family on an annual basis, prior to any deductions or discounts
Guidelines for Billing and Collection

The 2001 edition of the Program Guidelines for Project Grants for Family Planning Services states in part: “A grantee is responsible for the implementation of policies and procedures for charging, billing, and collecting funds for the services provided by the project. The formulation of billing and collection policies and procedures should be a collaborative process involving different levels of staff, knowledgeable board members, and the agency’s accountant. The policies and procedures are approved by the governing board or advisory board and the Regional Office”. The following guidelines for billing and collection MUST be adhered to:

► Districts must have written billing and collection policies and procedures, which are approved by the State office. The written billing and collection policies and procedures must include a procedure for aging outstanding accounts receivable. The Federal regulations suggest that accounts be written off in 15 months.

Title X regulations require that delegate agencies make an effort to collect on all outstanding accounts and that a method for aging outstanding accounts be established. Refer to Section 6.3 (10) of the Guidelines. It is suggested that the agency implement an aging system representing 30, 60, 90, 120, 180 days and 1 year. The “Aging Report” should be generated on a monthly basis and should show the 30 days to 1 year spread. The Aging Report is a management tool that allows administrative and financial management to monitor how their revenue collection system is working for the agency. It is also suggested that agencies write off outstanding self-pay accounts $25.00 or less after 180 days and all other accounts after 13-15 months. It is also important to age 3rd party bill accounts to determine if they are being processed in a timely and correct manner. Outstanding Medicaid billings over 6 months old would indicate problems in the billing process.

► Financial management should adhere to the characteristics set forth in Section 6.3 of the Program Guidelines for Project Grants for Family Planning Services (January 2001).

► All persons seeking family planning services must be assessed a fee in accordance with the DHHS approved family planning sliding fee schedule which is updated by the district annually.

► Services for clients holding valid Medicaid cards must be billed to the Division of Medical Assistance.

► The Family Planning Program will post its Fee Schedule in a public area, with a notation that discounts are available based upon need, or a notice will be posted that such information is available at the front desk of the clinic.
► It is **not allowable to have a general policy of no fees, flat fees or a minimum fee** for the provision of services.

► A residency requirement is not allowable. Family Planning services **MUST** be provided to any person wanting and needing this service.

**Guidelines for Income Assessment**

Each client must have his/her income assessed and documented in his/her record at least annually. The following are instructions for performing the financial assessment:

**Income Inclusions**

► Monetary compensation for services, including wages, salary, commissions, or fees

► Net income from farm and non-farm self employment

► Social Security benefits and/or Supplemental Security Income (SSI)

► Dividends or interest on savings or bonds, income from estates or trusts, or net rental income

► Public assistance or welfare payments

► Unemployment compensation

► Government civilian employees or military retirement, pensions, or veterans’ payments

► Private pensions or annuities

► Alimony or child support payments

► Regular contributions from persons not living in the household

► Basic Allowance for Subsistence (BAS) is cash payment added to base pay and is counted as part of all cash income for military families

► Net royalties

► Other cash income including, but is not limited to, cash amounts received or withdrawn from any source including savings, investments, trust accounts, and other resources which are available to the family (e.g., money from friends and relatives).
Proof of income **may be requested but cannot be required** in order to receive family planning service. For clients without documents proving income, a document for self-declaration of income **MUST** be available. Documentation of income is a particularly difficult requirement for low-income individuals and families whose work is often informal and episodic.

**Violation of Title X Law and Regulations**

The following actions are violations of Title X Law and could result in paying back funds and/or an audit. **Districts cannot:**

► Require any type of ID in order to receive family planning services (photo, driver’s license, birth certificate, etc.)

► Require proof of the following:
  - Citizenship
  - Residency in county where service occurs
  - Income, including tax statements, pay stubs, letters from employers

► Charge full fees when clients do not bring proof of income or proof of insurance. Clients must be allowed to self-declare income.

► Reschedule appointments when clients do not bring documents proving income, residency, etc.

► Charge minimum fees. All fees must slide to zero.

► Require a donation for service.

District Health Directors are required to sign the Georgia Division of Public Health, Assurance of Compliance acknowledging assurance of the above Title X Law and Regulations. A copy of the form can be found at the end of this section.

**Use of Fees Collected**

All monies collected as family planning fees must be retained by the family planning services provider.

**Family planning fees collected must be used to expand, improve, or offset the costs of the family planning service delivery system** as documented by agency FPAR and time studies.
Sliding Fee Schedule

A fee will be assessed using the sliding fee schedule. The only allowable fees for family planning clients, regardless of income level, are the fees established in the Sliding Fee Schedule. No local health department or contract agency of family planning services may charge a registration or mandatory donation fee for these services.

The Georgia Family Planning Health Program will update the sliding fee schedule based on the cost to the program for providing specific family planning services and in accordance with federal regulations for charging fees for these services.

The current federal poverty income guidelines and fee schedule (updated yearly) are located at http://aspe.hhs.gov/poverty/. The Georgia Family Planning Program begins using the new Federal Poverty Income Guidelines as soon as they are posted on the Department of Health and Human Services (DHHS) Federal Register (usually in January or February).

Non-Medicaid Clients

Family planning clients will be assessed a fee depending on their family size, determined income, and type of service visit. Some clients will fall into the no fee category because of limited income. These clients cannot be refused service because of inability to pay. However, donations may be solicited but not required in these cases.

Provider agencies must provide a receipt to assist clients in securing any third party benefits for which they may be eligible.

Medicaid Clients

All persons who have been certified for Medicaid are told that the cost of services will be covered by Medicaid and Medicaid eligibility status is entered on the family planning record. Provider agencies should bill Medicaid for the full cost of services provided to each Medicaid client. All Medicaid financial activity must be recorded in the fee for service system. Should a Medicaid service be denied for payment as ineligible, the fee for this service should revert to the patient fee system.


Financial Accountability

The process of determining the income level, family size, and discount group is typically done during the early stages of the client’s clinic visit. Usually, the type of visit will be known upon the client's arrival at the clinic. It is against Federal regulations to charge family planning clients clinic registration or any other fees in addition to or in lieu of fees.
based on the family planning sliding fee schedule.

It is the option of clinic management staff to bill the family planning client either before or after delivering services. However, services may not be denied to clients who are unable to pay at the time of the clinic visit.

At times it may be difficult to distinguish between a no charge visit and a medical visit. Therefore, it is suggested that the fee for the medical visit be collected at the end of the visit after a medical professional has determined the visit type.

Clients must be given a receipt for services provided. The receipt should have a unique, chronological number and contain at least the following information:

► Name of client
► Date of service
► Type of service
  • Type of visit
  • CPT code
  • Diagnostic code (if applicable)
► Full cost of service
► Discounted fee for services this date
► Amount owed from previous visits
► Total amount of fees owed
► Amount paid on this date
► Balance of fees owed

Provider - Client Relationships

Family planning programs in Georgia and other states have found that if clients understand certain important facts, they have little difficulty adjusting to the fee system. In fact, many clients will feel more at ease about receiving their family planning services because they are sharing in the cost of the service rather than receiving the service as a benefit of charity.
Clients should be given the following information:

► Inform clients in advance of their clinic visit that there will be a fee for the services. If at all possible, clients should know the amount of the fee at 100% pay for the service requested, so they can come to the clinic prepared to pay.

► Inform clients that they are expected to pay the full amount due at the time of service.

Talking with Clients

Knowledge of the fee system is every clinic employee’s responsibility. The client may ask anyone a question regarding fees, and all family planning staff should be able to answer these questions.

Regardless of whom clients ask, there are several important things to keep in mind. Clients are often affected by:

► the way information is given

► the amount of information that is given.

► the tone of voice used by the staff.

► the non-verbal communications given by staff, such as facial expressions.

Consistency is fairness - all must give the same information.

Staff must be able to communicate effectively with clients and must understand that under no circumstances are they to turn anyone away because they are unable to pay on the date service is received. The success of the fee system is largely dependent upon the positive attitude and presentation of staff. The program’s objective is to serve the citizens of the State of Georgia by providing quality family planning services to all who desire them.

By understanding that it costs a great deal of money to provide these services and by knowing the sources of funding, staff can better explain the reasons for fees to their clients.
SAMPLE TEMPLATE
PATIENT INFORMATION AND INCOME DECLARATION

TODAY’S DATE: ____________

GUARDIAN’S OR PARENT’S NAME: __________________________________________________________________________ (if applicable)

PATIENT’S NAME: _______________________________________________________________________________________

                  Last                                    First   Maiden

ADDRESS: ________________________________________________________________________________________________

CITY: ___________________________________________STATE: ___________ ZIP CODE: __________

HOME PHONE: ________________ WORK PHONE: ________________ CELL PHONE: ________________

HOW CAN WE CONTACT YOU? CHECK ALL THAT APPLY:

  _____ MAIL  _____ HOME PHONE  ____ CELL PHONE  _______ WORK PHONE

DATE OF BIRTH: ______________

Male: ___ Female: ___


                Asian:____ Native American: ____ Hawaiian/Pacific Islander: ____ Multi-Racial: ____

Medicaid:   Yes ___ No ____              PeachCare:    Yes ____ No _____
Medicare:       Yes ___ No ____               Private Insurance:  Yes_____ No ____

___________________________________________________________________________________

NOTE: Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in household: __________

Total family income: $______________ per Week or Month or Year (Circle one).

___________________________________________________________________________________

CONSENT & STATEMENT OF ACCURACY OF INFORMATION PROVIDED
I consent for services to be performed by the ___________________. I understand I am responsible for full payment of Boards of Health scheduled fees in cash or by credit or debit cards at the time of service unless I qualify for special discounted fees certain programs offer. Discounted fees are based on my and/or my household’s income and number of dependents, which I have provided truthfully and accurately above.

Signature: ________________________________________________ Date: ____________

Patient, Parent or Guardian’s Signature
In addition to TITLE X ASSURANCE OF COMPLIANCE (Exhibit C, Revised 03/98)

__________________________ assurances that it will:

(Name of Organization)

1. Not require residency in the county where family planning service is provided.

2. Not require a photo or other form of identification in order to receive family planning services.

3. Not require documents for proof of income in order to receive family planning services.

4. Base client charges for family planning services on income assessment and a sliding fee schedule approved by Georgia Division of Public Health Office of Women’s Health Services.

5. Not charge a minimum fee for family planning service

__________________________

(Signature)

__________________________

(Title)

__________________________

(Date)

DPH 06/23/d

7/12/06
The services provided to family planning clients will depend on the type of visit and the nature of the service requested. The word “must” indicates mandatory and “should” indicates recommended.

**History**
At the initial comprehensive clinical visit, a complete medical history **MUST** be obtained on all clients. Pertinent history **MUST** be updated at subsequent clinical visits.

- The comprehensive **medical history MUST** address at least the following areas:
  - Significant illnesses; hospitalizations; surgery; blood transfusion or exposure to blood products; and chronic or acute medical conditions;
  - Allergies
  - Current use of prescription and over-the-counter medications;
  - Extent of use of tobacco, alcohol, and other drugs;
  - Immunization and Rubella status;
  - Review of systems;
  - Pertinent history of immediate family members; and
  - Partner history
    - injectable drug use
    - multiple partners
    - risk history of STDs and HIV
    - bisexuality
Histories of reproductive function in female clients MUST include at lease the following

- Contraceptive use past and current (including adverse effects);
- Menstrual history;
- Sexual history;
- Obstetrical history;
- Gynecological conditions;
- Sexually transmitted diseases including HBV;
- HIV
- Pap smear history
  - Date of last pap
  - Any abnormal Pap and
  - Treatment
- In utero exposure to diethylstilbesterol (DES)

Histories of reproductive function in male clients MUST include at least the following:

- Sexual history;
- Sexually transmitted diseases, including hepatitis B virus (HBV)
- HIV; and
- Urological conditions

Physical Assessment

Female

An initial complete physical examination should be performed that includes examination of the following:

- Thyroid
• Heart and lungs
• Extremities
• Breasts
• Abdomen
• Pelvis and rectum
• Height and weight

Family Planning clinics **MUST** provide and encourage clients to use health maintenance screening procedures, initially and as indicated. Clinics **MUST** provide and stress the importance of the following to all clients:

• Blood pressure evaluation;
• Breast exam
• Pelvic examination which includes vulvar evaluation and bimanual exam;
• Pap smear:
• Colo-rectal cancer screening in individuals over 40; and
• STD and HIV screening, as indicated.

Following counseling about the importance of the above preventive services, if a client chooses to decline or defer a service, this should be documented in their record. Counseling **MUST** include information about the possible health risks associated with declining or delaying preventive screening tests or procedures.

All physical examination and laboratory test requirements stipulated in the prescribing information for specific methods of contraception must be followed. Physical examination and related prevention services should not be deferred beyond 3 months after the initial visit, and in no case may be deferred beyond 6 months, unless in the clinician's judgment there is a compelling reason for extending the deferral. All deferrals, including the reason(s) for deferral, **MUST** be documented in the client record.
- **Male physical assessment**
  Physical assessment should be made available to male clients that include the following:
  - Height and weight
  - Thyroid
  - Heart and lungs
  - Breasts
  - Abdomen
  - Extremities
  - Genitals and rectum (including instructions in self-examination of the testes)
  - Palpation of the prostate, as appropriate

Clinics should stress the importance of the following to male clients:
  - Blood pressure evaluation;
  - Colo-rectal cancer screening in individuals over 40; and
  - STD and HIV screening, as indicated

► **Laboratory Testing**
Specific laboratory tests are required for the provision of specific methods of contraception. The following laboratory procedures **MUST** be provided to clients if required in the provision of a contraceptive method, and may be provided for the maintenance of health status and/or diagnostic purposes.

- Laboratory tests that **MUST** be provided on-site or by referral
  - Anemia assessment
  - Gonorrhea and Chlamydia test
  - Vaginal wet mount
  - Diabetes testing
- Cholesterol and lipids
- Hepatitis B testing
- Syphilis serology (VDRL, RPR)
- Rubella titer
- Urinalysis
- HIV testing
- Other laboratory services or procedures may be indicated for some clients

- Pregnancy testing MUST be available on-site
- Notification of Abnormal Lab Results

A procedure which addresses client confidentiality MUST be established to allow for client notification and adequate follow-up of abnormal laboratory results.

► Revisits

Revisit schedules must be individualized based upon the client’s need for education, counseling, and clinical care beyond that provided at the initial and annual visit.

Clients selecting hormonal contraceptives, intrauterine devices (IUDs), cervical caps, or diaphragms for the first time should be scheduled for a revisit as appropriate after initiation of the method to reinforce its proper use, to check for possible side effects, and to provide additional information or clarification. A new or established client who chooses to continue a method already in use need not return for this early revisit unless a need for reevaluation is determined on the basis of the finding at the initial visit.

When providing family planning services for clients with Medicaid, providers MUST follow the Policies and Procedures for Family Planning Services from the Georgia Department of Community Health, Division of Medical Assistance. Some of these requirements for service may differ from Title X Guidelines. A table which indicates the required services for Title X and for the Division of Medical Assistance can be found at the end of this section. The current provider manual for Family Planning Services can be found at the following site: https://www.ghp.georgia.gov/wps/portal
## FAMILY PLANNING REQUIREMENTS – TITLE X and MEDICAID

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### Lab work (performed on site)

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<td>36415</td>
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<td>81000</td>
<td>Urine dipstick</td>
<td>X^2</td>
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<td>Fecal occult blood test – over age 40</td>
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### Lab Tests (sent to outside lab)

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### Counseling

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### Teens (Adolescents) Only

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X = Required

1. See Women’s Health Protocol for deferral requirements for PE and lab.
2. If indicated based on client history, symptoms or the professional’s judgment or if required in the provision on contraceptive method.
3. If indicated based on screening criteria in GA DHR Cervical Program Manual 6/06.
4. Age 29 and under per DHR guidelines & if medically indicated by history or symptoms.
5. Counseling/education on all methods required on initial visit to make informed consent. Method specific consent required at initiation of prescriptive method or when there is a major in health history.
6. If client requests referral for sterilization.
Chapter 5

GEORGIA FAMILY PLANNING PROGRAM

CLIENT EDUCATION AND COUNSELING

The Georgia Family Planning Program, in compliance with Title X guidelines, provides relevant education and skilled counseling based on client's knowledge base, needs, and characteristics including age, language, cultural background, literacy, emotional state and readiness for behavior change. Education and counseling should be presented in an unbiased manner. Education and/or counseling can be provided through verbal, written and/or audio-visual methods and can be presented in a group or one-on-one setting by a knowledgeable health educator, counselor, or nurse. The purpose of counseling is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. A mechanism to determine that the information provided has been understood and individualized based on the above federal requirements should be established and documented. The above client education **MUST** be documented in the client’s chart.

**Education during the Initial Visit**

The following information **MUST** be provided to all clients; during the initial visit and individualized, based on the assessment of client’s current knowledge base and needs:

► Appropriate information so that informed decisions can be made about family planning;

► General benefits of family planning services and contraception for family and individual health;

► Information on how all available methods of contraception work, their effectiveness, risks and benefits;

► How to perform breast/testicular self examination;

► Risk reduction strategies for sexually transmitted infections and human immunodeficiency virus (HIV); all clients must receive thorough and accurate education and counseling on STIs and HIV. This includes individualized dialogue with a client in which there is a discussion of personal risks for STIs/HIV and steps to be taken by the individual to reduce risk, if necessary. Staff should receive training to provide HIV risk assessment, counseling and testing. If these services are not available onsite the clinic must provide the client with a list of health care providers who can provide these services.
The range of available services and the purpose and sequence of clinic procedures; and

The importance of recommended screening tests and other procedures involved in the family planning visit.

The client should be offered in addition to the above mandatory educational requirements the following information about basic female and male reproductive anatomy and physiology. Additional information, based on client needs, should include the following information on reproductive health and health promotion/disease prevention:

- Preconception counseling
- Interconception counseling
- Genetic concerns
- Immunizations
- Nutrition
- Exercise
- Smoking cessation
- Substance use and abuse
- Domestic violence
- Sexual abuse
- Sexual concerns
- Mental health concerns

Adolescent Clients

It is particularly important that adolescent clients receive skilled counseling information and that is age appropriated and based on client’s emotional status and readiness for behavior change. In addition to the educational information required for all clients, Title X requires that adolescents MUST be counseled on the following:

- Postponing sexual involvement and abstinence as contraceptive options;
Ways to reduce the risk of STI/HIV;
Resisting attempts to be coerced into sexual activities; and
Encouraging family participation in the decision of the minor to seek family planning services.

The above required counseling for adolescents, **MUST** be documented on the client’s record.

**Identification of Estrogen-Exposed Offspring**

Diethylstilbesterol (DES) became available for medical use in the 1940s. On the basis of an encouraging research report, physicians prescribed DES for some pregnant women in an attempt to prevent miscarriage. Later research indicated that DES does not prevent miscarriage and its use declined after 1955. In the 1970s the first study was published that demonstrated the link between DES and vaginal cancer in daughters of women who took DES during pregnancy. In November 1971, the Food and Drug Administration recommended that DES no longer be used during pregnancy. We now know that DES exposure may have harmful effects on daughters, sons, and women treated with DES.

Consider the possibility of DES exposure if:

- The client was pregnant or conceived between 1940 and 1975, especially between 1950 and 1960;
- The client or client’s mother had bleeding during early pregnancy or had a previous miscarriage (spontaneous abortion), or diabetes; or
- The client or her mother took oral medication during pregnancy.

**Possible Effects to Daughters of Women Treated with DES during Pregnancy**

- vaginal cancer (clear cell adenocarcinoma)
- dysplasia of the cervix
- structural abnormalities of the cervix and vagina
- adenosis
- menstrual irregularity and low fertility level
Possible Effects to Sons of Women Treated with DES during Pregnancy

► abnormal genital development
► impaired sperm production

For more information on DES exposure:
http://www.cdc.gov/des/consumers/download/know4_effects.pdf

Toxic Shock Syndrome (TSS): Reducing the Risk

Toxic Shock Syndrome (TSS) is a rare but potentially fatal disease that, when related to menstruation, occurs most frequently in young women aged 15 to 24, usually in association with tampon use. For additional information see FDA Publication No. 98-1196 which can be found at http://www.fda.gov/bbs/topics/consumer/con00116.html.

Clients should be given the following information regarding TSS symptoms:

► Remove your tampon if you are using one and get medical help right away if you have the following symptoms during menstruation:
  • sudden fever—102 degrees Fahrenheit (38.9 degrees Celsius) or higher
  • vomiting
  • diarrhea
  • muscle aches
  • dizziness, fainting, or near fainting when standing up
  • a rash that looks like a sunburn

► Symptoms may not appear until the first few days after the end of the menstrual period. Early diagnosis and speedy treatment are crucial to avoiding the most serious effects of TSS.

Method Counseling

Method counseling refers to an individualized dialogue with a client that covers the following:

► Informed consent
  Clients should be given information about their complete range of contraceptive
options and allowed to choose freely. Once clients choose a method, provide complete information about their choice. Only when these steps have been completed can the client make an informed decision and give consent by signing the consent form.

The mnemonic “BRAIDED” outlines the **steps of informed consent**:

- **B**enefits of the method
- **R**isks of the method (both major risks and all common minor ones), including consequences of method failure
- **A**lternatives to the method (including abstinence and no method)
- **I**nquiries about the method are the client’s right and responsibility
- **D**ecision to withdraw from using the method without penalty is the client’s right at any time
- **E**xplanation of the method is owed the client, in a format that is understandable to the client
- **D**ocumentation that the provider has ensured understanding of each of the preceding six points, usually by use of a consent form.

**The booklet, Family Planning Program, by Channing Bete** is used to assist in providing information to clients regarding the family planning visit and contraceptive options. The booklet is available in English and Spanish.

The client should be given the booklet, *Family Planning Program*, to read while waiting for the educational session and/or medical history interview. The person who obtains the medical history is the logical person to review information in the booklet with the client to assure that the client understands the following: information about the Family Planning Program; clinic services; the male and female reproductive health systems; contraceptive choices; sexually transmitted infections and condom use; the Pap test or the testicular exam; the breast exam and preconception health. If someone other than the person taking the medical history is responsible for obtaining client consent, this should be specified in District procedures for obtaining Informed Consent. The clinician should discuss specific medical questions with the client and determine that the client understands information regarding the chosen contraceptive method. The booklet should be given to the client for future reference. Refer to the end of this chapter for information about how to obtain copies.
of the *Family Planning Program*.

**Form 3700 (8/04) REQUEST FOR AND CONSENT TO FAMILY PLANNING SERVICES** is used for documentation of voluntary consent to receive family planning services and **MUST be signed by the client prior to receiving medical services.** The form should be written in the primary language of the client or witnessed by an interpreter.

The signed original of Request For and Consent to Family Planning Services form 3700 is filed in the client’s record and a copy is given to the client. **Form 3700 is required.** Use of method specific informed consent in addition to Form 3700 is also required for prescriptive contraceptive methods. The original signed copy is filed in the client’s chart and a copy of the consent is given to the client.

Form 3700 should be renewed and updated:

- When there is a major change in the client’s health status or a change to a different prescriptive contraceptive method; or
- When client returns for medical services after being inactive for 15 months or longer.

See the end of this section for a copy of Form 3700 Request For and Consent to Family Planning Services.

**Method Specific Consent for Prescriptive Contraceptive Methods** **MUST** be signed by the client

- At initiation/re-initiation of the method
- When there is a major change in the client’s health history

For the most current versions of the method specific consent forms, contact the State Office of Women’s Health Services, Family Planning Program.

**Post-assessment Counseling**

The counselor **MUST** be sufficiently knowledgeable to provide accurate method-specific information. The counselor must also be knowledgeable about the other services offered by the health department and available community resources.

Post-assessment counseling includes the following:
► Results of physical assessment and lab results
► Planned return schedule
► Emergency 24 hour telephone number
► Location where emergency services can be obtained; and
► Appropriate referral for additional services as needed including name and number of provider; client responsibility in complying with referral; importance of referral, and, agreed-upon method of follow-up

**Family Planning Publications and Forms: Education and Counseling**

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<tr>
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<td>Request For and Consent to Family Planning Services (available from State Office of Women’s Health Services, Family Planning Program)</td>
</tr>
<tr>
<td>NA</td>
<td>Family Planning Program (Channing Bete) available through the State Office or directly from Channing Bete at 1-800-477-4776.</td>
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The Office of Population Affairs Clearinghouse distributes Department of Health and Human Services (DHHS) -produced client and professional educational materials. All publications are free of charge in limited quantities. Publications can be ordered by email or downloaded at [http://opa.osophs.dhhs.gov/pubs/publications.html](http://opa.osophs.dhhs.gov/pubs/publications.html).
REQUEST FOR AND CONSENT TO FAMILY PLANNING SERVICES

NAME_____________________________________________ CLINIC______________________________________________________

NOTE: Information you give to any staff person and the services you receive here will be held in confidence. The clinic will not provide information about you to anyone unless you give your permission. However, state law requires the clinic to report any suspected cases of sexual coercion or abuse to the appropriate authorities. You will receive sexual coercion and/or abuse counseling and will be informed if a report or referral is made to the authorities.

I do not wish to become pregnant at this time. The benefit of choosing a method of birth control is that I will be better able to delay pregnancy until it is desired.

A. I understand that I may receive a physical examination which is necessary for the birth control method I have chosen which may include one or more of the following tests:

1. HIV testing
2. Blood test for anemia, hepatitis, syphilis, cholesterol and others if indicated
3. Urine test - sugar and bacteria if indicated
4. Pregnancy test if indicated
5. Blood pressure
6. Breast exam, abdominal exam and pelvic exam
7. Pap smear for cancer of the cervix (mouth of the womb)
8. Other tests such as screening for gonorrhea and chlamydia if indicated

B. The different methods of preventing pregnancy have been explained and I have chosen________________________ as my birth control method. I understand that I may change this method to another method provided there are no medical indications to the contrary. Also, I may discontinue using any birth control method if I wish to become pregnant. Instructions for the use of my chosen method have been given to me and I have also been given the following written materials which provide additional information:

“METHODS OF CONTRACEPTION” SPECIFIC CONTRACEPTIVE METHOD PACKAGE INSERT
PILL PACKAGE INSERT FOR WOMEN OVER 40
OTHER(List): _________________________________________________________________

C. I have also received education and counseling relating to the following:

   Rubella vaccination received or       Rubella information given
   HIV infection and AIDS (Risk for infection, prevention and referral services.)
   Hepatitis “B” vaccine received or   Hepatitis “B” information given.

   (For Adolescents Only): (1) Abstinence
   (2) The importance of involving my parents/family in decisions regarding my health including family planning
   (3) Ways to resist engaging in coercive sexual activity.

   (For Women over 40): I have been informed of the cardiovascular complications of the pill.

D. The side effects of the methods I have chosen and the symptoms which would alert me to the possible harmful side effects have been explained to me. I understand that I am to contact my physician, this clinic, or other health care provider immediately if any of these symptoms should appear.

E. The practice of medicine is not an exact science and no guarantees can be made to me about the effectiveness of any method of birth control.

I have read the above (or have had it read to me) and have been given the opportunity to ask questions. Being mentally competent, I hereby assume full responsibility and release the physician, nurse practitioner, other project staff or staff of the Department of Human Resources of any and all liability for any adverse results that may occur from my using the birth control method provided to me.

__________________________________________________________
Witness

__________________________________________________________
Signature of Patient/Legal Guardian

Title Date

County Health Department Telephone Number _________________________________
Hospital Emergency Room Telephone Number _________________________________

Form 3700 (8/04) DPH 04/278H

White ORIGINATOR’S COPY CANARY – PATIENT’S COPY
INSTRUCTIONS

PURPOSE

For ethical, medical, and legal reasons, an informed consent form documenting the client’s voluntary consent to receive services must be signed by the client prior to receiving medical services. The form should be written in a language understood by the client or translated and witnessed by an interpreter.

EDUCATION

In order to be able to give informed consent for contraception, the client must receive education on the benefits and risks of the chosen method and details on the effectiveness, potential side effects, complications, danger signs and discontinuation issues.

COMPLETION

The original signed consent form must be part of the client’s records. A method specific consent form is also required when a prescriptive contraceptive method is provided.

UPDATING

Form 3700 should be renewed and updated:

1. When there is major change in the client’s health status or a change to a different prescriptive contraceptive method; or
2. When client returns for medical services after being inactive for 15 month or longer from the last scheduled visit.
Chapter 6

GEORGIA FAMILY PLANNING PROGRAM

STERILIZATION SERVICES

Sterilizations paid with funds from the Georgia Family Planning Program must conform to the legal statutes of Georgia and the federal regulations for sterilizations.

The counseling and consent process must assure that the client’s decision to undergo sterilization is completely voluntary and made with the full knowledge of the permanence, risks, and benefits associated with male and female sterilization procedures.

Districts MUST have an established policy to inform Family Planning Program staff they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization.

Section 205 of Pub. L. 94-63 states: “Any (1) officer of the United States, (2) 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 (3) 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.

Requirements for Sterilization-Federal Sterilization Regulations [42 CFR Part 50, Subpart B]

Sterilizations will only be performed or arranged for if the individual applying for sterilization meets the following requirements:

► The individual must be at least 21 years of age at the time he/she signs the consent form. Verification of age should be obtained and recorded for an individual whose age is questionable.

► The individual applying for sterilization is not mentally incompetent.

● A mentally incompetent individual is defined by the Department of Health and Human Services as: “An individual who has been declared mentally
incompetent by a federal, state, or local court of competent jurisdiction for any purpose unless he or she has been declared competent for purposes which include the ability to consent to sterilization”.

► The individual has voluntarily given his or her informed consent following the informed consent guidelines.

● Title X Guidelines, Section 5-1 state, “Project staff must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo a sterilization procedure.”

► The sterilization procedure must not be performed prior to the 31st day and no later than 180 days from the date consent was given. Exceptions:

● Premature delivery

● Emergency abdominal surgery

An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed after he or she gave informed consent to sterilization. In the case of premature delivery the informed consent must have been given at least 30 days prior to the expected date of delivery.

Informed Consent

Informed consent does not exist unless a consent form is signed voluntarily and in accordance with all the requirements of this section § 50.204 and the following section on consent form requirements § 50.205 of the subpart B – Sterilization of persons in Federally assisted Family Planning Projects (Program Guidelines for Project Grant for Family Planning Services, January 2001).

► The person obtaining the consent for a sterilization procedure must offer to answer any questions concerning the procedure, provide a copy of the consent form, and provide orally all of the following information or advice to the individual who is to be sterilized:

● Advise that the individual is free to withhold or withdraw consent to the procedure anytime before the sterilization without affecting his or her future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;

● A description of available alternative methods of family planning and birth control;
Advise that the sterilization procedure is considered to be irreversable;

A thorough explanation of the specific sterilization procedure to be performed;

A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible side effects of any anesthetic to be used;

A full description of the benefits or advantages that may be expected as a result of the sterilization and;

Advice that the sterilization will not be performed for at least 30 days.

► An interpreter must be provided to assist the individual to be sterilized if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent.

► Suitable arrangements must be made to assure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped.

► A witness chosen by the individual to be sterilized may be present when consent is obtained.

► Informed consent may not be obtained while the individual to be sterilized is:
  ● in labor or childbirth;
  ● seeking to obtain or obtaining an abortion; or
  ● under the influence of alcohol or other substances that affect the individual's state of awareness.

► Spousal consent cannot be required for sterilization.
CONSENT FORM

The DHHS Informed Consent Form must be used. The booklets, “Information for Men: Your Sterilization Operation,” “Information for Women: Your Sterilization Operation,” used in the informed consent process and the “Consent for Sterilization” forms may be found and ordered at:  http://opa.osophs.dhhs.gov/pubs/publications.html#Sterilization

► The “Consent for Sterilization” form must be signed and dated by:
  ● The individual to be sterilized;
  ● The interpreter (if one is provided);
  ● The person providing the counseling and obtaining the consent; and
  ● The physician who performs the procedure.

► All dates should be written (not typed) by the persons signing the consent form.

► "White-outs" are not acceptable. Correct errors by a single line through the erroneous information. Write "error," the date and initial above the corrected section.

► All copies of the consent form must be completed and signed by the person to be sterilized, the interpreter (if applicable), and the person obtaining consent.

► A photocopy of the consent form is given to the patient. The county clinic retains a photocopy of the consent form in the patient’s medical record.

► The county clinic sends all 3 parts of the original signed consent form with a transmittal memo to the district office.

► The district health office reviews the form for completeness and accuracy, retains a photocopy and mails all 3 copies of the original consent form with transmittal memo to the agency or physician performing the sterilization.

Payment for Sterilization Services

Payment Process Using State Family Planning Funds

When the physician has completed the procedure, he/she will return the consent forms (state agency and physician copies) along with a bill for services to the Georgia Family Planning Program State Office. The physician's statement portion of the consent form must be completed.
Districts that have arrangements with local physicians to perform sterilization procedures will instruct the physician to submit the bill for service and the signed copies of the consent forms (state agency and physician copies) to the district health office. The district office will submit the bill for service, completed Basic Expenditure Form and consent forms (state agency and physician copies) to the Georgia Family Planning Program State Office within 15 days of receiving the bill for service.

**Payment Process Using District Patient Benefits Funds**

When the physician has completed the procedure, he/she will return the consent form (state agency and physician copies) along with a bill for services to the district health office. The physician's statement portion of the consent form must be completed. The district health office will complete a Basic Expense Form with physician's bill attached and submit for payment to the DHR Accounts Payable Unit.

**Record Retention**

County health department sterilization consents are to be maintained in the client’s record for 10 years from the date of last service.

**Sterilization Reports**

Refer to Family Planning Quarterly Report for instructions regarding reporting of sterilization services provided by the Georgia Family Planning Health Program.

**Audits**

Periodic audits will be conducted by state program staff of sterilization records.

The following compliance indicators will be audited on individual client records:

► Individual to be sterilized was 21 years of age or older when consent form was signed.

► Sterilization procedure not performed prior to the 31st day and not later than 180 days from date of consent.

► All signatures are originals.

► White-outs and obliterations are unacceptable.

► Correct errors by a single line through erroneous information. Write “error,” the date and initials above the corrected section.
Should any record be out of compliance in first and second indicators above, payment cannot be authorized. The district must refund the amount paid from non-federal funds. Non-compliance in indicators 3, 4 and 5 above will be noted on the audit summary sheet, discussed in the exit interview and may require a corrective action plan.

Sterilization Service Forms

The following consent, transmittal and application forms are used in the provision of sterilization services through the Georgia Family Planning Health Program. Consent for sterilizations (forms) can be downloaded or ordered from the following site:

- Memorandum of Transmittal (see end of this section)

Sterilization Service Provider Information and Procedures

Applications and referral information for specific providers are available through the State Office.
MEMORANDUM OF TRANSMITTAL

TO: (Physician Who Will Perform Procedure)
FROM: (County Office)
RE: (Name of Patient)
DATE:

Attached is an informed consent form for the patient listed above who wishes to be sterilized. We have counseled this patient and he/she understands that the sterilization procedure must be considered irreversible.

You will be reimbursed $__________ for the sterilization procedure. Please complete the Physician's Statement on the consent form and sign and date it (original signature and date). Return the consent form along with your bill for services rendered to:

Name/Address

This procedure cannot be performed until at least the 31st day following the date the consent form was signed by the patient or (enter date for 31st day) and no later than 180 days or (enter date for the 180th day).

Thank you for your cooperation.
Chapter 7
GEORGIA FAMILY PLANNING PROGRAM
PREGNANCY TESTING, DIAGNOSIS, COUNSELING AND REFERRAL

General Information

Title X Program Guidelines for Project Grants for Family Planning Services, "Pregnancy Diagnosis and Counseling", require the following of family planning projects:

"Grantees MUST provide pregnancy diagnosis and counseling to all clients in need of this service. Pregnancy testing is one of the most frequent reasons for an initial visit to the family planning facility, particularly by adolescents. It is therefore important to use this occasion as an entry for providing education and counseling about family planning."

The Georgia Family Planning Program has established the following guidelines and procedures to assure compliance with the Bureau of Community Health Services as it relates to pregnancy testing, counseling, and referral. Section 1008 of the Public Health Service Act states that "None of the funds appropriated under this Title shall be used in programs where abortion is a method of family planning." All Title X funded family planning services must be delivered in compliance with federal regulations and state program policies.

Pregnancy testing, diagnosis, counseling, and referral are required family planning services and MUST be available on-site or by a defined referral process to program participants.

Pregnancy Testing and Diagnosis

Pregnancy cannot be accurately diagnosed and staged through laboratory testing alone. Pregnancy diagnosis consists of:

► a history

► pregnancy test, (projects providing pregnancy testing on-site should have a pregnancy test of high sensitivity).
physical assessment with pelvic examination

- If the medical examination cannot be performed in conjunction with laboratory testing, the client **MUST** be counseled as to the importance of receiving a physical assessment as soon as possible, preferably within 15 days. The physical assessment can be done on-site, by a provider selected by the client, or by a referral provider.

- If ectopic pregnancy is suspected, the client **MUST** be referred for immediate diagnosis and therapy.

- For clients with **negative test diagnosis**, the cause of delayed menses should be investigated.

  - Clients should be offered a method of contraception or information regarding pregnancy planning and preconceptional health.

All services provided and plan of action **MUST** be documented in the client's medical record.

**Information and Counseling**

Programs **MUST** offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- prenatal care and delivery;

- infant care, foster care, or adoption;

- pregnancy termination.

If requested to provide such information and counseling, **provide neutral, factual information and nondirective counseling** on each of the options, upon request, except with respect to any option (s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

**Pregnant women planning to carry their pregnancies to term** should be **referred for early initiation of prenatal care.** Also, these women should be given information about good health practices during early pregnancy, especially those which protect the fetus during the first months. This information shall include, but is not limited to:

- importance of proper weight gain, nutrition, prenatal vitamins

- importance of proper medical supervision for conditions such as diabetes, hypertension, anemia, epilepsy, etc.
► problems associated with unusual diets or unhealthy habits

► importance of avoiding alcohol consumption

► importance of avoiding all drugs unless prescribed or approved by a physician who is aware that the client is pregnant

Clients who are found **not to be pregnant** should be given information about:

► the availability of contraceptives

► preconception health (see section on Preconception Health)

► infertility services if applicable

► specific information on exposure to rubella

**Abortion Policy**

To assure compliance with Section 1008 of the Public Health Service Act which states "**none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning**", the Georgia Family Planning Program has established the following policies:

► Districts **MUST** have an established policy to inform Family Planning Program staff they **may be subject to prosecution under Federal law** if they coerce or endeavor to coerce any person to undergo an abortion or sterilization.

Section 205 of Pub. L. 94-63 states: "Any (1) officer of the United States, (2) 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 (3) 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.

► Counseling can be conducted only in a **general unbiased, factual discussion of all alternatives**, such as prenatal care and delivery services, placing the baby in temporary foster care, placing the baby for adoption, keeping the baby or pregnancy termination.
► No referrals or recommendations can be made to any one agency or facility. When lists of facilities, agencies and providers are given to patients, the lists should contain as many sources as possible but no fewer than two options when possible.

► **Lobbying** either pro-abortion or anti-abortion is **prohibited** using grant or grant-related income.

► No transportation will be provided for abortion services.

In each instance where problem pregnancy counseling is provided, the patient's medical record must contain sufficient documentation to confirm compliance with the above policies.

**Monitoring and Compliance**

Monitoring for compliance will include single purpose audits, medical record reviews, and on-site visits.
Chapter 8

GEORGIA FAMILY PLANNING PROGRAM

PRECONCEPTION HEALTH

The Georgia Family Planning Program, in compliance with Title X guidelines, provides opportunities for women to have their health status assessed, health risks identified and education and interventions provided to improve their health status. Preconception care is recognized as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception care is part of a larger health-care model that results in healthier women, infants and families.

Client information, Planning Ahead for a Healthy Pregnancy, can be accessed at:

http://health.state.ga.us/programs/women/pregnancyplanning.asp.
The Georgia Department of Human Resources, Family Health Branch supports the Preconception Health project through the following statement:

**Family Health Branch**

**Preconception Health Initiative**

Preconception health care refers to identifying the health risks to women of child-bearing age, and providing them with the resources necessary to achieve the best state of health possible prior to considering pregnancy. A portion of poor birth outcomes result from poor maternal health issues which had not been identified or addressed prior to pregnancy.

The infant mortality rate (IMR) is one important indicator used to compare the health and well being of populations across the country. The infant mortality rate in Georgia in 2004 was 8.5, compared to the national average of 6.6. Examples of causes associated with infant death include: low birth weight, premature birth, congenital anomalies, and Sudden Infant Death Syndrome. Good maternal health can improve women's general health and well-being, as well as the prevalence of positive birth outcomes.

The Department of Human Resources, Family Health Branch, is dedicated to assuring that women of child-bearing age in Georgia have access to the information and resources necessary to achieve optimal wellness and can plan for and have healthy babies. The family health branch supports providing women of child-bearing age with the opportunity to have their health status assessed, identify their health risks, and provide them with the necessary interventions when feasible (or provide them with referrals to receive appropriate services elsewhere) to achieve and maintain the best health status possible.

By identifying women of child-bearing age that have existing medical conditions, or are practicing unhealthy behaviors prior to becoming pregnant, health care providers can have the opportunity to positively impact birth outcomes in Georgia.

The Family Health Branch of the Georgia Department of Human Resources developed a document, the Preconception Health paper for health care providers, to provide guidance on key health concepts for health care providers to discuss with women of childbearing age prior to child bearing. This document can be accessed at [http://www.health.state.ga.us/pdfs/epi/PreconceptionHealthpaper2006.pdf](http://www.health.state.ga.us/pdfs/epi/PreconceptionHealthpaper2006.pdf). Also, it is provided in its entirety below:
Preconception Health

Health care providers should strive to help women achieve optimal health before conception so they may have healthy pregnancies and healthy infants. Currently, much of the health information given to women considering pregnancy is provided during the prenatal period or after delivery. Since most women’s reproductive capacity spans many decades, and because nearly half of United States pregnancies are unintended, it is important that health care providers integrate health promotion and disease prevention into a continuum of care throughout the lifecycle (1). Below are the key elements to include as part of a comprehensive package of information that women should receive prior to pregnancy to achieve optimal health.

Create a Non-threatening Medical Environment
Many women may not be aware of the importance of preconception health. To help improve birth outcomes, health care providers can assure that women of child-bearing age achieve and maintain good health status before conception by initiating a dialogue with them regarding their reproductive health plan. If health care providers take the initiative to discuss with all women of child-bearing age the importance of preconception health, it will help create a non-threatening environment in which a woman will feel more comfortable talking about her own health concerns. As a result, health care providers can more easily assess and identify opportunities for improving the woman’s overall health status before pregnancy.

Provide Genetic Screening and Counseling
Depending on a woman’s ethnic background and family medical history, some women should be screened and counseled for certain genetic conditions before conception. Examples include: sickle cell anemia, thalassaemia, cystic fibrosis, chromosomal abnormalities, and muscular dystrophy (2). Counseling enables couples to become more informed about the potential genetic disorders, the current availability of prenatal and postnatal testing, the accuracy and limitations of such testing, as well as their reproductive options (3).

Review Immunization Records
Though screening for immunizations should be routinely conducted, this is not always the case. Encouraging and administering vaccinations prior to pregnancy is preferable (1). Health care professionals should review the last time of administration of a woman’s standard adult immunizations including: tetanus, rubella, hepatitis, varicella, and influenza. Susceptible women should receive vaccinations for rubella and varicella at least 28 days before becoming pregnant.
Screen for Sexually Transmitted Infection (STI) and Human Immunodeficiency Virus (HIV)

STIs and HIV can have many of the same consequences for pregnant women as women who are not pregnant, for example: cervical and other cancers, chronic hepatitis, pelvic inflammatory disease, infertility, and other complications. Furthermore, a pregnant woman with an STI or who is HIV-positive may have early onset of labor, premature rupture of the membranes (PROM), and intrauterine infection after delivery. The harmful effects of STIs in babies may include: stillbirth, low birth weight, conjunctivitis, pneumonia, neonatal sepsis, neurological damage, blindness, deafness, acute hepatitis, meningitis, chronic liver disease, and cirrhosis (5).

Because infections passed through sexual contact are harmful during pregnancy and can also infect babies, women should be advised to get tested before pregnancy to improve perinatal outcomes. It should be explained to women that it is better to get tested and treated before pregnancy if they feel there is a chance of having contracted an STI or HIV, even if they have been tested previously. It is important that a woman know her STI and HIV status before pregnancy so that if the test is positive, she can make an informed decision regarding appropriate treatment for herself and prophylaxis for her infant.

Ensure Optimal Management of Preexisting Medical Conditions

Preexisting medical conditions, such as obesity, diabetes, cardiovascular disease, hypertensive disorders, epilepsy, deep venous thrombosis (DVT), systemic lupus, thyroid disorders, and depression/anxiety can be affected by pregnancy. Women with these conditions are at a higher risk of serious pregnancy complications and poor birth outcomes. It is important for health care providers to inform women of child-bearing age of the risks associated with these conditions and the need for optimal management before becoming pregnant. Certain medications may need to be managed differently before and during a woman’s pregnancy in order to achieve an optimal pregnancy outcome (24). Women will need to be educated on the importance of adherence to medication regimens and disease monitoring during this critical time period, and the risks of not doing so.

Promote Achievement and Maintenance of a Healthy Weight

A woman’s weight at conception can influence her pregnancy and delivery as well as the infant’s health (6). Body Mass Index (BMI), defined as weight (kg)/height (m²), is one method of determining a woman’s weight status.

Overweight

In 2002, over half (53%) of women in Georgia were overweight or obese (7). Women who are overweight (BMI ≥25) or obese (BMI ≥30) before conception are at increased risk of several adverse pregnancy outcomes including preterm
delivery, gestational diabetes, preeclampsia, macrosomia, neonatal death, and fetal death (8, 6, 9, 10). Furthermore, women who are obese before conception tend to gain and retain more weight during pregnancy than recommended by the Institute of Medicine (11). After delivery, overweight and obese women have more difficulty initiating and maintaining breastfeeding than do women of normal weight (8, 12, 13, 14).

It is **not** recommended that women lose weight during pregnancy. Therefore, it is important to identify women who are overweight or obese as early as possible, and refer them to a registered dietitian who can help them lose weight safely before conception.

**Underweight**

Women who are severely underweight (BMI <18.5) are also at increased risk for a number of adverse pregnancy outcomes, including low birth weight, preterm birth, and intrauterine growth retardation (15, 16). Women identified by health care providers as underweight before they become pregnant should be referred to a registered dietitian to receive guidance on how to increase their weight.

**Encourage Optimal Nutrition Intake through a Balanced Diet**

Women should consume a balanced diet rich in fruits and vegetables, low-fat dairy products, whole grains and high-protein foods (see 2005 Dietary Guidelines for Americans at [www.mypyramid.gov](http://www.mypyramid.gov) for more information). A balanced diet will ensure that women acquire the recommended daily requirements for vitamins and minerals, and also adequate nutrient stores for pregnancy. Women with a low income should be referred to the local food bank, and/or other relevant food assistance programs in the community.

**Highlight the Importance of Folic Acid**

Folic acid is an especially important nutrient for women of child-bearing age. Taking a folic acid supplement before conception as part of a healthy diet reduces the risk of neural-tube defects (NTD) such as spina bifida. The recommended daily intake for all women of child-bearing age is at least 400 micrograms (mcg), or 0.4 milligrams (mg). Though it is ideal that all women of child-bearing age take folic acid daily, it is essential that women trying to get pregnant begin supplementation immediately. Food sources of folic acid include enriched grain products such as breakfast cereals, bread, pasta, and rice, and natural sources such as dark green leafy greens and legumes. Health care providers may recommend a higher level of folic acid intake for women with a family history of NTD, or women who have had a previous pregnancy affected by a NTD (2, 8).
Raise Awareness of the Significance of Safe Food Preparation

Preparing food safely is as important as eating the right things. Consuming food contaminated with methylmercury or toxoplasma may cause harm to an unborn baby. To avoid the harmful effects of these food-borne illnesses, women should be advised to follow recommendations of the Food and Drug Administration (FDA) and the Environmental Protection Agency (EPA) before and during pregnancy (http://www.cfsan.fda.gov/pregnancy.html) (17):

- **Methylmercury:**
  - Do not eat Shark, Swordfish, King Mackerel, or Tilefish because they contain high levels of mercury.
  - Eat up to 12 ounces (2 average meals) a week of a variety of fish and shellfish that are lower in mercury.
  - Check local advisories about the safety of fish caught by family and friends in local lakes, rivers, and coastal areas. If no advice is available, eat up to 6 ounces (one average meal) per week of fish you catch from local waters, but don't consume any other fish during that week.

- **Toxoplasmosis:**
  - Wash hands with soap and warm water *after* touching soil, sand, raw meat, cat litter, or unwashed vegetables.
  - Wash all cutting boards and knives thoroughly with soap and hot water *after* each use.
  - Thoroughly wash and/or peel all fruits and vegetables before eating them.
  - Separate raw meat from other foods in grocery shopping cart, refrigerator, and while preparing and handling foods at home.
  - Cook meat thoroughly. The internal temperature of the meat should reach 160°F (71°C). Use a food thermometer to check.
  - Don't sample meat until it's cooked.
  - Avoid drinking untreated water, particularly when traveling in less-developed countries.

Be a Breastfeeding Advocate

The American Academy of Family Physicians, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists, recommend that all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first 6 months of life (18,19, 27). As part of preconception counseling, women should receive information on the benefits of breastfeeding for mother and infant. Benefits include: decreased severity or incidence of allergies, reduced risk of overweight and obesity, increased bonding, a decreased postpartum recovery time, and cost and time savings. Discussing breastfeeding information before pregnancy allows women to explore concerns, fears and myths that may inhibit successful breastfeeding (20). Encouragement to breastfeed from a health care provider, as well as from family...
members will increase the likelihood that a woman will initiate breastfeeding and maintain breastfeeding for a longer period of time (18).  

- **Strategies for Health Care Providers** (7)  
  - Train staff on the importance of breastfeeding, and its promotion and support  
  - Provide education and counseling to mothers before conception and during pregnancy and breastfeeding support after birth  
  - Know your area lactation consultants, and inform women of their availability  
  - Encourage hospitals to adopt the Baby Friendly Hospital 10-step program  
  - Create and maintain breastfeeding friendly clinic areas  
  - Encourage staff to receive training in lactation management skills

**Emphasize the Benefits of an Active Lifestyle**

Incorporating physical activity into a daily routine has many benefits such as: contributing to weight management, decreasing stress, improving healthy birth weight outcomes, and reducing risk of chronic diseases. Women planning on becoming pregnant should engage in moderate-intensity physical activity of 30 minutes or more on 5 or more days of the week, beginning at least 3 months before conception. Women should consult their health care provider before starting an exercise program (21).

**Incorporate Advice on Good Maternal and Infant Oral Health**

Studies have shown a relationship between periodontal disease and preterm, low birth weight babies. Periodontal disease may increase this risk by up to seven times. The American Academy of Periodontology recommends that women considering pregnancy have a periodontal evaluation, and a biannual comprehensive dental examination. Removing plaque and tartar from the roots of the teeth may significantly reduce the risks of having a preterm birth.

Women and their partners should be counseled on:

- The importance of how to avoid transmission of the decay causing bacteria, *streptococcus mutans*, present in the saliva of adults who have had tooth decay, but not present in the saliva of newborns.
- To avoid activities that increase the likelihood of sharing saliva, such as sharing food, and eating utensils, as well as placement of the baby’s fingers into another’s mouth.
- The importance of a dental inspection at each “well baby” visit, so that physicians can visually inspect the infant’s mouth. Infants identified as at risk for poor oral health should be referred to a pediatric dentist by one year of age. Establishment of the dental home for both mother and child is an important step to ensure good oral health (28-33).
Assess Exposure to Alcohol, Caffeine, and Other Drugs

Alcohol
In Georgia in 2003, 8.7% of women of child-bearing age (18-44 years) reported binge* drinking in the past month (22). Women should be informed that consumption of alcohol for those who may become pregnant should be avoided, as a safe level of alcohol consumption has not been established at any stage during pregnancy. * Binge alcohol use is defined as having five or more drinks on at least one occasion during the past month.

Caffeine
Some evidence suggests that caffeine consumption may delay conception as well as affect iron and calcium absorption (8). Common sources of caffeine include coffee, colas, chocolate, tea and some prescription or over the counter drugs.

Tobacco
In Georgia in 2003, 23.3% of women of child-bearing age (18-44 years) reported smoking (22). Chemicals in tobacco have a cumulative deleterious effect on the health of the smoker but are particularly detrimental during the reproductive period. The toxic substances found in tobacco products adversely affect the reproductive capacity of females and males, as well as have damaging effects on their offspring. Some of the adverse effects of smoking on reproductive health include:

- Reduced length of gestation leading to low birth weight
- Perinatal mortality, stillbirths, and spontaneous abortions
- Fetal malformations
- Male and female infertility
  - In females, cigarette smoking has been linked with both an early onset of menopause as well as directly with infertility
  - In males cigarette smoking has been linked with decreased sperm density, a lower proportion of motile sperm, decreased total sperm count, reduced testosterone secretion and, as previously shown, an increase in abnormal spermatids and spermatozoa, which can be a direct cause of various fetal malformations (23).

Illegal Drugs
Women should be informed that use of illegal drugs (such as cocaine, marijuana, and heroin) can affect a pregnancy and the fetus. Illegal drug use before conception is associated with miscarriage, prematurity, growth retardation, congenital defects, intrauterine growth restriction, hyperactivity, and severe neonatal withdrawal syndrome (2).
Discuss Men’s Role in Pregnancy Planning
Information should be provided to couples that are planning to get pregnant on the impact that the male’s health status can have on conception.

Similar to the health issues of women that affect pregnancy, there are many important male health concerns that may impact conception, pregnancy, and birth outcomes that should also be addressed.

- Male fertility: contributes to approximately 50% of all infertility cases (5). It can be difficult to get pregnant if a man has a low sperm count. Some examples of factors that can negatively affect sperm include (4):
  - drinking alcohol
  - smoking cigarettes
  - using anabolic steroids
  - using illegal drugs, such as marijuana, cocaine, or heroin
  - taking certain antibiotics, prescription drugs, or over-the-counter medicine
  - using saunas, whirlpools, or hot tubs at more than 102ºF
  - unhealthy diet
  - stress, certain bacterial and viral infections, some medical conditions, and exposure to pesticides may also reduce sperm count or the quality of semen
- Genetics and family history
- Exposures affecting reproduction: occupational, HIV, and STI’s

Take Simple Steps to Provide Preconception Care
There is a comprehensive list of important issues that need to be discussed with women of child-bearing age and their partners, to adequately prepare them for achieving a safe and healthy pregnancy. If integrated into routine visits and the clinic environment, providing preconception care and information will not add an extra burden to a clinician’s workload. Simply:

- Incorporate preconception health discussions into every visit
- Administer preconception screening, and plan for appropriate follow-up
- Stock waiting rooms with posters, and magazines addressing preconception health related issues
- Distribute pamphlets on preconception care, from reputable sources such as: March of Dimes, ACOG, AAP, etc.
- Refer women to a maternal-fetal medicine specialist as necessary
- Be an advocate for preconception health interventions in the community and schools
References


The Preconception Nutrition Position Paper 2006 explains the Georgia Department of Human Resources, Division of Public Health, Nutrition Section’s stance on the importance of assessing nutrition status, and making necessary changes prior to conception. This document can be accessed on the internet at http://www.health.state.ga.us/pdfs/epi/PreconceptionNutritionpositionpaper2006.pdf and is provided in its entirety below:

Position Paper

Preconception Nutrition

Good nutrition is an essential component of attaining a healthy pregnancy and birth outcome. Currently, women of child-bearing age do not typically receive information about proper nutrition until they are already pregnant, during the prenatal period or after delivery.

Though it is important for women to receive information about nutrition during the prenatal and postnatal period, achieving proper nutrition prior to conception provides numerous health benefits to both the mother and infant.

It is the position of the Georgia Department of Human Resources that women of child-bearing age should achieve and maintain good nutritional status prior to conception to help minimize health risks to both mothers and infants.

Many women may not be aware of the importance of preconception nutrition or have access to information. Health care providers should be knowledgeable about sound nutrition and nutrition-related guidelines and take the initiative to discuss this information during preconception counseling with women of child-bearing age.

Recommendations:

Achieve and Maintain a Healthy Weight

A woman’s weight at conception can influence her pregnancy and delivery as well as the infant’s health (3). Body Mass Index (BMI), defined as weight (kg)/height (m²), is one method of determining a woman’s weight status.

- **Overweight**
  In 2002, over half (53%) of women in Georgia were overweight or obese (16). Women who are overweight (BMI ≥25) or obese (BMI ≥30) before conception are at increased risk of several adverse pregnancy outcomes including preterm delivery, gestational diabetes, preeclampsia, macrosomia, neonatal death, and fetal death.
(1,3, 5, 11). Furthermore, women who are obese before conception tend to gain and retain more weight during pregnancy than recommended by the Institute of Medicine (6). After delivery, overweight and obese women have more difficulty initiating and maintaining breastfeeding than do women of normal weight (1, 10,12,13).

It is important to identify women who are overweight or obese as early as possible, and refer them to a registered dietitian who can help them lose weight safely before conception. It is not recommended that women lose weight during pregnancy.

- **Underweight**
  Women who are severely underweight (BMI <18.5) are also at increased risk for a number of adverse pregnancy outcomes, including low birth weight, preterm birth, and intrauterine growth retardation (2, 4). Women identified by health care providers as underweight before they become pregnant should be referred to a registered dietitian to receive guidance on how to increase their weight.

**Optimize Nutrition Intake through a Balanced Diet**
Women should consume a balanced diet rich in fruits and vegetables, low-fat dairy products, whole grains and high-protein foods (see 2005 Dietary Guidelines for Americans at www.mypyramid.gov for more information). A balanced diet will ensure that women acquire the recommended daily requirements for vitamins and minerals, and also adequate nutrient stores for pregnancy. Women with a low income should be referred to the local food bank, and/or other relevant food assistance programs in their community.

**Consume a Diet Rich in Folic Acid or Take a Folic Acid Supplement**
Folic acid is an especially important nutrient for women of child-bearing age. Taking a folic acid supplement before conception as part of a healthy diet reduces the risk of neural-tube defects (NTD) such as spina bifida. The recommended daily intake for all women of child-bearing age is at least 400 micrograms (mcg), or 0.4 milligrams (mg). Though it is ideal that all women of child-bearing age take folic acid daily, it is essential that women trying to get pregnant begin supplementation immediately. Food sources of folic acid include enriched grain products such as breakfast cereals, bread, pasta, and rice, and natural sources such as dark green leafy greens and legumes. Health care providers may recommend a higher level of folic acid intake for women with a family history of NTD, or women who have had a previous pregnancy affected by a NTD (1,18).
Prepare Food Safely
Preparing food safely is as important as eating the right things. Consuming food contaminated with methylmercury or toxoplasma may cause harm to a fetus. To avoid the harmful effects of these food-borne illnesses, women should be advised to follow recommendations of the Food and Drug Administration (FDA) and the Environmental Protection Agency (EPA) before and during pregnancy (http://www.cfsan.fda.gov/pregnancy.html) (19):

- **Methylmercury:**
  - Do not eat Shark, Swordfish, King Mackerel, or Tilefish because they contain high levels of mercury.
  - Eat up to 12 ounces (2 average meals) a week of a variety of fish and shellfish that are lower in mercury.
  - Check local advisories about the safety of fish caught by family and friends in local lakes, rivers, and coastal areas. If no advice is available, eat up to 6 ounces (one average meal) per week of fish you catch from local waters, but don’t consume any other fish during the week.

- **Toxoplasmosis:**
  - Wash hands with soap and warm water after touching soil, sand, raw meat, cat litter, or unwashed vegetables.
  - Wash all cutting boards and knives thoroughly with soap and hot water after each use.
  - Thoroughly wash and/or peel all fruits and vegetables before eating them.
  - Separate raw meat from other foods in grocery shopping cart, refrigerator, and while preparing and handling foods at home.
  - Cook meat thoroughly. The internal temperature of the meat should reach 160° F(71° C). Use a food thermometer to check.
  - Don’t sample meat until it’s cooked.
  - Avoid drinking untreated water, particularly when traveling in less-developed countries.

Be Knowledgeable about the Benefits of Initiating and Maintaining Exclusive Breastfeeding
The American Academy of Family Physicians, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists, recommend that all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first 6 months of life (7,15,17). As part of preconception counseling, women should receive information on the benefits of breastfeeding for mother and infant. Benefits include: decreased severity or incidence of allergies, reduced risk of overweight and obesity, increased bonding, decreased postpartum recovery time, and cost and time
savings. Discussing breastfeeding information before pregnancy allows women to explore concerns, fears and myths that may inhibit successful breastfeeding (8).

Receiving encouragement to breastfeed from a health care provider, as well as from family members will increase the likelihood that a woman will initiate breastfeeding and maintain breastfeeding for a longer period of time (7).

Assess Consumption of Alcohol and Caffeine

Alcohol
In Georgia in 2003, 8.7% of women of child-bearing age (18-44 years) reported binge* drinking in the past month (20). Women should be informed that consumption of alcohol for those who may become pregnant should be avoided, as a safe level of alcohol consumption has not been established at any stage during pregnancy.

*Binge alcohol use is defined as having five or more drinks on at least one occasion during the past month

Caffeine
Some evidence suggests that caffeine consumption may delay conception as well as affect iron and calcium absorption (1). Common sources of caffeine include coffee, colas, chocolate, tea and some prescription or over the counter drugs.

Be Physically Active
Incorporating physical activity into a daily routine has many benefits such as: contributing to weight management, decreasing stress, improving birth outcomes, and reducing risk of chronic diseases. Women planning on becoming pregnant should engage in moderate-intensity physical activity of 30 minutes or more on 5 or more days of the week, beginning at least 3 months before conception. Women should consult their health care provider before starting an exercise program (14).
References


Georgia Department of Human Resources
Division of Public Health
Family Health Branch, Nutrition Section
(404) 657-4656
http://health.state.ga.us/programs/nutrition/
DPH06.020HW
Chapter 9
GEORGIA FAMILY PLANNING HEALTH PROGRAM
FERTILITY AWARENESS
NATURAL FAMILY PLANNING

General Information

In 1979, a federal mandate from the Department of Health and Human Services addressed the provision of Natural Family Planning (NFP) services in Title X programs. It stated that all Title X programs must offer NFP as a method of family planning either on-site or through referral. The Georgia Family Planning Program is making every effort to meet this requirement. Since 1989, the Georgia Family Planning Program has offered NFP awareness training and case manager training to health educators, nurses and nurse practitioners who provide family planning services. Participants who complete the intensive case manager training become certified to teach clients in natural family planning to either avoid or achieve pregnancy.

Implementation of Services

There are several ways health departments can meet the requirements of providing NFP services. One of the most important steps to be taken is for service providers to become familiar with current methods of natural family planning and the key concepts of fertility awareness education. When a patient expresses an interest in natural family planning, they should be referred to an appropriate NFP resource.

Each county health department should identify a resource for their county that can provide NFP services to interested clients. There are three ways to meet this requirement:

► Have a certified NFP case manager on staff.

► Identify a resource within the county where interested clients can be referred for NFP services, i.e., private physician, other agency or faith community.

► Identify the nearest county with a NFP case manager and establish a referral system with that county to enable interested clients to receive NFP services.

It is recommended that a county with a NFP case manager on staff develop its
own policy, procedure and guidelines for the delivery of NFP services. Suggestions to include in these guidelines are:

► Identifying staff positions in the health department that may make initial contact with interested clients, and discussing how to refer those clients for natural family planning instruction.

► Establishing a procedure the NFP case manager will use to set up instruction with the client. The case manager needs to obtain medical records on clients who do not have records on file at the health department. The case manager should keep all forms and records related to NFP in the client medical record.

► Detailing an outline of NFP instruction. It is recommended that instruction include a minimum of two sessions, 60 to 90 minutes in length, with six months of follow-up to ensure that client has full understanding of natural family planning.

► Keeping a record of clients counseled on NFP as part of the Family Planning Quarterly Report (maintain report at district office)

► Establishing a procedure for out-of-county referrals.

Using NFP to help couples achieve pregnancy has been very successful in counties with a case manager. Providing Level 1 Infertility Counseling is also a requirement for Title X programs. NFP services can help meet this requirement.

NFP case managers are valuable resources who can be used to teach fertility awareness education to youth and NFP to couples for avoiding or achieving pregnancy. Title X agencies are committed to providing couples with good health care and helping them meet their family planning needs. Including NFP as a component of the health department family program will help attain this goal.
Chapter 10

GEORGIA FAMILY PLANNING PROGRAM

HIV COUNSELING

Introduction

Worldwide the number of women with HIV (Human Immunodeficiency Virus) infection and AIDS (Acquired Immune Deficiency Syndrome) is steadily increasing. In the United States, women represent one of the fastest growing segments of the HIV epidemic. 85% of women infected with HIV are of childbearing age. HIV disproportionately affects African-American and Hispanic women. There is an increase in HIV/AIDS among young women and women over 50.

Women are most often infected with HIV during heterosexual sex. During unprotected heterosexual intercourse, women have a greater risk of becoming infected than men. Sexually transmitted infections greatly increase a woman’s risk of becoming infected with HIV. Factors related to an increased risk of heterosexual transmission include: alcohol use, history of childhood sexual abuse, current domestic abuse, use of crack/cocaine, exchanging sex for money or drugs, powerlessness, poverty, socioeconomic status, and culture.

According to the January 2001 USDHHS, “Program Guidelines for Project Grants for Family Planning Services:"

- All persons receiving Family Planning services must receive education to reduce risk of transmission of sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV).
- All clients must receive thorough and accurate individualized counseling to reduce personal risk for STDs/HIV.
- All FP programs must also offer referral services.
- All FP programs must provide clients with STD/HIV screening as indicated.
- Adolescent services must include discussions of safer sex practice options to reduce risks for STD/HIV.

This Chapter of the GA Family Planning Manual covers HIV services including HIV counseling and testing, pregnancy and HIV, and FP services for HIV-infected clients.

HIV Counseling and Testing Recommendations

The CDC’s Revised Recommendations replace the CDC’s 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in
Acute-Care Hospital Settings and update the CDC’s 2001 Revised Guidelines for HIV Counseling, Testing, and Referral, and Revised Recommendations for HIV Screening of Pregnant Women. These recommendations are intended for all public and private-sector health care providers. The purpose is to increase routine HIV screening: to promote earlier detection of HIV infection; to identify, counsel and refer persons with unidentified HIV infection to clinical and prevention services; and to reduce perinatal transmission of HIV.

HIV prevention counseling is a direct, personalized and client-centered intervention designed to help initiate and sustain behavior change to avoid infection or, if infected, to avoid re-infection and prevent transmission to others. Only trained staff will provide HIV counseling, referrals to medical, preventive, psychosocial and other services as needed. The focus of the counseling session is to provide information and assist the client in developing prevention strategies.

HIV prevention counseling and testing are routine components of all family planning visits. In 2006, the Centers for Disease Control and Prevention (CDC) recommended HIV screening in all health care settings, after notifying the patient that the test will be done unless the patient declines (opt-out screening). The purpose of this recommendation is to increase routine HIV screening in adults, adolescents and pregnant women; foster early detection of HIV infection by identifying new cases and linking them to clinical and prevention services; and to further reduce HIV transmission from mother to child in the United States.

Performing HIV testing routinely also reduces the stigma associated with HIV testing that requires assessment of behavioral risks. **Opt-out** screening is the performance of an HIV test after notifying the patient that the test will be done unless they decline. More patients accept the recommended HIV test when it is routinely offered to everyone, without the risk assessment. The new CDC guidelines suggest that mandatory risk assessments and prevention counseling are resource intensive and reduce the numbers of patients tested when they cannot be performed. Therefore, prevention counseling is not required in conjunction with HIV testing. Furthermore, a separate written consent for HIV testing is not required. General consent for medical care is sufficient to encompass consent for HIV testing.

**All family planning clients will be provided:**

- Information regarding HIV prevention and opportunity to ask questions.
- Voluntary confidential opt-out HIV testing during initial and annual visits. (Repeat HIV screening at least annually.)
- Voluntary confidential opt-out HIV testing when seeking treatment for STDs.
- General consent for treatment to include HIV testing (Utilize the FP program consent form that includes HIV testing).
- HIV test results in the same manner as other diagnostic tests (i.e., HIV...
positive results should be communicated through personal contact by a trained clinician, nurse or counselor.
• Referrals for clinical care consistent with USPHS guidelines for management of HIV-infected persons if HIV positive.

All family planning clients’ records should include:

• Risk behaviors
• Attempted behavior change
• Risk reduction plan
• HIV lab results
• General Consent for treatment
• Follow-up appointment date
• Evidence that client received test results
• Post test counseling and referrals if HIV positive
• Completed HIV counseling and testing scan tran forms

Pregnancy

Introduction

Perinatal HIV transmission is defined as HIV transmission from mother to child during pregnancy, labor, delivery, or breastfeeding. Almost all pediatric AIDS cases are the result of Perinatal HIV transmission. In the United States, Perinatal HIV testing is far from universal and HIV infected infants continue to be born to undiagnosed HIV infected women. As part of CDC’s 2003 Advancing HIV Prevention (AHP), routine voluntary testing of all pregnant women was recommended in order to take advantage of the medical interventions that dramatically reduce the risk of transmission. Data indicates that when antiretrovirals are provided during the prenatal, intrapartum and neonatal periods, transmission rates can be reduced to less than 2% compared with approximately 25% when no interventions are provided. HIV transmission from mother to child can be reduced dramatically if women know their HIV status and, if HIV-infected, receive appropriate medical intervention. By following CDC’s recommendation to screen all pregnant women for HIV by including HIV screening in the routine panel of prenatal screening tests, our public health goal to reduce perinatal HIV transmission maybe reached. Therefore:

• All pregnant women seeking prenatal care at a Division of Public Health-funded site will be:
  ✓ Provided Opt-out testing:
  • Notify pregnant women that an HIV test will be performed as part of the standard battery of prenatal tests, but that they can decline the test.
  • Document a pregnant woman’s consent for the routine battery of prenatal tests, including HIV screening and, if
she declines HIV testing, document this in her medical chart.

- Notify pregnant woman that if she declines HIV testing, she will still receive care.
- Provided HIV testing on a confidential basis at the time of the initial prenatal visit and repeat in third trimesters or as indicated (women with symptoms suggesting acute HIV infections should have HIV RNA tests). **Note: Anonymous testing is not an option in prenatal care.**
- Informed of the benefits of knowing their HIV status.
- Scheduled a return appointment for test results and post-test counseling.

- Ensure that HIV-infected pregnant women, who do not return for test results, receive priority follow-up for notification of test results and counseling.
- Refer all HIV-infected pregnant women to the local Ryan White CARE Act funded HIV clinic for:
  - Additional medical, psychosocial, preventive and other services as needed.
  - Referral to obstetrical services experienced with care of HIV-infected pregnant women.

**HIV-Infected Women**

**Introduction**

HIV-infected women often obtain FP services at their local health departments. HIV-infected women require routine gynecological care (e.g., physical examinations, Pap smears, sexually transmitted infection (STI) screening, mammography, contraceptives, and preconceptual counseling) and evaluation and treatment of gynecological problems. Gynecologic problems are common among HIV-infected women including higher rates of abnormal Pap smears, higher rates of invasive cervical cancer, higher prevalence of bacterial vaginosis, and more frequently reported menstrual disorders than HIV-negative women.

All HIV-infected women should be under the care of an HIV/AIDS experienced medical provider. If the woman is not receiving care for HIV infection, refer her to the local HIV clinic (e.g., the local Ryan White CARE Act funded clinic).

**Guidelines**

For guidelines on care of HIV-infected women please utilize the following
resources:


**Key Points**

- **Pap Smears:**
  - Obtain Pap smears twice within the first year of HIV diagnosis, and then annually if results are normal.
  - More frequent screening is indicated with a history of abnormal Pap smear results, with HPV infection, after treatment for cervical dysplasia, and with symptomatic HIV infection including CD4 counts < 200/mm³.

- **Colposcopy:**
  - Colposcopy is indicated for cytologic abnormalities (atypia or greater, including atypical squamous cells [ASC] and atypical glandular cells [AGC]) and history of untreated abnormal Pap smear.
  - Consider colposcopy periodically after treatment of cervical dysplasia, with evidence of HPV infection, and for screening with CD4 counts < 200/mm³.

- **STI screening:**
  - Annual syphilis screening or with development of neurologic signs/symptoms;
  - Gonorrhea/chlamydia testing: annually at time of GYN visit, if sexually active; and as indicated by the presence of symptoms or exam findings, new sex partners, history of STI in sexual partner, or as indicated by sexual practices.

- **Contraceptives:**
  - Encourage use of barrier methods (e.g. latex or polyurethane male condoms with a water-based lubricant or female polyurethane condoms for penile/vaginal or penile/anal sex, and/or latex dental dams for oral sex).

  **Note:** Recommend polyurethane condoms for those clients with a history of latex allergy (e.g., exposure to latex results in skin rash, hives, itching, nasal, eye, and sinus symptoms).
Avoid use of nonoxynol-9 (N-9) spermicides. Recent data suggests that N-9 may actually increase risk of HIV transmission during vaginal intercourse. N-9 may damage rectal lining and should never be used for anal intercourse.

According to the WHO, Medical Eligibility Criteria for Contraceptive Use 3rd Ed., 2004, for women who are HIV-infected (non-AIDS) or those with AIDS doing well on antiretroviral therapy the advantages of using intrauterine devices (IUD) generally outweigh the theoretical or proven risks. For females with AIDS, the theoretical or proven risks usually outweigh the advantages of using IUDs. However, some HIV providers generally do not recommend use of IUDs in women with HIV infection for the following reasons:

- IUDs do not protect against STIs.
- There are concerns about the risk of enhanced susceptibility to IUD-related infections such as PID, in those who are at increased risk for acquiring other STIs. The WHO recommends IUD users with AIDS should be closely monitored for pelvic infection.
- Possible microabrasions of the penis or condom may occur, which may increase the risk of HIV transmission to the woman’s sexual partner. However, the WHO reports that studies have found that IUD use among HIV-infected women was not associated with increased risk of transmission to sexual partners.
- Copper IUDs are associated with increased menstrual flow and duration, possibly contributing to transmission and risk of anemia in HIV-positive women.

Presently there are no contraindications to steroid hormonal contraception in women with HIV infection.

- Advanced HIV disease may affect hepatic and hematologic systems, and these systems should be evaluated prior to choosing this form of contraception.
- Evaluate for drug-drug interactions because antiretroviral agents, especially protease inhibitors and nonnucleoside reverse transcriptase inhibitors, may decrease the levels of oral contraceptives (e.g., ethinyl estradiol levels are decreased by 32% when taken with ritonavir [Norvir R]).

Reproduction and HIV:

HIV-infected persons are living longer and the majority of HIV-infected women are of reproductive age. It is likely that many HIV-infected women will desire to become mothers.

- HIV-infected women should regularly receive counseling about pregnancy and HIV as part of their HIV care.
Decisions about if or when to get pregnant should be informed and carefully considered.
Refer HIV-infected women to their HIV providers for pregnancy-related counseling and evaluation.
If the HIV-infected woman is already pregnant, refer immediately for both obstetrical and HIV care.
For more information see:


References


CDC, Advancing HIV Prevention: the science behind the new initiative [Qs and As], September 2003, http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/ga/AdvancingFS.pdf, (June 2, 2006)


CDC, Mother-to-Child (Perinatal) HIV Transmission and Prevention, May 2006 http://www.cdc.gov/hiv/resources/factsheets/perinatal.htm (June1, 2006)


CDC, Revised Recommendations For HIV Testing of Adults, Adolescents and Pregnant Women In Health Care Settings (draft 3/7/06)

Chapter 11
GEORGIA FAMILY PLANNING PROGRAM

SUBSTANCE ABUSE PREVENTION, SCREENING AND REFERRAL

Overview
According to Title X Guidelines, clients should be offered appropriate counseling and referral as indicated regarding future planned pregnancies, management of a current pregnancy, and other individual concerns (e.g., substance abuse use and abuse, sexual abuse, domestic violence, genetic issues, nutrition, sexual concerns, mental health issues, etc.) as indicated.

The Centers for Disease Control (CDC) and Prevention reports that girls and women of childbearing age are drinking earlier, more heavily and continuing to drink during pregnancy. As a result of such behaviors, many babies born each year are exposed before birth to the harmful effects of alcohol, tobacco and other drugs. This exposure may lead to poor birth outcomes and even lifelong problems for the child. About 10% of infants in the U.S. are born to mothers who used alcohol and/or illicit drugs during pregnancy. More than 17% of infants are born to mothers who smoked during their pregnancy.

Reducing and eliminating maternal substance abuse has been a national public health priority for more than 25 years. The Surgeon General has issued warnings and advisories that have included avoiding tobacco use and avoiding all types of alcohol and other street drugs when planning a pregnancy and as soon as a woman believes that she may be pregnant.

Leading healthcare organizations have recommended that health professionals provide:

- Screening
- Advice about the dangers of alcohol, tobacco and other drug (ATOD) use, and
- Referrals to treatment if needed to all women of childbearing age, especially women who are pregnant.

Research has shown that pregnant women and women who are planning to become pregnant are highly receptive to advice from health professionals to stop smoking and to avoid alcohol and other drug use. It has also been demonstrated that pregnant and parenting women are more willing to participate in treatment when specific services to help their child are offered.

Preconception, pregnancy and the early childhood years are ideal times to provide prevention, intervention and treatment for substance use and abuse
problems.
Providing appropriate services during these critical periods greatly improves the health status of mothers and children, reduces public expenditures for health and welfare services, and keeps families together.

Prevention
The overall goal of prevention practitioners is to foster a climate in which:

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences I minimal;
- Prescription and over-the-counter drugs are used only for the purposes for which they were intended;
- Other abusable substances (e.g. gasoline or aerosols) are used only for their intended purposes; and
- Illegal drugs and tobacco are not used at all. ²

In order to effectively foster a climate of prevention, multiple prevention strategies must be put into practice. Such strategies include:

- Information dissemination
- Prevention education
- Alternatives
- Problem identification and referral
- Community-based processes
- Environmental approaches

Clinics should provide awareness and knowledge of the nature and extent of ATOD use, abuse and addiction and their effects on individuals, families and communities as well as information to increase perceptions of risk. Increasing awareness and knowledge of the harmful affects of substance use before and during pregnancy can be integrated into family planning visits by displaying health education materials in waiting and in examinations rooms and reviewing the consequences of substance use during client consultation. A list of policies related to ATOD, community prevention programs and services should also be readily available for clients.

Links to the following education materials my be helpful:

Publications, Facts and Multimedia by Drug Type
http://ncadistore.samhsa.gov/catalog/drugs.aspx

Alcohol Alert: Alcohol—An Important Women’s Health Issue

Surgeon General’s Advisory on Alcohol Use for Pregnant Women and Those Who Want to Become Pregnant
Screening and Counseling

Identifying, educating and counseling clients who are using ATOD are meaningful strategies that work toward reducing or eliminating further substance use or abuse. A routine preventive practice standard should include screening of all childbearing age patients for alcohol and other drug use combined with preconception health promotion, contraceptive counseling, and referrals to substance abuse programs. Title X Guidelines state that a comprehensive medical history MUST address extent and use of tobacco, alcohol and other drugs.

Clients can be assessed for substance use and abuse using any of a variety of screening tools. Some of those tools are listed below:

CRAFFT (Adolescent Interview Guide)
Includes questions to open the discussion of substance use, a six-question screening tool (CRAFFT), follow-up questions when screening is positive, and steps to take when screening is negative.

AUDIT (Alcohol Use Disorders Screening Test) – 10 Questions
A brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history.
http://www.projectcork.org/clinical_tools/html/AUDIT.html

T-ACE (Practical prenatal detection of risk-drinking) – 4 Questions

TWEAK (Screen for pregnant women) – 5 Questions
http://www.projectcork.org/clinical_tools/html/TWEAK.html
CAGE (Screening Test for Detecting Alcoholism) – 4 Questions

Used with adults routinely and periodically as a cost-effective way of screening for substance abuse and detecting possible problems at an early stage in their development.

http://www.projectcork.org/clinical_tools/html/CAGE.html

Referrals

A critical way to assist clients who are using substances is to make appropriate referrals to substance abuse counseling and treatment programs. Both public and private substance abuse treatment services are available to clients in Georgia. Georgia law chapter 290-4-2:(10) requires that pregnant women be given priority access to all substance abuse treatment programs, regardless of fund source. If no slots are available for a given program, preference must be given to admitting her to another appropriate program.

A client can access services through a Substance Abuse and Mental Health Services Administration’s treatment facility by calling SAMHSA's Toll-Free Referral Helpline at 1-800-662-HELP (1-800-662-4357) or by going to the SAMHSA Substance Abuse Treatment Facility Locator at http://dasis3.samhsa.gov/.

The Georgia Department of Human Resources through its Division of Mental Health, Developmental Disabilities and Addictive Diseases offers substance abuse treatment services to Georgia residents. The services a person receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include:

- **Outpatient Services** - evaluation, diagnosis, comprehensive assessment of needs, counseling, consumer and family education.

- **Crisis Services** – telephone or face-to-face intervention with the consumer and family to address immediate crisis and link to services. Available around the clock and in any setting.

- **Detoxification** – helps adults and teens at risk of complications withdraw safely from the physical affects of alcohol and drug use.

- **Residential Programs** – intensive treatment and structure to help people live a drug-free life style, for adults or adolescents with serve addictive disease.
• **Special “ready for work” programs** – treatment for women on welfare who are unable to find jobs due to alcohol or other drug problems. Includes intensive outpatient treatment continuing care and residential treatment with a therapeutic childcare component.

• **DUI Schools** – risk reduction programs for people who have been arrested for driving or boating while under the influence of alcohol or other drugs, or for possession of illegal drugs.

These services can be accessed through a single point of entry (SPOE) by calling the **Georgia Crisis and Access Line** at 1-800-715-4225, 1-800-225-0056 (TTY) or 1-800-255-0135 (Voice). The Crisis and Access line website is housed by Behavioral Health Link at [http://www.behavioralhealthlink.com](http://www.behavioralhealthlink.com).

A list of private mental health providers throughout the state of GA specializing in substance abuse counseling has also been compiled in a **Mental Health Private Sector Provider Resource Directory**. Access this directory by contacting the Healthy Mother, Health Babies Powerline at 1-800-822-2539. Electronic and hard copies are available upon request. Providers are listed by county and details about their practice includes: populations served, business hours, proximity to public transportation, payment options, and languages spoken.

**Additional Resources**

A Guide to Substance Abuse Services for Primary Care Clinicians

CORK
Authoritative information on substance abuse for clinicians, educators, and policy makers founded at Dartmouth Medical School 1978.
[http://www.projectcork.org/index.html](http://www.projectcork.org/index.html)

The Council on Alcohol and Drugs

The GA Council on Substance Abuse
[www.gasubstanceabuse.org/](http://www.gasubstanceabuse.org/)

Chapter 12

GEORGIA FAMILY PLANNING PROGRAM

COMMUNITY PARTICIPATION, EDUCATION AND PROJECT PROMOTION

The Georgia Family Planning Program, in compliance with Title X Guidelines, provides an opportunity for participation by community members in the development, implementation and evaluation of the program. This is accomplished through community involvement, education and project promotion.

Community Participation

Each district MUST have an I&E (informational and educational) advisory committee. This committee will:

► Be comprised of five to nine members

► Be broadly representative (in terms of demographic factors, such as race, color, national origin, handicapped condition, sex and age) of the community where services are delivered and

► Be comprised of persons in the community knowledgeable about the community’s needs for family planning services

The I&E committee will have the responsibility of reviewing and approving all informational and educational materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X. The advisory committee MUST:

► Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;

► Consider the standards of the population or community to be served with respect to such materials;

► Review the content of the material to assure that the information is factually correct. The committee may delegate responsibility for the review of the factual, technical and clinical accuracy to appropriate project staff.

► Determine whether the material is suitable for the population or community to which it is to be made available; and
Establish a written record of its determinations. Attached at the end of this chapter is a sample form that can be used to record the findings of the I & E Committee.

The I&E Advisory Committee may serve the community participation function if it meets the above requirements, or a separate group may be identified. The I&E committee MUST meet face-to-face at least annually or more often as appropriate.

Community Education and Project Promotion

Each family planning program MUST provide community education programs and project promotion services that will:

► Enhance community understanding of the objectives of the project;

► Make the availability of services to potential clients;

► Encourage continued participation by persons to whom family planning may be beneficial (uninsured, under-insured, homeless, immigrants, and other vulnerable and at-risk populations;

► Be based on an assessment of the needs of the community;

► Contain implementation and evaluation strategy; and

► Include promotional activities reviewed annually to assure they are responsive to the changing needs of the community.

Meetings of I & E/Advisory Committee and community education and project promotion activities are to be reported quarterly on Family Planning Quarterly Reports submitted to the State Office.
## Review Form for Information and Education Materials

**Family Planning Program**

**Title:**

**Subject Matter:**

**AV Format:**
- Video
- CD Rom
- Other

**Publication Format:**
- Pamphlet (1-5 pages)
- Booklet (5-15 pages)
- Book (15+ pages)
- Magazine

**Produced by:**

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**Recommended Priority Rating**

**Review Summary**

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**Name:**

**Department/Agency**

**Date** / /

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Chapter 13

GEORGIA FAMILY PLANNING PROGRAM

QUALITY ASSURANCE

The Georgia Family Planning Program, in compliance with Title X guidelines, provides specific standards, measurement tools and processes for improving the quality of care provided to Family Planning patients by maintaining compliance to the Quality Assurance/Quality Improvement for Public Health Nursing Practice Manual 2002.

Quality Assurance
Each project is responsible for having an ongoing quality assurance system in place as outlined in the Program Guidelines for Project Grants for Family Planning Service (Section 10.4). The quality assurance system should include the following:

► An established set of clinical, administrative and programmatic standards by which conformity would be maintained

► A tracking system to identify clients in need of follow-up and/or continuing care

► Ongoing medical audits to determine conformity with agency protocols

► Peer review procedures to evaluate individual clinician performance, to provide feedback to providers, and to initiate corrective action when deficiencies are noted

► Periodic review of medical protocols to insure maintenance of current standards of care

► A process to elicit consumer feedback; and

► Ongoing and systematic documentation of quality assurance activities.
Each project will comply with the quality assurance system by:


► Being knowledgeable regarding the information in Quality Assurance/Quality Improvement for Public Health Nursing Practice Manual 2002


► Maintaining a tracking system to identify clients in need of follow-up and/or continuing care.

The Office of Family Planning, which administers the Title X program, is part of the Office of Population Affairs (OPA) in the Office of Public Health and Science. OPA regional office monitor grantees through comprehensive program reviews and annual site visits. The four components of the comprehensive program review are: financial, administrative, counseling and clinical. These four Title X Program Review Tools can be obtained at the State Office upon request.
Chapter 14

GEORGIA FAMILY PLANNING PROGRAM

REPORTING REQUIREMENTS

The Georgia Family Planning Program, in compliance with Program Guidelines for Project Grants for Family Planning Services (Office of Population Affairs of U.S. Department of Health and Human Services), has developed a protocol to assist staff in notification or reporting of child abuse. Documentation of staff training on protocols and procedures regarding reporting of child abuse, child molestation, sexual abuse, rape, incest or any form of domestic violence as required by applicable State laws must be maintained by each district.

In addition to the Program Guidelines for Project Grants for Family Planning Services, the Office of Population Affairs, U.S. Department of Health and Human Resources provides detailed guidance, updated clinical information and clarification of specific program issues in the form of periodic Program Instruction Series to Regional Offices.

The most current Program Instruction released June 5, 2006, Compliance with State Reporting Laws – Reminder Notification, can be found at:

http://opa.osophs.dhhs.gov/titlex/pis/opa06-01.pdf
Memorandum

Date: June 5, 2006

From: Deputy Assistant Secretary for Population Affairs

Subject: OPA Program Instruction Series, OPA 06-01: Compliance with State Reporting Laws – Reminder Notification (Revised)

To: Regional Health Administrators, Regions I-X

This memorandum serves as a reminder notification regarding the following longstanding provision governing the use of Title X funds, which is included as section 213 of the Fiscal Year 2006 HHS appropriations act (Pub. L. No. 109-149):

Notwithstanding any other provision of law, no provider of services under title X of the Public Health Service Act shall be exempt from any State law requiring notification, or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

Previously, on January 12, 1999, the Office of Population Affairs (OPA) issued OPA Program Instruction Series, OPA 99-1, "Compliance with State Reporting Laws." OPA 99-1, which is attached to this memorandum, remains in effect. A copy of this memorandum, as well as the attached OPA 99-1, should be provided to all Title X grantees in your region. Title X grantees should be reminded that they are responsible for ensuring that all sub-recipients receive the information contained in this memorandum and OPA 99-1, and for ensuring that policies and procedures are in place to appropriately address notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest, or any other form of domestic violence, as required by applicable State law.
Regional Offices are responsible for periodic review of Title X grantees to ensure compliance with the provisions of the appropriations language as they relate to applicable State law. The Regional Office must undertake immediate steps to address any issues related to adherence to established policies and procedures. Outcome of all Regional Office reviews, including any corrective action, must be included in the official grant file for the applicable Title X grantee. Title X grantees are responsible for conducting periodic reviews of sub-recipient agencies for compliance, and must undertake immediate steps to address issues related to adherence to established policies and procedures. Grantees must maintain documentation of reviews, including outcomes, and any corrective action steps necessary.

Title X providers are encouraged to work with appropriate local authorities to ensure that policies and procedures are compliant with applicable State laws. In addition, providers are encouraged to establish formal referral relationships and community collaborations with other local health care providers who may also have reporting obligations under State law, law enforcement officials, child protective services, social service experts and others in order to explore how to best address the issues involved.

Title X grantees are encouraged to ensure that periodic training regarding the provisions of this mandate is available to project staff. Questions relating to the requirements addressed in this memorandum and/or OPA 99-1 should be addressed to the appropriate Office of Family Planning Regional Office, or the Office of Family Planning/Office of Population Affairs, as applicable.

Alma L. Golden, MD, FAAP

Attachment:  OPA Program Instruction Series, OPA 99-1: Compliance with State Reporting Laws
Mandatory Reporting Protocol for Child Abuse

In the state of Georgia, physicians, hospital staff, medical personnel, dentists, licensed psychologists and persons participating in internships to obtain licensing; registered professional nurses or licensed practical nurses; professional counselors, social workers, child welfare agency personnel; child-counseling personnel or law enforcement personnel having reasonable cause to believe that a child has been abused, defined as any person under 18 years of age, is required to report abuse (O.C.G.A § 19-7-5).

Abuse is defined as, “[Physical injury or death inflicted upon a child; neglect or exploitation of a child by a parent or caretaker by other than accidental means; sexual abuse, which does not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and adult, who is not more than five years older than the minor and sexual exploitation]”. Any person required to report abuse shall:

- Immediately notify the person in charge of the establishment, or the designated delegate thereof;

- The person so notified shall immediately make a report to the Department of Family and Children Services and provide the following information, if possible:
  - Names and addresses of the child and the child’s parent or caretakers, if known,
  - the child’s age,
  - the nature and extent of the child’s injuries, including any evidence of previous injuries,
  - any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator, and
  - Photographs of the child’s injuries to be used as documentation in support of allegations by hospital staff, physicians or legally mandated public or private child protective agencies may be taken without the permission of the child’s parent or guardian. The photographs shall be made available as soon as possible to the chief welfare agency providing protective services and to the appropriate police authority.
- A staff member who makes a report to the person designated pursuant to this paragraph shall be deemed to have fully complied with this subsection. Under no circumstances shall any person in charge of such hospital, school, agency, or facility, or the designated delegate thereof, to whom such notification has been made exercise any control, restraint, modification, or make other change to the information provided by the reporter, although each of the aforementioned persons may be consulted prior to the making of a report and may provide any additional, relevant, and necessary information when making the report. O.C.G.A. 19-7-5 (c) (2)

- If the person is making an oral report, it shall be made immediately, but in no case later than 24 hours from the time there is reasonable cause to believe a child has been abused, by telephone or otherwise and followed by a report in writing, if requested, to the designated child welfare agency or Department of Family and Children Services. Reports can be made to the local law enforcement or the district attorney in the absence of a designated child and welfare agency; O.C.G.A. 19-7-5 (d)

- If a report of child abuse is made to the Department of Family and Children Services, or independently discovered by the agency, and the agency has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, the agency shall immediately notify the appropriate police authority or district attorney. O.C.G.A. 19-7-5(e)

**Statutory Rape Law § O.C.G.A. 16-6-3**

According to O.C.G.A. §16-6-3, “A person commits the offense of statutory rape when he or she engages in sexual intercourse with any person under the age of 16 years and not his or her spouse."

Given the above definition, there are circumstances where the sexual activity does not meet the requirements of child abuse, as defined by O.C.G.A. §19-7-5, however, it may fall within the parameters of statutory rape. In that case, you should evaluate the matter and decide whether it should be reported. You are not required to report the conduct unless it meets the requirements of O.C.G.A. §19-7-5. Based upon the individual circumstances, it may be in the best interest of a child’s health, safety and welfare to report the sexual activity.

Where the abuse falls under the mandatory reporting law and statutory rape law, your duty to report is satisfied when you comply with the protocol for reporting child abuse, as outlined in O.C.G.A. § 19-7-5.

If you decide to report sexual activity that is defined as statutory rape, which does
not meet the definition of abuse as defined by O.C.G.A. §19-7-5, you should follow the protocol for reporting child abuse. Instead of reporting the activity to the child welfare agency or Department of Family and Children Services, you must report to your local law enforcement or District Attorney’s Office.
Compilation of State Statutes – Georgia

This document presents citations and texts of State laws on different topics related to child maltreatment reporting laws, central registries, permanency planning and domestic violence. The information contained in this compilation was obtained from the National Clearinghouse on Child Abuse and Neglect Information, a service of the Administration for Children and Families, U.S. Department of Health and Human Services, as well as individual state legal codes. It is intended to provide the healthcare provider with information regarding their state’s statutory provisions defining acts that are reportable as abuse, enumerating mandated reporters, and specifying procedures for the making and receiving of child maltreatment reports, as required by the Child Abuse and Neglect Prevention and Treatment Act, as amended (CAPTA) (45 USC 5106a).

While every attempt has been made to be as complete as possible, additional information on the topics covered in this compendium may be in other sections of a State’s code as well as in agency regulations, case law, and informal practices and procedures. Readers interested in interpretation of specific statutory provisions within an individual jurisdiction should consult with professionals within the State familiar with the statutes’ implementation.

To obtain more information about CAPTA, definitions of child abuse and neglect, or legal issues regarding the mandatory reporting of child abuse and neglect, contact the Clearinghouse at:

NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION
Children’s Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC  20024
Phone: (800) 394-3366
E-mail:  nccanch@caliber.com
Website:  http://nccanch.acf.hhs.gov/general/legal/state/reporting.cfm
Definitions of Child Abuse and Neglect

There are three places in State statutory provisions where "child abuse" and "child neglect" are defined:

- Child abuse reporting laws for the identification of cases that warrant reporting;
- Criminal codes for defining unlawful behavior; and
- Statutes governing the juvenile court for determination of child dependency.

Under the Child Abuse Prevention and Treatment Act (CAPTA), in order to receive a Federal grant, States must have provisions or procedures for the reporting of known and suspected instances of child abuse and neglect. CAPTA also provides minimum standards for the definition of child abuse and neglect that States must incorporate in their statutory definitions. Under CAPTA, child abuse and neglect means, at a minimum:

- Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

The term sexual abuse includes:

- The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or
- The rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Each State provides its own definitions of child abuse and neglect. As applied to reporting statutes, these definitions determine the grounds for State intervention in the protection of a child's well-being. Definitions vary among States. For example, some States define child abuse and neglect as a single concept, while others provide separate definitions for physical abuse, neglect, sexual abuse, and/or emotional abuse.

Many States define abuse in terms of harm or threatened harm to a child's health or welfare. All States include sexual abuse in their definitions. Some States refer in general terms to sexual abuse, while others specify various acts as sexual abuse. Neglect is frequently defined in terms of deprivation of adequate food, clothing, shelter, or medical care. Several States distinguish between failure to
provide based on the financial inability to do so, and the failure to provide for no apparent financial reason. The latter constitutes neglect.

In addition to defining the acts or omissions that constitute maltreatment, several statutes provide specific definitions of the perpetrators of abuse and neglect—parents, guardians, foster parents, relatives, or caretakers responsible for the child's welfare. A number of States also provide exemptions in their reporting laws, which exempt certain acts or omissions from their statutory definitions of child abuse and neglect. For instance, many States carve out a religious exemption for parents who choose not to seek medical care for their children due to religious beliefs.

1 The State Statutes contain excerpts from specific sections of each State’s code. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State’s code as well as in agency regulations, case law, and informal practices and procedures.

2 This element only focuses on child abuse reporting laws.


7 The term "child" means a person who has not attained the age of 18.


# State Definitions

**Ga. Code Ann. § 19-7-5(b)**

As used in this Code section, the term:

"**Abused**" means subjected to child abuse.

"**Child**" means any person under 18 years of age.

"**Child abuse**" means:

- Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child;
- Neglect or exploitation of a child by a parent or caretaker thereof;
- Sexual abuse of a child; or
- Sexual exploitation of a child.

"**Sexual abuse**" means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:

- Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;
- Bestiality;
- Masturbation;
- Lewd exhibition of the genitals or pubic area of any person;
- Flagellation or torture by or upon a person who is nude;
- Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;
- Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;
- Defecation or urination for the purpose of sexual stimulation; or
- Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

"Sexual exploitation" means conduct by a child's parent or caretaker who allows, permits, encourages, or requires that child to engage in:

- Prostitution, as defined in Code Section 16-6-9; or
- Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

Exceptions

Ga. Code Ann. § 19-7-5(b)(3), (A), (D), (3.1)(I)

Physical forms of discipline may be used as long as there is no physical injury to the child.

No child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be an "abused" child.

"Sexual abuse" shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than five years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5

Summary of Statutory Rape Laws

Most states do not refer specifically to statutory rape; instead they use designations such as sexual assault and sexual abuse to identify prohibited activity. Regardless of the designation, these crimes are based on the premise that until a person reaches a certain age, he is legally incapable of consenting to
sexual intercourse. Thus, instead of including force as a criminal element, these crimes make it illegal for anyone to engage in sexual intercourse with anyone below a certain age, other than his spouse. The age of consent varies by state, with most states, including Connecticut, setting it at age 16. The age of consent in other states ranges from ages 14 to 18.

Some states base the penalty for violations on the age of the offender, with older offenders receiving harsher penalties. For example, California, Maryland, Missouri, Nevada, and New York reserve their harshest statutory rape penalty for offenders who are age 21 or older.

**Georgia § 16-6-3**

A person commits the offense of statutory rape when he or she engages in sexual intercourse with any person under the age of 16 years and not his or her spouse, provided that no conviction shall be had for this offense on the unsupported testimony of the victim.

A person convicted of the offense of statutory rape shall be punished by imprisonment for not less than one nor more than 20 years; provided, however, that if the person so convicted is 21 years of age or older, such person shall be punished by imprisonment for not less than ten nor more than 20 years; provided, further, that if the victim is 14 or 15 years of age and the person so convicted is not more than three years older than the victim, such person shall be guilty of a misdemeanor.

From: [http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=16-6-3](http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=16-6-3)

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**Incest**

**Georgia §16-6-22**

A person commits the offense of incest when he engages in sexual intercourse with a person to whom he knows he is related either by blood or marriage as follows:

- Father and daughter or stepdaughter;
- Mother and son or stepson;
- Brother and sister of the whole blood or of the half blood;
- Grandparent and grandchild;
- Aunt and nephew; or
- Uncle and niece.
A person convicted of the offense of incest shall be punished by imprisonment for not less than one nor more than 20 years.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=16-6-22

### Aggravated Child Molestation

**Georgia §16-6-4 (c), (d)(1)**

A person commits the offense of aggravated child molestation when such person commits an offense of child molestation which act physically injures the child or involves an act of sodomy.

A person convicted of the offense of aggravated child molestation shall be punished by imprisonment for not less than ten nor more than 30 years.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=16-6-4

### Definitions of Domestic Violence

Although the statutes governing juvenile or family court and the mandatory reporting of child maltreatment are the primary laws that protect abused and neglected children, the majority of States are moving toward greater protection of children by specifically including child victims in their domestic violence definitions. Of the 50 States and the District of Columbia, in which all have enacted legislation defining domestic violence, approximately 40 jurisdictions recognize children as a class of persons intended to be protected by the legislation.

Within these States, statutory provisions identify which particular children are protected from abusive behavior. The majority of States require that a special relationship exist between the child victim and the perpetrator. For example, some States include a minor child of a household member when the defendant is an adult household member, while others include a child of a spouse, a child of a respondent, or any child of a party. A few States extend protection to any child residing in the household. Certain jurisdictions also specifically include foster children, stepchildren, and grandchildren. Many jurisdictions just specify that children are covered. Although not explicitly listing children as persons intended to be protected, some additional States cover household members related by blood or marriage, persons residing in the same household, and persons living in the same domicile.

Domestic violence definitions also identify the prohibited abusive conduct committed toward children. Such behavior usually includes physical, sexual, and emotional attacks against a child. It may also involve stalking, threatening, harassing and placing a child in fear of physical harm. Many States, however, do...
not specify the amount or extent of violence required by the perpetrator. Under the plain language of some statutes, a single act of domestic violence can suffice.

A small number of States also provide exemptions in their definitions of domestic violence. These States have exempted certain acts or omissions from their statutory definitions. The most common exemptions are in the areas of corporal punishment and self-defense. For example, in several jurisdictions, corporal discipline of a child by a parent or guardian for disciplinary purposes does not constitute domestic violence when the discipline is reasonable.

From: http://nccanch.acf.hhs.gov/general/legal/statutes/domviolall.pdf


"Family violence" means the occurrence of one or more of the following acts between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household:

- Any felony; or
- Commission of offenses of battery, simple battery, simple assault, assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass.

EXCEPTIONS


Family violence shall not be deemed to include reasonable discipline administered by a parent to a child in the form of corporal punishment, restraint, or detention.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-13-1
Reporting Procedures

Every State and the District of Columbia have statutes specifying procedures that a mandatory reporter must follow when making a report of child abuse or neglect. Reports typically include the name and address of the child and the child's parents or other persons responsible for the child's care, the child's age, the nature and extent of the child's injuries, and any other information relevant to the investigation.

In addition to procedures a mandatory reporter must follow, many statutes also specify procedures for cross-reporting among professional entities. Typically, reports are shared among social services agencies, law enforcement agencies and prosecutors' offices.

Some States also include specific reporting procedures for special situations. Several States have enacted reporting procedures to be followed in the event of a suspicious child death. In addition, a few States have enacted legislation regarding specific reporting procedures to be followed for drug-exposed infants.

1 The State Statutes contain excerpts from specific sections of each State's code. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State's code as well as in agency regulations, case law, and informal practices and procedures.

From: http://nccanch.acf.hhs.gov/general/legal/statutes/repproc.cfm

Ga. Code Ann. § 19-7-5(c), (d), (e)

Individual Responsibility

Any mandated reporter having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made as provided by statute.

If a person is required to report abuse pursuant to the reporting laws because that person attends to a child pursuant to such person's duties as a member of the staff of a hospital, school, social agency, or similar facility, that person shall notify the person in charge of the facility, or the designated delegate thereof, and the person so notified shall report or cause a report to be made in accordance with the statute. A staff member who makes a report to the person designated pursuant to this paragraph shall be deemed to have fully complied with this subsection.
Any other person, other than any specified mandatory reporters, who has reasonable cause to believe that a child is abused may report or cause reports to be made.

An oral report shall be made as soon as possible by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Resources, or, in the absence of such agency, to an appropriate police authority or district attorney.

Department Responsibility

If a report of child abuse is made to the child welfare agency or independently discovered by the agency, and the agency has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, then the agency shall immediately notify the appropriate police authority or district attorney.

Content of Reports

Such reports shall contain the names and addresses of the child and the child's parents or caretakers, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

Photographs of the child's injuries to be used as documentation in support of allegations by hospital staff, physicians, law enforcement personnel, school officials, or staff of legally mandated public or private child protective agencies may be taken without the permission of the child's parent or guardian; provided, however, that any photograph taken pursuant to this Code section shall, if reasonably possible, be taken in a manner which shall not reveal the identity of the subject. Such photograph shall be made available as soon as possible to the chief welfare agency providing protective services and to the appropriate police authority.

From: [http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5](http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5)

Ga. Code Ann. § 16-12-100(c)

Individual Responsibility

A person who, in the course of processing or producing visual or printed matter either privately or commercially, has reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct shall immediately report such incident, or cause a
report to be made, to the Georgia Bureau of Investigation or the law enforcement agency for the county in which such matter is submitted.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=16-12-100

Mandatory Reporters of Child Abuse and Neglect

Each State designates individuals, typically by professional group, who are mandated by law to report child maltreatment. Any person, however, may report incidents of abuse or neglect.

Individuals Typically Mandated to Report

Individuals typically designated as mandatory reporters have frequent contact with children. Such individuals include:

- Health care workers
- School personnel
- Day-care providers
- Social workers
- Law enforcement officers
- Mental health professionals

Some States also mandate animal control officers, veterinarians, commercial film or photograph processors, substance abuse counselors, and firefighters to report abuse or neglect. Four States—Alaska, Arkansas, Connecticut, and South Dakota—include domestic violence workers on the list of mandated reporters. Approximately¹ eighteen States require all citizens to report suspected abuse or neglect regardless of profession.

Standard for Making a Report

Typically a report must be made when the reporter suspects or has reasons to suspect that a child has been abused or neglected.

Privileged Communications

Approximately thirty-four states specify in their reporting laws when a communication is privileged.² Privileged communications, which is the statutory recognition of the right to maintain the confidentiality of communications between
professionals and their clients or patients, are exempt from mandatory reporting laws. The privilege most widely recognized by the States is that of attorney-client. The privilege pertaining to clergy-penitent also is frequently recognized, but limited to situations in which a clergy person becomes aware of child abuse through confessions or in the capacity of spiritual advisor. However, five States, New Hampshire, North Carolina, Rhode Island, Texas, and West Virginia, deny the clergy-penitent privilege. Very few States recognize the physician-patient and mental health professional-patient privileges as exempt from mandatory reporting laws.

1 The word approximately is used to stress the fact that statutes are constantly being revised and updated.
2 Privilege communications may be addressed in other sections of State law, typically in rules of evidence of civil procedure.

From: [http://nccanch.acf.hhs.gov/general/legal/statutes/manda.cfm](http://nccanch.acf.hhs.gov/general/legal/statutes/manda.cfm)

**Ga. Code Ann. §§ 19-7-5(c)(1); 16-12-100(c)**

**Who Must Report**

- Physicians licensed to practice medicine; interns; residents; hospital and medical personnel; dentists; podiatrists; registered professional nurses or licensed practical nurses;
- School teachers; school administrators; school guidance counselors, visiting teachers, school social workers, or school psychologists;
- Licensed psychologists; persons participating in internships to obtain licensing as psychologists; professional counselors, social workers, or marriage and family therapists; child-counseling personnel;
- Child welfare agency personnel (including any child-caring institution, child-placing agency, maternity home, family day-care home, group day-care home, and day-care center); child service organization personnel;
- Law enforcement personnel;
- Persons who process or produce visual or printed matter.

**Circumstances**

- When they have reasonable cause to believe that a child has been abused;
- A person who, in the course of processing or producing visual or printed matter either privately or commercially, has reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct.
Privileged Communications

Ga. Code Ann. § 19-7-5(g)

Mandatory reporters are required to report even if the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part on any communication to the reporter which would otherwise be privileged or confidential, by law.

From: [http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5](http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5)

Immunity for Reporters

Under the Child Abuse Prevention and Treatment Act (CAPTA), in order to receive a Federal grant, States must provide provisions for immunity from prosecution under State and local laws and regulations for individuals making good faith reports of suspected or known instances of child abuse or neglect.

Every State provides some form of immunity from liability for persons who in good faith report suspected instances of abuse or neglect under the reporting laws. Immunity statutes protect reporters from civil or criminal liability that they might otherwise incur. Several States provide immunity not only for the initial report, but also during any judicial proceedings arising from the report.

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1 The State Statutes contain excerpts from specific sections of each State’s code. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State’s code as well as in agency regulations, case law, and informal practices and procedures.


From: [http://nccanch.acf.hhs.gov/general/legal/statutes/immunity.cfm](http://nccanch.acf.hhs.gov/general/legal/statutes/immunity.cfm)

Ga. Code Ann. § 19-7-5(f)

Any person(s), partnership, firm, corporation, association, hospital, or other entity participating in the making of a report or causing a report to be made to a child welfare agency providing protective services or to an appropriate police authority pursuant to the reporting laws or any other law, or participating in any judicial proceeding or any other proceeding resulting there from shall in so doing, be immune from any civil or criminal liability that might otherwise be incurred or imposed, provided such participation is made in good faith. Any person making a report, whether required by reporting laws or not, shall be immune from liability.

From: [http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5](http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5)
Reporting Penalties

Many cases of child abuse or neglect are neither reported nor investigated even when suspected by professionals. Therefore, almost every State imposes penalties, in the form of a fine or imprisonment, on those who knowingly and/or willfully fail to report. Also, in order to prevent malicious or intentional reporting of cases that are not founded, several States impose additional penalties for false reports of child abuse or neglect.

Penalties for Failure to Report

Approximately\(^1\) forty-five States and the District of Columbia have enacted statutes specifying the penalties for failure to report child abuse or neglect. Of these jurisdictions, approximately thirty-three States and the District of Columbia use a "knowingly," "knows or should have known," and/or "willfully" standard. Other standards include "intentionally" and "purposely." A few States impose penalties without providing a standard. Failure to report is classified as a misdemeanor in approximately thirty-five States.

Penalties for False Reports

Approximately 31 States have statutes specifying penalties for false reports of child abuse or neglect. The most common standards are "knowingly" and/ or "willfully." The penalties imposed are similar to those for failure to report. The majority of States classify false reporting as a misdemeanor. In nine States, however, a false report may be classified as a felony under specific circumstances.

\(^1\) The word approximately is used to stress the fact that statutes are constantly being revised and updated.

From: http://nccanch.acf.hhs.gov/general/legal/statutes/report.cfm

Ga. Code Ann. § 19-7-5(h)

Any person or official required by law to report a suspected case of child abuse who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=19-7-5

Disclosure of Confidential Records

Approximately\(^1\) 43 States and the District of Columbia have statutes authorizing the establishment of a Statewide central registry. A central registry is a centralized database or listing of child maltreatment records. Several States only
mandate by law that agencies, usually public social services agencies, collect and maintain child abuse and neglect records.

Central registry records are typically used to aid social services agencies in the investigation, treatment and prevention of child abuse cases, and to maintain statistical information for staffing and funding purposes. The type of information contained in registry and department records varies from State to State, as does access to the information maintained.

**Record Protection**

Statutory provisions concerning access to central registry and department records are one answer to the question of how to protect family autonomy and privacy rights, and yet ensure protection for children. All jurisdictions have confidentiality provisions to protect abuse and neglect records from public scrutiny. Confidentiality provisions mandate that such records are confidential, and many include specific mechanisms for protecting them from public view.

**Access to Records**

Most jurisdictions permit certain persons access to registry and department records. In general, these are people with a direct interest in a case, in the child's welfare, or in providing protective or treatment services. Many statutes specifically describe who may access the records and under what circumstances. Typically, persons entitled to access include physicians, researchers, police, judges and other court personnel. Several States also provide confidential records to any person who is the subject of a report.

**Employment Eligibility**

Central registries are increasingly used to screen adults for various employment opportunities. Approximately 29 states and the District of Columbia allow or require central registry checks for individuals applying to be child or youth care providers. Information may thus be available to employers in the childcare business, schools, or health care industry. Information, however, is generally limited to whether there are substantiated reports of child maltreatment for potential employees who will have significant contact with children.

1 The word approximately is used to stress the fact that statutes are constantly being revised and updated.

2 Under the Child Abuse Prevention and Treatment Act (CAPTA), in order to receive a Federal grant, States must preserve the confidentiality of all child abuse and neglect reports and records to protect the privacy rights of the child and of the child's parents or guardians except in certain limited circumstances. 42 U.S.C.A. §5106a(b)(2)(A)(v) (West Supp. 1998).

From: [http://nccanch.acf.hhs.gov/general/legal/statutes/confideall.pdf](http://nccanch.acf.hhs.gov/general/legal/statutes/confideall.pdf)
Ga. Code Ann. § 49-5-185

Except as otherwise provided in the paragraph below and subsection (b) of § 49-5-186, only an abuse investigator, medical examiner, coroner, or out-of-state abuse investigator which has investigated, or is investigating, a case of possible child abuse shall be provided any information from the abuse registry and shall only be provided information relating to that case for purposes of using that information in such investigation.

The Department shall provide the Governor's office, the General Assembly, district attorneys, and law enforcement agencies with a statistical analysis of reported cases from the abuse registry at the end of each calendar year. This analysis shall not include the names of any children, parents, or persons alleged to have committed child abuse. This analysis shall not be protected by any laws prohibiting the dissemination of confidential information.

A person may make a written request to any DFACS office to find out whether such person's name is included on the abuse registry. Upon presentation of a passport, military identification card, driver's license, or identification card, the office receiving such request shall disclose to such person whether that person's name is included on the abuse registry and, if so, whether the report is classified as confirmed or unconfirmed, the date upon which the person's name was listed on the registry, and the county in which the investigation was conducted which resulted in such inclusion.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=49-5-185


Information in the abuse registry shall be confidential and access thereto is prohibited except as provided in this article. Such information shall not be deemed to be a record of child abuse for purposes of Article 2 of this chapter.

Information obtained from the abuse registry may not be made a part of any record which is open to the public except as provided below and except that a district attorney may use in any court proceeding that information in the course of any criminal prosecution for any offense which constitutes or results from child abuse if such information is otherwise admissible.

Notwithstanding any other provisions of law, information in the abuse registry applicable to a child who at the time of his or her death was in the custody of a State Department or agency or foster parent which information relates to the child while in the custody of the State Department or agency or foster parent whose custody the child was in at the time of the child's death shall not be confidential and shall be subject to Article 4 of Chapter 18 of Title 50, relating to open records.
Notwithstanding Code Section 49-5-40, the following persons or agencies shall have reasonable access to such records concerning reports of child abuse:

Legally mandated, public or private, child protective agency of this state or any other state;

A court, or grand jury, by subpoena, or a district attorney or assistant district attorney;

Any adult who makes a report of suspected child abuse, but such access shall include only whether the investigation is ongoing or completed, and if completed, whether child abuse was confirmed or unconfirmed;

Any adult requesting information regarding investigations by the department regarding an identified deceased child, but such access shall be limited to whether there is an ongoing or completed investigation of such death, and if completed, whether child abuse was confirmed or unconfirmed;

The State Personnel Board, on a finding by an administrative law judge that access to such records may be necessary for a determination of an issue involving department personnel. The name of any complainant or client shall not be identified or entered into the record;

A child advocacy center which is certified by the Child Abuse Protocol Committee of the county where the principal office of the center is located and which is operated for the purpose of investigation of known or suspected child abuse, provided, however, that any child advocacy center which is granted access to records concerning reports of child abuse shall be subject to the penalties imposed by Code Section 49-5-44 for authorizing or permitting unauthorized access to or use of such records;

Police or any other law enforcement agency of this state or any other state or any medical examiner or coroner investigating a report of known or suspected abuse;

The Governor, the Attorney General, the Lieutenant Governor, or the Speaker of the House of Representatives when such officer makes a written request to the commissioner of the department;

Individuals or entities who are engaged in legitimate research for educational, scientific or public purposes, upon application to the juvenile
court in the county in which are located such records concerning reports of child abuse, and after a hearing by the court on the issue;

The department or a county or other state or local agency may permit access to records concerning reports of child abuse to the following, when deemed appropriate by such department:

A physician who has before him a child whom he reasonably suspects may be abused;

A licensed child-placing agency or child-caring institution of this state which is assisting the Department of Human Resources by locating or providing foster or adoptive homes for children;

A person legally authorized to place a child in protective custody when such person has before him a child he reasonably suspects may be abused;

An agency or person having the legal custody, responsibility or authorization to care for, treat or supervise the child who is the subject of a report or record or an agency, facility or person having responsibility or authorization to assist in making a judicial determination for the child who is the subject of the record or report;

A legally mandated public child protective or law enforcement agency of another state when, during or following the department’s investigation of a report of child abuse, the alleged abuser has left this state;

A child welfare agency or a school where the department has investigated allegations or child abuse made against any employee of such agency or school and any child remains at risk from exposure to that employee, except that such access or release shall protect the identity of any person reporting the child abuse and any other person whose life or safety has been determined by the department likely to be endangered if the identity were not so protected;

An employee of a school or child welfare agency against whom allegations of child abuse have been made, when the department has been unable to determine the extent of the employee’s involvement in alleged child abuse. Such access or release shall protect the identity or any person reporting the child abuse and any other person whose life or safety has been determined by the department likely to be endangered if the identity were not so protected.
Any person who has an ongoing relationship with the child named in the record, but only if that person is required to report suspected abuse of that child pursuant to subsection (b) of Code Section 19-7-5; and

Any school principal or any school guidance counselor, school social worker or school psychologist who is counseling a student as a part of such counseling person’s school employment duties.

The Department of Early Care and Learning or the Department of Education, Division of School Readiness.

From: http://www.legis.state.ga.us/cgi-bin/gl_codes_detail.pl?code=49-5-41
Family Planning Reports

► Monthly

- Family Planning Data Report
  Data included in the Family Planning Encounter Form. Verification of transmission report is run on the 16th day of each month at 8:00am

  ▪ **Due dates:**
  Transmit visit data anytime from the 1st thru the 15th day of each month using Attachmate or Telnet QWS3270 by Jolly Giant.

► Quarterly

- Quarterly Family Planning Reports Include the following:
  - Sterilization Report
  - Community Participation / Materials Review Committee Report
  - Grant-In-Aid Report (036 & 305)
  - Drug Report
  - District Family Planning Work Plan
  - Non-Traditional Site Reports (Albany, Macon, Augusta, Gainesville, Columbus, LaGrange)

  ▪ **Due dates:** (all items listed above)
    - 1st Quarter (July–September) by **October 15th**
    - 2nd Quarter (October – December) by **January 15th**
    - 3rd Quarter (January – March) by **April 15th**
    - 4th Quarter (April – June) by **June 15th**
► Annual Reports

- Family Planning Annual Report (FPAR)  

- Number of Family Planning Encounter by Type of Provider – Table 13 located at the end of this section

- Revenue Report – Table 14, which is also located at the end of the chapter

- **Due date: January 31st** to the Family Planning Manager at the state office

- **Information requested by State Office to Complete Family Planning Grant Application**
  
  - Copy of Title X Assurance of Compliance  
  
  - District summary table, Services Provider
  
  - District summary table, Services Site Information
  
  - Districts sliding scale of fees for services and supplies
  
  - Districts sliding scale of fees based on current Federal Poverty Level
  
  - Additional information to complete grant application as requested

- **Due date: January 31st** to the Family Planning Manager at the state office
TABLE 13

NUMBER OF FAMILY PLANNING ENCOUNTERS BY TYPE OF PROVIDER

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>NUMBER OF FTES (A)</th>
<th>NUMBER OF FAMILY PLANNING ENCOUNTER (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Clinical Services Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b Physician assistants/nurse practitioners/certified nurse midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1c Other clinical services providers (e.g., registered nurses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 NON-CLINICAL SERVICES PROVIDERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 TOTAL FAMILY PLANNING ENCOUNTER (SUM ROWS 1+2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Title X Family Planning Annual Report

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TABLE 14
REVENUE REPORT

<table>
<thead>
<tr>
<th>FEDERAL GRANTS</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Title X (family planning services)</td>
<td>$</td>
</tr>
<tr>
<td>2 Bureau of Primary Health Care (BPHC)</td>
<td>$</td>
</tr>
<tr>
<td>3 Other federal grant (Specify:</td>
<td>$</td>
</tr>
<tr>
<td>4 Other federal grant (Specify:</td>
<td>$</td>
</tr>
<tr>
<td>5 TOTAL- FEDERAL GRANTS</td>
<td></td>
</tr>
<tr>
<td>(SUM ROWS 1 To 4)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAYMENT FOR SERVICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Total client collections/self-pay</td>
<td>$</td>
</tr>
<tr>
<td>7 Third-party payers</td>
<td></td>
</tr>
<tr>
<td>7a Medicaid (Title XIX)</td>
<td>$</td>
</tr>
<tr>
<td>7b Medicare (Title XVIII)</td>
<td>$</td>
</tr>
<tr>
<td>7c State Children’s Health Insurance Program (state CHIP)</td>
<td>$</td>
</tr>
<tr>
<td>7d Other public health insurance</td>
<td>$</td>
</tr>
<tr>
<td>7e Private health insurance</td>
<td>$</td>
</tr>
<tr>
<td>8 TOTAL - THIRD-PARTY PAYERS</td>
<td>$</td>
</tr>
<tr>
<td>(SUM Rows 7a To 7e)</td>
<td></td>
</tr>
<tr>
<td>9 TOTAL - PAYMENT FOR SERVICES</td>
<td>$</td>
</tr>
<tr>
<td>(SUM ROW 6 + CELL 8A + CELL 8B)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER REVENUE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Title V (MCH Block Grant)</td>
<td>$</td>
</tr>
<tr>
<td>11 Title XX (Social Services Block Grant)</td>
<td>$</td>
</tr>
<tr>
<td>12 Temporary Assistance for Needy Families (TANF)</td>
<td>$</td>
</tr>
<tr>
<td>13 Local government grants and contracts</td>
<td>$</td>
</tr>
<tr>
<td>14 Other (Specify:______________________)</td>
<td>$</td>
</tr>
<tr>
<td>15 Other (Specify:______________________)</td>
<td>$</td>
</tr>
<tr>
<td>16 Other (Specify:______________________)</td>
<td>$</td>
</tr>
<tr>
<td>17 Other (Specify:______________________)</td>
<td>$</td>
</tr>
<tr>
<td>18 TOTAL- OTHER REVENUES</td>
<td>$</td>
</tr>
<tr>
<td>(SUM ROWS 10 To 17)</td>
<td></td>
</tr>
<tr>
<td>19 TOTAL REVENUES</td>
<td>$</td>
</tr>
<tr>
<td>(Sum Rows 5+9+18)</td>
<td></td>
</tr>
</tbody>
</table>

Title X Family Planning Annual Report
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