

WOMEN'S HEALTH SERVICES PROGRAM GUIDELINES

The Women's Health Services Program Guidelines are based on guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Report of the U.S. Preventive Services Task Force, Guide to Clinical Preventive Services. Each encounter with the health care system should be viewed as an opportunity to reinforce healthy lifestyles and preventive health practices; for women of child-bearing age, this may lead to better birth outcomes.

1. Pelvic Exams/Lab Testing

Introduction:

The following components are all to be performed if the pelvic examination is part of an annual well woman gynecologic visit. If such an examination has been performed within the preceding year and the pelvic exam is being performed as part of a problem-focused visit, then only those components that are clinically necessary need to be performed.

Recommendations:

- A. Written protocols and operating procedures must be in place for the medical history and physical examination including pelvic portion with the appropriate laboratory evaluation (as determined by the history and physical)
 1. At the initial visit a pertinent personal and family medical history must be obtained on all clients.
 - a. The initial history should include the following:
 - (1) Allergies
 - (2) Immunizations: in particular, Rubella, Varicella, and Hepatitis B
 - (3) Current prescriptive and over-the-counter medications
 - (4) Past medical history including significant illnesses, hospitalizations, surgeries, and chronic or acute medical conditions
 - (5) Blood transfusion or exposure to blood products
 - (6) Systems review
 - (7) Alcohol, drug or tobacco use
 - (8) Sexual activity and risk behavior
 - (9) Family medical history
 - (10) Partner history including intravenous drug use, number of current and past partners, age at first intercourse, risk history for STD/HIV, and presence of bisexual partners.
 - b. Gynecological and reproductive history must include the following:
 - (1) Menstrual history
 - (2) Sexual history
 - (3) Obstetrical history
 - (4) Gynecological conditions
 - (5) In utero exposure to DES
 - (6) History of STDs, including Hepatitis B and HIV

- (7) Pap smear history (date of last Pap, any abnormal Pap, treatment)
- (8) Contraceptive use history including:
 - a. Current birth control method, if any
 - b. Method desired, if any desired
 - c. Previous birth control methods and reason for stopping
- 2. A complete physical examination should be performed and include the following components:
 - a. Initial and subsequent annual physical exams should include at least the following:
 - (1) Height and weight
 - (2) Blood pressure
 - (3) Examination of the thyroid
 - (4) Heart and lungs
 - (5) Extremities
 - (6) Breast, including instruction in self-examination
 - (7) Abdomen
 - (8) Pelvic and bimanual
 - (9) Rectal exam as appropriate
 - (10) Pap Smear
 - (11) STD and HIV screening for high risk patients
 - (12) Colo-Rectal cancer screening in clients over 50
 - b. Following counseling about the importance of preventive service, if a client chooses to decline or defer a service, this should be documented in their record.
 - c. All physical examinations and laboratory test requirements stipulated in the prescribing information for specific methods of contraception must be followed.
- 3. Written laboratory protocols and operating procedures must be in place as follows:
 - a. The following lab procedures should be repeated annually or as clinically indicated for maintenance of health status and/or diagnostic purpose:
 - (1) Anemia assessment
 - (2) Pap smear
 - (3) STD testing including HIV, HBV, Syphilis (VDRL or RPR) for high risk patients
 - (4) Urinalysis, as indicated
 - (5) Pregnancy testing
 - (6) Vaginal wet mount
 - (7) Blood Glucose test
 - (8) Cholesterol and lipids
 - (9) Colo-Rectal screening for women over 50
 - (10) Cancer screening
- 4. Quality control, equipment maintenance and proficiency testing for on-site lab testing, including Clinical Laboratory Improvement Amendments (CLIA) as required.

5. Assurance of high quality lab testing for off-site labs.
 - a. A system for assessing credentials of contracted labs should be in place.
 - b. Competitive bidding should take place prior to contracting with an outside lab.
 - c. Cytology services must be provided by laboratories compliant with state licensure regulations.
 6. Referral and follow-up for abnormal tests must include:
 - a. Notification of the client (refer to agency-specific policy regarding patient contact, confidentiality).
 - b. Documentation of the appropriate management for abnormalities
 - c. Referral of the client for necessary service if not provided on-site.
 - d. When initial contact is not successful, a reasonable further effort should be made (refer to agency-specific policy on follow-up of abnormal lab results).
 - e. Assessment of successful referral –appointment made and kept by patient
- C. Pre-pregnancy and Inter-pregnancy considerations
1. General health
 - a. Acute/chronic medical conditions
 - b. Immunization status
 - c. Teratogenic/environmental/occupational exposures
 - d. Infectious diseases (STD's/HIV)
 - e. Nutritional status: includes weight optimization and discussion of folic acid supplementation
 2. Genetic
 - a. Advanced maternal age (≥ 35 years): assessment of chromosomal aneuploidy risk
 - b. Family history of birth defect/inheritable condition
 - c. History of recurrent pregnancy loss
 - d. Assessment of race- or ethnic-specific genetic risk: i. e. Tay-Sachs disease, sickle cell disease, cystic fibrosis, or thalassemia
 3. Psycho-social
 - a. Domestic violence/sexual coercion
 - b. Substance abuse
 - c. Health care access (includes payment methods and transportation)
 - d. Stress level
 - e. Depression screen

Return Visits

- A. Return visits must be individualized based upon the client's need for education and clinical care beyond that provided at the initial and annual visit.
 1. Clients using a new method of contraception should be scheduled for a revisit as appropriate after initiation of the method to check for possible side effects, and to provide additional information. 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 findings at the initial visit.

2. Assessment of compliance with referrals. Patient care is considered complete when a referral has been made and the patient has been documented as keeping the appointment. Follow-up contact should be made to ensure this and if it has not occurred, to re-schedule.
3. Follow-up contact should be made to those clients who have been counseled or been educated about making lifestyle changes. This provides an opportunity to assess the effectiveness of the education and ask any questions.

Reference:

The American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care, 2nd edition, pages 121-144.

2. Breast Cancer Screening and Patient Education

Introduction:

Breast cancer is the second leading cause of death due to cancer in women. One in eight women will develop breast cancer during her lifetime.

Recommendations:

- A. Breast examination by visual inspection and palpation should be an integral part of initial obstetric and all complete gynecologic examinations.
- B. Patients should be counseled as to the importance of self breast exams and instructed in the technique.
- C. Patients should be encouraged to undergo mammography screening in accordance with ACOG guidelines.
- D. When indicated, referrals should be made to physicians who specialize in the diagnosis and treatment of breast disease.
- E. A persistent palpable breast mass requires evaluation.

Reference:

The American College of Obstetricians and Gynecologists. Committee Opinion # 186—September, 1997.

3. Cervical Cancer Screening

Introduction:

Despite the introduction of cervical cancer screening via the Pap test more than five decades ago, there are still about 13,000 new cases of cervical cancer diagnosed each year. About 50 million Pap tests are performed annually in the United States.

Recommendations:

- A. Annual visits and pap smears should begin by age 21 years or 3 years after the first sexual intercourse, whichever comes first.
- B. For women less than 30 years of age, annual cervical cytology screening should occur.
- C. For women age 30 and older there are two acceptable screening options:
 - 1. After three (3) consecutive annual cervical cytology tests with negative results, re-screening may occur every two-three (2-3) years; or
 - 2. Women may have a combined pap smear with HPV DNA test. If negative on each they should be re-screened with the combined test no more frequently than every 3 years. If only one of the tests is negative, more frequent screening will be needed.
 - 3. Exceptions that require more frequent screening include HIV positive women, immuno-suppressed women, those with perinatal exposure to DES, or those with a prior history of cervical cancer.
- D. For women who have had a hysterectomy including removal of the cervix, routine cytology testing may be discontinued. Those with a prior history of CIN 2 or 3 should be screened annually until three consecutive, negative vaginal cytology tests are obtained and then routine screening may be discontinued.

Reference:

The American College of Obstetricians and Gynecologists. News Release, July 31, 2003.
<http://www.acog.org>.

4. Screening and Treatment for Sexually Transmitted Diseases (including HIV)

Introduction:

According to the US Centers for Disease Control and Prevention, more than 90% of the common infectious diseases in women are sexually transmitted. Many such infections are either more easily transmitted from men to women or have more serious consequences in women. These consequences include ectopic pregnancy, infertility, cervical cancer and the possibility of transmission from a pregnant woman to her offspring with deleterious results.

Recommendations:

- A. Counseling
 - 1. All clients must receive thorough and accurate counseling on STDs and HIV. STD/HIV counseling refers to an individualized dialogue with a client in which there is a discussion of personal risks for STD/HIV, and the steps to be taken by the individual to reduce any identified risk. Persons found to have behaviors which currently put them at risk for STD/HIV must be advised whether clinical evaluation is indicated. Appropriate referrals must be made as indicated.

B. Screening and Treatment

1. Written protocols and operating procedures must meet the following required standards:
 - a. Gonorrhea and chlamydia tests should be provided at the agency or by referral for high-risk clients, as recommended for specific contraceptive methods, and upon request.
 - b. When treatment is provided on-site, appropriate follow -up measures must be undertaken.
 - c. Adherence to state and local STD reporting requirements must be present.
 - d. When parenteral antibiotics are administered, personnel capable of handling an anaphylactic reaction must be in attendance and appropriate resuscitation drugs and equipment must be available.
 - e. Screening for other STDs as indicated.
2. HIV/AIDS services must cover:
 - a. HIV/AIDS counseling on risks, infection prevention and referral services.
 - b. Testing or referral for testing.
 - c. All staff must receive in-service training regarding:
 - (1) HIV infection and its prevention
 - (2) Infection control and universal precautions
 - d. Coordination of AIDS activities with local AIDS counseling and testing centers.

References:

The American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care, 2nd edition—pages 372-374.

The Report of the US Preventive Task Force. Guide to Clinical Preventive Services, 2nd edition—pages 721-737.

5. Contraception (Including Abstinence and Natural Family Planning)

Introduction:

At any given time, approximately two thirds of American women of reproductive age wish to avoid or postpone pregnancy. Despite this, the United States has one of the highest unintended pregnancy rates among developed nations. Women should be counseled about the need for family planning and options for contraception, including abstinence.

Recommendations:

- A. Written protocols and operating procedures for contraceptive methods must be in place that meets the following required standards:
 1. A broad range of FDA approved categories of contraception must be made available on site or through referral (including hormonal, barrier, abstinence,

- natural family planning, permanent sterilization, and emergency contraception).
- 2. Current FDA guidelines as to relative and absolute contraindications should be followed when prescribing contraceptives.
- 3. More than one method may be used simultaneously and should be offered if the client requests. Clients with high-risk sexual behavior patterns should be encouraged to use condoms in addition to any other chosen method.
- B. Permanent Contraception (Sterilization)
 - 1. Counseling and consent process for sterilization must assure that the client's decision to undergo sterilization is completely voluntary and made with full knowledge of the permanence, risks, and benefits.
 - 2. All federal regulations on sterilization must be met if the procedure is performed or arranged by the sub-grantee.
- C. Emergency Contraception
 - 1. Certain oral contraceptive regimens have been found by the Federal Food and Drug Administration to be safe and effective for use as post coital emergency contraception when initiated within 72 hours after unprotected intercourse.
 - 2. If the sub-grantee provides this service, comprehensive contraceptive counseling should be provided to the client so that she can make an informed decision concerning future contraceptive methods.

Reference:

The American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care, 2nd edition—pages 150-162.

6. Patient Education/Pre-Pregnancy Counseling: Substance Use & Abuse—Tobacco, Alcohol, and Illegal Drugs

Introduction:

Although the prevalence of tobacco, alcohol, and illegal drug use varies, it is present in all socioeconomic, cultural, and ethnic groups. Smoking cessation reduces risks of poor reproductive outcome during pregnancy and also benefits women's long term health by reducing risk of cervical cancer, kidney disease, respiratory disease, hip fractures, menstrual disorders, early menopause, fertility problems, and depression. Prenatal alcohol abuse is a preventable cause of birth defects, mental retardation and neuro-developmental defects. Chemical dependency is likely to be a chronic, relapsing, and progressive disease. Many drug-dependent women do not seek prenatal care and are at increased risk for medical and obstetric complications.

Recommendations:

A. The Five A's for Brief Tobacco Intervention:

- 1. **Ask** all patients about their smoking status at every visit; place a sticker on the patient chart indicating tobacco use (current, former, or never)

2. **Advise** to quit in a clear, strong personalized manner
 3. **Assess** willingness to make a quit attempt
 4. **Assist** in quit attempt (counseling and pharmacotherapy as appropriate)
 5. **Arrange** follow-up (preferably within the first week after the quit date)
- B. All women should be questioned at their first prenatal or women's health care visit about their past and present use of alcohol and/or other drugs.
 - C. Use of specific screening questionnaires may improve detection rates. (i.e. The CAGE Questionnaire to detect problem drinking).
 - D. Counsel as to perinatal implications and offer referral to an appropriate drug-treatment program.
 - E. Reinforce and encourage continued abstinence; periodic questioning and/or drug (metabolite) testing may be desirable.

References:

The American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care, 2nd edition—pages 375-381.

The American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, 5th edition—pages 84-87.

The American College of Obstetricians and Gynecologists. Educational Bulletin #260—September, 2000.

7. Patient Education on Sexual Coercion and Relationship Violence

Introduction:

Sexual abuse includes a wide range of behaviors and activities. Its incidence is difficult to quantify. It includes activities such as kissing, fondling, genital exposure, and observation of adult sexual activity by a child.

Violence by an intimate partner accounts for about 21% of the violent crime experienced by women. Among female murder victims, about 30% are killed by their partner. Such abuse is likely to continue during pregnancy. About 9-20% of obstetric patients are abused in pregnancy, and such assaults can result in placental separation; antepartum hemorrhage; fetal fracture; rupture of the uterus, liver, or spleen; and preterm labor.

Recommendations:

- A. The American College of Obstetrics and Gynecology encourages universal screening leading to identification of victims of domestic violence at their annual examinations and new patient visits.

- B. During pregnancy, assessment is also recommended in each trimester and in the postpartum period.
- C. Follow-up involves: assessment of immediate safety, establishing a safety plan, review of options, and offering educational materials along with a list of community resources.
- D. The provider should also provide referrals, document interactions and provide ongoing support at subsequent visits.
- E. Information about sexual coercion should be provided to all clients, especially when there is suspicion of abuse or forced activity. This may be given as a part of a group session, one-on-one counseling session, by using pamphlets or videos, or as part of the follow-up to a client administered history.

Reference:

The American College of Obstetricians and Gynecologists. Guidelines for Women's Health Care, 2nd edition—pages 230-235.

8. Prenatal Care

Introduction:

Institution of early and regular prenatal care plays a role in both maternal outcome and perinatal morbidity and mortality.

Recommendations:

- A. Institution of first trimester prenatal care with regularly scheduled visits as per ACOG guidelines.
- B. A post-partum visit should be included as a routine part of care.
- C. All pregnant women should have access in their community to readily available and regularly scheduled obstetric care.
- D. Pregnant women should also have access to unscheduled or emergency visits on a 24-hour basis.

Reference:

American College of Obstetrics and Gynecology. Guidelines for Perinatal Care, 5th edition - pages 73-124.