

**Section 1.0**  
**FAMILY PLANNING PROGRAM**  
**GUIDELINES**  
**FOR**  
**CLINICAL SERVICES**

The Title X Mission is to assist individuals and couples in planning and spacing births, contribute to positive birth outcomes and improve health for women and infants, as well as men and families. This is accomplished through the provision of voluntary, confidential and low-cost education, counseling, and related comprehensive medical services to eligible clients (<https://www.hhs.gov/opa/about-opa/mission/index.html>). The Title X Family Planning program was enacted in 1970 as Title X of the Public Health Service Act (Public Law 91-572 Population Research and Voluntary Family Planning Programs). Congressional appropriations fund the Title X grant program annually. The Department of Health is the Grantee in New Mexico. Services are provided through state local public health offices (PHOs); community health centers; school-based health centers; and other private nonprofits.

The U.S. Department of Health & Human Services Office of Population Affairs (OPA) sets the standards for publicly funded family planning services in the U.S. The Title X statutes, regulations and guidance offer client protections by requiring that programs are voluntary, confidential and include a broad range of U.S. Food and Drug Administration (FDA) approved contraceptive methods. By law, Title X funds may not be used in programs where abortion is a method of family planning (<https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/index.html>).

The wording of the core family planning services that each project should offer have been revised by OPA. The major changes are highlighted below:

1. Discussion with the client about their reproductive life plan. (<https://www.cdc.gov/preconception/planning.html>).
2. A broad range of acceptable and effective family planning methods and services for delaying or preventing pregnancy, which should include:
  - Counseling, especially for adolescents, that avoiding sex is the only 100% effective method to prevent pregnancy and STDs; therefore, delaying the onset of sexual activity, or if already sexually active, choosing to avoid sexual activity for a defined period of time, is an option; and
  - Instruction in fertility awareness-based methods (previously referred to as natural family planning) that includes staff who are specifically trained in providing instruction in these methods; and
  - Availability of several categories of contraceptive methods, such as: hormonal methods (oral contraceptives, rings and patches, injection, implants, intrauterine devices or systems), barrier methods (diaphragms, condoms), and/or permanent sterilization.
3. The broad range of family planning services does not include abortion as a method of family planning.
4. Pregnancy testing and counseling
5. Services centered around pre-conception health and achieving pregnancy, which should include:
  - Basic infertility services;
  - STD prevention education, screening, and treatment;
  - HIV testing and referral for treatment when appropriate; and
  - Screening for substance use disorders and referral when appropriate to help reduce adverse pregnancy-related outcomes and improve individuals' reproductive health generally.

Title X projects may also include other reproductive health and related preventive health services that are considered beneficial to reproductive health such as HPV vaccination, provision of HIV pre-exposure prophylaxis (PrEP), breast and cervical cancer screening, and screening for obesity, smoking, drug and alcohol use, mental health, and intimate partner violence.

The OPA Program Guidelines, which are comprehensive, evidence-informed guidelines for a delivery of family planning and related preventive health services, are comprised of two documents: (<https://www.hhs.gov/opa/guidelines/program-guidelines/index.html>)

- 1) **Program Requirements** for Title X Funded Family Planning Projects and

- 2) Providing **Quality Family Planning Services**: Recommendations of Center for Disease Control and Prevention (CDC) and the U.S. OPA (**QFP**), 2014 and updates.

The NM Family Planning Program (FPP) Protocol is based on these resources, in addition to the Title X Program Priorities, Key Issues, Legislative Mandates, and other appropriate nationally recognized standards of care. With proper agency's approval, this manual serves as policies and procedures for all personnel providing Title X Family Planning health care services in New Mexico at PHOs and provider agreement (PA) sites. Annually, each Title X clinic must have appropriate signatures of agency and clinic staff on the "Clinical Protocol Approval Sheet" on file to demonstrate that appropriate personnel have received, reviewed and will follow the Protocol and its applicable Standing Orders.

Title X Family Planning services are embedded within a broader framework of preventive health services. Figure 1 illustrates the QFP's classification of health services into three main categories. **NM Title X providers should be trained to be able to offer all family planning and related preventive health services described in both subsections 1 and 2 below.**

1. **Family planning services** in the central circle are the priority for NM Title X providers including:
  - a. **Contraceptive services** for clients who want to prevent pregnancy and space births.
  - b. **Pregnancy testing and counseling** to be provided in conjunction with other appropriate FP services, such as contraceptive services or preconception health services.
  - c. **Assistance to achieve pregnancy (preconception health services) and other related health services** (e.g., screening for obesity, smoking, and mental health).
  - d. **Basic infertility services**
  - e. **STD testing, treatment and counseling services** (including HIV testing) are considered family planning services because they improve women's and men's health and can influence a person's ability to conceive or to have a healthy birth outcome. However, they are provided in conjunction with other appropriate FP services, such as contraceptive or preconception health services.
2. **Related preventive health services** are considered to be beneficial to reproductive health, are closely linked to FP services, and are appropriate to deliver in the context of a FP visit but that do not contribute directly to achieving or preventing pregnancy (e.g., breast and cervical cancer screening).
3. **Other preventive health services**: Examples are screening for lipid disorders, skin cancer, colorectal cancer, or osteoporosis. Although important in the context of primary care, these have no direct link to family planning services. These services may be provided either on-site or by referral.



## Figure 1: Family Planning and Related and Other Preventive Health Services

In addition to the FPP Protocol, providers, especially clinicians, could find additional reproductive care information that may apply to individual client's clinical condition from the following references:

1. [Contraceptive Technology](#), 21<sup>st</sup> revised edition, Robert A. Hatcher, MD, MPH, et al.
2. [Managing Contraception](#), 14<sup>th</sup> edition, 2017-2018, Robert A. Hatcher, MD, et al.
3. [Managing Contraception For Your Pocket](#), 2015-2016, M. Zieman, MD, R. Hatcher, MD., A. Allen, MD
4. [Managing Contraceptive Pill Patients](#), 15th Edition, Richard P. Dickey, MD, PhD.
5. [MEC](#) U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (App, MMWR, Summary Chart)
6. [SPR](#) U.S. Selected Practice Recommendations for Contraceptive Use 2016 (eBook, App, MMWR)
7. [PCC](#) Recommendations to Improve Preconception Care, MMWR April 21, 2006, Vol. 55.

### 1.1 SERVICE POPULATION

Projects funded under Title X are intended to enable all persons who want to obtain family planning care to have access to such services. **Services must be provided without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, or marital status.** Services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician.

Title X services are to be provided to those who are in need to **plan or prevent pregnancy according to their RLP**. Priority for New Mexico Title X services is for uninsured, reproductive-aged women and men from low-income families. However, Title X clinics may not deny insured clients FP services due to the clinic's inability to bill certain insurance agencies.

#### A. WOMEN AND MEN OF REPRODUCTIVE AGE

When serving women and men of reproductive age, the QFP recommendations provide a clinical pathway (Figure 2) to assist providers in determining the client's need for family planning services. The following questions are most appropriate for a given visit.

1. **What is the client's reason for the visit?** The client's visit goal should be addressed to the extent possible.
2. **Does the client have another source of primary health care?** The answer will help clinic staff in identifying what preventive services should be offered.
  - a. If the clinic is the client's main source of primary care, it will be important to assess the client's needs for other FP-related preventive services, e.g., screening for breast and cervical cancer.
  - b. If the client receives ongoing primary care from another provider, clinic staff should confirm that the client's preventive health needs are met while avoiding the delivery of duplicative services.
3. **What is the client's reproductive life plan (RLP)?** Providers should avoid making assumptions about the client's needs based on his or her characteristics, e.g., sexual orientation or disabilities.

A RLP outlines the client's personal goals about becoming pregnant.

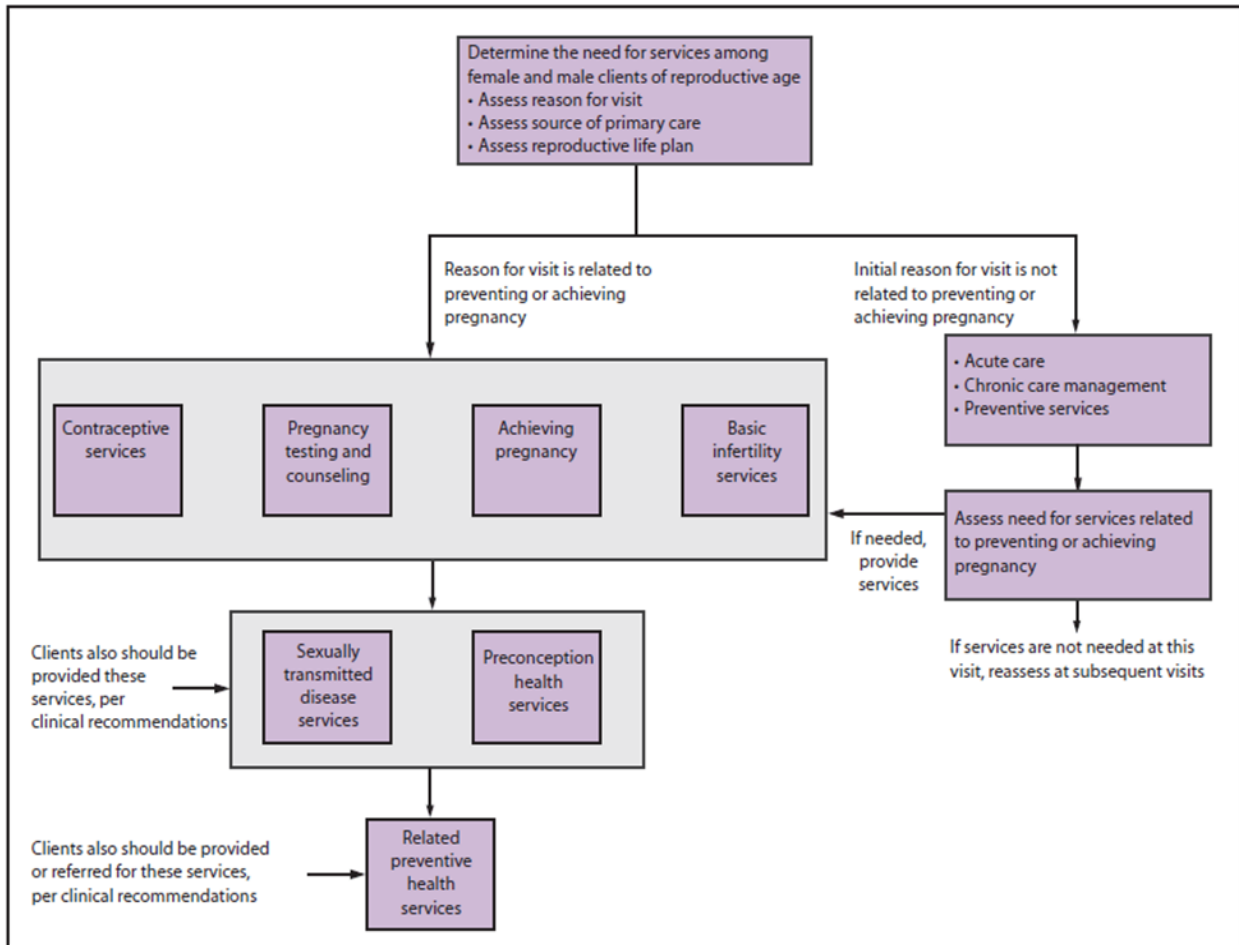
Providers should assess the client's RLP by asking the client questions such as:

- **Would you like to become pregnant in the next year?**
- **Do you have any children now?**
- **Do you want to have (more) children?**
- **How many (more) children would you like to have and when?**

For clients whose reason for visit was not related to preventing or achieving pregnancy, asking questions about his or her RLP might help identify unmet reproductive health care needs.

- a. If a client who is at risk of having/causing an unintended pregnancy, does not want to have a child at this time, and is sexually active, offer contraceptive services.
- b. If a client desires pregnancy testing, provide pregnancy testing and counseling.

- c. If a client wants to have a child now, provide services to help the client achieve pregnancy.
- d. If a client wants to have a child and is experiencing difficulty conceiving, provide basic infertility services.



**Figure 2: Clinical Pathway for Family Planning Services for Women and Men of Reproductive Age**

**B. TEEN CLIENTS**

Title X regulation requires that Title X services be available to all teens, regardless of age (*42 CFR Part 59.5 (a) (4)*). Additionally, NM law allows minors of any age to consent themselves to FP/contraceptive services (*NM STAT.ANN§ 24-8-5*), examination and diagnosis for pregnancy (*NM STAT.ANN§ 24-1-13*), prenatal care (*NM STAT.ANN§ 24-1-13.1*), examination and treatment for any sexually transmitted disease (*NM STAT.ANN§ 24-1-9*), and testing for Human Immunodeficiency Virus (*NM STAT.ANN§ 24-2B-3*).

**C. CLIENTS WITH LIMITED ENGLISH PROFICIENCY**

Title X clinics must comply with the Title VI of the Civil Rights Act of 1964 “Prohibition against National Origin Discrimination as It Affects Persons with Limited English Proficiency (LEP),” by providing language assistance (verbal and written) necessary to ensure access to FP services, at no cost to the person at every clinic. Educational materials and forms are available in the Spanish language from the State FPP Office, and may be ordered using the guidelines in Appendix C.

Language identification flash cards (Appendix E) may be used to allow clients to indicate their primary language. The preference is that the provider converses in the client's language. A professional interpretation service may be used or bilingual staff member may also serve as an interpreter. It is not acceptable for clinics to rely upon an LEP individual's family members or friends to provide the interpreter services. Staff can learn more about LEP by accessing <http://www.lep.gov/>.

## 1.2 METHODOLOGY

### A. DEFINITION OF TITLE X FAMILY PLANNING ENCOUNTER

A family planning encounter is a documented, face-to-face contact between an individual and a family planning provider that takes place in a Title X service site. The purpose of a family planning encounter is to provide family planning and related preventive health services to female and male clients who want to avoid unintended pregnancies or achieve intended pregnancies (Title X Family Planning Annual Report Instructions).

In addition, PHO telemedicine visits that follow the NMDOH PHD Telemedicine Protocol meet the definition of a face-to-face encounter. Please contact your NMDOH Director of Nursing Services or Regional Health Officer for further information before implementing telemedicine services.

### B. CLINIC FACILITIES

Title X clinics should be geographically accessible for the population being served and should consider clients' access to transportation, clinic locations, hours of operation, and other factors that influence clients' abilities to access services. Clinic staff should ensure that all notices and signs posted are in the primary languages of the population to be served. The office telephone answering machine should have instructions for clients in case of emergency, directing them where to obtain emergency care.

The family planning clinic should provide for comfort, privacy and safety of clients and should facilitate the work of the staff. The minimum standards include the following:

- A. A facility that is in compliance with the Americans with Disabilities Act (ADA) "Access to Medical Care for Individuals with Mobility Disabilities" ([http://www.ada.gov/medicare\\_mobility\\_ta/medicare\\_ta.htm](http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm)).
- B. A comfortable waiting room with an area for client reception, registration and record processing. Shelves or tables for client information brochures are to be kept stocked. **FP brochures must be current and approved by the Informational & Educational (I&E) Committee and contain Title X grant acknowledgement, as listed in Appendix C.**
- C. A private area where interviews, counseling and education may be done confidentially.
- D. A private dressing area for client use within or adjacent to the examination room.
- E. At least one completely enclosed examination room with a sink, an exam table, an examiner's stool, a good source of exam light, an instrument cabinet or table, and a writing surface.
- F. Adequate toilet facilities near the examination room.
- G. A dedicated laboratory area where tests can be performed and clinical specimens can be processed in accordance with Clinical Laboratory Improvement Amendments (CLIA) and Occupational Safety and Health Administration (OSHA) regulations.
- H. An emergency cart that has non-expired medications/supplies and a copy of the current medical emergency protocol that includes the following situations: vasovagal reaction/syncope (fainting), anaphylaxis, cardiac arrest/respiratory difficulties, and shock/hemorrhage (Appendix A). Emergency equipment must be accessible to clinic staff at each clinic site. For after-hours emergencies requirement see EMERGENCY SERVICES Section.

- I. Emergency escape routes that can be identified by clinic staff and exits that are recognizable and free from barriers. Clinic must meet applicable standards established by federal, state and local governments (e.g., local fire, building, and licensing codes). Clinics must have disaster plans and require clinic staff to complete training and drill on a regular basis so that they understand their role in an emergency or natural disaster. Annual fire and other emergency drills must be documented and this documentation must be kept in the clinic.

### **C. CLIENT EDUCATION MATERIALS**

Each clinic should have the following teaching materials:

- A broad range of FDA-approved contraceptives: IUD, implant, sterilization educational materials, Depo-Provera, vaginal ring, several types of birth control pills, male and female condoms, film, foam, fertility awareness-based methods, emergency contraceptive pill (ECP), and sexual risk avoidance/abstinence education materials.
- 3-D female pelvis and penis models.
- Educational posters (e.g., contraceptive counseling poster, pills poster).
- When providing services to teens, educational materials on confidentiality of family planning services and sexual coercion should be utilized.
- Other approved handouts and brochures: The DOH Informational and Educational Committee (I and E) must approve all educational materials distributed in Family Planning Clinics. Each educational material must display acknowledgement of the Federal grant number used as the funding source. See Appendix C for a current list of approved educational resources available to order from the FPP State Office.

### **D. STAFF ORIENTATION AND TRAINING REQUIREMENTS**

Appropriate trainings are required by the Title X Guidelines. See Appendix D for links to required trainings (Title X Orientation, Reporting of Child Abuse/Neglect & Human Trafficking and VAST-D) and details.

### **E. CONFIDENTIALITY AND MANDATORY REPORTING REQUIREMENTS**

While clinics must comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which permits disclosure of certain protected health information (PHI), the Title X regulations are more stringent and do not allow the disclosure of information about individuals receiving services through the FPP except:

- a. With documented consent;
- b. To provide services to the client; or
- c. As required by law: NM reporting requirements are for child abuse/neglect and abuse/neglect/exploitation of incapacitated adults ONLY.

*[All information as to personal facts and circumstances obtained by the Title X project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals. (45 CFR Part 59.11)]*

For example, a provider of non-family planning services may disclose PHI to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public. A Title X provider, however, may not do so without the patient's documented consent (unless the report is required by law).

**In addition to the required family participation and sexual coercion teen counseling and documentation (Section 5), Title X Legislative Mandates require that providers comply with State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.** Therefore, the NM DOH FPP requires that:

1. All clinic staff (every person who works with or has contact with Title X clients, including receptionist/clerk) must familiarize themselves and comply with NM legal requirements regarding notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest, as well as human

- trafficking (*OPA Program Instructions 11-01; 06-01 and 99-1*) and are required to take “Child Abuse/Neglect Reporting & Human Trafficking” training annually. See Staff Orientation Appendix D.
2. Child abuse/neglect/human trafficking reporting must be documented in the client record.
  3. All clinics must have a mechanism in place to document reports made, for example a log. When in doubt as to whether the NM legal requirements apply to your client’s situation, consult with your clinician/supervisor, Regional Health Officer and/or agency’s legal counsel.

#### **F. SCHEDULING A FP APPOINTMENT & TITLE X FEE COLLECTION PROCEDURE**

To prioritize NM Title X services to uninsured, reproductive-aged women and men from low-income families and to comply with the federal Title X regulations governing charges of Title X services, clinics will follow the procedures described in the Appendix B: Fee Collection Protocol. However, Title X clients must not be denied project services or be subjected to any variation in quality of services because of inability to pay and Title X clinics may not deny insured clients FP services due to the clinic’s inability to bill certain insurance agencies.

In the case of limited resources, clinic services are to be scheduled prioritizing families who may experience unintended pregnancy or high medical risk if pregnant, particularly:

- Male and female adolescents,
- Men and women whose income is at or below 250% poverty,
- Women with a history of difficult pregnancy,
- Women with pregnancies spaced less than 2 years apart, and
- Women over the age of 35.

If the person qualifies for a priority appointment, he/she should be seen within two weeks of the request. Any client not able to be seen in clinic within 2 weeks should be made aware of other providers in the area.

#### **G. CONSENT AND OTHER REQUIRED FORMS**

Figure 3 shows an algorithm that provides clinic staff with the procedure to obtain all Title X required consent and other forms.

1. **Parental/Family Involvement Form for Services to Minor-Age Clients** (for clients < 18 years old) includes elements that:
  - a. Nurse/clinician has discussed with the client the **visit confidentiality and the limitation of confidentiality** (i.e., the staff’s obligation for reporting of child abuse, child molestation, sexual abuse, rape, or incest, as well as human trafficking).
  - b. The nurse/clinician has screened the client for coercion and counseled the client on how to resist being coerced into engaging in sexual activities. The coercion screening and counseling documentation is required annually.  
In addition, the provider should ensure this screening occurs and is documented when there is: (1) a positive pregnancy test; (2) a positive STD test; or (3) concerns for coercion (see Section 5.1.3).
  - c. The nurse/clinician has discussed with the client about involving family members in the decision of minors to seek family planning services.
  - d. The client has/has not chosen confidential family planning visit.
  - e. The client’s alternate contact information for future communication from the clinic.
2. **Consent for Family Planning Services** states that services are provided on a voluntary basis.

Title X family planning services are to be provided solely on a voluntary basis. A client’s acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by the clinic. Clients cannot be coerced to accept services or to use or not use any particular contraceptive method. Personnel working within the family planning project may be subjected to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.



Federal law requires that a consent for FP services must be signed by the client prior to receiving Title X services. The combination Consent for Family Planning Services and Parental/Family Involvement Form in Services to Minor-Age Clients in English and Spanish are available in Appendix B.

3. **Income Worksheet** is available in Appendix B.
4. **Consent Forms for Intrauterine Devices/Implant (English and Spanish)** are available in the corresponding method subsection of Section 2 of this Protocol.

**Informed Consent:** means voluntary, knowing consent from the individual to whom any contraception or sterilization is to be provided after she/he has been given the components of informed consent by the following:

The Braided Model

Benefits of the method

Risks of the method

Alternatives to the method

Inquiries about the method are okay and encouraged

Decision to withdraw from using the method is okay

Explanation of the procedure, what to expect, what to do

Documentation of the above

Consent forms must be written in a language understood by the client or translated and witnessed by an interpreter. Written informed consent specific to certain contraceptive methods (IUDs, implant and sterilization) must also be signed before the contraceptive method is provided. The “BRAIDED” format is used on the Family Planning Program’s required method-specific consent forms (available in Section 2). All the information contained on the form for the chosen method must be discussed with the client. Copies of the signed consent forms are filed in the client’s medical record and a copy of method-specific consent form is given to the client. Consent forms must be obtained when a contraceptive device (IUDs, implant) is inserted or removed.

Although a signed consent form is not required for providing other methods, documentation of counseling done by the Nurse or the Clinician must be included in the client’s record. Evaluate if the client comprehends method/treatment and document the client’s recall and understanding of the counseling (based on the “teach-back” method) in the medical record.

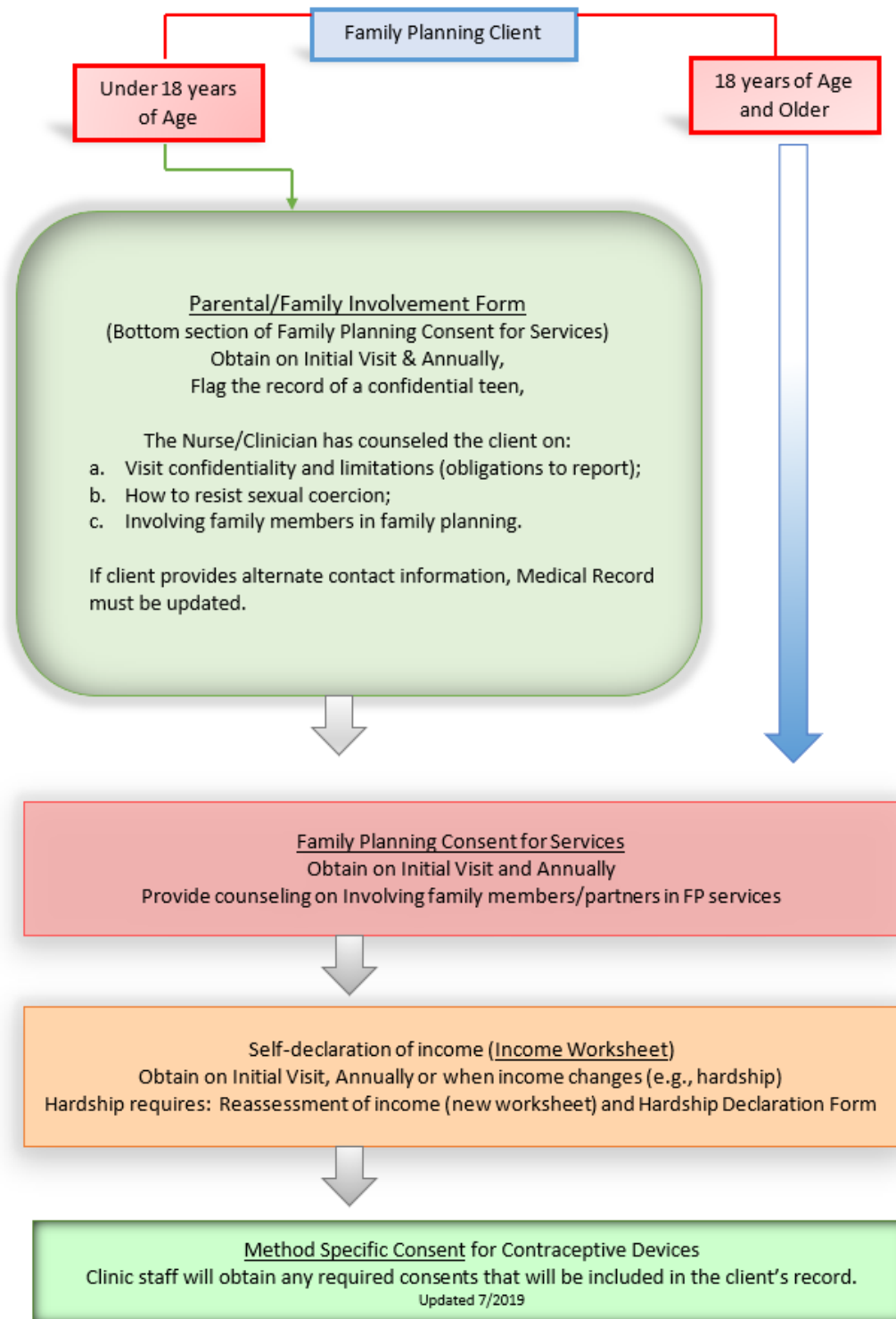
It is prudent to verify the client’s capacity to understand the nature and consequences of the method/treatment to which they are consenting. It is the responsibility of the nurse/clinician to use good judgment through reasonable inquiry of the client, i.e., does the client understand why they are here, and what they expect to receive from the clinic? Ascertain if further assessment is needed.

- **If nurse/clinician has reasonable doubt regarding a client’s mental capacity, consultation with another qualified medical staff member is indicated**, and the client should be asked if they have a legal guardian for medical decisions or if there is someone else responsible for their major decisions.
  - If the client has a legal guardian with current documentation of medical guardianship by court order, the guardian must give consent for services.
  - If they deny having a guardian, the nurse/clinician must consult with other medical staff.
- **If interpretation is needed for informed consent because the client cannot read English or Spanish**, the interpreter should sign consent form as well, certifying they have interpreted correctly. The nurse/clinician should be present during the interpretation, and is responsible for answering questions, or clarifying information through the interpretation.

**SAMPLE INTERPRETERS STATEMENT:**

“I have interpreted the information and advice presented orally to the individual (Name) by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge, I believe that he/she understood this explanation.

**Algorithm for Required Family Planning Forms and Consents**



## H. TITLE X FAMILY PLANNING SERVICES

Tables 1 & 2 summarize required items for providing NM Title X services to women and men, and related preventive health services.

**Table 1: Checklist for Providing Family Planning Services: Women**

Family Planning Services for Women (provide services in accordance with the appropriate clinical recommendations)							
	Screening components	Contraceptive services <sup>1</sup>	Pregnancy testing and counseling <sup>2</sup>	Basic infertility services	Preconception health services	STD services <sup>3</sup>	Related preventive health services
History	Reproductive life plan	√	√	√	√	√	
	Medical history	√	√	√	√	√	√
	Current pregnancy status	√					
	Sexual health assessment	√		√	√	√	
	Intimate partner Violence				√		
	Alcohol & Substance use				√		
	Tobacco use	√ (combined hormonal methods for clients ≥35 years)				√	
	Depression					√	
	Immunizations					√	√ <sup>5</sup> (HPV & HBV)
	Folic acid				√		
Physical examination	Height, weight, BMI	√ (hormonal methods) <sup>4</sup>	√	√	√		
	Blood pressure	√ (combined hormonal methods)	√	√	√ <sup>5</sup>		
	Clinical breast exam			√			√ <sup>5</sup>
	Pelvic exam	√ (initiating IUD)	√ (if clinically indicated)	√			
	Signs of androgen excess				√		
	Thyroid exam				√		
Laboratory testing	Pregnancy test	√ (if clinically indicated)	√				
	Chlamydia	√ <sup>6</sup>				√ <sup>5</sup>	
	Gonorrhea	√ <sup>6</sup>				√ <sup>5</sup>	
	Syphilis					√ <sup>5</sup>	
	HIV/AIDS					√ <sup>5</sup>	
	Hepatitis C					√ <sup>5</sup>	
	Diabetes					√ <sup>5</sup>	
	Cervical cytology						√ <sup>5</sup>
Mammography						√ <sup>5</sup>	

**Source:** Centers for Disease Control and Prevention (CDC). (2014, April 25). Providing quality family planning services: Recommendations of CDC and the US Office of Population Affairs. *MMWR. Morbidity and Mortality Weekly Reports*. Retrieved from <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>

**Abbreviations:** BMI = body mass index; HBV = hepatitis B virus; HIV/AIDS: human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus; IUD = intrauterine device; STD = sexually transmitted disease; MEC = US medical eligibility criteria for contraceptive use 2010 MMWR 2010; 59[No. RR-4].

<sup>1</sup> This table presents highlights from CDC's recommendations on contraceptive use. However, providers should consult appropriate guidelines when treating individual patients to obtain more detailed information about specific medical conditions and characteristics.

<sup>2</sup> Pregnancy testing and counseling are provided in conjunction with other appropriate FP services according to RLP e.g., contraceptive or preconception health services.

<sup>3</sup> STD services also promote preconception health but are listed separately here to highlight their importance in the context of all types of family planning visits. The services listed in this column are for women without symptoms suggestive of an STD.

<sup>4</sup> Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (MEC 1) or generally can be used (MEC 2) among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

<sup>5</sup> Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of an infection or condition.

<sup>6</sup> Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD Treatment Guidelines (Sources: CDC STD treatment guidelines. Atlanta, GA: US Department of Health and Human Services, CDC; 2013. Available at <http://www.cdc.gov/std/treatment>. CDC. Sexually transmitted diseases treatment guidelines, 2010. MMWR 2010; 59[No. RR-12]). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydia infection or gonorrhea should not undergo IUD insertion (MEC 4). Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (MEC 3). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

**Table 2: Checklist for Providing Family Planning Services: Men**

Family Planning Services for Men (provide services in accordance with the appropriate clinical recommendations)						
	Screening components	Contraceptive services <sup>1</sup>	Basic infertility services	Preconception health services <sup>2</sup>	STD services <sup>3</sup>	Related preventive health services
<b>History</b>	Reproductive life plan	√	√	√	√	
	Medical history	√	√	√	√	
	Sexual health assessment	√	√	√	√	
	Alcohol & Substance use			√		
	Tobacco use			√		
	Depression			√		
	Immunizations			√		√ <sup>4</sup> (HPV & HBV)
	Height, weight, BMI			√		
<b>Physical examination</b>	Blood pressure			√ <sup>4</sup>		
	Genital exam		√ (if clinically indicated)		√ (if clinically indicated)	√ <sup>4</sup>
<b>Laboratory testing</b>	Chlamydia				√ <sup>4</sup>	
	Gonorrhea				√ <sup>4</sup>	
	Syphilis				√ <sup>4</sup>	
	HIV/AIDS				√ <sup>4</sup>	
	Hepatitis C				√ <sup>4</sup>	
	Diabetes				√ <sup>4</sup>	

**Source:** Centers for Disease Control and Prevention (CDC). (2014, April 25). Providing quality family planning services: Recommendations of CDC and the US Office of Population Affairs. *MMWR. Morbidity and Mortality Weekly Reports*. Retrieved from <http://www.cdc.gov/mmwr/pdf/rr/r6304.pdf>

**Abbreviations:** BMI = body mass index; HBV = hepatitis B virus; HIV/AIDS: human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus; IUD = intrauterine device; STD = sexually transmitted disease.

<sup>1</sup> No special evaluation needs to be done prior to making condoms available to males. However, when a male client requests advice on pregnancy prevention, he should be provided contraceptive services as described in the section "Provide Contraceptive Services."

<sup>2</sup> The services listed here represent a sub-set of recommended preconception health services for men that were recommended and for which there was a direct link to fertility or infant health outcomes (Source: Frey K, Navarro S, Kotelchuck M, Lu M. The clinical content of preconception care: preconception care for men. *Am J Obstet Gynecol* 2008; 199 [6 Suppl 2]:S389-95).

<sup>3</sup> STD services also promote preconception health, but are listed separately here to highlight their importance in the context of all types of family planning visit. The services listed in this column are for men without symptoms suggestive of an STD.

<sup>4</sup> Indicates that screening is suggested only for individuals at highest risk or for a specific subpopulation with high prevalence of infection or condition.

**a. Contraceptive Services**

Providers will offer contraceptive services to clients who wish to delay or prevent pregnancy. Contraceptive services should include consideration of a full range of FDA-approved contraceptive methods, a brief assessment to identify the contraceptive methods that are safe for the client, contraceptive counseling to help a client choose a method of contraception and use it correctly and consistently, and provision of one or more selected contraceptive method(s), preferably on site, but by referral if necessary.

**FIVE KEY STEPS IN PROVIDING CONTRACEPTIVE SERVICES**

1. Establish and maintain rapport with the client.
2. Obtain clinical and social information from the client.
3. Work with the client interactively to select the most effective & appropriate contraceptive method.
4. Conduct a physical assessment related to contraceptive use, only when warranted.
5. Provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow up, and confirm client understanding.

## STEP 1: Establish and maintain rapport with the client

Strategies to achieve these goals include:

- **P: Ensure privacy and confidentiality** - To help the individual feel more comfortable in discussing her/his situation, a counseling session should be conducted in a quiet, private area with limited or no distractions.
- **A: Demonstrate accessibility and expertise.**
- **T: Demonstrate trustworthiness.**
- **H: HIPAA** Explain how personal information will be used.
- **O: Use open-ended questions** - Open-ended questions are loosely structured, and are designed to let the client talk freely. They usually start with "How," "What", or "Who." Examples are, "What do you know about how the pill works?", "Could you tell me more about...?" and "How do you feel about what has happened?"
- **P: Listen to, observe the client and paraphrasing/reporting back the client's main points** – Examples are: "Let me see if I've got it right", "I think I hear you saying..." and "So, in other words..." A paraphrase may be ended by asking, "Is that right?"
- **E: Encourage the client to ask questions and share information** - Provider can encourage communication by maintaining eye contact with your client, nodding in encouragement, not interrupting until the individual is through speaking, and keeping a pleasant tone of voice.
- **N: Use non-defensive statements, be encouraging, demonstrate empathy and acceptance** - To further convey understanding, reflective statements can be used to mirror the client's message and help bring to the surface underlying attitudes and values. Examples of non-defensive statements are, "You seem to have had a great deal of difficulty with contraception" and "It sounds like you're very angry." The expression, "I understand," should generally be avoided because it is perceived to be presumptuous. It is also possible that provider does not truly understand.

## STEP 2: Obtain clinical and social information from the client

- a) **Confirm the client's pregnancy intention or Reproductive Life Plan (RLP):** Each client should be encouraged to clarify decisions about her/his RLP (i.e., whether the client wants to have any or more children and, if so, the desired timing and spacing of those children). Ideally, this should be done at each family planning visit because it may change over time. Providers should avoid making assumptions about the client's needs based on his or her characteristics e.g., sexual orientation or disabilities.

A RLP outlines the client's personal goals about becoming pregnant. Providers should assess the client's RLP by asking the client questions such as:

- **Would you like to become pregnant in the next year?**
- **Do you have any children now?**
- **Do you want to have (more) children?**
- **How many (more) children would you like to have and when?**

- b) **Obtain Medical History:** A medical history should be taken for two main purposes:

- 1) To determine the client's current pregnancy status.
- 2) To ensure that contraceptive methods considered by a client are safe for that particular client.

For a Female client, the medical history should include:

- **HPI (History of present illness)** last menstrual period (LMP), current gynecologic or pregnancy symptoms. *An unusually light or mistimed period may mean fertilization actually occurred before the LMP, and for this reason, the date of the previous menstrual period (PMP) should be determined.*
- **Contraceptive experiences and preferences** – Example questions are:  
"What method(s) are you currently using, if any?"  
"What method(s) have you used in the past?"

“Have you previously used emergency contraception?”

“Did you use contraception with last sex?”

“What difficulties did you experience with prior methods if any (e.g., side effects, noncompliance)?”

“Do you have a specific method in mind?”

- **Menstrual history** including menstrual frequency, length and amount of bleeding, and other patterns of uterine/vaginal bleeding.
- **Recent intercourse and last unprotected intercourse**
- **Gynecologic and obstetrical history** including recent delivery, miscarriage, or termination.
- **Allergies**
- **Relevant infectious/chronic health conditions** (e.g., hypertension, diabetes, medical diagnosis of migraine headache with aura, blood clots) and other characteristics and exposures (e.g., age, tobacco use, breastfeeding) that might affect the client’s medical eligibility criteria (MEC) for contraceptive methods.
- **Past surgical history** (for PHO clients seeking sterilization).
- **Laboratory** (for PHO clients seeking sterilization, provider may request from client’s PCP) CBC for any clients reporting a recent history of anemia; HgbA1c for patients with diabetes.

For a Male client, the medical history should include:

- **Contraceptive experiences** (e.g., partner’s use of contraception- Example questions are: “Have you discussed method options with your partner?” and “Does your partner have any preferences for which method you use?”; client’s use of condoms; interest in vasectomy);
- **Recent intercourse and last unprotected intercourse;**
- **Whether his partner is currently pregnant or has had a child, miscarriage, or termination;**
- **Allergies** (including known allergies to condoms);
- **Relevant infectious/chronic health conditions.**

The taking of a medical history should not be a barrier to making male condoms available in the clinical setting (i.e., a formal visit should not be a prerequisite for a client to obtain male condoms).

**c) Sexual Health Assessment and Counseling:** A sexual history and risk assessment that considers the client’s sexual practices, partners, past STD history, and steps taken to prevent STDs help the client select the most appropriate method(s) of contraception. Correct and consistent condom use is recommended for those at risk for STDs. CDC recommendations for how to conduct a sexual health assessment have been summarized below (some of which may have already been included in the medical history above):

- **Partners:** Ask questions to **determine the number, gender** (men, women, or both), and **concurrency of the client’s sex partners** (if partner had sex with another partner while still in a sexual relationship with the client). It might be necessary to define the term “partner” to the client or use other, relevant terminology.
- **Pregnancy prevention:** Discuss current and future contraceptive options. Ask about current and previous use of methods, use of contraception at last sex, difficulties with contraception, and whether the client has a particular method in mind.
- **Protection from STDs:** Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. Topics such as monogamy and abstinence also can be discussed.
- **Past STD history:** Ask about any history of STDs, including whether their partners have ever had an STD. Explain that the likelihood of an STD is higher with a past history of an STD.
- **Practices:** Explore the types of sexual activity in which the client engages, e.g., vaginal, anal, or oral sex.

**STEP 3: Work with the client interactively to select the most appropriate method(s) based on the following steps:**

- Using **shared decision-making** concepts, the provider will discuss with all clients the information listed on the handout below based on the client's preferences, such as: the risk of pregnancy, how the method is used, how often a method is used, menstrual/other possible side effects and other considerations e.g., non-contraceptive benefits.

### Birth Control Method Options

	Most Effective										Least Effective				
	Female Sterilization	Male Sterilization	IUD	Implant	Injectables	Pill	Patch	Ring	Diaphragm	Male Condom	Female Condom	Withdrawal	Sponge	Fertility Awareness Based Methods	Spermicides
<b>Risk of pregnancy*</b>	.5 out of 100	.15 out of 100	LNG: .2 out of 100 Copper I: .8 out of 100	.05 out of 100	6 out of 100	9 out of 100			12 out of 100	18 out of 100	21 out of 100	22 out of 100	12-24 out of 100	24 out of 100	28 out of 100
<b>How the method is used</b>	Surgical procedure		Placement inside uterus	Placement into upper arm	Shot in arm, hip or under the skin	Take a pill	Put a patch on skin	Put a ring in vagina	Use with spermicide and put in vagina	Put over penis	Put inside vagina	Pull penis out of the vagina before ejaculation	Put inside vagina	Monitor fertility signs. Abstain or use condoms on fertile days.	Put inside vagina
<b>How often the method is used</b>	Permanent		Lasts up to 3-12 years	Lasts up to 3 years	Every 3 months	Every day at the same time	Each week	Each month		Every time you have sex				Daily	Every time you have sex
<b>Menstrual side effects</b>	None		LNG: Spotting, lighter or no periods Copper I: Heavier periods	Spotting, lighter or no periods	Spotting, lighter or no periods	Can cause spotting for the first few months. Periods may become lighter.				None					
<b>Other possible side effects to discuss</b>	Pain, bleeding, infection		Some pain with placement		May cause appetite increase/weight gain	May have nausea and breast tenderness for the first few months.				Allergic reaction, irritation		None	Allergic reaction, irritation	None	Allergic reaction, irritation
<b>Other considerations</b>	Provides permanent protection against an unintended pregnancy.		LNG: No estrogen. May reduce cramps. Copper I: No hormones. May cause more cramps.	No estrogen	No estrogen. May reduce menstrual cramps.	Some client's may report improvement in acne. May reduce menstrual cramps and anemia. Lowers risk of ovarian and uterine cancer.			No hormones	No hormones. No prescription necessary.		No hormones. Nothing to buy.	No hormones. No prescription necessary.	No hormones. Can increase awareness and understanding of a woman's fertility signs.	No hormones. No prescription necessary.

Counsel all clients about the use of condoms to reduce the risk of STDs, including HIV infection.

\*The number of women out of every 100 who have an unintended pregnancy within the first year of typical use of each method.  
Other Methods of Birth Control: (1) Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception, and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy. Reference for effectiveness rates, Trussell J. Contraceptive failure in the United States. Contraception 2011; 83: 207-204. Other references available on www.dnrc.org.



- Once the client decides on a method, ensure the following understanding (Counseling Tool/Consent in Section 2 may be used):
  - Method effectiveness
  - Correct use of the method
  - Non-contraceptive benefits
  - Side effects
  - Protection from STDs, including HIV.
- Provider should help the client identify potential factors in using the method(s) under consideration based on the following:
  - Social and behavioral factors: method perception by client, partner or peer, method compliance.
  - Intimate partner violence and sexual violence might impede correct/consistent contraception use.
  - Mental health, alcohol/substance use behaviors might affect correct/consistent contraception use.

If the chosen method is not available at the service site, providers should actively refer the client to a clinic that can provide the client's desired method. The client should be provided another method to use until she or he can start the chosen method.

#### STEP 4: Conduct a physical assessment

At a minimum, all Title X clients should have measurements of BP, weight, height and BMI documented at every Family Planning visit including a supply pick up visit. Please note that after the initial Title X clinician visit, an annual visit or exam is not required for all Title X clients, but may be necessary if the client is due for labs (e.g., Pap or STI testing), renewal of contraceptive method orders (e.g., OCP, DMPA, or ring), if the client requests or needs to change birth control method, or at the clinician's discretion.

- **Blood pressure**
- **Weight, height and BMI:** Weight measurement is not needed to determine medical eligibility for any method of contraception because all methods generally can be used among obese women. However, measuring height and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
- **Assess the current pregnancy status** based on the medical history obtained as described above. Perform urine hCG pregnancy testing if clinically indicated, e.g., the client had unprotected sexual intercourse (USIC) after her LMP and  $\geq 14$  days have passed since the last USIC.
- **Clinical breast exam (CBE):** Documentation of the CBE is utilized for reporting in the Family Planning Annual Report (FPAR). Guidelines for providing CBE screening varies between nationally recognized organizations. The decision to provide CBE screening should be made between the clinician and client, using the following resources.

#### ACOG

Screening clinical breast examination may be offered to asymptomatic, average-risk women in the context of an informed, shared decision-making approach that recognizes the uncertainty of additional benefits and the possibility of adverse consequences of clinical breast examination beyond screening mammography.

If performed for screening, intervals of every 1-3 years for women aged 25-39 years and annually for women 40 years and older are reasonable. The clinical breast examination continues to be a recommended part of evaluation of high-risk women and women with symptoms. (ACOG Number 179, July 2017). <https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Breast-Cancer-Risk-Assessment-and-Screening-in-Average-Risk-Women>

#### ACS

Research has not shown a clear benefit of regular physical breast exams done by either a health professional (clinical breast exams) or by women (breast self-exams). There is very little evidence that these tests help find breast cancer early when women also get screening mammograms. Most often when breast cancer is detected because of symptoms (such as a lump), a woman discovers the symptom during usual activities such as bathing or dressing. Women should be familiar with how their breasts normally look and feel and report any changes to a health care provider right away (2017). <https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html>

#### USPSTF

The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older (2016). <http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening>



- **Pelvic:** Indications for a bimanual/speculum pelvic examination for women of any age may include:
  - Contraceptive procedure/counseling regarding use of an IUD, diaphragm or sterilization;
  - Pregnancy (known or to make a diagnosis);
  - Performing cervical cytology (Pap) in women 21 and older; Family Planning has agreed to cover the cost of HPV testing in some circumstances. While co-testing is a good routine screening strategy, general use is not currently allowed under FPP due to program funding limitations. Please see section 4 for more detailed instructions regarding HPV testing.
  - Vulvar or vaginal complaints;
  - Dysuria or other urinary symptoms;
  - Dysmenorrhea unrelieved by treatment with non-steroidal anti-inflammatory drugs;
  - Amenorrhea;
  - Abnormal vaginal bleeding;
  - Pelvic or lower abdominal pain; or
  - Exposure to STD.
- For **sterilization clients**, a physical examination including heart, lungs, abdomen and genitalia is required as a part of comprehensive evaluation of the client's risk for surgery/anesthesia (see Section 2.3).

**STEP 5: Provide the method along with instructions about correct/consistent use. Help the client develop a plan for using the selected method & follow up. Confirm/document client understanding.**

- Providers should instruct the client about correct and consistent use of chosen method and employ the following strategies to facilitate a client's use of contraception:
  - Provide onsite dispensing of a broad range of FDA-approved contraceptive methods. Appropriate referrals should be provided, particularly to another nearby Title X site, for methods not available onsite.
  - Begin contraception at the time of the visit rather than waiting for next menses ("Quickstart") if the provider can reasonably be certain that the client is not pregnant.

**How to Be Reasonably Certain that a Woman Is Not Pregnant**

A health-care provider can be reasonably certain that a woman is not pregnant if she has **no symptoms of pregnancy**, and **meets any one of the following criteria**:

- Is  $\leq 7$  days after the start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is  $\leq 7$  days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breast-feeding, (exclusively breastfeeding or the vast majority [ $\geq 85\%$ ] of feeds are breastfeeds), amenorrheic, and  $< 6$  months postpartum.

**Symptoms of pregnancy**

- ❖ absent or altered menses
- ❖ breast tenderness and enlargement
- ❖ nausea (with or without vomiting)
- ❖ increased frequency of urination
- ❖ fatigue (persistent)

- Provide/prescribe multiple cycles of the method whenever possible (e.g., OCPs, ideally a full year's supply; for vaginal ring, three months).
- If the chosen method is not available onsite or the same day, provide the client another method to use until she or he can start the chosen method. For nurses with no Title X clinician's order, available methods are limited to over-the-counter methods such as condoms, contraceptive film/foam, etc.
- Help the client develop a plan for using the selected method correctly.
  - Providers should encourage clients to anticipate reasons why they might not use their chosen method(s) correctly/consistently, and help them develop strategies to deal with these possibilities. For example, a client selecting OCPs may forget to take a pill and may want to use reminder systems such as daily text messages or cell phone alarms.
  - Side effects (e.g., irregular vaginal bleeding) are a primary reason for method discontinuation, so providers should discuss ways to deal with potential side effects.
- Develop an appropriate follow-up plan with the client to meet their individual needs. Recommended follow up visits for each birth control method is described in detail in Section 2 of this protocol.
- Use **teach-back method** to confirm client's understanding by asking the client to repeat back messages about risks, benefits, appropriate method use and follow up. Document (by checkbox/written statement) the client's repeat back messages as this provides an alternative to a written method-specific informed consent form.

**PHD Clinicians Prescribing Contraceptives vs. Dispensing Title X Supplies in PHOs**

To maximize Title X supplies, PHO clinicians may prescribe methods that are available in the PHO formulary to insured (including Medicaid) clients. PHO clinicians may not prescribe methods that are not available in the PHO formulary to insured clients (because filling a similar prescription would pose a barrier to uninsured clients).

## #1 Standing Order for Public Health Nurses to Dispense Quickstart

**Purpose:** When a woman first requests hormonal birth control (excluding ECP) and there is no PHO clinician available to prescribe a contraceptive method, the PHN may start new Family Planning clients on a 3-month supply of COCs/POPs/vaginal rings or DMPA. Clients requesting Quickstart who have received birth control from public health in the last year will need to have a clinician order to provide the method. Patients are allowed one Quickstart per year (with verbal orders as needed). Clients should be scheduled for a PHO clinician visit at the earliest available time.

### Subjective and objective nursing assessment:

The PHN will:

- I. Document the client's reproductive life plan, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.2.H.a. in the medical record (EHR). This includes LMP and previous menstrual period (PMP).  
*An unusually light or mistimed period may mean fertilization actually occurred before the LMP, i.e., the client may already be pregnant. See box below.*
- II. Document the client's blood pressure, weight, height, and BMI.
- III. Utilize the calendar/pregnancy wheel to determine if the client is already pregnant by:
  - a. Documenting date(s) of last unprotected sexual intercourse (USIC) since the last normal menses.
  - b. Assess the client's current pregnancy status by assuring that the client has no "symptoms of pregnancy" listed in the "How to be Reasonably Sure a Woman is not Pregnant" box below.

### How to Be Reasonably Certain that a Woman Is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has **no symptoms of pregnancy, and meets any one of the following criteria:**

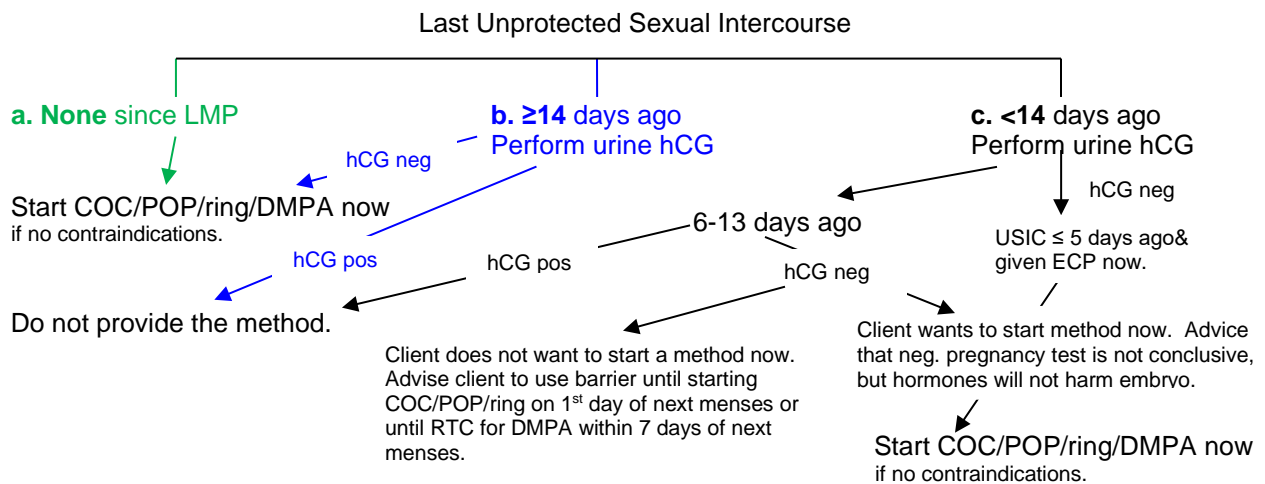
- is  $\leq 7$  days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is  $\leq 7$  days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breast-feeding, (exclusively breastfeeding or the vast majority [ $\geq 85\%$ ] of feeds are breastfeeds), amenorrheic, and  $< 6$  months postpartum.

#### Symptoms of pregnancy

- ❖ absent or altered menses
- ❖ nausea (with or without vomiting)
- ❖ fatigue (persistent)
- ❖ breast tenderness and enlargement
- ❖ increased frequency of urination

**Nursing assessment of normal and abnormal findings (also see algorithm below):**

1. Dates of USIC, LMP and PMP help determine the likelihood of a client being pregnant.
  - a. **If the client has not had any USIC since the last normal LMP**, you can be reasonably sure that she is not pregnant. Document why you are reasonably sure she is not pregnant. If client has no contraindications, use appropriate QUICKSTART tool below to start medically qualified client on COCs/POPs/vaginal rings/DMPA now.
  - b. **If client has had recent USICs, or had used an unreliable method since the last normal LMP and one of these recent USICs is  $\geq 14$  days since USIC**, perform urine pregnancy test per Standing Order #2.
    - If urine hCG is positive, do not provide the method and follow Pregnancy Test Standing Order “COUNSELING IF THE (PREGNANCY) TEST IS POSITIVE” Section.
    - If urine hCG is negative and client has no contraindication, use appropriate QUICKSTART tool below to start medically qualified client on the birth control method now.
  - c. **If one of the recent USICs is < 14 days**, still perform urine hCG; however, inform the client that urine hCG may not be useful in ruling out pregnancy.
    - If negative and USIC is < 5 days, consider ECP (Use ECP Standing Order). Assess client’s desire to start a birth control method now, counsel client per algorithm; and document the client’s decision and counseling in the medical record.
    - If last USIC was 6-13 days ago, using the client’s RLP to assess the client’s desire to start a birth control method now, counsel client per algorithm; and document the client’s decision and counseling in the medical record.



2. Use the following corresponding Quickstart Tool as a guide to assess if the client qualifies for COCs/POPs/vaginal rings/DMPA Quickstart and to screen out clients who may need immediate clinical attention.

## QUICKSTART TOOL FOR COMBINED ORAL CONTRACEPTIVES (COCs) OR VAGINAL CONTRACEPTIVE RINGS

Client **qualifies** for Quickstart supply of COCs or vaginal contraceptive rings if she has all of the following:

1. Client is female below age 35.
2. Client states that she is not currently pregnant and has passed the pregnancy assessment criteria above. If the client was recently pregnant, the client is >6 weeks postpartum.
3. Client's BP is < 140/90.
4. Client **does not** have **any** medical conditions or precautions listed below:
  - hypertension (controlled or uncontrolled)
  - migraines w/aura (blurred vision, spots/zig-zag lines or difficulty speaking/using an extremity)
  - multiple sclerosis with prolonged immobility
  - age ≥ 35 yr. and is smoking
  - multiple risk factors for arterial CVD (older age, diabetes, HTN, smoking, low HDL, high LDL, or high triglyceride levels)
  - stroke, blood clots (current or history of DVT/pulmonary embolism, acute or history of superficial venous thrombosis), major surgery that will immobilize her for ≥ 1 week
  - diabetes (with vascular disease or neuropathy, retinopathy, nephropathy, >20 yr. duration)
  - ischemic heart disease, peripartum cardiomyopathy, valvular heart disease (complicated)
  - breast cancer (current or history)
  - bariatric surgery (malabsorptive procedure; for COCs only), inflammatory bowel disease (ulcerative colitis/Crohn's) with an increased risk for VTE (e.g., those with active or extensive disease, surgery, immobilization, corticosteroid use, vitamin deficiencies, or fluid depletion)
  - viral hepatitis (acute/flare), cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
  - gallbladder disease (current and/or medically treated), cholestasis in past related to COCs
  - lupus (positive/unknown antiphospholipid antibodies), thrombogenic mutations (e.g. factor V Leiden; prothrombin mutation; and protein S, protein C, and antithrombin deficiencies, etc.)
  - Rifampicin/rifabutin, anticonvulsant therapy, fosamprenavir antiretroviral therapy.

### Plan of care for COC/Vaginal Ring PHN Quickstart:

**Consent:** Title X does not require a method-specific consent form for COCs/vaginal rings, and they can be started when the woman is medically eligible and if it is reasonably certain that she is not pregnant. The PHN will:

1. As described in Step 5 of Section 1.2.H.a, provide method-specific counseling and education using the corresponding Counseling Tool in Section 2 as well as help the client develop a plan for using the selected method correctly.
2. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.

For Quickstart COCs, dispense 3 cycles of 28-days Class I, II, III, IV or VI oral contraceptives for new users. Patients are allowed one Quickstart in a one year period, with verbal orders as needed to continue the method until a visit with a clinician is scheduled.

3. **Directions for COC use:** Take one pill by mouth each day.  
If client expresses a preference for a specific type, dispense a comparable available COCs within the same class (see OCP Substitute Table for full medication names in each OCP class). OCP classes are based on estrogen (ethinyl estradiol) content:
  - a. Class I-20mcg ethinyl estradiol
  - b. Class II-30mcg ethinyl estradiol
  - c. Class III-35mcg ethinyl estradiol/norethindrone (progestin)
  - d. Class IV-35mcg ethinyl estradiol/norgestimate (progestin)
  - e. Class VI-Triphasic ethinyl estradiol dosage.

4. **Directions for Vaginal Ring use:** Dispense 3 vaginal rings. Instruct client to leave the ring in place for 3 weeks in a row. After 3 full weeks remove the ring on the same day of the week you put it in. Wait 7 days and insert a new ring, even if you have not finished your menstrual period.

Following the Quickstart algorithm above, instruct client to start pills or vaginal ring **either** today by taking first dose/inserting first ring while in the office **or** the first day of next menses. Give spermicide and condoms with instructions for use as backup for the first 7 days of pill pack/ring and **return for pregnancy test if period does not occur at normal time.**

5. Schedule the client to return to clinic for a PHO clinician visit within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription and other related prevention services. This visit should not be deferred beyond 3 months after the initial visit.
6. For a client who **does not qualify** for Quickstart supply,
  - Consult with PHO Clinician for:
    - Client whose menses are late or unsure if client is pregnant.
    - Client with medical precautions against COCs or vaginal rings.
  - Dispense spermicide and condoms with instructions for use as appropriate.
  - Schedule an earliest available appointment with a clinician within the next 2 weeks.
7. After the initial dispensing by the PHN, a clinician order is needed to either continue or change BCM, including switching OCP class. Patients are allowed one Quickstart in a one year period, with verbal orders as needed to continue the method until a visit with a clinician is scheduled.

## QUICKSTART TOOL FOR DMPA

Client **qualifies** for Quickstart supply of DMPA if she has all of the following:

1. Client is not planning pregnancy within the next year.
2. Client states she is not pregnant now and has passed the pregnancy assessment criteria above.
3. Client's BP is < 140/90.
4. Client **does not** have **any** medical conditions or precautions listed below:
  - o HTN with vascular disease, history of stroke
  - o multiple risk factors for arterial CVD (older age, diabetes, HTN, smoking, low HDL, high LDL, or high triglyceride levels)
  - o diabetes (with vascular disease or neuropathy, retinopathy, nephropathy, >20 yr. duration)
  - o ischemic heart disease (current or history)
  - o breast cancer (current or history)
  - o cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
  - o lupus (positive/unknown antiphospholipid antibodies or severe thrombocytopenia)
  - o rheumatoid arthritis receiving long-term corticosteroid therapy with non-traumatic fractures (history or risk factors)
  - o unexplained vaginal bleeding (suspicious for serious condition e.g., pelvic malignancy) before evaluation

### Plan of care for DMPA PHN Quickstart:

**Consent:** Title X does not require a method-specific consent form for DMPA, and DMPA can be started when the woman is medically eligible and if it is reasonable certain that she is not pregnant. The PHN will:

1. As described in Step 5 of Section 1.2.H.a, provide method-specific counseling and education using the corresponding Counseling Tool in Section 2 as well as help the client develop a plan for using the selected method correctly.
2. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
3. For Quickstart DMPA, per the algorithm above, PHN will **either** give the first DMPA 150 mg by deep intramuscular injection now **or** have the client return for their first DMPA injection within 7 days of their next menses according to the client's desire.
  - Instruct client not to rub/massage injection site. Give spermicide & condoms with instructions to use as backup for 7 days. Return for pregnancy test if period does not occur at normal time.
  - Counsel client regarding importance of adequate daily calcium intake:  
1,000 mg for women over age 25 and 1,300 mg for adolescents to build bones.
  - Emphasize the importance of weight bearing exercise and refrain from smoking.
4. Schedule the client to return to clinic for a PHO clinician visit within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription and other related prevention services. This visit should not be deferred beyond 3 months after the initial visit, unless verbal orders from a clinician are given to continue method until a visit with a clinician is scheduled.
5. For a client who **does not qualify** for Quickstart supply,
  - Consult with PHO Clinician for:
    - o Client whose menses are late or unsure if client is pregnant.
    - o Client with medical precautions against DMPA.
    - o New PHO client who is already on DMPA and early or late for their shot.
  - Dispense spermicide and condoms with instructions for use as appropriate.
  - Schedule an earliest available appointment with a clinician within the next 2 weeks.
6. After the initial dispensing by the PHN, a clinician order is needed. Patients are allowed one Quickstart in a one year period, with verbal orders as needed to continue or change the method until a visit with a clinician is scheduled

## QUICKSTART TOOL FOR PROGESTIN ONLY PILLS (POPs)

Client **qualifies** for Quickstart supply of POPs if she has all of the following:

1. Client states she is not pregnant now and has passed the pregnancy assessment criteria above.
2. Client's BP is < 140/90.
3. Client **does not** have **any** medical conditions or precautions listed below:
  - o history of stroke
  - o ischemic heart disease (current or history)
  - o breast cancer (current or history)
  - o bariatric surgery (malabsorptive procedure)
  - o cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
  - o lupus (positive/unknown antiphospholipid antibodies)
  - o Rifampicin/rifabutin, anticonvulsant therapy.

### Plan of care for POP PHN Quickstart:

**Consent:** Title X does not require a method-specific consent form for POPs, and POPs can be started when the woman is medically eligible and if it is reasonable certain that she is not pregnant. The PHN will:

1. As described in Step 5 of Section 1.2.H.a, provide method-specific counseling and education using the corresponding Counseling Tool in Section 2 as well as help the client develop a plan for using the selected method correctly.
2. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
3. Directions for POP use: Dispense 3 cycles of Class V (progestin only) oral contraceptives. Instruct client to take one pill by mouth each day at the same time, with no hormone-free interval.

Following the Quickstart algorithm above, instruct client to start pills today by taking first dose while in the office or at home. Give spermicide and condoms with instructions for use as backup for the first 7 days of pill pack and return for pregnancy test if period does not occur at normal time. Counsel that menses may change due to POPs.

4. Schedule the client to return to clinic for a PHO clinician visit within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription from a PHO clinician and other related prevention services. This visit should not be deferred beyond 3 months after the initial visit.
5. For a client who **does not qualify** for Quickstart supply,
  - Consult with PHO clinician for:
    - o Client whose menses are late or unsure if client is pregnant.
    - o Client with medical precautions against POP.
  - Dispense spermicide and condoms with instructions for use as appropriate.
  - Schedule the earliest available appointment with a clinician within the next 2 weeks.
6. After the initial dispensing by the PHN, a PHO clinician order is needed. Patients are allowed one Quickstart in a one year period, with verbal orders as needed to continue or change the method until a visit with a clinician is scheduled.



## #2 Standing Order for Public Health Nurses to Dispense Levonorgestrel Emergency Contraceptive Pill (ECP)

**Purpose:** ECP will be dispensed to women per FP Standing Order/protocol only. ECP can prevent pregnancy after unprotected sexual intercourse (USIC) or after a contraceptive accident when taken as soon as possible within 120 hours after USIC. ECP is most effective when used within the first 72 hours. Examples of indications are:

1. No contraceptive was used at the time of intercourse.
2. A couple attempting to practice periodic abstinence, inadvertently had intercourse.
3. An attempt at coitus interruptus resulted in ejaculation in the vagina or on external genitalia.
4. A male condom slipped, broke, or leaked.
5. A female condom, diaphragm, or cervical cap was inserted incorrectly, dislodged during intercourse, removed too early, or found to be torn. A female condom was inserted or removed incorrectly leading to spillage of semen, or the penis was inserted mistakenly between the female condom and the vaginal wall resulting in intra-vaginal ejaculation.
6. A breastfeeding woman has had her menstrual period return or is feeding her baby anything other than breast milk, or is more than 6 months postpartum even if she remains amenorrheic.
7. A woman missed COC pills:
  - During week one: when a woman missed 1 or more pills.
  - During week 2 or 3: when a woman missed 2+ consecutive pills containing 20 mcg or less ee or 3+ consecutive pills containing 30 to 35 mcg ee.
8. A woman was late in using her contraceptive
  - 3 or more hours late taking a progestin-only pill.
  - More than 14 days late for a DMPA injection or did not know date or type of previous injection.
  - 2 or more days late starting a new patch or vaginal ring cycle.
9. An IUD is expelled or a woman cannot feel her IUD string or the IUD was removed less than 8 days after her last act of intercourse.
10. A woman is exposed to a possible teratogen. (e.g., has unprotected or inadequately protected intercourse while taking the prescription acne medicine "Accutane").
11. One future use Levonorgestrel Emergency Contraceptive Pill can be supplied to women who are not on a reliable form of birth control or using a less effective method (e.g. Condoms/spermicides/withdrawal) without a clinician order.

A Clinician order is required for dispensing to male FP clients, see the following section.

**Subjective and objective nursing assessment:** The PHN will:

- A. Document the client's RLP, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.2.H.a. in the medical record (BEHR). This includes LMP and PMP. *An unusually light or mistimed period may mean fertilization actually occurred before LMP.*
- B. Document the client's height, weight, BMI and blood pressure.
- C. Utilize the calendar/ pregnancy wheel to determine if the client is already pregnant by
  - a. Documenting date(s) of last USIC since the last normal menses.
  - b. Assess the client's current pregnancy status by assuring that the client has no "symptoms of pregnancy" listed in the "How to be Reasonably Sure a Woman is not Pregnant" box.
- D. Perform urine hCG test in office if indicated:
  - ❖ The woman has irregular menses.
  - ❖ LMP was not normal in length or timing.
  - ❖ USIC >14 days ago. Urine hCG may not detect pregnancy from USIC < 14 days ago.
  - ❖ Current period is late.
  - ❖ You are not sure the sexual history is accurate.
  - ❖ Any other reason to suspect the woman may be pregnant

### **Nursing assessment of normal and abnormal findings**

Known pregnancy is the only absolute contraindication.

#### **Plan of care for client, including:**

1. CONSENT: Title X does not require a method-specific consent form for ECP.

2. ECP specific counseling includes:

Levonorgestrel prevents pregnancy by delaying/inhibiting ovulation. ECPs do not interrupt an established pregnancy. If ECP treatment fails, women can be reassured that a pregnancy that occurs after ECP does not have an increased risk of adverse outcome.

Levonorgestrel ECP reduces pregnancy risk by 89% (based on WHO perfect use study).

**The FDA has completed a review of available scientific data concerning the effectiveness of levonorgestrel emergency contraceptives in women who weigh more than 165 pounds or have a body mass index above 25 kg/m<sup>2</sup>. The data are conflicting and too limited to reach a definitive conclusion as to whether effectiveness is reduced in this group. The most important factor affecting how well emergency contraception works is how quickly it is taken after unprotected sex. ECP is most effective when used within the first 72 hours.**

ECPs may cause changes in menstrual bleeding for example, shortened menstrual cycle, heavier menstrual bleeding, and inter-menstrual bleeding. If her period does not start within 3 weeks after taking ECPs or if she is worried and/or feels pregnant, she should have a pregnancy test.

3. For women who have an indication to take Levonorgestrel ECP and who are assessed by the PHN and found to be reasonably sure that they are not pregnant, the PHN will:  
Give a single dose of 1.5 mg levonorgestrel to be taken by mouth now. No individual/additional clinician order is required. (One Future Use ECP is permitted for clients who are not on a method or using condoms/spermicides/or withdrawal as only method).
4. If vomiting occurs within 3 hours, another dose of ECP should be taken as soon as possible.
5. Emphasize that ECPs are for emergency use only. ECP should not be used in place of ongoing, correct use of regular contraceptives. Counsel on alternate methods of birth control to prevent pregnancy in the future. For new (to FP) female clients who desire ongoing effective contraception, offer Quickstart per Standing Order #1. For clients who are interested in long-term contraception, inform about an alternative emergency contraceptive (by referral or at DOH clinician discretion; See Section 2.2): ParaGard can be inserted within 5 days of the first act of USIC as an emergency contraceptive which reduces the risk of pregnancy by 99% and provides immediate, ongoing contraception for up to 10 years.
6. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
7. Schedule a follow up Family Planning appointment as appropriate.

#### **Conditions requiring notification of a Clinician**

Although there is no limit of how many times per year a woman can safely use ECP, given its limited effectiveness, it is important to explore the psychosocial issues that may have led to recurrent unprotected intercourse such as difficulties using condoms, coercion, and ambivalence about pregnancy. Notify a clinician when women present for 3 or more ECP office visits per year while continuing to have USIC. If a clinician is unavailable, dispense ECP and give an appointment with a clinician.

**For PHOs only:** Dispensing ECP to **Male** FP clients

Dispensing ECP to male FP clients may be done on a case by case basis by a **clinician only**. Like other FP clients, document the man's comprehensive medical history, BP/wt/ht/BMI and counseling as outlined in Section 1.2.H.a. in the medical record (BEHR).

The clinician will talk to the female partner on the phone to assess existing pregnancy risk:

- Obtain the date of the last USIC since the last normal menses;
- Ascertain that she has chosen to take ECP;
- Provide brief counseling on ECP use, pregnancy as the only contraindication, and that she should go to a clinic for a pregnancy test if she does not have menses within 3 weeks post ECP;
- Counsel on ongoing birth control;
- Document information gathered from the female partner and telephone counseling in the male client's medical record.

If unable to speak to the female partner, the clinician should not dispense ECP to male clients.

If dispensed to a male client under a clinician's order, the nurse will sign out the non-340B ECP under the male client's name in the Pharmacy log and write the male client's name on the label.

**b. Pregnancy Testing and Counseling Services: Gateway to Other FP Services**

NM Title X providers may offer pregnancy testing and counseling services as part of family planning services. A client should not be made Title X or FPP for the purposes of having a pregnancy test. PHO clients of reproductive age who are seen for other services where knowledge of pregnancy status may affect management, such as immunization (with a live virus vaccine) or an STD where an antibiotic is contraindicated in pregnancy, but who are not otherwise being seen for family planning services, may need a urine hCG pregnancy test. However, if the client expresses an interest or need to be seen for family planning services, their visit may be converted into a FP visit.

The visit should include:

- A discussion about her reproductive life plan. RLP is particularly important in determining the client's need for other core FP services such as contraceptive services and preconception health services.

**Note:** For **non-PHO (Provider Agreement/Contracted)** The Title X contract states that the contracted clinics must screen the client for their RLP and include the following:

- A **medical history** that includes asking about date of last normal menstrual period (LMP), previous normal menstrual period (PMP), last USIC (since normal LMP), symptoms of pregnancy and any coexisting conditions (e.g., chronic medical illnesses, physical disability, psychiatric illness).
- A **pelvic exam** with a clinician if clinically indicated.
- In most cases, a qualitative urine **pregnancy test** will be sufficient. However, in certain cases, a clinician may consider a quantitative serum pregnancy test (at the client's own expense), if exact hCG levels would be helpful for diagnosis and management.
- **The test results should be presented to the client, following the instructions in this section, on page 28, if the test is positive.** A female client might wish to include her partner in the discussion; however, if a client chooses not to involve her partner, confidentiality must be assured.

### #3 PHN Standing Order: Urine hCG for Pregnancy Testing

**Purpose:** Pregnancy testing provides the opportunity as an entry point for contraceptive needs assessment, health education and counseling about reproductive life plan.

#### **Subjective and objective nursing assessment:**

1. The PHN will interview clients and:
  - A. Document the client's RLP, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.2.H.a. in the medical record (BEHR). This includes LMP and PMP. *An unusually light or mistimed period may mean fertilization has already occurred before LMP.*
  - B. Review symptoms: Often the woman herself suspects pregnancy or has reason to believe that she could be pregnant. A particularly useful question to ask is "Do you think you are pregnant now?"
    - The most common sign that prompts a woman to seek pregnancy evaluation is an overdue menstrual period.
    - Breast tenderness and nipple sensitivity typically begin 1-2 weeks after fertilization.
    - Fatigue, nausea, and urinary frequency begin at about 2 weeks.
    - Bleeding, spotting, or lower abdominal pain may signal ectopic gestation or threatened spontaneous abortion.
2. Document the client's blood pressure, weight, height and BMI.
3. Based on the history, the PHN may perform a urine hCG pregnancy test as appropriate. The test is supplied by the PHD pharmacy and is to be done per the manufacturer's instructions and the "Public Health Division Laboratory Standard Operating Procedures Manual".

#### **Nursing assessment of normal and abnormal findings**

Pregnancy diagnosis should not be based on urine hCG results alone. According to the 2015-2016 Managing Contraception For Your Pocket, *β-hCG can be detected as early as 7-10 days after conception thereby "ruling in" pregnancy, but pregnancy cannot be "ruled out" until 7 days after expected menses.*

When the results of the test are not consistent with client history and/or physical exam, consider the test limitation, particularly false negative when the pregnancy is either too early (< 14 days) or too late (>10 weeks, for example client has missed two periods). If it is too early for testing, have the client return for repeat test in 2 weeks. The client may also be referred for serum hCG at their own expense.

#### **Plan of care:**

***For women younger than 25, consider sending chlamydia specimen to lab if not done within the last 12 months.***

1. Document all services provided in the clinical record.
2. RLP counseling is particularly important in determining the plan of care.
3. Client (and her partner) will be provided appropriate counseling and education according to their RLP and pregnancy test result as outlined below.

#### COUNSELING IF THE TEST IS NEGATIVE:

1. Counsel the client regarding the basics of the female reproductive cycle and the signs and symptoms of pregnancy.
2. Discuss other possible reasons for her symptoms such as medications like oral contraceptives, use of DMPA, medical conditions that may need further medical evaluation, or stress from illness or surgery.
3. If she does not want to be pregnant,
  - a. Discuss birth control choices (Is it early enough for ECP?).
  - b. For new clients who desire a hormonal birth control method, give supplies per Quickstart Standing Order.
  - c. Dispense foam or film and condoms as appropriate.
  - d. Offer a clinician appointment within the next 3 months. If the client did not receive any contraceptive except a barrier method, offer the first available family planning appointment at your clinic. If the appointment is not available within the next few weeks, offer information for other Title X clinics in your area or make appropriate referral.
4. If she wants to be pregnant,
  - a. Discuss preconception health using the “Preconception Health and Instructions for an Optimal Pregnancy.” For additional information see: Recommendations to improve preconception health and health care — United States: a report of the CDC/ ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55(No. RR- 6) <http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf>.
  - b. **Providers may dispense one bottle of Prenatal Vitamins according to non-Title X agency or site policy/procedure.**
  - c. If the client has been attempting to get pregnant for several months without success, offer an appointment with a clinician.

#### COUNSELING IF THE TEST IS POSITIVE:

1. **Once a client served by a Title X service site is verified as pregnant, it is required that she be referred to a health care provider for prenatal health care.**
2. Calculate pregnancy EDC by reviewing dates of unprotected sexual intercourse and menstrual history using tools such as a pregnancy due date wheel.
3. Document the client’s pertinent history that helps determine pregnancy risk including genetic family history and pregnancy intention information.
4. **There are no restrictions on which personnel may refer for prenatal care. Staff members may use factual materials such as CHOICES and should continue to make referrals for prenatal care. Staff should provide the DOH county resource list for pregnant clients.**
5. If the client has any questions or concerns beyond confirming pregnancy and providing basic facts about options, the client must be referred to a physician or advanced practice provider (APP). Nondirective pregnancy counseling may be provided by a physician or APP. Nondirective pregnancy options counseling refers to general information given to clients that neither encourages nor discourages options. Medical questions about the options must be answered by a physician or APP.
6. **If a physician or APP is not onsite staff may offer the options below for nondirective counseling if the client agrees:**
  - **By phone to a designated clinician or RHO according to PHD process; or by telemedicine, referring to PHD’s telemedicine policy and procedures; or rescheduling to follow up with a provider.**
  - **PA sites should follow their own agency policy for phone or telemedicine counseling.**
7. **Advanced practice provider includes physician assistants and advanced practice registered nurses. Examples include certified nurse practitioner, clinical nurse specialist, and certified nurse-midwife.**
8. Document in the client record that pregnancy options counseling was done.
9. Counsel client using “**Instructions for an Optimal Pregnancy**” and assess their social support.

**CARRYING PREGNANCY TO TERM:**

Client should receive prenatal care as soon as possible. A physical exam for pregnant women is important and should be arranged for preferably within 2 weeks.

1. Review ways to access prenatal care.
  - If she will qualify and wants Medicaid Presumptive Eligibility, start that process.
  - If she has insurance, encourage her to call today for an appointment.
2. Discuss "Instructions for an Optimal Pregnancy". If there are any potential problems, tell the client to discuss them with her prenatal care provider.

**ADOPTION:**

Staff should provide the DOH county resource list for pregnant clients.

- New Mexico offers several options for adoption such as open (fully disclosed) and closed (confidential). Adoptions are completed by agencies and/or attorneys.
- The procedures are the same whether you are under 18 or older.
- Consent from biological father is required if he is married to the mother or he establishes paternity.
- Consent to adoption can be signed any time after the baby is 48 hours old.

**ABORTION/TERMINATION:**

1. Although pregnancy options **should** be available to all clients, personnel working with Title X clients may be subject to prosecution if they (try to) coerce a Title X client to undergo an abortion.
2. If you do not feel comfortable discussing this option, have someone else counsel the client. Discuss arrangements for this with your supervisor in advance. **Physicians and APP may provide nondirective counseling, including abortion.** For pregnant clients, there is a DOH approved resource list for each county. The lists include providers for adoption, health care providers for prenatal care and abortion. The approved list does not specify which services are offered by each provider. The physician or APP cannot identify which services are offered by which provider. The provider may state to the client, "This is a list of providers who serve pregnant women. Reach out to these providers to learn about the services they provide". These lists are available on the DOH FPP website: <https://nmhealth.org/about/phd/fhb/fpp/pvdr>
3. A Title X service site may not perform, promote, refer for or support abortion as a method of family planning, nor take any other affirmative action to assist a patient to secure such an abortion (§ 59.14). Staff may provide the DOH resource list to the client.
4. It is prohibited to make a referral for abortion except in cases of medical emergencies or when pregnancy resulted from rape or incest.
5. If she will qualify and wants Medicaid Presumptive Eligibility, start that process so that if there are any pregnancy-related problems, she will be covered.
6. Discuss what she will choose for birth control after the procedure and where she can receive **contraception.**
7. Refer to support agencies such as rape crisis, mental health counseling, etc. as needed.
8. Discuss the "Instructions for Clients for Optimal Pregnancy," so that she is in the best possible shape for the procedure or the pregnancy if she changes her mind.

**Conditions requiring notification of a clinician**

Early pregnancy danger signs; need **immediate** evaluation by a clinician, either in your clinic or by referral to another clinic or emergency room:

- Sudden intense or persistent pain, or cramping in the lower abdomen, usually localized to one side.
- Irregular bleeding or spotting, with abdominal pain, when period is late or after an abnormally light period.
- Fainting or dizziness persisting more than a few seconds. These may be signs of internal bleeding. Internal bleeding is not necessarily associated with vaginal bleeding.
- The last period was late and bleeding is now heavy, possibly with clots or clumps of tissue.
- Cramping is more severe than usual.
- Period is prolonged and heavy--5-7 days of heavy bleeding.
- Abdominal pain or fever.

# CHOICES:

If being pregnant is a problem, you may feel alone, scared, guilty, angry or confused at a time when an important decision must be made.

Many women of all ages and backgrounds have had to make the difficult choice between parenthood, adoption, and abortion. Knowing yourself, being honest with yourself, and remaining true to your own standards will help you make the most responsible decision.

Take into consideration your feelings as well as facts when you consider how this pregnancy will affect your life situation now and in the future.

The choice is yours, but that doesn't mean you must be alone in making your decision. Seek out the people who will support you: your partner, family, friends, clergy or a professional counselor.

## Parenthood

May be considered if...

I believe I am ready to assume the responsibility of being a parent.

I can accept the physical and emotional aspects of pregnancy, delivery, and child care.

I have considered the feelings of my partner and my family.

I am willing to consider my child's needs for the next 18 years.

I will learn and practice parenting skills.

I have discussed my need for support with those who care about me: my partner, my family, or my friends.

I have considered the possibility that I may have to raise the child alone.

I can arrange the necessary finances for this child: medical care, food, clothing, housing, etc.

## Adoption

May be considered if...

I believe I should continue this pregnancy but cannot raise a child at this time.

I believe this child will have a chance for a better life in another family.

I am willing to get good medical care, go through labor, delivery and make adoption arrangements.

I have considered the feelings of my partner and my family.

I am willing to wait for another time to have a child to raise.

I can accept the possibility of never seeing this child again.

I realize there is a possibility this child may re-enter my life at a later time.

I am prepared to handle the emotional aspects of adoption.

## Abortion

May be considered if...

I believe I have the right to choose an abortion.

I am choosing abortion out of thoughtful consideration rather than panic or desperation.

I can make an early decision.

I have considered the feelings of my partner and my family.

I am willing to wait for another time to have a child to raise.

I can manage the finances for a legal abortion.

I am willing to make arrangements for the abortion and necessary aftercare.

I am prepared to handle the emotional aspects of abortion.

# OPCIONES:

Si su embarazo es un problema, es posible que se sienta sola, asustada, culpable, enojada o confundida en los momentos en que se debe hacer una decisión importante.

Muchas mujeres de todas edades y orígenes han tenido que tomar la difícil elección entre la maternidad, la adopción y el aborto. Conocerse a sí misma, ser honesta con uno misma, y mantenerse fiel a sus propias valores le ayudará a tomar la decisión más responsable.

Tome en cuenta sus sentimientos, así como los hechos al tener en cuenta cómo el embarazo afectará su vida ahora y en el futuro.

La elección es suya, pero no significa que usted debe estar sola su decisión. Busque a las personas que le apoyarán: su pareja, familia, amigos, clero o un consejero profesional.

## La maternidad

Puede considerar...

Creo que estoy lista para asumir la responsabilidad de ser madre.

Puedo aceptar los aspectos físicos y emocionales del embarazo, del parto y del cuidado infantil

He considerado los sentimientos de mi pareja y mi familia.

Estoy dispuesta a considerar las necesidades de mi hijo durante los próximos 18 años. Voy a aprender y practicar las habilidades de crianza.

He hablado de mi necesidad de apoyo con los que se preocupan por mí: mi pareja, mi familia y mis amigos.

He considerado la posibilidad que voy a tener que criar a mi hijo sola.

Yo puedo arreglar las finanzas necesarias para este niño: atención médica, alimentación, ropa, vivienda, etc.

## Adopción

Puede considerar...

Creo que debo continuar con este embarazo, pero no puedo criar a un niño en este momento.

Creo que este niño tendrá la oportunidad de una vida mejor en otra familia.

Estoy dispuesto a recibir buena atención médica, a pasar por el parto y hacer los arreglos de adopción.

He considerado los sentimientos de mi pareja y de mi familia.

Estoy dispuesto a esperar a otro momento para tener un hijo que criar.

Puedo aceptar la posibilidad de no volver a ver a este niño de nuevo.

Me doy cuenta de que existe la posibilidad que este niño puede volver a entrar en mi vida en un momento posterior.

Estoy preparada para manejar los aspectos emocionales de la adopción.

## Aborto

Puede considerar...

Creo que tengo derecho a elegir un aborto.

Elijo el aborto después de una consideración cuidadosa en lugar de pánico o desesperación.

Yo puedo tomar una decisión temprana.

He considerado los sentimientos de mi pareja y mi familia.

Estoy dispuesta a esperar a otro momento para tener un hijo que criar.

Puedo manejar las finanzas para un aborto legal.

Estoy dispuesta a hacer los arreglos para el aborto y los necesarios cuidados posteriores.

Estoy preparada para manejar los aspectos emocionales del aborto



## Preconception Health and Instructions for an Optimal Pregnancy

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1. Write down the dates of each menstrual period.
2. Take a vitamin that contains 400 micrograms (mcg) of folic acid every day beginning several months before pregnancy to prevent major birth defects of the baby's brain and spine. If you have had a baby with a birth defect of the baby's brain or spine you should take 4 milligrams (mg) of folic acid daily through the first three months of pregnancy.
3. Make sure your immunizations are up to date, especially rubella and whooping cough vaccines.
4. Avoid exposure to:
  - Alcohol, smoking, excessive caffeine, drugs;
  - X-ray of the abdominal area, or other area without shield;
  - And all potential toxic chemicals.
5. Don't take any prescribed or non-prescribed medications until you have discussed this with your provider. This includes herbal remedies.
6. Avoid exposure to sexually transmitted infections.
7. Review the medical/family history for you and the baby's father, including genetic risk factors.
8. If you have a serious medical condition; speak to your provider about risks to you and your baby if you get pregnant, and how to reduce those risks.
9. Reach your ideal weight before you get pregnant. This may reduce your risk of complications during and after pregnancy for you and your baby.
10. Make a healthy diet and moderate exercise a priority. Eat a variety of foods to get all the nutrients you need. Include whole grain breads or pasta, fresh vegetables and fruits, lean protein (meat, poultry, fish, eggs or nuts) and dairy products (milk, cheese, and yogurt) in your daily diet. Limit fats and sweets.  
If you are pregnant, avoid eating fish that may contain high levels of mercury. Eat no more than 6 ounces of canned tuna per week and no more than one serving of farm-raised salmon per month.
11. Avoid fever or elevated body temperature like hot tubs, saunas, prolonged physical exertion that increases core body temperature.
12. Don't clean cat's litter boxes.
13. When you are pregnant, start prenatal care as soon as possible.
14. Watch for the danger signs of possible pregnancy complications as listed below. If you experience any of these danger signs seek health care immediately:
  - Pronounced swelling in face or hands
  - Blurring of vision or spots before the eyes
  - Any bleeding from the vagina
  - Severe or constant headaches
  - Severe or continuous vomiting
  - Fever/chills
  - Burning or pain when urinating
  - Sharp, rhythmic or constant pain in abdomen or back
  - Fluid coming from vagina.

More information at <http://www.cdc.gov/preconception/planning.html>.

## **Precauciones e instrucciones para tener una buena salud durante su embarazo**

1. Anote las fechas de cada menstruación.
2. Tome una vitamina que contenga 400 microgramos – mcg de ácido fólico todos los días empezando varios meses antes de que se embarace, para prevenir defectos de nacimiento importantes en el cerebro y la espina dorsal del bebé.
3. Asegúrese de que esté al corriente en sus vacunas, lo más importante las rubéola y las vacunas contra la tos ferina.
4. Evite exponerse a:
  - Alcohol, fumar, cafeína excesiva, drogas ilegales;
  - Rayos X del área abdominal, o de otra área sin que le pongan protección;
  - Todas las sustancias químicas que son potencialmente tóxicas.
5. No tome ninguna medicina de receta o sin receta hasta que la haya discutido con su proveedor de atención médica. Esto incluye remedios de yerbas.
6. Evite exponerse a infecciones de transmisión sexual.
7. Revise los historiales médicos y familiares suyos y los del papá del bebé, incluyendo los factores genéticos de riesgo.
8. Si usted sufre de una enfermedad grave, hable con su doctor acerca de los riesgos para usted y su bebé si se llegara a embarazar, y también sobre cómo reducir esos riesgos.
9. Alcance su peso ideal antes de que se embarace. Esto puede reducir su riesgo de complicaciones durante y después del embarazo para usted y para su bebé.
10. Haga de una dieta sana y de un ejercicio moderado una prioridad. Coma una variedad de alimentos para que le den todas las sustancias nutritivas que necesita. Incluya panes o pasta integrales, verduras y frutas frescas, proteína magra (carne, pollo, pescado, huevos o nueces) y productos lácteos (leche, queso y yogur) en su dieta diaria. Limite las grasas y los dulces.  
Si usted está embarazada, evite comer pescado que pueda contener altos niveles de mercurio. Como no más de 6 onzas de atún enlatado por semana y no más de una porción de salmón de granja por mes.
11. Evite que le de calentura o que se eleve su temperatura corporal, como darse baños de tina con agua caliente, saunas, y ejercicio prolongado que le aumente la temperatura interna corporal.
12. No limpie las cajas de arena que los gatos usan para defecar.
13. Cuando usted esté embarazada, empiece su cuidado prenatal tan pronto como sea posible.
14. Esté alerta a las señales de peligro de posibles complicaciones del embarazo que se mencionan abajo. Si usted siente cualquiera de estas señales de peligro, busque cuidados de salud inmediatamente:
  - Hinchazón muy marcada de la cara o las manos.
  - Visión borrosa o si ve manchas delante de sus ojos.
  - Cualquier sangrado de la vagina.
  - Dolor de cabeza constante o grave
  - Vómitos graves o continuos
  - Fiebre o escalofríos
  - Dolor o sensación de ardor al orinar
  - Dolor agudo, rítmico o constante en el abdomen o en la espalda
  - Líquido que le sale de la vagina.

Para más información, visite <https://www.cdc.gov/preconception/spanish/planning.html>

### c. Preconception Health Services for Clinicians

The term “preconception” describes any time that a woman of reproductive potential is not pregnant but at risk of becoming pregnant, or when a man is at risk for impregnating his female partner. Preconception health services are beneficial because of their effect on pregnancy and birth outcomes and their role in improving the health of women and men.

Preconception services for women aim to identify/modify biomedical, behavioral, and social risks to women’s health or pregnancy outcomes through prevention and management. It promotes the health of women of reproductive age before conception, and thereby helps to reduce pregnancy-related adverse outcomes, such as low birth weight, premature birth, and infant mortality.

Preconception services for men address men as partners in family planning (i.e., both preventing and achieving pregnancy), their direct contributions to infant health (e.g., genetics), and their role in improving the health of women (e.g., through reduced STD/HIV transmission).

When providing these services to Title X clients, clinicians will follow recommendations described in Section 1.2 Tables 1 and 2: Checklists for Providing Family Planning Services for Women and Men when collecting/performing/documenting client’s history and physical exam. The QFP recommendation summary is:

- Discussion of a **Reproductive Life Plan** (See Step 2.a of Section 1.2.H.a.)
- **Sexual health assessment** (See Step 2.c of Section 1.2.H.a.)
- **Medical History:**
  - For female clients, the medical history includes:
    - Reproductive Hx including poor birth outcomes (preterm, cesarean delivery, miscarriage, stillbirth)
    - Chronic medical illnesses (e.g., DM, HTN, thyroid diseases)
    - Environmental exposures, hazards and toxins (e.g., smoking, alcohol, other drugs)
    - Medications (concerns are for medications that are known teratogens)
    - Genetic conditions
    - Family medical history.
  - For male clients, the medical history includes:
    - The client’s past medical and surgical history that might impair his reproductive health (e.g., genetic conditions, history of reproductive failures, or conditions that can reduce sperm quality, such as obesity, diabetes mellitus, and varicocele).
    - Environmental exposures, hazards and toxins (e.g., smoking).
- **Screening for Intimate Partner Violence, Alcohol and Other Drug Use, Tobacco Use and Depression (VAST-D):** Title X licensed providers are required to take the VAST-D training and familiarize themselves with screening questions, appropriate management and referral.
- **Immunizations:** Female and male clients should be screened for age-appropriate vaccinations, such as influenza and tetanus–diphtheria–pertussis (Tdap), measles, mumps, and rubella (MMR), varicella, pneumococcal, and meningococcal.

**Rubella status:** Documentation can be a self-reported history that the woman has had a baby born in the U.S., personal immunization record, or a serological report. For clients with unknown rubella status, make a note in the client’s medical record of the lack of documented rubella immunity and recommend:

- Immunization with MMR (**PHO staff:** please follow PHD/Immunization Program policy for adult MMR vaccine eligibility). Clients should be strongly counseled that pregnancy should be avoided for 1 month after MMR vaccine and should be provided an interim contraceptive method if necessary.

**Note:** Parental consent is required for immunization of a minor with the exception of Hep A, Hep B or HPV vaccines. Minors presenting for confidential services may consent for HPV, Hep A or Hep B vaccination (refer to the Immunization Protocol).

- Rubella serology at the client's own expense.

- **Physical exam:**

- **BP:** Hypertension increases risks for morbidity and mortality to mother and fetus.
- **Height, Weight, and BMI**

- Obese clients should be counseled on:

- ❖ Adverse perinatal outcomes associated with maternal obesity, which include neural tube defects, preterm delivery, diabetes, cesarean section, hypertensive, and thromboembolic disease.
- ❖ Weight loss before pregnancy reduces these risks. For general information on WEIGHT MANAGEMENT, please refer to Section 5 of the Protocol.
- ❖ If possible, obese adult clients should be referred for intensive counseling and behavioral interventions to promote sustained weight loss. These interventions typically comprise 12 to 26 sessions in a year and include multiple behavioral management activities (e.g., group sessions, individual sessions, setting weight-loss goals, improving diet/nutrition, physical activity sessions, addressing barriers to change, active use of self-monitoring, and strategizing how to maintain lifestyle changes).

- **Laboratory Screening Test for Diabetes:** For female and male clients, providers should follow the USPSTF recommendation (Grade B) to screen/refer the client to be screened for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) >135/80 mmHg. The screening will be done at the client's own expense and should be referred to a primary care clinician.

### **Counseling for Women**

- A. Counseling is based on "Preconception Health and Instructions for an Optimal Pregnancy." For additional information on preconception care, including counseling for each health topic, see updated information on the CDC website e.g., MMWR Recommendations to Improve Preconception Health and Health Care - United States; A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>.
- B. For women using contraceptives who desire pregnancy, discontinue the method. Clinician may order PNV to correct possible nutritional deficiencies. After stopping the method, she may have a 1-2 month(s) delay before menses become regular (or several months if on DMPA). She may wish to use a non-hormonal method until 2-3 normal periods have occurred. Careful notation of menstrual dates will help establish correct gestational age when pregnancy occurs. Advise client to return for evaluation if she does not have menses 6-8 weeks after stopping combined-contraceptives.
- C. Emphasize the need for early and continuing care during pregnancy with referral to prenatal clinics.

For additional information on preconception care, see MMWR Recommendations to Improve Preconception Health and Health Care - United States; A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

### **FOLIC ACID:**

All women planning/capable of pregnancy should be counseled about the need to take 0.4-0.8 mg of folic acid daily. Adequate stores of folic acid in a woman's body BEFORE and during the FIRST 28 DAYS of pregnancy greatly reduce the risk of having a baby with neural tube (brain and spine) defects (NTD). When pregnancy is confirmed, Institute of Medicine recommends women increase folic acid dose to 0.6 mg/day. Most doctors recommend a prenatal vitamin that contains at least this amount of folic acid. Women should not take more than 1 mg/day without a doctor's advice. High doses of folic acid can mask a vitamin B-12 deficiency (including pernicious anemia) while allowing irreversible neurologic damage to take place.

If a woman already has had a baby with NTD, she should consult her doctor before her next pregnancy about the amount of folic acid she should take. In this situation, studies showed that beginning at least one month before pregnancy and in the first trimester of pregnancy, taking a larger dose of folic acid daily (4

mg) reduces by about 70% the risk of having another affected pregnancy. [MMWR, 9/11/92, 41(RR-14); 001]

#### **D. Basic (Level I) Infertility Services for Clinicians**

Infertility commonly is defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse (80% of couples achieve pregnancy within one year). Infertility investigation is difficult, complex and expensive; therefore, it is customary not to begin medical infertility investigations until the couple has been trying to conceive for at least 12 months. Earlier assessment (such as 6 months of regular unprotected intercourse) is justified in cases of:

- Women aged >35 years
- Women with a history of oligomenorrhea (infrequent menstruation)
- Women with known or suspected uterine or tubal disease or endometriosis
- Women with a partner known to be subfertile (the condition of being less than normally fertile though still capable of effecting fertilization)
- A couple with known risk factors of male infertility or if there are questions regarding the male partner's fertility potential.

The Title X Guidelines require providers to offer at least Level I or basic infertility services. Infertility visits to a Title X provider are focused on determining potential causes of the inability to achieve pregnancy and making any needed referrals to specialist care. American Society of Reproductive Medicine recommends that evaluation of both partners should begin at the same time. PHOs will have a very limited role in cases of true infertility; therefore, caution should be exercised so that couples are not subjected to steps (in-depth medical history, physical examinations) which would invariably be repeated by the infertility specialist.

When providing basic infertility services to Title X clients, clinicians will follow the recommendation described in Section 1.2 Tables 1 & 2: Checklists for Providing Family Planning Services for Women and Men when collecting, performing and documenting client's history/physical exam. Summary is as follows:

#### **Basic Infertility Care for Women**

##### **Medical History:**

- **Reproductive Life Plan** (See Step 2.a of Section 1.2.H.a) & **difficulty in achieving pregnancy.**
- **Reproductive history** include age at menarche; cycle length/characteristics/dysmenorrhea (onset/severity); gravidity/parity/pregnancy outcome(s)/associated complications; past history of birth control usage; how long the client has been trying to achieve pregnancy; coital frequency and timing; level of fertility awareness and results of any previous evaluation/treatment.
- **Sexual health assessment** (See Step 2.c of Section 1.2.H.a), including history of pelvic inflammatory disease (PID), STDs or exposure to STDs.
- **Medical conditions associated with reproductive failure** e.g., thyroid disorders, hirsutism, or other endocrine disorders (e.g., Polycystic Ovarian Syndrome-PCOS), leiomyoma or uterine tumors.
- A **review of systems** should emphasize symptoms of thyroid disease, pelvic or abdominal pain, dyspareunia, galactorrhea, and hirsutism.
- **Previous hospitalizations, childhood disorders and family Hx of reproductive failure.**
- **Serious illnesses/injuries and past surgery** (e.g., D&C) including indications & outcome(s).
- **Results of cervical cancer screening** and any follow-up treatment, e.g., LEEP/cryo of cervix
- **Current medication use and allergies**

##### **Physical examination (by a clinician):**

- **Weight, Height, and BMI** calculation.
- **Thyroid examination** to identify any enlargement, nodule, or tenderness.
- **Clinical breast examination;** and **assessment for any signs of androgen excess.**
- **Pelvic examination:** pelvic/abd/adnexal/cul-de-sac mass or tenderness; organ enlargement; vaginal or cervical abnormality/secretions/discharge; uterine size/shape/position/mobility.

**Laboratory testing:** Referral is made at the client's own expense (serum progesterone levels, FSH/LH

hormone levels, thyroid function tests, prolactin levels, endometrial biopsy, transvaginal ultrasound, hysterosalpingography, laparoscopy, and clomiphene citrate).

### **Basic Infertility Care for Men**

#### **Medical History:**

- Discuss the client's **Reproductive Life Plan**.
- **Past medical history:** systemic medical illnesses (e.g., DM), prior surgeries, past infections.
- **Reproductive Hx:** contraception, coital frequency/timing, duration of infertility, prior fertility.
- **Sexual health assessment**
- **Medications** (prescription and nonprescription) and **allergies**
- **Lifestyle exposures** e.g., gonadal toxin including heat and the use of saunas or hot tubs.
- **Female partners' history** of PID/STDs, and problems with sexual dysfunction.

#### **Physical examination (by a clinician):**

- Examination of **penis** (including urethral meatus location), **testes** (palpation, measure size)
- Presence and consistency of both **vas deferens** and **epididymis**, presence of a **varicocele**
- **Secondary sex characteristics**
- A **digital rectal exam**.

**Laboratory testing:** Semen analysis (to be done at the client's own expense) is the first and most simple screen for male fertility. Clients with abnormal semen test should be referred for diagnosis (e.g., second semen analysis, endocrine evaluation, post-ejaculate urinalysis) and treatment.

**Infertility Counseling** should be guided by information elicited from the client during the medical and reproductive history and physical exam findings. If there is no apparent cause of infertility or the client does not meet the infertility definition above, providers should educate the client about how to maximize fertility.

Key points are as follows:

- Peak days and signs of fertility, including the 6-day interval ending on the day of ovulation that is characterized by slippery, stretchy cervical mucus and other possible signs of ovulation.
- For women with regular menstrual cycles (26-32 days), vaginal intercourse every 1–2 days after the menstrual period ends can increase the likelihood of becoming pregnant.
- Discuss methods or devices designed to determine or predict the time of ovulation (e.g., over-the-counter ovulation kits, smart phone applications, or CycleBeads®).
- Lower fertility rates in very thin/obese women or those consuming excessive caffeine (e.g., >5 cups/day).
- Discourage smoking, alcohol, recreational drugs, and vaginal lubricant usage.
- Recommend daily preconception intake PNV with 0.4 mg of folic acid to reduce risk for NTD.

#### **Referral:**

- Refer to physician or specific specialists as indicated. The couple should be given a copy of their clinic records, especially if a detailed menstrual/sexual history has been taken, and a summary of any education or counseling that was provided.
- The American Congress of Obstetricians and Gynecologists (ACOG) notes the importance of addressing the emotional and educational needs of clients with infertility and recommends that providers consider referring clients for psychological support, infertility support groups, or family counseling.

RESOLVE ([www.resolve.org](http://www.resolve.org)) is the National Infertility Association that provides free support

programs in communities throughout the country. Mailing address is RESOLVE: The National Infertility Association, 7918 Jones Branch Road, Suite 300 McLean, VA 22102 Phone: 703.556.7172 Fax: 703.506.3266.

## E. Sexually Transmitted Diseases Services

Providers should offer STD services in accordance with current CDC STD treatment and HIV testing guidelines. It is important to test young sexually active females (< 25 years old) for chlamydia annually because CT can cause tubal infertility in women if left untreated.

STD services for Title X clients include the following steps, which should be provided at the initial visit and annually thereafter:

### Step 1. Assess:

- The client's **Reproductive Life Plan** (See Step 2.a of Section 1.2.H.a).

**Note:** For **non-PHO** Title X clinics (FP Provider Agreement sites outside of PHO), in order for a new client to be eligible for Title X STD testing/treatment, Title X contract states that the client must have a clinic visit to evaluate their RLP, and provide a contraceptive method (including male condoms) to assist clients in preventing unintended pregnancy.

- Conduct a standard medical history and sexual health assessment (See Step 2.c of Section 1.2.H.a), and check immunization status (HPV and HBV).
- A pelvic exam is not indicated in patients with no symptoms suggestive of an STD. Genital exam in male clients is done if clinically indicated.

**Step 2. Screen:** a client who is at risk of an STD (i.e., sexually active and not involved in a mutually monogamous relationship with an uninfected partner) for HIV and the other STDs listed below, in accordance with CDC's STD treatment guidelines <http://www.cdc.gov/std/treatment> and recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

**Chlamydia (CT) and Gonorrhea (GC)** as a combination test - For female clients, providers should screen:

- All sexually active women aged <25 years for chlamydia annually.
- Females requesting IUD insertion, regardless of age.
- Women aged ≥25 years at higher risk include sexually active women who:
  - Have a new sex partner
  - Have more than one sex partner
  - Have a partner who has other concurrent partners
  - Have a partner with an STD infection.
- Females with CT/GC infection for re-infection at 3 months after treatment.

**Note that the following guidelines apply to clinic sites operated by FP Provider Agreement sites (outside PHO):** Providers should screen:

- All sexually active women ages <25 years for chlamydia annually.
- Females requesting IUD insertion, regardless of age.

CT testing may also be provided for female and male FP clients who are <30 years old and are:

- symptomatic, or
- those diagnosed with an STD in the last year, or
- a known contact to an STD infected partner.

Any testing outside of these parameters is not covered by the FP Provider Agreement, and the client must pay for this testing. Also ensure that all clients who are tested under the FP Provider Agreement have the

appropriate health history, counseling, and medical record documentation, in order to qualify them as FP clients (refer to Step 1, above).

**Syphilis** - For all (female and male) clients, providers should screen clients who are at risk for syphilis, for example commercial sex workers, persons who exchange sex for drugs, those in adult correctional facilities and those living in communities with high prevalence of syphilis.

**HIV/AIDS** - For female and male clients, providers should follow CDC recommendations that:

- All clients aged 13–64 years be offered the HIV screening routinely.

**Note:** Clients who already know their HIV status and are not at high risk for HIV do not need to be offered screening/screened annually. History such as from female clients who have given birth in the U.S. is useful in providing indirect evidence that the client may have already been screened for HIV during pregnancy.

- All persons likely to be at high risk for HIV who should be rescreened at least annually include:
  - Injection-drug users and their sex partners
  - Gay, bisexual men, other men who have sex with men (MSM) and transgender persons
  - Persons who exchange sex for money or drugs
  - Sex partners of HIV-infected persons
  - Persons who have been diagnosed with an STD.

CDC further recommends that screening be provided after the client is notified that testing will be performed as part of general medical consent unless the patient declines (opt-out screening).

“Opt-out screening” is defined as performing HIV screening after notifying the patient that:

- 1) The test will be performed.
- 2) The patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing.

Title X family planning services should not be withheld for declining the HIV screening; rather, make a note in the client record of the client’s refusal and reason.

**Note:** For **non-PHO** FP clients, HIV screening/testing is not considered a Title X test and is not covered in the FPP agreement. Client must pay for this testing.

### **Step 3. Treat:**

- A client with an STD and her/his partner(s) should be treated in a timely fashion to prevent complications, re-infection and further spread of the infection in the community. Ideally, STD treatment should be directly observed in the clinic. If a referral is made to a service site that has the necessary medication available on-site, such as the recommended injectable antimicrobials for gonorrhea (GC) and syphilis, then the referring provider must document when the treatment was given at another clinic.

For partners of PHO clients with confirmed CT or GC,

- One option is to schedule them to come in with the client.
- Another option for partners who cannot come in with the client is expedited partner therapy (EPT), in which medication or a prescription is provided to the patient to give to the partner to ensure treatment. EPT is a partner treatment strategy for partners who are unable to access care and treatment in a timely fashion. Because of concerns related to resistant gonorrhea, efforts to bring in for treatment partners of patients with gonorrhea infection are recommended; EPT for gonorrhea should be reserved for situations in which efforts to treat partners in a clinical setting are unsuccessful and EPT is a gonorrhea treatment of last resort.

**For PHOs:** Clinic staff will follow the current STD Protocol for implementing “Expedited Partner Treatment (EPT)” Standing Order.

**For non-PHOs:** Partners of clients who require EPT are not themselves Title X clients, therefore precluding clinics from dispensing Title X meds. (Title X and 340B federal Programs with which the State purchases antibiotics for STD treatment require that clients must have a face-to-face encounter with the provider in a Title X clinic.)

- Clients with HIV infection should be linked to HIV care and treatment. Clients should be counseled



about the need for partner evaluation and treatment to avoid reinfection at the time the client receives the positive test results.

**Step 4. Provide/document risk counseling:** STD education/counseling may be done in several ways:

- **One-on-one conversations** with a health care professional or counselor, aimed at motivating a sexually active person to practice safer sex behaviors. These conversations may be more effective when they are tailored to a person's age, gender, race, and ethnicity.
- **Educational materials** and **phone conversations** can also help people reduce their risk for getting or spreading an STD.

**Behavioral counseling interventions to prevent STD** involves:

- Providing basic information about STD and how they are passed from one person to another.
- Assessing a person's risk of getting or spreading an STD.
- Reducing risks by helping clients develop skills to reduce the chances of getting an STD, which include:
  - Using latex condoms correctly and consistently including hands-on practice with a model & condoms.
  - Talking with partners about safer sex.
  - Training in common behavior change process such as problem-solving, decision making and goal-setting.

[September 2014 Task Force FINAL Recommendation. Behavioral Counseling Interventions to Prevent STIs. <http://www.uspreventiveservicestaskforce.org/uspstf/uspstfstds.htm> ]

If the client is at risk for or has an STD, **high-intensity (>2 hours) behavioral counseling** for sexual behavioral risk reduction should be provided in accordance with the USPSTF recommendation (Grade B).

- All sexually active adolescents are at risk.
- Adults are at increased risk if they:
  - Have current STD
  - Had an STD in the past year
  - Have multiple sexual partners
  - Are in non-monogamous relationships
  - Are sexually active and live in a community with a high rate of STD.

Clinicians, nurses, or health educators can provide the high-intensity counseling or they can refer patients to trained behavioral counselors. The Task Force found that high-intensity counseling is the most effective, although some moderate-intensity (30 minutes to 2 hours) and low-intensity (<30 minutes) counseling showed benefits as well.

One high-intensity behavioral counseling model that is similar to the contraceptive counseling model is Project Respect <https://www.cdc.gov/hiv/research/interventionresearch/rep/packages/respect.html>, which could be implemented in family planning settings. On-line training information is available at <https://www.effectiveinterventions.org/HighImpactPrevention/Interventions/RESPECT.aspx>.

Other key messages to give infected clients before they leave the clinic include the following:

- 1) Refrain from unprotected sexual intercourse during the period of STD treatment for 7 days after the start of treatment.
- 2) If the partner did not accompany the client to the clinic for treatment, encourage partner(s) to be screened or to get treatment as quickly as possible (partners in the past 60 days for CT and gonorrhea, 3 to 6 months plus the duration of lesions or signs for primary and secondary syphilis, respectively). If the partner is unlikely to access treatment quickly, then EPT for CT or gonorrhea should be considered (See Step 3 above).
- 3) Return for retesting in 3 months.
- 4) A client using or considering contraceptive methods other than condoms should be advised that these methods do not protect against STD.

## **F. Related Preventive Health Services**

In addition to physical exam such as clinical breast exam (CBE) and pelvic exam, providers may provide cervical cytology test to Title X clients as clinically indicated (See Section 4: FP Lab for details).

#### **I. FAMILY PLANNING SERVICES FOR CLIENTS PRESENTING FOR OTHER PHD PROGRAM SERVICES**

When a STD, B&CC, immunization or other PHD Program client requires FP supplies/tests (e.g., packs of OCP's, ECPs, or a DMPA injection), it becomes a Family Planning visit. The PHN will:

1. Ask client to complete FP consent/other required forms (income worksheet & parental involvement).
2. Calculate the percent pay. If the client falls into a percent pay category and paying for these services creates a barrier to service, see Appendix B, Special Circumstances for Hardship Cases criteria.
3. Follow the appropriate Standing Order and guidelines in delivering Title X FP Services (Section 1.2, which includes Tables 1 & 2: Checklist for Providing Family Planning Services for Women and for Men). Client must be given RLP screening and counseling. Clients who require additional or comprehensive FP services will be given an appropriate and timely appointment to return to clinic.

#### **J. THE TRANSFER CLIENT**

The client who wishes to transfer from another provider (any other clinic or private physician) can be allowed to transfer reports of their most recent medical history, physical exam, and laboratory tests.

Title X Clinician will review and can accept these reports providing:

1. The complete medical history and/or physical exam are dated within the past 12 months;
2. Collect and document all missing health information required for Title X FP clients as described in Section 1.2.
3. Perform physical exam or necessary testing if it is clinically indicated.

#### **K. REFERRAL SERVICES**

Because some Family Planning clients may have need for services that are not provided by the Family Planning Clinic, referrals to appropriate providers are an integral part of the program. Local staff must keep a current list of local providers by service.

There is a legal responsibility to follow up and document the outcome of referrals. For instance, an individual referred out of the Family Planning clinic should receive follow-up to ascertain that the visit was, in fact, made. Failure to provide follow-up and documentation of same could create a liability problem for the clinic staff and the agencies involved.

Per Clinician's order, there must be a written referral for clients with abnormal finding on history or physical examination to an appropriate medical provider when care is not provided at the Family Planning Clinic.

When clients are referred to other sources of care, the timing and manner of referral and follow-up depend upon the nature of the problem for which the referral was made. For example:

- Emergency referrals (e.g., possible ectopic pregnancy, malignant hypertension) should be made immediately with the provider;
- Urgent referrals (e.g., solitary breast nodule) should be followed up within two weeks with the client;
- Essential referrals (e.g., hypertension) should be followed up with the client. The timing should depend on clinician's judgment;
- **Referrals in cases of medical necessity, including for prenatal care for pregnant women.**
- Discretionary referrals (made at the request of client) should be followed up with the client at the next clinic visit. Further follow-up may not be necessary but should be based on clinician's judgment. This type of referral may include Medicaid clients seeking sterilization or colo-rectal cancer screening for clients >50.
- Prior to submitting the sterilization application to the State Office for approval, clinician will consult with

the sterilization provider chosen by the client regarding medical conditions that are not conducive to the procedure or anesthesia. If the sterilization provider accepts the referral, document the communication in the medical record prior to submitting the sterilization application.

Quality assurance monitoring systems are required at the Family Planning clinic level including referral tracking system to monitor whether clinics are providing high quality care to clients referred by Family Planning.

#### **L. EMERGENCY SERVICES**

In order to provide services for emergencies which arise outside of clinic hours, each Title X clinic should have medical backup through local after-hours providers. Contraceptive emergencies may include chest pain and dyspnea, intractable headache, or sudden onset of diplopia or blindness in pill, and vaginal ring users; and severe abdominal pain, fever, or severe or unexpected uterine bleeding in IUD users. All clients should be given emergency instructions at service initiation time. Sample forms follow this section.

## Birth Control Pill/Patch/Vaginal Ring Users - Complication/Emergency Care

### Para Mujeres Que Usan Pastilla Anticonceptiva/Parche/Anillo Vaginal - Complicaciones/Emergencias

You have received \_\_\_\_\_. If you have any questions regarding how to use this method or about any side effects of this method, please call the Family Planning clinic at \_\_\_\_\_.

The possibility of any serious side effects is very rare. However, if you should have any of the following problems, please contact one of the following:

- ✓ \_\_\_\_\_ Office (Office hours: 8 a.m. to 5 p.m. Monday through Friday)
- ✓ Your own physician or Hospital Emergency Room (Evening or weekends)

Serious problems

**A**bdominal Pain - severe pain or tenderness in the stomach area

**C**hest Pain – crushing or sharp chest pain or tightness in the chest; coughing of blood, or sudden shortness of breath

**H**eadaches - sudden severe headaches or vomiting, dizziness or fainting

**E**ye Problems - sudden onset of blurred or double vision or blindness

**S**evere Leg Pain - painful or swollen leg or calf

Disturbances of vision or speech, weakness, or numbness in an arm or leg

Breast lumps

Severe problems with sleeping, weakness, lack of energy, fatigue, or change in mood

Jaundice or a yellowing of the skin or eyeballs accompanied frequently by fever, fatigue, loss of appetite, dark colored urine, or light colored bowel movements

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Usted ha recibido \_\_\_\_\_. Si tiene alguna pregunta sobre cómo se usa este método anticonceptivo o sobre los efectos secundarios de este método, por favor llame a la clínica de Planificación Familiar al \_\_\_\_\_.

Es muy raro que se produzcan efectos secundarios graves. Sin embargo, si usted tuviera alguno de los siguientes problemas, contacte con uno de los siguientes lugares:

- ✓ Oficina \_\_\_\_\_ (Horario de atención: de 8 de la mañana a 5 de la tarde de lunes a viernes)
- ✓ Su médico o sala de emergencias del hospital (por la noche o los fines de semana)

Problemas graves

**D**olor abdominal – dolor grave en el área del estómago o sensibilidad (dolor al tocar) esta área.

**O**jos – problemas de la vista como visión borrosa, visión doble o ceguera.

**L**e duelen las piernas – si alguna de sus piernas o pantorrillas está hinchada o le duele.

**O**presión en el pecho – siente un dolor opresivo o agudo en el pecho o sensación de presión en el pecho; tose sangre o le falta el aire al respirar.

**R**epentinos o graves dolores de cabeza – Dolores de cabeza graves o repentinos, vómitos, mareos o desmayos.

Alteraciones en la vista o el habla, debilidad o entumecimiento de algún brazo o pierna

Bultos en los senos

Problemas graves para dormir, debilidad, falta de energía, fatiga o cambios en su estado de ánimo

Ictericia o color amarillento de la piel o de los ojos que se presenta con frecuencia con fiebre, fatiga, falta de apetito, orina de color oscuro o deposiciones de color claro

## IUD Users - Complication/Emergency Care

### Para Mujeres Que Usan un DIU - Complicaciones/Emergencias

You have received \_\_\_\_\_. If you have any questions about any side effects of the IUD, please call the Family Planning clinic at \_\_\_\_\_.

The possibility of any serious side effects is very rare. However, if you should have any of the following problems, please contact one of the following:

- ✓ \_\_\_\_\_ Office (Office hours: 8 a.m. to 5 p.m. Mon-Fri)
- ✓ Your own physician or Hospital Emergency Room (evening or week-ends)

Serious problems or warning signs:

Abdominal pain  
Increased temperature, fever, chills  
Unusual or abnormal vaginal discharge  
Cannot feel IUD string  
Can feel the plastic part of the IUD  
See that the IUD has come out  
Spotting, bleeding, heavy periods, clots  
Pain with intercourse  
Period late, no period (Paragard IUD users)

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Usted ha recibido \_\_\_\_\_. Si tiene alguna pregunta sobre los efectos secundarios del DIU, por favor llame a la clínica de Planificación Familiar al \_\_\_\_\_.

Es muy raro que se produzcan efectos secundarios graves. Sin embargo, si usted tuviera alguno de los siguientes problemas, contacte con uno de los siguientes lugares:

- ✓ Oficina \_\_\_\_\_ (Horario de atención: de 8 de la mañana a 5 de la tarde, de lunes a viernes)
- ✓ Su médico o Sala de emergencias del hospital (por la noche o los fines de semana)

Problemas graves o señales de advertencia:

Dolor abdominal  
Aumento de la temperatura, fiebre, escalofríos  
Secreción vaginal anormal  
No puede sentir el hilo del DIU  
Puede sentir la parte de plástico del DIU  
El DIU se ha salido  
Está manchando, sangrando, tiene su menstruación con sangrado muy abundante o coágulos  
Dolor al tener relaciones sexuales  
Se le retrasa su menstruación, no tiene su menstruación (para las que usen el DIU Paragard)

**DEPO PROVERA/IMPLANT USERS - COMPLICATION/EMERGENCY CARE**

**PARA MUJERES QUE USAN DEPO PROVERA/CÁPSULA - COMPLICACIONES/EMERGENCIAS**

You have received \_\_\_\_\_ If you have any questions about any side effects of this birth control method; please call the Family Planning clinic at \_\_\_\_\_.

The possibility of any serious side effects is very rare. However, if you should have any of the following problems, please contact one of the following:

- ✓ \_\_\_\_\_ Office (Office hours: 8 a.m. to 5 p.m. Monday- Friday)
- ✓ Your own physician or Hospital Emergency Room (Evening or week-ends)

Serious problems or warning signs:

1. Headaches
2. Heavy bleeding
3. Depression - Severe problems with sleeping, weakness, lack of energy, fatigue, or change in mood

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Usted ha recibido \_\_\_\_\_ Si tiene alguna pregunta sobre los efectos secundarios de este método anticonceptivo, por favor llame a la clínica de Planificación Familiar al \_\_\_\_\_.

Es muy raro que se produzcan efectos secundarios graves. Sin embargo, si usted tuviera alguno de los siguientes problemas, contacte con uno de los siguientes lugares:

- ✓ Oficina \_\_\_\_\_ (Horario de atención: de 8 de la mañana a 5 de la tarde, de lunes a viernes)
- ✓ Su médico o sala de emergencias del hospital (por la noche o los fines de semana)

Problemas graves o señales de advertencia:

1. Dolores de cabeza
2. Sangrado abundante
3. Depresión – problemas graves para dormir, debilidad, falta de energía, fatiga o cambios en su estado de ánimo