Section 1.0

FAMILY PLANNING PROGRAM

POLICIES AND PROCEDURES

FOR

CLINICAL SERVICES

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1.0 INTRODUCTION

The Title X Family Planning Program (Title X) was established in 1970 when Congress enacted Title X of the Public Health Service (PHS) Act and is the only domestic federal program dedicated solely to family planning and related preventive health services. It is administered by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health (OASH) in the United States Department of Health and Human Services (HHS) and implemented through competitively awarded grants to a diverse network of public and private nonprofit health and community-based clinics.

The Title X family planning program is a critical part of America's public health safety net, serving as a point-of-entry into care for millions and the gold standard for providing high-quality, affordable, and confidential voluntary family planning and related preventive health services, with priority given to low-income clients. Family planning services delivered by Title X recipients include a broad range of medically approved services, which includes all Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods for clients who want to prevent pregnancy and space births; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; sexually transmitted infection (STI) services; and other preconception health services. (Title X Program Handbook (July 2022) (hhs.gov)). Abortion is not provided as a method of family planning (CFR59.5(a)(5).

Title X Program services are based on comprehensive, evidence-informed guidelines for the delivery of family planning and related preventive health services, and incorporate:

1. 2021 Title X Final Rule
2. Title X Program Expectations
3. Title X Program Handbook (July 2022) (hhs.gov)
4. Providing Quality Family Planning Services (QFP) 2024

The NM Department of Health Family Planning Program (NM DOH FPP) Policies and Procedures Protocol is based on these resources, in addition to other appropriate nationally recognized standards of care. With proper agency's approval, this manual serves as the policies and procedures manual for all personnel providing Title X Family Planning health care services in New Mexico at Public Health Offices (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.

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

1. Contraceptive Technology, 22nd Ed., Robert A. Hatcher, MD, MPH, et al.
2. Managing Contraception, 14th Ed., 2017-2018, Robert A. Hatcher, MD, et al.
3. Managing Contraception *For Your Pocket*, 17th Ed., M. Zieman, MD, R. Hatcher, MD., A. Allen, MD
4. Managing Contraceptive Pill Patients, 17th Ed., Richard P. Dickey, MD, PhD.
5. MEC U.S. Medical Eligibility Criteria for Contraceptive Use, 2024 (App, MMWR, Summary Chart)
6. SPR U.S. Selected Practice Recommendations for Contraceptive Use 2024 (eBook, App, MMWR)
7. U.S. MEC/SPR Provider Tools
8. PCC Recommendations to Improve Preconception Care, MMWR April 21, 2006, Vol. 55.

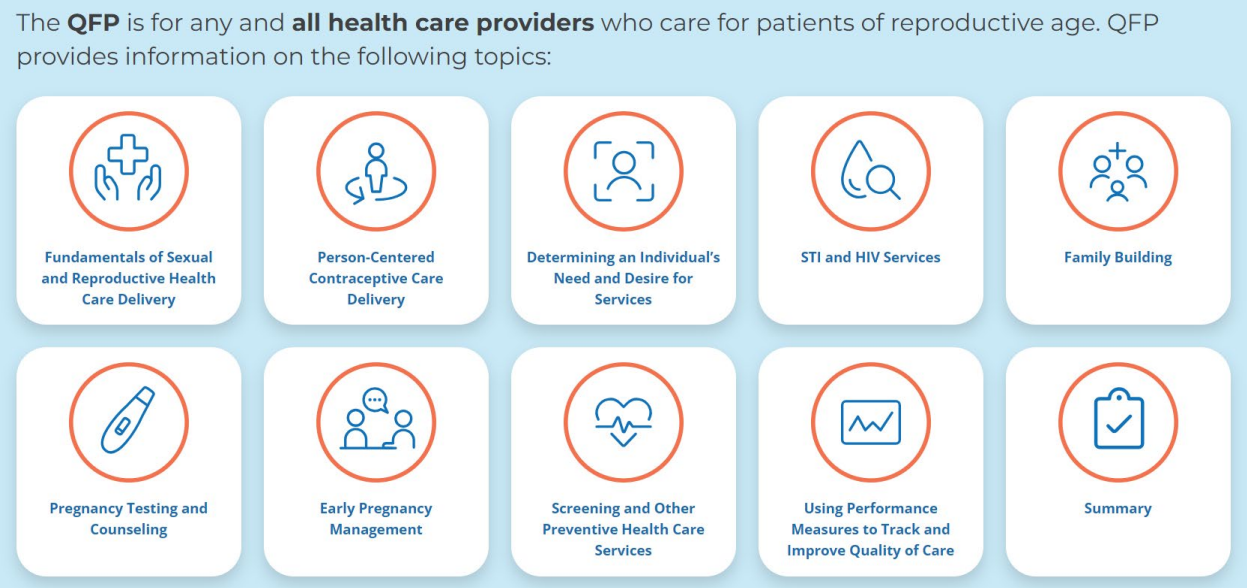
Overview of Quality Family Planning Recommendations (2024)

The 2024 Quality Family Planning (QFP) recommendations are an update to those originally published in 2014. QFP is grounded in a health equity framework that supports all people in meeting their sexual and reproductive health needs and goals, regardless of gender identity, sexual orientation, age, ability, race or ethnicity. Developed by the Office of Population Affairs within the Office of the Assistant Secretary for Health, the QFP recommendations are intended to set the standard of sexual and reproductive health care and be used by all staff and providers of sexual and reproductive health services working in diverse clinical settings. The QFP provides recommendations for how to determine someone's need and desire for sexual and reproductive health services, including how to take a sexual history and screen for reproductive desires and related care in a person-centered way.

The QFP also provides recommendations for contraceptive care, STI and HIV services, family building, including strategies for ensuring a healthy pregnancy and basic infertility services, pregnancy testing and counseling, early pregnancy management, and screening and other preventive health services. These preventative health services include healthy weight management, screening for chronic medical conditions and cancer, immunizations, gender-affirming care, perimenopausal care, mental health, alcohol and other substance use, sexual violence and intimate partner violence, and human trafficking. The 2024 QFP provides a vision for quality sexual and reproductive health care that emphasizes person centeredness, inclusion, and equity.

2024 QFP resources include:

- QFP Recommendations
- QFP 2024 At a Glance
- QFP Guide



Although the audience for both the 2014 and 2024 QFPs include, but are not limited to, providers funded by the Title X program, the scope differs between the two QFPs. The 2014 recommendations were more focused on the type of family planning services provided in Title X projects. The 2024 QFP recommendations are broader than the provision of Title X family planning services, and include recommendations for providing additional quality sexual and reproductive health services. With respect to Title X-funded providers, the scope of the 2024 QFP recommendations is broader than Title X family planning services and may conflict with the Title X statute, legislative mandates, regulations, or court orders (Program Policy Notice 2024-02).

1.1 FAMILY PLANNING SERVICES

Projects funded under Title X are intended to enable all persons who want to obtain family planning care to have access to such services (2021 Title X Final Rule). **Services must be provided in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status** (42 CFR § 59.5(a)(4)). Services must also be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician (42 CFR § 59.5(b)(5)). It is expected that Title X clients will receive services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed, protects the dignity of the individual, and ensures equitable and quality service delivery consistent with nationally recognized standards of care (42 CFR § 59.5(a)(3)).

- *Client-centered care* is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions.
- *Culturally and linguistically* appropriate services are respectful and responsive to the health beliefs, practices and needs of diverse patients.
- *Health equity* is when all persons have the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- *Inclusive* is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color, members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons, persons with disabilities, persons who live in rural areas, and persons otherwise adversely affected by persistent poverty or inequality.
- *Quality healthcare* is safe, effective, client-centered, timely, efficient, and equitable.
- *Trauma-informed* means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively avoid re-traumatization.
  (CFR59.2)

Title X services are to be provided to those who are in need to plan or prevent pregnancy according to their reproductive preferences and goals. Priority for New Mexico Title X services are for uninsured, reproductive-aged low-income clients. However, Title X clinics may not deny insured clients FP services due to the clinic's inability to bill certain insurance plans (CFR 59.5(a)(6)).

A. ASSESSING NEED FOR FAMILY PLANNING SERVICES

What are the client's reproductive preferences? Providers should avoid making assumptions about the client's needs based on characteristics, e.g., sexual orientation or disabilities. For clients whose reason for visit was not originally related to preventing or achieving pregnancy, asking questions about their need for contraceptive services or pregnancy prevention might help identify unmet reproductive health care needs.

A note about the "Reproductive Life Plan": "The CDC has promoted the use of a "Reproductive Life Plan" approach, in which individuals of reproductive age define how many children they wish to have, and when, as a means of determining which services (e.g., preconception care, contraceptive care) are appropriate for an individual. This approach has been criticized as being overly proscriptive and not reflecting the ways in which people develop and modify their reproductive goals over time, including the potential of welcoming an unintended pregnancy." (UpToDate "*Contraception: Counseling and Selection*", May 17, 2024).

Because of this shift, NMDOH FPP is moving away from the strict "Reproductive Life Plan" questions, and instead utilizing the Self-Identified Need for Contraception (SINC) screening question (which is also in alignment with the FPAR 2.0 requirements). This standardized needs assessment question is based on research and was created to give providers an easy-to-use tool that can be used to help identify the client's reproductive needs. It is intended to be integrated into the existing clinic workflow and can be added to Electronic Health Records (Contraceptive Technology, 22nd Ed., p. 85).

"We ask everyone about their reproductive health needs.
Do you want to talk about contraception or pregnancy prevention during your visit today?"

If **yes**:

- Document and provide contraceptive counseling.

If **no**:

- Clarification prompt: "There are a lot of reasons why a person wouldn't want to talk about this, and you don't have to share anything you don't want to.

  Do any of these apply to you? (document all that apply)
  - **I'm here for something else**
  - **The question does not apply to me / I prefer not to answer**
  - **I am already using contraception (and what type)**
  - **I am unsure or don't want to use contraception**
  - **I am hoping to become pregnant in the near future**

If clients disclose an interest in future pregnancy, the PATH framework can be utilized (see "Preconception Health Services" section). (UpToDate, Contraception: Counseling and selection, 2024). The PATH (Parenting/Pregnancy Attitudes, Timing, How important?) questions can be utilized by clinic staff, as needed. These questions include:

- Do you think you might like to have (more) children at some point? (Parenting/Pregnancy Attitudes)
- When do you think that might be? (Timing)
- How important is it to you to prevent pregnancy (until then)? (How important)

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*). For additional information, please refer to Section 5 Special Populations.

C. TESTOSTERONE USE AND PREGNANCY RISK

It is important to counsel clients that testosterone use might not prevent pregnancy among transgender, gender diverse, and nonbinary persons with a uterus who are using testosterone. Offer contraceptive counseling and services to those who are at risk for and do not desire pregnancy. Transgender, gender diverse, and nonbinary persons assigned female sex at birth often have a uterus, ovaries, and fallopian tubes. In a national survey of transgender, gender diverse, and nonbinary persons assigned female or intersex at birth, 54% of pregnancies were reported to be unintended, 61% of respondents did not want to be pregnant in the future, and 11% of respondents considered themselves to be at risk for pregnancy when they did not want to be pregnant. Some transgender, gender diverse, and nonbinary persons use testosterone for gender-affirming hormone therapy. Although certain regimens of testosterone might suppress fertility, testosterone therapy has not been studied as contraception. Testosterone is teratogenic and might have androgenic effects on fetal genitalia, reproductive systems, or endocrine systems. (U.S. SPR, 2024).

D. 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 NMDOH FPP State 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 a LEP individual's family members or friends to provide the interpreter services.

Clinics must take reasonable steps to ensure that your project provides meaningful access to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov (Title X Program Handbook, page 30).

1.2 METHODOLOGY

A. DEFINITION OF TITLE X FAMILY PLANNING ENCOUNTER

A family planning encounter is a documented contact between an individual and a family planning provider that is either face-to-face in a Title X service site or virtual using telehealth technology. The purpose of a family planning encounter is to provide family planning and related preventive health services that align with the definition of family planning services in 42 CFR § 59.2. A written record of the services provided during the family planning encounter must be documented in the client record for FPAR (FPAR-2.0-Implementation-Guide-2024).

Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services (42 CFR § 59.2).

In addition, PHO telehealth visits that follow the NMDOH PHD Telehealth 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 telehealth services.

Provider agreement sites should refer to agency policies for telehealth.

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 message system should have instructions for clients in case of emergency, directing them where to obtain emergency care (Title X Program Handbook, page 30, and 69).

The Family Planning Clinic should provide comfort, privacy and safety for clients and should facilitate the work of the staff. The minimum standards include the following:

1. A facility that follows the Americans with Disabilities Act (ADA) "Access to Medical Care for Individuals with Mobility Disabilities" (http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm, and http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html).

2. 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.

3. A private area where interviews, counseling, and education may be done confidentially.

4. A private dressing area for client use within or adjacent to the examination room, if possible.

5. 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.

6. Adequate toilet facilities near the examination room and lab, if possible.

7. 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.

8. 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 requirements, see EMERGENCY SERVICES Section.

9. 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 drills 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. (Title X Program Handbook (July 2022) (hhs.gov), page 31, and https://www.osha.gov/).

C. CLIENT EDUCATION MATERIALS

Each clinic should have the following teaching materials:

1. Education materials for a broad range of FDA-approved contraceptives: IUD, implant, sterilization, Depo-Provera, vaginal ring, several types of birth control pills, external and internal condoms, spermicides, fertility awareness-based methods, emergency contraceptive pill (ECP), and abstinence.
2. 3-D vagina/uterus/ovaries/pelvis and penis models.
3. Educational posters (e.g., contraceptive counseling poster, pills poster).
4. When providing services to teens, educational materials on confidentiality of family planning services and sexual coercion should be utilized.
5. Other approved handouts and brochures: The NMDOH Information and Education (I & E) Committee must approve all family planning educational materials distributed in Family Planning Clinics (CFR 59.6, and Title X Program Handbook, page 7). Appendix C contains a current list of approved educational resources available to order from the NMDOH FPP State Office.

D. STAFF TITLE X TRAINING REQUIREMENTS

Appropriate trainings are required by the Title X Guidelines (CFR 59.5(b)(4). See Appendix D for links to required trainings e.g., Title X Orientation, Serving Minors and Mandatory Reporting, and Cultural Competency for 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 NM DOH FPP except:

- With documented consent
- To provide services to the client
- 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 59.10)]*
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).

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 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 and are required to take "Serving Minors and Mandatory Reporting" training annually. See Appendix D.
2. Child abuse/neglect/human trafficking reporting must be documented in the client record.
3. 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 AN APPOINTMENT

To prioritize NM Title X services to uninsured, reproductive-aged clients from low-income families (CFR 59.5(a)(6)) 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: Title X Service Sites Financial Policies and Procedures. 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 plans (CFR 59.5(a)(3)).

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:

- Teen clients
- Clients whose income is at or below 250% poverty
- Clients with a history of difficult pregnancy
- Clients with pregnancies spaced less than 2 years apart
- Clients over the age of 35.

If the person qualifies for a priority appointment, they should be seen within two weeks of the request. Any client not able to be seen in clinic within two weeks should be made aware of other providers in the area (CFR 59.5(a)(1)).

G. CONSENT AND OTHER REQUIRED FORMS

The *Algorithm for Required Family Planning Forms and Consents* (following this section) 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. The 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 (Title X Legislative Mandate).
   c. To the extent practical, Title X projects shall encourage family participation. However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services (CFR5910(b)).
   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 (CFR 59.5(a)(2)).

   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. Services must be provided without subjecting individuals to any coercion to accept services or to employ or not to employ any particular method of family planning (CFR 59.5(a)(2)).

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 (42 U.S.C. 300a-8).

Federal law requires that a consent for FP services must be signed by the client prior to receiving Title X services (at the initial visit and annually thereafter). 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, and under "Forms" on the NMDOH FPP website.

3. **Income Worksheet** is available in Appendix B and on the NMDOH FPP website under Forms.

4. **Consent Forms for Intrauterine Devices/Implant (English and Spanish)** are available in the corresponding method subsection of Section 2 of this Protocol, as well as posted on the NMDOH FPP website under Forms.

Informed Consent: means voluntary, knowing consent from the individual to whom any contraception or sterilization is to be provided after the client 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

The "BRAIDED" format is used on the NMDOH FPP's required method-specific consent forms (available in Section 2, and NM DOH FPP website under Forms). 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.

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 can be offered 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 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.

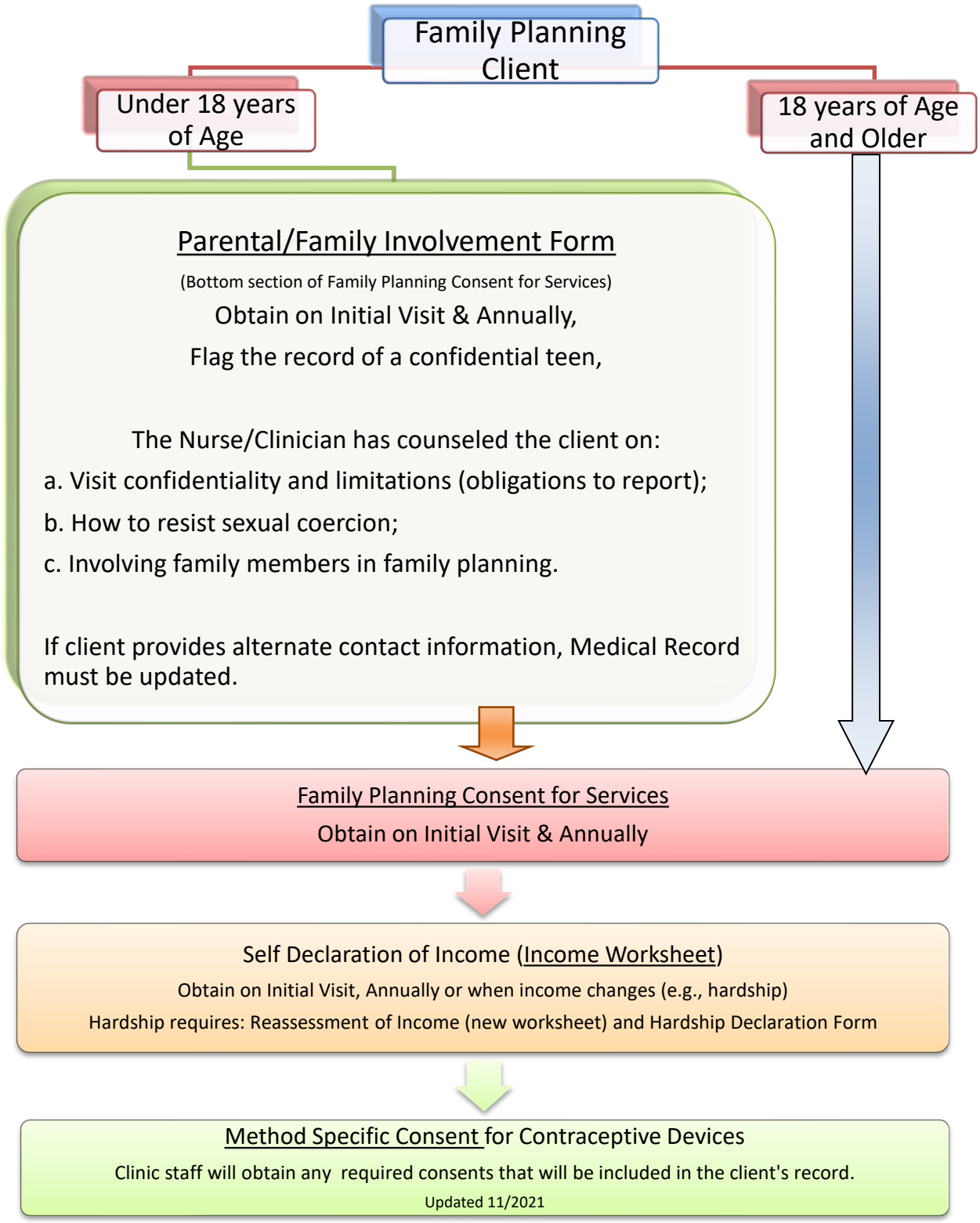
- **If the nurse/clinician has reasonable doubt regarding a client's mental capacity, consultation with another qualified medical staff member is indicated**, and the client should be asked if they have a legal guardian for medical decisions or if there is someone else responsible for their major decisions.
    - 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 the 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. If a phone translation service is utilized, staff should document the details of the service/interpreter that assisted.

SAMPLE INTERPRETER'S 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 the client understood this explanation.

ALGORITHM FOR REQUIRED FAMILY PLANNING FORMS AND CONSENTS



H. FAMILY PLANNING SERVICES FOR CLIENTS PRESENTING FOR OTHER PROGRAM SERVICES

When a STD, B&CC, immunization or other PHD Program client requires FP supplies/tests (e.g., OCPs, ECPs, DMPA, LARC, etc.), it becomes an integrated 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.
4. Provide person-centered contraceptive counseling, including assessment of the client's reproductive preferences/goals. Clients who require additional or comprehensive FP services will be given an appropriate and timely appointment to return to clinic.

I. 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 1.3.
3. Perform physical exam or necessary testing if it is clinically indicated.

J. 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. Title X clinics should provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care (CFR 59.5(b)(2) and CFR59.5(b)(8).

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 a 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 the clinician's judgment.
- Referrals in cases of medical necessity (e.g., prenatal care referrals for pregnant clients) should be followed up with the client. The timing should depend on the clinician's judgment.
- 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 colorectal cancer screening for clients >50 years of age.

- Prior to submitting the sterilization application to the State Office for approval, the 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 a referral tracking system.

Additional referral resources can be found in Appendix F.

K. EMERGENCY SERVICES

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. Clients should be given emergency instructions as applicable at the time of their visit. An example, NM PHD Emergency Medical Response Protocol, can be found in Appendix A.

1.3 TITLE X FAMILY PLANNING CLINIC SERVICES

A. Contraceptive Services

The 2024 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) provides recommendations to improve contraceptive services in clinic settings. Contraceptive services should be accessible, non-coercive, and provided in an equitable manner. They should be offered in a way that supports the client's values, goals, and reproductive autonomy, through a shared decision-making process with clinical staff to ensure they are provided a method that is clinically appropriate for them. Unintentional coercive practices in the health care system can include provider bias (unconscious or explicit) for certain contraceptive methods over a client's reproductive goals and preferences, or a lack of person-centered counseling and support. It is important that persons can select the method that best meets their needs to promote reproductive autonomy.

Clinical staff can support the contraceptive needs of all clients by using a person-centered framework and recognizing the many factors that influence individual decision-making about contraception. Clients should have equitable access to the full range of FDA-approved contraceptive methods that are safe for them, and be given the information they need for contraceptive decision-making in a noncoercive manner (U.S. MEC, 2024, pages 1-5). It is preferable for clinics to provide the selected contraceptive method(s) on site, but a prescription, referral, or guidance on over-the-counter options can be provided if necessary.

Using the U.S. MEC and U.S. SPR Recommendations to Support Contraceptive Decision-Making
(U.S. Medical Eligibility Criteria for Contraceptive Use, 2024 (cdc.gov) page 5

- CDC acknowledges the paramount importance of personal autonomy in contraceptive decision-making.
- Persons should have equitable access to the full range of contraceptive methods.
- Contraceptive services should be offered in a noncoercive manner that honors a person's values, goals, and reproductive autonomy.
- Shared decision-making and person-centered approaches recognize the expertise of both the health care provider and the person.
- A person-centered approach to contraceptive decision-making
  - prioritizes a person's preferences and reproductive autonomy rather than a singular focus on pregnancy prevention,
  - respects the person as the main decision-maker in contraceptive decisions, and
  - includes respecting the decision not to use contraception or to discontinue contraceptive method use.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to support persons in contraceptive decision-making.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to remove unnecessary medical barriers to accessing and using contraception.

Abbreviations: U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use*; U.S. SPR = *U.S. Selected Practice Recommendations for Contraceptive Use*.

The 2024 QFP provides additional guidance when providing contraceptives and other family planning services.

FIVE KEY PRINCIPLES GUIDE QUALITY COUNSELING (QFP, page 10).

1. Establish and maintain rapport with the person.
2. Assess the person's preferences, values, and goals; personalize discussions accordingly.
3. Work with the person to interactively establish a plan.
4. Provide accurate and understandable information that supports the person's desires.
5. Confirm understanding.

STEP 1: Establish and maintain rapport with the person.

Rapport is fundamental for establishing trust and open communication and has been shown to affect outcomes, including client satisfaction.

Several elements build rapport:

- Simple acts such as a warm welcome, a handshake, and "taking the time to connect as human beings"
- Ensuring privacy and confidentiality
- Asking permission to discuss sexual and reproductive health (SRH) topics as well as inquiring, acknowledging, and centering the person's goals and desires for the visit.
- Matching the client's tone, paraphrasing what the client has said, and asking if you got it right
- Focus more attention on respectful listening versus talking "at the patient"

STEP 2: Assess the person's preferences, values, and goals; personalize discussions accordingly.

- Both open-ended discussion and structured questionnaires can contribute to understanding client preferences, values, and goals. Assessment should encompass not only the type of care but also the type of information a person might want or need as well as how the person prefers to receive information and make decisions. Meet people where they are. Avoid attempts to redirect their goals. Set aside personal biases that may conflict with client preferences and work to support the client's desired outcomes.
- **Assess the client's reproductive goals.** Each client should be asked which services they would like today, to include contraceptive or pregnancy prevention services. Ideally, this should be done annually and as indicated during a clinic 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., religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

Self-Identified Need for Contraception (SINC) Question

"We ask everyone about their reproductive health needs.
Do you want to talk about contraception or pregnancy prevention during your visit today?"

If **yes**:

- Document and provide contraceptive counseling.

If **no**:

- Clarification prompt: "There are a lot of reasons why a person wouldn't want to talk about this, and you don't have to share anything you don't want to.

Do any of these apply to you? (document all that apply)

- **I'm here for something else**
- **The question does not apply to me / I prefer not to answer**
- **I am already using contraception (and what type)**
- **I am unsure or don't want to use contraception**
- **I am hoping to become pregnant in the near future**

STEP 3: Work with the person to interactively establish a plan.

- Establishing a plan includes setting goals, using a strengths-based approach in discussing possible difficulties, and developing action plans to deal with these difficulties. Ground all plans in the individual's owns goals, interests, and readiness for change.
- An earlier counseling model was the "tiered effectiveness" approach, which structured contraceptive counseling according to the effectiveness of methods, with a corresponding emphasis on those that are most effective. This approach is not ideally person-centered in that it does not prioritize the client's preferences for method characteristics and makes assumptions about the relative importance of effectiveness at preventing pregnancy (UpToDate, Contraception: Counseling and selection).
- Using **shared decision-making** and a **person-centered contraceptive counseling** framework, based on the client's preferences (e.g., "Do you have a sense of what is important to you about your method?"), the provider will discuss with clients the requested information 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 such as non-contraceptive benefits.
- Health care providers should always consider the individual clinical and social factors of each person seeking contraceptive services and discuss reproductive desires, expectations, preferences, and priorities regarding contraception. A person might consider and prioritize many elements when choosing an acceptable contraceptive method, such as safety, effectiveness, availability (including accessibility and affordability), side effects, user control, reversibility, and ease of removal or discontinuation. A person-centered approach to contraceptive decision-making prioritizes a person's preferences and reproductive autonomy rather than a singular focus on pregnancy prevention and respects the person as the main decision-maker in contraceptive decisions, including the decision not to use contraception or to discontinue contraceptive method use (MEC, 2024, page 5).
- Persons should have equitable access to the full range of contraceptive methods and be given the information they need for contraceptive decision-making in a noncoercive manner. Patient (person)-centeredness has been defined by the Institute of Medicine as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (MEC, 2024, page 5).
- 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.

The RHNTC Birth Control Methods Chart, below, can help the provider focus on the client's preferences during the discussion.

Birth Control Methods Chart

RHNTC REPRODUCTIVE HEALTH NATIONAL TRAINING CENTER

Designed for providers to help clients consider their birth control options, this chart takes client autonomy into account and presents methods that clients can start and stop on their own and those that require provider involvement (prescription or procedure). The chart highlights method characteristics, including use & frequency, so clients can make informed decisions, based on their own preferences. Note: Within each table, the methods are listed in order of pregnancy risk, and side effects are alphabetized within each method.

CLIENTS CAN START AND STOP ON THEIR OWN

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Pill (progestin-only), Opill	9 out of 100	Client takes by mouth same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Available OTC. Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.
Condom (external)	13 out of 100	Client rolls onto erect penis (external) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Fertility Awareness-based (FAB)	15–24 out of 100 (depends on specific FAB method)	Client tracks signs of fertility daily and abstains from sex on fertile days.	None	None	Must have regular cycles and be comfortable tracking basal body temperature and cervical mucus.
Spermicide or vaginal sponge	21 (spermicide alone) or 9 (sponge) out of 100	Client inserts into vagina before penile-vaginal sex every time.	None	Vaginal irritation	Pair with another method for back-up.
Condom (internal)	21 out of 100	Client inserts into vagina (internal) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Withdrawal	25 out of 100	Partner with penis ejaculates outside of and away from vagina.	None	None	Requires a cooperative partner.

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED ON OTHER SIDE*

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Shot (IM/SC) progestin-only	4 out of 100	Provider administers shot (IM), or the client self-administers (SC) shot every 12–15 weeks.	Spotting, lighter period, or no period	Bone density loss, headache, weight gain	Delay in fertility return. Not visible to others.
Patch (transdermal system estrogen + progestin)	7 out of 100	Client places patch on back, butt, or belly. Every month, changes patch weekly for 3 weeks and no patch for 1 week.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, skin irritation, stomach pain	May be less effective in people with a BMI of 30 or over. Extended/continuous use option.
Pill (combined estrogen + progestin)	7 out of 100	Client takes by mouth daily.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, risk for blood clots	May reduce acne, cramping, and PMS. Extended/continuous use option.
Ring (estrogen + progestin)	7 out of 100	Client places ring into vagina. Every month, keeps ring in vagina for 3 weeks and then removes for 1 week.	Lighter period or temporary spotting	Breast tenderness, nausea	Two types: monthly and yearly. May reduce acne, cramping, and PMS. Not visible but can be felt by partners.
Pill (progestin-only, "the mini pill")	9 out of 100	Client takes by mouth at the same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.

**The number of people out of every 100 who have an unintended pregnancy within the first year of typical use of each method.*

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED*

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Vaginal contraceptive gel (Phexxi)	14 out of 100	Client inserts into vagina before each act of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	May act as lubricant for dryness.
Diaphragm or cervical cap	17 (diaphragm) and 29 (cap w/spermicide) out of 100	Client inserts into vagina with spermicide before every instance of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	Same device may be used for two years.

REQUIRES PROVIDER FOR CLIENTS TO START AND STOP (REVERSIBLE METHODS)

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Implant (progestin-only)	<0.1 out of 100	Provider inserts rod under skin in upper arm. Lasts up to 5 years and can be removed earlier.	Unpredictable spotting, lighter period, or no period	Acne, depressed mood, headache, mood swings, weight gain	Mild pain with placement. Not visible but can be felt by partners.
Levonorgestrel IUD (progestin-only)	<0.2 out of 100	Provider inserts device into uterus. Varies by type, up to 8 years, and can be removed earlier.	Spotting, lighter period, or no period	Cramping pain with placement	Not visible but can be felt by partners.
Non-hormonal copper IUD	0.8 out of 100	Provider inserts device into uterus. Lasts up to 12 years and can be removed earlier.	Spotting or heavier period	Cramping pain with placement	Effective as EC within 7 days of unprotected sex. Not visible but can be felt by partners.

REQUIRES PROVIDER TO PERFORM PROCEDURE (PERMANENT METHODS)

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Tubal ligation	<0.1 out of 100	Single surgical procedure done at a hospital.	None	Bleeding, surgical pain	Requires anesthesia and up to 2 weeks of recovery.
Vasectomy	1 out of 100	Single outpatient surgical procedure.	NA	Bleeding, surgical pain	Up to 2 days for recovery.

EMERGENCY CONTRACEPTION

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Non-hormonal copper IUD	0.8 out of 100	Provider inserts device into uterus within 7 days of unprotected sex.	Spotting or heavier period	Cramping pain with placement	Lasts up to 12 years and can be removed earlier.
Ulipristal acetate (ella)	1 out of 100	Client takes by mouth as soon as possible within 5 days of unprotected sex.	Spotting or period at new time	Abdominal pain, dizziness, headache, nausea	Requires prescription. May be less effective in people over 194 pounds.
Levonorgestrel 1.5mg pill (Plan B)	1–2 out of 100	Client takes by mouth within 120 hours (–5 days) of unprotected sex.	May induce spotting or period	Breast tenderness, dizziness, headache, nausea, stomach pain, tiredness, vomiting	Available OTC. May be less effective in people over 165 pounds.

**The number of people out of every 100 who have an unintended pregnancy within the first year of typical use of each method.*

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STEP 4: Provide accurate and understandable information that supports the person's desires.

- Provide information that is balanced, nonjudgmental, and supported by scientific research. Educational materials and decision aids should be offered in a variety of formats (written, audio/visual, video, interactive) to enable clients to select the format(s) that work best for them. Visual and tactile aids can help clients integrate new information that is relevant to their decision making. Many people have basic or below-basic health literacy; understanding health information improves short-and long-term health outcomes and is essential for shared decision making.

STEP 5: Confirm understanding.

- Most people do not understand or recall all the information they are offered in a clinical encounter. Asking people to repeat back what they heard ("teach-back") can be a helpful way of confirming their understanding and determining what additional information sharing may be needed. For example, "I've shared a lot of information and I want to be sure I was clear, can you tell me what you understand about [*topic*]?"
- 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 STIs, including HIV.
- Providers should also 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, or prescriptions can be offered for methods not available onsite CFR 59.5(1).
    - 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.
    - 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 they 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 spermicides Opill and emergency contraceptive pills, or by following the Quickstart standing orders (found at the end of this Section).
- Recommended follow up visits for each birth control method is described in detail in Section 2 of this protocol.
- Document the specific contraceptive given (or reasons no contraceptive was provided) and how it was provided to the client (FPAR 2.0: provided on site, referral, prescription).
- 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 they can start the chosen method (CFR 59.5(b) (1).

1. Medical History

For a person capable of pregnancy, the medical history should include:

- **HPI (History of present illness)** last menstrual period (LMP), current gynecologic or pregnancy symptoms.
- **Contraceptive experiences and preferences** – Example questions are:
  "What method(s) are you currently using, if any?" (FPAR 2.0: Contraceptive reported at intake)
  "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, difficulty remembering to take method)?"
  "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.
- **Tobacco smoking status** (In addition to contributing to safe provision of contraceptives, this is a data collection element for FPAR 2.0)
- **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 males or persons capable of producing sperm, the medical history should include:

- **Contraceptive experiences and preferences** (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). (FPAR 2.0: Contraceptive reported at intake)
- **Recent intercourse and last unprotected intercourse;**
- **Whether their partner is currently pregnant or has had a child, miscarriage, or termination;**
- **Allergies** (including known allergies to condoms);
- **Relevant infectious/chronic health conditions**.
- **Tobacco smoking status** (FPAR 2.0)

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

2. Sexual Health Assessment

An open-ended sexual history can help a provider assess what resources and services can be offered to the client and guide appropriate counseling and information. Even if a person does not currently consider themselves sexually active, it is still important to take a sexual history. Approach and questions can be tailored to each person's identity and understanding. Providers can take a few steps to reduce stigma and build rapport at the outset of taking a sexual history (QFP 2024):

- Ensure that the client understands that they can decline answering questions or sharing information; respect their right to decline.
- Avoid any judgment of the client's behavior or preferences.
- Avoid using terms that make assumptions about sexual behavior or orientation.
- Ensure shared understanding around terminology and pronunciation to avoid confusion.
- Use a sensitive tone that normalizes the topics being discussed.

QFP's and CDC's recommendations for how to conduct a sexual history have been summarized below (some of which may have already been included in the medical history above).

The 6 Ps of Sexual History QFP 2024 page 12

- **Partners:** It is important to determine the number and gender of your client's sex partners. Never make assumptions about the client's sexual orientation or the gender identity of the client or partners. Even if only one sex partner is noted over the last 12 months, be certain to inquire if that partner is a new sex partner. Ask about the partner's risk factors, such as other concurrent partners, past sex partners or drug use.
- **Practices:** Asking about sex practices will guide the assessment of client risk, risk-reduction strategies, the determination of necessary testing, and the identification of anatomical sites from which to collect specimens for STI testing.
- **Protection from STIs:** Determine the appropriate level of risk-reduction counseling for each client. For example, if a client is in a mutually monogamous relationship, risk-reduction counseling may not be needed unless the client or their partner is engaging in activities that will put them at risk. You may need to explore the subjects of abstinence, or not having sex, number

of sex partners, condom use, the client's perception of their own risk and their partner's risk, and STI testing. It is important to not assume risk or lack of risk for any client.

- **Past History of STIs:** Ask about any history of STIs, including whether their partners have ever had an STI. Explain that the likelihood of an STI is higher with a past history of an STI.
- **Pregnancy Intention:** Based on the information from the prior section, you may determine that the client or the client's partner(s) could become pregnant. Questions should be focused on determining pregnancy intention and what information/services they need.
- **Plus:** Pleasure, problems, and pride. For examples: "*Are you having any difficulties when you have sex*? Is the sex you're having pleasurable for you?"

3. Physical Assessment

When possible, all Title X clients should have measurements of BP, weight, height and BMI documented at every in-person Family Planning visit including a supply pick up visit. During a telehealth visit, the necessity to have the client come in to obtain these measurements, especially BP, is at the discretion of the clinician. 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:** *The U.S. Selected Practice Recommendations for Contraceptive Use* (SPR, p.30-32) states that "Blood pressure should be measured before initiation of combined hormonal contraceptives. In instances in which blood pressure cannot be measured by a provider, blood pressure measured in other settings can be reported by the patient to their provider". Subsequently, at the time of other routine follow-up visits, assessment of blood pressure is recommended, but again the SPR states that "Health care providers might consider recommending patients obtain blood pressure measurements in other settings, including self-measured blood pressure". Other settings may include blood pressure measured on a home monitor or using a BP machine at a local pharmacy.

  If a client has a current recorded normal BP in the system's electronic medical record in any clinical setting (for instance if they saw a provider for a different reason), that reading can be used.
- **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 clients with obesity. However, measuring height and calculating BMI at baseline might be helpful for monitoring any changes and counseling clients who might be concerned about weight change perceived to be associated with their contraceptive method. In addition, the effectiveness of some methods (such as emergency contraceptive pills) may be impacted by BMI.
- **Assess the current pregnancy status** based on the medical history obtained and using the CDC's "How to Be Reasonably Certain that a Client is Not Pregnant" guidance, below. Perform urine hCG pregnancy testing if clinically indicated.

How to Be Reasonably Certain that a Client Is Not Pregnant

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

- Is ≤ 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 ≤ 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 [≥ 85%] of feeds are breastfeeds), amenorrheic, and < 6 months postpartum.

Symptoms of Pregnancy:

- *absent or altered menses*
- *breast tenderness/enlargement*

- *nausea (with or without vomiting)*
- *fatigue (persistent)*
- *increased frequency of urination*

- **Clinical Breast Exam (CBE):** 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. (Breast Cancer Risk Assessment and Screening in Average-Risk Women, ACOG Practice Bulletin Number 179, July 2017, 2021).

  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 (American Cancer Society Recommendations for the Early Detection of Breast Cancer, December 19, 2023).

  USPSTF
  The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond biennial screening mammography in women aged 40 to 74 years (Breast Cancer: Screening Final Recommendation Statement, USPSTF, April 30, 2024).

- **Pelvic Exam:** Indications for a bimanual/speculum pelvic examination for a client with a uterus 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 clients 21 and older. NMDOH FPP 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 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
  - Exposure to an STI

- For **clients requesting sterilization services**, 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).

B. Pregnancy Testing and Counseling Services

NM Title X providers may offer pregnancy testing and counseling services as part of family planning services. 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) but who are not initially being seen for family planning services, may need a urine hCG pregnancy test. If the client expresses an interest or need to be seen for family planning services, their visit should be integrated into a FP visit, along with the initial requested services. At the time of pregnancy testing, the SINC question should be asked (reproductive goals), and counseling related to their reproductive preferences should be provided and documented.

In addition to the other required components necessary for FP services, the following should be included:

- A **medical history** that includes asking about date of last normal menstrual period (LMP), last USIC (since normal LMP), symptoms of pregnancy, any coexisting conditions, medication and substance use, reproductive goals/pregnancy intention (FPAR 2.0: ""Yes, I want to become pregnant", "I'm OK either way", "No, I don't want to become pregnant").
- 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 at the end of this section under "STANDING ORDER FOR PUBLIC HEALTH NURSES FOR URINE HCG PREGNANCY TESTING" Additional lab work at the time of the positive pregnancy test (i.e., syphilis/HIV screening/testing), counseling, etc., is also included in that section.

C. Preconception Health Services for Clinicians

The term "preconception" describes any time that a person is at risk for pregnancy. Preconception services aim to identify/modify biomedical, behavioral, and social risks to the client's health or pregnancy outcomes through prevention and management. It promotes the health of reproductive aged clients before conception, and thereby helps to reduce pregnancy-related adverse outcomes, such as low birth weight, premature birth, and infant mortality.

Preconception services for clients' partners are important in family planning given their direct contributions to infant health and their role in affecting the health of their partners.

When providing these services to Title X clients, clinicians will follow recommendations described in Section 1.2 Tables 1 and 2. The QFP(2024) and American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and the American Society for Reproductive Medicine's recommendation (Reaffirmed 2024) provide a summary for preconception care counseling.
Elements include:

- Discussion of their reproductive goals. For example, the Self-Identified Need for Contraception question (SINC) (See Step 2.a of Section 1.3.). In addition, the PATH (**P**arenting/**P**regnancy **A**ttitudes, **T**iming, **H**ow Important?) framework is a person-centered model designed to help health care providers and staff engage in conversations with people about their sexual and reproductive health (What is PATH | PATH Framework (path-framework.com)).

PA- Parenting/**P**regnancy **A**ttitudes: *Do you think you might like to have (more) children at some point?*
T- Timing: *When do you think that might be?*
H- How important: *How important is it to you to prevent pregnancy (until then)?*

For female clients and persons capable of becoming pregnant, the medical history includes:

- Reproductive History including poor birth outcomes (preterm, cesarean delivery, miscarriage, stillbirth)
- Chronic medical illnesses (e.g., diabetes, hypertension, thyroid diseases, bariatric surgery, mood disorders)

- 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
- Diet, particularly folic acid supplements.

For male clients and persons capable of producing sperm, the medical history includes:

- Past medical and surgical history that might impair their 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:** Title X licensed providers should familiarize themselves with screening questions, appropriate management, and referral.
- **Immunizations:** All clients should be screened for age-appropriate vaccinations in accordance with recommendations of CDC's Advisory Committee on Immunization Practices. These may include Tdap, MMR, hepatitis B, varicella, annual influenza, and HPV, depending on their current pregnancy status.
- **Physical exam:**
  - **BP:** Hypertension increases risks for morbidity and mortality to mother and fetus.
  - **Height, Weight, and BMI:** Although a healthy pregnancy is possible at any size and many people with a higher BMI have healthy pregnancies, individuals who are obese encounter increased risks of pregnancy complications.
    - 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.
- **Laboratory Screening Test for Diabetes:** Providers should follow the USPSTF recommendations for testing to detect prediabetes/type 2 diabetes in asymptomatic clients who are overweight or obese (BMI ≥ 25kg/m²). Clients who meet these criteria can be referred to their primary care provider for screening (USPSTF 2021 Prediabetes and Type 2 Diabetes: Screening).
- Another resource is the RHNTC job aid "Lifestyle Recommendations for Prediabetes" https://rhntc.org/sites/default/files/resources/rhntc_lifestyle_rec_counsel_prediab_job_aid_8-10-2021.pdf
- **Screening for STI:** following CDC guidance**.**

Counseling for Females and Persons Capable of Becoming Pregnant

- One helpful resource is the Preconception Counseling Checklist (rhntc.org)
- An available handout is the "Preconception Health and Instructions for an Optimal Pregnancy."
- For additional information on preconception care, including counseling for each health topic, see https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/01/prepregnancy-counseling.pdf
- https://www.aafp.org/about/policies/all/preconception-care.html
- For clients using contraceptives who desire pregnancy, discontinue the method. Clinician should counsel clients about the importance of folic acid in preventing neural tube defects (see below). After stopping the method, the client may have a 1-2 month(s) delay before menses become regular (or several months if on DMPA). The client 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 they do not have menses 6-8 weeks after stopping contraceptives.
- Emphasize the need for early and continuing care during pregnancy with referral to prenatal clinics.
- Clients who have a chronic condition such as: hypertension, diabetes, thyroid disease, seizure disorders, psychiatric conditions or other chronic conditions that may impact pregnancy outcomes should be recommended to see their PCP or other managing provider to optimize these conditions prior to achieving pregnancy. If the client is taking medications to manage a condition, they should be encouraged to discuss the medication with the managing provider prior to attempting pregnancy.

Folic Acid:

To reduce an infant's risk of neural tube defects (NTD), all clients planning/capable of pregnancy should be counseled about the need to take 0.4 mg of folic acid daily.

If a client already has had a baby with NTD, they should consult their doctor before their next pregnancy about the amount of folic acid they should take as they might need to take a larger dose of folic acid daily (4 mg) and should be prescribed for additional folic acid supplements and not just taking additional PNVs, which will pose a risk of vitamin A toxicity.

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:

- Persons capable of pregnancy aged >35 years
- Clients with a history of oligomenorrhea (infrequent menstruation)
- Clients with known or suspected uterine or tubal disease or endometriosis
- Clients (or their partners who are) 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 infertility or if there are questions regarding 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. Title X Statute Sec. 1001[300]

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

Basic Infertility Care for Females and Persons Capable of Becoming Pregnant:
Medical History:

- **Reproductive Goals** & **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**, including history of pelvic inflammatory disease (PID), STIs or exposure to STIs
- **Medical conditions associated with reproductive failure** e.g., thyroid disorders, hirsutism, or other endocrine disorders (e.g., Polycystic Ovarian Syndrome), 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 history 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

Further Testing: If needed, clients should be referred at their own expense for further diagnosis and treatment (e.g., serum progesterone levels, follicle-stimulating hormone/luteinizing hormone levels, thyroid function tests, prolactin levels, endometrial biopsy, transvaginal ultrasound, hysterosalpingography, laparoscopy, and clomiphene citrate challenge test).

Basic Infertility Care for Males and Persons Capable of Producing Sperm:

Medical History:

- Discuss the client's **Reproductive Goals**
- **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
- **History** of **partners'** PID/STIs, 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. Clients with abnormal semen test should be referred for diagnosis (e.g., second semen analysis, endocrine evaluation, post-ejaculate urinalysis) and treatment.

Infertility Counseling: 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:**

- 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 clients 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 clients who are very thin/obese 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) is the National Infertility Association that provides free support programs in communities throughout the country. Mailing address is RESOLVE: The National Infertility Association, 1660 International Drive, Suite 600, McLean, VA 22102 Phone: 703.556.7172 Fax: 703.506.3266 info@resolve.org

E. Sexually Transmitted Infection Services

Providers should offer STI services in accordance with current CDC STI treatment and HIV testing guidelines. STI 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 Goals** (Section 1.3).
  - **Note for FP Provider Agreement Sites (non-PHO)**: in order for a new client to be eligible for Title X STI testing/treatment, Title X contracts state that the client must have a clinic visit to evaluate their Reproductive Goals and provide/document contraceptive counseling to assist clients in preventing or planning pregnancy.
- Conduct a standard medical history and sexual health assessment, and check immunization status (HPV, HAV, and HBV).
- A pelvic exam is not indicated in patients with no symptoms suggestive of an STI. Genital exam in clients is done if clinically indicated.

Step 2: Screen

A client who is at risk of an STI (i.e., sexually active and not involved in a mutually monogamous relationship with an uninfected partner) for HIV and the other STIs listed below, in accordance with CDC's STI treatment guidelines https://www.cdc.gov/std/treatment-guidelines/toc.htm and recommendations for HIV testing of adults, adolescents, and pregnant clients in health-care settings.

A. Chlamydia (CT) and **Gonorrhea (GC):** order as a combination test**.**

- All Providers should screen:
  - All sexually active persons with uterus aged <25 years for CT annually, using opt-out language because CT can cause tubal infertility in clients if left untreated.
  - Clients requesting IUD insertion, regardless of age.

- CT testing may also be provided for FP clients who are <30 years old and are (one or more of the following):
  - Symptomatic
  - Those diagnosed with an STI in the last year
  - A known contact to an STI infected partner

- **PHO Providers:** for diagnostic testing of high-risk PHO clients, please refer to the STD Program Protocol for testing guidelines.

- **FP Provider Agreement Sites/Non-PHO Providers:** 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.**

B. Syphilis: For all FP clients, providers should screen those who are just given pregnancy diagnosis or 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 (which includes many areas of New Mexico). Providers should follow the current Public Health Order requirements.

C. HIV/AIDS: providers should follow NMDOH STD Program recommendations for testing:
- Any client who seeks evaluation and treatment for STIs.
- Clients requesting HIV testing.
- Client who is pregnant and has not been tested for HIV.

- Confirmation of a rapid HIV test result (must be blood draw sent to reference lab).
- Anyone who CDC recommends should be screened (listed below).
- All clients aged 13–64 years should have at least one HIV test.
- Sexually active MSM should be tested at least annually if HIV status is unknown or negative, and the client or their sex partner(s) have had more than one sex partner since most recent HIV test. Testing every 3-6 months is indicated for those at higher risk.
- Any client who seeks evaluation and treatment for STIs.
- HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk.

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:

- The test will be performed.
- 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 FP Provider Agreement Sites (non-PHO): HIV screening/testing is not paid for through the NMDOH FPP agreement.

Step 3: Treat

- A client with an STI and their partner(s) should be treated in a timely fashion to prevent complications, re-infection and further spread of the infection in the community. Ideally, STI 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 to receive services at the clinic.
- Another option for partners who cannot come in 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.

For PHOs: Clinic staff will follow the current NMDOH STD Protocol for implementing the "Expedited Partner Therapy (EPT)" Standing Order.

For FP Provider Agreement Sites (non-PHOs): As of 2024, changes to the Title X grant and documentation now allow Title X clinics to utilize 340B medication for EPT to prevent the reinfection of the Title X family planning 340B eligible client. This includes medications listed on the provider agreement formulary. Resources to STI treatment, including EPT, can be found at the CDC STI webpage: https://www.cdc.gov/std/treatment/default.htm

- 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

STI 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, sexual orientation, race, and ethnicity.
- Educational materials and phone conversations can also help people reduce their risk for being infected with or transmitting an STI.

Behavioral counseling interventions to prevent STI involves:

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

Recommendation: Sexually Transmitted Infections: Behavioral Counseling | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

F. RELATED PREVENTIVE HEALTH SERVICES

In addition to a physical exam, such as clinical breast exam (CBE) and/or pelvic exam as appropriate, providers may provide cervical cytology testing to Title X clients as clinically indicated (See Section 4: Laboratory for details).

Family Planning Program Standing Orders for NMDOH Public Health Nurses

Standing Orders for NMDOH Public Health Nurses providing Family Planning Services are listed on the following pages. Guidance may be beneficial for Provider Agreement (PA sites) as well.

Client consents, handouts, counseling tools and client emergency instructions are posted on the NMDOH FPP website, for easier printing by clinic staff.

STANDING ORDER FOR PUBLIC HEALTH NURSES TO DISPENSE QUICKSTART

Purpose: The PHN can initiate a Quickstart for clients with a 3-month supply of COC/POP/Vaginal Ring/Patch or DMPA if the client is not currently on a hormonal contraception (HC) through the PHO and no PHO clinician is available. Clients should be scheduled for a PHO clinician visit at the earliest available time.

PHN can initiate a Quickstart for clients with:

- 3-month supply of COC/POP/Vaginal Ring or DMPA
- 3-month prescription for patch for those willing to pay (contact PHO clinician for prescription)

A clinician's order for HC is required for clients who have used public health services for HC within the last six months and are requesting Quickstart again. Clients are allowed more than one Quickstart per year (with verbal orders as needed).

Subjective and objective nursing assessment:

The PHN will:

I. Document the client's reproductive goals, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.3 in the medical record (EHR).

II. Document the client's LMP (last normal menstrual period), blood pressure, weight, height, BMI, and date(s) of last unprotected sexual intercourse since the last normal menses.

III. Assess the client's current pregnancy status by assuring that the client has no "symptoms of pregnancy" listed in the "How to be Reasonably Certain that a Client is not Pregnant" box below.

How to Be Reasonably Certain that a Client Is Not Pregnant

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

- Is ≤ 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 ≤ 7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breast/chest feeding, (exclusively breastfeeding or the vast majority [≥ 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 on next page):

1. Using dates to determine safe start of birth control:

   a. **If the client's first day of LMP was ≤7 days ago,** you can be reasonably sure that the client is not pregnant. Document your reasoning. If client has no contraindications, use the appropriate QUICKSTART tool below to start the client on COCs/POPs/vaginal rings/DMPA now.

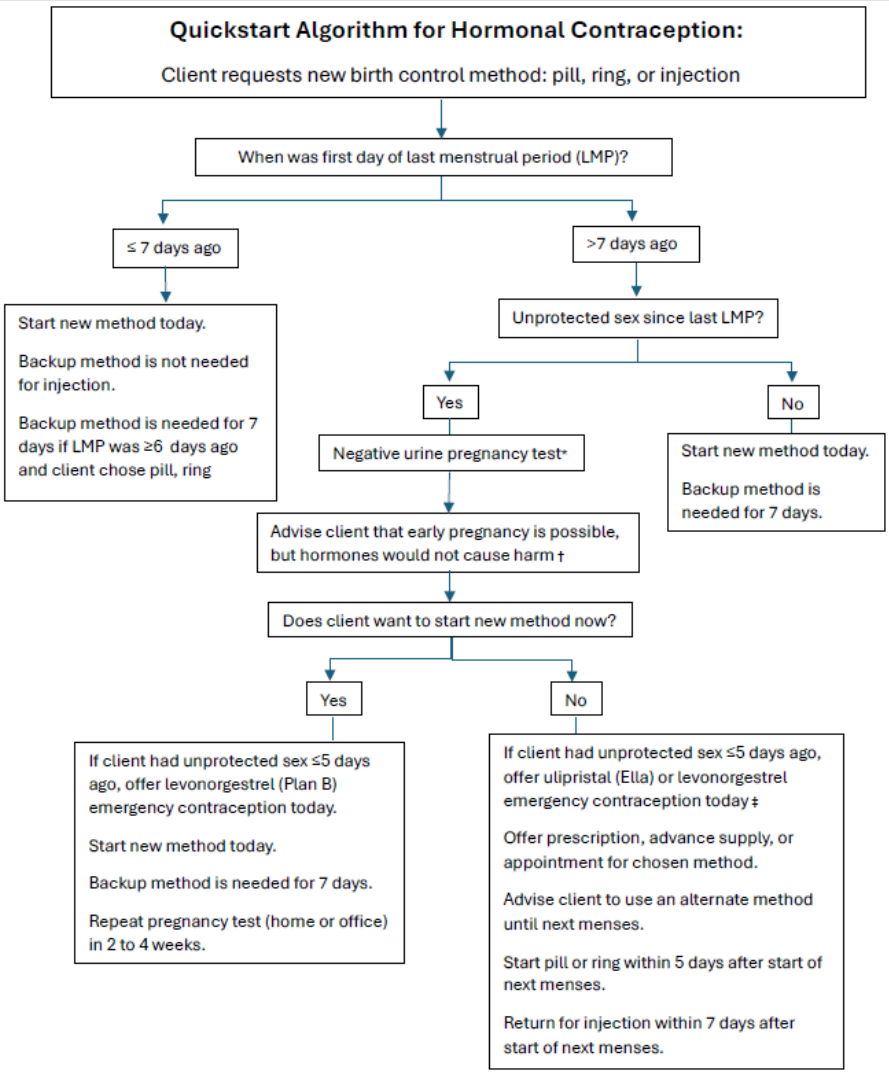
   b. **If the client's first day of LMP was >7 days ago, and client reports no USIC since LMP,** you can be reasonably sure that the client is not pregnant. Document your reasoning. If the client has no contraindications, use the appropriate QUICKSTART tool below to start the client on COCs/POPs/vaginal rings/DMPA now.

   c. **If the client's first day of LMP was >7 days ago, and there was USIC since then, perform urine hCG**. Inform the client that this test may not definitively rule out pregnancy.

      - If urine hCG is positive, follow the Pregnancy Test Standing Order "COUNSELING IF THE (PREGNANCY) TEST IS POSITIVE" Section.

      - If urine hCG is negative and USIC is < 5 days, offer ECP (Use ECP Standing Order). Assess client's desire to start a birth control method now, and document the client's decision and counseling in the medical record.

      - If urine hCG is negative and client has no contraindication, use appropriate QUICKSTART tool on the following pages to offer the client birth control method now



* -- If pregnancy test is positive, provide Title X options counseling.

† --The Centers for Disease Control and Prevention advises that the benefits of starting contraception likely exceed the risk of early pregnancy.

‡ --Levonorgestrel emergency contraception is no more effective than placebo in clients with a body mass index > 25 kg per m^2. Emergency contraception with ulipristal is more effective than with levonorgestrel in people who had unprotected sex 3 to 5 days ago. Because hormones may decrease the effectiveness of ulipristal, the new method should be started no earlier than 5 days after ulipristal is taken.

Adapted from Reproductive Health Access Project. Quick start algorithm for hormonal contraception. Accessed August 9, 2024. Reproductive Health Access Project | Quick Start Algorithm - Reproductive Health Access Project (reproductiveaccess.org)

Permission received from Reproductive Health Access Project on 8/16/24 Lesnewski-Hormonal-Contraception.pdf (reproductiveaccess.org)

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. Consider offering future use LNG ECP for clients who may have difficulty with condom use/abstinence when initiating Quickstart BCM.

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

Client **qualifies** for Quickstart supply of COCs or vaginal contraceptive rings if they meet **all** the following conditions:

1. Client is not planning pregnancy ~~and below age 40~~.
2. Client has passed the pregnancy assessment criteria above. If the client was recently pregnant, the client is >6 weeks postpartum.
3. Client's SBP is < 140 and DBP is < 90.
4. Client **does not** have **any** of the following disqualifying conditions:
   - hypertension (controlled or uncontrolled), vascular disease
   - 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 cigarettes
   - multiple risk factors for arterial CVD (older age, diabetes, HTN, smoking, low HDL, high LDL, or high triglyceride levels)
   - stroke, blood clots (current of history of DVT/pulmonary embolism, acute or history of superficial venous thrombosis), major surgery that will immobilize 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 OCPs 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 (impaired liver function/decompensated), liver tumors (adenoma or malignant) complicated sold organ transplant and Budd-Chiari syndrome.
   - 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.), sickle cell disease
   - chronic kidney disease (current nephrotic syndrome, dialysis)
   - Rifampicin/rifabutin, anticonvulsant therapy, fosamprenavir antiretroviral therapy.

Plan of care for COC/Vaginal Ring PHN Quickstart

Consent: Title X does not require a specific consent form for COCs or vaginal rings. Ensure the client is medically eligible and it is reasonably certain they are not pregnant.

PHN will:

1. **Counseling and Education:**
   - Provide method-specific counseling and education using the Counseling Tool (see Section 2 and under Forms on the FPP webpage)
   - Help the client develop a plan for correct use of the chosen method
   - Document the client's understanding and recall of the counseling using teach-back method.
   - ACOG states that "regular exercise, including weight-bearing exercise; smoking cessation; and age-appropriate calcium and vitamin D intake should be encouraged for all women…these recommendations can benefit general health".
2. **Quickstart for COCs:**
   - Dispense 3 cycles of 28-day oral contraceptives for new users.
   - Clients are allowed more than one Quickstart per year (with verbal orders as needed).
   - COC use**:**
     - Take one pill by mouth each day at the same time of the day.
     - If the client prefers a specific type, provide a similar COC from the same category (refer to the OCP Substitute Table for details).
     - OCP categories are based on estrogen dose (ethinyl estradiol) and progestin type:
       - Progestin Only Pill Norethindrone
       - 20 MCG EE with Norethindrone
       - 20 MCG EE with Levonorgestrel
       - 25 MCG EE with Triphasic-Norgestimate
       - 30 MCG EE with Norethindrone
       - 30 MCG EE with Levonorgestrel
       - 35 MCG EE with Norgestimate
     - Any combined-hormonal pill can be used for Quickstart as long as there are no contraindications. PHNs may not substitute the prescribed OCP without consulting the clinician.
3. **Quickstart for Vaginal Ring:**
   - Dispense 3 vaginal rings.
   - Instructions to Client:
     - Insert the ring and leave it in place for 3 weeks.
     - After 3 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 menstruation hasn't finished.
4. **Initiation Timing:**
   - Follow the Quickstart algorithm above to start the pill or vaginal ring today or according to the client's preferred schedule. 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.**
   - If initiating within 5 days since menstrual bleeding started, no additional contraceptive needed.
   - If more than 5 days since menstrual bleeding started, advise abstinence or use of backup contraception for 7 days.
   - Provide spermicide and condoms and instructions for use.
5. **Follow-up Appointment:**
   - Schedule a follow-up visit with a PHO clinician within 3 months, either in-clinic or via telehealth for assessment of method suitability, side effects counseling, one-year prescription, and other related prevention services.
   - Ensure this visit occurs within 3 months of the initial visit.
6. **Clients Not Eligible for Quickstart:**
   - 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.
  - Provide spermicide and condoms, as well as future use ECP with instructions for use as appropriate.
  - Schedule an appointment with a clinician within the next 2 weeks.
7. **Post-Dispensing Care:**
  - After the initial PHN dispensing, a clinician order is required to continue or change BCM, including switching to a different OCP with a different estrogen dose progestin type.
  - Clients are allowed more than one Quickstart per year (with verbal orders as needed).

QUICKSTART FOR DMPA

Client **qualifies** for Quickstart supply of DMPA if they meet **all** the following conditions:

1. ~~Client is not planning to get pregnant within the next year.~~
2. Client has passed the pregnancy assessment criteria.
3. Client's SBP is < 160 and DBP is <100
4. Client **does not** have **any** of the following disqualifying conditions:
   - HTN with vascular disease, history of stroke
   - Multiple risk factors for arterial CVD (older age, diabetes, HTN, smoking, low HDL, high LDL, or high triglyceride levels)
   - Diabetes with complications (with vascular disease or neuropathy, retinopathy, nephropathy, or >20 yr. duration)
   - Current or past ischemic heart disease; Peripartum cardiomyopathy (moderately/severely impaired cardiac function).
   - Current or past breast cancer
   - Cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
   - Lupus (positive/unknown antiphospholipid antibodies or severe thrombocytopenia), Thrombogenic mutations (e.g. factor V Leiden; prothrombin mutation; and protein S, protein C, and antithrombin deficiencies, etc.), sickle cell disease
   - Rheumatoid arthritis receiving long-term corticosteroid therapy with non-traumatic fractures (history or risk factors)
   - Unexplained vaginal bleeding (suspicious for serious condition e.g., pelvic malignancy) before evaluation
   - Solid organ transplant (using long-term immunosuppressive therapy with fracture risk/history)

Plan of care for DMPA PHN Quickstart

Consent: Title X does not require a specific consent form for DMPA. Ensure the client is medically eligible and it is reasonably certain they are not pregnant.

PHN will:

1. **Counseling and Education:**
   - Provide method-specific counseling and education using the Counseling Tool (see Section 2 and under Forms on the NMDOH FPP webpage).
   - Discuss both in-clinic administration of intramuscular (IM) DMPA 150 mg and home self-administration or in-clinic administration of subcutaneous (Sub-Q) DMPA 104 mg.
   - If the client chooses Sub-Q, start with a clinic dose and schedule a follow-up clinician visit within 3 months.
   - Help the client develop a plan for correct use of the chosen method
   - Document the client's understanding and recall of the counseling using teach-back method.
   - ACOG states that "regular exercise, including weight-bearing exercise; smoking cessation; and age-appropriate calcium and vitamin D intake should be encouraged for all women. Although there have been no studies showing that these measures will offset loss of BMD during DMPA use, these recommendations can benefit general health".
2. **Quickstart for DMPA:**
   - Administer DMPA 150 mg by deep intramuscular injection or 104 mg by subcutaneous injection.
   - Instruct client to not rub/massage injection site.
   - Ask the client to remain in clinic for 15 minutes following injection, to ensure no reaction.
3. **Initiation Timing:**
   - If within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
   - If more than 7 days since menstrual bleeding started, advise abstinence or use of backup contraception for 7 days. Provide spermicide & condoms with instructions to use as backup for 7 days.
   - Return for pregnancy test if signs or symptoms of pregnancy.

4. **Follow-up Appointment:**
    - Schedule a PHO clinician visit (or by telehealth) within 3 months for method assessment, side effects counseling, one-year prescription and other related preventive services.
    - This visit should not be deferred beyond 3 months unless there are verbal orders from a clinician to continue the method.
5. **Clients Not Eligible for Quickstart:**
    - Consult with PHO Clinician for:
        - Client whose menses are late or in whom pregnancy is uncertain.
        - Client with medical precautions against DMPA.
        - New PHO client who is already on DMPA and early or late for their shot.
    - Provide spermicide and condoms with instructions for use as appropriate.
    - Schedule an appointment with a clinician within the next 2 weeks.
6. **Post-Dispensing Care:**
    - After the initial PHN dispensing, a clinician order is required to continue or change BCM.
    - Clients are allowed more than one Quickstart per year (with verbal orders as needed).

QUICKSTART FOR PROGESTIN ONLY PILLS (POPs)

Client **qualifies** for Quickstart supply of POPs if they meet **all** the following conditions:

1. Client is not planning pregnancy.
2. Client has passed the pregnancy assessment criteria above.
3. Client's SBP is < 160 and DBP is < 100 (POPs may be given if BP>160/100 with a clinician's order).
4. Client **does not** have **any** of the following disqualifying conditions:
   - Ischemic heart disease (current or history)
   - Breast cancer (current or history)
   - Bariatric surgery (Malabsorptive procedure – Roux-en-Y gastric bypass or biliopancreatic diversion)
   - Cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
   - Chronic kidney disease (current nephrotic syndrome, dialysis)
   - Lupus (positive/unknown antiphospholipid antibodies)
   - Rifampicin/rifabutin, anticonvulsant therapy.

Plan of Care for POP PHN Quickstart

Consent: Title X does not require a specific consent form for POPs. Ensure the client is medically eligible and it is reasonably certain they are not pregnant.

PHN will:

1. **Counseling and Education:**
   - Provide method-specific counseling and education using the Counseling Tool (see Section 2 and under Forms on the NMDOH FPP webpage)
   - Help the client develop a plan for correct use of the chosen method
   - Document the client's understanding and recall of the counseling using teach-back method.
2. **Quickstart for POPs:**
   - Dispense 3 cycles of POPs for new users.
   - Clients are allowed more than one Quickstart per year (with verbal orders as needed).
3. **Initiation Timing:**
   - Follow the Quickstart algorithm above, to start the pill today or according to the client's preferred schedule.
   - Instruct client to take one pill by mouth at the same time every day with no breaks between packs.
   - If initiating within 5 days since menstrual bleeding started, no additional contraceptive or abstinence is needed.
   - If more than 5 days since menstrual bleeding started, advise abstinence or use of backup contraception for 7 days.
   - Provide spermicide and condoms with instructions.
   - Counsel that menses may change due to POPs.
4. **Follow-up Appointment:**
   - Schedule a follow-up visit with a PHO clinician within 3 months, either in-clinic or via telehealth for assessment of method suitability, side effects counseling, one-year prescription, and other related prevention services.
   - Ensure this visit occurs within 3 months of the initial visit.
5. **Clients Not Eligible for Quickstart:**
   - Consult with PHO Clinician for:
     - Client whose menses are late or unsure if client is pregnant.
     - Client with medical precautions against POPs.
     - Provide spermicide and condoms with instructions for use as appropriate.
     - Schedule an appointment with a clinician within the next 2 weeks.
6. **Post-Dispensing Care:**
   - After the initial PHN dispensing, a PHO clinician order is required to continue or change BCM.
   - Clients are allowed one Quickstart in a one-year period, with verbal orders as needed until a clinician visit is scheduled.

STANDING ORDER FOR PUBLIC HEALTH NURSES TO DISPENSE LEVONORGESTREL EMERGENCY CONTRACEPTIVE PILL (ECP)

Purpose: Levonorgestrel (LNG) ECP will be dispensed to clients capable of becoming pregnant per FP Standing Order/protocol only (this standing order **does NOT** include use of Ella/ulipristal acetate UPA EC- which requires a clinician prescription for each use). LNG ECP is most effective in preventing pregnancy when taken as soon as possible after unprotected sex or a contraceptive miss, delay or failure. It is most effective within 72 hours but can be taken within 120 hours.

Indications for Use: LNG ECP can be used in the following situations:

1. No contraceptive was used at the time of intercourse.
2. A couple attempting to practice periodic abstinence but had intercourse.
3. Withdrawal was attempted, but ejaculation occurred in the vagina or on the external genitalia.
4. An external condom slipped, broke, or leaked.
5. An internal condom, diaphragm, or cervical cap was inserted incorrectly, dislodged during intercourse, removed too early, or found to be torn. An internal condom was inserted or removed incorrectly leading to spillage of semen, or the penis was inserted mistakenly between the internal 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 the client 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 15 weeks since the last 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 clients without a clinician order.

A clinician order is required for dispensing to FP client partners, see the following section.

Subjective and objective nursing assessment:

The PHN will:

I. Document the client’s reproductive goals, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.3 in the medical record (EHR).

II. Document the client’s LMP (last normal menstrual period), blood pressure, weight, height, BMI, and date(s) of last unprotected sexual intercourse since the last normal menses.

III. Assess the client’s current pregnancy status by assuring that the client has no “symptoms of pregnancy” listed in “How to be Reasonably Certain that a Client is not Pregnant”

IV. Perform urine hCG test in office if indicated:

- ❖ The person 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 person may be pregnant

Note on dispensing LNG ECP to partners of FP clients who are male or persons capable of producing sperm (PHOs only):

- Dispensing ECP to the FP client's partner may be done on a case-by-case basis by a **clinician only**. Like other FP clients, document the partner's comprehensive medical history, BP/wt/ht/BMI and counseling in the medical record (BEHR).
- The clinician will talk to the female or person capable of becoming pregnant on the phone to assess existing pregnancy risk (If unable to speak to the person who will be taking the ECP, the clinician should not dispense ECP to the partner):
  - Obtain the date of the last USIC since the last normal menses.
  - Ascertain that the client has chosen to take ECP.
  - Provide brief counseling on ECP use, pregnancy as the only contraindication, and that the client should go to a clinic for a pregnancy test if they do not have menses within 3 weeks post ECP.
  - Counsel on ongoing birth control.
  - Document information gathered and telephone counseling in the medical record of the person at the clinic who is picking up the ECP.
  - Consider option of using telehealth services for this visit type.
- If dispensed to a client under a clinician's order, the nurse will sign out the non-340B ECP and write on the label the name of the client seen in person at clinic (not the client taking the ECP).

Plan of care for PHN Levonorgestrel ECP Quickstart

Consent: Title X does not require a specific consent form for ECP. Ensure client is medically eligible and it is reasonably certain they are not pregnant. Known pregnancy is the only absolute contraindication.

PHN will:

1. **Counseling and Education:**
   - Levonorgestrel prevents pregnancy by delaying/inhibiting ovulation. ECPs do not interrupt an established pregnancy. If ECP treatment fails, clients 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 clients who weigh more than 165 pounds or have a body mass index above 25 kg/m^2. 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 the client's period does not start within 3 weeks after taking ECPs or if they are worried and/or feels pregnant, they should have a pregnancy test.
   - Provide method-specific counseling and education using the Counseling Tool (see Section 2 and under Forms on the NMDOH FPP webpage)
   - Document the client's understanding and recall of the counseling using teach-back method.

2. **Quickstart for LNG ECP:**
   - Dispense a single dose of 1.5 mg levonorgestrel to be taken by mouth now. No individual/additional clinician order is required. (Future Use ECP is permitted as needed without clinician order).
   - Instructions to Client:

- If vomiting occurs within 3 hours, another dose of ECP should be taken as soon as possible.
- For new (to FP) clients who desire ongoing effective contraception, offer Quickstart per Standing Order. 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): 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 12 years.

3. **Follow-up Appointment**:
   - Schedule a follow-up Family Planning appointment as appropriate.

Although there is no limit of how many times per year a client can safely use ECP, given its limited effectiveness, it is important to explore with the client their reproductive goals and preferences, and if they are interested in other options for an on-going birth control method. It is important to remember that some clients may decline contraceptive counseling or other contraceptives. Although it is recommended that clinical staff offer contraception counseling, clients are not required to use an ongoing regular method of contraception, and this should never be a prerequisite for providing ECP (this would be considered coercion) (Contraceptive Technology 22nd Ed., p.529).

STANDING ORDER FOR PUBLIC HEALTH NURSES FOR URINE HCG PREGNANCY TESTING
(Guidance may be used for Provider Agreement Sites as well)

Purpose: Pregnancy testing provides the opportunity as an entry point for contraceptive needs assessment, health education and assessment of the client's reproductive goals.

Subjective and objective nursing assessment:

1. The PHN will interview clients and:
   A. Document the client's reproductive goals, pregnancy intention (FPAR 2.0: "Yes, I want to become pregnant"; "I'm OK either way"; "No, I don't want to become pregnant"), medical, and sexual health history as outlined in Step 2 of Section 1.3. in the medical record (BEHR).
   B. Review symptoms: Often the client themself suspects pregnancy or has reason to believe that they could be pregnant. A particularly useful question to ask is "Do you think you are pregnant now?"
      - The most common sign that prompts a client 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 last normal menses, 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.

Plan of care:

For clients younger than 25, consider sending chlamydia specimen to lab if not done within the last 12 months. Test client for syphilis/HIV as appropriate.

1. Document all services provided in the clinical record.
2. Reviewing the client's reproductive goals is particularly important in determining the plan of care.
3. Client will be provided appropriate counseling and education according to their reproductive goals and pregnancy test result as outlined below.

COUNSELING IF THE TEST IS NEGATIVE:

1. Counsel the client regarding the basics of the 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 the client 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 the client 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 MMWR 2006;55(No. RR- 6) http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf or Preconception Counseling Checklist (rhntc.org)
   b. Providers (PHO and PA) should counsel clients about the importance of folic acid in preventing neural tube defects and if available, may dispense one bottle of Prenatal Vitamins according to the 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. With increasing syphilis rates and concurrent congenital syphilis cases in New Mexico, ALL clients with a positive pregnancy test should be screened for syphilis. This preliminary syphilis test does not replace regularly scheduled prenatal laboratory testing, and referral to prenatal, maternal-child health or primary care providers for prenatal care is provided upon client request.
2. Calculate pregnancy EDD by reviewing dates of unprotected sexual intercourse and menstrual history using tools such as a pregnancy due date wheel, ACOG app, or UpToDate calculator.
3. Document the client's pertinent history that helps determine pregnancy risk including genetic family history and pregnancy intention information.
4. Ascertain client's plans for pregnancy continuation or termination by providing **"All Options Counseling".** Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options:
   - Prenatal care and delivery;
   - Infant care, foster care, or adoption; and
   - Pregnancy termination.

   If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling (CFR59.5(a)(5). Written materials (e.g., CHOICES) may be used to counsel the client (posted on NMDOH FPP website).
5. Document in the client record that pregnancy options counseling was done.
6. Counsel client using "**Instructions for an Optimal Pregnancy"** and assess their social support.
7. Providers should counsel clients about the importance of folic acid in preventing neural tube defects and if available, may dispense Prenatal Vitamins according to the site policy/procedure.

CARRYING PREGNANCY TO TERM:

Discuss "Instructions for an Optimal Pregnancy" (under Forms on the NMDOH FPP webpage). Client should receive prenatal care as soon as possible, by referral or on-site based on clinic capacity. A physical exam for pregnant clients is important and should be arranged for preferably within 2 weeks. If there are any potential problems, tell the client to discuss them with her prenatal care provider. If the

client will qualify and wants Medicaid Presumptive Eligibility and/or home visiting services (via Early Childhood Education & Care Department-provider list on ECECD website), start the process.

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 partner is required if they are married or the partner 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.
3. Upon client's request, provide a list of agencies helping with this service and discuss any questions they may have. Referral for abortion may include providing a client with the name, address, telephone number, and other relevant information (such as whether the provider accepts Medicaid, charges, etc.).
4. Staff may <u>not</u> provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion. The limitations on referrals do not apply in cases in which a referral is made for medical indications (client's condition or the condition of the fetus- such as where the client's life would be endangered).
   https://www.govinfo.gov/content/pkg/FR-2000-07-03/pdf/00-16759.pdf
5. If the client qualifies and wants Medicaid Presumptive Eligibility, start that process as they might be covered for pregnancy-related benefits, including pregnancy termination.
6. Discuss what they will choose for birth control after the procedure and where the client 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 the client is in the best possible shape for the procedure or the pregnancy if they change their mind.

Conditions requiring notification of a clinician:
Early pregnancy danger signs need **<u>immediate</u>** evaluation by a clinician, either in your clinic or by referral to another clinic or emergency room:

- Sudden intense/persistent pain, or cramping in the lower abdomen, usually localized to one side.
- Irregular bleeding/spotting, 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.