

Section 1.0
FAMILY PLANNING PROGRAM
GUIDELINES
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.

The OPA Program Guidelines, which are comprehensive, evidence-informed guidelines for the delivery of family planning and related preventive health services, are comprised of two documents:

1. **Program Expectations** for Title X Funded Family Planning Projects
2. Providing **Quality Family Planning** Services: Recommendations of Center for Disease Control and Prevention (CDC) and the U.S. OPA (**QFP**), 2014 and updates.

Links to these documents can be found under the "Key Resources for Title X Grantees" section:

<https://opa.hhs.gov/grant-programs/title-x-service-grants/key-resources-title-x-grantees>

The NM Family Planning Program (FPP) 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 policies and procedures 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 and reviewed and will follow the Protocol and its applicable Standing Orders.

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

1. **FAMILY PLANNING SERVICES** in the central circle are the priority for NM Title X providers including:
 - a. **Contraceptive services** for clients who want to prevent pregnancy and space births.
 - b. **Pregnancy testing and counseling** to be provided in conjunction with other appropriate FP services, such as contraceptive services or preconception health services.
 - c. **Assistance to achieve pregnancy (preconception health services) and other related health services** (e.g., screening for obesity, smoking, mental health and substance use).
 - d. **Basic infertility services**
 - e. **STI testing, treatment and counseling services** (including HIV testing) are considered family planning services because they improve clients' health and can influence a person's ability to conceive or to have a healthy birth outcome. However, they are provided in conjunction with other appropriate FP services, such as contraceptive or preconception health services.

2. **RELATED PREVENTIVE HEALTH SERVICES:** considered to be beneficial to reproductive health, closely linked to FP services, and appropriate to deliver in the context of a FP visit but that do not contribute directly to achieving or preventing pregnancy (e.g., breast and cervical cancer screening).
3. **OTHER PREVENTIVE HEALTH SERVICES:** Examples are screening for lipid disorders, skin cancer, colorectal cancer, or osteoporosis. Although important in the context of primary care, these have no direct link to family planning services. These services may be provided either on-site or by referral.



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

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

1. [Contraceptive Technology](#), 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](#), 16th Ed., M. Ziemann, 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, 2016 (App, MMWR, Summary Chart)
6. [SPR](#) U.S. Selected Practice Recommendations for Contraceptive Use 2016 (eBook, App, MMWR)
7. [PCC](#) Recommendations to Improve Preconception Care, MMWR April 21, 2006, Vol. 55.

1.1 SERVICE POPULATION

Projects funded under Title X are intended to enable all persons who want to obtain family planning care to have access to such services. **Services must be provided 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.** Services must also be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician. 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.

- *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 is trauma-informed 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 resist re-traumatization.

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

A. CLIENTS OF REPRODUCTIVE AGE

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

1. **What is the client's reason for the visit?** The client's visit goal should be addressed to the extent possible.
 - a. If a client, who is at risk of having/causing an unintended pregnancy, does not want to have a child at this time, and is sexually active, offer contraceptive services.
 - b. If a client desires pregnancy testing, provide pregnancy testing and counseling.
 - c. If a client wants to have a child now, provide services to help the client achieve pregnancy.
 - d. If a client wants to have a child and is experiencing difficulty conceiving, provide basic infertility services.
2. **Does the client have another source of primary health care?** The answer will help clinic staff in identifying what preventive services should be offered.

- a. If the clinic is the client's main source of primary care, it will be important to assess the client's needs for other FP-related preventive services, e.g., screening for breast and cervical cancer.
 - b. If the client receives ongoing primary care from another provider, clinic staff should confirm that the client's preventive health needs are met while avoiding the delivery of duplicative services.
3. **What is the client's reproductive life plan (RLP)?** Providers should avoid making assumptions about the client's needs based on characteristics, e.g., sexual orientation or disabilities. A RLP outlines the client's personal goals about becoming pregnant. For clients whose reason for visit was not related to preventing or achieving pregnancy, asking questions about their RLP might help identify unmet reproductive health care needs.

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

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

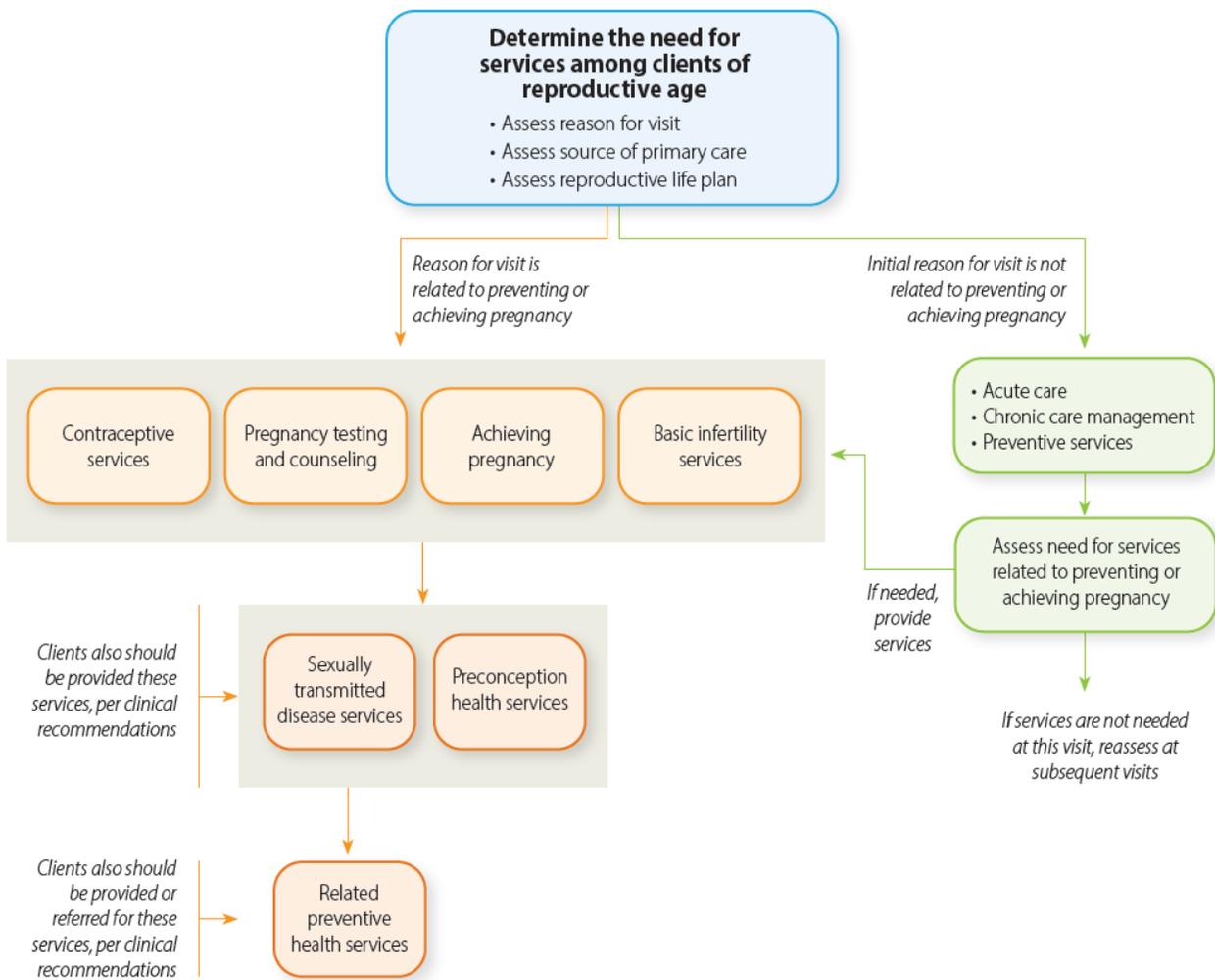


Figure 2: Clinical Pathway for Family Planning Services for Clients of Reproductive Age

B. TEEN CLIENTS

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

C. CLIENTS WITH LIMITED ENGLISH PROFICIENCY

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

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

1.2 METHODOLOGY

A. DEFINITION OF TITLE X FAMILY PLANNING ENCOUNTER

A family planning encounter is a documented 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 to clients who want to avoid unintended pregnancies or achieve intended pregnancies. A written record of the services provided during the family planning encounter must be documented in the client record. (Title X Family Planning Annual Report Instructions, 2021).

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 answering machine should have instructions for clients in case of emergency, directing them where to obtain emergency care.

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

1. A facility that is in compliance with the Americans with Disabilities Act (ADA) "Access to Medical Care for Individuals with Mobility Disabilities" (http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm).
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. **FP brochures must be current and approved by the Informational & Educational (I&E) Committee and contain Title X grant acknowledgement, as listed in Appendix C.**
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.

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 female 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 DOH I & E Committee must approve all educational materials distributed in Family Planning Clinics. Each educational material must display acknowledgement of the Federal grant number used as the funding source. Appendix C contains a current list of approved educational resources available to order from the FPP State Office.

D. STAFF ORIENTATION AND TRAINING REQUIREMENTS

Appropriate trainings are required by the Title X Guidelines. See Appendix D for links to [required trainings](#) 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 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 (*OPA Program Instructions 11-01; 06-01 and 99-1*) 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. All clinics must have a mechanism in place to document reports made, for example, a log. When in doubt as to whether the NM legal requirements apply to your client's situation, consult with your clinician/supervisor, Regional Health Officer and/or agency's legal counsel.

F. SCHEDULING AN APPOINTMENT AND TITLE X FEE COLLECTION PROCEDURE

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

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 2 weeks should be made aware of other providers in the area.

G. CONSENT AND OTHER REQUIRED FORMS

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

1. **Parental/Family Involvement Form for Services to Minor-Age Clients** (for clients < 18 years old) includes elements that:
 - a. 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.
 - 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.
 - d. The client has/has not chosen confidential family planning visit.
 - e. The client's alternate contact information for future communication from the clinic.

2. **Consent for Family Planning Services** states that services are provided on a voluntary basis.

Title X family planning services are to be provided solely on a voluntary basis. A client's acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by the clinic. 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.

Personnel working within the family planning project may be subjected to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.

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

<https://www.nmhealth.org/about/phd/fhb/fpp/pvdr?updated=20170630>

3. **Income Worksheet** is available in Appendix B and on the 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 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 Family Planning Program's required method-specific consent forms (available in Section 2, and 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 is 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 the clinician must be included in the client's record. Evaluate if the client comprehends method/treatment and document the client's recall and understanding of the counseling (based on the "teach-back" method) in the medical record.

It is prudent to verify the client's capacity to understand the nature and consequences of the method/treatment to which they are consenting. It is the responsibility of the nurse/clinician to use good

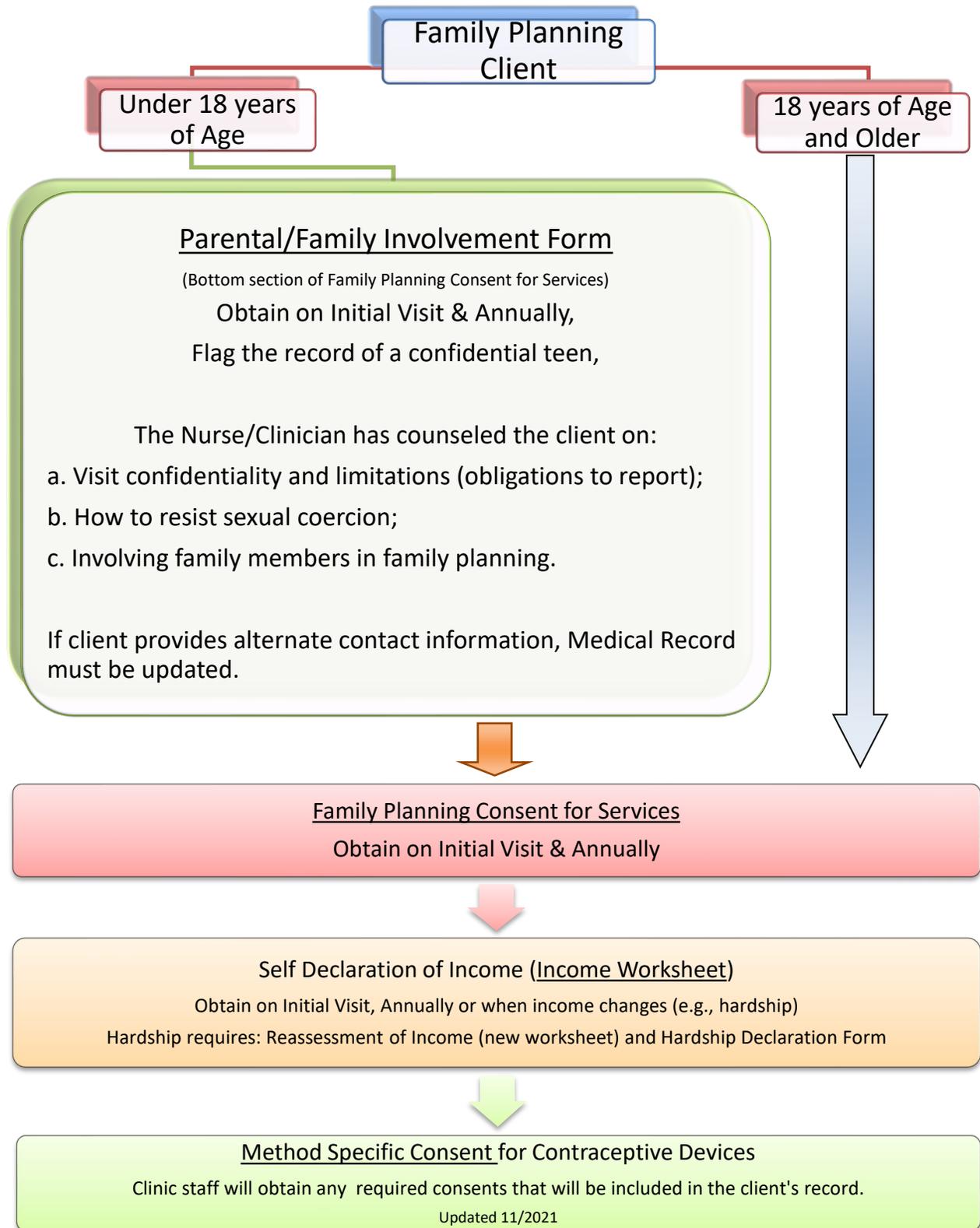
judgment through reasonable inquiry of the client, i.e., does the client understand why they are here, and what they expect to receive from the clinic? Ascertain if further assessment is needed.

- **If 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 consent form as well, certifying they have interpreted correctly. The nurse/clinician should be present during the interpretation, and is responsible for answering questions, or clarifying information through the interpretation.

SAMPLE 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.

Figure 3: ALGORITHM FOR REQUIRED FAMILY PLANNING FORMS AND CONSENTS



H. TITLE X FAMILY PLANNING SERVICES

According to the QFP, Tables 1 & 2 summarize required items for providing NM Title X services to clients, and related preventive health services.

Table 1: Checklist for Providing Family Planning Services: Persons Capable of Pregnancy

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

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

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

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

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

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

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

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

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

Table 2: Checklist for Providing Family Planning Services: Biological Male Sex Client

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

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

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

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

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

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

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

A. Contraceptive Services

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

FIVE KEY STEPS IN PROVIDING CONTRACEPTIVE SERVICES

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

STEP 1: Establish and maintain rapport with the client with trauma-informed awareness and approaches.

Strategies to achieve these goals include:

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

STEP 2: Obtain clinical and social information from the client

- A. Confirm the client's pregnancy intention or Reproductive Life Plan (RLP):** Each client should be encouraged to clarify decisions about their RLP (i.e., whether the client wants to have any or more children and, if so, the desired timing and spacing of those children). Ideally, this should be done at each family planning visit because it may change over time. Providers should avoid making assumptions about the client's needs based on his or her characteristics, e.g., religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

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

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

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

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

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

- **HPI (History of present illness)** last menstrual period (LMP), current gynecologic or pregnancy symptoms. *An unusually light or mistimed period may mean fertilization actually occurred before the LMP, and for this reason, the date of the previous menstrual period (PMP) should be determined.*
- **Contraceptive experiences and preferences** – Example questions are:
“What method(s) are you currently using, if any?”
“What method(s) have you used in the past?”
“Have you previously used emergency contraception?”
“Did you use contraception with last sex?”
“What difficulties did you experience with prior methods if any (e.g., side effects, noncompliance)?”
“Do you have a specific method in mind?”
- **Menstrual history** including menstrual frequency, length and amount of bleeding, and other patterns of uterine/vaginal bleeding.
- **Recent intercourse and last unprotected intercourse**
- **Gynecologic and obstetrical history** including recent delivery, miscarriage, or termination.
- **Allergies**
- **Relevant infectious/chronic health conditions** (e.g., hypertension, diabetes, medical diagnosis of migraine headache with aura, blood clots) and other characteristics and exposures (e.g., age, tobacco use, breastfeeding) that might affect the client's medical eligibility criteria (MEC) for contraceptive methods.
- **Past surgical history** (for PHO clients seeking sterilization).
- **Laboratory** (for PHO clients seeking sterilization, provider may request from client's PCP) CBC for any clients reporting a recent history of anemia; HgbA1c for patients with diabetes.

For a designated Male at birth client, 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);
- **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.**

The taking of 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).

C. Sexual Health Assessment and Counseling: A sexual history and risk assessment that considers the client’s sexual practices, partners, past STI history, and steps taken to prevent STIs help the client select the most appropriate method(s) of contraception. Correct and consistent condom use is recommended for those at risk for STIs.

CDC recommendations for how to conduct a sexual health assessment have been summarized below (some of which may have already been included in the medical history above):

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

<https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf>
<https://www.cdc.gov/std/treatment-guidelines/default.htm>

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

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

Birth Control Method Options



Clients considering their birth control method options should understand the range and characteristics of available methods. Providers can use this chart to help clients consider their birth control method options. Clients should also be counseled about their options for reducing risk of STIs.

METHOD	What is the risk for pregnancy?*	How do you use this method?	How often is this used?	What are menstrual side effects?	Other possible side effects?	Other things to consider?
FEMALE STERILIZATION	.5 out of 100	Surgical procedure	Once	No menstrual side effects	Pain, bleeding, risk of infection	Permanent
MALE STERILIZATION	.15 out of 100					
LNG IUD	.2 out of 100	Placed inside uterus	Up to 8 years	Spotting, lighter or no periods	Some discomfort with placement	No estrogen May reduce cramps
COPPER IUD	.8 out of 100		Up to 10 years	May cause heavier, longer periods		No hormones May cause cramps
IMPLANT	.05 out of 100	Placed in upper arm	Up to 3 years	Spotting, lighter or no periods		No estrogen May reduce cramps
INJECTABLES	4 out of 100	Shot in arm, hip, or under the skin	Every 3 months	Spotting, lighter or no periods	May cause weight gain	No estrogen May reduce cramps
PILL	8 out of 100	Take by mouth	Every day at the same time	Can cause spotting for the first few months Periods may become lighter	Nausea, breast tenderness Risk for blood clots	May improve acne May reduce menstrual cramps
PATCH	9 out of 100	Put on skin	Weekly			
RING	9 out of 100	Put in vagina	Monthly			Lowers ovarian and uterine cancer risk
DIAPHRAGM	12 out of 100	Put in vagina with spermicide	Every time you have sex	No menstrual side effects	Allergic reaction, irritation	No hormones
EXTERNAL CONDOM	13 out of 100	Put over penis	Every time you have sex	No menstrual side effects	Allergic reaction, irritation	No hormones No prescription
VAGINAL GEL	14 out of 100	Put in vagina			Allergic reaction, irritation	No hormones
WITHDRAWAL	20 out of 100	Pull penis out of vagina before ejaculation			No side effects	No hormones Nothing to buy
INTERNAL CONDOM	21 out of 100	Put in vagina			Allergic reaction, irritation	No hormones No prescription
SPONGE	24 out of 100	Put in vagina				No hormones No prescription
FERTILITY AWARENESS-BASED METHODS	24 out of 100	Monitor fertility signs and abstain or use condoms on fertile days	Every day		No side effects	No hormones Increased awareness of fertility signs
SPERMICIDES	28 out of 100	Put in vagina	Every time you have sex		Allergic reaction, irritation	No hormones No prescription

MOST EFFECTIVE
MODERATELY EFFECTIVE
LEAST EFFECTIVE

*The number of women out of every 100 who have an unintended pregnancy within the first year of typical use of each method. Other methods of birth control: (1) Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception; and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy. Reference for effectiveness rates: Trussell J. Contraceptive failure in the United States. *Contraception* 2011; 83: 397-404. Sundaram A. Contraceptive failure in the United States. *Perspect Sex Reprod Health* 2012; 49:7-16. Other references available on www.rhntc.org. This publication was supported by the Office of Population Affairs (Grants FP79A00030, TP5AHD00006) and the Office on Women's Health (Grant ASTWH2009-96-01-06). The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

- 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.
- The provider should help the client identify potential factors in using the method(s) under consideration based on the following:
 - Social and behavioral factors: method perception by client, partner or peer, method compliance.
 - Intimate partner violence and sexual violence might impede correct/consistent contraception use.
 - Mental health, alcohol/substance use behaviors might affect correct/consistent contraception use.

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

STEP 4: Conduct a 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.24 and 27) states that “BP should be measured before initiation of combined hormonal contraceptives. In instances in which BP cannot be measured by a provider, BP measured in other settings can be reported by the woman to her provider”. Subsequently, at the time of other routine follow-up visits, assessment of BP is recommended, but again the SPR states that “BP measurement in other settings is acceptable”. Other settings may include BP measured on a home monitor or using a BP machine at a local pharmacy. If a client has a 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. The [current USPSTF recommendation](#) is: “Adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be rescreened every 3 to 5 years,” which provides an outer time limit for use of the last BP reading. ([COVID-19 and Family Planning Services FAQ | Reproductive Health National Training Center \(rhntc.org\)](#))
- **Weight, Height, and BMI:** Weight measurement is not needed to determine medical eligibility for any method of contraception because all methods generally can be used among obese clients. 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.
- **Assess the current pregnancy status** based on the medical history obtained as described above. Perform urine hCG pregnancy testing if clinically indicated, e.g., the client had unprotected sexual intercourse (USIC) after her LMP and ≥14 days have passed since the last USIC.
- **Clinical Breast Exam (CBE):** Documentation of the CBE is utilized for reporting in the Family Planning Annual Report (FPAR). Guidelines for providing CBE screening varies between nationally recognized organizations. The decision to provide CBE screening should be made between the clinician and client, using the following resources:

ACOG

Screening clinical breast examination may be offered to asymptomatic, average-risk women in the context of an informed, shared decision-making approach that recognizes the uncertainty of additional benefits and the possibility of adverse consequences of clinical breast examination beyond screening mammography. If performed for screening, intervals of every 1-3 years for women aged 25-39 years and annually for women 40 years and older are reasonable. The clinical breast examination continues to be a recommended part of evaluation of high-risk women and women with symptoms. (ACOG Number 179, July 2017). <https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Breast-Cancer-Risk-Assessment-and-Screening-in-Average-Risk-Women>

ACS

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

USPSTF

The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older (2016):

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening>

- **Pelvic Exam:** Indications for a bimanual/speculum pelvic examination for a client with 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. Family Planning has agreed to cover the cost of HPV testing in some circumstances. While co-testing is a good routine screening strategy, general use is not currently allowed under FPP due to program funding limitations. Please see section 4 for more detailed instructions regarding HPV testing.
 - Vulvar or vaginal complaints
 - Dysuria or other urinary symptoms
 - Dysmenorrhea unrelieved by treatment with non-steroidal anti-inflammatory drugs
 - Amenorrhea
 - Abnormal vaginal bleeding
 - Pelvic or lower abdominal pain
 - Exposure to an STI

- For **sterilization clients**, a physical examination including heart, lungs, abdomen, and genitalia is required as a part of comprehensive evaluation of the client's risk for surgery/anesthesia (see Section 2.3).

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

- Providers should 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, for methods not available onsite.
 - Begin contraception at the time of the visit rather than waiting for next menses ("Quickstart") if the provider can reasonably be certain that the client is not pregnant.

How to Be Reasonably Certain that a 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 [$\geq 85\%$] of feeds are breastfeeds), amenorrheic, and < 6 months postpartum.

Symptoms of Pregnancy:

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

- 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, etc.
- Help the client develop a plan for using the selected method correctly.
 - Providers should encourage clients to anticipate reasons why they might not use their chosen method(s) correctly/consistently and help them develop strategies to deal with these possibilities. For example, a client selecting OCPs may forget to take a pill and may want to use reminder systems such as daily text messages or cell phone alarms.
 - Side effects (e.g., irregular vaginal bleeding) are a primary reason for method discontinuation, so providers should discuss ways to deal with potential side effects.
- Develop an appropriate follow-up plan with the client to meet their individual needs. Recommended follow up visits for each birth control method is described in detail in Section 2 of this protocol.
- Use **teach-back method** to confirm client's understanding by asking the client to repeat back messages about risks, benefits, appropriate method use and follow up. Document (by checkbox/written statement) the client's repeat back messages as this provides an alternative to a written method-specific informed consent form.

B. Pregnancy Testing and Counseling Services: Gateway to Other FP Services

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

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

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

- A **medical history** that includes asking about date of last normal menstrual period (LMP), previous normal menstrual period (PMP), last USIC (since normal LMP), symptoms of pregnancy and any coexisting conditions (e.g., chronic medical illnesses, physical disability, psychiatric illness).
- A **pelvic exam** with a clinician if clinically indicated.
- In most cases, a qualitative urine **pregnancy test** will be sufficient. However, in certain cases, a clinician may consider a quantitative serum pregnancy test (at the client's own expense), if exact hCG levels would be helpful for diagnosis and management.
- The test results should be presented to the client, following the instructions in this section on page 44 if the test is positive. A client might wish to include their partner in the discussion; however, if a client chooses not to involve their partner, confidentiality must be assured.

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 recommendation summary is:

- Discussion of a **Reproductive Life Plan** (See Step 2.a of Section 1.2.H.A.)
- **Sexual health assessment** (See Step 2.c of Section 1.2.H.A.)
- **Medical History:**

For clients capable of pregnancy, the medical history includes:

- Reproductive Hx including poor birth outcomes (preterm, cesarean delivery, miscarriage, stillbirth)
- Chronic medical illnesses (e.g., DM, HTN, thyroid diseases)
- Environmental exposures, hazards and toxins (e.g., smoking, alcohol, other drugs)
- Medications (concerns are for medications that are known teratogens)
- Genetic conditions
- Family medical history.

For designated male at birth clients, 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, such as influenza and tetanus–diphtheria–pertussis (Tdap), measles, mumps, and rubella (MMR), varicella, pneumococcal, and meningococcal.
 - **Note:** Parental consent is required for immunization of a minor with the exception of Hep A, Hep B or HPV vaccines. Minors presenting for confidential services may consent for HPV, Hep A or Hep B vaccination (refer to the Immunization Protocol).
 - **Rubella status:** Documentation can be a self-reported history that the client capable of pregnancy has had a baby born in the U.S., personal immunization record, or a serological report. For clients with unknown rubella status, make a note in the client’s medical record of the lack of documented rubella immunity and recommend:
 - Immunization with MMR (**PHO staff:** please follow PHD/Immunization Program policy for adult MMR vaccine eligibility). Clients should be strongly counseled that pregnancy should be avoided for 1 month after MMR vaccine and should be provided an interim contraceptive method if necessary.
 - **Note:** Rubella serology done at the client’s own expense.
 - **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.
 - If possible, obese adult clients should be referred for intensive counseling and behavioral interventions to promote sustained weight loss. These interventions typically comprise 12 to 26 sessions in a year and include multiple behavioral management activities (e.g., group sessions, individual sessions, setting weight-loss goals, improving diet/nutrition, physical activity sessions, addressing barriers to change, active use of self-monitoring, and strategizing how to maintain lifestyle changes).
 - **Laboratory Screening Test for Diabetes:** Providers should follow the Select Panel on Preconception Care recommendations for testing to detect prediabetes/type 2 diabetes in asymptomatic clients who are overweight or obese (BMI \geq 25kg/m²) and who have one or more additional risk factor for diabetes, including a history of gestational diabetes mellitus. Clients who meet these criteria can be referred to their primary care provider for screening.
<https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes#fullrecommendationstart>
 - 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

Counseling for Persons Capable of Pregnancy

- Counseling is based on “Preconception Health and Instructions for an Optimal Pregnancy.” For additional information on preconception care, including counseling for each health topic, see <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 uterus and a history of oligomenorrhea (infrequent menstruation)
- Clients with a uterus and known or suspected uterine or tubal disease or endometriosis
- Clients capable of pregnancy with a designated male at birth sex partner known to be subfertile (the condition of being less than normally fertile though still capable of effecting fertilization)

A couple with known risk factors of 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.

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 Persons Capable of Pregnancy:

Medical History:

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

Physical examination (by a clinician):

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

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).

Basic Infertility Care for Designated Male at Birth Clients:

Medical History:

- Discuss the client's **Reproductive Life Plan**
- **Past medical history:** systemic medical illnesses (e.g., DM), prior surgeries, past infections
- **Reproductive Hx:** contraception, coital frequency/timing, duration of infertility, prior fertility
- **Sexual health assessment**
- **Medications** (prescription and nonprescription) and **allergies**
- **Lifestyle exposures** e.g., gonadal toxin including heat and the use of saunas or hot tubs
- **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, 7918 Jones Branch Road, Suite 300 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 Life Plan** (See Step 2.a of Section 1.2.H.A).
 - **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 contract states that the client must have a clinic visit to evaluate their RLP and provide a contraceptive method (including external condoms) to assist clients in preventing unintended pregnancy.
- Conduct a standard medical history and sexual health assessment (See Step 2.c of Section 1.2.H.A), and check immunization status (HPV and HBV).
- A pelvic exam is not indicated in patients with no symptoms suggestive of an STI. Genital exam in designated male at birth 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 <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

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).

C. HIV/AIDS: providers should follow NMDOH STD Program recommendations that:

- All clients aged 13–64 years be offered the HIV screening routinely.
Note: Clients who already know their HIV status and are not at high risk for HIV do not need to be offered screening/screened annually. History such as from clients who have given birth in the U.S. is useful in providing indirect evidence that the client may have already been screened for HIV during pregnancy.
- All persons likely to be at high risk for HIV who should be rescreened at least annually include:
 - Injection-drug users and their sex partners
 - Gay, bisexual men, other men who have sex with men (MSM) and transgender persons
 - Persons who exchange sex for money or drugs
 - Sex partners of HIV-infected persons
 - Persons who have been diagnosed with an STI

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

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

For FP Provider Agreement Sites (non-PHOs): Partners of clients who require EPT are not themselves Title X clients, therefore precluding clinics from dispensing them Title X 340B medications. (Title X and 340B federal Programs with which the State purchases antibiotics for STI treatment require that clients must have a face-to-face encounter with the provider in a Title X clinic or by telehealth.)

- 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, race, and ethnicity.
- Educational materials and phone conversations can also help people reduce their risk for getting or spreading 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 getting or spreading an STI.
- Reducing risks by helping clients develop skills to reduce the chances of getting an STI, which include:
 - Using latex condoms correctly and consistently including hands-on practice with a model & condoms.
 - Talking with partners about safer sex.
 - Training in common behavior change process such as problem-solving, decision making, and goal-setting.

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

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

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

One high-intensity behavioral counseling model that is similar to the contraceptive counseling model is Project Respect <https://www.cdc.gov/hiv/research/interventionresearch/rep/packages/respect.html>, which could be implemented in family planning settings. On-line training information is available at [Respect Workshop \(apa.org\)](https://www.apa.org); [Effective Interventions | HIV/AIDS | CDC](https://www.cdc.gov/hiv/aids)

F. RELATED PREVENTIVE HEALTH SERVICES

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

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

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

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

J. THE TRANSFER CLIENT

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

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

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

K. REFERRAL SERVICES

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

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 clinician's judgment.
- Referrals in cases of medical necessity, including for prenatal care for pregnant clients.
- 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.
- Prior to submitting the sterilization application to the State Office for approval, clinician will consult with the sterilization provider chosen by the client regarding medical conditions that are not conducive to the procedure or anesthesia. If the sterilization provider accepts the referral, document the communication in the medical record prior to submitting the sterilization application.

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

L. EMERGENCY SERVICES

To provide services for emergencies which arise outside of clinic hours, each Title X clinic should have medical backup through local after-hours providers. Contraceptive emergencies may include chest pain and dyspnea, intractable headache, or sudden onset of diplopia or blindness in pill, and vaginal ring users, and severe abdominal pain, fever, or severe or unexpected uterine bleeding in IUD users. All clients should be given emergency instructions at service initiation time. Sample forms are included on the website under forms: Client consents, handouts, and counseling tools.

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

Subjective and objective nursing assessment:

The PHN will:

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

How to Be Reasonably Certain that a 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:**

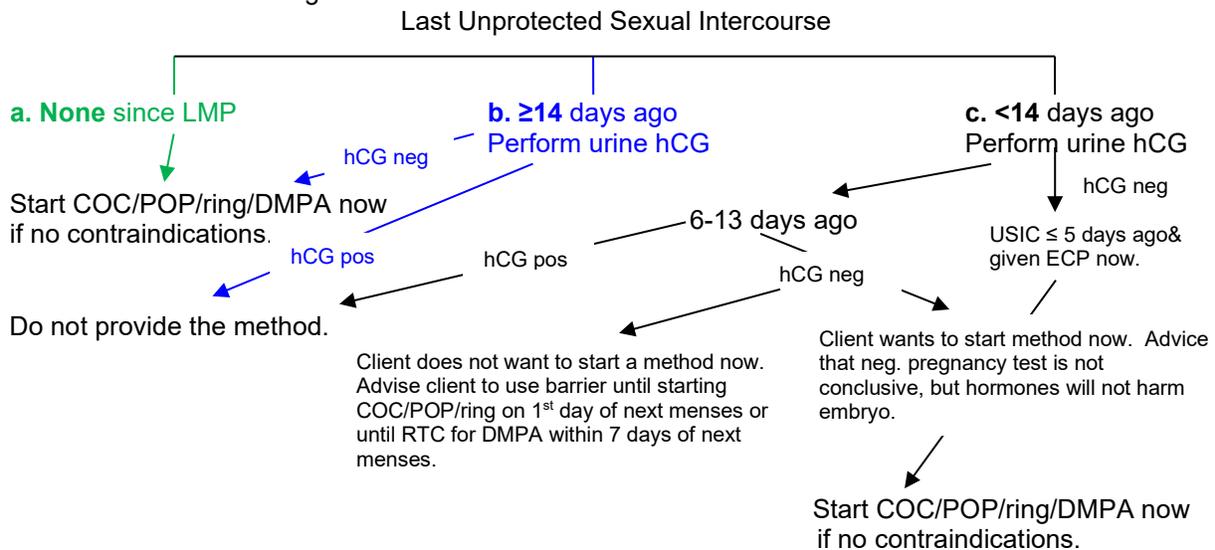
- Is ≤ 7 days after the start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception \
- Is ≤ 7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly 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*
- *nausea (with or without vomiting)*
- *fatigue (persistent)*
- *breast tenderness and enlargement*
- *increased frequency of urination*

Nursing Assessment of Normal and Abnormal Findings (also see algorithm below):

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



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

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

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

1. Client is female below age 40.
2. Client states that they are not currently pregnant and has passed the pregnancy assessment criteria above. If the client was recently pregnant, the client is >6 weeks postpartum.
3. Client's BP is < 140/90.
4. Client **does not** have **any** medical conditions or precautions listed below:
 - hypertension (controlled or uncontrolled)
 - migraines w/aura (blurred vision, spots/zig-zag lines or difficulty speaking/using an extremity)
 - multiple sclerosis with prolonged immobility
 - age ≥ 35 yr. and is smoking
 - multiple risk factors for arterial CVD (older age, diabetes, HTN, smoking, low HDL, high LDL, or high triglyceride levels)
 - stroke, blood clots (current or history of DVT/pulmonary embolism, acute or history of superficial venous thrombosis), major surgery that will immobilize her for ≥ 1 week
 - diabetes (with vascular disease or neuropathy, retinopathy, nephropathy, >20 yr. duration)
 - ischemic heart disease, peripartum cardiomyopathy, valvular heart disease (complicated)
 - breast cancer (current or history)
 - bariatric surgery (malabsorptive procedure; for COCs only), inflammatory bowel disease (ulcerative colitis/Crohn's) with an increased risk for VTE (e.g., those with active or extensive disease, surgery, immobilization, corticosteroid use, vitamin deficiencies, or fluid depletion)
 - viral hepatitis (acute/flare), cirrhosis (severe/decompensated), liver tumors (adenoma or malignant) complicated solid 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.)
 - Rifampicin/rifabutin, anticonvulsant therapy, fosamprenavir antiretroviral therapy.

Plan of care for COC/Vaginal Ring PHN Quickstart:

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

1. As described in Step 5 of Section 1.2.H.A, provide method-specific counseling and education using the corresponding Counseling Tool (found in Section 2 and under Forms on the FPP webpage) as well as help the client develop a plan for using the selected method correctly.
2. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
3. For Quickstart COCs, dispense 3 cycles of 28-days oral contraceptives for new users. Clients are allowed one Quickstart in a one-year period, with verbal orders as needed to continue the method until a visit with a clinician is scheduled.

4. **Directions for COC use:** Take one pill by mouth each day.

If client expresses a preference for a specific type, dispense a comparable available COCs within the same category (see OCP Substitute Table for full medication names in each OCP category). OCP categories are based on doses of estrogen (ethinyl estradiol) and types of progestins:

- 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

There are no wrong combined-hormonal pills to Quickstart a client with (as long as no contraindications discovered through Quickstart guide).

Once the clinician has ordered the OCPs, Nurses may only give that specific estrogen strength and progestin type, unless they consult with the clinician (no substitutions to another OCP).

5. **Directions for Vaginal Ring use:** Dispense 3 vaginal rings. Instruct client to leave the ring in place for 3 weeks in a row. After 3 full weeks remove the ring on the same day of the week you put it in. Wait 7 days and insert a new ring, even if you have not finished your menstrual period.
6. Following the Quickstart algorithm above, instruct client to start pills or vaginal ring either today or the first day of next menses (**administration timing is according to the client's preferred schedule, to support consistent method usage**). 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**.
7. Schedule the client for a PHO clinician visit **in clinic or through telehealth** within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription and other related prevention services. This visit should not be deferred beyond 3 months after the initial visit.
8. For a client who **does not qualify** for Quickstart supply,
 - Consult with PHO Clinician for:
 - Client whose menses are late or unsure if client is pregnant.
 - Client with medical precautions against COCs or vaginal rings.
 - Dispense spermicide and condoms with instructions for use as appropriate.
 - Schedule an earliest available appointment with a clinician within the next 2 weeks.
9. After the initial dispensing by the PHN, a clinician order is needed to either continue or change BCM, including switching OCP to a brand with different dosage of estrogen and/or type and dosage of progestin. Clients are allowed one Quickstart in a one-year period, with verbal orders as needed to continue the method until a visit with a clinician is scheduled.

QUICKSTART FOR DMPA

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

1. Client is not planning pregnancy within the next year.
2. Client states they are not pregnant now and has passed the pregnancy assessment criteria above.
3. Client's SBP is < 160 and DBP is <100
4. Client **does not** have **any** medical conditions or precautions listed below:
 - 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 vascular disease or neuropathy, retinopathy, nephropathy, >20 yr. duration)
 - Ischemic heart disease (current or history)
 - Breast cancer (current or history)
 - Cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
 - Lupus (positive/unknown antiphospholipid antibodies or severe thrombocytopenia)
 - 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

Plan of care for DMPA PHN Quickstart:

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

1. As described in Step 5 of Section 1.2.H.A, provide method-specific counseling and education using the corresponding Counseling Tool (found in Section 2 and under Forms on the FPP webpage) as well as help the client develop a plan for using the selected method correctly.
2. Counsel the patient about both intramuscular (IM) in clinic administration of DMPA 150 mg and home self-administration or in-clinic administration of subcutaneous (Sub-Q) DMPA 104 mg. For patients desiring self-administration of Sub-Q DMPA, let the patient know that they will start on a Sub-Q dose in clinic and schedule her for a clinician visit within 3 months.
3. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
4. For Quickstart DMPA, per the algorithm above, the first DMPA injection can be given at any time if it is reasonably certain that the woman is not pregnant (see Section 1, Pages 18-19) PHN will give or administer DMPA 150 mg by deep intramuscular injection or 104 mg by subcutaneous injection.
 - Instruct client not to rub/massage injection site.
 - If DMPA is started within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
 - If DMPA is started > 7 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. Provide spermicide & condoms with instructions to use as backup for 7 days. Return for pregnancy test if signs or symptoms of pregnancy or period does not occur at normal time.
 - Counsel client regarding importance of adequate daily calcium intake:
1,000 mg for clients over age 25 and 1,300 mg for adolescents to build bones.
 - Emphasize the importance of weight bearing exercise and refrain from smoking.
5. Schedule the client to return to clinic for a PHO clinician visit **or by telehealth** within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription and other related prevention services.

This visit should not be deferred beyond 3 months after the initial visit unless verbal orders from a clinician are given to continue method until a visit with a clinician is scheduled.

6. For a client who **does not qualify** for Quickstart supply,
 - Consult with PHO Clinician for:
 - Client whose menses are late or unsure if client is pregnant.
 - Client with medical precautions against DMPA.
 - New PHO client who is already on DMPA and early or late for their shot.
 - Dispense spermicide and condoms with instructions for use as appropriate.
 - Schedule an earliest available appointment with a clinician within the next 2 weeks.
7. After the initial PHN dispensing, a clinician order is needed. Patients are allowed one Quickstart in a one-year period, with verbal orders as needed to continue or change the method until a visit with a clinician.

QUICKSTART FOR PROGESTIN ONLY PILLS (POPs)

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

1. Client states they are not pregnant now and has passed the pregnancy assessment criteria above.
2. Client's SBP is < 160 and DBP is < 100 (POPs may be given if BP>160/100 if clinician order is obtained).
3. Client **does not** have **any** medical conditions or precautions listed below:
 - history of stroke
 - ischemic heart disease (current or history)
 - breast cancer (current or history)
 - bariatric surgery (malabsorptive procedure)
 - cirrhosis (severe/decompensated), liver tumors (adenoma or malignant)
 - lupus (positive/unknown antiphospholipid antibodies)
 - Rifampicin/rifabutin, anticonvulsant therapy.

Plan of care for POP PHN Quickstart:

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

1. As described in Step 5 of Section 1.2.H.A, provide method-specific counseling and education using the corresponding Counseling Tool (found in Section 2 and under Forms on the FPP webpage) as well as help the client develop a plan for using the selected method correctly.
2. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
3. Directions for POP use: Dispense 3 cycles of progestin only oral contraceptives. Instruct client to take one pill by mouth each day at the same time, with no hormone-free interval. Following the Quickstart algorithm above, instruct client to start pills today by taking first dose while in the office or at home. Give spermicide and condoms with instructions for use as backup for the first 7 days of pill pack and return for pregnancy test if period does not occur at normal time. Counsel that menses may change due to POPs.
4. Schedule the client to return to clinic for a PHO clinician visit **or by telehealth** within 3 months for assessment of suitability of the method for her, side effects counseling, one-year prescription from a PHO clinician and other related prevention services. This visit should not be deferred beyond 3 months after the initial visit.
5. For a client who **does not qualify** for Quickstart supply,
 - Consult with PHO clinician for:
 - Client whose menses are late or unsure if client is pregnant.
 - Client with medical precautions against POP.
 - Dispense spermicide and condoms with instructions for use as appropriate.
 - Schedule the earliest available appointment with a clinician within the next 2 weeks.
6. After the initial dispensing by the PHN, a PHO clinician order is needed. Patients are allowed one Quickstart in a one-year period, with verbal orders as needed to continue or change the method until a visit with a clinician is scheduled.

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 can prevent pregnancy after unprotected sexual intercourse (USIC) or after a contraceptive accident when taken as soon as possible within 120 hours after USIC. LNG ECP is most effective when used within the first 72 hours. Examples of indications are:

1. No contraceptive was used at the time of intercourse.
2. A couple attempting to practice periodic abstinence, inadvertently had intercourse.
3. An attempt at coitus interruptus resulted in ejaculation in the vagina or on external genitalia.
4. 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 14 days late for a DMPA injection or did not know date or type of previous injection.
 - 2 or more days late starting a new patch or vaginal ring cycle.
9. An IUD is expelled, or a woman cannot feel her IUD string or the IUD was removed less than 8 days after her last act of intercourse.
10. A woman is exposed to a possible teratogen. (e.g., has unprotected or inadequately protected intercourse while taking the prescription acne medicine "Accutane").
11. One future use Levonorgestrel Emergency Contraceptive Pill can be supplied to clients who are not using a most effective method without a clinician order.

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

Subjective and objective nursing assessment: The PHN will:

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

Note on dispensing ECP to designated male at birth FP clients (PHOs only):

- Dispensing ECP to male FP clients may be done on a case-by-case basis by a **clinician only**. Like other FP clients, document the man's comprehensive medical history, BP/wt/ht/BMI and counseling as outlined in Section 1.2.H.A. in the medical record (BEHR).
- The clinician will talk to the female partner on the phone to assess existing pregnancy risk (If unable to speak to the female partner, the clinician should not dispense ECP to male clients):
 - 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 from the female partner and telephone counseling in the male client's medical record.
 - Consider option of using telehealth services for this visit type.
- If dispensed to a male client under a clinician's order, the nurse will sign out the non-340B ECP under the male client's name in the Pharmacy log and write the male client's name on the label.

Nursing Assessment of Normal and Abnormal Findings:

Known pregnancy is the only absolute contraindication.

Plan of care for PHN Levonorgestrel ECP Quickstart:

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

Levonorgestrel prevents pregnancy by delaying/inhibiting ovulation. ECPs do not interrupt an established pregnancy. If ECP treatment fails, 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/m². The data are conflicting and too limited to reach a definitive conclusion as to whether effectiveness is reduced in this group. The most important factor affecting how well emergency contraception works is how quickly it is taken after unprotected sex. ECP is most effective when used within the first 72 hours.

ECPs may cause changes in menstrual bleeding for example, shortened menstrual cycle, heavier menstrual bleeding, and inter-menstrual bleeding. If her period does not start within 3 weeks after taking ECPs or if they are worried and/or feels pregnant, they should have a pregnancy test.
3. For clients who have an indication to take Levonorgestrel ECP and who are assessed by the PHN and found to be reasonably sure that they are not pregnant, the PHN will:

Give a single dose of 1.5 mg levonorgestrel to be taken by mouth now. No individual/additional clinician order is required. (One Future Use ECP is permitted without clinician order for clients who are not using a most effective method).
4. If vomiting occurs within 3 hours, another dose of ECP should be taken as soon as possible.
5. Emphasize that ECPs are for emergency use only. ECP should not be used in place of ongoing, correct use of regular contraceptives, which are more effective at preventing pregnancy. Counsel on alternate methods of birth control to prevent pregnancy in the future. For new (to FP) clients who desire ongoing effective contraception, offer Quickstart per Standing Order #1. For clients who are interested in long-term contraception, inform about an alternative emergency contraceptive (by referral or at DOH clinician discretion; See Section 2.2): ParaGard can be inserted within 5 days of the first act of USIC as an emergency contraceptive which reduces the risk of pregnancy by 99% and provides immediate, ongoing contraception for up to 12 years.
6. Document the client's recall and understanding of the counseling (based on the teach-back method) in the medical record.
7. Schedule a follow up Family Planning appointment as appropriate.

Conditions requiring notification of a Clinician:

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

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 counseling about reproductive life plan.

Subjective and objective nursing assessment:

1. The PHN will interview clients and:
 - A. Document the client's RLP, comprehensive medical and sexual health history as outlined in Step 2 of Section 1.2.H.A. in the medical record (BEHR). This includes LMP and PMP. *An unusually light or mistimed period may mean fertilization has already occurred before LMP.*
 - B. Review symptoms: Often the client themselves 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 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.

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

COUNSELING IF THE TEST IS NEGATIVE:

1. Counsel the client regarding the basics of the female reproductive cycle and the signs and symptoms of pregnancy.
2. Discuss other possible reasons for her symptoms such as medications like oral contraceptives, use of DMPA, medical conditions that may need further medical evaluation, or stress from illness or surgery.
3. If 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 — United States: a report of the CDC/ ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55(No. RR- 6) <http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf>.
 - b. Providers (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.
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. Written materials (e.g., CHOICES) may be used to counsel the client (posted on 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 (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.

CARRYING PREGNANCY TO TERM:

Discuss "Instructions for an Optimal Pregnancy" (under Forms on the FPP webpage). Client should receive prenatal care as soon as possible. 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 father is required if he is married to the mother or he establishes paternity.
- Consent to adoption can be signed any time after the baby is 48 hours old.

ABORTION/TERMINATION:

1. Although pregnancy options should be available to all clients, personnel working with Title X clients may be subject to prosecution if they (try to) coerce a Title X client to undergo an abortion.
2. If you do not feel comfortable discussing this option, have someone else counsel the client. Discuss arrangements for this with your supervisor in advance.
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 factual information (such as whether the provider accepts Medicaid, charges, etc.).
4. Staff may not 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 **immediate** evaluation by a clinician, either in your clinic or by referral to another clinic or emergency room:

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