

ALL METHODS, INITIAL AND/OR ANNUAL FAMILY PLANNING VISIT

GENERAL INFORMATION

A physical exam is not necessary to begin most methods of contraception. Occasionally a woman may request a method of contraception when clinic staffing or circumstances may not allow for the exam on the date of the clinic visit. Or, the client may ask to defer or delay a physical examination until a later visit. Collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

SUBJECTIVE FINDINGS

- The medical history is reviewed
- Complaints related to any previous or current use of the method or other complaints are noted

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening per current STD Program guidance.

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher (*See below for these counties.).
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast – Franklin and Marion
Upper Cumberland – Overton and Smith
Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

PLAN OF CARE FOR A DEFERRED EXAM VISIT

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral

- A comprehensive medical history for the initial client. The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4.
- The updated medical history for the annual client who needs new orders for her method but who has either missed her annual appointment or the clinic cannot provide the exam visit at this time. The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4. See the PTBMIS codes manual for the coding of this visit.
- For annual visits (or supply visits), consult for Pill side effects that have not responded to standard treatments (i.e., Pill at bedtime for nausea), complications, or warning signs. Record consultant instructions in chart.
- Blood pressure measurement
- Hemoglobin or hematocrit as indicated
- Name, dosage, route, and frequency of the contraceptive chosen
- The number of cycles given (up to 3 cycles)
- Informed consent form for an initial client or if giving the return client a new method
- Necessary health teaching to use method correctly and consistently
- Document health teaching/counseling on the table provided on the history form.
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment

PLAN OF CARE FOR AN EXAM VISIT

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The ongoing plan of care written by the examiner must be reviewed by the PHN at each visit. Possible components of the ongoing (NP or physician) plan of care can be found in The Family Planning Clinical Guidelines. The most current edition of Contraceptive Technology is also a good resource for the NP or physician plan of care.

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics should be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the topics at each visit until all topics, required and optional, are covered. Topics do not need to be repeated unless the client requests a review or the provider assesses that a review is in order. Address client counseling at each visit and base counseling/education on client needs and program requirements. The **REQUIRED TOPICS** are listed below. (For additional information see "Federal Program Guidelines for Project Grants for Family Planning Services, January 2001" or "Tennessee's Family Planning Clinical Guidelines January 2011, Visit Guidelines, Minimum Requirements".) Document health teaching on the table provided with the history form. Client Instruction sheets in English and Spanish are available in the appendix of Tennessee Family Planning Clinical Guidelines. There is also a teaching tool on the back of each consent form. Other tools include DH 0015 and DH 0015S entitled, “Get the Facts About HPV”; DH 0018 and DH 0018S entitled Family Planning is More Than You Think, and

Welcome To Your County Health Department – a "print your own" brochure available in English and Spanish. Contact the regional family planning program administrator to obtain a copy of this pdf document for your use.

Required counseling/education topics:

- Purpose and sequence of clinic procedures including the return visit schedule
- Health Department services (can be given in writing)
- Importance of recommended tests and screenings
- Information necessary to be able to give informed consent
- Information about all contraceptive methods, including fertility awareness-based methods and abstinence, (can be given to the client in writing)
- Information necessary to be able to use the chosen contraceptive method correctly and consistently including how to discontinue the method, back-up methods, and ECPs.
- Information necessary to be able to identify adverse reactions, common side effects and possible complications of the method selected and what to do in case any of these occur
- Education regarding safer sex, STDs and the importance of HIV/AIDS testing
- The importance of family involvement and how to recognize and resist sexual coercion (all adolescents on first visit)
- Self breast exam for females and self-testicular exam for males (can be given in writing)
- Emergency contraception (ECPs)
- Results of the history, physical examination, laboratory studies or instructions as to when test results will be available
- Emergency 24-hour telephone number and where emergency services can be obtained
- Appropriate referrals for additional services as needed
- Reproductive life planning

Optional counseling topics:

- Nutrition
- High-risk sexual behaviors related to STDs
- Pap smear testing and cervical cancer
- Disease prevention and maintenance of health
- Instructions regarding calcium supplementation as a precaution against osteoporosis (adolescents and young adults, 1200-1500 mg day; adults aged 25-50, 1000 mg day; post menopausal women, 1000-1500 mg day)
- Instructions regarding folic acid supplementation (400 mcg daily)
- Instructions regarding the ABC's of HIV prevention
- Counseling regarding avoidance of tobacco products
- Counseling regarding the adverse effects of alcohol and drug abuse
- Domestic violence and personal safety
- General safety such as seat belts, driving safety, helmets, gun safety etc.
- Unintended pregnancy prevention and its value in maintaining individual, child and family health (Highly recommended)
- Basic female and male anatomy and physiology (can be given in writing)

REFERENCES

Contraceptive Technology, Robert A. Hatcher, M.D., et al., Nineteenth Revised Edition, 2007

“Family Planning Clinical Guidelines”, Tennessee Department of Health, January 2011

“Program Guidelines for Project Grants for Family Planning Services,” Office of Population Affairs, U.S. DHHS, Health Service, 2001

"Guide to Clinical Preventive Services", Report of the U.S. Preventive Services Task Force, Williams and Wilkins, Third edition, 2002

CERVICAL CANCER SCREENING

GENERAL INFORMATION

How Do We Screen For Cervical Cancer?

The Tennessee Department of Health screens women for cervical cancer using liquid-based Pap testing. While both the conventional Pap smear and the liquid-based Pap test are equally effective, LB eliminates the need for annual screening in women with a negative result.

Clients should be prepared for cervical cancer screening. They will need the following information:

- Avoid douching for 2 days before the examination
- Avoid putting **ANYTHING** into the vagina for 2 days before the exam
- Make appointment for Pap test 1-2 weeks after the end of menses
- Whenever possible, have abnormal vaginal secretions treated before a Pap test is scheduled

What is HPV Testing

Human papilloma virus (HPV) testing refers to the identification of high risk HPV strains that can become precursors to cervical cancer. HPV testing is a tool used to triage atypical squamous cells, undetermined significance (ASC-US). HPV testing is not appropriate for women ages 20 years and younger. Please see the appropriate section below and the associated algorithm.

Who and When Do We Screen For Cervical Cancer?

The Tennessee Department of Health has several programs and services that offer cervical cancer screening. Beginning at age 21, the Family Planning Program offers screening to women who come to the health department for contraception. The Breast and Cervical Cancer Program offers screening to women who are no longer of reproductive age and who met program criteria. When counties provide full service prenatal care to women, they offer cervical cancer screening during pregnancy. The Primary Care Service also offers screening to women.

For all programs and services, Cervical Cancer screening begins at age 21.

Within the Family Planning Program, cervical cancer screening can be delayed at the client's request or as might be necessary due to the clinic's schedule. In either case, the physical exam and Pap test can be delayed for 3-6 months. **Always document in the chart why the Pap test was delayed.**

The client, who comes to the health department with a history of abnormal Pap test results, will sign the appropriate release of information in order for the health department

to send for and receive these records. Pap management will reflect consideration of these records, and may include (but is not limited to) consult with the assigned health officer and referral for follow-up.

While cervical cancer screening may not be necessary at all Family Planning Program visits, this does not mean that a pelvic exam will not be necessary. Other components of the reproductive health exam must be completed including the breast exam with teaching regarding self exams; pelvic exam including the visual exam and bimanual exam for normal anatomy/absence of pathology; and infection check including appropriate screening for sexually transmitted infections. A blood test for human immunodeficiency virus (HIV) should be encouraged.

Women Age 20 and Younger

Women age 20 years and younger will not receive cervical cancer screening because they essentially do not develop cervical cancer. All abnormal cervical cells found in this age group are the result of human papilloma virus (HPV). This age group almost always clears HPV in 24 months. Therefore, this age group does not require cervical cancer screening or HPV testing. For young women in this age group with abnormal cervical cells found prior to January 2011 or those who are inadvertently Pap tested after January 2011, conservative observational management should be the mainstay of care. See the Pap algorithm that addresses this special situation.

Women age 20 years and younger who are TennCare participants and are receiving the major components of a Child Health/EPSTD exam through one of the health department's programs, should also receive the developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

Women Age 21 Years and Older

Women age 21 years and older are given a liquid-based Pap test for cervical cancer screening. When the results of this test are normal, the test is repeated every two years. When the results are ASC-H, LSIL, HSIL or greater abnormality, the client is referred for colposcopy. When the results of Pap test are ASC-US, an HPV test is reflexively run by the laboratory. HPV positive tests are scheduled for colposcopy. If the HPV test is negative, the client will return in one year for another liquid-based Pap test. If the one-year Pap is normal, she returns to testing every two years. If it is abnormal, she is referred to colposcopy. **Please see the appropriate algorithm for this age group.**

Women age 30 and older, who have had 3 consecutive (not to exceed 60 months) satisfactory and normal Pap tests (either conventional or liquid), will be tested every 3 years.

PROCEDURE

Subjective

The client reports to a program or service within the health department for a service that could include cervical cancer screening.

Objective

The client meets the screening criteria established by the health department.

Assessment

The client is appropriate for cervical cancer screening. The timing of her screening test is based upon either her age or the results of her last Pap test or both.

Plan

- Review the Pap history in the chart.
- Based on history, prepare the necessary materials for a Pap test or for no Pap.
- If no Pap, document why in the chart.
- Explain to the client how she will receive her Pap results if a Pap is to be collected. If no Pap is to be collected, explain why.
- Follow-up the Pap results as required (see section that follows Health Teaching).
- Provide reproductive health teaching.

HEALTH TEACHING

- Explain that nearly all sexually active individuals will be exposed to HPV sometime in their lifetime; 80% by age 50. Most women will have a natural immune response and clear the HPV on their own. Only a few at risk individuals will eventually develop cervical cancer from HPV exposure. This process takes many years. Therefore, cervical cancer screening must continue throughout a woman's life.
- Provide an overview of all sexually transmitted infections.
- Promote and instruct in the correct use of condoms.
- Review the risks associated with early onset of sexual intercourse (i.e., first sexual intercourse before the age of 18) including increased likelihood of exposure to STDs and the increased risk of teen pregnancy and unintended pregnancy. Both teen pregnancy and unintended pregnancy are associated with infant mortality and morbidity.
- Review the risks associated with having multiple sexual partners.
- Review the risks associated with having a sexual partner who has multiple partners.

- Review the risks associated with having numerous sexual partners in a lifetime (serial monogamy).
- Review the risks associated with having a sexual partner who has had numerous partners, through serial monogamy, over their lifetime.
- Review the risks associated with having sexual intercourse without a latex male condom or female condom.
- Note that sexual behaviors such as oral or anal sex are also at risk for STDs.
- Review the increased risk of cervical cancer in women who smoke cigarettes.
- Review the risk to daughters of women who took the hormone diethylstilbestrol (DES) during their pregnancies (for clients born before 1970, DES was used primarily to prevent repeat miscarriages.) These daughters are at greater risk for developing vaginal and cervical cancers.
- Review the HPV vaccine and how it may benefit women.

MINIMUM REQUIREMENTS FOR PAP TEST AND HPV FOLLOW-UP

Federal Title X Guidelines state, “a procedure must be established to allow for client notification and adequate follow-up of abnormal laboratory results.” Pap test and HPV follow-up guidelines are to be used when clients have stated that they may be contacted by phone or at home. **Use the regional policy for notifying confidential clients.**

Abnormal Pap test and positive HPV tests are reviewed by the nurse-practitioner or physician. Follow-up orders are given to the assigned public health nurse(s) for follow-up and tracking. Recommendations by the pathologist are taken into consideration. Follow-up and tracking must comply with regional protocols and must be documented in the chart and/or in the electronic record (i.e., tracking).

Client Notification

A regional policy must be established for notification of "Negative for intraepithelial lesion or malignancy" or “negative for high-risk HPV”.

For Pap test results indicating the presence of an organism or condition that the practitioner or physician wishes to address or treat (such as yeast, numerous red blood cells or shift in bacterial flora), a minimum of two documented attempts to contact the client are required.

For Pap test reports indicating atypical squamous cells of undetermined significance or greater, a minimum of two documented attempts to contact the client are required.

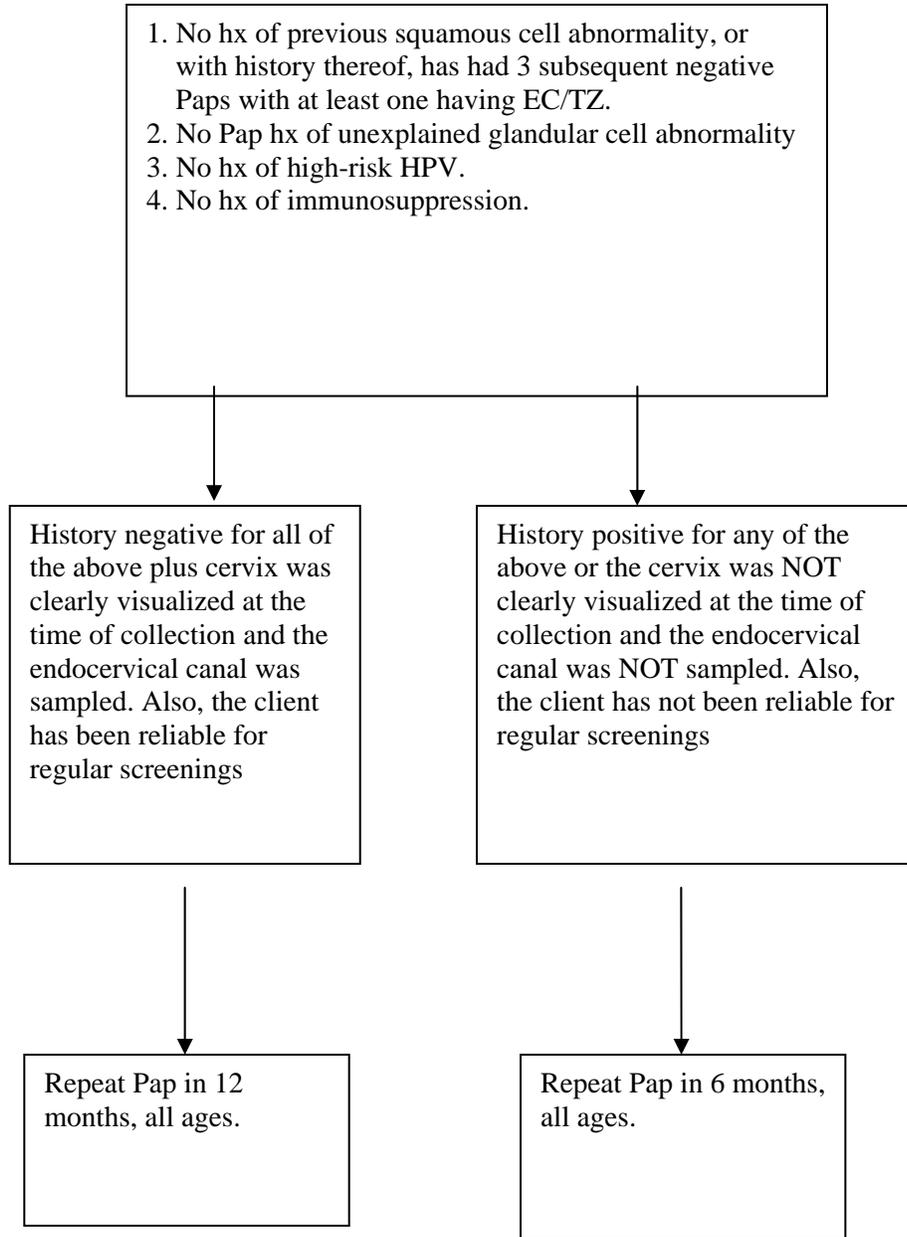
For Pap test or HPV reports indicating the need for referral to colposcopy, a minimum of two documented attempts to contact the client are required.

The sequence of attempts to contact the client proceeds as follows:

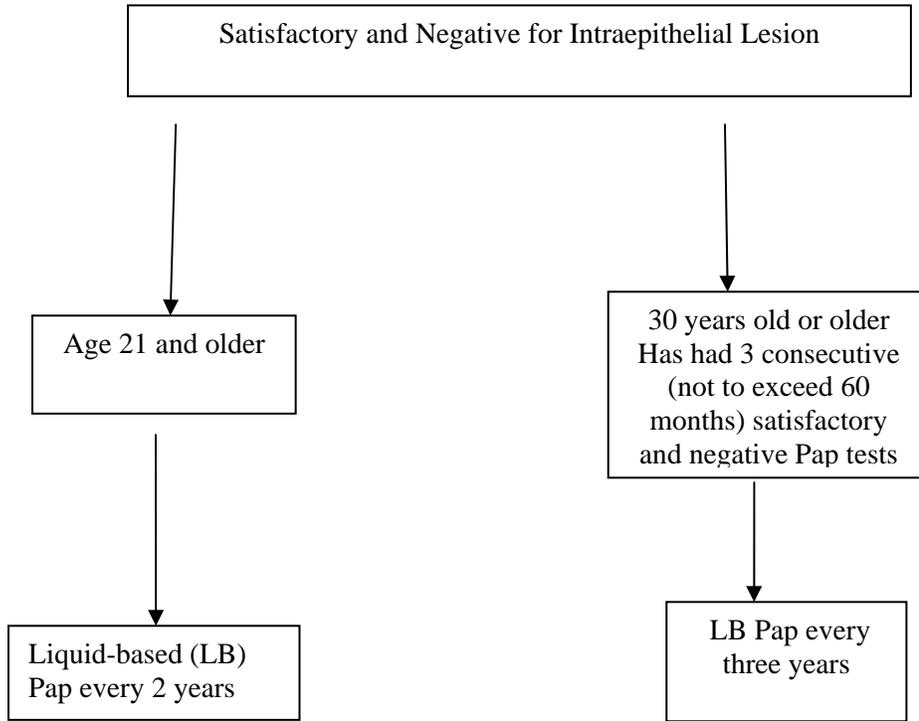
1. First attempt: Phone call, letter sent by first class mail, or direct contact during a clinic or home visit. Document attempt in the chart or the electronic record.
2. Second attempt: Registered letter or direct contact in clinic or by home visit. Document attempt in the chart or the electronic record.
3. Document all phone calls and letters in the chart or the electronic record. Regional policy determines the type of documentation related to the sending of the letters. Also regional policy determines whether further follow-up should occur if the client does not respond.
4. Clients with the epithelial cell abnormalities of atypical squamous cells cannot rule out high grade (ASC-H), high grade squamous intraepithelial lesion (HSIL), squamous cell carcinoma, atypical glandular cells, endocervical adenocarcinoma in situ, or any other malignant neoplasm are to be contacted **within 5 working days from the receipt of the laboratory report or the call from laboratory.** No minimum number of contacts can be established for these Pap findings. If the client cannot be contacted within the 5 working days, notify and seek direction from the assigned Health Officer. Every effort must be made to locate these clients including a home visit. Document all measures taken to make contact. Do not close the chart without Regional Office concurrence.

Within 6 weeks of the date the Pap test report or HPV test was reported by the laboratory, clinics should have an appropriate referral. Clinics are to document and facilitate any recommended follow-up. Clinics are not to coerce clients to undergo any consultation or procedure. However, clients must be informed of the possible consequences of failure to comply with recommended follow-up.

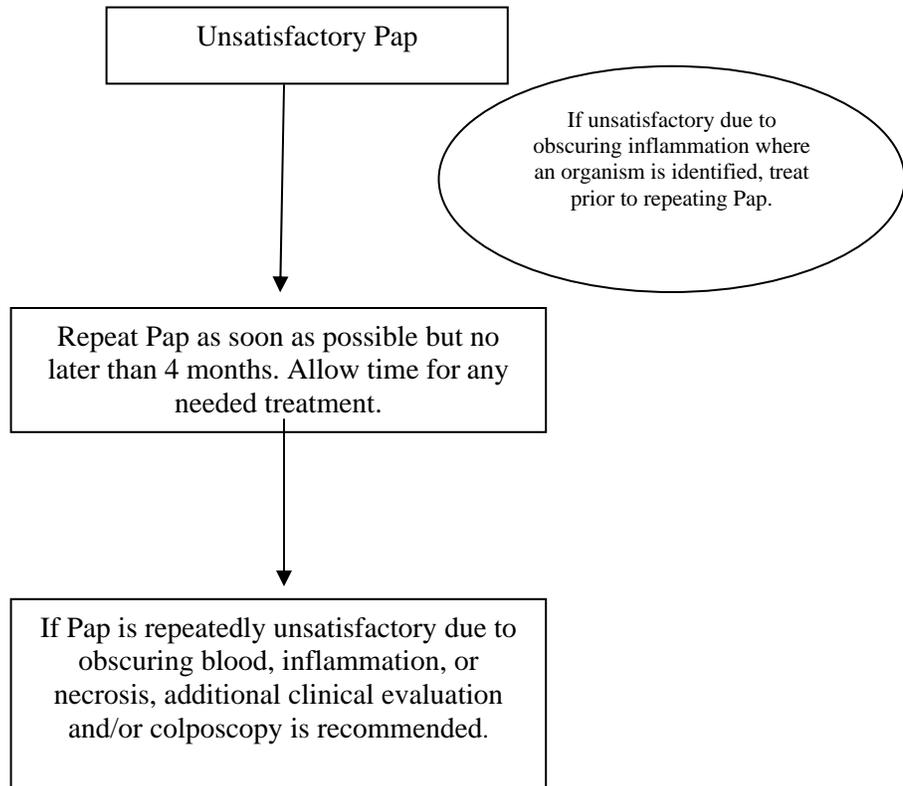
**Management Guidelines for
Satisfactory Pap test
With No Endocervical/Transformation Zone Component (EC/TZ)**



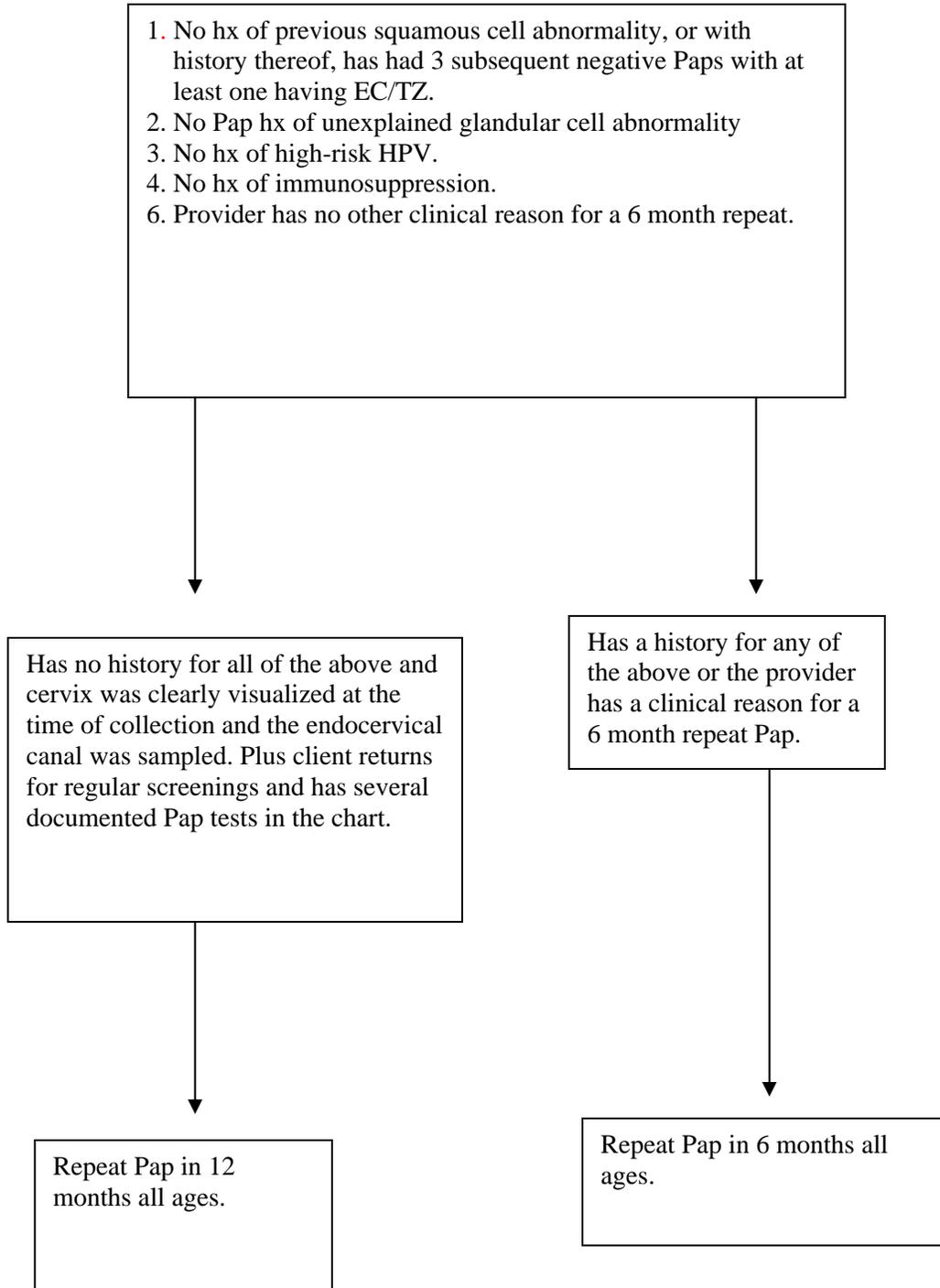
Management Guidelines for Women with Satisfactory Pap Test



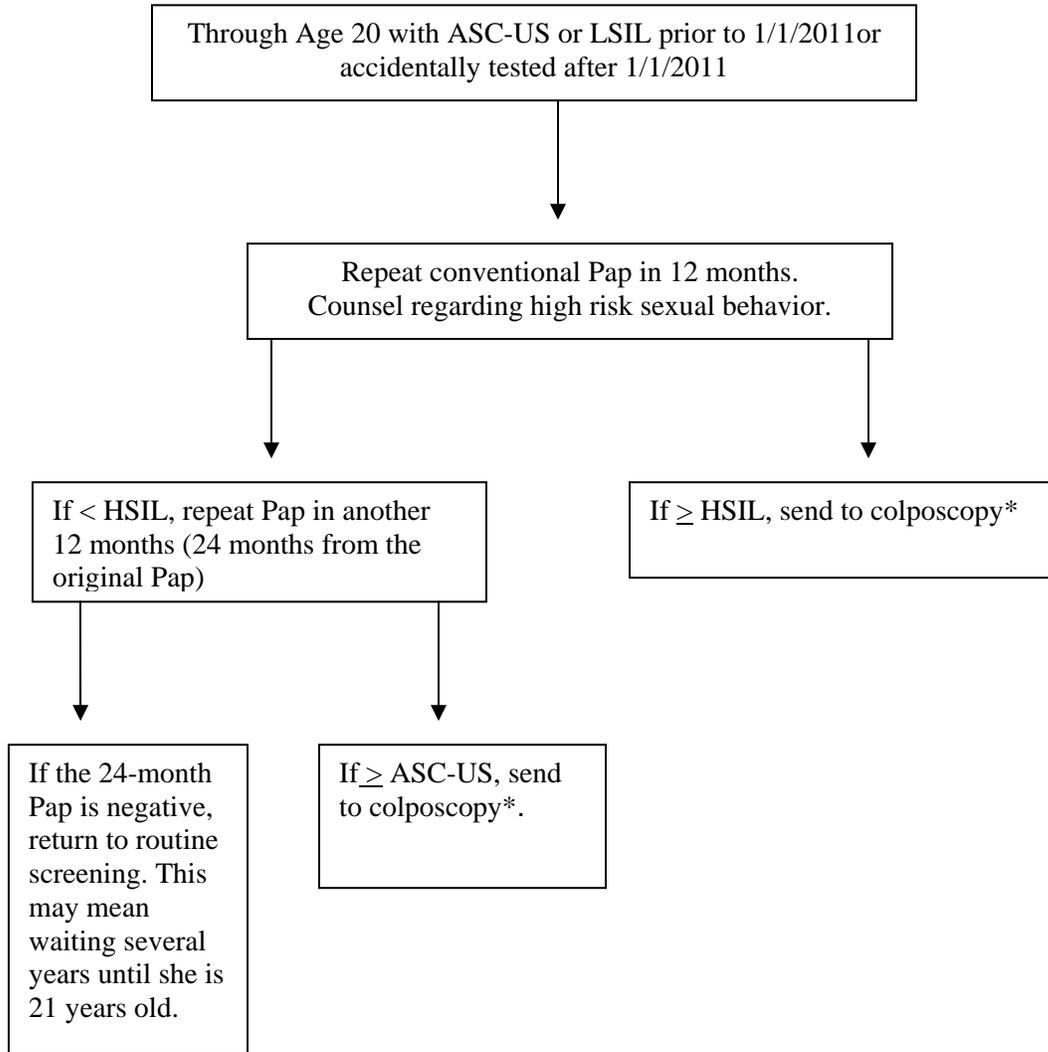
Management Guidelines for Women with Unsatisfactory Pap Test Results



**Management Guidelines for
Women with Pap Negative for Intraepithelial Lesion
With Numerous Red Blood Cells, Inflammatory Cells,
Reactive/Inflammatory Epithelial Cells, Air-Drying
Or Other Factors**

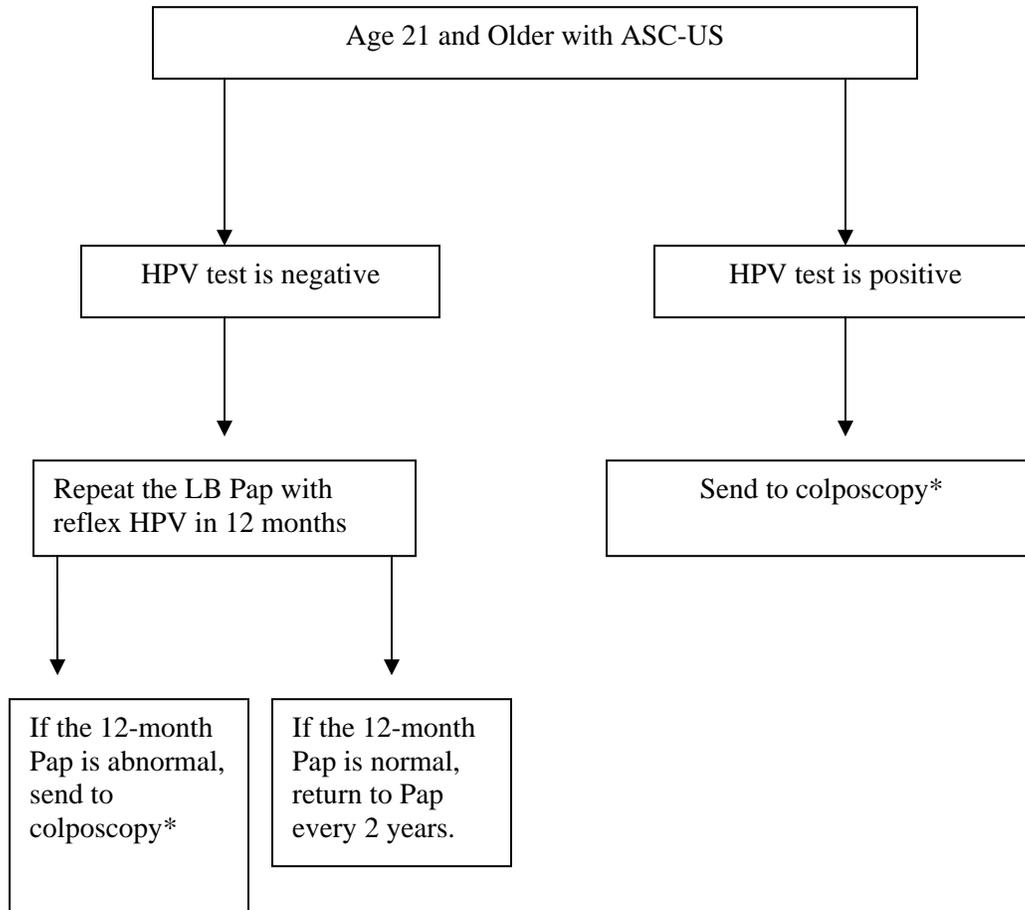


Management of Women Through Age 20 Years with ASC-US or LSIL who were Already in Follow-up as of January 2011 or in Situations of Inadvertent Non-adherence to Guidelines as of January 2011



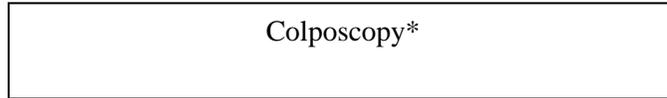
* The goal in this age group is to avoid excisional treatment. The colposcopist may elect to repeat the colposcopy and Pap every 6 months for 24 months if no CIN 2 or 3 was found on the colposcopy. After colposcopy, management is directed by the colposcopist.

**Management of Women Age 21 and Older with ASC-US
(Pap will be Liquid-based with Reflex HPV Test for ASC-US Results Only)**

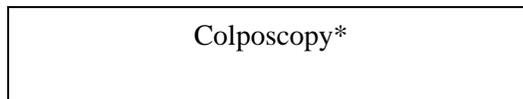


*After colposcopy, management is directed by the colposcopist

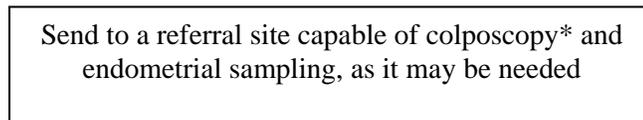
Management of Women HSIL or ASC-H, All Ages



Management of Women Age 21 and Older with LSIL including Women Who are Post Menopausal



Management of Women with Atypical Glandular Cells, All Ages



*After colposcopy, management is directed by the colposcopist.

REFERENCES

1. American College of Obstetricians and Gynecologists, ACOG Practice Bulletin, Number 109, December 2009.
2. American College of Obstetricians and Gynecologists, ACOG Committee Opinion, Number 463, August 2010
3. American College of Obstetricians and Gynecologists, ACOG Committee Opinion Number 330, April 2006
4. American Journal of Obstetrics and Gynecology, 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests, October 2007, pages 346-355.
5. American College of Obstetricians and Gynecologists, ACOG Committee Opinion Number 300, October 2004.
6. American Journal of Clinical Pathology, Volume 118, No. 5, ASCCP Patient Guidelines – Pap Test Specimen Adequacy and Quality Indicators, pages 714-718.
7. CA A Cancer Journal for Clinicians, Volume 52, No. 6, American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer, pages 342-362, November/December 2002.
8. Journal of the American Medical Association, Volume 287, No. 16, The Bethesda System, pages 2114-2119, April 24, 2002.
9. Journal of the American Medical Association, Volume 287, No. 16, 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities, pages 2120-2129, April 24, 2002.
10. U.S. Preventive Services Task Force, Screening for Cervical Cancer – Recommendations and Rational, www.ahrq.gov, January 2003.

COMBINED ORAL CONTRACEPTIVE PILLS

GENERAL INFORMATION

A physical exam is not necessary to begin oral contraceptives. While deferring the physical examination should not be routine, certain circumstances may exist which make it reasonable. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

SUBJECTIVE FINDINGS

How to use the U.S. Medical Eligibility Criteria category system

U.S. Medical Eligibility Criteria category system:

- 1 = May provide method
- 2 = May provide method with an APN or MD consult/approval
- 3 = May not provide method
- 4 = May not provide method

For the deferred exam, collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

U.S. Medical Eligibility Criteria for Combined Oral Contraceptives, Contraceptive Patch and Contraceptive Ring (I = to initiate and C = to continue)

| Condition | COC/Patch/Ring |
|-----------------------------|----------------|
| AGE | |
| Menarche to < 40 | 1 |
| Menarche to ≥ 40 | 2 |
| Menarche to <18 | |
| Age 18 to 45 | |
| Age > 45 | |
| Menarche to <20 | |
| Age ≥ 20 | |
| PARITY | |
| Nulliparous | 1 |
| Multiparous | 1 |
| PP BREASTFEEDING | |
| < 1 month postpartum | 3 |
| 1month to < 6 months | 2 |
| ≥ 6 months postpartum | 2 |
| PP NOT BREASTFEEDING | |
| < 21 days postpartum | 3 |
| ≥ 21 days postpartum | 1 |
| | |
| | |
| PP VAGINAL AND C/S | |

COMBINED ORAL CONTRACEPTIVE PILLS, (Continued)

| Condition | COC/Patch/Ring | |
|---|----------------|---------|
| DELIVERY | | |
| < 10 min after placenta is delivered | | |
| 10 min after placenta is delivered to < 4 wks | | |
| ≥ 4 wks | | |
| Puerperal sepsis | | |
| POSTABORTION | | |
| First Trimester | 1 | |
| Second Trimester | 1 | |
| Immediate post-septic AB | 1 | |
| | | |
| PAST ECTOPIC PREG | 1 | |
| | | |
| HISTORY OF PELVIC SURGEY | 1 | |
| SMOKING | | |
| Age < 35 years any amount | 2 | |
| Age ≥ 35 years & < 15 cigs/day | 3 | |
| Age ≥ 35 years & ≥ 15 cigs/day | 4 | |
| OBESITY | | |
| BMI ≥ 30 | 2 | |
| Age menarche to <18 yrs & BMI ≥ 30 | 2 | |
| BARIATRIC SURGERY | | |
| Restrictive-type (ie, banding) | 1 | |
| Malabsorbtive-type (ie, resection) | COC 3 | Pa/Ri 1 |
| CARDIOVASCULAR DISEASE (also see "other cardiac issues") | | |
| Multiple risk factors for arterial CVD | 3/4 | |
| Hypertension adequately controlled | 3 | |
| Systolic 140-159 or diastolic 90-99 | 3 | |
| Systolic ≥ 160 or diastolic ≥ 100 | 4 | |
| Vascular disease | 4 | |
| History of hypertension in a pregnancy but normal now | 2 | |
| HISTORY OF DVT/PE But not on coagulation therapy | | |
| History of estrogen associated DVT/PE | 4 | |
| History of pregnancy associated DVT/PE | 4 | |
| Idiopathic DVT/PE | 4 | |
| Known thrombophilia | 4 | |
| Active cancer (excluding non-melanoma skin ca) | 4 | |
| History of recurrent DVT/PE | 4 | |
| History of DVT/PE but no known risk factors | 3 | |
| Acute DVT/PE | 4 | |
| | | |
| | | |

COMBINED ORAL CONTRACEPTIVE PILLS, (Continued)

| Condition | COC/Patch/Ring |
|--|----------------|
| HISTORY OF DVT/PE ON COAGULATION THERAPY | |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>known</u> thrombophilia, active cancer (excluding non melanoma skin cancer), or history of recurrent DVT/PE | 4 |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>no known</u> risk factors as listed in cell above | 3 |
| OTHER DVT/PE RELATED ISSUES | |
| Family history of DVT/P in a 1 st degree relative | 2 |
| Major surgery with prolonged immobilization | 4 |
| Major surgery without prolonged immobilization | 2 |
| Minor surgery without immobilization | 1 |
| Known thrombogenic mutations | 4 |
| OTHER VASCULAR ISSUES | |
| Varicose veins | 1 |
| Superficial thrombophlebitis | 2 |
| History of cerebrovascular accident (stroke) | 4 |
| OTHER CARDIAC ISSUES | |
| Current or history of ischemic heart disease | 4 |
| Known hyperlipidemias | 2/3 |
| Uncomplicated valvular heart disease | 2 |
| Pulmonary hypertension | 4 |
| Risk of atrial fibrillation | 4 |
| History of subacute bacterial endocarditis | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function < 6 months | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function ≥ 6 months | 3 |
| Peripartum cardiomyopathy with moderate or severely impaired cardiac function | 4 |
| RHEUMATIC DISEASES | |
| Systemic lupus (SLE) with positive or unknown antiphospholipid antibodies | 4 |
| SLE with severe thrombocytopenia | 2 |
| SLE with immunosuppressive therapy | 2 |
| SLE without any of the above | 2 |

COMBINED ORAL CONTRACEPTIVE PILLS, (Continued)

| Condition | COC/Patch/Ring | |
|---|----------------|-----|
| Rheumatoid arthritis with immunosuppressive therapy | 2 | |
| Rheumatoid arthritis not on immunosuppressants | 2 | |
| NEUROLOGIC CONDITIONS | | |
| Mild or severe nonmigrainous headache | I=1 | C=2 |
| Migraine without aura age < 35 years | I=2 | C=3 |
| Migraine without aura age ≥ 35 years | I=3 | C=4 |
| Migraine with aura at any age | I=4 | C=4 |
| Epilepsy | 1 | |
| DEPRESSION | | |
| All depressive disorders | 1 | |
| REPRODUCTIVE TRACT DISEASE & DISORDERS | | |
| Irregular vaginal bleeding pattern without heavy bleeding | 1 | |
| Heavy or prolonged vaginal bleeding irregular & regular | 1 | |
| Unevaluated, unexplained, suspicious vaginal bleeding | 2 | |
| Endometriosis | 1 | |
| Benign ovarian tumors including cysts | 1 | |
| Sever dysmenorrhea | 1 | |
| Gestational trophoblastic disease decreasing BHCG | 1 | |
| Gestational trophoblastic disease persistently elevated BHCG or malignant disease | 1 | |
| Cervical extropion | 1 | |
| Undiagnosed breast mass | 2 | |
| Benign breast mass | 1 | |
| Family history of breast cancer | 1 | |
| Current breast cancer | 4 | |
| Past and no evidence of current disease for 5 years | 3 | |
| Cervical intraepithelial neoplasia | 2 | |
| Cervical cancer awaiting treatment | 2 | |
| Endometrial hyperplasia | 1 | |
| Endometrial Cancer | 1 | |
| Ovarian cancer | 1 | |
| Uterine fibroids | 1 | |
| Distorted uterine cavity | | |
| Cervical stenosis or laceration or other abnormality that does not distort the uterine cavity | | |
| Past PID with no current risk factors with subsequent pregnancy | 1 | |
| Past PID with no current risk factors without subsequent pregnancy | 1 | |
| Current PID, | 1 | |
| Current purulent cervicitis or | 1 | |

COMBINED ORAL CONTRACEPTIVE PILLS, (Continued)

| Condition | COC/Patch/Ring | |
|--|--|-----|
| chlamydial or gonorrhea infection | | |
| Other STDs excluding HIV and hepatitis | 1 | |
| Vaginitis including trichomonas and bacterial vaginosis | 1 | |
| Risk factors for STDs | 1 | |
| High risk for HIV | 1 | |
| HIV Infection | 1 | |
| AIDS clinically well on ARV therapy | Check drug interactions with these methods | |
| INFECTIONS | | |
| Uncomplicated Schistosomiasis | 1 | |
| Complicated schistosomiasis with fibrosis of the liver | 1 | |
| Nonpelvic tuberculosis | 1 | |
| Pelvic tuberculosis | 1 | |
| Malaria | 1 | |
| ENDOCRINE DISEASE | | |
| History of gestational diabetes | 1 | |
| Nonvascular noninsulin dependent diabetes | 2 | |
| Nonvascular insulin dependent diabetes | 2 | |
| Nephropathy, retinopathy, neuropathy with diabetes | 3/4 | |
| Other vascular disease or diabetes of ≥ 20 years | 3/4 | |
| Thyroid simple goiter | 1 | |
| Hyperthyroid | 1 | |
| hypothyroid | 1 | |
| GASTROINTESTINAL CONDITIONS | | |
| Inflammatory bowel diseases, ulcerative colitis, Crohn Disease | 2/3 | |
| Symptomatic gallbladder disease treated by cholecystectomy | 2 | |
| Symptomatic gallbladder disease medically treated | 3 | |
| Current, symptomatic gallbladder disease | 3 | |
| Asymptomatic gallbladder disease | 2 | |
| History of pregnancy-related cholestasis | 2 | |
| History of Past COC-related cholestasis | 3 | |
| Acute or flare – viral hepatitis | I=3/4 | C=2 |
| Viral hepatitis carrier | 1 | |
| Chronic viral hepatitis | 1 | |
| Mild compensated cirrhosis of the liver | 1 | |
| Sever decompensated cirrhosis of the liver | 4 | |

COMBINED ORAL CONTRACEPTIVE PILLS, (Continued)

| Condition | COC/Patch/Ring |
|---|----------------|
| Liver tumors focal nodular hyperplasia | 2 |
| Liver tumors hepatocellular adenoma | 4 |
| Malignant hepatoma | 3 |
| ANEMIAS | |
| Thalassemia | 1 |
| Sickle cell disease | 2 |
| Iron-deficiency anemia | 1 |
| SOLID ORGAN TRANSPLANTATION | |
| Complicated: acute or chronic graft failure; rejection, cardiac allograft vasculopathy | 4 |
| Uncomplicated | 2 |
| DRUG INTERACTIONS | |
| Antiretroviral therapy-NRTI's | 1 |
| Antiretroviral therapy-NNRTI's | 2 |
| Antiretroviral therapy-Ritonavir-boosted protease inhibitors | 3 |
| Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine | 3 |
| Anticonvulsant: lamotrigine | 3 |
| Broad spectrum antibiotics | 1 |
| Antifungals | 1 |
| Antiparasitics | 1 |
| Rifampicin or rifabutin | 3 |

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast – Franklin and Marion
Upper Cumberland – Overton and Smith
Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

ASSESSMENT

Appropriate to begin or continue COCs either with or without the physical examination.

PLAN OF CARE FOR DEFERRED EXAM VISIT

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- The medical history for the initial client, an updated medical history for the annual client who is deferring the exam, and an updated history for the supply client who is changing her method by deferred exam. (The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4 to dispense without an exam. A consult with a NP or MD may be needed for category 2.)
- Record consults with a NP or physician for category 2 found in the medical history before dispensing method without an exam.
- Blood pressure measurement, hemoglobin or hematocrit, weight
- Height for initial visit or annually for adolescents
- Name, dosage, route, and frequency of the oral contraceptive chosen
- The number of cycles given (up to 3 cycles)
- Informed consent
- Document necessary health teaching to start and use method correctly and consistently. (The preferred method of starting OCPs is “Quick Start”. See the Client Instruction Sheet available in English and Spanish found in the Appendix of the Family Planning Clinical Guidelines.)
- Document necessary health teaching regarding emergency warning signs:
 - A Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
 - C Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
 - H Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness or muscle weakness)
 - E Eye disturbances vision loss or blurring, also speech problems (cont. next page) (as might be seen with retinopathy or stroke)
 - S Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)
- Offer condoms for improved STD protection
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment or, in open access systems, note in the chart the date the client will be expected to return.

PLAN OF CARE FOR AN EXAM VISIT OR RESUPPLY VISIT

An ongoing plan of care will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The

ongoing plan of care written by the examiner must be reviewed and followed by the PHN at each visit.

For re-supply visits, consult NP or physician for complications and warning signs. Also consult for side effects that have not responded to standard treatments. Record consultant instructions in chart

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are also detailed there. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

REFERENCES

- Contraceptive Technology, Nineteenth Revised Edition, Robert A. Hatcher, M.D., et al, 2007.
A Pocket Guide to Managing Contraception, Hatcher, R.A., Nelson, A.L., Zieman, M. et. al., Tiger, Georgia: Bridging the Gap Foundation, 2010.
"Family Planning Program Clinical Guidelines," Tennessee Department of Health, 2011.
Center for Disease Control and Prevention, U.S Medical Eligibility Criteria for Contraceptive Use, 2010, MMWR early release, Volume 59, May 28, 2010.
"Program Guidelines for Project Grants for Family Planning Services," Office of Population Affairs, U.S. Department of Health and Human Services, January 2001.

CONDOMS, SPONGE, AND SPERMICIDAL AGENTS

GENERAL INFORMATION

Male Condoms

There are three types of male condoms:

Latex condom – a barrier to sperm and sexually transmitted infections

Polyurethane condom – also a barrier to sperm and sexually transmitted infection

Natural skin condom – a barrier to sperm ONLY

Female Condoms

There is one style of female condom sold under the trade name, FC2 Female Condom® by the Female Health Company (FHC). It is approved for both contraception and STD prevention.

Contraceptive Sponge

The Today Sponge® is the brand name of the contraceptive sponge currently available in the United States. The contraceptive sponge provides a spermicide and a polyurethane physical barrier to cover the cervix. The preservative in the Today Sponge® is metabisulfite. Persons with known allergy to sulfa drugs should not use the Today Sponge®.

Spermicides

Spermicides are also available over the counter and come in different formulations such as foam, gel, cream, film, suppository, or tablet. All are placed inside the vagina prior to sexual intercourse. Nonoxynol-9 is the active ingredient found in spermicides sold in the United States. Spermicides have been associated with vaginal irritation and microscopic ulceration that lead to easier transmission of HIV. **Clients at risk of HIV infection should never use a spermicide.**

SUBJECTIVE FINDINGS

A medical history is not required. If the client is participating in a visit with a nurse, collect a medical history

CONTRAINDICATIONS

Male and female clients may receive a supply of condoms and/or spermicide without collecting or reviewing the medical history. However, when possible:

- Inquire about latex, polyurethane or spermicide allergy with condom or spermicide users
- Sulfa allergy with sponge users.
- History of toxic shock syndrome for sponge users
- Inquire and counsel about sexual behaviors that increase STD/HIV risks such as multiple partners either consecutively or concurrently, partners who are strangers to the client, a client who has a partner known to have other partners, or a client whose partner has sex with men.

CAUTION

Nonprescriptive methods of contraception containing the spermicide nonoxynol-9 can increase the risk of HIV transmission.

OBJECTIVE FINDINGS

Male and female clients may receive a supply of male or female condoms and/or spermicide and/or contraceptive sponge without a physical examination or laboratory testing.

ASSESSMENT

Appropriate for condom and/or spermicide use

PLAN

- Provide health teaching either face to face or in writing
- Women will sign the consent for non-prescriptive method whether they are using a non-prescriptive as their method long term or short term (example, until they return for their implant or IUD)
- Provide requested method in adequate amount and include instruction for use and care
- Re-supply visits are based on the client's request
- Discuss, and if possible, provide emergency contraception with non-prescriptive barrier methods.
- Encourage consideration of a highly effective method of contraception.
- Discuss the benefits of planned pregnancy and the risks of unintended pregnancy

HEALTH TEACHING:

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are

detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol

REFERENCES

- Contraceptive Technology, Nineteenth Revised Edition, Robert A. Hatcher, M.D., et al, 2007.
- A Pocket Guide to Managing Contraception, Hatcher, R.A., Nelson, A.L., Ziemann, M. et. al., Tiger, Georgia: Bridging the Gap Foundation, 2010.
- "Family Planning Program Clinical Guidelines," Tennessee Department of Health, 2011.
- Today Sponge® package information, www.todaysponge.com 2010.
- "Program Guidelines for Project Grants for Family Planning Services," Office of Population Affairs, U.S. Department of Health and Human Services, January 2001.

CONTRACEPTIVE PATCH

GENERAL INFORMATION

A physical exam is not necessary to begin the contraceptive patch. While deferring the physical examination should not be routine, certain circumstances may exist which make it reasonable. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

See Family Planning Clinical Guidelines and the most current edition of Contraceptive Technology for method counseling details.

SUBJECTIVE FINDINGS

How to use the U.S. Medical Eligibility Criteria

U.S. Medical Eligibility Criteria category system:

- 1 = May provide method
- 2 = May provide method with an APN or MD consult/approval
- 3 = May not provide method
- 4 = May not provide method

For the deferred exam, collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

U.S. Medical Eligibility Criteria for Combined Oral Contraceptives, Contraceptive Patch and Contraceptive Ring (I = to initiate and C = to continue)

| Condition | COC/Patch/Ring |
|-----------------------------|----------------|
| AGE | |
| Menarche to < 40 | 1 |
| Menarche to \geq 40 | 2 |
| Menarche to <18 | |
| Age 18 to 45 | |
| Age > 45 | |
| Menarche to <20 | |
| Age \geq 20 | |
| PARITY | |
| Nulliparous | 1 |
| Multiparous | 1 |
| PP BREASTFEEDING | |
| < 1 month postpartum | 3 |
| 1month to < 6 months | 2 |
| \geq 6 months postpartum | 2 |
| PP NOT BREASTFEEDING | |
| < 21 days postpartum | 3 |
| \geq 21 days postpartum | 1 |
| | |

CONTRACEPTIVE PATCH (continued)

| Condition | COC/Patch/Ring | |
|---|----------------|---------|
| PP VAGINAL AND C/S DELIVERY | | |
| < 10 min after placenta is delivered | | |
| 10 min after placenta is delivered to < 4 wks | | |
| ≥ 4 wks | | |
| Puerperal sepsis | | |
| POSTABORTION | | |
| First Trimester | 1 | |
| Second Trimester | 1 | |
| Immediate post-septic AB | 1 | |
| PAST ECTOPIC PREG | 1 | |
| HISTORY OF PELVIC SURGEY | 1 | |
| SMOKING | | |
| Age < 35 years any amount | 2 | |
| Age ≥ 35 years & < 15 cigs/day | 3 | |
| Age ≥ 35 years & ≥ 15 cigs/day | 4 | |
| OBESITY | | |
| BMI ≥ 30 | 2 | |
| Age menarche to <18 yrs & BMI ≥ 30 | 2 | |
| BARIATRIC SURGERY | | |
| Restrictive-type (ie, banding) | 1 | |
| Malabsorbtive-type (ie, resection) | COC 3 | Pa/Ri 1 |
| CARDIOVASCULAR DISEASE (also see "other cardiac issues") | | |
| Multiple risk factors for arterial CVD | 3/4 | |
| Hypertension adequately controlled | 3 | |
| Systolic 140-159 or diastolic 90-99 | 3 | |
| Systolic ≥ 160 or diastolic ≥ 100 | 4 | |
| Vascular disease | 4 | |
| History of hypertension in a pregnancy but normal now | 2 | |
| HISTORY OF DVT/PE But not on coagulation therapy | | |
| History of estrogen associated DVT/PE | 4 | |
| History of pregnancy associated DVT/PE | 4 | |
| Idiopathic DVT/PE | 4 | |
| Known thrombophilia | 4 | |
| Active cancer (excluding non-melanoma skin ca) | 4 | |
| History of recurrent DVT/PE | 4 | |
| History of DVT/PE but no known risk factors | 3 | |
| Acute DVT/PE | 4 | |
| | | |
| | | |

CONTRACEPTIVE PATCH (continued)

| Condition | COC/Patch/Ring |
|--|----------------|
| HISTORY OF DVT/PE ON COAGULATION THERAPY | |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>known</u> thrombophilia, active cancer (excluding non melanoma skin cancer), or history of recurrent DVT/PE | 4 |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>no known</u> risk factors as listed in cell above | 3 |
| OTHER DVT/PE RELATED ISSUES | |
| Family history of DVT/P in a 1 st degree relative | 2 |
| Major surgery with prolonged immobilization | 4 |
| Major surgery without prolonged immobilization | 2 |
| Minor surgery without immobilization | 1 |
| Known thrombogenic mutations | 4 |
| OTHER VASCULAR ISSUES | |
| Varicose veins | 1 |
| Superficial thrombophlebitis | 2 |
| History of cerebrovascular accident (stroke) | 4 |
| OTHER CARDIAC ISSUES | |
| Current or history of ischemic heart disease | 4 |
| Known hyperlipidemias | 2/3 |
| Uncomplicated valvular heart disease | 2 |
| Pulmonary hypertension | 4 |
| Risk of atrial fibrillation | 4 |
| History of subacute bacterial endocarditis | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function < 6 months | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function ≥ 6 months | 3 |
| Peripartum cardiomyopathy with moderate or severely impaired cardiac function | 4 |
| RHEUMATIC DISEASES | |
| Systemic lupus (SLE) with positive or unknown antiphospholipid antibodies | 4 |
| SLE with severe thrombocytopenia | 2 |
| SLE with immunosuppressive therapy | 2 |
| SLE without any of the above | 2 |
| Rheumatoid arthritis with | 2 |

CONTRACEPTIVE PATCH (continued)

| Condition | COC/Patch/Ring | |
|---|----------------|-----|
| immunosuppressive therapy | | |
| Rheumatoid arthritis not on immunosuppressants | 2 | |
| NEUROLOGIC CONDITIONS | | |
| Mild or severe nonmigrainous headache | I=1 | C=2 |
| Migraine without aura age < 35 years | I=2 | C=3 |
| Migraine without aura age ≥ 35 years | I=3 | C=4 |
| Migraine with aura at any age | I=4 | C=4 |
| Epilepsy | 1 | |
| DEPRESSION | | |
| All depressive disorders | 1 | |
| REPRODUCTIVE TRACT DISEASE & DISORDERS | | |
| Irregular vaginal bleeding pattern without heavy bleeding | 1 | |
| Heavy or prolonged vaginal bleeding irregular & regular | 1 | |
| Unevaluated, unexplained, suspicious vaginal bleeding | 2 | |
| Endometriosis | 1 | |
| Benign ovarian tumors including cysts | 1 | |
| Sever dysmenorrhea | 1 | |
| Gestational trophoblastic disease decreasing BHCG | 1 | |
| Gestational trophoblastic disease persistently elevated BHCG or malignant disease | 1 | |
| Cervical extropion | 1 | |
| Undiagnosed breast mass | 2 | |
| Benign breast mass | 1 | |
| Family history of breast cancer | 1 | |
| Current breast cancer | 4 | |
| Past and no evidence of current disease for 5 years | 3 | |
| Cervical intraepithelial neoplasia | 2 | |
| Cervical cancer awaiting treatment | 2 | |
| Endometrial hyperplasia | 1 | |
| Endometrial Cancer | 1 | |
| Ovarian cancer | 1 | |
| Uterine fibroids | 1 | |
| Distorted uterine cavity | | |
| Cervical stenosis or laceration or other abnormality that does not distort the uterine cavity | | |
| Past PID with no current risk factors with subsequent pregnancy | 1 | |
| Past PID with no current risk factors without subsequent pregnancy | 1 | |
| Current PID, | 1 | |
| Current purulent cervicitis or chlamydial or gonorrhea infection | 1 | |
| Other STDs excluding HIV and | 1 | |

CONTRACEPTIVE PATCH (continued)

| Condition | COC/Patch/Ring | |
|--|--|-----|
| hepatitis | | |
| Vaginitis including trichomonas and bacterial vaginosis | 1 | |
| Risk factors for STDs | 1 | |
| High risk for HIV | 1 | |
| HIV Infection | 1 | |
| AIDS clinically well on ARV therapy | Check drug interactions with these methods | |
| INFECTIONS | | |
| Uncomplicated Schistosomiasis | 1 | |
| Complicated schistosomiasis with fibrosis of the liver | 1 | |
| Nonpelvic tuberculosis | 1 | |
| Pelvic tuberculosis | 1 | |
| Malaria | 1 | |
| ENDOCRINE DISEASE | | |
| History of gestational diabetes | 1 | |
| Nonvascular noninsulin dependent diabetes | 2 | |
| Nonvascular insulin dependent diabetes | 2 | |
| Nephropathy, retinopathy, neuropathy with diabetes | 3/4 | |
| Other vascular disease or diabetes of ≥ 20 years | 3/4 | |
| Thyroid simple goiter | 1 | |
| Hyperthyroid | 1 | |
| hypothyroid | 1 | |
| GASTROINTESTINAL CONDITIONS | | |
| Inflammatory bowel diseases, ulcerative colitis, Crohn Disease | 2/3 | |
| Symptomatic gallbladder disease treated by cholecystectomy | 2 | |
| Symptomatic gallbladder disease medically treated | 3 | |
| Current, symptomatic gallbladder disease | 3 | |
| Asymptomatic gallbladder disease | 2 | |
| History of pregnancy-related cholestasis | 2 | |
| History of Past COC-related cholestasis | 3 | |
| Acute or flare – viral hepatitis | I=3/4 | C=2 |
| Viral hepatitis carrier | 1 | |
| Chronic viral hepatitis | 1 | |
| Mild compensated cirrhosis of the liver | 1 | |
| Sever decompensated cirrhosis of the liver | 4 | |
| Liver tumors focal nodular hyperplasia | 2 | |
| Liver tumors hepatocellular adenoma | 4 | |

CONTRACEPTIVE PATCH (continued)

| Condition | COC/Patch/Ring |
|---|----------------|
| Malignant hepatoma | 3 |
| ANEMIAS | |
| Thalassemia | 1 |
| Sickle cell disease | 2 |
| Iron-deficiency anemia | 1 |
| SOLID ORGAN TRANSPLANTATION | |
| Complicated: acute or chronic graft failure; rejection, cardiac allograft vasculopathy | 4 |
| Uncomplicated | 2 |
| DRUG INTERACTIONS | |
| Antiretroviral therapy-NRTI's | 1 |
| Antiretroviral therapy-NNRTI's | 2 |
| Antiretroviral therapy-Ritonavir-boosted protease inhibitors | 3 |
| Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine | 3 |
| Anticonvulsant: lamotrigine | 3 |
| Broad spectrum antibiotics | 1 |
| Antifungals | 1 |
| Antiparasitics | 1 |
| Rifampicin or rifabutin | 3 |

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening.

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
 East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
 Southeast – Franklin and Marion
 Upper Cumberland – Overton and Smith
 Mid Cumberland – Sumner, Cheatham and Dickson
 South Central – Giles, Lawrence and Marshall
 West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
 Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
 Nashville/Davidson
 Knoxville/Knox
 Jackson/Madison

ASSESSMENT

Appropriate to begin or continue the contraceptive patch either with or without the physical examination.

Plan of Care for deferred exam visit

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- The medical history for the initial client, an updated medical history for the annual client who is deferring the exam, and an updated history for the supply client who is changing her method by deferred exam. (The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4 to dispense without an exam. A consult with a NP or MD may be needed for category 2.)
- Record consults with a NP or physician for category 2 found in the medical history before dispensing method without an exam.
- Blood pressure measurement, hemoglobin or hematocrit, weight
- Height for initial visit or annually for adolescents
- Name, dosage, route, and frequency of the oral contraceptive chosen
- The number of cycles given (up to 3 cycles)
- Informed consent
- Document necessary health teaching to start and use method correctly and consistently. (See Client Instruction Sheet found in Appendix of Family Planning Clinical Guidelines available in English and Spanish.)
- Document necessary health teaching regarding emergency warning signs:
 - A Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
 - C Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
 - H Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness or muscle weakness)
 - E Eye disturbances vision loss or blurring, also speech problems (cont. next page) (as might be seen with retinopathy or stroke)
 - S Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)
- Offer condoms for improved STD protection
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment or, in open access systems, note in the chart the date the client will be expected to return.

PLAN OF CARE FOR AN EXAM VISIT OR RESUPPLY VISIT

An ongoing plan of care will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The ongoing plan of care written by the examiner must be reviewed and followed by the PHN at each visit.

For re-supply visits, consult NP or physician for complications and warning signs. Also consult for side effects that have not responded to standard treatments. Record consultant instructions in chart

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol

REFERENCES

- Contraceptive Technology, Nineteenth Revised Edition, Robert A. Hatcher, M.D., et al, 2007.
 Contraceptive Technology Reports, A supplement to Contraceptive Technology Update, BB#S02103, May 2002.
 Contraceptive Technology Update, "FDA Revises Evra Safety Labeling Due To Increased Estrogen Levels", Volume 27, Number 1, January 2006.
A Pocket Guide to Managing Contraception, Hatcher, R.A., Nelson, A.L., Ziemann, M. et. al., Tiger, Georgia: Bridging the Gap Foundation, 2010.
 "Family Planning Program Clinical Guidelines," Tennessee Department of Health, 2011.
 Ortho Evra Package Insert, Ortho McNeil Pharmaceutical, Inc., November 2001.
 "Program Guidelines for Project Grants for Family Planning Services," Office of Population Affairs, U.S. Department of Health and Human Services, January 2001.
 Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR early release, Vol. 59, May 28, 2010.

DIAPHRAGM

GENERAL INFORMATION

A diaphragm cannot be supplied by deferred exam. because a fitting is required. As of August 2008, diaphragms by Ortho-McNeil Pharmaceuticals are made from silicone in the all-flex arcing spring style only. The size range has also changed. It is now available in sizes 65-80.

SUBJECTIVE FINDINGS

Collect medical history

Assess for allergy to spermicides

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening
-

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast – Franklin and Marion
Upper Cumberland – Overton and Smith
Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

PLAN OF CARE

A plan of care will be developed and signed by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The plan of care is developed in accordance with the protocol for the particular examiner. The plan of care written by the examiner must be reviewed and followed by the PHN at each visit.

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family

planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol

REFERENCES

A Pocket Guide to Managing Contraception, Hatcher, R. A., Nelson, A.L., Ziemann, M., et. al. Tiger, Georgia: Bridging the Gap Foundation, 2010
Contraceptive Technology, Nineteenth Edition, Robert A. Hatcher, MD, et. al.
Family Planning Clinical Guidelines, Tennessee Department of Health, January 2011
Ortho Diaphragm, FDA approved product literature, August 2008.

PRIMARY DYSMENORRHEA

GENERAL INFORMATION

Primary dysmenorrhea is defined as painful menstruation that begins with or shortly after menarche. It is physiologic in nature due to either excessive secretion of prostaglandin by the endometrium or structural abnormality of the uterus. Studies of uterine contractions with primary dysmenorrhea reveal uterine pressures that are similar to those found during the second stage of labor.

Secondary dysmenorrhea begins later in life and is the result of having developed other physical factors. Endometriosis is an example of secondary amenorrhea. Both primary and secondary dysmenorrhea can be debilitating.

SUBJECTIVE FINDINGS

The client complains of one or more of the following symptoms just before and/or as her menstrual period begins:

- Lower abdominal cramping pain with onset of menstrual flow
- Pain radiating to the lower back or down inner thigh
- Nausea, vomiting, urinary frequency, and/or diarrhea during first 48 hours of menses
- Headache, dizziness, chills
- Weakness or fainting (symptoms of vasomotor instability)

OBJECTIVE FINDINGS

- Normal blood pressure
- Normal temperature
- Normal Hgb or Hct
- The client is within 1-2 years of having started her menstrual cycles

ASSESSMENT

Primary Dysmenorrhea

PLAN

1. At the earliest sign or symptom of menstruation or 1-2 days before the onset of menses begin the following:
 - IBUPROFEN 400 mg every 4 hours until relief not to exceed 3.2 g/day **OR**

- NAPROXEN SODIUM 500 mg as an initial dose, then 250 mg every 6-8 hours as needed; not to exceed 1.25 g/day
2. Discuss oral contraceptive use with the client and consult with the APN or MD if the client would like to begin COC to treat her primary dysmenorrhea. DMPA and the levonorgestrel-releasing IUD also decrease menstrual pain and menstrual flow. A consult would be necessary for these as well.
 3. Other comfort measures:
 - Apply a warm heating pad to lower abdomen
 - Avoid constipation
 - Exercise regularly between menstrual cycles

Health Teaching:

- Review the signs and symptoms of toxic shock syndrome for tampon users
- Young women who are menstruating are of reproductive age and will benefit from information regarding reproductive health and human sexuality. These can be offered at time convenient for the client and the staff.

Referral Indicators:

- Severe cramping unrelieved by OTC analgesics that persists beyond the first 2 days and/or increases in severity throughout menses
- Dysmenorrhea with fever
- Tampon users who develop sudden onset of high fever, chills, sunburn-like rash, hypertension, vomiting, and diarrhea should immediately remove the tampon and be referred for emergency medical treatment
- Dysmenorrhea that begins later in life (years after menarche)

Follow-up:

- Patient will be asked to contact a health provider if no improvement in 48 hours

REFERENCES

1. Contraceptive Technology, Hatcher, et. al. 19th revised edition, 2007.

EMERGENCY CONTRACEPTIVE PILLS (ECPs)

GENERAL INFORMATION

Emergency contraceptive pills can be provided to clients by deferred exam. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

All clinics must have plans in place to provide ECPs on site to clients who request them. All clinics must have plans in place to educate clients regarding the availability of ECPs.

ECPs following rape and sexual abuse

The package label for ECPs recommends beginning ECPs within 72 hours of unprotected sexual intercourse. In instances of rape or sexual abuse that have occurred up to 120 hours ago, ECPs may still be effective. Giving ECPs after 72 hours is an off-label use but it is particularly important to make this use available to a woman in this difficult situation. Consult your health officer or NP for an order for this off-label use. Document the order in the chart. **Please note that for progestin-only ECPs with two tablets, another off-label use is to take both tablets at once. This use (of these products) requires an order from a physician or NP because of package labeling. One-tablet progestin only ECP products would require a separate order for 120 hour use.**

If the victim is underage, refer to *Health Services Administration (HSA) Policy Manual section 8.8* for direction regarding child abuse reporting. All citizens of Tennessee, including health care professionals, are required to report if they SUSPECT child abuse including child sexual abuse. The Department of Children’s Services (DCS) has established a central intake number: 1-877-237-0004 for reporting SUSPECTED child abuse or child sexual abuse. Tennessee citizens are required to report if they SUSPECT (child abuse or child sexual abuse), and it is the responsibility of DCS to decide whether or not the reported suspicion qualifies for investigation under Tennessee’s child abuse/child sexual abuse laws. DCS also has a website: at www.tennessee.gov/youth where the process for reporting SUSPECTED child abuse or child sexual abuse is described. The Child Protective Services section of the website provides the important reporting information. All nurses need to know the DCS central intake number for reporting SUSPECTED child abuse or child sexual abuse. Clinics are discouraged from defining what is or is not child abuse or child sexual abuse. Each individual citizen reports if they SUSPECT based on the situation as they observe it. DCS will decide if it qualifies for investigation under the law.

SUBJECTIVE FINDINGS

- Client reports unprotected sexual intercourse sometime in previous 72-120 hrs (note that beyond 72 hours the PHN will need a consult with APN or MD in order to dispense post 72 hours.)
- Record last menstrual period if known

Contraindications:

- A known established pregnancy (not that it is dangerous for the woman or the pregnancy but because ECPs cannot prevent an established pregnancy)
- Undiagnosed abnormal vaginal bleeding
- Allergy to the product

Caution:

According to the American College of Obstetricians and Gynecologists, there have been no reports of major cardiovascular or neurological side effects associated with estrogen containing ECPs; nevertheless, it may be preferable to choose a progestin-only ECP for clients with a history of the following:

- Heart attack
- Stroke
- Thrombophlebitis
- Blood clot in the brain, leg, lung, or eye

Instruct client to watch for **DANGER SIGNS** (“ACHES”) during the two weeks following the administration of ECPs:

- A** Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
- C** Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
- H** Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness or muscle weakness)
- E** Eye disturbances vision loss or blurring, also speech problems (as might be seen with retinopathy or stroke)
- S** Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)

OBJECTIVE FINDINGS

- Client is already late for her menstrual period; advise a pregnancy test
- Client is not late for her menstrual period; no pregnancy test needed

ASSESSMENT

Client requests ECPs and has no contraindications

PLAN OF CARE FOR PHN

- Physical examination and pregnancy testing are not required.
- Provide ECPs and document in chart.
- Consult health officer or NP before providing ECPs in an off-label regimen.
- Offer Family Planning clinic services on same day or offer an appointment.

- Provide literature and counseling on contraceptive methods and the benefits of consistent use of a regular contraceptive method. Most methods can be supplied at time of ECP visit for immediate use after completion of the ECP regimen.
- Clients without contraindications to combined hormonal methods can be given 3-month supply of the method and an appointment to return for her family planning physical exam (see deferred exam protocol); the client begins her method the day after emergency treatment is completed and continues with her method, as if the ECP treatment had been the beginning of a new cycle (she should use a back-up method for the first seven days of her contraceptive method).
- Counsel and educate according to consent form; sign consent form. There need be only one consent form in the chart for more than one request for ECPs.
- Encourage the client to eat or drink something with pills to prevent nausea and vomiting. **Nausea and vomiting is very unusual with progestin-only ECPs. Most women taking progestin-only ECPs will NOT require an anti-emetic.**
- Consult with health officers/local protocol for directives regarding care of client with emesis post ECP administration.
- Instruct client that nausea/emesis may occur with estrogen/progestin ECPs (some sites may have systems for providing prescriptive anti-emetics). Instruct client on the availability of OTC anti-nausea treatment options including the following:

| Choices of Non-prescriptive Anti-emetic Drugs | Dose | Timing of Administration |
|---|---|---|
| Meclizine hydrochloride (Dramamine II, Bonine) [the only 24 hour choice] | One or two 25 mg tablets | 1 hour before first ECP dose; repeat as needed in 24 hours |
| Diphenhydramine hydrochloride (Benadryl) | One or two 25 mg tablets | 1 hr before first ECP dose; repeat as needed q 4-6 hours |
| Dimenhydrinate (Dramamine) | One to two 50 mg tablets or 4 to 8 teaspoons liquid | 30 minutes to 1 hour before first ECP dose; repeat as needed every 4 to 6 hours |
| Cyclizine hydrochloride (Marezine) | One 50 mg tablet | 30 minutes before the first ECP dose; repeat as needed every 4 to 6 hours |

Provide emergency contraceptive pills (ECPs) from one of the following regimens:

| Brand | Pills per Dose Take 2 doses 12 hours apart | Ethinyl Estradiol per dose (mcg) | Norgestrel or Levonorgestrel (per dose) (mg) ^a |
|--|---|-------------------------------------|---|
| Alesse® | 5 pink pills | 100 | 0.5 |
| Aviane® | 5 orange pills | 100 | 0.5 |
| Cryselle® | 4 white pills | 120 | 0.6 |
| Enpresse® | 4 orange pills | 120 | 0.5 |
| Jolessa® | 4 pink pills | 120 | 0.6 |
| Lessina® | 5 pink pills | 100 | 0.5 |
| Levlen® | 4 light-orange pills | 120 | 0.6 |
| Levlite® | 5 pink pills | 100 | 0.5 |
| Levora® | 4 white pills | 120 | 0.6 |
| Lo Ovral® | 4 white pills | 120 | 0.6 |
| Low Ogestrel® | 4 white pills | 120 | 0.6 |
| Lutera® | 5 white pills | 100 | 0.5 |
| Nordette® | 4 light orange pills | 120 | 0.6 |
| Ogestrel® | 2 white pills | 100 | 0.5 |
| Ovral® | 2 white pills | 100 | 0.5 |
| Portia® | 4 pink pills | 120 | 0.6 |
| Quasense® | 4 white pills | 120 | 0.6 |
| Seasonale® | 4 pink pills | 120 | 0.6 |
| Seasonique® | 4 light blue-green pills | 120 | 0.6 |
| Trilevlen® | 4 yellow pills | 120 | 0.5 |
| Trivora® | 4 pink pills | 120 | 0.5 |
| Dedicated Emergency Contraception products | | | |
| Next Choice® | 2 peach pills | 0 | Levonorgestrel 0.75mg each tablet |
| Plan B One-step® | 1 pill and only 1 dose | 0 | Levonorgestrel 1.5 mg |
| Ella® | 1 pill, 1 dose, up to 120 hours after unprotected intercourse | 0 | Ulipristal acetate 30 mg |

^aThe progestin in Cryselle, Lo Ovral, Low Ogestrel, Ogestrel and Ovral is norgestrel which contains two isomers, only one of which is bioactive, the amount of norgestrel in each tablet is twice the amount of levonorgestrel.

HEALTH TEACHING:

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

REFERENCES

- American College of Obstetricians and Gynecologists (ACOG), "Emergency Contraception", ACOG Technical Bulletin, 69, December 2005.
- "Family Planning Program Clinical Guidelines", Tennessee Department of Health, January, 2011
- American Health Consultants, Contraceptive Technology Update: Emergency Contraception: New Regimens Eyed, 24(3), March 2003, p. 30-31.
- Grimes, D. A., Chaney, E. J., Connell, E. B., Creinin, M. D., Emans, S. J., Goldzieher, J. W., Hatcher, R. A., Trussell, J., Stewart, F., Cates, W., Stewart, G. K., Guest, F., & Kowal, D., Contraceptive Technology, Nineteenth Revised Edition, Irvington Publishers, Inc., New York, NY, 2007
- Hatcher, R. A., Nelson, A. L., Ziemann, M., et. al. A Pocket Guide to Managing Contraception. Tiger, Georgia: Bridging the Gap Foundation, 2010-2012.
- Package Insert Plan B One-Step®
- Package Insert Next Choice®
- Task Force on Postovulatory Methods of Fertility Regulation, "Randomized Controlled Trial of Levonorgestrel versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency Contraception", Lancet, p. 352, 428-433 1998.
- Tennessee Department of Health, Bureau of Health Services, Emergency Contraceptive Protocols, Memorandum from Spain, D., Long, W., & McCall, P., to Regional Directors and Regional Health Officers, June 2, 1995.
- Tennessee Department of Health, Bureau of Health Services, Guidelines for the Use of Emergency Contraceptive Pills, Memorandum from Long, W., Hagstrom, R., & Major, M., to

Regional Health Officers, Regional Nursing Directors, Regional and Agency Family Planning Administrators, November 8, 1994.

U.S. Department of Health and Human Services, Public Health Service, Office of Population Affairs, OPA Program Instruction Series, OPA 97-2: Emergency Contraception, April 23, 1997.

U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services, January 2001.*

FERTILITY AWARENESS-BASED METHODS (FAM)

GENERAL INFORMATION

Fertility awareness-based methods can be provided by deferred exam if the nurse is confident in her ability to teach the method. Otherwise she should defer to the NP or physician.

There are five different types of fertility awareness-based methods. Couples may elect to use more than one of these at a time. The methods are:

| Fertility Awareness-based Method | Synopsis |
|----------------------------------|--|
| Ovulation Method | This ovulation method relies on assessment of the cervical mucus by look, touch, and by the feeling of wetness at the vulva. |
| Symptothermal Method | The symptothermal method is a method that combines observation of cervical mucous with basal body temperature (BBT). |
| Calendar Method | The calendar rhythm method requires that a woman keep a record of the length of 6-12 menstrual cycles. Subtract 11 from the longest cycle to find the last fertile day and 18 from the shortest cycle to find the first fertile day. |
| Standard Days Method | The standard days method is only for women whose menstrual cycles are 26 to 32 days long. To simplify this method, the client may use a specially designed, color-coded string of beads, brand name CycleBeads®. |
| Simple Observation Method | Until a woman can say, "I do not have vaginal secretions today and I did not have secretions yesterday", she must consider herself fertile. |

For more detailed information, see Tennessee's Family Planning Clinical Guidelines and the most recent edition of Contraceptive Technology.

SUBJECTIVE FINDINGS

Collect and review medical history including obstetric and gynecologic history with emphasis on the menstrual cycle preferable for the previous 6-12 months.

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI

- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sick cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher . (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi

East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier

Southeast – Franklin and Marion

Upper Cumberland – Overton and Smith

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood,
Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

PLAN

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- The medical history for the initial client and an updated medical history for the annual client.
- For annual visits (or re-supply visits), consult NP or physician for problems that have not responded to standard FAM counseling. Record consultant instructions in chart.
- Blood pressure measurement, hemoglobin or hematocrit
- Name of the fertility awareness-based method chosen with summary of the instructions given for the particular method.
- Informed consent
- Necessary health teaching to use method correctly and consistently
- Document health teaching/counseling in chart.
- Offer condoms and/or contraceptive foam or film for and/or emergency contraception to use as back-up protection against unintended pregnancy.
- Date of the exam appointment

PLAN OF CARE FOR AN EXAM VISIT

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The ongoing plan of care written by the examiner must be reviewed at each visit and followed by the PHN. The suggested components of the ongoing (NP or physician) plan of care can be found in The Family Planning Clinical Guidelines. The most current edition of Contraceptive Technology is also a good resource for the NP or physician plan of care.

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each

visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol

REFERENCES

Contraceptive Technology, Hatcher, R.A., Trussell, J., Stewart, G.K., Kowal, D. Guest, F., Cates, W. & Policar, M., Nineteenth Edition, 2007

"Family Planning Clinical Guidelines" Tennessee Department of Health, January 2011

A Pocket Guide To Managing Contraception, Hatcher, R. A., et. al., . Tiger, Georgia: Bridging the Gap Foundation, 2010-2012.

www.cyclebeads.com

INTRAUTERINE DEVICE (IUD)

GENERAL INFORMATION

All PHNs must be able to discuss the intrauterine device (IUD) option with clients, provide the client with written information on the safety and effectiveness of IUDs, and answer any questions the client may have. All PHNs must know how to make IUD referrals. IUDs cannot be provided by deferred exam.

Before making an IUD referral, review the patient package insert (available on line at www.paragard.com listed on homepage top right or www.mirena.com under professional information, then educational materials) with the client and give it to her to read. Tell her to take the patient package insert with her to the IUD referral visit. Document in the chart that the patient package insert was reviewed with and given to the client.

Candidates for either IUD (levonorgestrel-releasing or copper-bearing) may have (but are not limited to) the following characteristics:

- Parous (Mirena® only)
- Nulliparous (Paragard only®)
- Interested in long-term, reversible, low-cost method
- Stable, monogamous relationship
- No recent history of STDs or PID (see package insert for both products as recommendation varies)
- No current evidence of active purulent cervicitis, gonorrhea, chlamydia, or other genital tract infection.
- No current risk factors for PID
- No known anatomic uterine anomalies
- No unexplained abnormal vaginal bleeding

SUBJECTIVE FINDINGS

Collect medical history for the NP or physician to review with the client.

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Physical examination¹ performed annually by examiner

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

- Height and weight for BMI
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening –new guidance 2010.

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
 East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
 Southeast – Franklin and Marion
 Upper Cumberland – Overton and Smith
 Mid Cumberland – Sumner, Cheatham and Dickson
 South Central – Giles, Lawrence and Marshall
 West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
 Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
 Nashville/Davidson

Knoxville/Knox
Jackson/Madison

ASSESSMENT

Possible candidate for IUD insertion/Candidate for IUD referral

PLAN

A **plan of care** will be developed and signed by either the PHN with gyn skills, the RN who graduated from a certificate program, the APN, or Physician (all referred to as “examiner”). The plan of care is developed in accordance with the protocol for the particular examiner. The plan of care written by the examiner must be reviewed and followed by the PHN at each visit. The suggested components of the examiner’s plan of care can be found in The Family Planning Clinical Guidelines. The most current edition of Contraceptive Technology is also a good resource for the examiner’s plan of care.

PHN with gyn skills will not insert either type of IUD. PHNs with gyn skills could perform the pre-insertion examination and collect the pre-insertion labs if requested to do so by the inserter.

INSTRUCTIONS

IUD insertion day instructions

- Provide written and oral instructions on the use of the IUD including name of the IUD, date of insertion, number of years the device is effective.
- Prior to insertion, assure informed consent using the patient package insert found packaged with the device (or online as noted above) and the teaching tool found on the back of the method specific consent form.
- With the inserter’s approval, advise client to take either aspirin 650 mg or acetaminophen 1000 mg by mouth., one hour prior to insertion.
- With the inserter’s approval, a prostaglandin inhibitor such as ibuprofen 400 mg. by mouth, repeat q 4-6 hrs prn can be used for post-insertion cramping.
- Advise client to bring someone with her to the clinic to provide a ride home in case she experiences pain or nausea immediately after insertion
- IUD users will need to check for the IUD string at the end of each period. After insertion, give the client the trimmed IUD strings to help her learn how they feel. She should report the absence of or any changes in the length of the strings. She should report the presence of the plastic portion of the IUD if it is palpable at the cervical os.
- Schedule IUD follow-up appointment in 4-12 weeks or as recommended by the inserter.
- Encourage the client to call or come in for any questions or problems.

IUD insertion charting and tracking

- Document in chart that the patient package insert was reviewed with and given to the client.
- Record name of IUD, lot number, date of insertion, date for removal, and expiration date in the chart.
- If region uses a problem list, record “IUD surveillance” on problem list with insertion date as

the date of onset.

IUD Warning Signs

All IUD clients must be counseled in and report the signs of pelvic infection. These include:

- Malodor
- Fever (101°F or more without obvious cause)
- Sudden severe abdominal or suprapubic pain
- Dyspareunia

Other **WARNING SIGNS** that IUD clients must report immediately include:

- Abdominal or pelvic pain (ectopic pregnancy)
- Prolonged or heavy bleeding/discharge/odor (infection)
- Painful sexual intercourse
- Fever or chills (infection)
- Any signs of pregnancy
- Exposure to gonorrhea/chlamydia/any STD
- Cannot feel string or can feel plastic
- Missed period or abnormal spotting or bleeding (infection or ectopic pregnancy)
- Flu-like illness (infection)

The following is a useful acronym for remember the IUD warning signs:

- P** Period late (pregnancy), abnormal spotting or bleeding
- A** Abdominal pain, pain with intercourse
- I** Infection exposure (any STD), abnormal discharge
- N** Not feeling well, fever, chills
- S** String missing, shorter or longer

IUDs do not protect against STDs and HIV. Advise clients to use latex condoms to decrease the risks of STDs. Also, counsel the client to avoid high risk sexual behaviors including multiple partners and having a sexual partner with multiple partners.

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, “counseling per protocol” is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

REFERENCES:

American College of Obstetricians and Gynecologists, “Intrauterine Devices”, Number 59, Jan 2005
Contraceptive Technology, Nineteenth-Revised Edition, 2007, Robert A. Hatcher, MD et. al.
Family Planning Clinical Guidelines, Tennessee Department of Health, 2011.
ParaGard T 380A, Intrauterine Copper Contraceptive, Prescribing Information, Duramed Pharmaceuticals, Inc., May 2006.
Mirena Intrauterine System, Prescribing Information, Bayer HealthCare Pharmaceuticals, July 2008.
A Pocket Guide to Managing Contraception, Hatcher, R. A., Nelson, A. L., Ziemann, A., et al., . Tiger, Georgia: Bridging the Gap Foundation, 2010-2012.
www.paragard.com
www.mirena.com
Center for Disease Control and Prevention, U.S Medical Eligibility Criteria for Contraceptive Use, 2010, MMWR early release, Volume 59, May 28, 2010.

PREGNANCY TEST

GENERAL INFORMATION

Infant Mortality reduction is a Department of Health priority and therefore the pregnancy test visit is a high priority visit. Patients requesting pregnancy tests at the Health Department should be tested on that day and only deferred if absolutely necessary. Pregnancy testing must be performed according to the *Pregnancy Testing Guidelines* contained in the Family Planning Clinical Guidelines. All women requesting a pregnancy test are eligible for this service regardless of insurance status.

Chlamydia and gonorrhea are STDs that can affect long term fertility and the health of any current pregnancy. Early detection and treatment can preserve fertility and improve pregnancy outcome.

Tennessee STD Program standards regarding the chlamydia/gonorrhea test at the time of the pregnancy test are as follows:

All women under age 30 reporting to clinic for a urine pregnancy test should be offered chlamydia and gonorrhea screening from their pregnancy test urine sample. Considering the sequelae that might occur in the mother and neonate if the infection persists, repeat testing is recommended 4 - 6 weeks after completion of therapy for all pregnant women to ensure therapeutic cure.

If the gonorrhea/chlamydia test is positive, refer to the treatment guidelines found in the PHN Protocol for Chlamydia and Gonorrhea and Chlamydia, Partner Delivered Treatment. Obtain informed consent and forward the record to the prenatal care provider. The prenatal care provider is responsible for the test of cure.

SUBJECTIVE FINDINGS

Date of LMP

History of unprotected coitus since LMP

Symptoms of pregnancy and date symptoms appeared:

- Breast tenderness
- Fatigue
- Nausea
- Urinary frequency

History of STDs

Current family planning method if any

Any over-the-counter and/or prescription drug use

Any alcohol use and/or substance abuse

Is she smoking cigarettes?

Does she want to be pregnant now? Does she want to be pregnant in the future? If so, when?

OBJECTIVE FINDINGS

Positive or negative pregnancy test

ASSESSMENT

Pregnancy test positive, pregnancy intended
Pregnancy test positive, pregnancy unintended
Pregnancy test negative, pregnancy desired
Pregnancy test negative, pregnancy not desired

PLAN OF CARE

- Inform client that pregnancy cannot be accurately diagnosed, nor gestational age determined, through laboratory testing alone; that pregnancy diagnosis consists of a history, pregnancy test, and physical examination, including pelvic examination
- Discuss test results clearly and objectively
- Complete relevant forms and document counseling in chart
- If pregnancy test is negative, repeat the pregnancy test if no menses in two weeks
- Compile and keep current a county specific resource list for referrals
- Inform the client that chlamydia and gonorrhea are STDs that can affect long term fertility and the health of any current pregnancy. Early detection and treatment can preserve fertility and improve pregnancy outcome.

If the pregnancy test is negative and pregnancy is not desired:

- Explore the client's feelings about the pregnancy test result
- Discuss contraception
- Discuss emergency contraception
- Provide condoms
- Offer the client a brochure on family planning program services and/or explain program services
- If the client is an adolescent, encourage her to discuss contraceptive use with parent(s) or another responsible family member
- If possible, admit the client to the family planning program that day, especially if she is an adolescent. If a clinic opening is not available that day, waive the physical exam and if there are no contraindications in her medical history, give 3 months supply of birth control method. Schedule a physical exam within 3 months. See PHN Protocol for the method of choice.
- Consider creating a tickler file (manual or PTBMIS) for this at risk client and follow-up as may be needed for an appropriate period of time (nursing judgment).

If the pregnancy test is negative and pregnancy is desired:

- Explore the client's feelings about the pregnancy test result
- Discuss the menstrual cycle and fertile days
 - Provide pre-conception counseling including:
 - Nutrition and the importance of folic acid
 - The importance of dental care to good pregnancy outcomes
 - The impact of smoking during pregnancy and after pregnancy

- The importance of early prenatal care
- The impact of alcohol, medications, and substance abuse during pregnancy
- The impact of sexually transmitted diseases on pregnancy
- Review services available at the local health department including WIC, presumptive eligibility for TennCare, and the HUGS home visiting program
- Encourage an adolescent to discuss their desire for pregnancy with a parent or another responsible family member; explore why they want to be pregnant
- Consider creating a tickler file (manual or PTBMIS) for the at-risk adolescent and follow-up as needed for an appropriate period of time (nursing judgment).

If the pregnancy test is positive and the pregnancy is desired:

- Discuss the importance of early prenatal care
- Enroll eligible clients for presumptive eligibility for TennCare
- Find a prenatal care resource if no private insurance and not TennCare eligible
- Enroll eligible clients for WIC
- Enroll eligible clients for HUGS
- Discuss nutrition, prenatal vitamins, and the importance of folic acid
- Discuss the importance of dental care to good pregnancy outcomes
- Make a dental referral
- Discuss the impact of smoking during pregnancy and after pregnancy
- Discuss the impact of alcohol, medications, and substance abuse during pregnancy
- Discuss the impact of sexually transmitted diseases on pregnancy

If the pregnancy test is positive and the pregnancy is not desired:

- Explore the client's feelings about the pregnancy test result
- Discuss termination options and review resources in the local area
- Discuss adoption as an option and review resources in the local area
- Discuss parenting as an option
- All clients need the information regarding good health practices in pregnancy (listed under test positive/pregnancy desired) until their decision regarding the pregnancy is made. Give as complete information as seems appropriate for the given client. Offer her the opportunity to return for further counseling; discuss the possibility of her bringing in her partner, a friend, or a family member.
- Encourage adolescents to speak with a parent or other responsible family member as soon as possible
- Consider whether or not a mental health referral is needed
- Consider creating a tickler file (manual or PTBMIS) for these at risk clients and follow-up for an appropriate period of time (nursing judgment)
- Make a HUGS referral if this pregnancy is continued

REFERENCES

- Tennessee Department of Health, "Family Planning Clinical Guidelines", January 2011
- U.S. Department of Health and Human Services, Public Health Service, Health Service Administration, Bureau of Community Health Services Program, *Program Guidelines For Project Grants For Family Planning*, 2001
- U.S. Department of Health and Human Services, Public Health Service, Standards of Compliance for Abortion-Related Services in Family Planning Service Projects, *Federal Register* 58(23), February 5, 1993.

Options Counseling Guide

Explore the patient's feelings about the pregnancy. If the patient is unsure of how to proceed with the pregnancy, it is the nurse's responsibility to explore all available options with the client. Assist the client in identifying health, social, and economic consequences of each option. It is important to introduce all options even if the client does not mention each one. Avoid personal biases.

Prenatal care and delivery

- Explain the system for prenatal care through Health Department, if offered
- Refer to HUGS home visiting program
- Refer to WIC
- Assess for Presumptive Eligibility for TennCare and enroll if eligible
- Explain the system for prenatal care in the private sector
- Find a prenatal care resource if no private insurance and not TennCare eligible
- Review danger signs of pregnancy, including signs and symptoms of a threatened miscarriage or ectopic pregnancy
 - Bleeding
 - Spotting
 - Lower abdominal pain
- Discuss nutrition, prenatal vitamins, and the importance of folic acid
- Discuss the importance of dental care to good pregnancy outcomes
- Make a dental referral
- Discuss the impact of smoking during pregnancy and after pregnancy
- Discuss the impact of alcohol, medications, and substance abuse during pregnancy
- Discuss the impact of sexually transmitted diseases on pregnancy

Infant care

- Discuss day care needs if returning to school or employment
- Explore family support system
- Explore the daily needs of a newborn and its impact on lifestyle

Foster Care or Adoption

- Refer to Department of Human Services
- Refer to local private agencies
- Offer to meet again to discuss further as questions may develop later

Pregnancy termination

- Answer patient's questions. Avoid personal biases.
- Remember that abortion is a legal option
- Remember that no state or federal funds are available
- Have a list of providers available
- Discuss the timetable for decision-making (obtaining pregnancy termination during the first trimester)
- Do not give specific facility brochures
- Do not make appointments for the patient (the patient should be given sufficient information to make her own appointment)
- Do not provide transportation

PREGNANCY TEST (continued)

- **All women under age 30** reporting to clinic for a urine pregnancy test should be offered chlamydia and gonorrhea screening from their pregnancy test urine sample. Considering the sequelae that might occur in the mother and neonate if the infection persists, repeat testing is recommended 3 - 4 weeks after completion of therapy for all pregnant women to ensure therapeutic cure.

PROGESTIN-ONLY IMPLANT(S)

GENERAL INFORMATION

All PHNs must be able to discuss progestin-only implant(s) option with clients, provide the client with written information on the safety and effectiveness of implants, and answer any questions the client may have. All PHNs must know how to make implant referrals. Implants cannot be provided by deferred exam. See Family Planning Clinical Guidelines, the package insert available on line, and the most current edition of Contraceptive Technology for method details.

Before making an implant referral, review the patient package insert (available on line at www.implanon-usa.com located at the bottom of the home page as patient information) with the client and give it to her to read. Tell her to take the patient package insert with her to the implant referral visit.

In August of 2006, the FDA approved Implanon®, a contraceptive implant containing the progestin, etonogestrel. Other implant products may become available. Implanon® does not contain silicone or latex. It is placed in the upper, inner aspect of the non-dominant arm by a health care provider who has received training in placement and removal from the manufacturer's training faculty.

Candidates for implant contraceptives include, but are not limited to:

- Women who want a 3 year contraceptive effect
- Women who are accepting of irregular menstruation
- Women who have no contraindications to the method

SUBJECTIVE FINDINGS

Collect medical history for NP or physician to review

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
 East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
 Southeast – Franklin and Marion
 Upper Cumberland – Overton and Smith
 Mid Cumberland – Sumner, Cheatham and Dickson
 South Central – Giles, Lawrence and Marshall
 West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
 Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
 Nashville/Davidson
 Knoxville/Knox
 Jackson/Madison

ASSESSMENT

Appropriate to refer for or to continue (annual or follow-up visit) the progestin-only implant

PLAN OF CARE FOR PHN

- Obtain informed consent prior to placement of the implant(s)
- Document necessary health teaching to use method correctly and consistently
- Record name of implant, lot number or other product ID number, placement site, date of placement, date for removal
- If the region uses a Problem List, record Implant Surveillance on the list with date of insertion as the date of onset
- Consult for problems with insertion site or other side effects or warning signs
- Document necessary health teaching regarding the following emergency warning signs:

Warning signs: The following are NOT NORMAL and should be reported to the clinic or hospital at once:

- Heavy vaginal bleeding
- Severe painful headaches, vomiting, dizziness or fainting, numbness in arm or leg (possible stroke)
- Blurred, double, or loss of vision (clot in eye)
- Coughing up blood, chest pain, shortness of breath (possible clot in lung)
- Severe crushing chest pain (possible heart attack),
- Severe abdominal pain (possible ectopic pregnancy, ovarian cyst, gallbladder disease, or liver problems)
- Severe and persistent leg pain (possible clot in leg)
- Jaundice
- Breast lump
- Sadness, tiredness, lack of energy, weakness, difficulty sleeping (possible severe depression)
- Pregnancy symptoms
- Allergic reaction (rare)
- Severe depression
- Pain, pus, or bleeding at insertion site

HEALTH TEACHING:

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

REFERENCES

1. Implanon® Physician and Patient Package Insert, Organon USA, 2006.
2. Contraceptive Technology Hatcher, R. A., Trussell, J., Stewart, F., Stewart, G. K., Kowal, D., Guest, F., Cates, W. & Policar, M., Nineteenth Revised Edition, 2007, Irvington Publishers, Inc., New York, NY.
3. Pocket Guide To Managing Contraception, Hatcher, R. A., Nelson, A. L., Ziemann, M., et. al., Tiger, Georgia: Bridging the Gap Foundation, 2010-2012.
4. Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR early release, Vol. 59, May 28, 2010.
5. Contraceptive Technology Update, "Bulletin: Single-rod contraceptive Implant Implanon gets Food & Drug Administration's OK", Vol. 27, No. 9, September 2006.
6. www.Implanon-usa.com

PROGESTIN-ONLY INJECTABLE CONTRACEPTION

GENERAL INFORMATION

A physical exam is not necessary to begin progestin-only injectable contraception. While deferring the physical examination should not be routine, certain circumstances may exist which make it reasonable. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

Progestin-only injectable contraceptives come in different dosages and require different routes of administration. PHNs will follow the package insert instructions for the particular progestin-only injectable product.

SUBJECTIVE FINDINGS

How to use the U.S. Medical Eligibility Criteria category system

U.S. Medical Eligibility Criteria category system:

1 = May provide method

2 = May provide method with an APN or MD consult/approval

3 = May not provide method

4 = May not provide method

For the deferred exam, collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

U.S. Medical Eligibility Criteria for DMPA (I = to initiate and C = to continue)

| Condition | DMPA |
|------------------------------------|------|
| AGE | |
| Menarche to < 40 | |
| Menarche to ≥ 40 | |
| Menarche to <18 | 2 |
| Age 18 to 45 | 1 |
| Age > 45 | 2 |
| Menarche to <20 | |
| Age > 20 | |
| PARITY | |
| Nulliparous | 1 |
| Multiparous | 1 |
| PP BREASTFEEDING | |
| < 1 month postpartum | 2 |
| 1month to < 6 months | 1 |
| ≥ 6 months postpartum | 1 |
| PP NOT BREASTFEEDING | |
| < 21 days postpartum | 1 |
| > 21 days postpartum | 1 |
| | |
| PP vaginal and C/S delivery | |
| <10 min after placenta delivers | |

| Condition | DMPA |
|---|------|
| 10 min after placenta is delivered to < 4 wks | |
| ≥ 4 wks | |
| Puerperal sepsis | |
| POSTABORTION | |
| First Trimester | 1 |
| Second Trimester | 1 |
| Immediate post-septic AB | 1 |
| | |
| PAST ECTOPIC PREG | 1 |
| | |
| HISTORY OF PELVIC SURGEY | 1 |
| SMOKING | |
| Age < 35 years any amount | 1 |
| Age ≥ 35 years & < 15 cigs/day | 1 |
| Age ≥ 35 years & ≥ 15 cigs/day | 1 |
| OBESITY | |
| BMI ≥ 30 | 1 |
| Age menarche to <18 yrs & BMI > 30 | 2 |
| BARIATRIC SURGERY | |
| Restrictive-type | 1 |
| Malabsorbitive-type | 1 |
| CARDIOVASCULAR DISEASE (also see "other cardiac issues") | |
| Multiple risk factors for arterial CVD | 3 |
| Hypertension adequately controlled | 2 |
| Systolic 140-159 or diastolic 90-99 | 2 |
| Systolic ≥ 160 or diastolic ≥ 100 | 3 |
| Vascular disease | 3 |
| History of hypertension in a pregnancy but normal now | 1 |
| History of DVT/PE But not on anticoagulation therapy | |
| History of estrogen associated DVT/PE | 2 |
| History of pregnancy associated DVT/PE | 2 |
| Idiopathic DVT/PE | 2 |
| Known thrombophilia | 2 |
| Active cancer (excluding non-melanoma skin ca) | 2 |
| History of recurrent DVT/PE | 2 |
| History of DVT/PE but no known risk factors | 2 |
| Acute DVT/PE | 2 |
| | |
| History of dvt/PE on coagulation therapy | |

| Condition | DMPA | |
|--|------|-----|
| DVT/PE on coagulation therapy for 3 months & <u>known</u> thrombophilia, active cancer (excluding non melanoma skin cancer), or history of recurrent DVT/PE | 2 | |
| DVT/PE on coagulation therapy for 3 months & <u>no known</u> risk factors as listed in cell above | 2 | |
| other DVT/PE related issues | | |
| Family history of DVT/P in a 1 st degree relative | 1 | |
| Major surgery with prolonged immobilization | 2 | |
| Major surgery without prolonged immobilization | 1 | |
| Minor surgery without immobilization | 1 | |
| Known thrombogenic mutations | 2 | |
| other vascular issues | | |
| Varicose veins | 1 | |
| Superficial thrombophlebitis | 1 | |
| History of cerebrovascular accident (stroke) | 3 | |
| Other cardiac issues | | |
| Current or history of ischemic heart disease | 3 | |
| Known hyperlipidemias | 2 | |
| Uncomplicated valvular heart disease | 1 | |
| Pulmonary hypertension | 1 | |
| Risk of atrial fibrillation | 1 | |
| History of subacute bacterial endocarditis | 1 | |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function < 6 months | 1 | |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function ≥ 6 months | 1 | |
| Peripartum cardiomyopathy with moderate or severely impaired cardiac function | 2 | |
| rheumatic diseases | | |
| Systemic lupus (SLE) with positive or unknown antiphospholipid antibodies | 3 | |
| SLE with severe thrombocytopenia | I=3 | C=2 |
| SLE with immunosuppressive therapy | 2 | |
| SLE without any of the above | 2 | |

| Condition | DMPA | |
|---|------|-----|
| Rheumatoid arthritis with immunosuppressive therapy | 2/3 | |
| Rheumatoid arthritis not on immunosuppressants | 2 | |
| Neurologic Conditions | | |
| Mild or severe nonmigrainous headache | 1 | |
| Migraine without aura age < 35 years | 2 | |
| Migraine without aura age ≥ 35 years | 2 | |
| Migraine with aura at any age | I=2 | C=3 |
| Epilepsy | 1 | |
| Depression | | |
| All depressive disorders | 1 | |
| reproductive tract disease & disorders | | |
| Irregular vaginal bleeding pattern without heavy bleeding | 2 | |
| Heavy or prolonged vaginal bleeding irregular & regular | 2 | |
| Unevaluated, unexplained, suspicious vaginal bleeding | 3 | |
| Endometriosis | 1 | |
| Benign ovarian tumors including cysts | 1 | |
| Sever dysmenorrhea | 1 | |
| Gestational trophoblastic disease decreasing BHCG | 1 | |
| Gestational trophoblastic disease persistently elevated BHCG or malignant disease | 1 | |
| Cervical exotropia | 1 | |
| Undiagnosed breast mass | 2 | |
| Benign breast mass | 1 | |
| Family history of breast cancer | 1 | |
| Current breast cancer | 4 | |
| Past breast cancer and no evidence of current breast cancer for 5 years | 3 | |
| Cervical intraepithelial neoplasia | 2 | |
| Cervical cancer awaiting treatment | 2 | |
| Endometrial hyperplasia | 1 | |
| Endometrial Cancer | 1 | |
| Ovarian cancer | 1 | |
| Uterine fibroids | 1 | |
| Distorted uterine cavity | | |
| Cervical stenosis or laceration or other abnormality that does not distort the uterine cavity | | |
| Past PID with no current risk factors with subsequent pregnancy | 1 | |

| Condition | DMPA |
|--|-------------|
| Past PID with no current risk factors without subsequent pregnancy | 1 |
| Current PID, | 1 |
| Current purulent cervicitis or chlamydial or gonorrhea infection | 1 |
| Other STDs excluding HIV and hepatitis | 1 |
| Vaginitis including trichomonas and bacterial vaginosis | 1 |
| Risk factors for STDs | 1 |
| High risk for HIV | 1 |
| HIV Infection | 1 |
| AIDS clinically well on ARV therapy | |
| infections | |
| Uncomplicated Schistosomiasis | 1 |
| Complicated schistosomiasis with fibrosis of the liver | 1 |
| Non-pelvic tuberculosis | 1 |
| Pelvic tuberculosis | 1 |
| Malaria | 1 |
| Endocrine disease | |
| History of gestational diabetes | 1 |
| Nonvascular noninsulin dependent diabetes | 2 |
| Nonvascular insulin dependent diabetes | 2 |
| Nephropathy, retinopathy, neuropathy with diabetes | 3 |
| Other vascular disease or diabetes of > 20 years | 3 |
| Thyroid simple goiter | 1 |
| Hyperthyroid | 1 |
| hypothyroid | 1 |
| gastrointestinal conditions | |
| Inflammatory bowel diseases, ulcerative colitis, Crohn Disease | 2 |
| Symptomatic gallbladder disease treated by cholecystectomy | 2 |
| Symptomatic gallbladder disease medically treated | 2 |
| Current, symptomatic gallbladder disease | 2 |
| Asymptomatic gallbladder disease | 2 |
| History of pregnancy-related cholestasis | 1 |
| History of Past COC-related cholestasis | 2 |
| Acute or flare – viral hepatitis | 1 |
| Viral hepatitis carrier | 1 |
| Chronic viral hepatitis | 1 |

| Condition | DMPA |
|---|-------------|
| Mild compensated cirrhosis of the liver | 1 |
| Sever decompensated cirrhosis of the liver | 3 |
| Liver tumors focal nodular hyperplasia | 2 |
| Liver tumors hepatocellular adenoma | |
| Malignant hepatoma | 3 |
| anemias | |
| Thalassemia | 1 |
| Sickle cell disease | 1 |
| Iron-deficiency anemia | 1 |
| solid organ transplantation | |
| Complicated: acute or chronic graft failure; rejection, cardiac allograft vasculopathy | 2 |
| Uncomplicated | 2 |
| drug interactions | |
| Antiretroviral therapy-NRTI's | 1 |
| Antiretroviral therapy-NNRTI's | 1 |
| Antiretroviral therapy-Ritonavir-boosted protease inhibitors | 1 |
| Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine | 1 |
| Anticonvulsant: lamotrigine | 1 |
| Broad spectrum antibiotics | 1 |
| Antifungals | 1 |
| Antiparasitics | 1 |
| Rifampicin or rifabutin | 1 |

Objective Findings (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- sickle cell screening
- syphilis serology

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

- Mantoux tuberculin test
- pregnancy test
- rubella titer
- wet prep (examiner)
- HIV testing
- urinalysis
- gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
 - Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi

East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier

Southeast – Franklin and Marion

Upper Cumberland – Overton and Smith

Mid Cumberland – Sumner, Cheatham and Dickson

South Central – Giles, Lawrence and Marshall

West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley

Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood

Nashville/Davidson

Knoxville/Knox

Jackson/Madison

Assessment

Appropriate to begin or continue the progestin-only injectable contraceptive either with or without the physical examination

Plan of Care for deferred exam visit

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- the medical history for the initial client, an updated medical history for the annual client who is deferring the exam, and an updated history for the supply client who is changing her method by deferred exam. (The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4 to dispense without an exam. A consult with a NP or MD may be needed for category 2.)
- Record consults with a NP or physician for category 2 found in the medical history before dispensing method without an exam. For annual visits (or re-supply visits), consult for progestin-only injectable side effects that have not responded to standard treatments, or complications, or warning signs. Record consultant instructions in chart.
- blood pressure measurement, hemoglobin or hematocrit
- name, dosage, route, and frequency of the method
- Informed consent
- Necessary health teaching to use method correctly and consistently
- Document health teaching/counseling in chart.
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment
- Document instructions regarding warning signs

Warning Signs: The following are not normal and should be reported to the clinic or hospital at once:

- A** Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
- C** Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
- H** Headache - severe, dizziness, weakness, or numbness, especially if one-sided
(as might be seen with migraine or stroke especially with numbness or muscle weakness)
- E** Eye disturbances vision loss or blurring, also speech problems
(as might be seen with retinopathy or stroke)
- S** Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)

How to administer progestin-only injectable contraception:

Depot medroxyprogesterone (DMPA) is an aqueous suspension of microcrystals. All DMPA products must be shaken vigorously immediately prior to administration or the crystals will leave suspension and clump in the needle. Also the nurse and client must never rub the injection site after administration as this will disrupt the crystals and can lead to method failure (i.e., pregnancy). progestin-only injectable contraceptives come in different dosages and require different routes of administration (subcutaneous or intramuscular). follow the package insert instructions for the particular progestin-only injectable product.

Administer progestin-only injectable contraception according to the following guidelines:

Initial injection

- During first five days of normal menstrual period
- Within 7 days of childbirth, if the client is not breastfeeding
- When milk supply is well established, if client is exclusively breastfeeding but not before one month postpartum
- “DMPA Now” - The DMPA Now strategy provides the initial injection the day of the office visit using the same algorithm used for late re-injection found in Managing Contraception for Your Pocket. Always include the client in this decision-making process.

Subsequent injection

- It is not harmful to a client to receive a re-injection as early as 10 weeks. However, some third party health insurance payors have restrictions regarding early re-injections. Therefore, your clients who need early re-injection and who have third party payors, need to find out what their health insurance plan requires by asking at their pharmacy. Early re-injection is not harmful, but it is not cost effective.
- The package insert for Depo Provera 104 Subq® advises repeating injections every 12-14 weeks.
- The package insert for Depo Provera 150 IM® advises repeating injections every 11-13 weeks.
- if greater than the 13-week (or 14-week for sub q) interval, has the client had unprotected intercourse? If so, perform a pregnancy test. A two week wait and a second pregnancy test is NOT the preferred approach UNLESS the client so chooses. Instead use the algorithm for late injections found in Managing Contraception for Your Pocket.

Plan of Care for an Exam Visit

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The

ongoing plan of care written by the examiner must be reviewed and followed by the PHN at each visit.

Health Teaching:

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the required counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

References

Contraceptive Technology, Robert A. Hatcher, MD, et. al.,. Nineteenth Revised Edition 2007
Depo-Provera package Insert, Pfizer Pharmaceutical Company
Depo-subQ Provera 104 Package Insert, Pfizer Pharmaceutical Company
Pocket Guide To Managing Contraception, Hatcher, R. A., Nelson, A. L., Ziemann, M., et. al.,
Tiger, Georgia: Bridging the Gap Foundation, 2010-12.
"Family Planning Clinical Guidelines, Tennessee Department of Health, January 2011
Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR early release, Vol. 59, May 28, 2010.

PROGESTIN-ONLY PILLS (MINIPILL)

GENERAL INFORMATION

A physical exam is not necessary to begin progestin-only oral contraceptives. While deferring the physical examination should not be routine, certain circumstances may exist which make it reasonable. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

SUBJECTIVE FINDINGS

How to use the U.S. Medical Eligibility Criteria category system

U.S. Medical Eligibility Criteria category system:

1 = May provide method

2 = May provide method with an APN or MD consult/approval

3 = May not provide method

4 = May not provide method

For the deferred exam, collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

U.S. Medical Eligibility Criteria for Progestin-only Pills (I = to initiate and C = to continue)

| Condition | POP |
|------------------------------------|----------|
| AGE | |
| Menarche to < 40 | |
| Menarche to \geq 40 | |
| Menarche to <18 | 1 |
| Age 18 to 45 | 1 |
| Age > 45 | 1 |
| Menarche to <20 | |
| Age \geq 20 | |
| PARITY | |
| Nulliparous | 1 |
| Multiparous | 1 |
| PP BREASTFEEDING | |
| < 1 month postpartum | 2 |
| 1month to < 6 months | 1 |
| \geq 6 months postpartum | 1 |
| PP NOT BREASTFEEDING | |
| < 21 days postpartum | 1 |
| \geq 21 days postpartum | 1 |
| | |
| | |
| PP VAGINAL AND C/S DELIVERY | |
| < 10 min after placenta is | |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP |
|---|-----|
| delivered | |
| 10 min after placenta is delivered to < 4 wks | |
| ≥ 4 wks | |
| Puerperal sepsis | |
| POSTABORTION | |
| First Trimester | 1 |
| Second Trimester | 1 |
| Immediate post-septic AB | 1 |
| | |
| PAST ECTOPIC PREG | 2 |
| | |
| HISTORY OF PELVIC SURGEY | 1 |
| SMOKING | |
| Age < 35 years any amount | 1 |
| Age ≥ 35 years & < 15 cigs/day | 1 |
| Age ≥ 35 years & ≥ 15 cigs/day | 1 |
| OBESITY | |
| BMI ≥ 30 | 1 |
| Age menarche to <18 yrs & BMI ≥ 30 | 1 |
| BARIATRIC SURGERY | |
| Restrictive-type | 1 |
| Malabsorbitive-type | 3 |
| CARDIOVASCULAR DISEASE (also see “other cardiac issues”) | |
| Multiple risk factors for arterial CVD | 2 |
| Hypertension adequately controlled | 1 |
| Systolic 140-159 or diastolic 90-99 | 1 |
| Systolic ≥ 160 or diastolic ≥ 100 | 2 |
| Vascular disease | 2 |
| History of hypertension in a pregnancy but normal now | 1 |
| HISTORY OF DVT/PE But not on coagulation therapy | |
| History of estrogen associated DVT/PE | 2 |
| History of pregnancy associated DVT/PE | 2 |
| Idiopathic DVT/PE | 2 |
| Known thrombophilia | 2 |
| Active cancer (excluding | 2 |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP | |
|--|-----|-----|
| non-melanoma skin ca) | | |
| History of recurrent DVT/PE | 2 | |
| History of DVT/PE but no known risk factors | 2 | |
| Acute DVT/PE | 2 | |
| | | |
| | | |
| HISTORY OF DVT/PE ON COAGULATION THERAPY | | |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>known</u> thrombophilia, active cancer (excluding non melanoma skin cancer), or history of recurrent DVT/PE | 2 | |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>no known</u> risk factors as listed in cell above | 2 | |
| OTHER DVT/PE RELATED ISSUES | | |
| Family history of DVT/P in a 1 st degree relative | 1 | |
| Major surgery with prolonged immobilization | 2 | |
| Major surgery without prolonged immobilization | 1 | |
| Minor surgery without immobilization | 1 | |
| Known thrombogenic mutations | 2 | |
| OTHER VASCULAR ISSUES | | |
| Varicose veins | 1 | |
| Superficial thrombophlebitis | 1 | |
| History of cerebrovascular accident (stroke) | I=2 | C=3 |
| OTHER CARDIAC ISSUES | | |
| Current or history of ischemic heart disease | I=2 | C=3 |
| Known hyperlipidemias | 2 | |
| Uncomplicated valvular heart disease | 1 | |
| Pulmonary hypertension | 1 | |
| Risk of atrial fibrillation | 1 | |
| History of subacute bacterial endocarditis | 1 | |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP | |
|--|-----|-----|
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function < 6 months | 1 | |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function ≥ 6 months | 1 | |
| Peripartum cardiomyopathy with moderate or severely impaired cardiac function | 2 | |
| RHEUMATIC DISEASES | | |
| Systemic lupus (SLE) with positive or unknown antiphospholipid antibodies | 3 | |
| SLE with severe thrombocytopenia | 2 | |
| SLE with immunosuppressive therapy | 2 | |
| SLE without any of the above | 2 | |
| Rheumatoid arthritis with immunosuppressive therapy | 1 | |
| Rheumatoid arthritis not on immunosuppressants | 1 | |
| NEUROLOGIC CONDITIONS | | |
| Mild or severe nonmigrainous headache | 1 | |
| Migraine without aura age < 35 years | I=1 | C=2 |
| Migraine without aura age ≥ 35 years | I=1 | C=2 |
| Migraine with aura at any age | I=2 | C=3 |
| Epilepsy | 1 | |
| DEPRESSION | | |
| All depressive disorders | 1 | |
| REPRODUCTIVE TRACT DISEASE & DISORDERS | | |
| Irregular vaginal bleeding pattern without heavy bleeding | 2 | |
| Heavy or prolonged vaginal bleeding irregular & regular | 2 | |
| Unevaluated, unexplained, | 2 | |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP |
|---|-----|
| suspicious vaginal bleeding | |
| Endometriosis | 1 |
| Benign ovarian tumors including cysts | 1 |
| Sever dysmenorrhea | 1 |
| Gestational trophoblastic disease decreasing BHCG | 1 |
| Gestational trophoblastic disease persistently elevated BHCG or malignant disease | 1 |
| Cervical extropion | 1 |
| Undiagnosed breast mass | 2 |
| Benign breast mass | 1 |
| Family history of breast cancer | 1 |
| Current breast cancer | 4 |
| Past and no evidence of current disease for 5 years | 3 |
| Cervical intraepithelial neoplasia | 1 |
| Cervical cancer awaiting treatment | 1 |
| Endometrial hyperplasia | 1 |
| Endometrial Cancer | 1 |
| Ovarian cancer | 1 |
| Uterine fibroids | 1 |
| Distorted uterine cavity | |
| Cervical stenosis or laceration or other abnormality that does not distort the uterine cavity | |
| Past PID with no current risk factors with subsequent pregnancy | 1 |
| Past PID with no current risk factors without subsequent pregnancy | 1 |
| Current PID, | 1 |
| Current purulent cervicitis or chlamydial or gonorrhea infection | 1 |
| Other STDs excluding HIV and hepatitis | 1 |
| Vaginitis including trichomonas and bacterial vaginosis | 1 |
| Risk factors for STDs | 1 |
| High risk for HIV | 1 |
| HIV Infection | 1 |
| AIDS clinically well on ARV therapy | |
| INFECTIONS | |
| Uncomplicated | 1 |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP |
|--|-----|
| Schistosomiasis | |
| Complicated schistosomiasis with fibrosis of the liver | 1 |
| Nonpelvic tuberculosis | 1 |
| Pelvic tuberculosis | 1 |
| Malaria | 1 |
| ENDOCRINE DISEASE | |
| History of gestational diabetes | 1 |
| Nonvascular noninsulin dependent diabetes | 2 |
| Nonvascular insulin dependent diabetes | 2 |
| Nephropathy, retinopathy, neuropathy with diabetes | 2 |
| Other vascular disease or diabetes of ≥ 20 years | 2 |
| Thyroid simple goiter | 1 |
| Hyperthyroid | 1 |
| hypothyroid | 1 |
| GASTROINTESTINAL CONDITIONS | |
| Inflammatory bowel diseases, ulcerative colitis, Crohn Disease | 2 |
| Symptomatic gallbladder disease treated by cholecystectomy | 2 |
| Symptomatic gallbladder disease medically treated | 2 |
| Current, symptomatic gallbladder disease | 2 |
| Asymptomatic gallbladder disease | 2 |
| History of pregnancy-related cholestasis | 1 |
| History of Past COC-related cholestasis | 2 |
| Acute or flare – viral hepatitis | 1 |
| Viral hepatitis carrier | 1 |
| Chronic viral hepatitis | 1 |
| Mild compensated cirrhosis of the liver | 1 |
| Sever decompensated cirrhosis of the liver | 3 |
| Liver tumors focal nodular hyperplasia | 2 |
| Liver tumors hepatocellular adenoma | |
| Malignant hepatoma | 3 |
| ANEMIAS | |
| Thalassemia | 1 |
| Sickle cell disease | 1 |

PROGESTIN-ONLY PILLS (MINIPILL) (continued)

| Condition | POP |
|---|----------|
| Iron-deficiency anemia | 1 |
| SOLID ORGAN TRANSPLANTATION | |
| Complicated: acute or chronic graft failure; rejection, cardiac allograft vasculopathy | 2 |
| Uncomplicated | 2 |
| DRUG INTERACTIONS | |
| Antiretroviral therapy-NRTI's | 1 |
| Antiretroviral therapy-NNRTI's | 2 |
| Antiretroviral therapy-Ritonavir-boosted protease inhibitors | 3 |
| Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine | 3 |
| Anticonvulsant: lamotrigine | 1 |
| Broad spectrum antibiotics | 1 |
| Antifungals | 1 |
| Antiparasitics | 1 |
| Rifampicin or rifabutin | 3 |

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk criteria, national recommendations, and availability of funds. The screening criteria for Family Planning Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast – Franklin and Marion
Upper Cumberland – Overton and Smith
Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

ASSESSMENT

Appropriate for progestin-only pill use with or without physical examination

PLAN OF CARE FOR DEFERRED EXAM VISIT

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- The medical history for the initial client, an updated medical history for the annual client who is deferring the exam, and an updated history for the supply client who is changing her method by deferred exam. (The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4 to dispense without an exam. A consult with a NP or MD may be needed for category 2.)
- Record consults with a NP or physician for category 2 found in the medical history before dispensing method without an exam.
- For annual visits (or re-supply visits), consult for side effects that have not responded to standard treatments (i.e., progestin-only pill at bedtime for nausea), complications, or warning signs. Record consultant instructions in chart.
- Blood pressure measurement, hemoglobin or hematocrit
- Name, dosage, route, and frequency of the progestin-only oral contraceptive chosen
- The number of cycles given (up to 3 cycles)
- Informed consent
- Necessary health teaching to use method correctly and consistently
- Document health teaching/counseling in chart.
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment
- Document necessary health teaching regarding emergency warning signs

Many of the **WARNING SIGNS** can be remembered through the acronym **ACHES**:

- A** Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
- C** Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
- H** Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness or muscle weakness)
- E** Eye disturbances vision loss or blurring, also speech problems (as might be seen with retinopathy or stroke)
- S** Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)

PLAN OF CARE FOR AN EXAM VISIT

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The ongoing plan of care written by the examiner must be reviewed by the PHN at each visit.

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. The preferred method to start OCPs is the "Quick Start" method. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

REFERENCES

Contraceptive Technology, Robert A. Hatcher, MD, et. al. Nineteenth Revised Edition, 2007.

"Family Planning Clinical Guidelines", Tennessee Department of Health, January 2011.

A Pocket Guide to Managing Contraception, Hatcher, R. A., Nelson, A. L., Ziemann, M., et. al., Tiger, Georgia: Bridging the Gap Foundation 2010-2012.

Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR early release, Vol. 59, May 28, 2010.

STERILIZATION, CONTINUING CONTRACEPTOR

GENERAL INFORMATION

Sterilization is the surgical interruption, or closure, of pathways for sperm or ova, preventing fertilization. The method should be considered a permanent means of contraception. Although some surgical procedures to reverse both vasectomies and tubal ligations have been successful, none are guaranteed. Sterilization is the most popular method of contraception in the United States and worldwide. Sterilization provides highly effective, permanent methods of birth control for both sexes.

The Family Planning Clinical Guidelines includes a section with detail information on policy, federal sterilization requirements, selection criteria, sterilization consent forms, and general instructions.

Sterilization is a service that may be provided or arranged for with government funding. When Family Planning Program funds are used to provide sterilization, federal sterilization consent guidelines must be followed. Medicaid and TennCare also have the same requirements as Title X. In Tennessee, program funding for sterilization is limited. Clinic sites should keep a list of clients requesting sterilization through the state sterilization program, and prioritize applicants when funds for sterilization are available.

Indications include:

Client desires permanent, low risk, highly effective contraceptive method.

Advantages of female sterilization (tubal ligation) include:

- One-time decision provides permanent fertility control
- Highly effective, convenient
- Cost effective
- Nothing to buy or remember
- Lack of significant long-term side effects
- No need for partner compliance
- No need to interrupt lovemaking
- Considered safe with low complication and morbidity rates
- Certain techniques can be performed immediately after pregnancy
- Can be performed while client is lactating
- Bilateral tubal ligation (BTL) is immediately effective
- Low long term risks and costs
- Privacy in choice of method

Advantages of male sterilization (vasectomy) include:

- One-time decision provides permanent fertility control
- Highly effective, convenient
- Considered safe with low complication and morbidity rates
- Cost effective (most cost effective of all contraceptive methods)
- Removal of contraceptive burden from the woman
- No need for partner compliance after post vasectomy sperm check is done to prove that no sperm remain in the reproductive tract
- No need to interrupt lovemaking
- Short recovery time
- Vasectomy is equally effective, simpler, safer, and much less expensive than BTL
- Privacy in choice of method

Disadvantages of female sterilization include:

- Inherent risks associated with any surgery, namely, infection, injury to other organs, hemorrhage, and complications of anesthesia
- Initial cost may be high
- Procedure to reverse sterilization is difficult, has limited success rates, is very expensive, and not covered by insurance
- Title X and Medicaid funding require a 30-day waiting period between the date of signature on consent form and day of surgery
- Provides no protection against HIV and other sexually transmitted infections
- Some clients may have regrets about having the procedure
- Menstrual irregularities, increased dysmenorrhea, and premenstrual syndrome are reported by some women following BTL (research thus far has been unable to support any pattern of identifiable changes)
- Possibility of ectopic pregnancy if method fails

Disadvantages of male sterilization include:

- Inherent risks associated with any surgery, namely, infection, injury to other organs, hemorrhage, and complications of anesthesia
- Initial cost may be high
- Some clients may have regrets about having the procedure
- Procedure to reverse sterilization is difficult, has limited success rates, is very expensive, and not covered by insurance
- Vasectomy is not immediately effective
- Title X funding requires a 30-day waiting period between the date of signature on consent form and day of surgery
- Possible post vasectomy complications can include hematoma formation, congestive epididymitis, and sperm granuloma

PLAN

- Current Family Planning client with current history and physical examination
- Discuss all available options of contraception
- Offer condoms, foam, or film for protection against STDs, if appropriate
- Provide written and oral instructions regarding various components of sterilization
- Obtain informed consent for sterilization
- Update immunizations, as indicated
- Obtain approval for sterilization via the appropriate process for region/agency
- Schedule appointment with provider for sterilization procedure
- Provide appropriate follow-up
- Return for recheck and/or for resolution of any complications

Health Teaching:

- Communicate the importance of following instructions and keeping all appointments as directed to complete the sterilization process
- Instruct client that sterilization does not protect against STDs and HIV
- Instruct orally and in writing the possible danger signs following sterilization and the necessary steps in follow-up
- See “All Contraceptors, Initial Family Planning Visit“ section in the PUBLIC HEALTH NURSING PROTOCOL,
- Instruct on 30 day waiting period

Referral Indicators after procedure:

- Side effects or complications to the sterilization procedure
- Pregnancy
- Client verbalizing feelings of regret about sterilization
- Client verbalizing sexual maladjustment

REFERENCES

1. U.S. Department of Health and Human Services, Office of Population Affairs, Office for Family Planning, Program Guidelines for Project Grants for Family Planning Services, Attachment C, January 2001.

QUICK REFERENCE TO STERILIZATIONS

1. Office of Population Affairs, Program Guidelines for Project Grants for Family Planning Services, January 2001

2. Family Planning Clinical Guidelines under Sterilization

Federal Guidelines:

- Minimum age is 21
- Mentally incompetent/institutionalized individual may not be sterilized
- Waiting period: 30 days between date of consent signed to date of surgery. Consent valid for up to 180 days only after date consent is signed
- Decision not to be sterilized at any time will not result in withdrawal or withholding of state or federal benefits
- Under no circumstances may a hysterectomy be performed using Title X dollars or as a part of Family Planning Program solely for purpose of rendering the individual unable to reproduce

Selection Criteria

- Family Planning Program client or partner of Family Planning client
- Low income client
- No clients with TennCare or insurance that covers sterilization: instead, refer client
- Clients with method failure
- Clients with medical contraindication to use of temporary methods
- Older client
- Clients who have had multiple pregnancies
- Clients with other high risks
- For female sterilization, priority should be given to those who will have an outpatient procedure, so that more clients can be served

Possible contraindications:

- Client has mental or emotional conditions that could interfere with informed consent
- Client or couple feels they are not yet ready to assume the responsibility of parenthood
- Client counts on reversing the operation in case of change of circumstances such as remarriage or death of children

3. Federal Sterilization Forms: Forms must be completed in compliance with regulations.

VAGINAL CONTRACEPTIVE RING

GENERAL INFORMATION

A physical exam is not necessary to begin the vaginal contraceptive ring. While deferring the physical examination should not be routine, certain circumstances may exist which make it reasonable. It is essential that the PHN see General Information and Plan of Care for a Deferred Exam found in, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

See Family Planning Clinical Guidelines and the most current edition of Contraceptive Technology for method counseling details.

SUBJECTIVE FINDINGS

How to use the Medical Eligibility Criteria category system

U.S. Medical Eligibility Criteria category system:

- 1 = May provide method
- 2 = May provide method with an APN or MD consult/approval
- 3 = May not provide method
- 4 = May not provide method

For the deferred exam, collect and review medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 and consider a physician or NP consult for any of the category 2.

U.S. Medical Eligibility Criteria for Combined Oral Contraceptives, Contraceptive Patch and Contraceptive Ring (I = to initiate and C = to continue)

| Condition | COC/Patch/Ring |
|-----------------------------|----------------|
| AGE | |
| Menarche to < 40 | 1 |
| Menarche to \geq 40 | 2 |
| Menarche to <18 | |
| Age 18 to 45 | |
| Age > 45 | |
| Menarche to <20 | |
| Age \geq 20 | |
| PARITY | |
| Nulliparous | 1 |
| Multiparous | 1 |
| PP BREASTFEEDING | |
| < 1 month postpartum | 3 |
| 1 month to < 6 months | 2 |
| \geq 6 months postpartum | 2 |
| PP NOT BREASTFEEDING | |
| < 21 days postpartum | 3 |
| \geq 21 days postpartum | 1 |
| | |
| | |

VAGINAL CONTRACEPTIVE RING (continued)

| Condition | COC/Patch/Ring | |
|---|----------------|---------|
| PP VAGINAL AND C/S DELIVERY | | |
| < 10 min after placenta is delivered | | |
| 10 min after placenta is delivered to < 4 wks | | |
| ≥ 4 wks | | |
| Puerperal sepsis | | |
| POSTABORTION | | |
| First Trimester | 1 | |
| Second Trimester | 1 | |
| Immediate post-septic AB | 1 | |
| | | |
| PAST ECTOPIC PREG | 1 | |
| | | |
| HISTORY OF PELVIC SURGEY | 1 | |
| SMOKING | | |
| Age < 35 years any amount | 2 | |
| Age ≥ 35 years & < 15 cigs/day | 3 | |
| Age ≥ 35 years & ≥ 15 cigs/day | 4 | |
| OBESITY | | |
| BMI ≥ 30 | 2 | |
| Age menarche to <18 yrs & BMI ≥ 30 | 2 | |
| BARIATRIC SURGERY | | |
| Restrictive-type (ie, banding) | 1 | |
| Malabsorptive-type (ie, resection) | COC 3 | Pa/Ri 1 |
| CARDIOVASCULAR DISEASE (also see "other cardiac issues") | | |
| Multiple risk factors for arterial CVD | 3/4 | |
| Hypertension adequately controlled | 3 | |
| Systolic 140-159 or diastolic 90-99 | 3 | |
| Systolic ≥ 160 or diastolic ≥ 100 | 4 | |
| Vascular disease | 4 | |
| History of hypertension in a pregnancy but normal now | 2 | |
| HISTORY OF DVT/PE But not on coagulation therapy | | |
| History of estrogen associated DVT/PE | 4 | |
| History of pregnancy associated DVT/PE | 4 | |
| Idiopathic DVT/PE | 4 | |
| Known thrombophilia | 4 | |
| Active cancer (excluding non-melanoma skin ca) | 4 | |
| History of recurrent DVT/PE | 4 | |
| History of DVT/PE but no known risk factors | 3 | |
| Acute DVT/PE | 4 | |
| | | |
| | | |
| HISTORY OF DVT/PE ON COAGULATION THERAPY | | |

VAGINAL CONTRACEPTIVE RING (continued)

| Condition | COC/Patch/Ring |
|--|----------------|
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>known</u> thrombophilia, active cancer (excluding non melanoma skin cancer), or history of recurrent DVT/PE | 4 |
| DVT/PE ON COAGULATION THERAPY for 3 months & <u>no known</u> risk factors as listed in cell above | 3 |
| OTHER DVT/PE RELATED ISSUES | |
| Family history of DVT/P in a 1 st degree relative | 2 |
| Major surgery with prolonged immobilization | 4 |
| Major surgery without prolonged immobilization | 2 |
| Minor surgery without immobilization | 1 |
| Known thrombogenic mutations | 4 |
| OTHER VASCULAR ISSUES | |
| Varicose veins | 1 |
| Superficial thrombophlebitis | 2 |
| History of cerebrovascular accident (stroke) | 4 |
| OTHER CARDIAC ISSUES | |
| Current or history of ischemic heart disease | 4 |
| Known hyperlipidemias | 2/3 |
| Uncomplicated valvular heart disease | 2 |
| Pulmonary hypertension | 4 |
| Risk of atrial fibrillation | 4 |
| History of subacute bacterial endocarditis | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function < 6 months | 4 |
| Peripartum cardiomyopathy with normal or mildly impaired cardiac function ≥ 6 months | 3 |
| Peripartum cardiomyopathy with moderate or severely impaired cardiac function | 4 |
| RHEUMATIC DISEASES | |
| Systemic lupus (SLE) with positive or unknown antiphospholipid antibodies | 4 |
| SLE with severe thrombocytopenia | 2 |
| SLE with immunosuppressive therapy | 2 |
| SLE without any of the above | 2 |
| Rheumatoid arthritis with immunosuppressive therapy | 2 |
| Rheumatoid arthritis not on immunosuppressants | 2 |

VAGINAL CONTRACEPTIVE RING (continued)

| Condition | COC/Patch/Ring | |
|---|----------------|-----|
| NEUROLOGIC CONDITIONS | | |
| Mild or severe nonmigrainous headache | I=1 | C=2 |
| Migraine without aura age < 35 years | I=2 | C=3 |
| Migraine without aura age ≥ 35 years | I=3 | C=4 |
| Migraine with aura at any age | I=4 | C=4 |
| Epilepsy | 1 | |
| DEPRESSION | | |
| All depressive disorders | 1 | |
| REPRODUCTIVE TRACT DISEASE & DISORDERS | | |
| Irregular vaginal bleeding pattern without heavy bleeding | 1 | |
| Heavy or prolonged vaginal bleeding irregular & regular | 1 | |
| Unevaluated, unexplained, suspicious vaginal bleeding | 2 | |
| Endometriosis | 1 | |
| Benign ovarian tumors including cysts | 1 | |
| Sever dysmenorrhea | 1 | |
| Gestational trophoblastic disease decreasing BHCG | 1 | |
| Gestational trophoblastic disease persistently elevated BHCG or malignant disease | 1 | |
| Cervical extropion | 1 | |
| Undiagnosed breast mass | 2 | |
| Benign breast mass | 1 | |
| Family history of breast cancer | 1 | |
| Current breast cancer | 4 | |
| Past and no evidence of current disease for 5 years | 3 | |
| Cervical intraepithelial neoplasia | 2 | |
| Cervical cancer awaiting treatment | 2 | |
| Endometrial hyperplasia | 1 | |
| Endometrial Cancer | 1 | |
| Ovarian cancer | 1 | |
| Uterine fibroids | 1 | |
| Distorted uterine cavity | | |
| Cervical stenosis or laceration or other abnormality that does not distort the uterine cavity | | |
| Past PID with no current risk factors with subsequent pregnancy | 1 | |
| Past PID with no current risk factors without subsequent pregnancy | 1 | |
| Current PID, | 1 | |
| Current purulent cervicitis or chlamydial or gonorrhea infection | 1 | |
| Other STDs excluding HIV and hepatitis | 1 | |
| Vaginitis including trichomonas and bacterial vaginosis | 1 | |
| Risk factors for STDs | 1 | |

VAGINAL CONTRACEPTIVE RING (continued)

| Condition | COC/Patch/Ring | |
|--|--|-----|
| High risk for HIV | 1 | |
| HIV Infection | 1 | |
| AIDS clinically well on ARV therapy | Check drug interactions with these methods | |
| INFECTIONS | | |
| Uncomplicated Schistosomiasis | 1 | |
| Complicated schistosomiasis with fibrosis of the liver | 1 | |
| Non-pelvic tuberculosis | 1 | |
| Pelvic tuberculosis | 1 | |
| Malaria | 1 | |
| ENDOCRINE DISEASE | | |
| History of gestational diabetes | 1 | |
| Nonvascular noninsulin dependent diabetes | 2 | |
| Nonvascular insulin dependent diabetes | 2 | |
| Nephropathy, retinopathy, neuropathy with diabetes | 3/4 | |
| Other vascular disease or diabetes of ≥ 20 years | 3/4 | |
| Thyroid simple goiter | 1 | |
| Hyperthyroid | 1 | |
| hypothyroid | 1 | |
| GASTROINTESTINAL CONDITIONS | | |
| Inflammatory bowel diseases, ulcerative colitis, Crohn Disease | 2/3 | |
| Symptomatic gallbladder disease treated by cholecystectomy | 2 | |
| Symptomatic gallbladder disease medically treated | 3 | |
| Current, symptomatic gallbladder disease | 3 | |
| Asymptomatic gallbladder disease | 2 | |
| History of pregnancy-related cholestasis | 2 | |
| History of Past COC-related cholestasis | 3 | |
| Acute or flare – viral hepatitis | I=3/4 | C=2 |
| Viral hepatitis carrier | 1 | |
| Chronic viral hepatitis | 1 | |
| Mild compensated cirrhosis of the liver | 1 | |
| Sever decompensated cirrhosis of the liver | 4 | |
| Liver tumors focal nodular hyperplasia | 2 | |
| Liver tumors hepatocellular adenoma | 4 | |
| Malignant hepatoma | 3 | |
| ANEMIAS | | |
| Thalassemia | 1 | |
| Sickle cell disease | 2 | |
| Iron-deficiency anemia | 1 | |

VAGINAL CONTRACEPTIVE RING (continued)

| Condition | COC/Patch/Ring |
|---|----------------|
| SOLID ORGAN TRANSPLANTATION | |
| Complicated: acute or chronic graft failure; rejection, cardiac allograft vasculopathy | 4 |
| Uncomplicated | 2 |
| DRUG INTERACTIONS | |
| Antiretroviral therapy-NRTI's | 1 |
| Antiretroviral therapy-NNRTI's | 2 |
| Antiretroviral therapy-Ritonavir-boosted protease inhibitors | 3 |
| Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine | 3 |
| Anticonvulsant: lamotrigine | 3 |
| Broad spectrum antibiotics | 1 |
| Antifungals | 1 |
| Antiparasitics | 1 |
| Rifampicin or rifabutin | 3 |

OBJECTIVE FINDINGS (Laboratory tests for FP clients are chosen as indicated by the method, or by client need. However, laboratory tests cannot exceed any established department or program screening or testing limits. Limitations on laboratory testing may be established to meet funding or other needs).

- Blood pressure
- Height and weight for BMI
- Physical examination¹ performed annually by examiner
- Hemoglobin or Hematocrit initially and then as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test
- Rubella titer
- Wet prep (examiner)
- HIV testing
- Urinalysis
- Gonorrhea and chlamydia screening

Screening Criteria for Chlamydia and Gonorrhea

The screening criteria for chlamydia and gonorrhea are established by the Tennessee STD Program. The screening criteria for chlamydia and gonorrhea have been revised based on risk

¹ If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care.

criteria, national recommendations, and availability of funds. The screening criteria for Family Planning in Tennessee are:

For Family Planning:

- Screen at the routine initial/annual exam:
 - all clients less than age 26
 - all clients ages 26-29 who receive family planning services in a county with a chlamydia positivity rate of 3 percent or higher. (*See below for these counties.)
- For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 - a client being prepared for IUD insertion;
 - a client with documented NEW signs or symptoms;
 - a client named as a contact;
 - a client using drugs;
 - a client exchanging sex for money or drugs.
- Regardless of age, a female client who has been treated for a positive chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regardless of whether the client believes her partner was treated.

The counties with positivity rates of 3 percent or higher are:

Northeast Region – Johnson and Unicoi
East Tennessee Region – Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast – Franklin and Marion
Upper Cumberland – Overton and Smith
Mid Cumberland – Sumner, Cheatham and Dickson
South Central – Giles, Lawrence and Marshall
West Tennessee – Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County – Health department clinics; Memphis Planned Parenthood
Nashville/Davidson
Knoxville/Knox
Jackson/Madison

ASSESSMENT

Appropriate to begin or continue the vaginal contraceptive ring either with or without the physical examination.

Plan of Care for deferred exam visit

The plan of care for a deferred exam visit is considered preliminary or temporary and can be established by the PHN. This preliminary or temporary plan of care must address the following:

- An explanation for the deferral
- The medical history for the initial client, an updated medical history for the annual client who is deferring the exam, and an updated history for the supply client who is changing her method by deferred exam. (The history must be negative for U.S. Medical Eligibility)

Criteria categories 3 and 4 to dispense without an exam. A consult with a NP or MD may be needed for category 2.)

- Record consults with a NP or physician for category 2 found in the medical history before dispensing method without an exam.
- Blood pressure measurement, hemoglobin or hematocrit, weight
- Height for initial visit or annually for adolescents
- Name, dosage, route, and frequency of the oral contraceptive chosen
- The number of cycles given (up to 3 cycles)
- Informed consent
- Document necessary health teaching to start and to use method correctly and consistently.(See Client Instruction Sheet available in English and Spanish found in the Appendix of the Family Planning Clinical Guidelines.)
- Document necessary health teaching regarding emergency warning signs:
 - A Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
 - C Chest pain - severe, (cough, shortness of breath or sharp pain on breathing in as might be seen with heart attack or pulmonary embolism)
 - H Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness or muscle weakness)
 - E Eye disturbances vision loss or blurring, also speech problems (cont. next page) (as might be seen with retinopathy or stroke)
 - S Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)
- Offer condoms for improved STD protection
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy.
- Date of the exam appointment or, in open access systems, note in the chart the date the client will be expected to return.

PLAN OF CARE FOR AN EXAM VISIT OR RESUPPLY VISIT

An **ongoing plan of care** will be developed and signed at the **exam visit** by either the PHN with gyn skills, RN-ES, Nurse Practitioner, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner. The ongoing plan of care written by the examiner must be reviewed and followed by the PHN at each visit.

For re-supply visits, consult NP or physician for complications and warning signs. Also consult for side effects that have not responded to standard treatments. Record consultant instructions in chart

HEALTH TEACHING

Through the Title X Program Guidelines, the federal Office of Population Affairs requires that counseling about certain topics occur with family planning clients. These required topics must be discussed with the client at least once during the time the client is under the care of the family planning program. Ideally, the client will receive instruction on 3-4 of the required topics at each

visit until all required topics are covered. Always review past client counseling at each visit and base current counseling/education on client needs and program requirements.

For contraceptive method education and counseling, use the Client Instruction Sheet found in the current revision of Tennessee's Family Planning Clinical Guidelines. Also use the teaching tool on the back of the method-specific consent form.

All providers must document education and counseling done during each family planning visit on the table found on the history form. The expression, "counseling per protocol" is not adequate documentation for Title X. education and counseling should occur during initial, annual, supply and medical visits.

There is a detailed list of the REQUIRED counseling/education topics in the Family Planning Program Clinical Guidelines, under Visit Guidelines. Other counseling topics are detailed there also. Or, you may review a brief list of counseling/education topics in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.

REFERENCES

- Contraceptive Technology, Nineteenth Revised Edition, Robert A. Hatcher, M.D., et al, 2007.
Contraceptive Technology Update, "Draw the Circle Wide to Add Contraceptive Ring", Volume 26, Number 6, June 2005.
- A Pocket Guide to Managing Contraception, Hatcher, R.A., Nelson, A.L., Ziemann, M. et. al., Tiger, Georgia: Bridging the Gap Foundation, 2010-12.
- "Family Planning Program Clinical Guidelines," Tennessee Department of Health, January 2011.
- NuvaRing Package Insert, Organon, Inc., 2005.
- "Program Guidelines for Project Grants for Family Planning Services," Office of Population Affairs, U.S. Department of Health and Human Services, January 2001.
- Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR early release, Vol. 59, May 28, 2010.