

## 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 an exam on the same day as the clinic visit. The client may also request to delay or defer a physical examination. If this occurs, collect and review the medical history to assure no U.S. Medical Eligibility Criteria categories 3 or 4 exist. Consider a physician or APN consult for any category 2 findings. The Summary chart of U.S. Medical Eligibility Criteria for Contraceptive Use is found in the Family Planning reference section 2.170.

### 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
- Height and weight for BMI
- Physical examination<sup>1</sup> performed annually by examiner
- Hemoglobin or Hematocrit 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

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<sup>1</sup> If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department's family planning clinic, she should also receive developmental screening and vision and hearing risk assessment/screening in order to complete the recommended AAP standards for preventive health care. REFER TO THE FAMILY PLANNING SECTION OF THE PTBMIS MANUAL FOR CORRECT CODING OF THIS TYPE VISIT.

## **REFER TO SCREENING CRITERIA FOR CHLAMYDIA AND GONORRHEA FOUND IN SECTION 2.170**

### **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. Consider a physician or APN consult for any category 2 findings and document appropriately. See the PTBMIS codes manual for the coding of this visit.
- For annual visits (or supply visits), consult for method 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, weight, hemoglobin or hematocrit as indicated.
- Height for initial visit or annually for adolescents.
- 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 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. In clinics with open access systems, chart the date the client is expected to return.

### **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, APN, or Physician (all referred to as “examiner”). The ongoing plan of care is developed in accordance with the protocol for the particular examiner (APN or physician). The ongoing plan of care written by the examiner must be reviewed by the PHN at each visit. Possible components of the ongoing 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 APN 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 or 4 of the required topics at each visit until instruction in all required topics is completed. Topics do not need to be repeated unless the client request a review or the provider assesses that a review is needed. **Address client counseling at each visit and base counseling/education on client needs and program requirements.**

The REQUIRED TOPICS are listed below. Additional information may be found in the "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". All providers must document education and counseling provided during each family planning visit on the table found on the history form in the medical record. The expression, "counseling per protocol" is not adequate documentation for Title X education and counseling that should occur during initial, annual, supply and medical visits.

Client Instruction sheets in English and Spanish are available in the appendix of Tennessee Family Planning Clinical Guidelines. For contraceptive method education and counseling, use the Client Instruction Sheet found in the current version of the Tennessee's Family Planning Clinical Guidelines. They are available in English and Spanish. Also use the teaching tool on the reverse side of the method-specific 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." A "print your own" brochure entitled "Welcome To Your County Health Department" is 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., Twentieth Revised Edition, 2011.

“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

## 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 Protocol 2.010, “All Methods, Initial and/or Annual Family Planning Visit” before dispensing a method without a physical exam.

### SUBJECTIVE FINDINGS

For method specific guidelines, including those for a deferred exam, refer to the Summary Chart of U. S. Medical Eligibility Criteria for Contraceptive Use in Family Planning Reference section 2.170.

U.S. Medical Eligibility Criteria category system:

- 1 = May provide method, no restrictions
- 2 = May provide method, as the advantages generally outweigh the risks. Consult with an APN or physician as needed and document appropriately
- 3 = May not provide method, proven risk usually outweigh the advantages
- 4 = Method may not be used

**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 examination<sup>1</sup> performed annually by examiner
- Hemoglobin or Hematocrit as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sickle cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test

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<sup>1</sup> If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department’s family planning clinic, she should also receive developmental screening and vision and hearing risk assessment/screening in order to complete the recommended AAP standards for preventive health care. REFER TO THE FAMILY PLANNING SECTION OF THE PTBMIS MANUAL FOR CORRECT CODING OF THIS TYPE VISIT.

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

**REFER TO SCREENING CRITERIA FOR CHLAMYDIA AND GONORRHEA SECTION 2.170.**

## 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. Consider a physician or APN consult for any category 2 findings and document appropriately.
- For annual visits (or re-supply visits), consult for side effects that have not responded to standard treatments (i.e., take COC pill at bedtime for nausea), complications, or warning signs. Record consult instruction in chart.
- Blood pressure measurement, weight, hemoglobin or hematocrit as indicated.
- 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 form for an initial client or if giving the return client a new method.
- 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 inhalation 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)

- 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. In clinics with open access systems, chart the date the client is 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, APN 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 APN or physician for complications and warning signs. Also consult for side effects that have not responded to standard treatments. Record consultant instructions in the 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 or 4 of the required topics at each visit until instruction in all required topics is completed. Topics do not need to be repeated unless the client request a review or the provider assesses that a review is needed. **Address client counseling at each visit and base counseling/education on client needs and program requirements.**

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

All providers must document education and counseling provided during each family planning visit on the table found on the history form in the medical record. The expression, “counseling per protocol” is not adequate documentation for Title X education and counseling that 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. A brief list of counseling/education topics is provided in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.**

## REFERENCES

- Contraceptive Technology, Twentieth Revised Edition, Robert A. Hatcher, M.D., et al, 2011.
- 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.
- 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.

## 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 Protocol 2.010, “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

For method specific guidelines, including those for a deferred exam, refer to the Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive use in Family Planning reference section 2.170.

U.S. Medical Eligibility Criteria category system:

- 1 = May provide method with no restrictions
- 2 = May provide method as the advantages generally outweigh the risks. Consult a physician or APN as necessary and document appropriately
- 3 = May not provide method, proven risk usually outweigh the advantages
- 4 = Method may not be used.

**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 examination<sup>1</sup> performed annually by examiner
- Hemoglobin or Hematocrit as indicated
- Pap smear in accordance with current Pap smear guidelines
- Sick cell screening
- Syphilis serology
- Mantoux tuberculin test
- Pregnancy test

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<sup>1</sup> If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department’s family planning clinic, she should also receive developmental screening and vision and hearing risk assessment/screening in order to complete the recommended AAP standards for preventive health care. REFER TO THE FAMILY PLANNING SECTION OF THE PTBMIS MANUAL FOR CORRECT CODING OF THIS TYPE VISIT.

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

**REFER TO SCREENING CRITERIA FOR CHLAMYDIA AND GONORRHEA SECTION 2.170.**

**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. Consider a physician or APN consult for any category 2 findings and document appropriately.
- For annual visits (or re-supply visits), consult for side effects that have not responded to standard treatments (i.e., take COC pill at bedtime for nausea), complications, or warning signs. Record consult instruction in chart.
- Blood pressure measurement, weight, hemoglobin or hematocrit as indicated.
- Height for initial visit or annually for adolescents.
- 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.
- 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 inhalation 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)

- 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. In clinics with open access systems, chart the date the client is 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, APN 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 APN 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 or 4 of the required topics at each visit until instruction in all required topics is completed. Topics do not need to be repeated unless the client request a review or the provider assesses that a review is needed. **Address client counseling at each visit and base counseling/education on client needs and program requirements.**

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

All providers must document education and counseling provided during each family planning visit on the table found on the history form in the medical chart. The expression, “counseling per protocol” is not adequate documentation for Title X education and counseling that 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 A brief list of counseling/education topics is provided in the All Methods, Initial and/or Annual Family Planning Visit section of the PHN Protocol.**

## REFERENCES

- Contraceptive Technology, Twentieth Revised Edition, Robert A. Hatcher, M.D., et al, 2011.
- 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, Vol. 59, June 18, 2010.

## EMERGENCY CONTRACEPTIVE PILLS (ECPs)

### GENERAL INFORMATION

Emergency contraceptive pills may 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 Protocol 2.010, “All Methods, Initial and/or Annual Family Planning Visit” before issuing 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.

The package label for ECPs recommends starting treatment within 72 hours of unprotected sexual intercourse, but they may be effective for up to 120 hours. An order is required from a physician or APN if patient is seeking treatment after 72 hours. **For progestin-only ECPs with two tablets, the tablets must be taken with the specified time period separating them. Taking them any other way requires an order from a physician or APN.**

### ECPs following rape and sexual abuse

If a victim of rape or sexual abuse 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 any suspicion of 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. Refer to the DCS website: at [www.tennessee.gov/youth](http://www.tennessee.gov/youth) for further information on the process for reporting suspected child abuse or child sexual abuse is described. The Child Protective Services section of the website provides the required reporting information. Clinics are discouraged from deciphering what is or is not child abuse or child sexual abuse. It is the responsibility of DCS to decide whether or not the reported suspicion warrants investigation under Tennessee’s child abuse/child sexual abuse laws.

### SUBJECTIVE FINDINGS

- Client reports unprotected sexual intercourse sometime within the previous 72-120 hours. Note that beyond 72 hours the PHN will need a consult with a physician or an APN in order to issue 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 inhalation 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, 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 physician or APN before providing ECPs if unprotected sexual intercourse greater than 72 hours prior to visit.
- 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 may 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 ECP regimen is completed and continues with her method, as if the ECP regimen 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. Only one consent form is needed 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 APN or physician/local protocol for directives regarding care of client with emesis after taking ECP.
- Instruct client that nausea/emesis may occur with estrogen/progestin ECPs Instruct client on the availability of non-prescriptive anti-nausea treatment options including the following:

<b>Choices of Non-prescriptive Anti-emetic Drugs</b>	<b>Dose</b>	<b>Timing of Administration</b>
Meclizine hydrochloride (Dramamine Less Drowsy Formula®, 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 or capsules	1 hour before first ECP dose; repeat as needed every 4-6 hours (Max of 300 mg/day)
Dimenhydrinate (Dramamine Original®)	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 -6 hours (Max of 400 mg/day)
Cyclizine hydrochloride (Marezine® - 50 mg tablets or Bonine for Kids® - 25 mg tablets)	One 50 mg tablet or two 25 mg tablets	30 minutes before the first ECP dose; repeat as needed every 4 -6 hours (Max of 200 mg/day)

Provide ECPs from one of the following regimens:

Brand Name	Pills per Dose Take 2 doses 12 hours apart	Ethinyl Estradiol per dose (mcg)	Levonorgestrel per dose (mg) <sup>a</sup>
Aviane <sup>®</sup>	5 orange pills	100	0.5
Cryselle <sup>®</sup>	4 white pills	120	0.6
Enpresse <sup>®</sup>	4 orange pills	120	0.5
Jolessa <sup>®</sup>	4 pink pills	120	0.6
Lessina <sup>®</sup>	5 pink pills	100	0.5
Levora <sup>®</sup>	4 white pills	120	0.6
Lo/Ovral <sup>®</sup>	4 white pills	120	0.6
LoSeasonique	5 orange pills	100	0.5
Low Ogestrel <sup>®</sup>	4 white pills	120	0.6
Lutera <sup>®</sup>	5 white pills	100	0.5
Lybrel	6 yellow pills	120	0.54
Nordette <sup>®</sup>	4 light orange pills	120	0.6
Ogestrel <sup>®</sup>	2 white pills	100	0.5
Portia <sup>®</sup>	4 pink pills	120	0.6
Quasense <sup>®</sup>	4 white pills	120	0.6
Seasonale <sup>®</sup>	4 pink pills	120	0.6
Seasonique <sup>®</sup>	4 light blue-green pills	120	0.6
Sronyx	5 white pills	100	0.5
Trivora <sup>®</sup>	4 pink pills	120	0.5
Dedicated Emergency Contraception products			
Next Choice <sup>®</sup>	1 pill, taken up to 72 hours after unprotected intercourse followed by a second pill 12 hours later	0	Levonorgestrel 0.75mg each tablet
Plan B One-step <sup>®</sup>	1 pill and only 1 dose up to 72 hours after unprotected intercourse	0	Levonorgestrel 1.5 mg
Ella <sup>®</sup> - requires prescription	1 pill, 1 dose, up to 120 hours after unprotected intercourse	0	Ulipristal acetate 30 mg

<sup>a</sup>The progestin in Cryselle<sup>®</sup>, Lo/Ovral<sup>®</sup>, Low-Ogestrel<sup>®</sup>, Ogestrel<sup>®</sup>, and Ovral<sup>®</sup> is norgestrel contains two isomers, only one of which is bioactive. Therefore, 1.2 mg of norgestrel equals 0.6 mg 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 or 4 of the required topics at each visit until instruction in all required topics is completed. Topics do not need to be repeated unless the client request a review or the provider assesses that a review is needed. **Address client counseling at each visit and base counseling/education on client needs and program requirements.**

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

All providers must document education and counseling provided during each family planning visit on the table found on the history form in the medical record. The expression, “counseling per protocol” is not adequate documentation for Title X education and counseling that 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. A brief list of counseling/education topics is provided in the “All Methods, Initial and/or Annual Family Planning Visit” section of the PHN Protocol.**

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# 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 examination performed annually by examiner

If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSTD exam through the health department's family planning clinic, she should also receive a developmental screening and vision and hearing risk assessment/screening in order to complete the recommended AAP standards for preventive health care. REFER TO THE FAMILY PLANNING SECTION OF THE PTBMIS MANUAL FOR CORRECT CODING OF THIS TYPE VISIT.

- Hemoglobin or Hematocrit 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

REFER TO SCREENING CRITERIA FOR CHLAMYDIA AND GONORRHEA FOUND IN SECTION 2.170.

## 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 APN or physician for problems that have not responded to standard FAM counseling. Record consultant instructions in chart.
- Blood pressure measurement, hemoglobin or hematocrit as needed
- 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 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. In clinics with open access systems, chart the date the client is expected to return.

## 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, APN 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 APN 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 or 4 of the required topics at each visit until instruction in all required topics is completed. Always review past client counseling at each visit. Base current visit counseling/education on client needs and Program requirements.

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

All providers must document education and counseling provided during each family planning visit on the table found on the history form in the medical record. The expression, "counseling per protocol" is not adequate documentation for Title X education and counseling that 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. A brief list of counseling/education topics is provided 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

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[www.cyclebeads.com](http://www.cyclebeads.com)

## **FAMILY PLANNING REFERENCE MATERIAL**

### **Screening Criteria for Chlamydia and Gonorrhea**

Effective September 1, 2010

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, 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



Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	c) Vascular disease	4		2		3		2		2		1	
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	2/3*		2		2		1		1		1	
Ischemic heart disease‡	Current and history of	4		2	3	3		2	3	2	3	1	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	2		2		2		2		2		1	
	ii) Hepatocellular adenoma‡	4		3		3		3		3		1	
	b) Malignant‡	4		3		3		3		3		1	
Malaria		1		1		1		1		1		1	
Multiple risk factors for arterial cardiovascular disease	(such as older age, smoking, diabetes and hypertension)	3/4*		2*		3*		2*		2		1	
Obesity	a) ≥30 kg/m <sup>2</sup> body mass index (BMI)	2		1		1		1		1		1	
	b) Menarche to < 18 years and ≥ 30 kg/m <sup>2</sup> BMI	2		1		2		1		1		1	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	1		1		1		1		2		2	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		2		1		1		1		1	
Pelvic inflammatory disease	a) Past, (assuming no current risk factors of STIs)												
	(i) with subsequent pregnancy	1		1		1		1		1		1	
	(ii) without subsequent pregnancy	1		1		1		2		2		2	
	b) Current	1		1		1		4		2*		4	
Peripartum cardiomyopathy ‡	a) Normal or mildly impaired cardiac function												
	(i) < 6 months	4		1		1		1		2		2	
	(ii) ≥ 6 months	3		1		1		1		2		2	
	b) Moderately or severely impaired cardiac function	4		2		2		2		2		2	
Post-abortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	1*		1*		1*		1*		2		2	
	c) Immediately post-septic abortion	1*		1*		1*		4		4		4	
Postpartum (see also Breastfeeding)	a) < 21 days	4		1		1		1					
	b) 21 days to 42 days												
	(i) with other risk factors for VTE	3*		1		1		1					
	(ii) without other risk factors for VTE	2		1		1		1					
	c) > 42 days	1		1		1							
Postpartum (in breastfeeding or non-breastfeeding women, including post-caesarean section)	a) < 10 minutes after delivery of the placenta							2		2		1	
	b) 10 minutes after delivery of the placenta to < 4 weeks							2		2		2	
	c) ≥ 4 weeks							1		1		1	
	d) Puerperal sepsis							4		4		4	
Pregnancy		NA*		NA*		NA*		NA*		4*		4*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		2/3*		1		2		2	
	b) Not on immunosuppressive therapy	2		1		2		1		1		1	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Severe dysmenorrhea		1		1		1		1		1		2	
Sexually transmitted infections	a) Current purulent cervicitis or chlamydial infection or gonorrhea	1		1		1		1		4		2*	
	b) Other STIs (excluding HIV and hepatitis)	1		1		1		1		2		2	
	c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1		1		1		1		2		2	
	d) Increased risk of STIs	1		1		1		1		2/3*		2	
Smoking	a) Age < 35	2		1		1		1		1		1	
	b) Age ≥ 35, < 15 cigarettes/day	3		1		1		1		1		1	
	c) Age ≥ 35, ≥ 15 cigarettes/day	4		1		1		1		1		1	
Solid organ transplantation‡	a) Complicated	4		2		2		2		3		2	
	b) Uncomplicated	2*		2		2		2		2		2	
Stroke‡	History of cerebrovascular accident	4		2		3		3		2		3	
Superficial venous thrombosis	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial thrombophlebitis	2		1		1		1		1		1	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4		3		3		3		3		1	
	b) Severe thrombocytopenia	2		2		3		2		2		3*	
	c) Immunosuppressive treatment	2		2		2		2		2		2	
	d) None of the above	2		2		2		2		2		1	
Thrombogenic mutations‡		4*		2*		2*		2*		2*		1*	
Thyroid disorders	a) Simple goiter/hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis‡	a) Non-Pelvic	1*		1*		1*		1*		1		1	
	b) Pelvic	1*		1*		1*		1*		4		3	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	2*		2*		3*		3*		4*		2*	
Uterine fibroids		1		1		1		1		2		2	
Valvular heart disease	a) Uncomplicated	2		1		1		1		1		1	
	b) Complicated‡	4		1		1		1		1		1	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		2		2		2		1		1	
	b) Heavy or prolonged bleeding	1*		2*		2*		2*		1*		2*	
Viral hepatitis	a) Acute or flare	3/4*		2		1		1		1		1	
	b) Carrier/Chronic	1		1		1		1		1		1	
<b>Drug Interactions</b>													
Antiretroviral therapy (ARV)	a) Nucleoside reverse transcriptase inhibitors	1*		1		1		1		2/3*		2*	
	b) Non-nucleoside reverse transcriptase inhibitors	2*		2*		1		2*		2/3*		2*	
	c) Ritonavir-boosted protease inhibitors	3*		3*		1		2*		2/3*		2*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1		2*		1		1	
	b) Lamotrigine	3*		1		1		1		1		1	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampicin or rifabutin therapy	3*		3*		1		2*		1		1	

I = initiation of contraceptive method; C = continuation of contraceptive method

\* Please see the complete guidance for a clarification to this classification. [www.cdc.gov/reproductivehealth/usmec](http://www.cdc.gov/reproductivehealth/usmec)

‡ Condition that exposes woman to increased risk as a result of unintended pregnancy.

§ Please refer to the US MEC guidance related to drug interactions at the end of this chart