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Family Planning Program 2021 Protocol Update

9/27/2021

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Objectives

By the end of this presentation, participants will be able to:

1. Summarize changes to the LARC protocol
2. Initiation and Use of Self-Administered DMPA-SubQ
3. Apply the new CDC STI Treatment Guidelines
4. Summarize the new pap guidelines
5. Identify the three required Title X trainings

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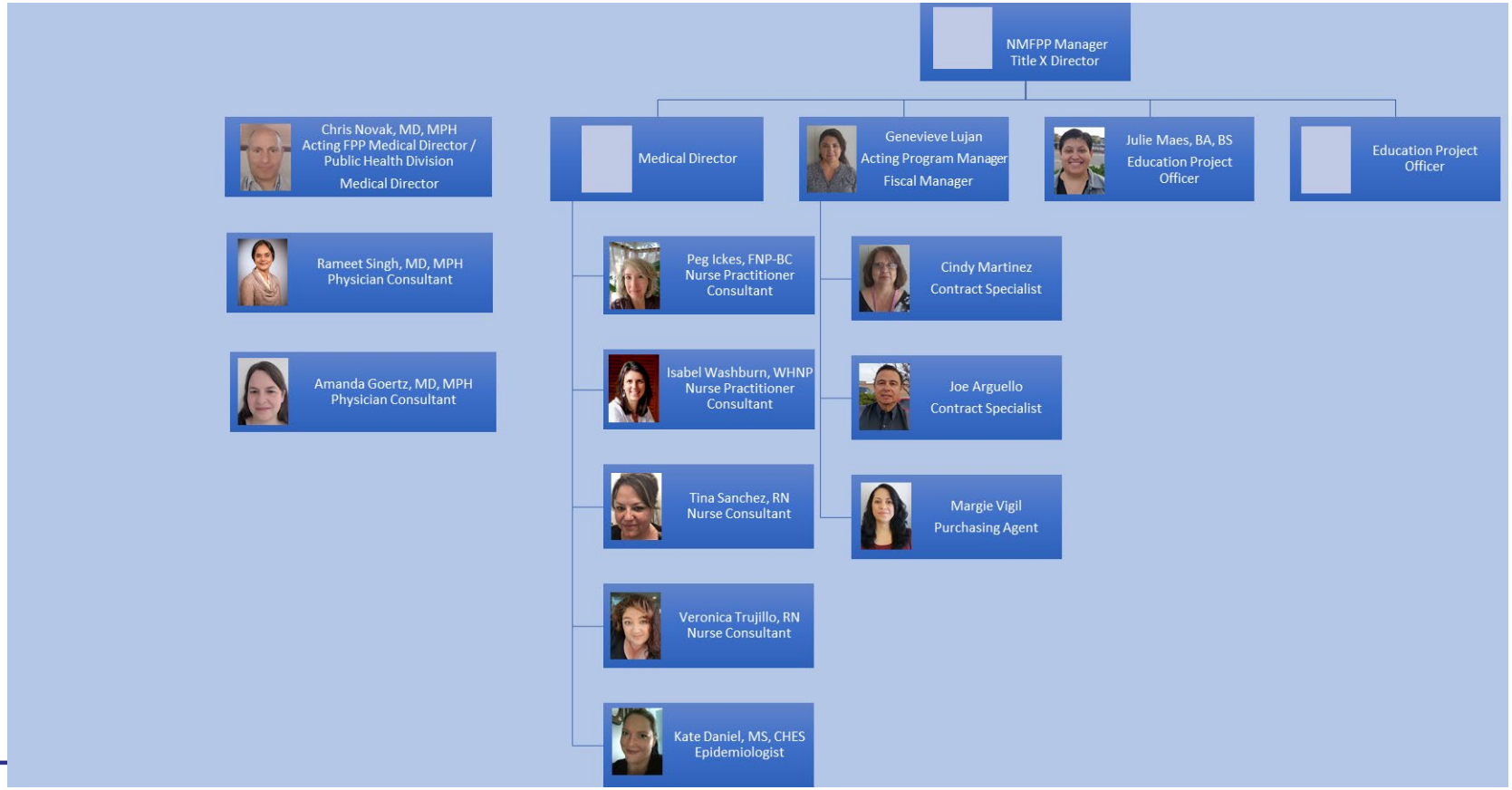
Family Planning Program (FPP) Update

Genevieve Lujan, Acting Program Manager

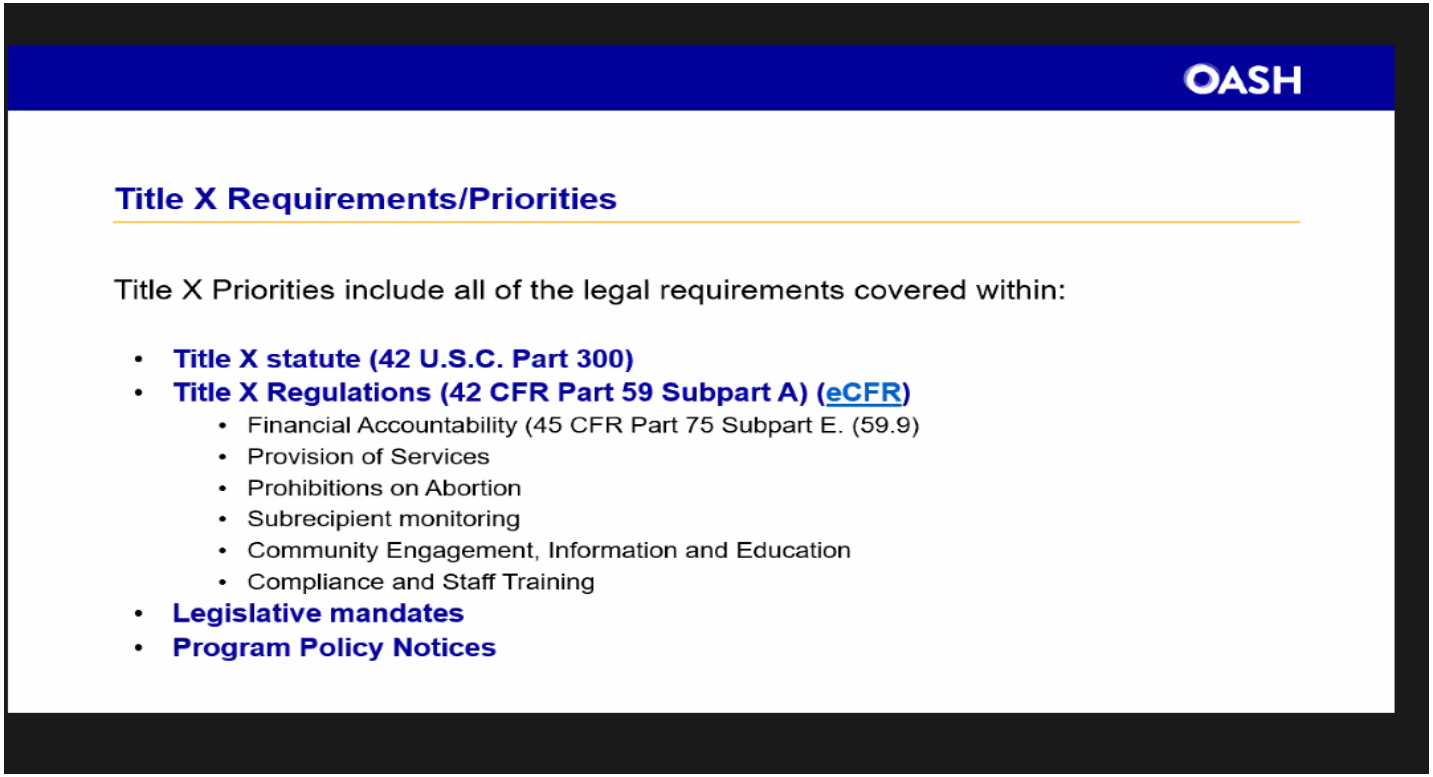
Fiscal Manager

Family Planning Program
State Office Staff



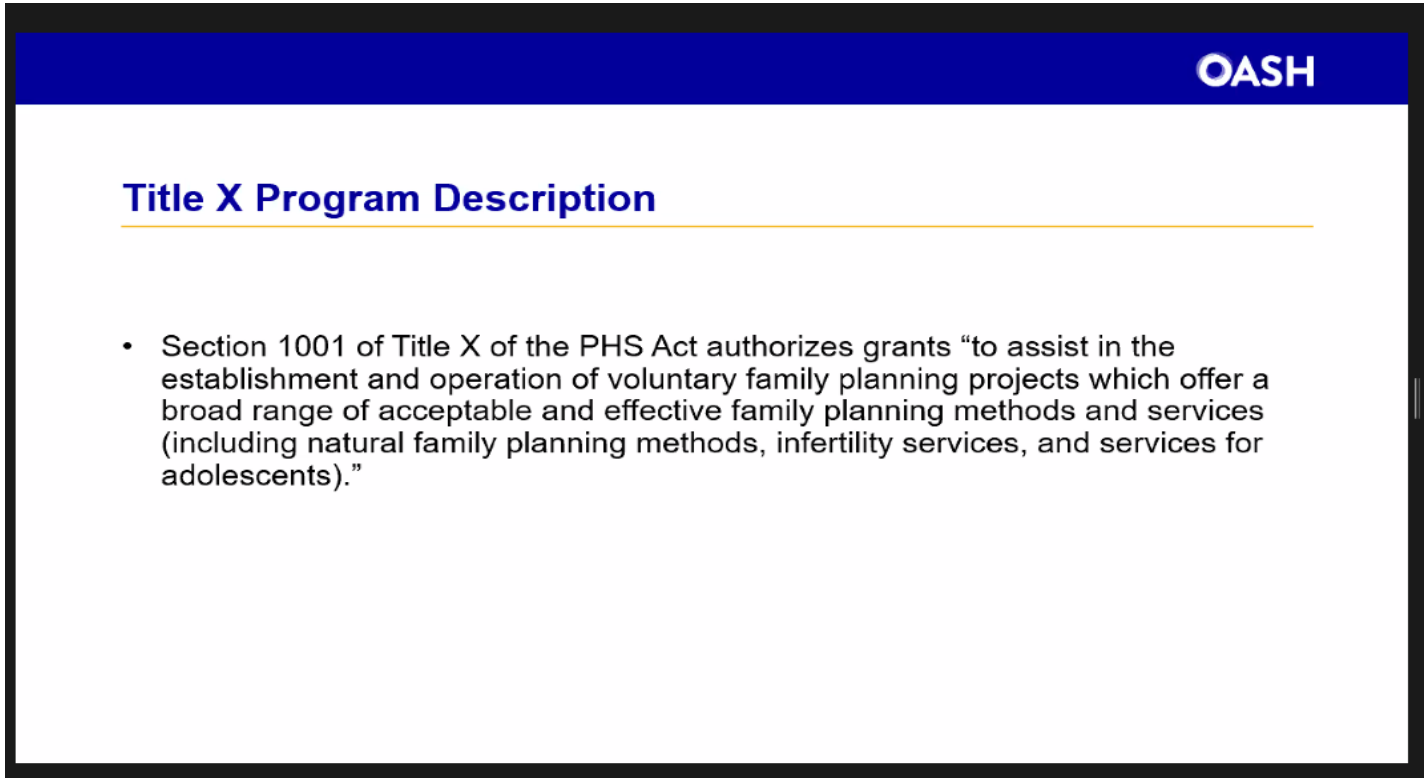
Title X Overview

from Grantee conference July 2021



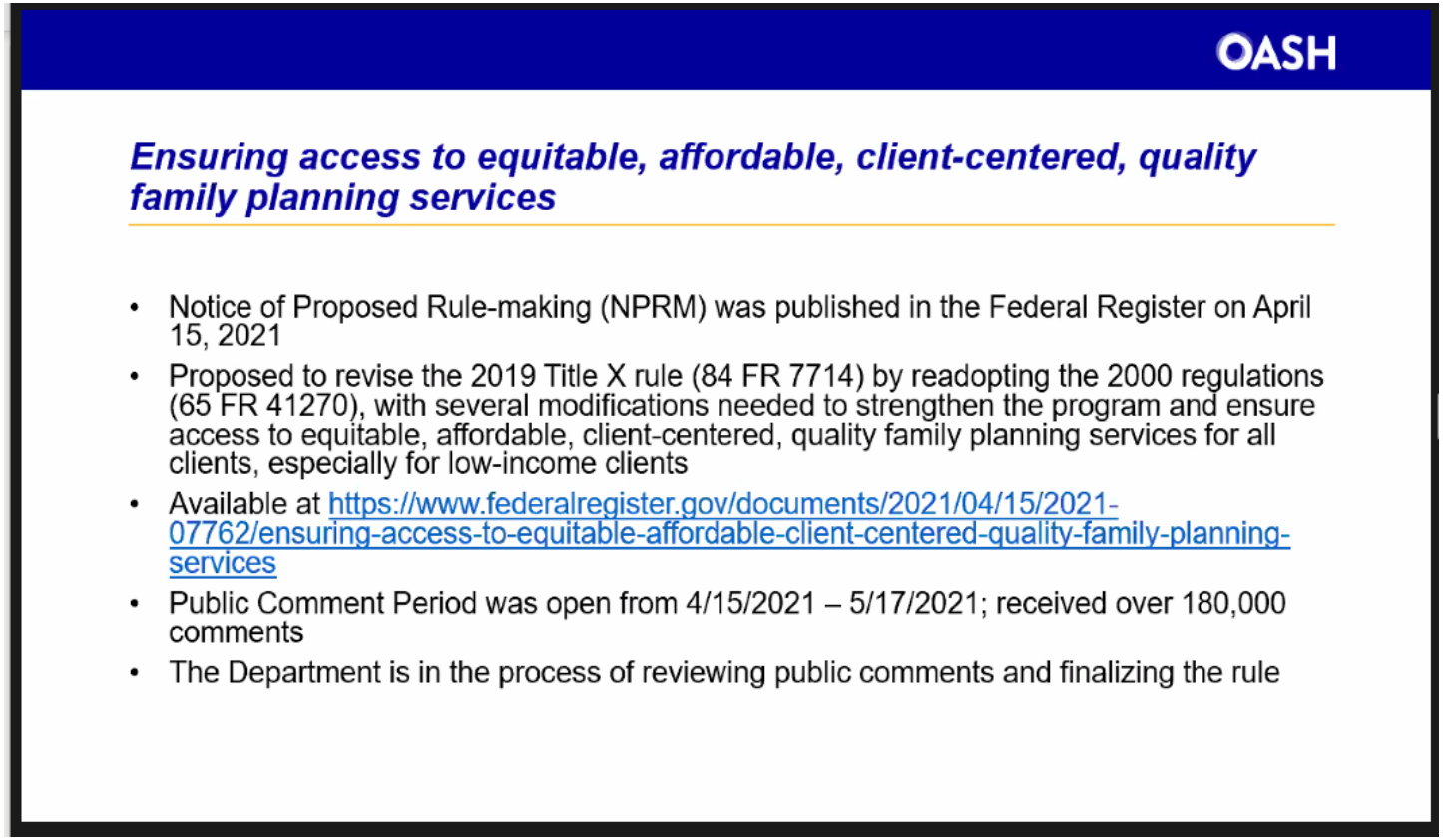
Title X Overview

from Grantee conference July 2021



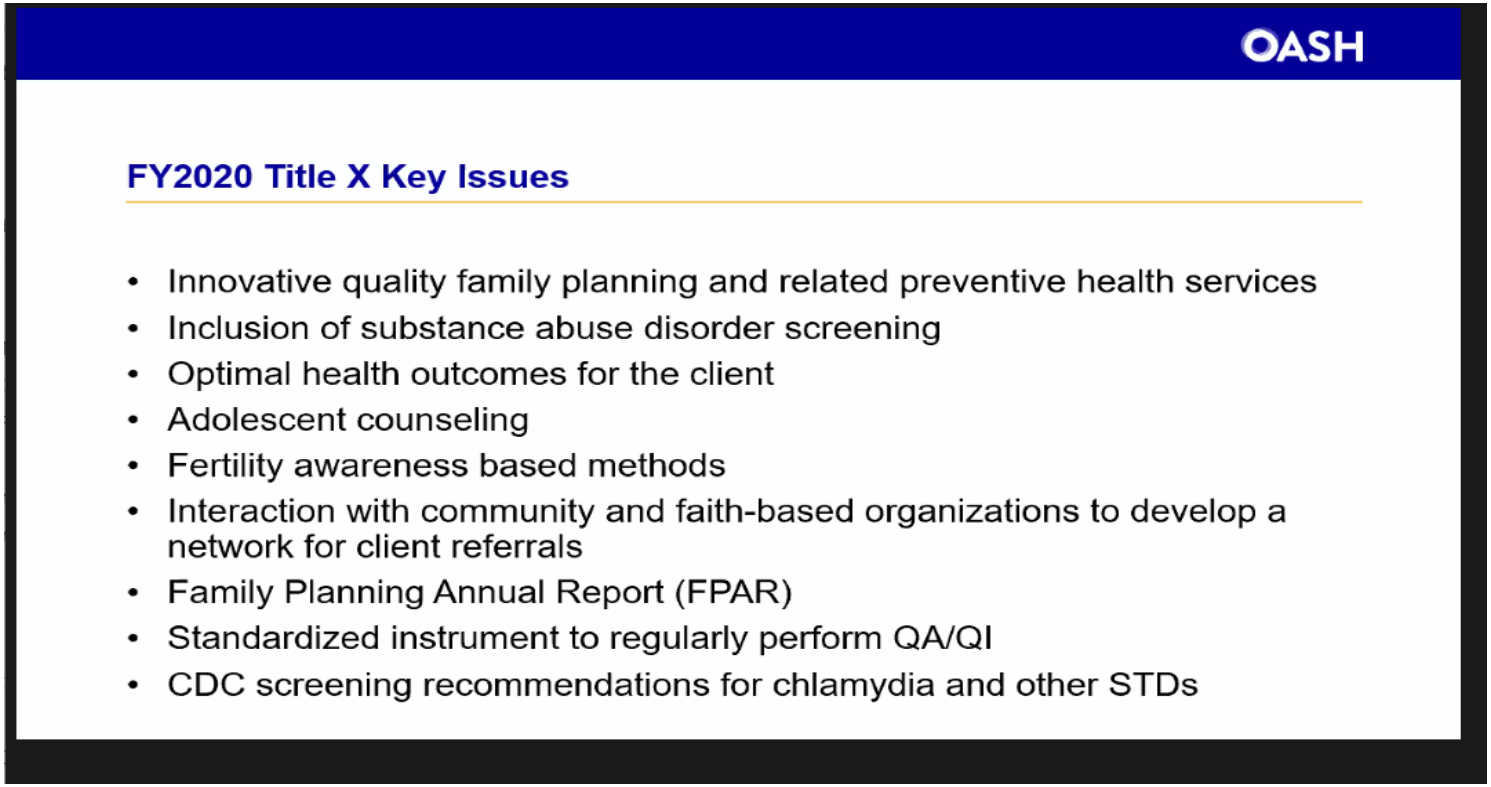
Title X Update

from Grantee conference July 2021



KEY Issues:

from Grantee conference July 2021



Title X Update

from NCTCFP Conference OPA Update 2021

OASH | Office of Population Affairs

Title X Family Planning Services

- Client-centered
- Confidential
- Culturally and linguistically appropriate
- Voluntary and non-coercive
- Inclusive
- Trauma-informed
- Youth-friendly
- Equitable

2022 Federal Program Review

- NMDOH has been notified the next federal program review shall be conducted in 2022. This may be an onsite visit and/or virtual components combined.
- The FPP will prepare and work with the federal reviewers and selected site staff to facilitate and support the process.
- This is an exciting opportunity to celebrate our strengths and identify areas of improvement in an environment of changes over the past two years.

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LARC update

Amanda Goertz, MD MPH

Physician Consultant, Family Planning Program

Extended use of LARCs

- Nexplanon: use for up to 5 years
- Paragard: up to 12 years
- Liletta/Mirena: up to 7 years.

- Source Contraceptive Technology 21st edition, Hatcher et al, page 133.
- Ali M, Bahamondes L, Bent Landoulsi S. Extended Effectiveness of the Etonogestrel-Releasing Contraceptive Implant and the 20 µg Levonorgestrel-Releasing Intrauterine System for 2 Years Beyond U.S. Food and Drug Administration Product Labeling. Glob Health Sci Pract. 2017 Dec 28;5(4):534-539. doi: 10.9745/GHSP-D-17-00296. PMID: 29263025; PMCID: PMC5752601.

Nexplanon

- No pregnancies up to 5 years in either of 2 studies
- Levels of ENG adequate for protection at 5 yrs
- Limited data in overweight/obese population
  - Serum levels in this population are still adequate
- Limited data in adolescents

Paragard

- Good evidence of effectiveness at 12 years
  - Study population were all >25 and parous
  - No pregnancies in years 10-12

Source: ACOG practice bulletin 186

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LNg IUDs

- Mirena and Liletta now both FDA approved for 6 years
- Both Mirena and Liletta have evidence demonstrating effectiveness to 7 years
  - At 7 years pregnancy rate lower than that of TCu380A
  - Study was parous women, median age 30
- No evidence yet on extended use for Skyla or Kyleena

https://doi.org/10.1016/j.contraception.2016.02.024

Client Counseling

- Review advantages: longer interval between procedures, potential savings for client
- Review disadvantages: progestin methods may have increased BTB due to lower progestin methods. Can replace if so.
- Nexplanon extended use Level B Recommendation, very good evidence
- Extended use of Liletta, Mirena and Paragard Level A recommendation, excellent evidence.
- Less evidence in special populations (younger, obese, or nulliparous)
- Off-label does not mean not safe
- Use shared decision making with the client, can extend or replace based on client preference

Reproductive autonomy

- Emphasis added in protocol:

Client can have LARC removed at any time for any reason

  - No obligation to keep and troubleshoot etc

Liletta inserter change

- Manufacturer has changed insertion device
- FPP has several months of prior Liletta device in stock
- Video available on Lilettahcp.com
- Additional training and support can be arranged if needed (live or virtual)

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Consent form changes

- More concise
- Fewer blocks of text
- Consistency in format between LARC methods

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CONTRACEPTIVE IMPLANT CONSENT FORM

BENEFITS: Contraceptive implants consist of one capsule that holds a small amount of birth control hormone, etonogestrel. This medicine is slowly released under the skin to prevent pregnancy. The contraceptive implant is over 99% effective.

CONTRAINDICATIONS (REASONS I CANNOT USE THIS METHOD):

- Pregnancy
- Current arm infection
- Current breast cancer

RISKS:

Common mild to moderate risks include:

- Menstrual changes including: irregular, lighter, heavier or absent periods
- Headaches
- Weight gain
- Anxiety and/or depression
- Scarring or bruising at the insertion/removal site

Seek immediate medical attention for these severe but rare side effects:

- Severe headaches
- Vision changes
- Pain in legs, abdomen, or chest
- Lump in breast
- Severe depression or anxiety
- Excessive bleeding
- Yellow skin or eyes

Possible complications of Insertion/Removal Procedures:

- Damage to blood vessels or nerves
- Difficult removal requiring referral to specialist
- Infection at procedure site

Provider Privileging

- New providers with adequate experience in providing LARCs:
  - Only require 1 IUD insertion observed
  - Only require 1 implant removal and insertion
- RHO will determine whether new provider has adequate experience
  - May require more at their discretion
- Inexperienced providers require same as before (5 IUD, 2 implant)

Summary

- Offer extended use LARC with shared decision making
- Always remove LARC if client requests
- Stay tuned for Liletta inserter change
- Simpler LARC consents
- Expedited Privileging

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DepoProvera®
DMPA

Rameet Singh MD MPH

Physician Consultant, Family Planning Program

DMPA - Dosages

- 150 mg IM
- 105 mg SubQ
- Mechanism of Action
  - Prevents ovulation
  - Thickens cervical mucus
- Menstrual cycles stop in most women
- Adverse Events:
  - Weight gain in Adolescents
  - Reversible bone loss

Subcutaneous DMPA

- Designed for self-administration
  - Greater autonomy
  - Reduced barriers
- Smaller needle
- 1/3rd the volume of medication compared to IM
- Compared to IM dosing
  - Equal or less pain
  - Less side effects

Process for Initiating DMPA Sub-Q

- Clinicians may prescribe the initial order for DMPA
- Dosing Interval
  - Q 11-15 weeks for 12 months
- Clinicians may chose to dispense 6 or 12 month supply
- Patient can initiate self-injection under direction of clinician in the clinic

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PHN – Quick start Initiation DMPA

- Counsel patients about IM in clinic versus home Sub-Q use
- First DMPA injection can be given any time if you are reasonably certain that the client is not pregnant.
- PHN can administer
  - DMPA 150 mg IM or
  - DMPA 104 mg Sub-Q
  - Instruct client on self-administration and observe first self Sub-Q injection in clinic

Self-Injection Simple Instructions

1. Wash hands
2. Remove syringe from package and shake for 1 min until mixed
3. Hold needle pointing up and tap syringe to shake air bubbles to top
4. Push syringe until air bubbles are out.
5. Choose injection site (in abdomen or anterior thigh), wipe with alcohol pad and let area dry.
6. Take cap off needle and hold syringe in dominant hand
7. Grab skin around injection site with non-dominant hand and insert needle all the way into the skin at 45-degree angle
8. Press syringe all the way in and keep needle in place while counting to five
9. Remove needle and dispose of into a sharps disposal container
10. Apply light pressure to prevent bleeding without massaging

Self-Injection Handout

HOW DO I USE DEPO?

- Give yourself a Depo shot in the belly or thigh.
- Use condoms as back-up for 7 days after your first shot of Depo.
- It's ideal to give your next shot in 11-13 weeks, but acceptable and effective for 2 more weeks. The calendar attached will provide the 11-15 week date range.

WHAT IF I AM LATE FOR THE NEXT SHOT?

- Your shot is late if it is past the date range on the calendar. If you are late on your shot, take a pregnancy test. If the test is negative take the next shot. Use condoms for the next 7 days. Take another pregnancy test 2 weeks from that date.

WHAT IF I AM LATE GETTING A SHOT AND HAD UNPROTECTED SEX?

- If your shot is late, take Emergency Contraception (EC) right after unprotected sex. EC can prevent pregnancy up to 5 days after sex, and it works better the sooner you take it.
- Contact your clinic for questions.

HOW DO I STORE MY DEPO INJECTION?

- You can store Depo at room temperature (for example in your bathroom cabinet).

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DMPA Injection Perpetual Calendar

DMPA Injection Perpetual Calendar/ Calendario Perpetuo de Inyección DMPA

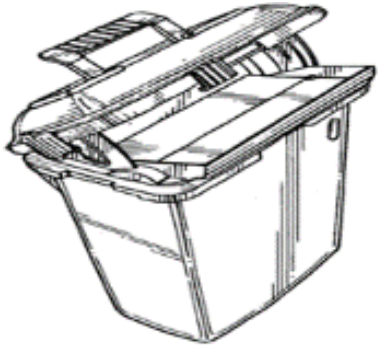
11-15 weeks after last injection/11-15 semanas después de la última invección

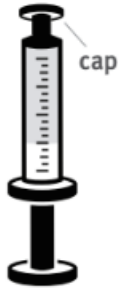
GIVEN/ ADMINI-STRADA	DUE/VENCE: 11-13 Weeks 11-13 Semanas	ACCEPTABLE/ ACECPTABLE 13-15 Weeks 13-15 Semanas	GIVEN/ ADMINI-STRADA	DUE/VENCE: 11-13 Weeks 11-13 Semanas	ACCEPTABLE/ ACECPTABLE 13-15 Weeks 13-15 Semanas	GIVEN/ ADMINI-STRADA	DUE/VENCE: 11-13 Weeks 11-13 Semanas	ACCEPTABLE/ ACECPTABLE 13-15 Weeks 13-15 Semanas	GIVEN/ ADMINI-STRADA	DUE/VENCE: 11-13 Weeks 11-13 Semanas	ACCEPTABLE/ ACECPTABLE 13-15 Weeks 13-15 Semanas
1/1	3/19 – 4/2	4/3 – 4/16	2/17	5/5 – 5/19	5/20 – 6/2	4/5	6/21 – 7/5	7/6 – 7/19	5/22	8/7 – 8/21	8/22 – 9/4
1/2	3/20 – 4/3	4/4 – 4/17	2/18	5/6 – 5/20	5/21 – 6/3	4/6	6/22 – 7/6	7/7 – 7/20	5/23	8/8 – 8/22	8/23 – 9/5
1/3	3/21 – 4/4	4/5 – 4/18	2/19	5/7 – 5/21	5/22 – 6/4	4/7	6/23 – 7/7	7/8 – 7/21	5/24	8/9 – 8/23	8/24 – 9/6
1/4	3/22 – 4/5	4/6 – 4/19	2/20	5/8 – 5/22	5/23 – 6/5	4/8	6/24 – 7/8	7/9 – 7/22	5/25	8/10 – 8/24	8/25 – 9/7
1/5	3/23 – 4/6	4/7 – 4/20	2/21	5/9 – 5/23	5/24 – 6/6	4/9	6/25 – 7/9	7/10 – 7/23	5/26	8/11 – 8/25	8/26 – 9/8
1/6	3/24 – 4/7	4/8 – 4/21	2/22	5/10 – 5/24	5/25 – 6/7	4/10	6/26 – 7/10	7/11 – 7/24	5/27	8/12 – 8/26	8/27 – 9/9
1/7	3/25 – 4/8	4/9 – 4/22	2/23	5/11 – 5/25	5/26 – 6/8	4/11	6/27 – 7/11	7/12 – 7/25	5/28	8/13 – 8/27	8/28 – 9/10
1/8	3/26 – 4/9	4/10 – 4/23	2/24	5/12 – 5/26	5/27 – 6/9	4/12	6/28 – 7/12	7/13 – 7/26	5/29	8/14 – 8/28	8/29 – 9/11
1/9	3/27 – 4/10	4/11 – 4/24	2/25	5/13 – 5/27	5/28 – 6/10	4/13	6/29 – 7/13	7/14 – 7/27	5/30	8/15 – 8/29	8/30 – 9/12
1/10	3/28 – 4/11	4/12 – 4/25	2/26	5/14 – 5/28	5/29 – 6/11	4/14	6/30 – 7/14	7/15 – 7/28	5/31	8/16 – 8/30	8/31 – 9/13
1/11	3/29 – 4/12	4/13 – 4/26	2/27	5/15 – 5/29	5/30 – 6/12	4/15	7/1 – 7/15	7/16 – 7/29	6/1	8/17 – 8/31	9/1 – 9/14
1/12	3/30 – 4/13	4/14 – 4/27	2/28	5/16 – 5/30	5/31 – 6/13	4/16	7/2 – 7/16	7/17 – 7/30	6/2	8/18 – 9/1	9/2 – 9/15
1/13	3/31 – 4/14	4/15 – 4/28	3/1	5/17 – 5/31	6/1 – 6/14	4/17	7/3 – 7/17	7/18 – 7/31	6/3	8/19 – 9/2	9/3 – 9/16
1/14	4/1 – 4/15	4/16 – 4/29	3/2	5/18 – 6/1	6/2 – 6/15	4/18	7/4 – 7/18	7/19 – 8/1	6/4	8/20 – 9/3	9/4 – 9/17
1/15	4/2 – 4/16	4/17 – 4/30	3/3	5/19 – 6/2	6/3 – 6/16	4/19	7/5 – 7/19	7/20 – 8/2	6/5	8/21 – 9/4	9/5 – 9/18
1/16	4/3 – 4/17	4/18 – 5/1	3/4	5/20 – 6/3	6/4 – 6/17	4/20	7/6 – 7/20	7/21 – 8/3	6/6	8/22 – 9/5	9/6 – 9/19
1/17	4/4 – 4/18	4/19 – 5/2	3/5	5/21 – 6/4	6/5 – 6/18	4/21	7/7 – 7/21	7/22 – 8/4	6/7	8/23 – 9/6	9/7 – 9/20
1/18	4/5 – 4/19	4/20 – 5/3	3/6	5/22 – 6/5	6/6 – 6/19	4/22	7/8 – 7/22	7/23 – 8/5	6/8	8/24 – 9/7	9/8 – 9/21
1/19	4/6 – 4/20	4/21 – 5/4	3/7	5/23 – 6/6	6/7 – 6/20	4/23	7/9 – 7/23	7/24 – 8/6	6/9	8/25 – 9/8	9/9 – 9/22
1/20	4/7 – 4/21	4/22 – 5/5	3/8	5/24 – 6/7	6/8 – 6/21	4/24	7/10 – 7/24	7/25 – 8/7	6/10	8/26 – 9/9	9/10 – 9/23
1/21	4/8 – 4/22	4/23 – 5/6	3/9	5/25 – 6/8	6/9 – 6/22	4/25	7/11 – 7/25	7/26 – 8/8	6/11	8/27 – 9/10	9/11 – 9/24
1/22	4/9 – 4/23	4/24 – 5/7	3/10	5/26 – 6/9	6/10 – 6/23	4/26	7/12 – 7/26	7/27 – 8/9	6/12	8/28 – 9/11	9/12 – 9/25
1/23	4/10 – 4/24	4/25 – 5/8	3/11	5/27 – 6/10	6/11 – 6/24	4/27	7/13 – 7/27	7/28 – 8/10	6/13	8/29 – 9/12	9/13 – 9/26
1/24	4/11 – 4/25	4/26 – 5/9	3/12	5/28 – 6/11	6/12 – 6/25	4/28	7/14 – 7/28	7/29 – 8/11	6/14	8/30 – 9/13	9/14 – 9/27
1/25	4/12 – 4/26	4/27 – 5/10	3/13	5/29 – 6/12	6/13 – 6/26	4/29	7/15 – 7/29	7/30 – 8/12	6/15	8/31 – 9/14	9/15 – 9/28
1/26	4/13 – 4/27	4/28 – 5/11	3/14	5/30 – 6/13	6/14 – 6/27	4/30	7/16 – 7/30	7/31 – 8/13	6/16	9/1 – 9/15	9/16 – 9/29

Self-Injection Handout

HOW DO I INJECT MY HOME DEPO INJECTION?

- Gather your supplies:
  - Alcohol pad, Depo syringe and needle, and sharps container to safely throw away your syringe after injection.
  - If no sharps container, use an empty plastic laundry soap bottle or other thick plastic bottle with a lid or cap. (Refer to your Disposal of Needles Handout).

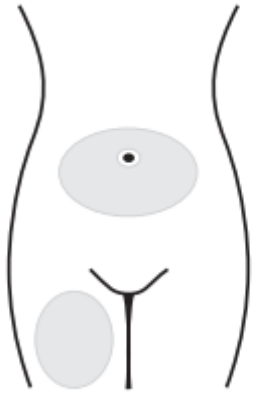




Prefilled syringe

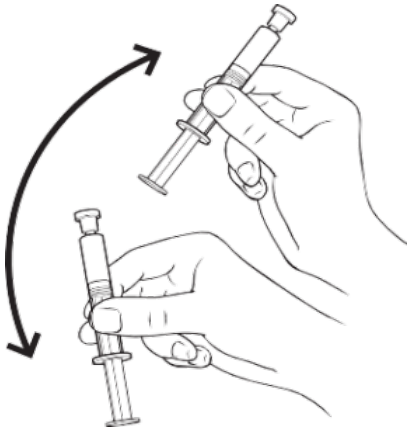
Self-Injection Handout

- Wash your hands.
- Pick your injection site: either upper thigh or belly. Avoid your belly button and bony areas.



Self-Injection Handout

- Wipe your skin with an alcohol pad and wait for the area to dry. If no alcohol pad is available, wash the area with soap and water.
- Take the syringe out of the package and shake it for 1 minute to mix it.



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Self-Injection Handout

- Remove the cap from the tip of the syringe.
- Attach the needle to the syringe.
- Move the safety shield away from the needle.
- Remove the plastic needle cover from the needle. Pull it straight off. (Do not twist it).

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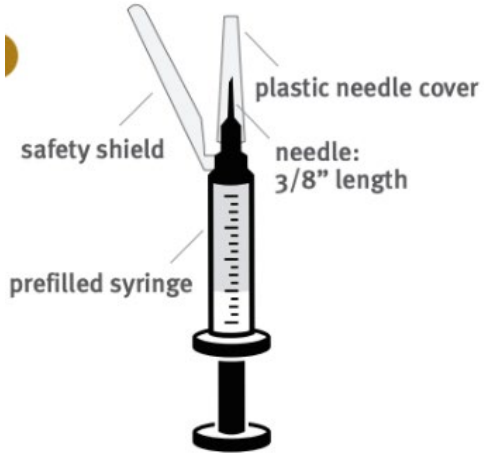
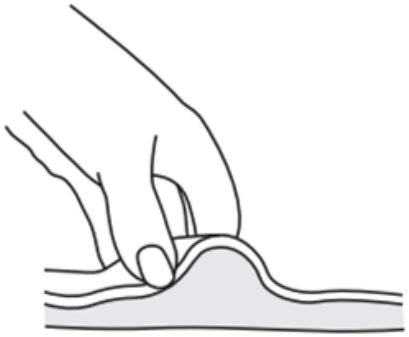
Self-Injection Handout

- Hold the needle pointing up. Let the bubbles settle. Hold the needle pointing up and tap the syringe to shake any air bubbles to the top. Very gently and slowly push the plunger up until the air bubbles are out and the medicine reaches the top.



Self-Injection Handout

- Hold your syringe in your dominant hand (whichever hand you use to write).
- Pinch the skin around the injection site with your other hand.



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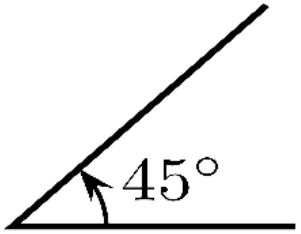
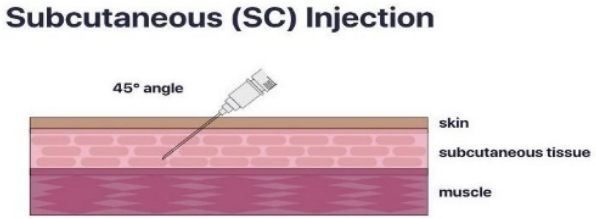
Self-Injection Handout

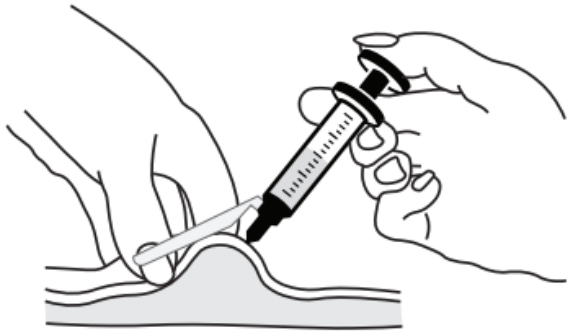
- Push the small needle all the way into this skin at about a 45-degree angle.





Self-Injection Handout

- Inject the Depo slowly, over 5-7 seconds. Push the plunger all the way in.



Self-Injection Handout

- Pull the syringe out. Push the safety shield back until it clicks. Put the used syringe in the Sharps container. Keep the Sharps container for the next syringe.
- Apply pressure to the spot but don't rub it.
- Your next dose is due in 11-15 weeks. Mark this in your calendar or set a reminder on your phone.
- When you are ready to throw away the sharps container or other plastic container you used please refer to the instruction sheet given. DO NOT PLACE IN RECYCLING.

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Disposal of Needles

- What to do with used needles (also known as SHARPS)?

Option One: You can discard sharps in a container provided by the Public Health Office or Title X clinic.

Disposal of Needles

- Return a used container provided by the Public Health Office or Title X clinic to an approved needle exchange site (Public Health Office) in the community. Call ahead for instructions. If there is not an approved needle exchange site in your community, you may discard used needles as described in Option Two.
- **Do NOT** place used needles or your sharps container in recycling bins.
- **Do NOT** place loose needles in trash bags or carts.
- **Do NOT** recap needles.

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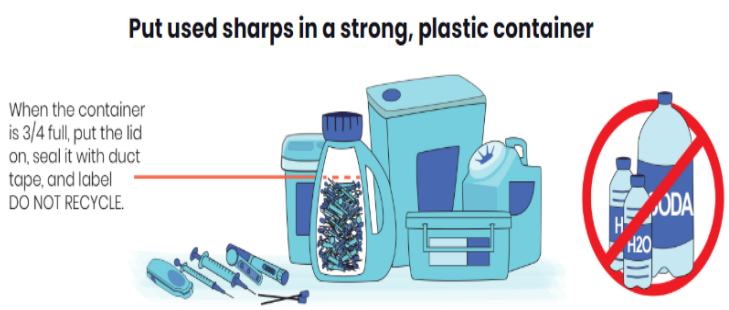
Disposal of Needles

Option Two: You can use a rigid plastic container that has a lid, such as an empty laundry detergent bottle. If so:

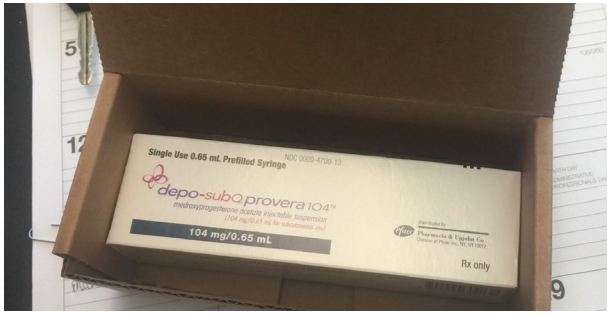
- Be sure the container is cleaned thoroughly before using and avoid using bottles that have had certain types of cleaners in them. Avoid using a bottle from ammonia (such as glass or multi-purpose cleaners) or vinegar-based products. Check the empty bottle's label for a warning about not mixing with bleach to make sure.

Disposal of Needles

- Add a small amount of bleach (enough to cover the bottom).
- The container can be used for multiple syringes/needles. When the container is ¾ full: place the lid on the container, seal the container with duct tape, and place it in the trash (DO NOT RECYCLE the container).



Disposal of Unused Medication



Medications may be disposed of through local take-back programs. Please contact your local drugstore, law enforcement agency, fire department, hospital, clinic, or public health office to find out whether take-back services are offered.

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STI Updates – 2021

Christopher Novak, MD, MPH
Medical Director, PHD
Acting Medical Director, FPP

CDC STI Treatment Guidelines

- Prior version released 2015
- Updated July 21, 2021
  - www.cdc.gov/std/treatment-guidelines/default.htm
  - General format follows 2015
  - Many small changes to information due to:
    - New studies
    - Laboratory testing options
    - Prevention techniques
    - Etc.
  - Moderate changes to treatment options

Overall

In the Summary, the CDC highlights these updates:

1. Updated recommendations for treatment of
   - *Neisseria gonorrhoeae,*
   - *Chlamydia trachomatis*, and
   - *Trichomonas vaginalis*
2. Addition of metronidazole to the recommended treatment regimen for PID
3. Alternative treatment options for BV

***Refraining from alcohol use while taking metronidazole is unnecessary!**

1. Management of *Mycoplasma genitalium*
2. HPV vaccine recommendations and counseling messages
3. Expanded risk factors for syphilis testing among pregnant women
4. One-time testing for hepatitis C infection
5. Evaluation of men who have sex with men after sexual assault, and
6. Two-step testing for serologic diagnosis of genital herpes simplex virus

General

- STI/HIV Risk Assessment
  - The Five P's approach for health care providers
- Primary Prevention Methods
- Partner Services
  - EPT – consider more flexible for MSM
- STIs in Special Populations (e.g., pregnancy, children/adolescents, MSM, WSW, WSWM, transgender/gender diverse, corrections)
- Penicillin allergy management

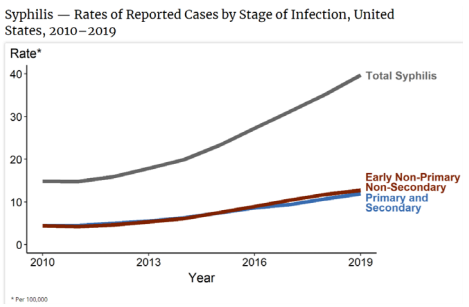
HIV Screening

- Recommend voluntary, informed screening for all persons seeking STI evaluation not already known to have HIV infection
- At least once for all persons aged 15–65 years
- Higher risk for HIV acquisition (e.g., sexually active gay, bisexual, and other MSM)
  - At least annually
  - May be more frequent (e.g., every 3–6 months)
- Screen during the first prenatal visit
  - Second test during 3rd trimester (<36 weeks' gestation) recommended if high risk

HIV Management

- ART as soon as possible for all persons with HIV infection
  - Acute HIV:
    - Immediate referral to an HIV clinical care provider
    - Prevention counseling
    - Screen for STIs
    - PEP for contacts <72 hours

Syphilis – Prim/Sec



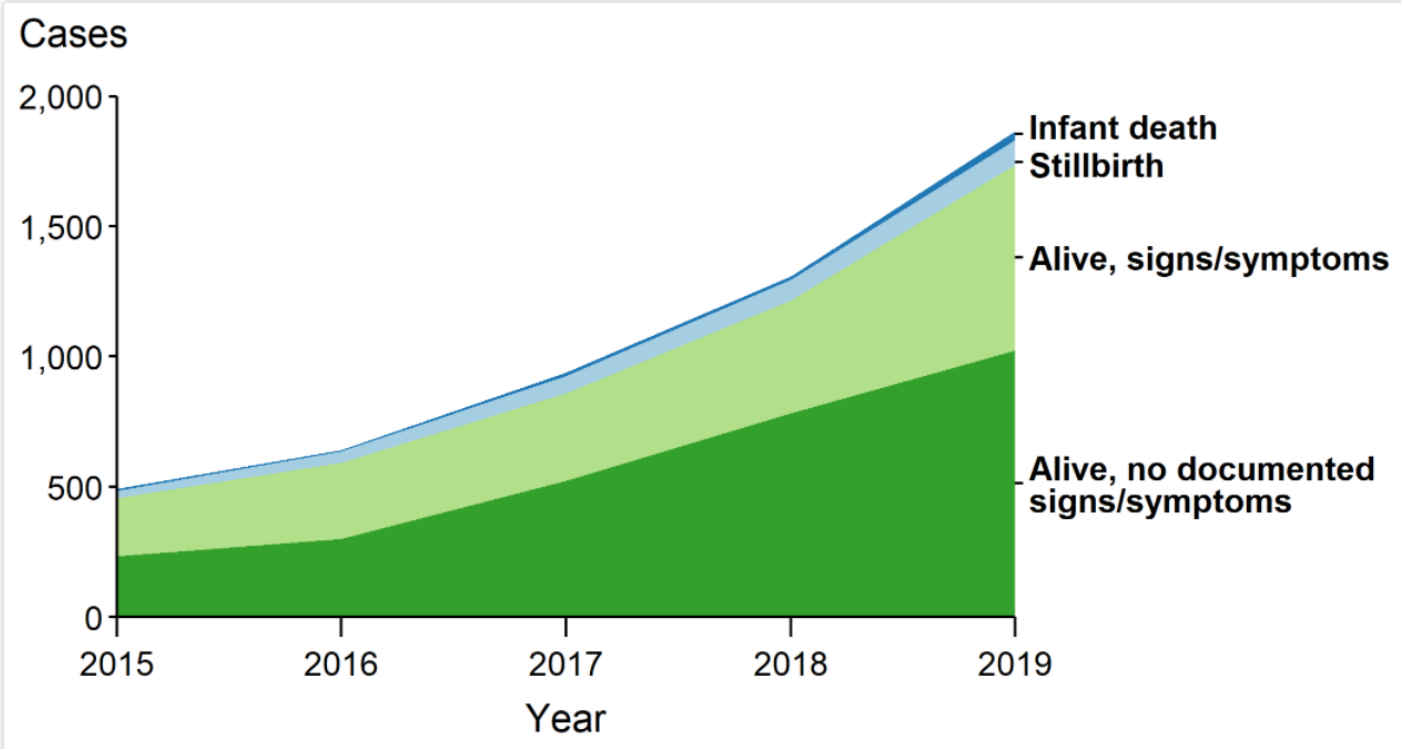
Syphilis — Rates of Reported Cases by Stage of Infection, United States, 2010–2019 (cdc.gov)

- Treatment: unchanged (Benzathine penicillin G 2.4 million units IM x 1)
- Alternatives:
  - Doxycycline if adequate adherence/follow-up
  - Desensitize/BIG if pregnant or inadequate follow-up
- Other
  - Test for HIV – if negative, offer HIV PrEP
  - Routine CSF exam not needed
  - Neurologic disease – evaluation including CSF
  - Ocular syphilis – CNS exam, ocular slit-lamp, ophthalmologic exam – CSF may not be needed
  - Otic syphilis – otologic exam – CSF not needed
- Follow-up
  - At 6 and 12 months
  - Failure of titers to decrease 4-fold in 12 months might indicate failure (10-20% do not)
    - Neuro exam, annual testing, re-evaluate HIV – consider re-treatment, consider CSF and 3-week tx

Syphilis – Latent

- Goal is prevention of complications (incl congenital syphilis)
- Treatment: Unchanged
  - Delayed doses (10-14 days) may be acceptable, but >9 days in pregnancy = re-start course
- Alternatives:
  - Doxycycline if adequate adherence/follow-up
  - Desensitize/BIG if pregnant or inadequate follow-up
- Other
  - Test for HIV – if negative, offer HIV PrEP
  - Routine CSF exam not needed
  - Neurologic disease, ocular syphilis, otic syphilis – see primary/secondary
- Follow-up
  - At 6, 12, and 24 months
  - Failure of titers to decrease 4-fold at 24 months might indicate failure (10-20% do not)
    - Neuro exam, annual testing, re-evaluate HIV – consider re-treatment, consider CSF and 3-week tx

Congenital Syphilis — Reported Cases by Vital Status and Clinical Signs and Symptoms* of Infection, United States, 2015–2019

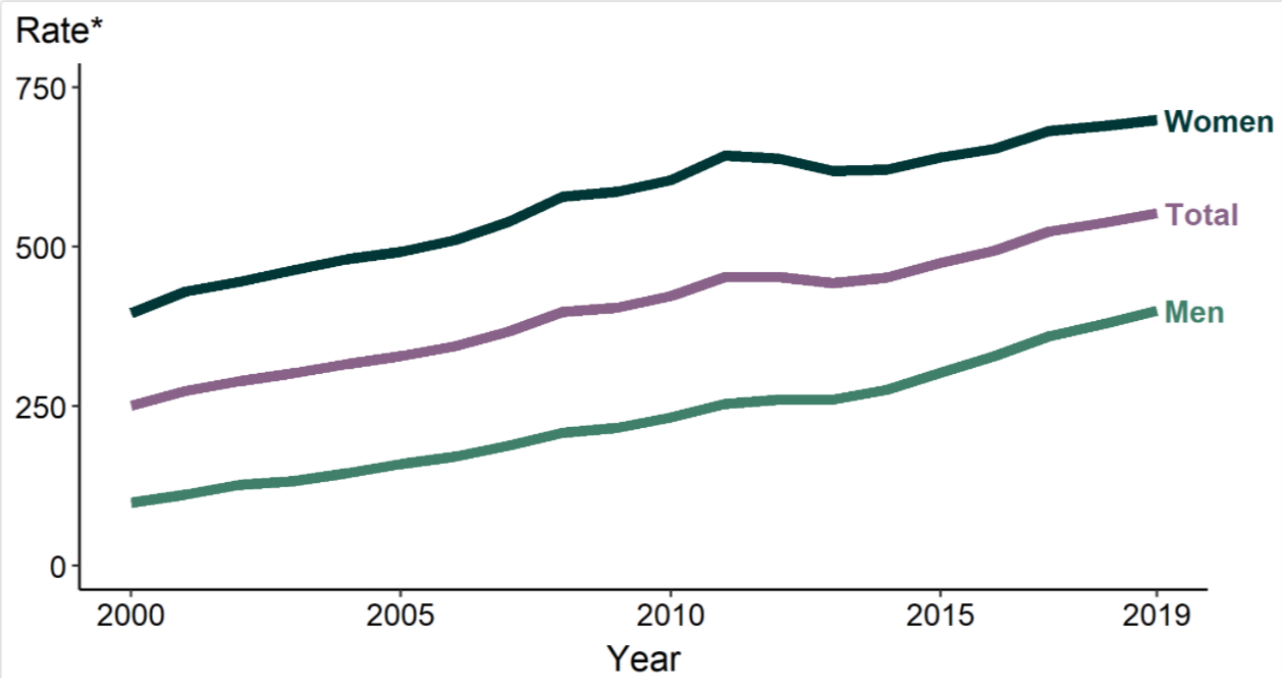


Congenital Syphilis — Reported Cases by Vital Status and Clinical Signs and Symptoms* of Infection, United States, 2015–2019 (cdc.gov)

Syphilis During Pregnancy

- Screen all women
  1. First prenatal visit
     - Consider at time of pregnancy testing
  2. 28 weeks' gestation
  3. Delivery if in communities with high rates or have risk
- Stable, serofast low titers if prior tx may not need additional treatment – treat if increasing or high
- If screen w/trep (EIA, CIA) and positive → non-trep (RPR, VDRL) neg → second trep (TPPA) and risk for decisions
- Tx by stage
  - Consider second dose of BIG
  - Missed doses (>9 days) not acceptable – repeat full course

Chlamydia — Rates of Reported Cases by Sex, United States, 2000–2019



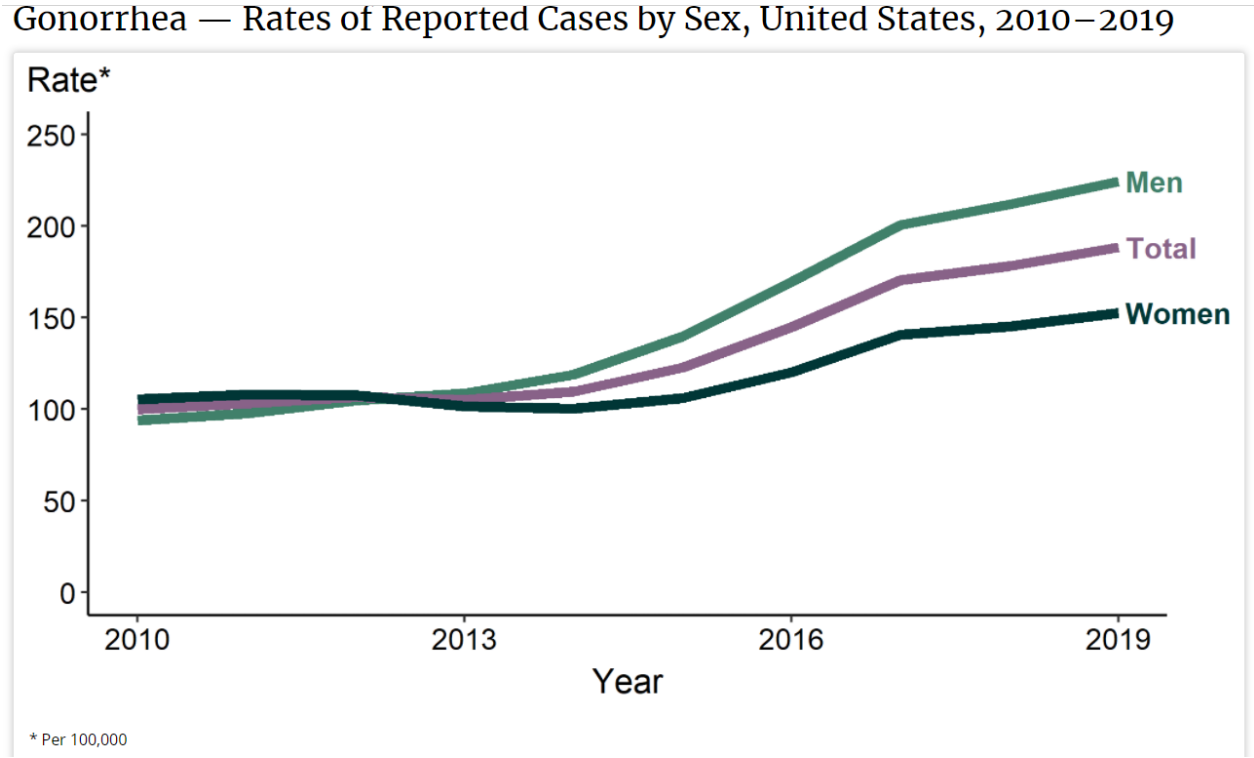
Chlamydia — Rates of Reported Cases by Sex, United States, 2000–2019 (cdc.gov)

Chlamydia

- Annual screening all sexually active women aged <25 years or increased risk
  - Routine screening in males unclear - consider if resources, high prevalence
  - More frequent possible based on risk
  - Self-collected vaginal or male meatal swab equiv to clinician-collected
- Rectal infection
  - Annual for males with rectal exposure; consider for females based on risk
  - Self-collected equiv to clinician-collected
- Oropharyngeal infection
  - Significance unclear – routine screening not recommended
- Point of Care (POC) tests exist

Chlamydia

- Treatment Change!
  - Recommend (non-pregnant):
    - Doxycycline 100 mg orally 2 times/day for 7 days
    - Less failure, better for rectal (and ?oral) infection
  - Alternative:
    - Azithromycin 1 g orally in a single dose – esp pregnancy or adherence issues (OR Levofloxacin 500 mg orally once daily for 7 days or Amoxicillin 500 mg orally 3 times/day for 7 days in pregnancy)
- First dose (multi- or single-) should be directly observed
- Test/presumptive treat partners < 60 days or most recent partner
  - EPT
- Test of cure:
  - Non-pregnant: not advised unless adherence, symptoms persist, reinfection suspected
  - Pregnant: 4 weeks after tx completion
- Retest at three months



Gonorrhea — Rates of Reported Cases by Sex, United States, 2010–2019 (cdc.gov)

Gonorrhea

- Annual screening all sexually active women aged <25 years or increased risk
  - MSM annually – all sites; if high risk, every 3-6 months
  - Non-MSM and women ≥25 y.o. routine screening not recommended
  - Self-collected vaginal or male meatal swab equiv to clinician-collected
- Point of Care (POC) tests exist

Gonorrhea

- Treatment Change!
  - Recommend (non-pregnant):
    - <150 kg (330lb): Ceftriaxone 500 mg IM in single dose
      - ≥ 150 kg: Ceftriaxone 1,000 mg IM in single dose
  - Alternative:
    - Gentamicin 240 mg IM in a single dose
      AND
    - Azithromycin 2 g orally in a single dose

    OR
    - Cefixime 800 mg orally in a single dose
- Treat for chlamydia (doxycycline) if not excluded (and not covered by regimen)
- First dose (multi- or single-) should be directly observed
- Test/presumptive treat partners < 60 days or most recent partner
  - EPT – Cefixime 800 mg orally in single dose (+/- doxycycline for CT if not excluded)
- Test of cure:
  - Urogenital/Rectal: Not advised unless adherence, symptoms persist, reinfection suspected
  - Pharyngeal: 7–14 days after initial treatment
- Retest at three months

Trichomoniasis

- Uncertain value screening/tx asymptomatic trich
  - Routine annual screening among asymptomatic women with HIV infection recommended
- Extragenital possible but very uncommon - efficacy, benefit, cost-effectiveness of screening unknown
- Pro Tip: to improve detection, wet mount evaluation immediately after specimen collection (sensitivity 20% within 1 h after collection)
- Treatment:
  - Women: Metronidazole 500 mg orally twice daily x 7 days
  - Men: Metronidazole 2 g orally once
  - Limited alternatives – can request CDC culture if failure

Epididymitis

- Treatment
  - GC plus CT
  - If enteric organisms (men who practice insertive anal sex):
    - Levofloxacin 500 mg orally once daily for 10 days

Other Items

- National Shortages (www.cdc.gov/std/treatment/drug-notices.htm):
  - Current
    - Trichloracetic acid (TCA)
    - Gentamicin
  - Resolved
    - Azithromycin
    - Procaine Penicillin
- Additional Resources:
  - *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020*

    www.cdc.gov/std/qcs/default.htm

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Lab Updates

Amanda Goertz, MD MPH

Physician Consultant, Family Planning Program

Cervical Cancer Screening

- Major changes to ASCCP guidelines
  - Algorithms largely replaced by webtool/app
  - Co-testing largely replaced with “HPV-based testing”
- Change in programmatic process for HPV testing

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HPV testing

- At this time, primary method of screening in clients without a history of abnormality is still cytology q3 yrs
  - HPV for universal screening is under consideration but NOT currently covered by FPP
- New guidelines call for “HPV-based testing” for follow up paps, for FPP this will continue to be co-testing
  - Due to programmatic constraints HPV test with reflex cytology (as mentioned in guidelines) is not available

HPV and pap orders

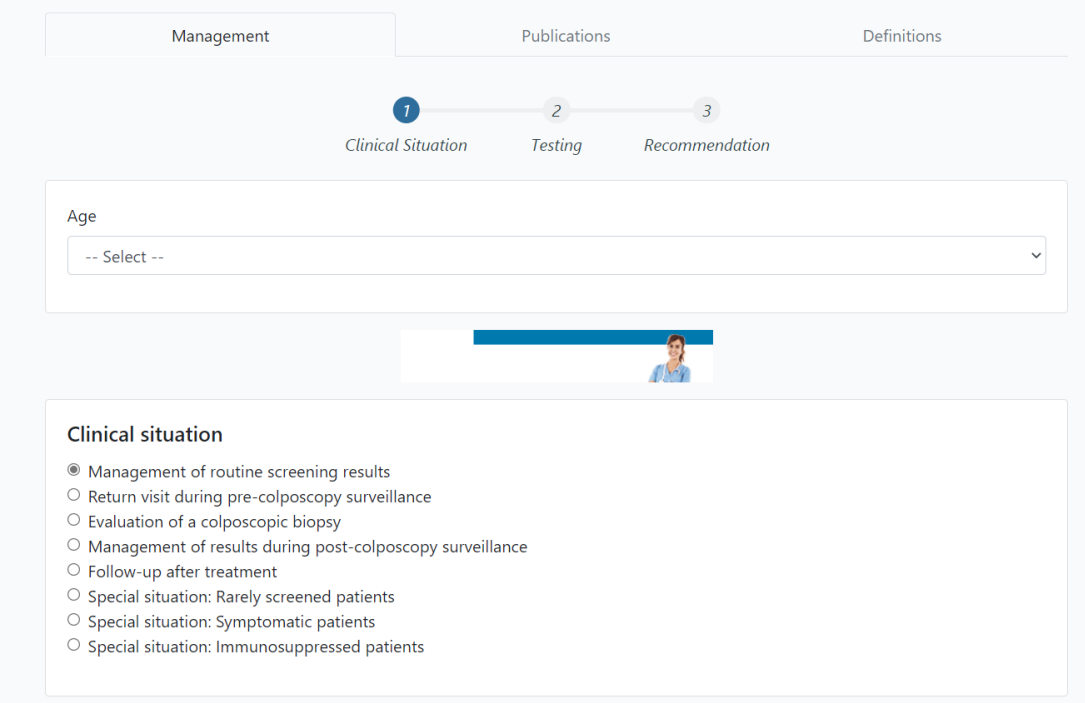
- FP Thin Prep pap
  - Main screening modality
- FP HPV test
  - Add on for ASCUS in 25+
- FP Thin Prep pap/HPV co-test
  - When indicated as per ASCCP tool

ASCCP webtool

- Uses risk-based strategy
  - Takes into account prior results, or lack thereof
  - Equivalent management for equivalent risk
- Many algorithms no longer in use
- Webtool/app will be updated in ongoing fashion, in place of larger updates every few years
- Webtool free, app can be purchased at your own expense
  - App gives more detailed recommendations

ASCCP webtool

- App.asccp.org
- Note special situations (eg rarely screened or immunosuppressed)



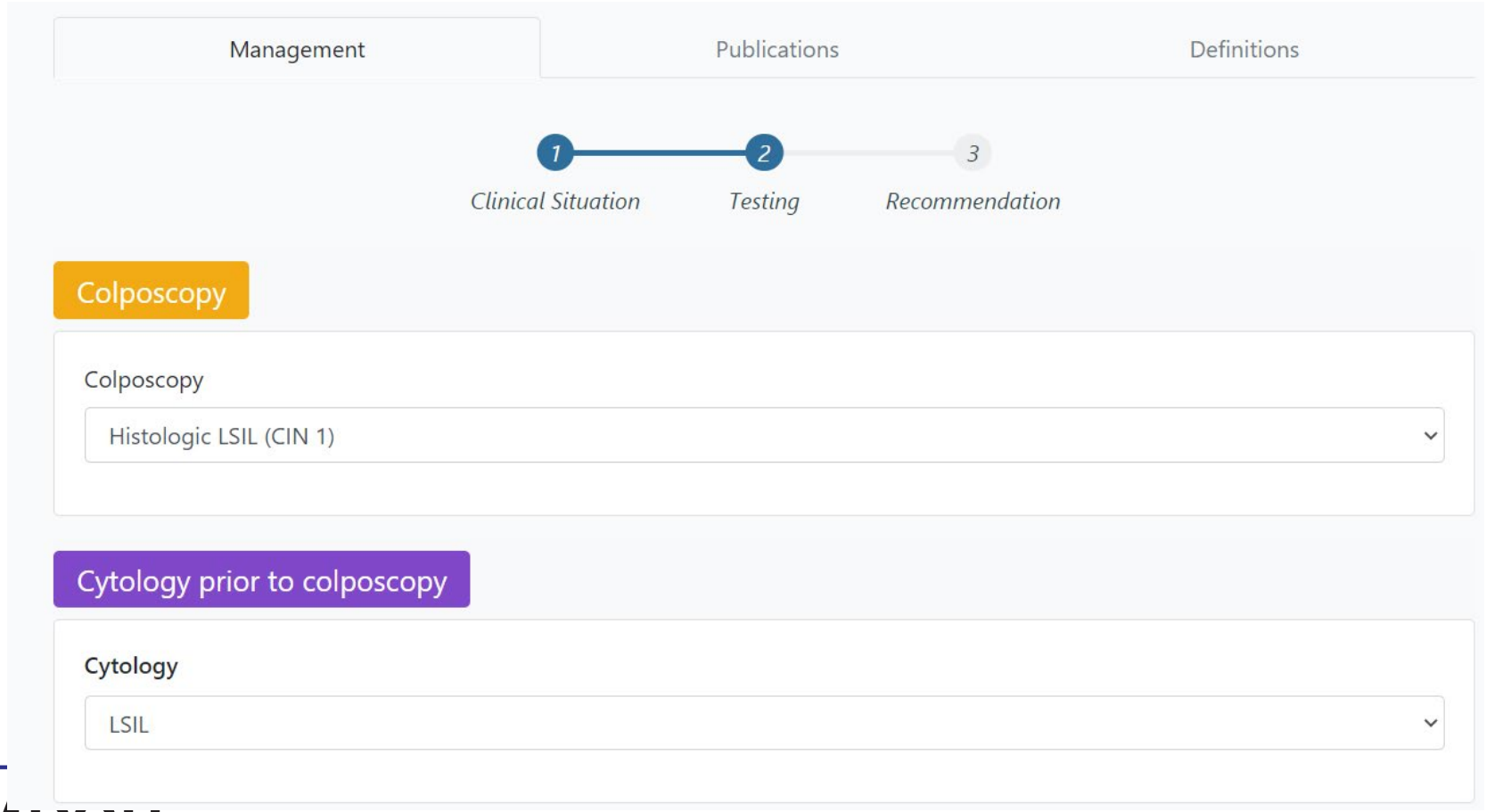
1 Clinical Situation — 2 Testing — 3 Recommendation

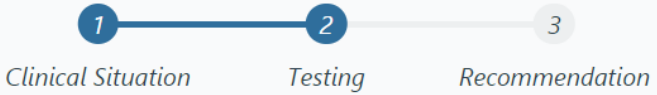
Age

30 to 65

Clinical situation

- ○ Management of routine screening results
- ○ Return visit during pre-colposcopy surveillance
- ◉ Evaluation of a colposcopic biopsy
- ○ Management of results during post-colposcopy surveillance
- ○ Follow-up after treatment
- ○ Special situation: Rarely screened patients
- ○ Special situation: Symptomatic patients
- ○ Special situation: Immunosuppressed patients


Management
Publications
Definitions
1
2
3
Clinical Situation
Testing
Recommendation
Colposcopy
Colposcopy
Histologic LSIL (CIN 1)
Cytology prior to colposcopy
Cytology
LSIL



Confirmation

Evaluation of a colposcopic biopsy
Age: 30 to 65

Current results

Colposcopy with a biopsy of CIN 1

Cytology prior

LSIL

1 Clinical Situation — 2 Testing — 3 Recommendation

RECOMMENDATION

1-year follow-up[1]

REFERENCES

1. Perkins RB, Guido RS, Castle PE, et al. 2019 ASCCP risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors. J Low Genit Tract Dis 2020;24:102–31.

App vs Webtool

- Most specific guidance available via app
  - General rule of thumb: all f/u testing in 25+ is HPV-based (eg Co-test)
- Webtool is more general, but specific guidance can be found in guidelines paper
- Call FPP clinical team to discuss if unclear what the guidance is

Chlamydia testing

- Reminder: all female clients under 25 should be screened annually for chlamydia with OPT-OUT language
  - This is grant mandated performance measure
  - Click the order with FP in the title to ensure we are able to track the data

Summary

- Use ASCCP web tool
- Use Cytology q3 years for most clients
- Use co-test for follow up whenever “HPV based test” is recommended
- Don’t forget to screen for Chlamydia!

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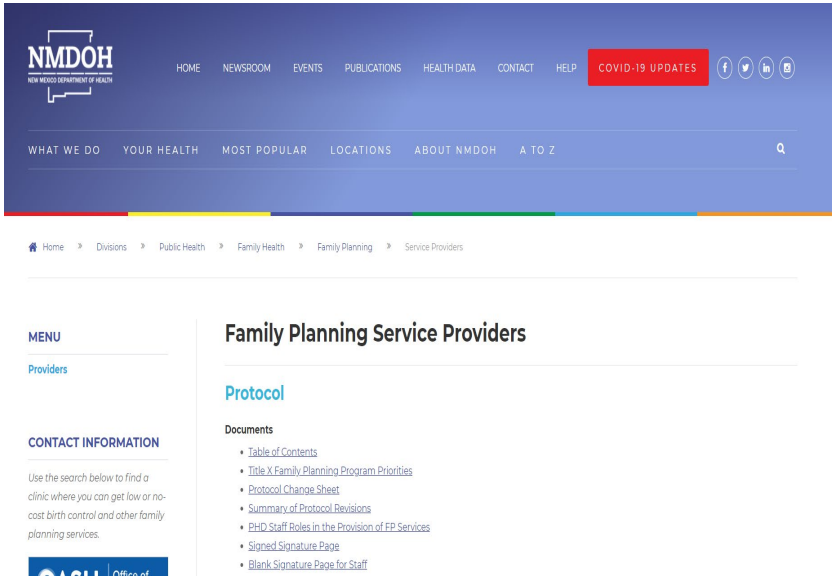
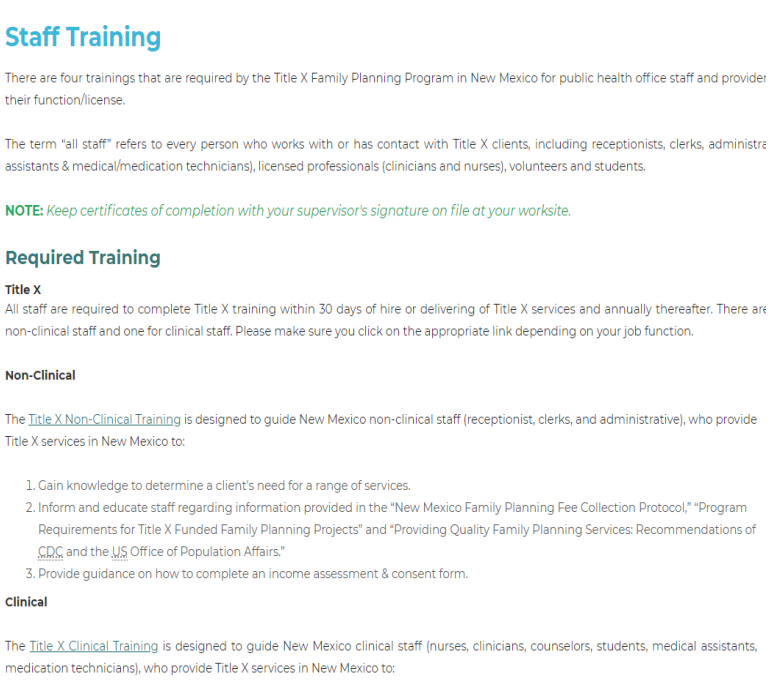
Appendix D
Staff Orientation & Training

Tina Sanchez, Nurse Consultant

Title X Mandatory Trainings

Training links and details are on the FPP website at
https://nmhealth.org/about/phd/fhb/fpp/pvdr





Title X Mandatory Trainings

In Appendix D, the term “all staff” refers to every person who works with or has contact with Title X clients, including receptionists, clerks, administrative staff, clinical staff (medical assistants & medical/medication technicians), licensed professionals (clinicians and nurses), volunteers, and students.

Up-to-date certificates of completion/attendance must be maintained at each Public Health Office (PHO) and Provider Agreement (PA) site for all mandatory (or accepted) courses. Certificates will be requested for all site visits conducted by the NM Family Planning Program.

Title X Mandatory Trainings

Refer to the FPP Protocol Appendix D Staff Orientation & Training links on the FPP website Service Providers at https://nmhealth.org/about/phd/fhb/fpp/pvdr

- Title X Orientation - Clinical and Non-Clinical (Revised):
  - All staff (both Public Health Office & Provider Agreement) are required to complete trainings within 30 days of hire or delivering Title X services.
  - Current employees must complete within 90 days from date of 2021 protocol update.
  - Completion required annually.

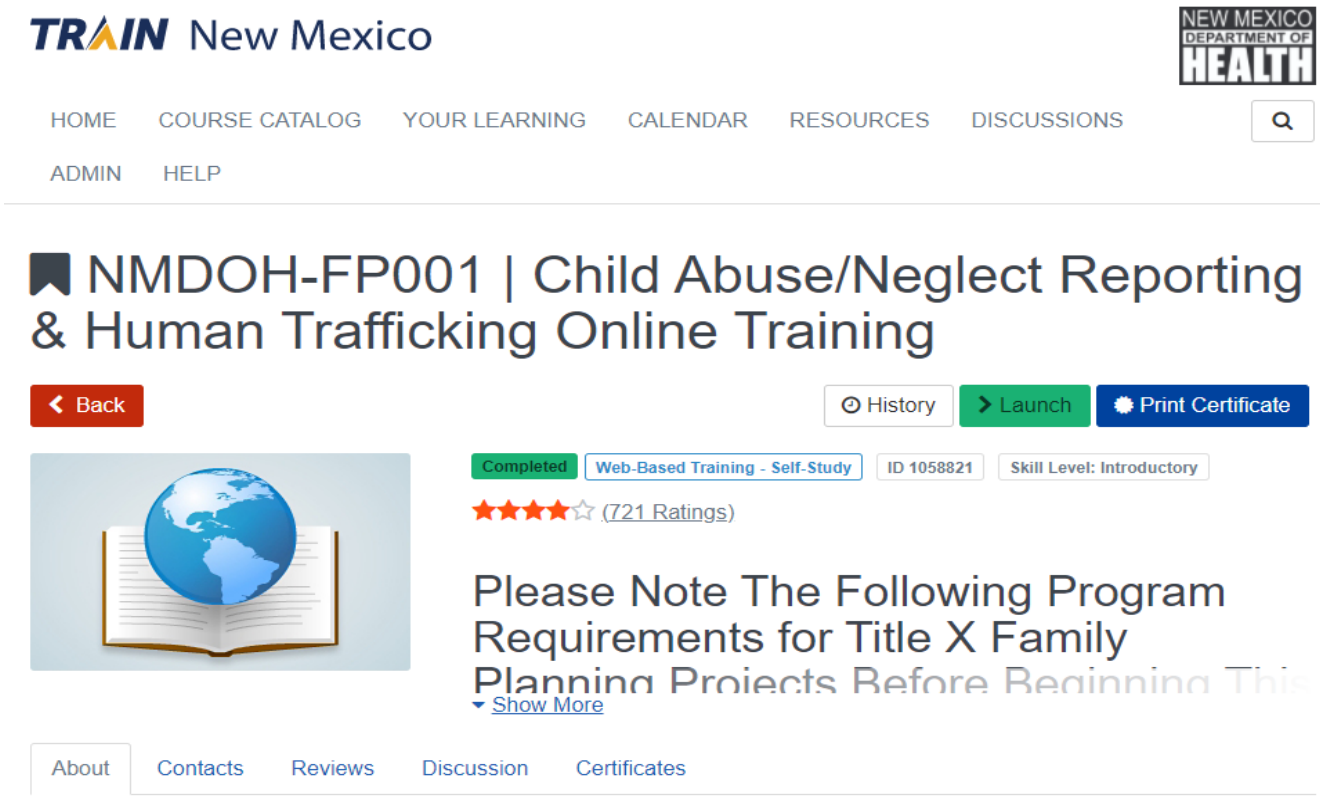
  Use current links on the FPP webpage for these courses now. Do not use old course links (from your NM TRAIN training history) as they will take you to obsolete courses that are missing required information and for most users do not launch.

- Reporting Abuse and Human Trafficking:
  - All staff (both Public Health Office & Provider Agreement sites) are required to complete training within 30 days of hire or delivering Title X services.
  - Completion required annually.

NMTRAIN REVISED Title X Clinical and Non-Clinical Orientation courses

Do NOT take old courses that are entitled NMDOH-FP005 Clinical Title X and NMDOH-FP004 Non-Clinical Title X

NMTRAIN Child Abuse/Neglect Reporting & Human Trafficking course



Title X Mandatory Trainings

Refer to the FPP Protocol Appendix D Staff Orientation & Training links on the FPP website Service Providers at https://nmhealth.org/about/phd/fhb/fpp/pvdr

- Cultural Competency (New FPP Required Course):
  - All staff (both Public Health Office & Provider Agreement sites) are required to complete training within 90 days of hire or delivering Title X services.
  - Current employees must complete within 90 days from date of 2021 protocol update.
  - Completion required once.

FIRST, go to www.RHNTC.org and create an account, log in, and do course "search" by entering the name "Cultural Competency in Family Planning Care eLearning". THEN proceed in completing the course and evaluation. You have to be signed in to complete the evaluation and generate a certificate of completion. **Important to log in FIRST, do course search, select course, then complete the course.**

Title X Mandatory Trainings

www.rhntc.org

Title X Mandatory Trainings

Refer to the FPP Protocol Appendix D Staff Orientation & Training links on the FPP website Service Providers at https://nmhealth.org/about/phd/fhb/fpp/pvdr

- VAST-D (Violence, Alcohol Use, Substance Use, Tobacco Use-Depression):
  - Only licensed professionals (both Public Health Office & Provider Agreement sites) are required to complete training within 30 days of hire or delivering of Title X services.
  - Completion required once.

Title X Mandatory Trainings

Refer to the FPP Protocol Appendix D Staff Orientation & Training links on the FPP website at https://nmhealth.org/about/phd/fhb/fpp/pvdr

WORKPLACE-SPECIFIC REQUIRED TRAININGS

- PA Sites: refer to your agency's written policies & procedures for trainings that address HIPAA, civil rights and work safety.

PA sites Title X staff are now required to complete the RHNTC cultural competency course – link on FPP website.

Title X Mandatory Trainings

Refer to the FPP Protocol Appendix D Staff Orientation & Training links on the FPP website at https://nmhealth.org/about/phd/fhb/fpp/pvdr

- PHO Sites: see table below of required Title X courses and HIPAA requirements and continue to follow DOH/PHD policies for work safety and civil rights.

Course	Upon Hire (or within 30 days of seeing clients)	Upon Hire (or within 90 days of seeing clients)	Annually	Every 2 years	Once
HIPAA Privacy Rule Overview				X	
Cultural Competency (New FPP Required Course)		X			X
Title X Orientation – Clinical (Revised)	X		X		
Title X Orientation – Non-Clinical (Revised)	X		X		
Reporting Abuse & Human Trafficking	X		X		
VAST-D – for licensed professionals only	X				X

Recommended Courses and Resources

Details and links in Appendix D on FPP website at
https://nmhealth.org/about/phd/fhb/fpp/pvdr

- **Reproductive Health ECHO Clinics** https://hsc.unm.edu/echo/institute-programs/reproductive-health/
- **Putting the QFP (Quality Family Planning) into Practice Series Toolkit** (RHNTC)
- **Title X Orientation** (RHTNC); does not replace Clinical and Non-Clinical Title X courses
- **Substance Use Disorder** (SUD) and Related Topics (RHNTC)
- **Fertility Awareness Based Methods (FABMS) (FPP Protocol/Section 2, RHNTC, RH ECHO, Contraceptive Technology, Apps, etc.)**
- **Adolescent Counseling** (RHNTC)
- **Human Trafficking** (RHNTC) and Human Trafficking Hotline, Job Aids
- **Sexually Transmitted Infections (STIs)** (CDC, RHNTC) **including Chlamydia Screening Toolkit**
- **Trauma-Informed Care** (TIC) (RHNTC, NCTCFP, National Center on Domestic Violence)
- **Cultural Competency** (RHNTC) optional; do not meet cultural competency equivalent

Offers free CMEs, CNEs, CEUs, etc.

Join Us for Reproductive Health (RH) ECHO

2nd and 4th Monday, from 12:00 pm to 1:10 pm (MT).

For more information contact us at ReproductiveHealthECHO@salud.unm.edu.

Register for Reproductive Health ECHO (for clinic notifications, link to recorded sessions, curriculum and case form).

RH ECHO Resources

- Curriculum – sessions are also recorded and available to view on-demand (CEs are not available for recorded sessions)
- New Online Case Presentation Form - quick and easy to submit directly from the form and presentation is scheduled for a RH ECHO clinic with facilitation by one of the RH ECHO Medical Directors. Please review the form and consider submitting and presenting a case.

National Training Centers

RHNTC
REPRODUCTIVE HEALTH
NATIONAL TRAINING CENTER

www.rhntc.org
Formerly known as FPNTC

NCTCFP
NATIONAL CLINICAL TRAINING
CENTER FOR FAMILY PLANNING

www.ctcfp.org

For any questions, please contact
Tina.Sanchez2@state.nm.us

Thank you!

- We would like to thank all staff who provide these important services, for the work that you do.

- FPP would also like to extend an additional thank you to our Protocol Reviewers, who provide their expertise and input to improve the Protocol each year.

- If you are interested in becoming a Protocol Reviewer, please contact Peg Ickes at peggy.ickes@state.nm.us