NM Department of Health
Family Planning Program (FPP) Title X
Annual Protocol Update

December 9, 2024

Disclosures

- NMDOH Family Planning Program staff
  - None

Objectives

- By the end of the presentation, participants will be able to:
  - Recognize the major changes in the 2024 FPP Protocol update.
  - Navigate the 2024 U.S. Medical Eligibility Criteria (US MEC) and Selected Practice Recommendations (US SPR) in clinical practice.
  - Apply evidence-based strategies for pain management during IUD insertion based on the latest SPR guidelines.
  - Understand and integrate thee revised clinical recommendations for several different conditions: Postpartum; Systems Lupus Erythematous; Post-abortion; Sickle Cell Disease; Additional concerns with increased risk of Thrombosis
  - Know how to submit timely and accurate Monthly Fee Collection reports.
  - Understand Title X clinics' fee collection as part of financial accountability of the Title X expectations.
  - Have an opportunity to ask questions or get clarification on the presentation contents.


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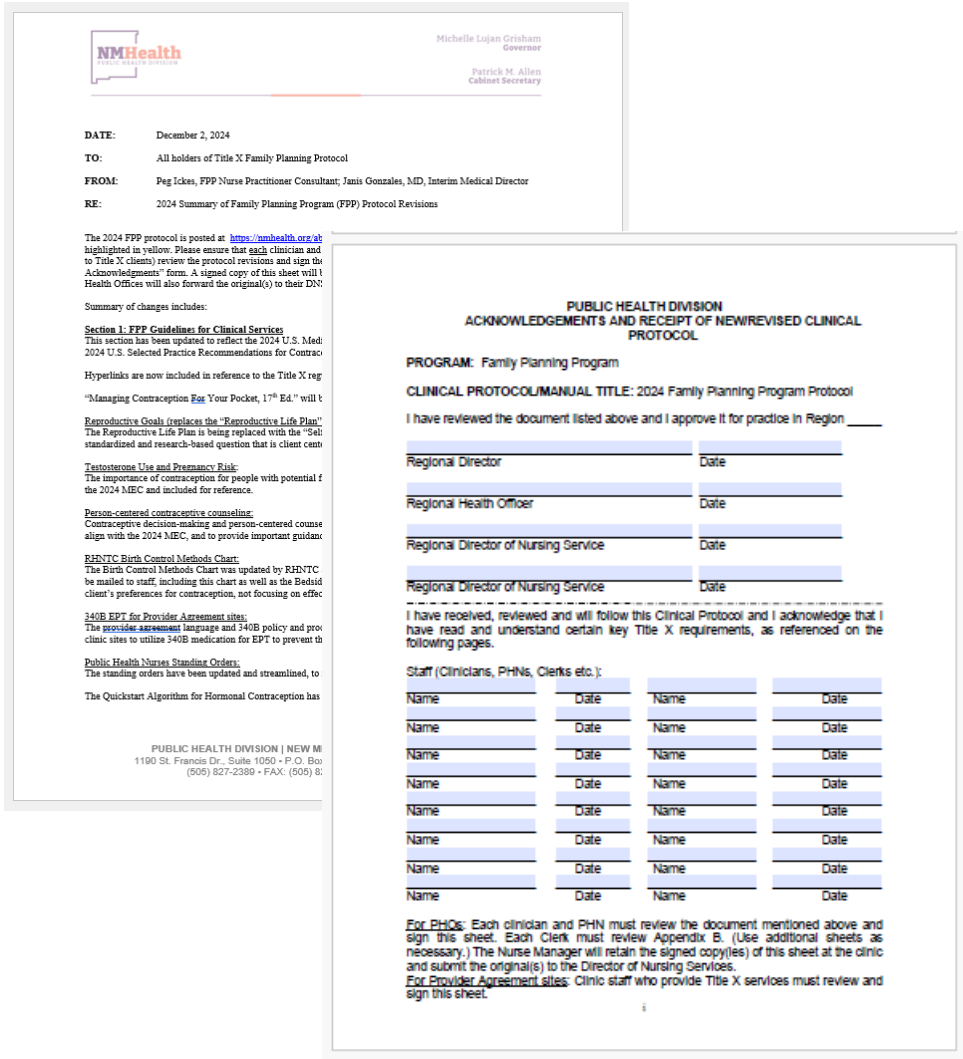
OPA Title X and Family Planning Program Updates

- Results of 2023 Federal Program Review
  - Third-party billing of insurance – policies and procedures
  - Suppression of confidential EOBs
  - Insured clients receiving Title X services (and site billing HMO)
  - Expanded definition of “family planning user” to include all sexual/reproductive health services, not only FP.
    - Integrated visits in PHOs – FP and STD services can be provided in the same visit.
- Year 4/5 – Non-Compete Continuation
- Client Demographics – 2023
  - 13,999 clients
    - 67% female
    - 15% 19yo and younger
    - 96% at or below 100 % FPL
    - 54% un- or under-insured; 31% on Medicaid
    - Female – top 3 most popular methods: OCP (18%), Depo (14%), Implant 7%).
    - 88% of clients seen at PHOs
  - 220 clients were served through telehealth services
    - 54 clients completed a client satisfaction survey, and all respondents agreed that they would use telehealth again for their family planning needs.

2024 Protocol Updates

- The 2024 FPP protocol is posted at https://nmhealth.org/about/phd/fhb/fpp/pvdr
- Changes or new material are highlighted in yellow.
- Please ensure that each staff that provide services to Title X clients review the protocol revisions and signs the "**Protocol Approval *Signature Pages* and Acknowledgments**" form. (Clerks must review Appendix B – Fee Collection Protocol and sign).
- A signed copy of this sheet will be maintained at the clinic.
- A summary letter outlines the changes.



NMHealth

Michelle Lujan Grisham
Governor

Patrick M. Allen
Cabinet Secretary

DATE: December 2, 2024

TO: All holders of Title X Family Planning Protocol

FROM: Peg Ickes, FPP Nurse Practitioner Consultant; Janis Gonzales, MD, Interim Medical Director

RE: 2024 Summary of Family Planning Program (FPP) Protocol Revisions

The 2024 FPP protocol is posted at https://nmhealth.org/ab
highlighted in yellow. Please ensure that each clinician and
to Title X clients) review the protocol revisions and sign th
Acknowledgments" form. A signed copy of this sheet will b
Health Offices will also forward the original(s) to their DN

Summary of changes includes:

Section 1: FPP Guidelines for Clinical Services
This section has been updated to reflect the 2024 U.S. Medi
2024 U.S. Selected Practice Recommendations for Contrac

Hyperlinks are now included in reference to the Title X reg

"Managing Contraception For Your Pocket, 17th Ed." will b

Reproductive Goals (replaces the "Reproductive Life Plan"
The Reproductive Life Plan is being replaced with the "Sel
standardized and research-based question that is client cent

Testosterone Use and Pregnancy Risk:
The importance of contraception for people with potential f
the 2024 MEC and included for reference.

Person-centered contraceptive counseling:
Contraceptive decision-making and person-centered counse
align with the 2024 MEC, and to provide important guidanc

RHNTC Birth Control Methods Chart:
The Birth Control Methods Chart was updated by RHNTC
be mailed to staff, including this chart as well as the Bedsid
client's preferences for contraception, not focusing on effec

340B EPT for Provider Agreement sites:
The provider agreement language and 340B policy and proc
clinic sites to utilize 340B medication for EPT to prevent th

Public Health Nurses Standing Orders:
The standing orders have been updated and streamlined, to

The Quickstart Algorithm for Hormonal Contraception has

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PUBLIC HEALTH DIVISION
ACKNOWLEDGEMENTS AND RECEIPT OF NEW/REVISED CLINICAL PROTOCOL

PROGRAM: Family Planning Program

CLINICAL PROTOCOL/MANUAL TITLE: 2024 Family Planning Program Protocol

I have reviewed the document listed above and I approve it for practice in Region ____

Regional Director — Date

Regional Health Officer — Date

Regional Director of Nursing Service — Date

Regional Director of Nursing Service — Date

I have received, reviewed and will follow this Clinical Protocol and I acknowledge that I have read and understand certain key Title X requirements, as referenced on the following pages.

Staff (Clinicians, PHNs, Clerks etc.):

Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date
Name	Date	Name	Date

For PHOs: Each clinician and PHN must review the document mentioned above and sign this sheet. Each Clerk must review Appendix B. (Use additional sheets as necessary.) The Nurse Manager will retain the signed copy(ies) of this sheet at the clinic and submit the original(s) to the Director of Nursing Services.
For Provider Agreement sites: Clinic staff who provide Title X services must review and sign this sheet.

2024 Protocol: Policies and Procedures Updates

- Links to Title X regulations/etc. throughout policies and procedures.
- Reference books: Managing Contraception For Your Pocket, 17th Ed. released December 2024- to be mailed to clinic sites. Please return acknowledgement of receipt to FPP.
- Beyond the Pill- Birth Control: What's Important to You? Flip book- English/Spanish contraceptive counseling tool for staff- to be mailed to clinics. Educational Materials | Beyond the Pill (ucsf.edu)
- RHNTC 9/24 updated Birth Control Methods Chart- to be mailed to clinics for client contraceptive counseling Birth Control Methods Chart (rhntc.org)

Quality Family Planning (QFP) 2.0

- QFP originally written in 2014, updated on November 19, 2024.
  - Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (QFP)
  - Quality Family Planning (QFP) Guide
- RHNTC (Reproductive Health National Training Center) provides updated information:
  - QFPguide.org
  - QFP At A Glance
  - And more trainings are being developed over the next few months.

These changes have been integrated into the 2024 FPP Protocol.
An additional training on RH ECHO will focus on the QFP 2.0 updates in 2025.

Assessing Need for Family Planning Services

- The Reproductive Life Plan approach.
  - Focused on plans around pregnancy
  - Did not resonate with clients who are uncertain if they would like pregnancy or not
  - Not aligned with how clients want to be asked about their reproductive needs
  - Did not identify the client's reproductive health preferences, values, needs
  - RLP does not always reflect the ways people develop and modify their reproductive goals over time.
- Assessment of Reproductive Needs should be person-centered, and equity informed.

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

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

SINC

- Self-Identified Need for Contraception
- Part of FPAR 2.0 required data, included in UDS for FQHCs, and listed as performance measure in Medicare/Medicaid bulletin
- Research based, person-centered
- Can be integrated into EHRs
- RH ECHO 9/23/24 recording: Also, at iecho

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

If **yes**:
- Document and provide contraceptive counseling.

If **no**:
- Clarification prompt: "There are a lot of reasons why a person wouldn't want to talk about this, and you don't have to share anything you don't want to.

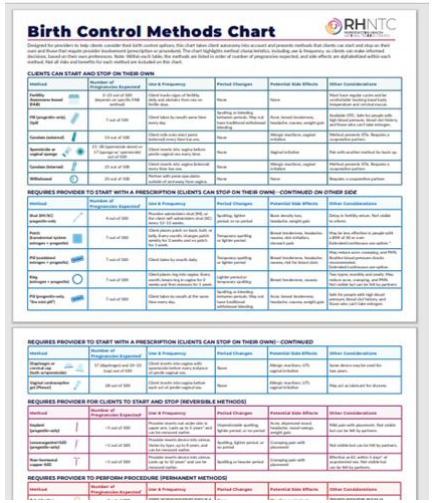
  Do any of these apply to you? (document all that apply)
  - **I'm here for something else**
  - **The question does not apply to me / I prefer not to answer**
  - **I am already using contraception (and what type)**
  - **I am unsure or don't want to use contraception**
  - **I am hoping to become pregnant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

Contraceptive Counseling

- Tiered Effectiveness counseling does not necessarily benefit the client
- Contraceptive services should be accessible, non-coercive, and provided in an equitable manner
- Should use a person-centered framework, supportive the client's values, goals and reproductive autonomy
- Recognize that many factors influence client's decision-making about contraception
- For example: "Do you have a sense of what is important to you about your method?"
- Tools such as the: Beyond the Pill- Birth Control: What's Important to You? Flip book; and RHNTC Birth Control Methods Chart, can be used to guide counseling

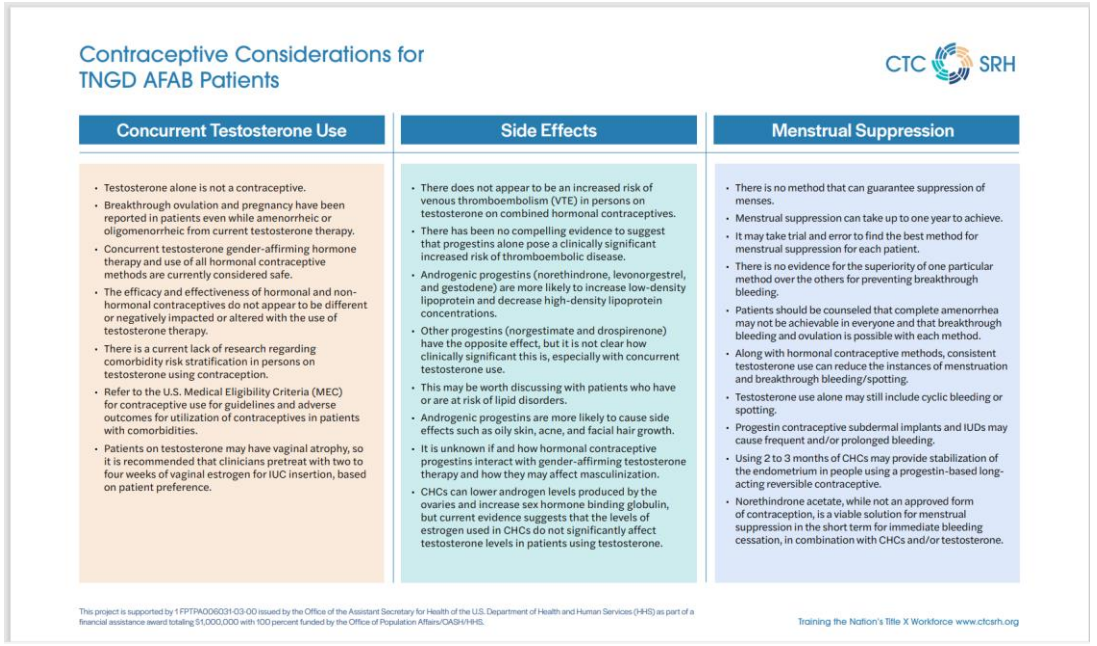
- CDC acknowledges the paramount importance of personal autonomy in contraceptive decision-making.
- Persons should have equitable access to the full range of contraceptive methods.
- Contraceptive services should be offered in a noncoercive manner that honors a person's values, goals, and reproductive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

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



Testosterone Use and Pregnancy Risk

- It is important to counsel clients that testosterone use might not prevent pregnancy among transgender, gender diverse, and nonbinary persons with a uterus who are using testosterone. Testosterone is teratogenic, and testosterone therapy has not been studies as contraception. Offer contraceptive counseling and services to those who are at risk for and do not desire pregnancy (U.S. MEC, 2024).
- American Society for Emergency Contraception: Emergency Contraception for Transgender and Nonbinary Patients
- Birth Control across the Gender Spectrum: Reproductive Health Access Project
- CTC SRH Contraceptive Considerations for TNGD AFAB Patients 2024



Contraceptive Considerations for TNGD AFAB Patients

CTC SRH

Concurrent Testosterone Use	Side Effects	Menstrual Suppression
• Testosterone alone is not a contraceptive. • Breakthrough ovulation and pregnancy have been reported in patients even while amenorrheic or oligomenorrheic from current testosterone therapy. • Concurrent testosterone gender-affirming hormone therapy and use of all hormonal contraceptive methods are currently considered safe. • The efficacy and effectiveness of hormonal and non-hormonal contraceptives do not appear to be different or negatively impacted or altered with the use of testosterone therapy. • There is a current lack of research regarding comorbidity risk stratification in persons on testosterone using contraception. • Refer to the U.S. Medical Eligibility Criteria (MEC) for contraceptive use for guidelines and adverse outcomes for utilization of contraceptives in patients with comorbidities. • Patients on testosterone may have vaginal atrophy, so it is recommended that clinicians pretreat with two to four weeks of vaginal estrogen for IUC insertion, based on patient preference.	• There does not appear to be an increased risk of venous thromboembolism (VTE) in persons on testosterone on combined hormonal contraceptives. • There has been no compelling evidence to suggest that progestins alone pose a clinically significant increased risk of thromboembolic disease. • Androgenic progestins (norethindrone, levonorgestrel, and gestodene) are more likely to increase low-density lipoprotein and decrease high-density lipoprotein concentrations. • Other progestins (norgestimate and drospirenone) have the opposite effect, but it is not clear how clinically significant this is, especially with concurrent testosterone use. • This may be worth discussing with patients who have or are at risk of lipid disorders. • Androgenic progestins are more likely to cause side effects such as oily skin, acne, and facial hair growth. • It is unknown if and how hormonal contraceptive progestins interact with gender-affirming testosterone therapy and how they may affect masculinization. • CHCs can lower androgen levels produced by the ovaries and increase sex hormone binding globulin, but current evidence suggests that the levels of estrogen used in CHCs do not significantly affect testosterone levels in patients using testosterone.	• There is no method that can guarantee suppression of menses. • Menstrual suppression can take up to one year to achieve. • It may take trial and error to find the best method for menstrual suppression for each patient. • There is no evidence for the superiority of one particular method over the others for preventing breakthrough bleeding. • Patients should be counseled that complete amenorrhea may not be achievable in everyone and that breakthrough bleeding and ovulation is possible with each method. • Along with hormonal contraceptive methods, consistent testosterone use can reduce the instances of menstruation and breakthrough bleeding/spotting. • Testosterone use alone may still include cyclic bleeding or spotting. • Progestin contraceptive subdermal implants and IUDs may cause frequent and/or prolonged bleeding. • Using 2 to 3 months of CHCs may provide stabilization of the endometrium in people using a progestin-based long-acting reversible contraceptive. • Norethindrone acetate, while not an approved form of contraception, is a viable solution for menstrual suppression in the short term for immediate bleeding cessation, in combination with CHCs and/or testosterone.

This project is supported by 1 FPTPA006031-03-00 issued by the Office of the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,000,000 with 100 percent funded by the Office of Population Affairs/OASH/HHS.

Pharmacy:
FP Provider Agreement Sites (non-PHO)

- Changes were made to allow Title X clinics (PA sites) to utilize 340B medication for EPT (expedited partner therapy) to prevent the reinfection of the Title X 340B eligible client.
- This includes medications listed on the provider agreement formulary, for utilization as outlined in the provider agreement contracts and FPP protocol.

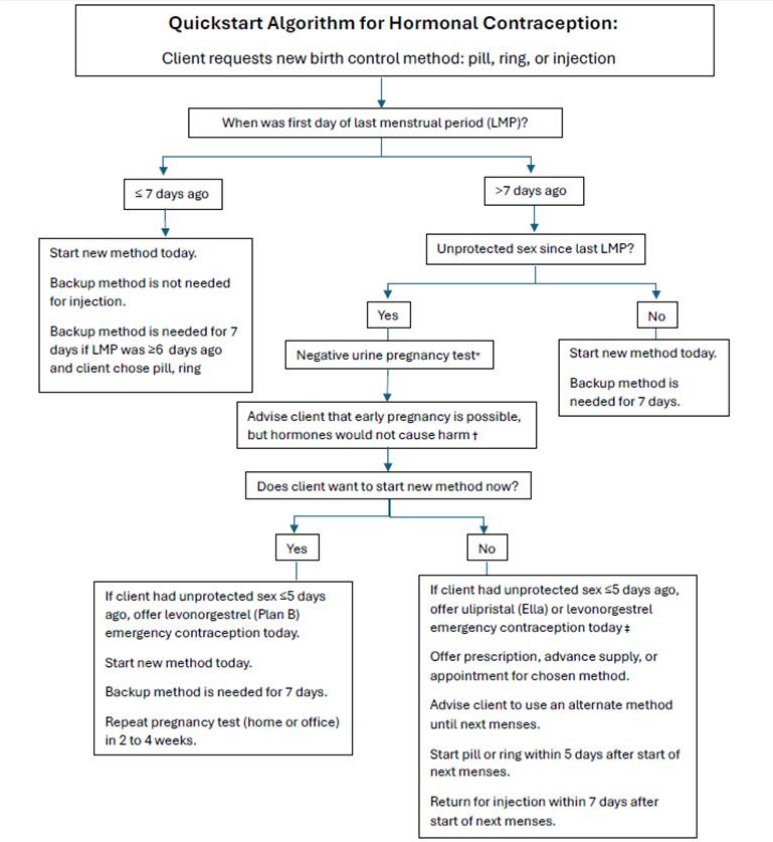
EPT
EXPEDITED PARTNER THERAPY

Pharmacy: All sites

- NMDOH Pharmacy informed us that Paragard IUD redid their inserter for easier insertion. The previous version is still available and will be for several months before we switch to the products with the new inserter.
- The new inserter appears to be very similar in many ways to the LNG IUD systems we have used.
- Resources to help with the upcoming transition:
  - Clinician training is available: https://hcp.paragard.com/placement-removal/
  - Demo units are being ordered and will be shipped to clinicians at the PHOs, and to each Provider Agreement clinic site.
  - If additional training is needed, we will have contacts available.

Public Health Nurses Standing Orders

- Were updated and streamlined, for better utilization.
- Include an updated Quickstart Algorithm
- For Quickstart of Combined Contraceptive methods- “below age 40” was removed.
- Chronic Kidney Disease was added (per 2024 MEC)
- Limitations to number of times client can use ECP (before visit with clinician must occur) was updated



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

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

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

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

OBJECTIVES

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

1. Understand the 2024 U.S. Medical Eligibility Criteria (US MEC) and Selected Practice Recommendations (US SPR) in clinical practice
2. Understand the 2024 US MEC and US SPR changes.
3. Apply evidence-based strategies for pain management during IUD insertion based on the latest SPR guidelines
4. Understand and integrate the revised clinical recommendations for several different conditions with respect to DMPA

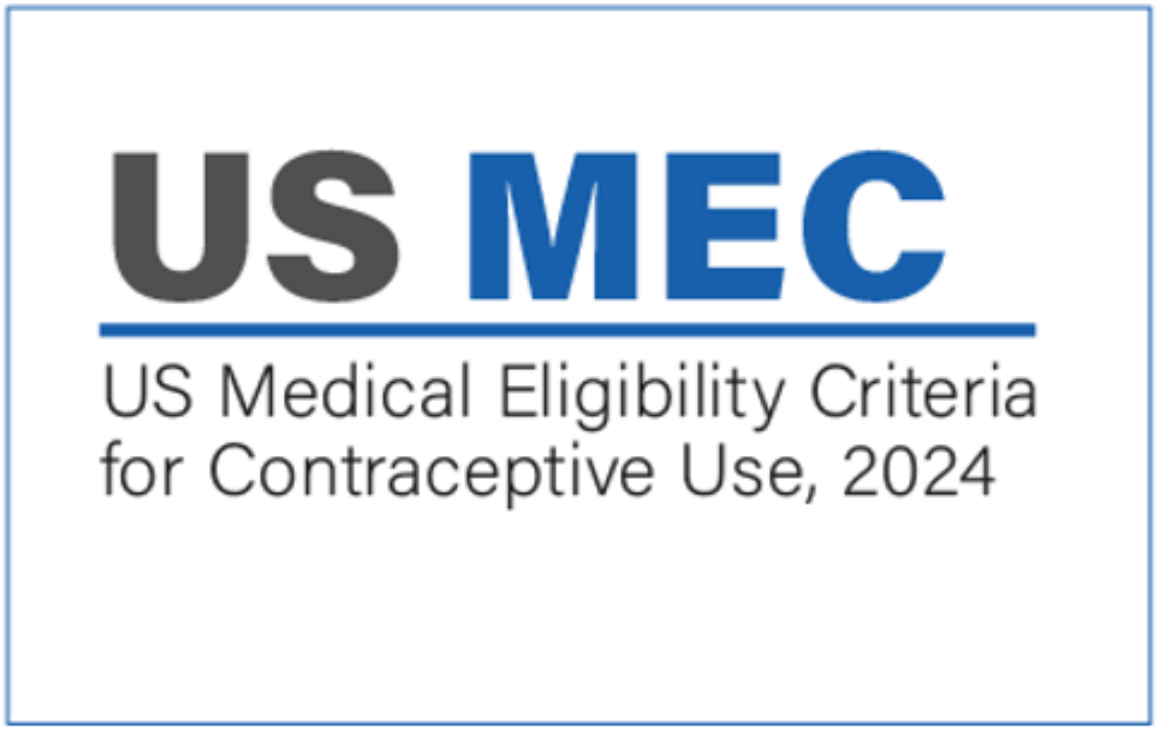
Disclosures

None

Slide Acknowledgements

- Michael Policar MD MPH
- Antoinette Nguyen MD
- Kate Curtis PhD

CDC Contraception Guidance



U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC)

- Clinical guidance for safe use of contraceptive methods by medical conditions and characteristics

- **> 1800 recommendations for > 60 conditions and characteristics, e.g.**
  - Is it safe to use Combined hormonal contraception after age 40?
  - Is it safe for a patient with a history of ectopic pregnancy to use Progestin-only Pills?

U.S. Medical Eligibility Criteria: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Categories

NMHealth

Category	Definition	Recommendation
1	No restriction for the use of the contraceptive method for a woman with that condition	Use the method
2	Advantages of using the method generally outweigh the theoretical or proven risks	May need follow-up
3	Proven risks or Theoretical or proven risks outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable	• Use clinical judgement that the person can use safely • The severity of the condition and the availability, practicality, and acceptability of alternative methods should be considered
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition	Do not use the method

U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)

- Clinical guidance that address provision of contraception, management of side effects, and issues related to contraceptive method use, e.g.
  - How to be reasonably certain that a person is not pregnant
  - What exams and tests are needed before starting a method
  - What follow-up is needed
  - Medications for IUD placement
  - How to manage bleeding irregularities when using hormonal contraception

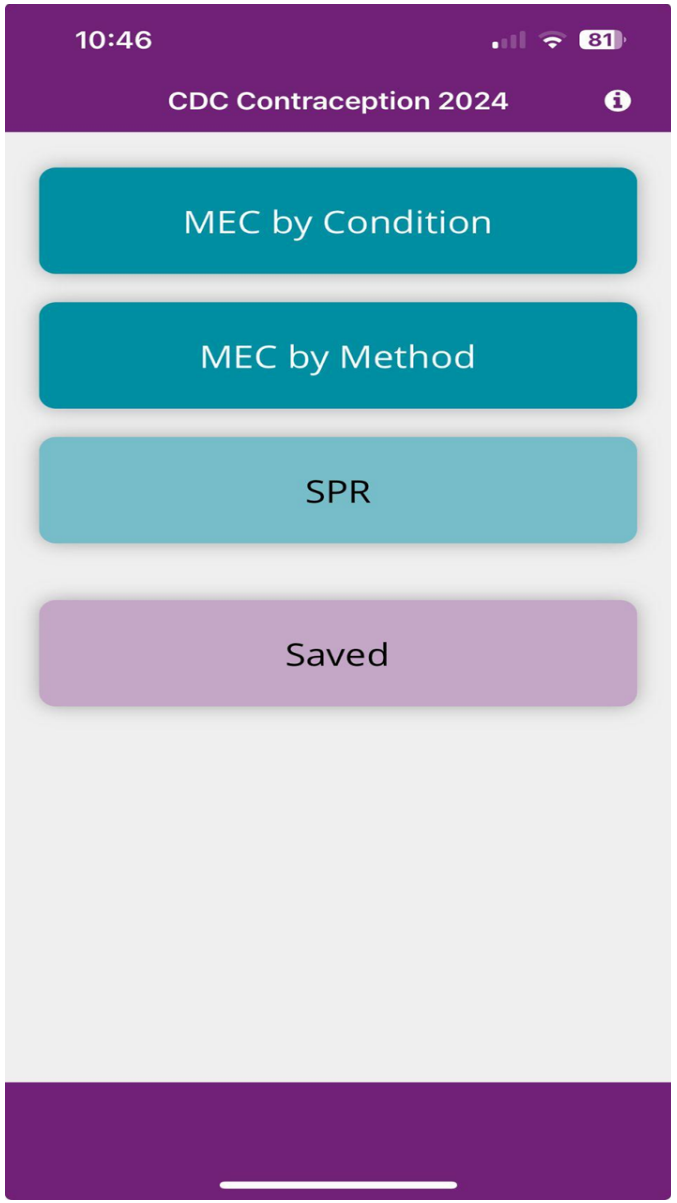
Tools for Providers

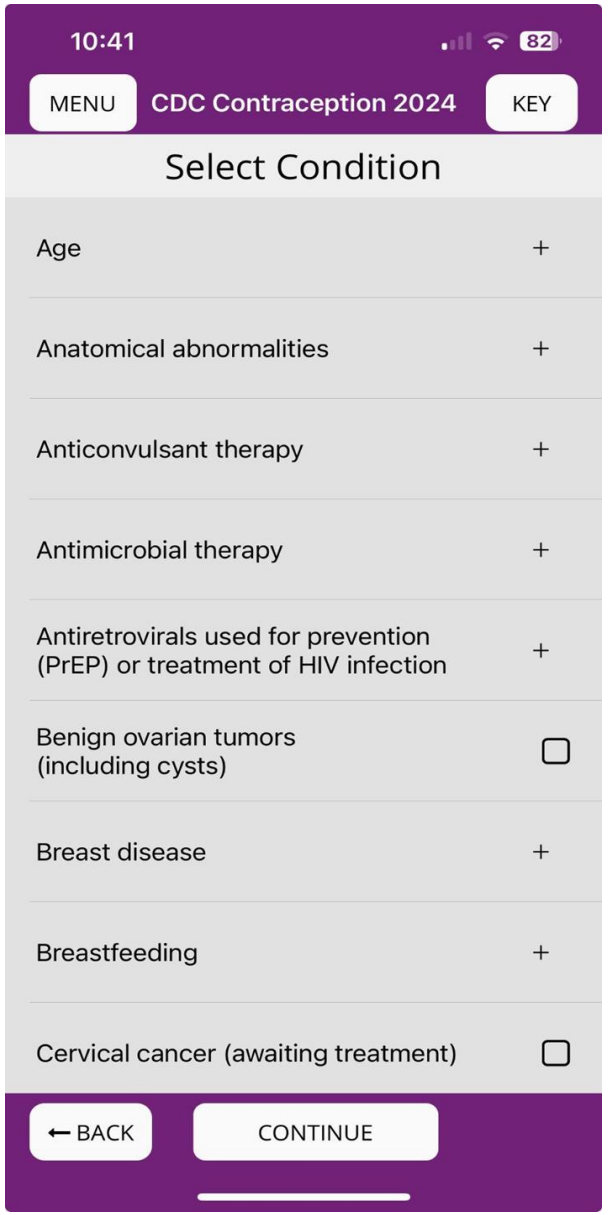
1. US MEC/SPR App

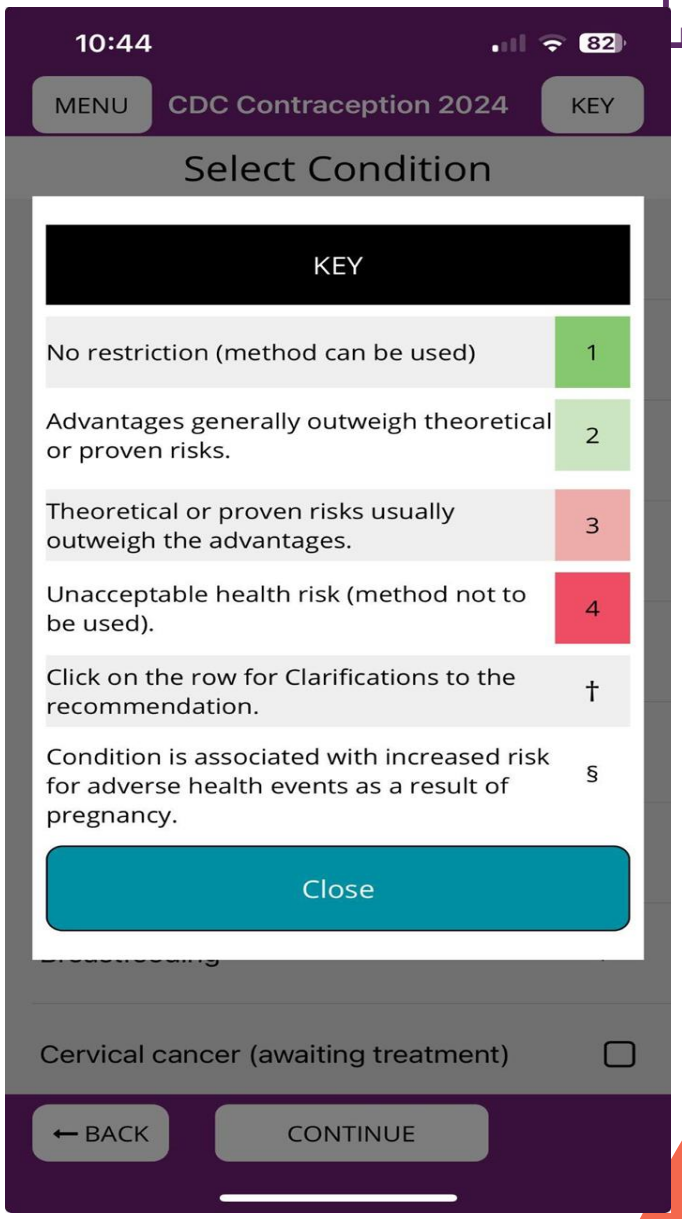
1. Online Access

1. US MEC Summary Table and US SPR Quick Reference Charts

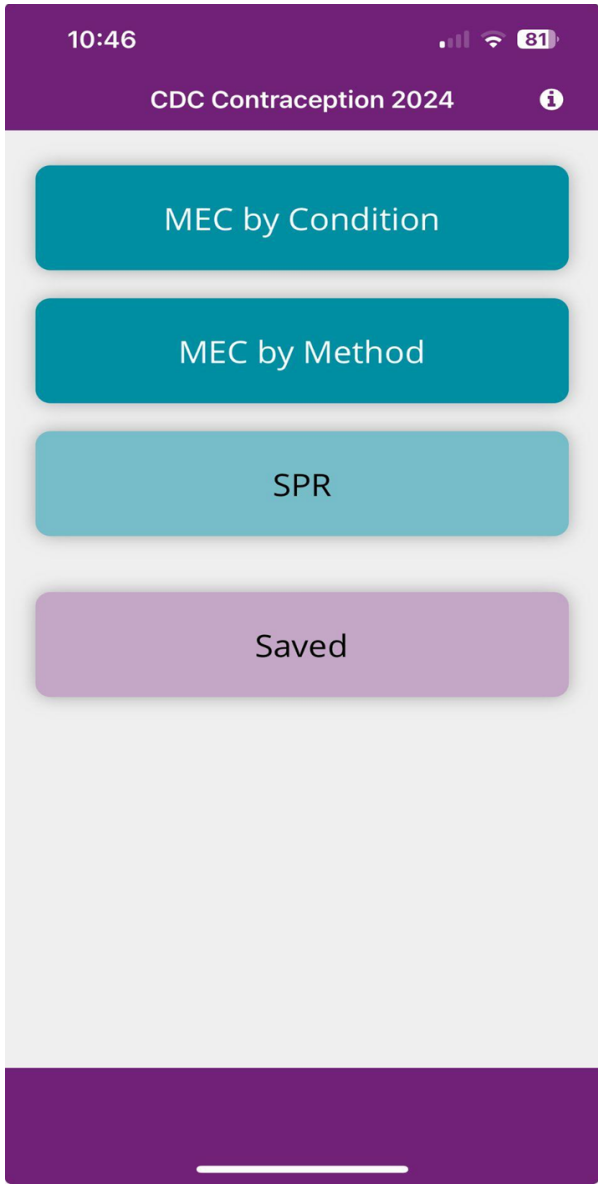
US MEC/SPR App

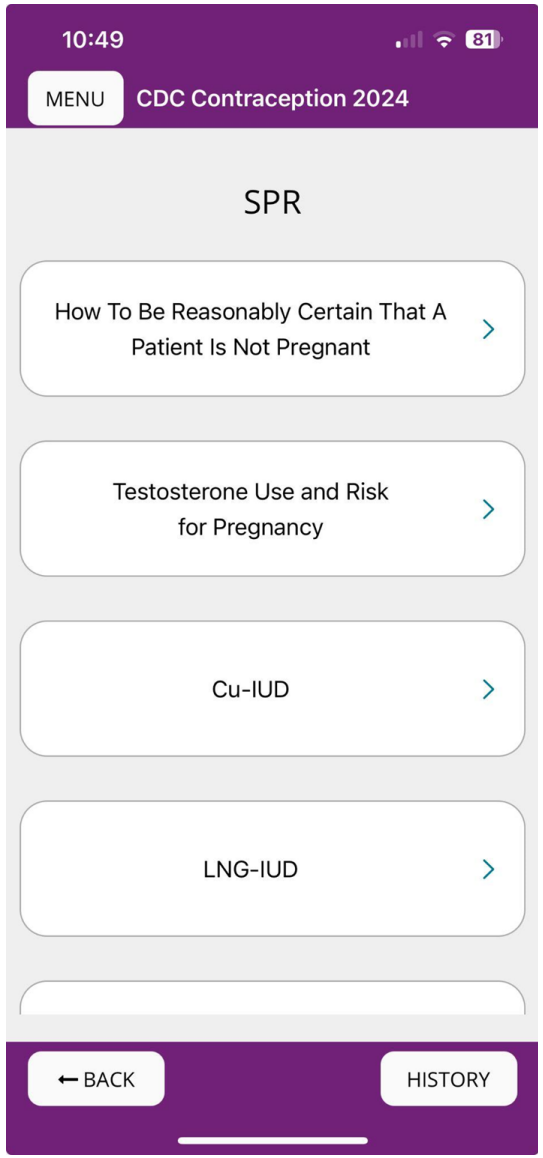


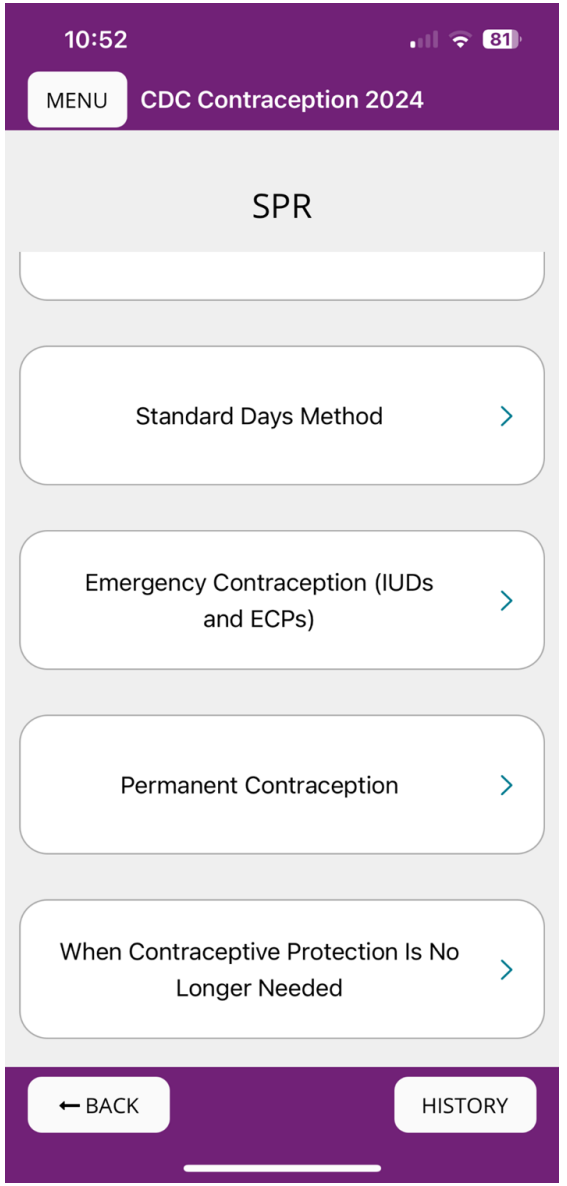




US MEC/SPR App



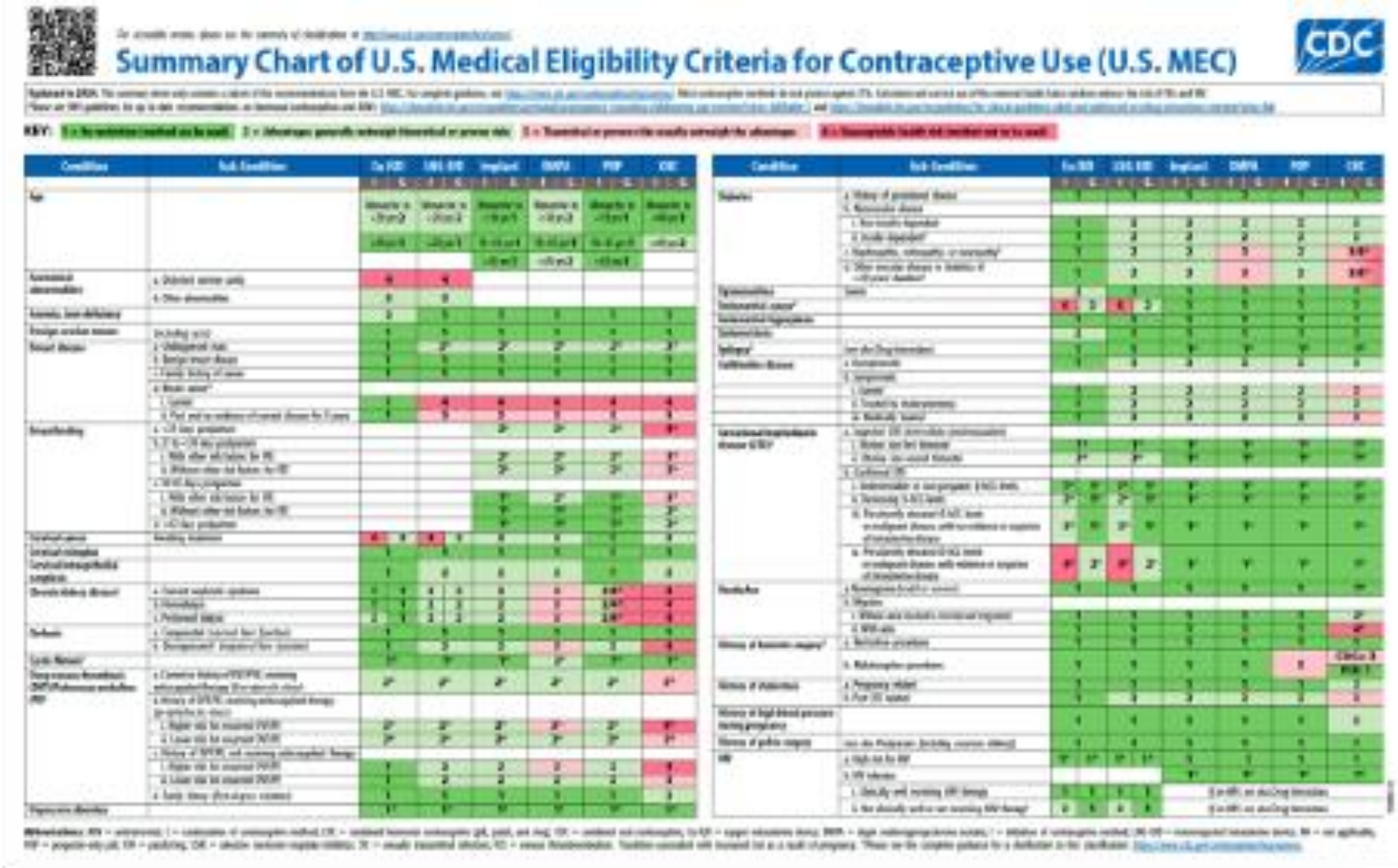




Online Access

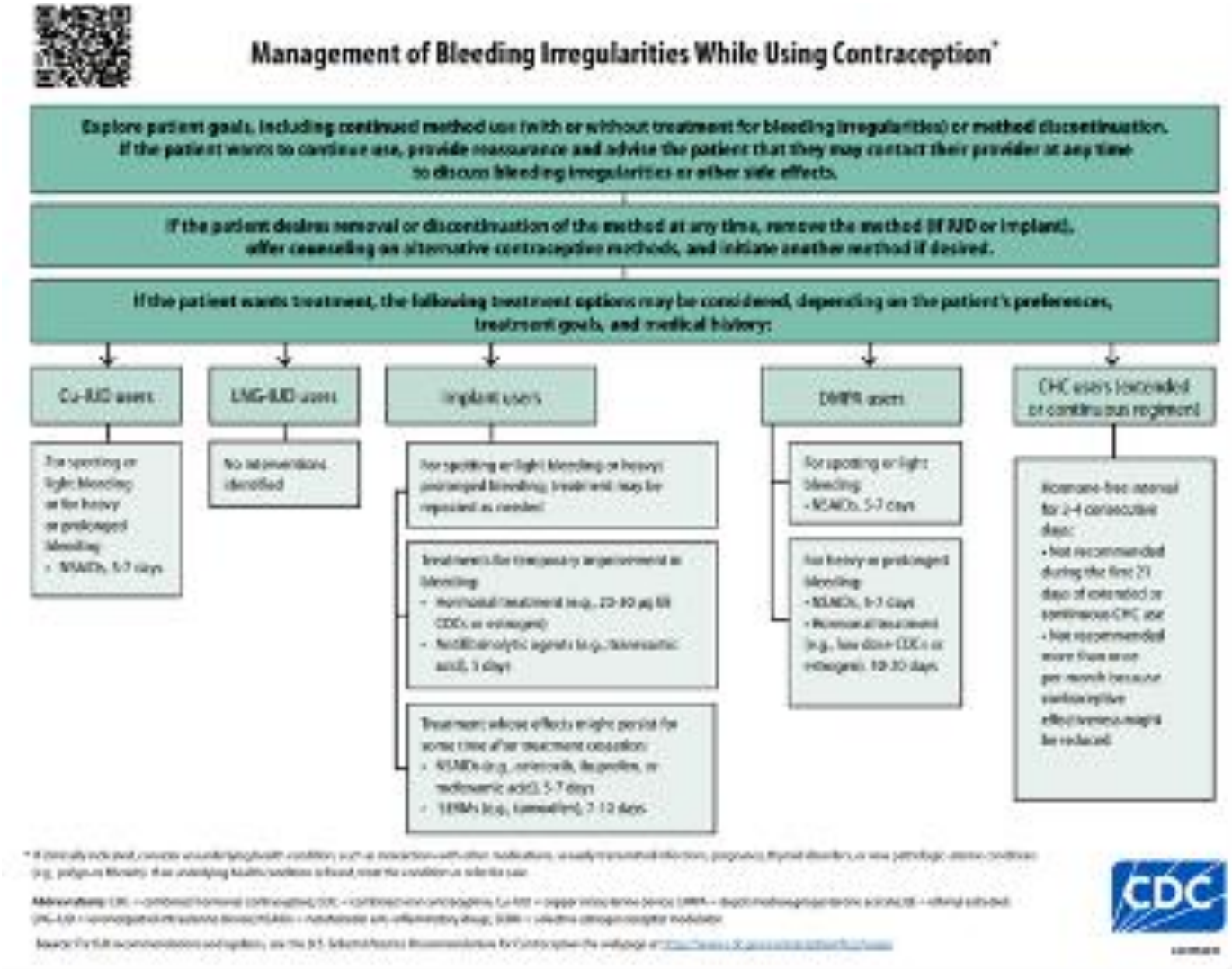
- https://www.cdc.gov/contraception/hcp/contraceptive-guidance/

US MEC Summary Table/ SPR Quick Reference Charts



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

US MEC Summary Table/ SPR Quick Reference Charts



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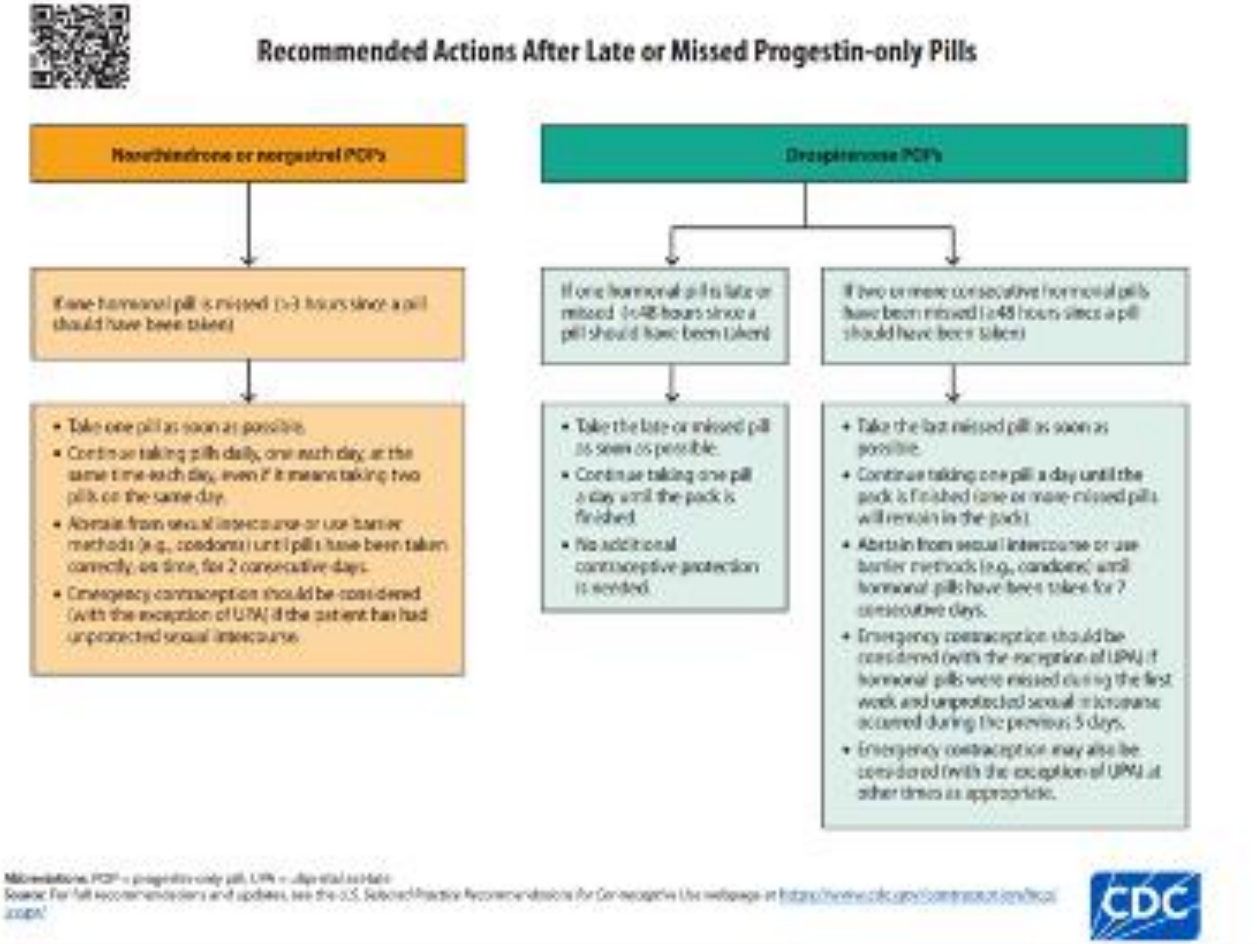


US MEC: 2024 Notable Updates

1. Addition of Chronic Kidney Disease
2. **Revisions to recommendations for persons with certain medical conditions or characteristics**
3. Inclusion of New Contraceptive Methods
    - New doses or formulations of COCs, patches and rings
    - Progesterone Only Pills and LNG IUDs
    - Vaginal pH modulator

DMPA - Increased Concern About Safety

CONDITION	2016	**2024**
Postpartum (Breastfeeding women) 30-42 days postpartum i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m2, postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking)	1	2*

*Indicates a condition for which the classification changed for one or more contraceptive methods or for which the condition description underwent a substantive modification.

DMPA - Increased Concern About Safety

CONDITION	2016	2024
Postpartum (nonbreastfeeding women) a. <21 days postpartum	1	2
b. 21–42 days postpartum i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, peripartum cardiomyopathy, BMI ≥30 kg/m2, postpartum hemorrhage, postcesarean delivery, preeclampsia, or smoking)	1	2*
ii. Without other risk factors for VTE	1	1

*For persons with other risk factors for VTE, these risk factors might increase the

DMPA - Increased Concern About Safety

CONDITION	2016	2024
Peripartum Cardiomyopathy a. Normal or mildly impaired cardiac function (New York Heart Association Functional Class I or II: patients with no limitation of activities or patients with slight, mild limitation of activity)		
i. < 6 months	1	2
ii. ≥6 months	1	2

Limited indirect evidence from noncomparative studies of women with cardiac disease demonstrated few cases of hypertension, thromboembolism, and heart failure in women with cardiac disease using POPs and DMPA. Use of DMPA, which has been associated with a higher risk for venous thrombosis compared with nonuse might further elevate risk for thrombosis among persons with peripartum cardiomyopathy.

DMPA - Increased Concern About Safety

CONDITION	2016	2024
Peripartum Cardiomyopathy b. Moderately or severely impaired cardiac function (New York Heart Association Functional Class III or IV: marked limitation of activity or should be at complete rest)	2	3

Limited indirect evidence from noncomparative studies of women with cardiac disease demonstrated few cases of hypertension, thromboembolism, and heart failure in women with cardiac disease using POPs and DMPA. Use of DMPA, which has been associated with a higher risk for venous thrombosis compared with nonuse might further elevate risk for thrombosis among persons with peripartum cardiomyopathy.

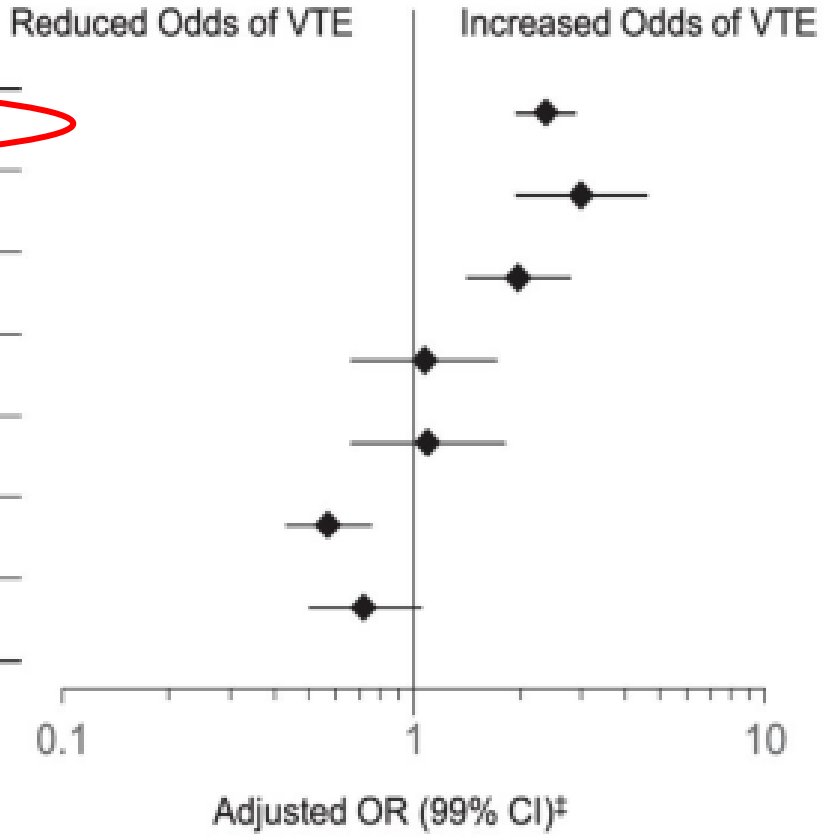
DMPA - Increased Concern About Safety

CONDITION	2016	2024
Superficial venous thrombosis (acute or history)	1	2
Valvular heart disease a. Uncomplicated	1	1
b. Complicated (pulmonary hypertension, risk for atrial fibrillation, or history of subacute bacterial endocarditis)	1	2

Use of DMPA, which has been associated with a higher risk for venous thrombosis compared with nonuse, might further elevate risk for thrombosis among persons with acute history of superficial venous thrombosis or complicated valvular heart disease.

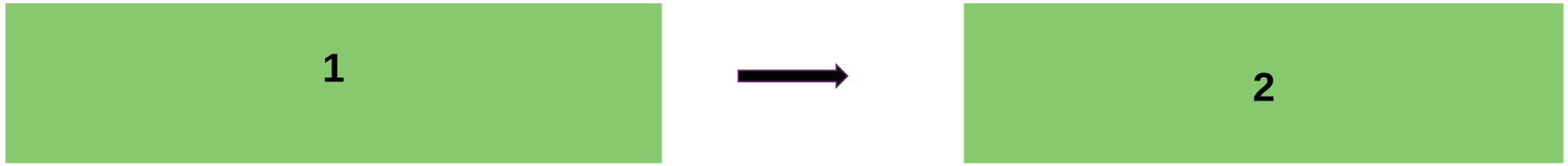
Risk of VTE with Progestin-only Contraceptive Use Among the General Population

Progestogen*	No. (%) Case Group	Control Group	Crude OR (99% CI)†	Adjusted OR (99% CI)†
DMPA	355 (1.66)	657 (0.61)	2.76 (2.42-3.14)§	2.37 (2.04-2.75)§
NETA	87 (0.41)	114 (0.11)	3.88 (2.93-5.12)§	3.00 (2.17-4.15)§
MPA	111 (0.52)	232 (0.22)	2.43 (1.94-3.05)§	1.98 (1.53-2.58)§
Prog	51 (0.24)	202 (0.19)	1.28 (0.94-1.75)	1.07 (0.75-1.54)
Implant	39 (0.18)	177 (0.17)	1.14 (0.80-1.61)	1.09 (0.74-1.61)
NET	131 (0.61)	724 (0.68)	0.92 (0.76-1.11)	0.57 (0.46-0.71)§
LNG-IUD	77 (0.36)	446 (0.42)	0.88 (0.69-1.13)	0.72 (0.54-0.96)



US MEC Updated Recommendations DMPA

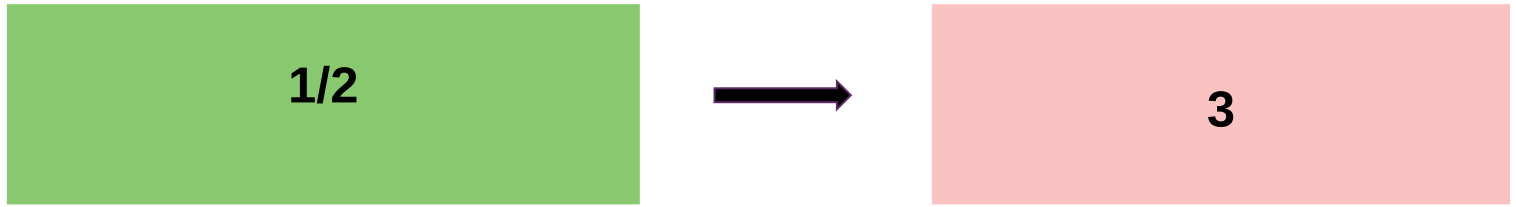
Changes that reflect more concern about safety



- Postpartum (nonbreastfeeding)
    a. <21 days postpartum
    b. 21-42 days postpartum , with other risk factors for VTE
- Postpartum (Breastfeeding)
    a. 30-42 days, with other risk factors for VTE
- Superficial venous thrombosis (acute or history)
- Valvular heart disease
- Peripartum cardiomyopathy, normal or mildly impaired cardiac function

US MEC Updated Recommendations DMPA

Changes that reflect more concern about safety



Conditions with increased risk of VTE (DMPA)*

- H/O DVT/PE on AC (prophylactic dose), higher risk for recurrent VTE
- H/O DVT/PE not on AC, higher risk for recurrent VTE
- Thrombophilia
- Sickle cell disease (MEC ⅔)
- Peripartum cardiomyopathy, moderately or severely impaired cardiac function

US MEC Updated Recommendations DMPA

Changes that reflect concern about reducing treatment effectiveness

1	2

Conditions with decreased effectiveness

- Postabortion, 1st trimester medication abortion with mifepristone at time of abortion initiation (DMPA)

US MEC: Updated recommendations POC and thrombosis

Changes that reflect less concern about safety

3/4 → **1/2**

- SLE, positive or unknown antibodies (LNG-IUD, implant, POP)
- Decompensated cirrhosis (LNG-IUD, implant, POP)

2 → **1**

- Major surgery with prolonged immobilization (LNG-IUD, implant, POP)

US SPR: 2024 Notable Updates

1. **Updated recommendations for provision of medications for IUD placement.**
2. Updated recommendations for bleeding irregularities during implant use
3. New recommendations for testosterone use and risk of pregnancy
4. *New* recommendations for self-administration of injectable contraception

Updated recommendations for provision of medications for IUD placement.

Predictors of Pain

POTENTIAL INCREASE IN PAIN WITH IUD INSERTION	
Physical Factors	**Psychological & Sociocultural Factors**
Nulliparity, low parity	Anticipated Pain
>13 mo between last birth and placement	History of sexual trauma
Dysmenorrhea	Previous negative reaction to vaginal exam
Not breastfeeding at time of placement	Previous placement reported as painful
Multiple Cesarean Deliveries	Presence of Mood Disorders
Shorter uterine length	
Age - adolescence	

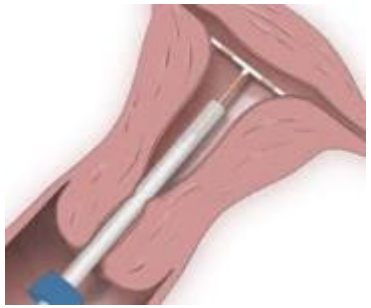
Pain Management for IUD Insertions

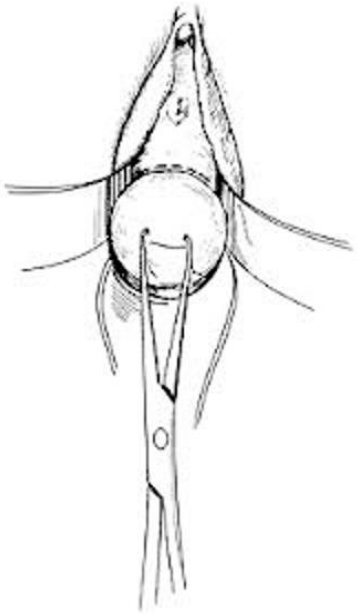
1. Counsel all patients:
    - Pain during placement and afterwards
    - Pain management options
1. Elicit and address patient concerns
2. Establish stopping rules

What hurts?

- Dry 13 ± 34 mm
- Water 22 ± 19 mm
- Gel 14 ± 16 mm

p < 0.01





- Nothing ~ 42 mm
- Topical 37 ± 23 mm
- Intracervical 12 ± 17 mm injection

p < 0.001

Words hurt!

Lots of pressure

Cold gel …

Little pinch

Misoprostol for IUD Insertion

- 14 Randomized controlled trials
  - 400 mcg - 11 trials
  - < 400 mcg - 3 trials
- Variable route of administration (vaginal, buccal, SL, & oral)
- Timing of administration 1-8 hours before IUD placement

Misoprostol for IUD Insertion

Misoprostol **DOES NOT**

- Reduce patient pain
- Reduce adverse events
- Reduce the need for adjunctive measures
- Improve provider ease of placement
- Improve placement success
- Increase patient satisfaction with procedure

Misoprostol for IUD Insertion

Misoprostol **DOES INCREASE**

- Patient pain
- Pre-placement abdominal pain or cramping
- Diarrhea

Misoprostol for IUD Insertion

In persons with recent failed IUD placement:

- 200 mcg vaginal 10 hours before and 200 mcg vaginal 4 hours before placement
- Might result in higher placement.

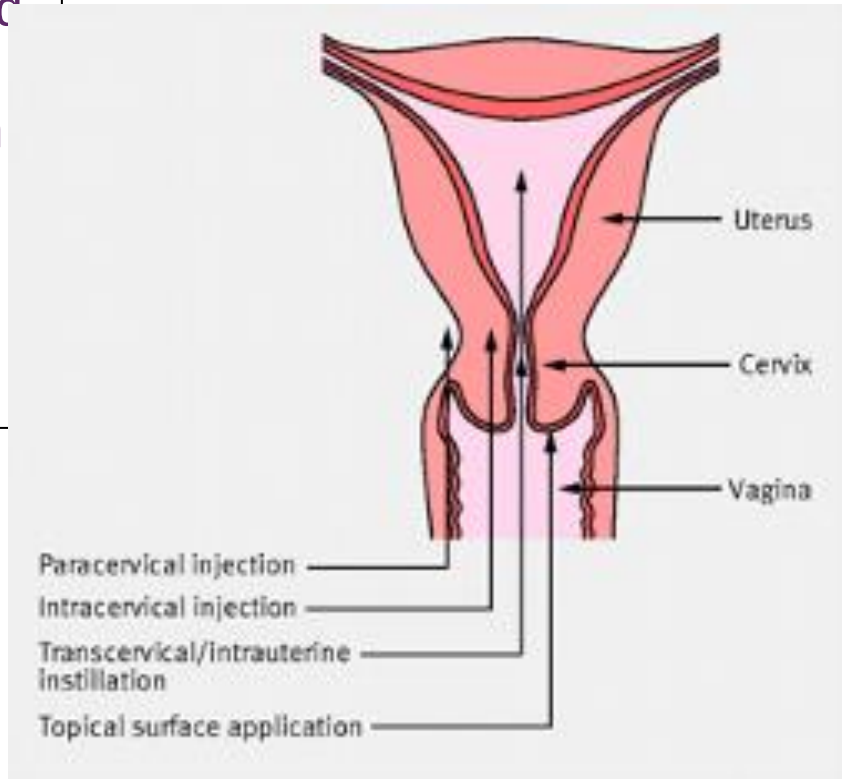
Paracervical Block for IUD Insertion

- Evidence for lidocaine as a PCB (6 RCTs)
  - 4 trials - 1% lidocaine (10-20 mL)
  - 2 trials - 2% lidocaine (10-12mL)
  - Timing - before to 5 min
  - All trials - 2-point injections
  - 2 trials - tenaculum site injection

Paracervical Block for IUD Insertion

Mody: A 20-mL buffered 1% lidocaine paracervical block decreases pain with IUD placement, uterine sounding, and 5 minutes after placement. Although paracervical block administration can be painful, perception of pain for overall IUD placement procedure is lower compared with no block.

de Oliveira: Lidocaine intracervical block was found to be more effective than naproxen in reducing placement pain.



De Nadai: A 3.6-mL 2% lidocaine intracervical block decreased pain at tenaculum placement and IUD placement among nulligravidas. It also provided a better overall experience during the procedure

Akers: A 10-mL 1% lidocaine paracervical nerve block reduces pain during IUD insertion in adolescents and young women compared with a sham block with pressure on the vaginal epithelium.

Akers AT, et al., 2017; Mody, SK, et al., 2018, De Nadai MN, et al., 2020; de Oliveira ECF, et al., 2021

Paracervical Block for IUD Insertion

1. Evidence suggests that Lidocaine as a PCB **might** reduce patient pain
   - Reduction in pain at Tenaculum site, during or after IUD placement (3 trials)
     - 1% lidocaine just before to 3 minutes before
     - 2% lidocaine at least 5 minutes before
   - 3 trials did not suggest a reduction in patient pain
2. Evidence suggests that Lidocaine as a PCB **DOES NOT**
   - Reduce adverse events
   - Need for adjunctive measures
   - *Increase side-effects (tinnitus, vomiting or dizziness)*
   - Improve placement success
   - Improve patient satisfaction

Lidocaine as Topical Gel, Cream, or Spray

Evidence from 13 randomized control trials (RCTs)

- Varying doses and formulations of topical lidocaine
  - 2% lidocaine [intracervical, cervical, or vaginal] gel (5 RCTs)
  - 10% lidocaine intracervical spray (1 RCT)
  - 10% lidocaine intracervical cream (1 RCT)
  - 10% lidocaine cervical spray (3 RCTs)
  - Lidocaine-prilocaine cervical cream (3 RCTs)
  - 2% lidocaine cervical gel plus oral diclofenac (1 RCT)
- Administration by provider, 1-7 minutes before IUD placement (11 RCTs)
- Self-administration by patient, at least 15 minutes before IUD placement (2 RCTs)

Lidocaine as *Topical Gel, Cream, or Spray*

- Patient pain: **Might reduce patient pain**
  - Meta-analysis of 4 RCTs: Reduction during tenaculum placement
  - 2 RCTs found reduction at either tenaculum placement, during IUD placement, or before clinic discharge
  - 7 RCTs suggest no reduction
- Provider ease of placement: No evidence
- No difference: treatment vs. placebo
  - Need for adjunctive measures
  - Placement success
  - Side effects
  - Adverse events
  - Patient satisfaction

Additional IUD Pain Control Interventions

No positive effect or information too limited

- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Lidocaine intracervical block
- Intrauterine instillation
- Smooth muscle relaxants

Medications for IUD Placement - Misoprostol

Take Home

- Misoprostol is NOT recommended for routine use for IUD placement
  - Misoprostol might be useful in selected circumstances
- Lidocaine (cervical block or topical) for IUD placement might be useful for reducing patient pain

US SPR 2024: Tests Needed Before IUD Placement

- Bimanual exam and cervical inspection are necessary
- People with purulent cervicitis or current GC or CT should not undergo IUD placement: US MEC 4
- People with vaginitis (trichomoniasis, bacterial vaginosis): US MEC 2
- Other factors related to STIs: US MEC 2

  - Clarification: If a person with risk factors for STIs has not been screened for GC and CT, perform at the time of insertion

US SPR 2024: Other IUD Recommendations

- Prophylactic antibiotics not recommended at IUD placement
- Routine follow-up after IUD insertion
    - No routine follow-up visit is required
- Advise a client to return at any time
    - To discuss bleeding, side effects, or other problems
    - If she wants to change the method
    - When it is time to remove or replace the IUD

Appendix B:

Title X Service Sites Financial Policies and Procedures

Title X Expectation for Income Assessment, Sliding Fee Scale and Fees

- The Federal Title X expectation is for clinics to assess fees for services rendered to clients with family income above 100% Federal Poverty Level (FPL). Both family size and family income are used to determine the client's percent pay rate on the clinic's sliding fee scale. Family income should be assessed before determining whether sliding fees are charged.

Fee Collection

- Sliding Fee Scale
  - Must slide from 0% to 250% of the current Federal Poverty Levels (FPL)
    - FQHCs slide up to 200% but Title X clients must have slide up to 250%

- Income Worksheet
  - Income worksheet must be completed annually or whenever the client has a change in income or family size. Whenever a new income worksheet is obtained the previous income worksheet must be expired, and the new income worksheet will be valid for one year.
  - Both family size and gross annual (monthly, weekly, etc) family income are used to determine the percentage of actual costs that a client will be assessed utilizing the FPL.
  - Must clearly state what the client's percent-pay is.

NMHealth

ANNUAL INCOME WORKSHEET

Place patient label here

Please write down any money you **AND** anybody else in your family or household received.
Check the appropriate box for how often the amount is received (e.g., weekly, monthly, annually, etc.).

Salaries, wages, tips - (include seasonal and part- time work/labor)	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐
Unemployment compensation	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐
Social Security, Social Security Disability Income (SSDI) - (does NOT include Supplemental Security	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐
Retirement, pension, investment income	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐
Alimony - (does NOT include child support)	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐
Other	$	Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐

Number of people in the household that are supported by this income: #

I have told the truth about **ALL** sources of my family's income. To the best of my knowledge, I have not given false information nor withheld information.

Client's Printed Name: _____ **Client Signature:** _____ **Date:** _____

STAFF USE ONLY **Income information collected by <u>self-declaration</u> unless indicated below:**

Income verified by: Check stub ☐ Letter from employer ☐ Bank Statement ☐ Other ☐

Weekly Total $_____ MULTIPLY BY 52 = Annual Total $_____

Bi-Weekly Total $_____ MULTIPLY BY 26 = Annual Total $_____

Monthly Total $_____ MULTIPLY BY 12 = Annual Total $_____

Annual Total $_____ MULTIPLY BY 1 = Annual Total $_____

Client is at_____% Pay **Grand Annual Total $_____**

I have seen this document and witnessed the client's signature.

<u>STAFF</u> SIGNATURE & TITLE:_____ **Date:**___/___/_____

Revised 12/24

Fee Collection (Continued)

- Confidential Teen Clients- For unemancipated minors who receive confidential services, charge for services (percent pay) must be determined based on the income of the minor only (and family/household size of “1”).
- Confidential Adult Clients - For adults who receive confidential services, charge for services (percent pay) must be determined based on the income of the confidential adult only and the reported family size.
- If a confidential teen or adult is insured, all precautions should be used to guarantee that the client’s confidentiality is not breached .
- Clients who are at or below the FPL can not be charged for FP services(including non-PHO clinic that have flat fees in place.)
- Proof of Income can be requested but not be required to qualify for discounted FP services . A verbal declaration of income is acceptable, and the client is charged based on what he/she/they have declared.

Hardships

- Occasionally, the client may experience problems beyond their control which constitutes a temporary financial hardship.
  - Examples of hardship situations are illness in the family, fire/flood/natural disaster, theft, being underinsured, job loss, etc.

- After a good faith determination of financial need by the Clerk/Receptionist and Nurse Manager/billing department supervisor, a Title X clinic may waive fees for the visit date stated in the Hardship Declaration Form.

Pt.name
MRN
DOB
Affix Label

Family Planning/Title X
Hardship Declaration form

Client_____requests a temporary financial hardship for today's Family planning services only.

☐ New Income Worksheet has been reassessed.

Client is eligible for a temporary financial hardship after a good faith determination of financial need on (Date)_____by the clinic staff (Clerk/Receptionist and Nurse Manager/billing department supervisor) due to the following reason as per the FPP Protocol Appendix B (Section III-C.1 Special Circumstances-Documented Hardship)

_____
_____
_____
_____
_____

I have told the truth about ALL sources of my family's income. To the best of my knowledge. I have not withheld or given false information.

_____
Client Printed Name

_____ _____
Client Signature Date

I have seen this document and witnessed client's signature.

_____ _____
Staff Signature & Title Date

Steps to Document Hardship

1. Hardship declaration form is filled out by staff and signed and dated by the client.
2. Since hardship may result in a change of the client's family income, a new income worksheet is completed by the client and there us thorough review of the income worksheet by the Clerk/ receptionist and nurse manager/ billing department supervisor.
3. Only the charge for services and supplies provided on that day will be assessed and waived.
4. All subsequent visits should revert back to the most current regular income worksheet unless a new one is needed.
5. A client is able to document hardship as many times as necessary.
6. A client requesting sterilization does not constitute a hardship.
7. For PHOs, percent-pay clients should be prepared to pay for their procedure when they come in to Pick up their approved paperwork.

Charges

- Clients will be informed of any charges for any Title X services provided. Title X clinics will apply fees according to the sliding fee scale and a statement/receipt will be provided to the client.

Billing and Collections (PHOs)

- For insured clients, Title X clinics must make reasonable efforts to collect charges by billing third party payor and/or outstanding balances without jeopardizing client confidentiality. Clinic staff must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client.
- Reminder that Family Planning clients may not be denied services based on their ability to pay.

Billing and Collections PA Sites

- For a Provider Agreement (PA), non-PHO clinic, this means that:
  - FP Services provided to insured clients should be billed for the third-party reimbursement instead of using Title X contraceptives, supplies, or lab tests.
  - The exception is when the client requests confidential Title X services; in which case the PA clinic can dispense Title X contraceptives/supplies and utilize Title X lab tests according to the contract. In doing so, the PA clinic cannot bill the third-party payor for all services provided that the client deemed confidential.
  - Reasonable efforts should be made to collect outstanding balances on FP accounts without jeopardizing confidentiality.
  - Contracted Providers should follow their aging balance policy with a reminder that Family Planning clients must not be sent to collections nor denied services based on their ability to pay.

Monthly Reports (PHOs)

- Monthly reports are submitted to the Family Planning Program and Administrative Services Division by the **5th** of the month via email.
  - E-mail Monthly Reports:
    - FP: DOH-FPP_Monthly_Financial_Reports@doh.nm.gov
    - ASD: Lewanda.platero@doh.nm.gov
- Monthly report must include all percent-pay clients seen in the clinic who have a current or past balance for the month whether a payment was made or not.
- If there are no fees collected for the entire month, please note "No fees collected" on the Monthly Payment Ledger form with a reminder to include all percent–pay clients.
- Medicaid clients and clients who are "0 pay" without a previous balance should not be listed. Please fill in all the information requested on this form
- Each PHO Monthly Report packet should include:
  - Family Planning Payment Ledger
  - Fee Deposit Register
  - Proof of Deposit
- For more information or training, contact Tracy, tracy.romero@doh.nm.gov

Fee Collection Quarterly Incentive

The Family Planning Program is offering a new quarterly incentive for the Public Health Office that collects the most Family Planning Fees.

- The way this incentive will work is: The Public Health Office that collects the most Family Planning fees per capita in a quarterly period (every 3 months)wins a $100.00 Staples shopping spree for your office.

Questions?

1190 S. St. Francis Drive • Santa Fe, NM 87505 • Phone: 505-827-2613 • Fax: 505-827-2530 • nmhealth.org

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 Family Planning Program at: DOH-FPP-Clinical@doh.nm.gov

Reproductive Health ECHO

in Partnership with New Mexico Department of Health

Please join us for:

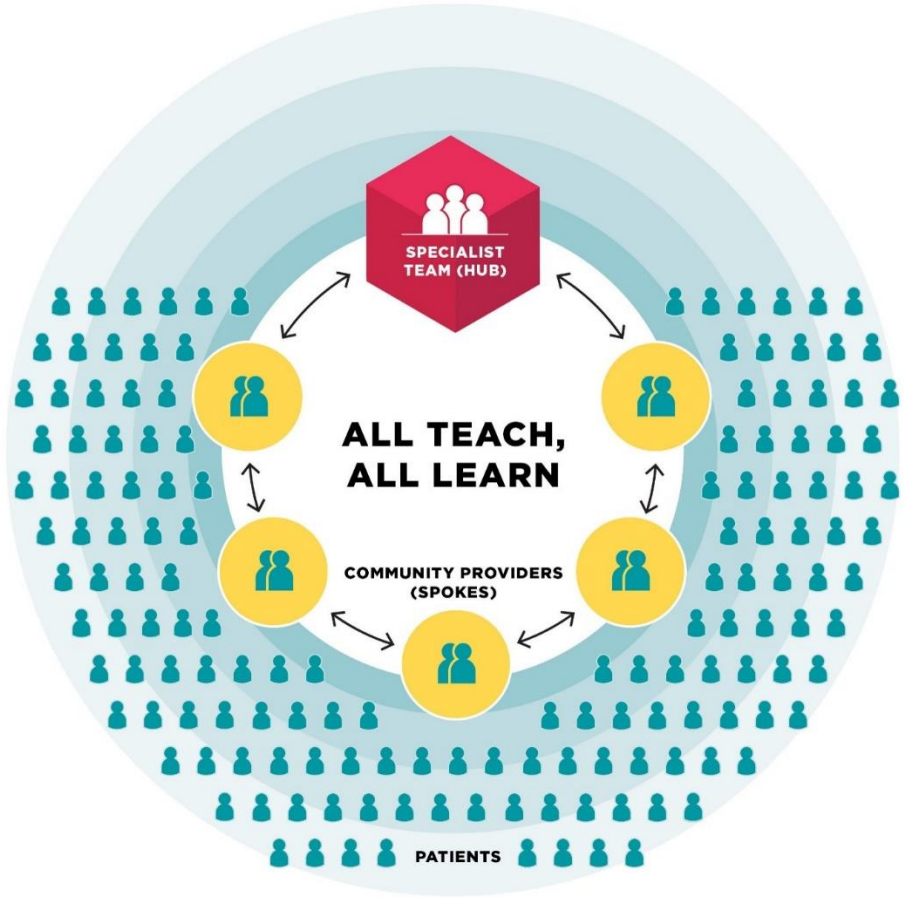
- *Bi-weekly ECHO sessions on Reproductive Health related topics*
- *Ongoing Family Planning Protocol in-service trainings*
- *Patient case presentations to learn as a community*
- *Opportunities to earn free CMEs, CNEs, CEUs, etc. when you join our ECHO sessions*

RH ECHO Resources:

Curriculum Schedule
Online Patient Case Form
Recorded Didactics + Presentations

Register Here

For help registering in iEcho, please contact the RH ECHO Support Team via email.



When:
2nd and 4th Mondays of the Month
12 to 1 p.m. MT

Where:
Via Zoom in iECHO

Who:
Anyone interested in Reproductive Health

Email:
ReproductiveHealthECHO@salud.unm.edu

NMDOH NEW MEXICO DEPARTMENT OF HEALTH
UNM HEALTH SCIENCES
Project ECHO®