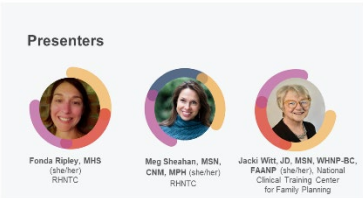
Strengthening Infertility Services in Title X Programs
February 23, 2023
Transcript

Slide 1

- [Fonda] Hello, everyone. This is Fonda Ripley with the Reproductive Health National Training Center, and I'm pleased to welcome you all to today's webinar on Strengthening Infertility Services in Title X Agencies. I have a few announcements before we begin. Everyone in the webinar today is muted given the large number of participants. We plan to have some time for questions near the latter part of our hour together, and you can ask your questions using the chat at any time during the webinar. Caila will be monitoring the chat for questions that come in, and our speakers will address those questions from that list at the start of that section. A recording of today's webinar, the slide deck, and the transcript will be available on rhntc.org in a few days, in the next few days. The closed captioning has been enabled for this webinar, and you can view that by clicking on the CC icon at the bottom of your screen. Caila is going to share a link to the evaluation for today's webinar in the chat, and we share that in advance noting that your feedback is very important to us, and it has enabled RHNTC to make quality improvements in our work based on your comments. So please take a moment to open the link and consider completing the evaluation in real time. If you'd like to receive a certificate of completion for attending the webinar, you must be logged into rhntc.org when you complete the evaluation. And a note that this presentation was supported by the Office of Population Affairs or OPA, and the Office on Women's Health and its contents are solely the responsibility of the authors and do not represent the official views of OPA, OWS, or HHS.

Slide 2



So I'd like to start with introductions of our speakers today. As I said, I'm Fonda Ripley, and I serve as a training and technical assistance coordinator and a grantee liaison with the RHNTC. My primary function involves developing training resources with a focus on supporting Title X agencies and their service delivery related to achieving healthy pregnancy, fertility awareness, and basic infertility services. I'm joined by two presenters today. Meg Sheahan, Meg is a certified nurse midwife who has provided sexual reproductive and pregnancy care in low resource clinical settings for the past 15 years. She directed the Title X Family Planning Program in the Virgin Islands for nearly a decade before joining the RHNTC. And

in addition to working with RHNTC, she maintains a busy part-time clinical practice. We're also joined by Jacki Witt. Jacki is a clinical professor at the University of Missouri-Kansas City School of Nursing and Health Studies. She's also a women's health nurse practitioner. She's provided healthcare services for over 35 years and has taught nursing in a variety of educational settings for over 30 years. During her career, she has been certified as a nurse midwife and as a sexual assault nurse examiner. Jacki has been the project director for the Title X-funded National Clinical Training Center for Family Planning since its inception in 2006. So welcome, Jacki and Meg.

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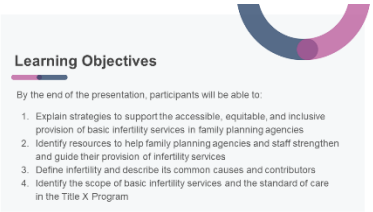

The webinar today has been designed to support participants to be able to explain strategies to support the accessible, equitable, and inclusive provision of basic infertility services and family planning agencies. Also to identify resources to help family planning agencies and staff strengthen and guide their provision of infertility services, define infertility, and describe its common causes and contributors, and to identify the scope of basic infertility services and the standard of care in Title X programs.

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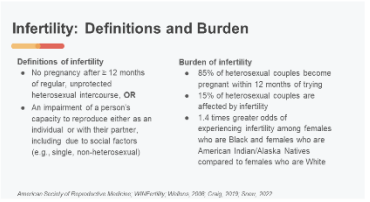

So let's start with a brief overview of infertility, including how it's defined and it's prevalence. Historically, infertility has been defined as the failure to achieve a pregnancy after 12 months or more of regular unprotected heterosexual intercourse or due to an impairment of a person's capacity to reproduce either as an individual or with their partner. And more recently, we see an evolving and expansive definition in understanding of infertility that includes social causes of infertility as well, such as being single or non-heterosexual. Social or relational infertility is shaped by a person's relationships and circumstances rather than a purely physiological diagnosis. So it's possible, for example, to be both socially infertile and physiologically infertile. The data that we have available on infertility prevalence is limited to heterosexual couples. We know that among heterosexual couples, 85% will become pregnant within 12 months of trying, and that infertility affects up to 15% of heterosexual couples. This makes infertility one of the most common conditions for people between the ages of 20 and 45, and it's important to note or be aware of that this rate does not capture the burden of infertility among LGBTQ+ and single individuals who may need fertility assistance to support their reproductive and family-building goals. And therefore, it's an underestimate of the true rate of those who experience infertility. We also know that there's a disproportionate burden among those who experience infertility. So, for example, racial disparities exist with data showing higher rates of infertility among Black females, and

American Indian, Alaska Native females compared to white females. One study reports infertility prevalences that are about 1.4 times greater for females who identified as Black, as well as for females who identified as American Indian or Alaska Native versus those who identify as white. Another study has reported that females identifying as Black had two times the odds of experiencing infertility compared to females identifying as white.

References:

- ASRM, What is Infertility
- WINFertility, The Labels of infertility
- Wellons MF, et al. Racial differences in self-reported infertility and risk factors for infertility in a cohort of black and white women: the CARDIA Women's Study. Fertil Steril. 2008 Nov;90(5):1640-8. doi: 10.1016/j.fertnstert.2007.09.056.
- Craig LB, Peck JD, Janitz AE. The prevalence of infertility in American Indian/Alaska Natives and other racial/ethnic groups: National Survey of Family Growth. Paediatr Perinat Epidemiol. 2019 Mar;33(2):119-125. doi: 10.1111/ppe.12538.
- Perritt J, Eugene N. Inequity and injustice: recognizing infertility as a reproductive justice issue. F S Rep. 2021 Sep 2;3(2 Suppl):2-4. doi: 10.1016/j.xfre.2021.08.007.
- Snow M, Vranich TM, Perin J, Trent M. Estimates of infertility in the United States: 1995-2019. Fertil Steril. 2022 Sep;118(3):560-567. doi: 10.1016/j.fertnstert.2022.05.018.

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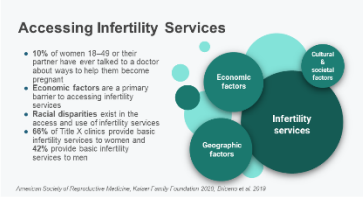

In the slide that I just shared, I had talked a bit about some disparities in infertility prevalence. We also know that there are disparities in services for access and use of infertility services. So, for example, we know that there are racial disparities for those that use infertility services, particularly for those who identify as Black, Hispanic, and America Indian, Alaska Native, studies have demonstrated that they're all less likely to access and use infertility services compared to those who identify as white. I want to point out some other data on the slide. Based on data from the National Survey of Family Growth, we know that 10% of women 18 to 49 years of age or their partners have ever talked to a doctor about ways to help them become pregnant. And then at the same time, we know that services for the evaluation and treatment of infertility or fertility assistance is not accessible to all and that many experience limitations and access due to economic factors such as the high cost associated with evaluation and treatment services and limited insurance coverage by private insurance and Medicaid. There's other barriers that we have identified that impede access to infertility care as well, including cultural stigmas, prior bad experiences with the US health system, provider bias, ability to take time off and or to travel to geographically distant medical facilities for treatment. And I'd like to now drill down to the Title X network specifically and share some data related to provision of basic infertility services. Based on a 2013-2014 survey of Title X clinics, they demonstrated or indicated that 66% of those surveyed reported providing basic infertility services for female and 42% reported providing basic infertility services for males.

References:

- Weigel G, Ranji U, Long M, and Salganicoff A. Coverage and use of fertility services in the U.S. KFF. 2020.
- Ethics Committee of the American Society for Reproductive Medicine. Electronic address: asrm@asrm.org. Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion. Fertil Steril. 2021 Jul;116(1):54-63. doi: 10.1016/j.fertnstert.2021.02.019.
- Komorowski AS, Jain T. A review of disparities in access to infertility care and treatment outcomes among Hispanic women. Reprod Biol Endocrinol. 2022 Jan 3;20(1):1. doi: 10.1186/s12958-021-00875-1.
- Janitz AE, Peck JD, Craig LB. Racial/Ethnic Differences in the Utilization of Infertility Services: A Focus on American Indian/Alaska Natives. Matern Child Health J. 2019 Jan;23(1):10-18. doi: 10.1007/s10995-018-2586-y.
- Chandra A, Copen CE, Stephen EH. Infertility service use in the United States: data from the National Survey of Family Growth, 1982-2010. Natl Health Stat Report. 2014 Jan 22;(73):1-21.
- Loyola Briceno AC, Ahrens KA, Thoma ME, Moskosky S. Availability of Services Related to Achieving Pregnancy in U.S. Publicly Funded Family Planning Clinics. Womens Health Issues. 2019 Nov-Dec;29(6):447-454. doi: 10.1016/j.whi.2019.07.005.

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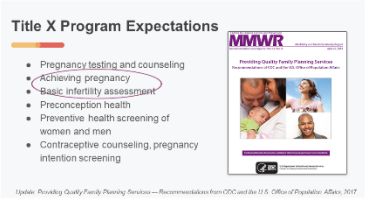

A reminder that the QFP defines the range of services that should be offered in a family planning setting and is the guideline for Title X agencies. The QFP emphasizes the role of helping clients to achieve pregnancy as well as to prevent pregnancy and describes how to provide pregnancy testing and counseling, and highlights the role of quality improvement in improving health outcomes.

Reference: Gavin L, Pazol K, Ahrens K. Update: Providing Quality Family Planning Services — Recommendations from CDC and the U.S. Office of Population Affairs, 2017. MMWR Morb Mortal Wkly Rep 2017;66:1383–1385. DOI: http://dx.doi.org/10.15585/mmwr.mm6650a4

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Title X services are guided by the expectations of the Title X statute, regulations, and legislative mandates, and the Title X program priorities, which include providing care in a manner that is client-centered, culturally and linguistically appropriate, inclusive, trauma-informed, protects the dignity of the individual, and ensures equitable and quality service delivery, consistent with the national standards of

care. So with this framing in mind, I want to pass the mic to Meg for her to share information on how family planning agencies and staff can strengthen their provision of infertility services and referrals to support clients experiencing infertility.

Resource: OPA, Title X Family Planning Program

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- [Meg] Thanks, Fonda. So over the years, we've heard from many Title X staff that providing basic infertility services is challenging and it can feel frustrating because of the many barriers that confront both the program, and the providers, and the clients as well. But there is a lot that we can do within the Title X setting to support a client in achieving a healthy pregnancy and in their journey to build a family. By understanding the scope of basic infertility services, by strengthening the provision of those services, and by providing referrals to clients experiencing infertility, Title X staff can help individuals and couples build the family that they envision. So for the next few minutes, we'll be discussing how Title X programs can strengthen their provision of basic infertility services. The RHNTC has developed a toolkit that brings together guidance on how to strengthen infertility services and resources to help along the way.

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The toolkit recommends the following strategies. First, assess your program's infertility services, train and prepare staff to deliver basic infertility services, integrate infertility prevention and education into client care for all, provide quality, accessible, equitable, and inclusive infertility services, and finally, strengthen referrals for additional services and supports for clients with infertility. All of the resources that I mentioned over the next few minutes can be found in this toolkit.

Resource: Infertility Services in Family Planning Care Toolkit

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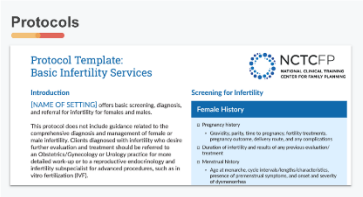
A solid first step in strengthening your program's infertility services is to identify what you're doing well and where your program could improve. So to do this, we need a basic baseline understanding of the Title X requirements for basic infertility services as described by the QFP and national recommendations. From here, you can take a close and thorough look at your program's services, policies and protocols, and go from there to determine the extent to which they align with the Title X program expectations, professional guidelines, and recommendations. So using a self-assessment checklist like the one you see on your screen here can help you see clearly what your program does well and where the opportunities for improvements lie so that you can best direct your focus. Next, protocols.

Slide 11



Protocols should contain a brief explanation of what constitutes infertility and should spell out the components of the history, the physical exam, counseling considerations, and the plan of care. The development of a thorough and up-to-date protocol can be daunting, but you do not have to reinvent the wheel. The National Clinical Training Center for Family Planning has developed a protocol template that programs can tailor to reflect their own practice settings.

Resource: [Protocol Template: Basic Infertility Services]

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A lot goes into our understanding of fertility and foundational understanding of infertility is evolving. In addition to knowing definitions, causes, risk factors, evaluation, and treatment considerations, all of which are very important, quality care also includes working to understand and to recognize and address the challenges faced by those who have historically not had equitable access to fertility care and infertility services. Infertility is a reproductive justice issue. Specialized infertility services have long been considered elective and even luxury and are still in many states, considered elective, as well as under

many insurance plans. The high cost and inaccessibility of services as well as infertility that could have been prevented but wasn't, for example, due to untreated pelvic infections, pose real burdens for people experiencing infertility. Also, LGBTQ+ and gender nonconforming individuals have experienced bias and discrimination in building their families. These constructs create and perpetuate disparities in access to infertility services and care and an infertility treatment outcomes. Providing inclusive and culturally affirming infertility services that support the family building goals of all clients, including LGBTQ+ clients, is one very important way that we can work toward eliminating these disparities. The toolkit highlights two e-learning courses, Infertility as a Reproductive Justice Issue and Cultural Competency in Family Planning Care. Program staff can take these courses to learn more about disparities in access to infertility care and outcomes and how to address the disparities, as well as learning about strategies for using a cultural humility approach to providing family planning services.

Resources:

- eLearning courses:
  - Infertility as a Reproductive Justice Issue
  - Cultural Competency in Family Planning Care
- Job aid: Support LGBTQ+ Clients with Affirming Language

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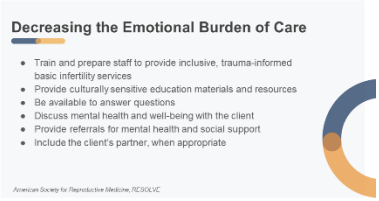

Many people feel unsure about which terms to use when discussing sexual orientation and gender identity. Appropriate terms and definitions to use with clients may differ from person to person, they depend on the community and the context, and they evolve over time, so it's best to use the terms that your clients use to describe themselves. If a client uses an unfamiliar term, ask them to explain it and do research on your own to understand it. The RHNTC has a job aid entitled Support LGBTQ+ Clients with Affirming Language that offers language that providers can use to deliver client-centered, equitable, and culturally affirming care to all clients, regardless of sex, gender, or sexual orientation. Providing affirming care and using inclusive language is so important in helping people who identify as LGBTQ+ feel that their identities and their characteristics are acknowledged and supported. Emotional burden is a significant reality for clients experiencing infertility. While we, as healthcare professionals, and as compassionate humans recognize this, we aren't necessarily trained in how to help ease the burden, and it's easy to find ourselves at a loss for truly supportive work. This emotional burden may manifest in psychological distress for the client, specifically anxiety and depression, which may result in their decision ultimately to discontinue seeking care and treatment and possibly not achieving the family that they envision. Many clients are more distressed than their care team actually recognizes. I think it's really important to let this sink in a bit and step into their care in a trauma-informed way and not underestimate how important our client-centered care is to them, and how important every interaction that we have with them is. Helping to ease clients' emotional burden is also important because clients who are anxious tend not to retain information as well, which can hinder their adherence to care plans and recommendations, which may in turn hinder their success in achieving a healthy pregnancy. So how

can we decrease the emotional burden of care? In addition to doing the work of training on barriers, disparities, and inequities, and how to look at fertility and the experience of infertility with humility, we can provide culturally sensitive educational materials and resources and the available to answer questions. We should discuss mental health and wellbeing with the client and provide referrals when needed, and we can include the client's partner when and if that's the desire of the client.

Resources:

- American Society for Reproductive Medicine. Micro-video: Decreasing the Emotional Burden of Care
- RESOLVE: The National Infertility Association

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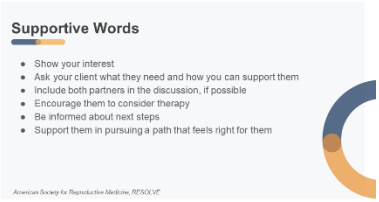

Talking with clients about infertility can be really hard. We want to say the right things, we want to be reassuring, and we want to share sincere care and concerns. So here are some tips for talking with clients who are experiencing infertility. First, show your interests by focusing on them and only them when talking with them about their infertility, look them in the eye and don't multitask. Ask them what they need and how you can support them. Include both partners in the discussion if two are present. When appropriate, gently encourage them to consider therapy and offer referral to a therapist who has experience with clients struggling with infertility. Be informed about next steps in evaluation and treatment and support them in pursuing the path that feels right to them.

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Sometimes, our helpful suggestions can be felt as insensitive. So here are a few things not to say. First, don't tell them to relax. This can come across as judgmental, and it minimizes the complexity and the significance of what they're experiencing. Don't try to deflect with comments that highlight the supposed upside of not having a child, like just enjoy being able to sleep in right now or kids are really expensive. Don't tell them it will happen. In truth, we don't know that it will happen. There's no guarantee, and they know this too. So telling them that it will happen may come off as trite and dismissive. This is a difficult and a potentially uncomfortable conversation. Don't use humor to try to lighten the atmosphere and don't be crude by saying things like are you sure the little guys are swimming? Finally, don't push adoption or other solutions. They need to work through many issues before they'll be ready to make an adoption decision or choose another family building option.

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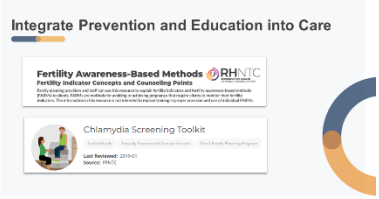

Another important thing that we can do is focus on infertility prevention through screening for and treating conditions that may influence fertility and providing quality preconception health services. This means assessing clients reproductive goals and counseling on proactively supporting fertility and achieving healthy pregnancy. Long standing and/or untreated gonorrhea and chlamydia is one of the most common preventable causes of infertility because this can cause scar tissue to form in the uterus and fallopian tubes, which can prevent successful fertilization and implantation. So one huge thing that Title X programs can do is provide STI screening according to the most current guidelines and strengthen their chlamydia screening services by including screening as part of routine care, using normalizing and opt-out screening language and leveraging payment options to reduce cost if a barrier for both the program and the clients. Programs seeking to strengthen their chlamydia screening services and increase chlamydia screening rates can look to the RHNTC chlamydia screening toolkit. Also, health educators and clinic teams can help clients optimize their fertility by teaching them about the fertile window, fertility indicators, and fertility awareness, so that the client can predict ovulation and time intercourse to coincide. The two images on the slide are clip from RHNTC's fertility awareness-based methods, fertility indicator concepts, and counseling points job aid and the chlamydia screening toolkit.

Resources:

- Fertility Awareness-Based Methods: Fertility Indicator Concepts and Counseling Points Job Aid
- Chlamydia Screening Toolkit

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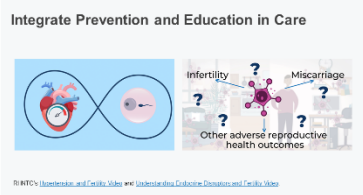

Health educators and clinic teams can also teach clients about conditions and environmental exposures that may influence fertility. For example, we can educate clients on the link between hypertension and impaired fertility. We can also share information on how exposure to endocrine disruptors may interfere with the hormones in our body to potentially impact reproductive health and fertility along with actions that clients may take to reduce their exposure. The images on this slide are clips from two RHNTC videos. Hypertension and fertility and understanding endocrine disruptors and fertility.

Resources:

- Hypertension and Fertility Video
- Understanding Endocrine Disruptors and Fertility Video

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Finally, when necessary, provide clients with referrals and resources that go beyond what you can offer at your site. In addition to linking clients to specialist care for clinical infertility services, family planning agencies can provide clients with information, education, and resources on the social, emotional, financial, and other aspects of navigating infertility and treatment. Agencies seeking to strengthen their referral system can call upon the Establishing and Providing Effective Referrals for Clients: A Toolkit for Family Planning Providers. To make providing these referrals easier, it may be helpful to spend a little time pulling together a list of local resources including support groups that you can draw upon when you need it. The American Society for Reproductive Medicine has a health professional locator on their website, which may help clients identify fertility care providers. We'll chat that link in now. People experiencing infertility may find strengths, hope, courage, and information through the stories of others.

Resources:

- Establishing and Providing Effective Referrals for Clients: A Toolkit for Family Planning Providers
- ASRM Find a Health Professional

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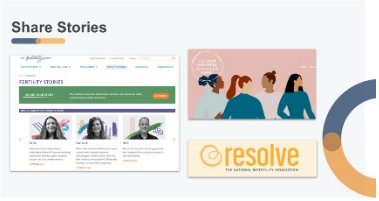

These stories can help them navigate their own journeys, but people may not know of someone who has experienced infertility that they feel comfortable talking with. That's why providing information about local and online support groups can be really helpful. There are online resources that can help people connect with others who have experienced infertility. Websites like RESOLVE, My Fertility Story, and the National Infertility Awareness Week resources can bring community and personal connection to people, which can provide irreplaceable comfort and support.

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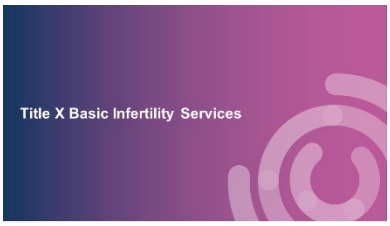
So I have shared a lot, but there is so much more. Please take some time to explore the infertility services in Family Planning Care toolkit. In the meantime, I'm going to pass it over to Jacki, who's going to share some information about definitions, common causes, and contributors of infertility, and the scope of Title X basic infertility services. Over to you, Jacki.

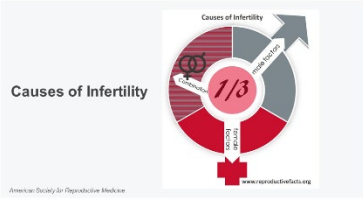
Resource: Infertility Services in Family Planning Care Toolkit

Slide 21



- [Jacki] Thank you, Meg. So this section will focus specifically on required basic infertility assessment services in Title X settings.

Slide 22



First, just a recap of the causes of infertility. About 1/3 of causes are attributed to the male partner, about 1/3 to the female partner, and about 1/3 to the couple. What this graphic does not represent, and I think is important to remember, about 10% of infertility is called unexplained, and that is where no direct cause can be determined.

Resource: American Society for Reproductive Medicine. What Causes Infertility?

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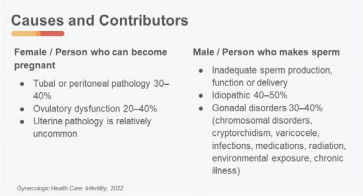
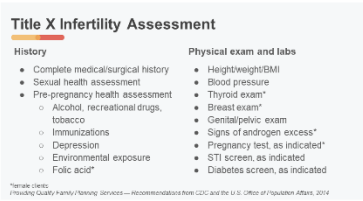


Let's talk a little bit about causes and contributors. On the left-hand side, you'll see the female or the person who can become pregnant. Causes and contributors to infertility are tubal or peritoneal pathology. That accounts for about 30 to 40% of female infertility. Ovulatory dysfunction accounts for 20 to 40% of infertility in females. Uterine pathology is always in this list, but it's relatively uncommon in younger women. On the right-hand side, you see the male or the person who makes sperm. Most common cause about 50% of infertility cause in males is due to inadequate sperm production, function, or delivery, and will spend a little bit more time on that in just a minute. Unfortunately, about 50% of those cases are considered idiopathic. In other words, we're not sure why there's a problem in production, function, or delivery of sperm. Gonadal disorders also account for 30 to 40% of infertility cases in males. This includes chromosomal disorders, cryptorchidism, which is undescended testicles, even if it was repaired near the time of birth. Varicocele, which is large varicose veins in the testes or above the testes, actually in the scrotum. Genital infections, medications, and that can be prescription or non-prescription as well as environmental exposures like radiation, pesticides, plastics, other things, and then chronic illness, of course.

Reference: Moore, M. (2022) Chapter 20 Infertility in Schuiling & Likis Gynecologic Health Care (4th ed) Jones & Bartlett

Slide 24



So when we're talking about infertility assessment in a Title X setting, here you'll see history on the left and physical exam and labs on the right. You'll also see asterisks after several of the entries here. That indicates female only. So medical history for the person with a uterus should include questions about conditions associated with infertility like thyroid disease, polycystic ovarian syndrome, or PCOS, other hormonal or endocrine disorders, unusual hair growth or male pattern hair growth, and endometriosis. There are others, but those are the main ones. Sexual health assessment includes menstrual and reproductive history and should include how long the client has been trying to achieve pregnancy. We also should be asking about sexual intercourse timing and frequency, the level of the patient and partner's fertility awareness knowledge, and results of any previous evaluation or treatment for infertility. Obstetric history, if appropriate, should also be documented. Age of first menstrual period, cycle length, duration, and any symptoms associated with menstruation like cramps should also be noted. The review of systems should include length, duration, and other things associated with

abdominal pain, any kind of disease of the pelvis, surgery in the pelvis, pain with intercourse and breast secretions. Also note that we need to be careful if someone is wanting to achieve pregnancy that we also follow the guidelines for preconception or pre-pregnancy health assessment. And you see several questions that we would ask here. Alcohol, recreational drugs, tobacco use, up to date in immunizations, depression, or other mood disorders, environmental exposure or the potential for environmental exposure and documenting that the person with a uterus is taking the recommended folic acid supplementation. Examination, physical examination for the person who can become pregnant should include height, weight, and BMI, thyroid and clinical breast examinations to identify normal or abnormal findings and also a skin and hair distribution assessment, especially noting any male pattern hair growth. Pelvic examination should be thorough and should include pelvic or abdominal tenderness, organ enlargement, or pain, or any masses. Also any vaginal or cervical abnormalities including uterine size, shape, ovarian masses, those sorts of things. Medical history for the person who produces sperm, which you see here on the right should include a complete medical and surgical history, including sexual and reproductive history with emphasis on conditions known to contribute to infertility. That would be diabetes, prior genital surgeries, genital infections, certain medications, prescription and non-prescription, and again, the lifestyle and potential environmental exposures that for males, that would include heat, radiation, certain plastics, pesticides, and others, including air pollution. History should also include coital frequency and timing for the male and prior fertility with another partner. For the person who produces sperm, a physical exam is focused on a thorough genital exam, and this includes penis, scrotum, and testicles to identify any abnormalities. I mentioned that before, particularly a varicocele or those large varicose veins above the testicles, and also a prostate exam.

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There are basically five questions that we ask in a basic infertility assessment.

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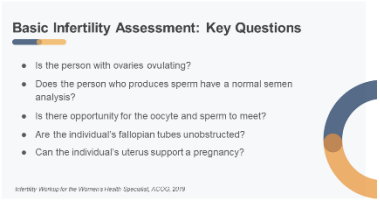

And these are is the person with ovaries ovulating? Does the person who produces sperm have a normal semen analysis? Is there opportunity for the oocyte and the sperm to meet? Are the individual's tubes unobstructed, open, patent? Can the individual's uterus support a pregnancy? So basic assessment, which Title X settings routinely provide includes the ovulation assessment, attention to coital timing and frequency, and education about fertility awareness, and the fertility window, and semen analysis for the male.

Resource: [Infertility Workup for the Women's Health Specialist]

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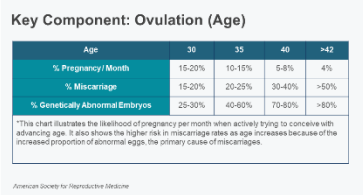

The other two parameters, the last two here, are considered in the key questions for infertility assessment, but they're beyond the scope of most Title X settings. Here is just a review of some of the issues that occur with aging with the female partner. As you can see from the chart, the probability of pregnancy per month from left to right decreases. It's 15 to 20% for a 30-year-old, 10 to 15% in a 35-year-old, declines to five to 8% in the 40-year-old and to 4% in the person who is over 42. Conversely, the next row shows the chance for miscarriage and it increases as the woman's age increases. Again, follow along, 15 to 20% at age 30, 20 to 25% at age 35, 30 to 40% at age 40, and more than 50% for those over age 42. Genetic abnormalities also increase as the woman ages with about 20 to 30% for the 30-year-old, 40 to 60% for the 35 year old, 70 to 80% for the 40-year-old, and 80% plus for someone over the age of 42.

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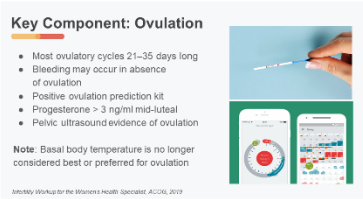

Let's look at ovulation first. So most ovulatory cycles are 21 to 35 days long. That is from the FIGO definition for normal menstruation. And this provides at least presumptive evidence of ovulation. Periodic bleeding may occur in the absence of ovulation, but that's not very common. And usually when you're doing the history, that bleeding is erratic in timing and amount or characteristics. Other signs and symptoms that indicate probable ovulation include PMA symptoms and mild dysmenorrhea or cramping at the time of menstruation. Women can be taught to track cervical mucus changes, Meg mentioned that, through the cycle, and they can notice ovulatory mucus, which is slippery, stretchy, and watery. Some women also report transient pelvic pain at the time of ovulation, and this can be accompanied by a little bit of pink spotting. Other women report increased sex drive or libido around the time of ovulation. This has been linked to high estrogen level at that time, high circulating estrogen levels.

Ovulation kits which measure LH or luteinizing hormone, that's the hormone which actually causes ovulation are helpful for identifying the ovulatory or fertile window in the cycle. And they're usually pretty accessible. There are some as low as $15 per kit now, so. A serum progesterone level, which we would draw at the clinic if we were to do that is we would look at anything over three nanograms per mil in the mid-luteal phase. That's around days 24 to 28 in a 28 to 30-day cycle. Pelvic sonogram is the gold standard for documenting ovulation, but that is usually done in specialized infertility settings, not in basic OB-GYN or Title X settings. Note that basal body temperature is no longer considered the best or preferred method for documenting ovulation.

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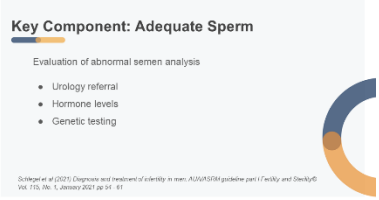

Next, let's look at adequate sperm. So when there's an abnormal semen analysis, urology referral for further testing, including hormone levels and genetic testing is the most likely next step for someone in a Title X setting. Clients with abnormal findings on history or physical exam would also be referred to a urologist.

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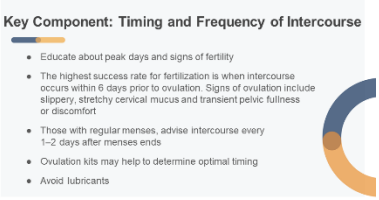

Spend a minute talking about timing and frequency of intercourse because it's amazing how many people are not aware of these things, so we can really make a difference with education and counseling just about when to have intercourse. So to optimize the couple's natural fertility, we want them to know about the peak days of fertility. We want to educate that the highest fertilization success rate is achieved when sperm is deposited into the vagina in the six days before ovulation. For those with regular menses occurring about 21 to 35 days apart then, we want to advise intercourse every one to two days after the menstrual period ends. Ovulation kits may help determine optimal timing since they identify that LH surge that actually causes ovulation to occur. So most kits will turn a bright blue color about 36 hours before the patient is going to ovulate. So that gives people time to schedule, so to speak, sexual intercourse at the time or before the time of ovulation occurs. I think it's important to remind people too that there are no special positions or requirements for lying down after intercourse which have ever been proven to increase the rate of fertilization. So it's important that people know that. Additionally, we should, in general, tell people to avoid most lubricants. We know that a lot of water-based lubricants may decrease fertility, and we'll chat in some of the FDA-approved lubricants that can be used in patients wanting to achieve pregnancy. See those there. Also chat in some other resources.

Resources:

- FABM Resources
    - Billing and Coding Job Aid
    - Webinars about the Clue Fertility App and the Natural Cycles App (DISCLAIMER: current recommendation is that if someone is concerned about personal information, they should be advised to not use any of the cycle tracking mobile apps)
    - FABM eLearning Course
- Fertility Awareness-Based Methods: Fertility Indicator Concepts and Counseling Points Job Aid
- eLearning course: Support for Achieving a Healthy Pregnancy eLearning

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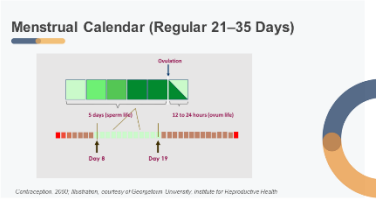

I like this graphic because it shows you the fertile window in a graphic representation. The graph illustrates a 28-day cycle. It indicates that, on average, the fertile window spans the time period from day eight to day 19, and that's if you're not pinpointing it with, for instance, an LH ovulation kit. This research has demonstrated that this is really the most likely fertile window time. And we know that sperm deposited in the vagina in the days leading up to ovulation have the most chance for fertilizing the ovum when it's expelled. So this fertile window also takes into account the physiologic approximate viability of sperm cells, which is three to five days, and also the viability of the ovum, which is about 24 hours. Ova may live a little bit longer than 24 hours, but most authorities don't think that they are fertilizable after 24 hours of age.

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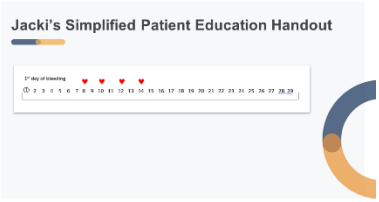

This is my really simplified education handout that I use with patients. I like it because I can write all over it, and make little notes, and make circles, and I can add things to the end if they have longer cycles. So I don't think you need real involved patient education when you're talking about timing intercourse and teaching about the fertile window.

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So let's go back to the key components beyond the scope of most Title X projects. These have to do with fallopian tubes being patent or unobstructed and the individual's uterus being able to support a pregnancy. Assessing the fallopian tube patency and uterine normality is beyond the scope of care for most Title X projects. Assessment for open or patent fallopian tubes is done by radiologic procedure called a hysterosalpingogram or a utero-tubogram. Assessing for uterine abnormalities including uterine polyps, fibroids, that sort of thing is usually done by transvaginal ultrasound.

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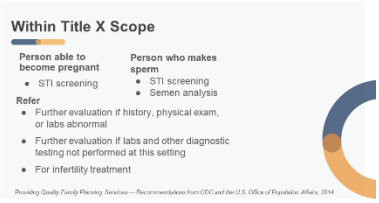

So within Title X scope, Meg emphasized this also. We very definitely are able to provide good prevention for infertility by providing STI screening, which is a core service for both the person able to become pregnant as well is the person who makes sperm. The other thing that we can provide for that person, the male, is semen analysis. We know that we'll be referring for any abnormalities in the history physical exam or labs, and we also may be referring directly if the patient is determined, by definition, to be infertile, and that would be for, of course, infertility treatment.

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Also, just want to note a caveat about labs that are considered basic or initial assessment for infertility. Those includes thyroid-stimulating hormone or TSH, mid-luteal phase progesterone, which I mentioned before, follicle-stimulating hormone, and estrogen levels, anti-Mullerian hormone, which in which can uncover ovarian reserve issues, typing and Rh, genetic testing, and rubella and varicella titers. The caveat here is that your Title X project is probably not going to cover the costs of these tests. You may be able, however, to offer, under your public health contract with a lab, these tests were much cheaper than a patient can get them in a specialized reproductive endocrine office. So just a word to think about

that. Patients obviously have to be very clear on knowing that is an out-of-pocket expense and not covered by Title X, so it doesn't slide to zero.

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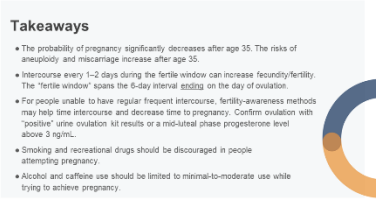

In summary, let me just remind you of things that we've talked about in the last few minutes. The probability of pregnancy significantly decreases after age 35, and we know the risk for chromosomal abnormalities and miscarriage increase after age 35. Intercourse every one to two days during the fertile window can increase fertility. The fertile window spans the six-day interval ending on the day of ovulation. Very, very important to stress to clients. For people unable to have regular frequent intercourse, fertility awareness methods may help and may help decrease the time to pregnancy. We can confirm ovulation with a positive urine ovulation kit, that's something done at home, or with a luteal phase progesterone level that we would draw in the office. Smoking and recreational drugs should be discouraged in people attempting pregnancy, alcohol, caffeine should be limited to minimal to moderate amounts if someone's trying to achieve pregnancy.

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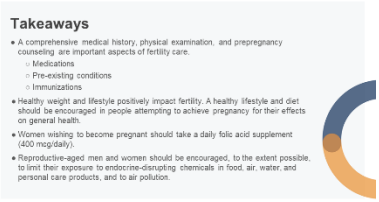

We know that a comprehensive medical history, physical examination and pre-pregnancy counseling are important aspects of fertility care. This, of course, includes medications, preexisting conditions and immunizations. Healthy weight and lifestyle can positively impact fertility. Women wanting to become pregnant should take a daily folic acid supplement of 400 micrograms daily. That's present in most multivitamins. People should check and make sure, but most multivitamins have 400 micrograms of folic acid. Reproductive age men and women should be encouraged to the extent possible to limit their exposure to endocrine-disrupting chemicals. And those occur everywhere as you know, food, air, water, and personal care products, even to the air that we breathe.

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I will end there and send it over to Fonda.

- [Fonda] Thanks so much, Jacki and Meg. Lots of great information there. We're going to move into our question time. We have about 10 or 12 minutes for that. We have collected a few questions that people shared during registration, so we'll start with those, and then we also see that some questions have been added to the chat and we've been taking note of those. So we'll work through those as well. And to start, I'll raise a question that came in for registration. The question is, who pays for infertility services? And Meg, I'll pass the mic to you for a response on that one.

- [Meg] Yeah, thank you. This is a really good question. It's a really important question. Fertility care in the US is inaccessible to many due to the cost. We know that fertility services are often not covered by public or private insurers. A minority of states require some private insurers to cover some fertility treatment, but only one state Medicaid program, which is New York, covers any fertility treatment and no Medicaid program covers artificial insemination or IVF, in vitro fertilization. Also, some people such as LGBTQ+ individuals or single individuals may not meet the definitions of infertility that would qualify them for coverage. So it's a good question because significant gaps remain, how can we address them? Well, if the client has third party insurance coverage that is authorized or legally obligated to pay for services, then the program is expected to take all reasonable efforts to obtain third party payment without the application of any discounts just like any other Title X service. It's important to note too, and it may be worth checking in with the individual's insurance if they've got it, it's important to note that while many insurance policies won't cover infertility treatment, they may very well cover evaluation components like ultrasound, or lab studies, or semen analysis. So, you know, it's important to share this with a client because they may be able to get a good amount of work done with insurance coverage and knowing this might help them get a little bit further down that road. To prioritize or optimize payments rather, it's important to comprehensively and accurately code a visit. The RHNTC has resources and support staff involved in billing and coding, including the ICD-10 codes for family planning services job aid, which has a section on codes specifically relevant to achieving pregnancy and infertility services. So that's one thing is to optimize the payments you can get. If the client does not have third party insurance coverage that includes infertility services, and we know a lot of our Title X clients don't, basic infertility services can be billed to the client who is placed on the sliding fee scale, just like any other Title X service. This doesn't necessarily provide a lot of support for outsourced services though like ultrasounds. We understand that. So in this case, in these cases, clients might find it helpful to receive some information from Title X staff about options for paying for care beyond basic infertility services that are provided within a Title X clinic, including specialist services. And these options might include scholarships and grants. They are out there, financing programs, loans or credits, or even, you know, giving some thought to the idea of crowdfunding. The RESOLVE website, which we had earlier, and it's in the toolkit, has information about some of these options if you would like to learn more that you can share with your clients. I would also recommend reaching out to the specialists that you may be

referring to for services that are not available within your Title X site because this might not be a new challenge for them, and they might have some information about different funding sources that they know of or work with that can be shared with the client.

- [Fonda] I wanted to note that there were some additional questions that came in related to payment. And Meg, I'm wondering, or Jacki, if you could speak to those since we're on that topic. So one of the questions is is semen analysis covered under the Title X program?

- [Meg] If the semen analysis is provided outside, not under the roof of the Title X's program that it would not be covered. Most Title X programs do not offer semen analysis underneath their roof, and therefore, it would not necessarily be, wouldn't be covered by Title X funding. Jacki, do you agree or do you have anything else to add?

- [Fonda] And so Jacki called out in the chat. It's called out in the QFP as a basic test for infertility. And so Meg and, I'm going to jump to... So I think Jacki, unfortunately, her microphone's not working, so I'm going to jump to another question that I noted you could respond to. So the menstrual calendar looks like CycleBeads, is it? And would you recommend people use this?

- [Meg] Yeah, yeah. So CycleBeads is one option. What I see my clients use more often than CycleBeads is apps on their phone, and some of these apps are getting really good. Clue is a newish app that's actually FDA-approved to help clients understand their fertile window so that they can time intercourse accordingly depending on whether they want to achieve or avoid pregnancy. And I see my clients using a lot of others as well. Period Tracker, P Tracker, and they can be pretty accurate. So yes, I do recommend that clients use them over the course of several months, and it's always helpful too if they can align their understanding of their own fertility markers, especially cervical mucus since this one is, you know, so observable without special kits and things like that. I recommend that they use their app for several months and align it with what they're observing to understand their fertility over time.

- [Jacki] Can you hear me now by any chance?

- [Fonda] Yes. Do you have anything you want to add onto that, Jacki?

- [Jacki] No, not particularly. I think in the environment we're living in, Meg, the only thing that I would caution is if people have privacy issues. There are a lot of questions about the fertility trackers right now, and the privacy of that information. Most people wanting to achieve pregnancy, that's not an issue. I see a question about semen analysis in-house. This is not a sperm count. There are actually four and potentially five parameters for a quantitative comprehensive semen analysis, including morphology, and motility, and you know, other factors like electrification and those kinds of things. So yes, if people are trained in semen analysis in your office, I think it would be great to be able to offer that. But I think it's beyond the scope of most advanced practice people, we're not taught that in school, so.

- [Fonda] Thanks, Jacki. And I'm going to jump back to one of the questions that came in through registration and ask you to respond. So the question is there exponential increase in infertility for patients who have more than one infection with chlamydia?

- [Jacki] Meg and and I discussed this earlier, and it would be a really difficult study to know. I think physiologically, it makes sense to think that the more times those delicate fallopian tubes are exposed to infection, the more likely there is damage that could affect fertility. The data has to do with pelvic

inflammatory disease. So if someone is diagnosed with pelvic inflammatory disease more than once, yes, their chance, their potential for infertility as well as ectopic pregnancy increases exponentially.

- [Fonda] Thanks, Jacki. So there's some additional questions that have come in related to semen analysis, and I know Jacki and Meg have both spoken to that some. There's one question around where are people referring for semen analysis? And Meg, I think you had raised maybe pulling that to the group. If folks have sources that you're referring to, please chat that in, and we'll monitor the chat and speak that back to you all.

- Yeah, I mean it can be a challenge. Sorry, it can be a challenge. Where I live, I live on an island, it's not available on the island, we have to send it 2,000 miles away. So I think you have to see what's available in your local area, but I'd be very curious to hear what others in the, other participants are doing with regard to referrals for semen analysis.

- [Jacki] Meg, you mentioned earlier to try to become familiar with reproductive endocrine and infertility specialty practices in the community. I have talked to people who refer there for semen analysis, and they get a reduced price because they're sending them from a public health, you know, entity, a safety net entity. So I wouldn't just look for labs, you can also look for practices.

- [Meg] Absolutely, and actually we had, at one point, a urologist who was doing them.

- [Jacki] Yes.

- [Meg] So it might be worth making some calls to the urology practices as well.

- [Fonda] Thanks, Meg and Jacki. We've had some additional questions come in, but I'm also recognizing we are just coming up on time, and I welcome folks to continue sharing questions in chat, and that helps the RHNTC understand what's coming up for you and how we can support and focus resources going forward. But that will conclude our question section for now. And I'd like to share a bit more information before we end our webinar.

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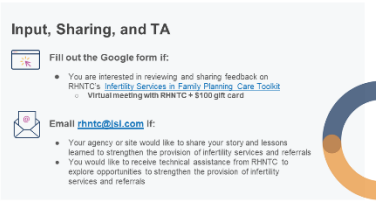

First, I'd like to share that... I'd like to pitch a few things to Title X grantees sub-recipients and service sites in attendance today. Let me come back on video. So as you know, we're always interested in gaining feedback from the folks who use our resources, and we'd like to learn about your experiences with using our resources. And so if you're a staff of a Title X grantee or a sub-recipient or service site and you're interested in reviewing the infertility services and family planning care toolkit that we shared today, please complete the Google Form link that Caila put in the chat. We're looking for up to five people to review and provide feedback, and the process will involve a Zoom meeting with a small team of RHNTC folks and yourself to talk through your experience and feedback. And we'll provide you in return $100 gift card for taking the time to talk with us and share what comes up for you and your

insights. So the link is in the chat. If it's not something you're sure you want to go forward with now, just copy that link, and you can fill it out at a later time. Also, a couple of other opportunities to share. So if your agency or site has worked to strengthen infertility services and referrals for your clients experiencing infertility, we're interested in hearing about that and spotlighting your story and lessons learned as an opportunity to inform other agencies and sites in the network. So again, if you have a story that we could share and highlight, we'd be thrilled to do that. And if you email us rhntc@jsi.com, we'll follow up with you. And then also on the other side of that, if your agency would like to prioritize infertility services as an area to strengthen, you can access technical assistance through the RHNTC. We can support you and explore what the TA might focus on and look like. And so as you may remember, all Title X grantees can request TA from the RHNTC. And again, you can do that by sending us an email. So thank you for considering that.

[Sign-up link to review and provide feedback to the Infertility Services in Family Planning Care Toolkit]

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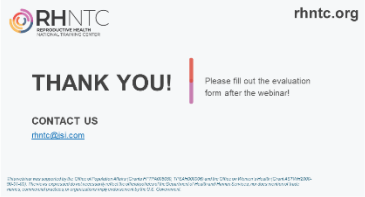

Thank you all for joining today, and I hope you'll join me in thanking Meg and Jacki for all of their information that they shared with us today. As a reminder, materials from our session today will be available on our website in the next few days, and we'll also email those out to all of the registrants of the webinar. If you have additional questions for the RHNTC on this topic, don't hesitate to email us. Again, just a final ask to take a few minutes to complete the evaluation for the session today. In order to obtain a certificate of completion, just a reminder that you need to be logged into rhntc.org when you complete the evaluation. And then lastly, a few things on how you can engage with the RHNTC going forward.

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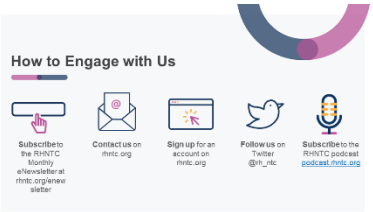

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