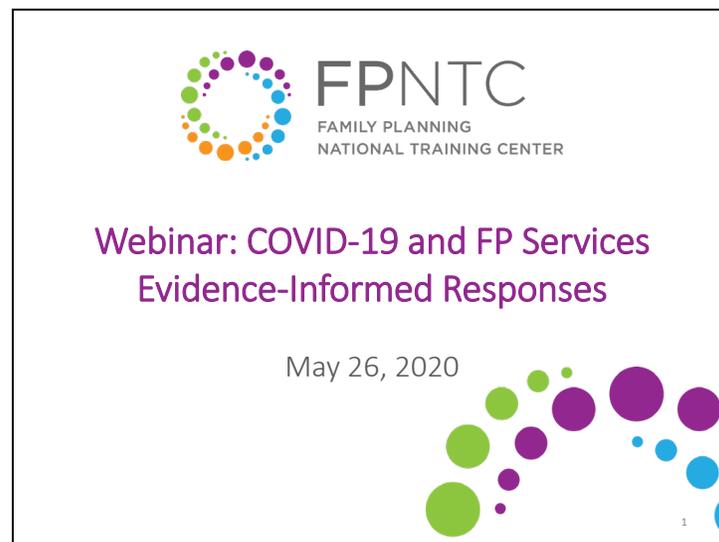


# Webinar: COVID-19 and FP Services Evidence-Informed Responses

May 26, 2020

Slide 1



Katie Quimby: Hello, everyone. This is Katie Quimby from the Title X Family Planning National Training Center. I'm so pleased to welcome you all to today's webinar. Today, we will discuss evidence-informed responses to frequently asked questions about COVID-19 and family planning services. I have a few announcements before we begin. First, everyone on the webinar today is muted given the large number of participants. We hope to have some time for questions at the end of the webinar, and you can ask your questions at any time using the Q&A pod on the side of your screen. A recording of today's webinar, the slide deck and the transcripts will be available on FPNTC within the next few days. Finally, this presentation was supported by the Office of Population Affairs. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Meet our speaker!



Michael Policar, MD, MPH  
Professor Emeritus of ObGyn  
and Reproductive Sciences  
University Of California, San  
Francisco, School of Medicine



2

Dr. Michael Policar: Okay, I'd like to briefly introduce our speaker today. We are joined today by Dr. Michael Policar, Professor Emeritus of Obstetrics, Gynecology, and Reproductive Services at the University of California San Francisco School of Medicine. Dr. Policar has had a long career serving in medical leadership roles for health systems and health plans. He has also served on expert advisory panels for CDC and OPA, contributing to foundational guidance documents including the medical eligibility criteria, and selected practice recommendations for contraceptive use, as well as QFP. With that, I'd now like to turn it over to Dr. Policar to get started. Dr. Michael Policar: Great, thank you, and thank you all for joining us. So, the genesis of this webinar is the fact that the Family Planning National Training Center has been doing some work on developing responses to the COVID-19 public health emergency. And one of the first things that we posted in working together were a set of frequently asked questions that we try to periodically update. And what I'm going to cover over the next hour or so are many of the questions that we covered in that particular document. First, there'll be some introductory material about telehealth services for family planning. And then after that, we'll explore a variety of questions that have to do with delivering contraceptive services and STD services during this time of the public health emergency.

## Learning Objectives

By the end of the webinar, participants will be able to:

- Provide evidence-informed answers to FAQs about providing family planning services during the COVID-19 pandemic
- Identify FPNTC resources that can be used to find current, as well as future, answers to FAQs

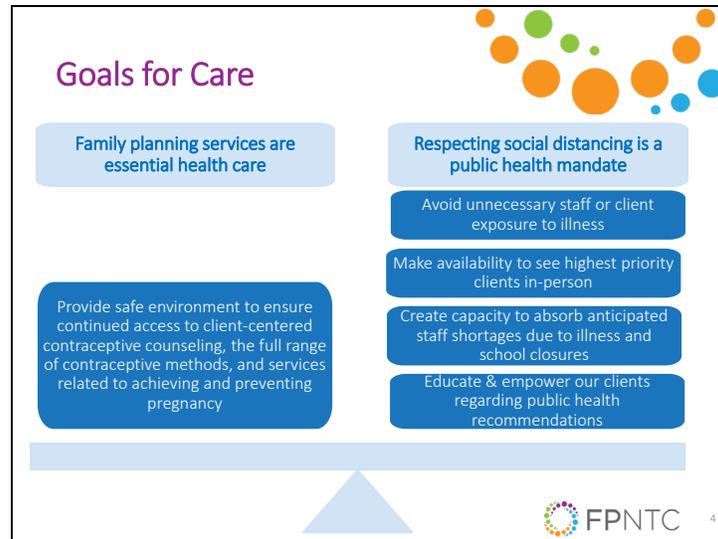


[COVID-19 and Family Planning Services FAQ](#)



3

So, our learning objectives are before you.



And these start by saying that the whole idea of crafting these areas responses to the public health emergency basically has to do with balancing two goals. On one side is the fact that we want to continue to deliver high quality family planning services, which the Office Population Affairs, all of us consider to be essential health care services. We want to be able to do that in a way which is client centered, offer as many of the methods as we can and help give people the opportunity of either preventing pregnancy or achieving pregnancy, exactly what we've always done in the best way that we can do that. But of course, we also have to respect the reality of physical distancing as a public health mandate. And therefore, what we're trying to do is avoid any unnecessary in-person visits as a way of both protecting our clients and our staff members. But on the other hand, there are certain circumstances where we really do need to see patients in person. Much of that of course is going to be related to management, especially placement of IUDs and implants, but we'll talk about some other circumstances as well where you need to prioritize face-to-face visits with patients. We also want to keep in mind the fact that you may be experiencing staff shortages, either because your staff might be out rather due to illness or illness in the family member. There could be school closures or other reasons that they have to be at home with kids or other family members as well. And unfortunately, we even heard of layoffs in some circumstances, which have led to downsizing. We also want to be able to do things in such a way that we not only educate all of our clients in the way that we normally do about family planning services, but also answer whatever questions they have about the public health recommendations, which are occurring both nationally and in your own community.



How can family planning  
providers use  
telemedicine to continue  
to meet client's family  
planning needs?



**Use Telemedicine to Facilitate Access to Family Planning Services and Respect Social Distancing During the Public Health Emergency**

- All counseling done via telehealth, unless client doesn't have access to smart phone or computer

**BE CREATIVE!**

- Screening for contraindications for method by history
- Utilize home measurement of vitals
- Expand use of self-administered DMPA-SQ if interested
- Elicit and honor client preferences for both insertion and removal of LARC



US MEC US SPR  
Contraception  
GET IT

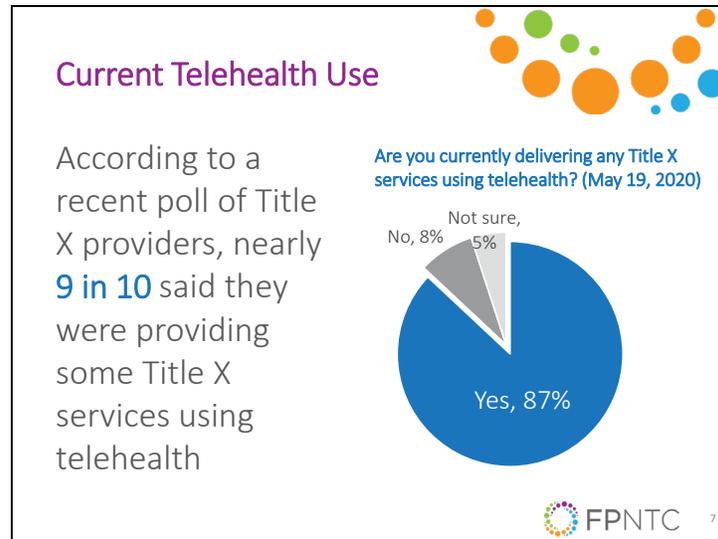
US MEC US SPR  
Contraception  
GET IT

Methods of Family Planning Methods

FPNTC 6

So, as I mentioned a moment ago, we're going to start with just a quick review about telemedicine and the way that it's been used in family planning. I can summarize that by saying that the large majority of what we do in family planning, particularly the counseling and shared decision-making can be done by telehealth. And certainly, we have to acknowledge the fact that some clients don't have access to smartphones or computers in order to be able to do these telehealth visits. But there are other workarounds, particularly telephonic without a computer that we'll be talking about in just a moment. And what we will do is provide to our patients exactly the same kind of educational materials that we normally do. This being a graphic of the various tiers of contraceptive advocacy. But we also want to be creative about how to do that. I'll be sharing some ideas with you about what other Title X family planning clinics have been doing in terms of shifting over to telehealth visits, screening for contraindications to particular methods by a history that we take over the phone, and then of course, using the US Medical Eligibility Criteria in the selected practice recommendations in making clinical decisions about how to manage our patients. We're shifting over much more to utilizing home measurements of vital signs. So for example, if a person shouldn't come in for a blood pressure check, that's something that she might be able to do at home with a home blood pressure monitor. Or when it comes to weight so that we can calculate the body mass index, that's something the patient can either tell you about to say that they know already, or hopefully they can weigh themselves at home. We'll be talking a little bit about the expanded use of DMPA what you may know as Depo-Provera given subcutaneously self-administered at home by the patient rather than needing to come in to the clinic. We'll also talk about our ability to elicit and honor client preferences, both for placement and removal of long-acting reversible methods like IUDs and

implants. And for those first couple of slides, I want to thank my colleague, Jennifer Carlin at UCSF.



Most of us have shifted over to using telehealth. In fact, in a survey that was done on Title X providers just a few weeks ago, almost 90% of Title X providers are using some amount of telehealth services or providing all of their services by telehealth. Fewer than 10% were not doing telehealth at all. So, this acknowledges the fact that there's an understanding that most of you have switched over to telehealth visits either partially or completely.



**Poll #1**

What best describes how you are providing telehealth?

- Providing services exclusively using telehealth
- Providing a mix of in-person and telehealth services
- Providing services exclusively in-person
- Providing no services temporarily (i.e. we are closed)
- N/A – We do not provide services directly



FPNTC 8

So now, what we're going to do is our first poll and we can really use this information going forward to find out more about whether or not you're providing telehealth services. So, what best describes how you're providing telehealth services in your clinic? You can see that there are five different possibilities of how you can answer that. All right. So, as we get our early responses in, it looks like about almost 5% are using telehealth services exclusively. Almost three quarters are doing a mix of in-person and telehealth visits. Almost 7% providing services exclusively in-person and about 2% aren't providing any services temporarily. And just so you can see what those results are and we'll go back to our slides.



**Poll #2**

Which services are you providing using telehealth? (select all that apply)

- Intake for in-person visit
- Contraceptive counseling/initiation
- Contraceptive counseling/continuation and refill
- Empiric treatment for STDs, UTI
- Pregnancy testing and diagnosis
- Emergency contraception
- Other services
- We are not providing any services using telehealth
- N/A – We do not provide services directly



9

Now, the next is which services are you providing using telehealth? Again, have a look at the lists and check all of the things that apply in your clinical setting in terms of the things that you are currently doing by telehealth. Okay, there we go. Wow. Quite a variety of responses there, although we don't have a full response yet. Now, we got more responses coming in. I'll wait a few more seconds before I share that information with you. All right, so all of the things on the list, I'll send out those results to you. You can see that most are in the 10 to 35% range of the kinds of services that you are providing by telehealth.



**Poll #3**

What type of platform are you using to provide telehealth? (select one)

- Telephone (audio only)
- EHR-integrated platform (eCW, Epic, etc.)
- Other HIPAA compliant platform (not integrated into EHR) (Zoom for Healthcare, etc.)
- Other non-HIPAA compliant platform (FaceTime, etc.)
- We are not providing any services using telehealth
- N/A – We do not provide services directly



10

Then we have one additional question that we're curious about before I give you a little bit more of the options about the services that are available by telehealth, and that is asking you which type of platform do you use to provide telehealth services, just the telephone only? Are you using platform integrated with your electronic health record? Some other HIPAA compliant platforms such as Zoom for Healthcare. You're only using noncompliant platforms such as FaceTime or Skype, and so on. And we will get your responses to that question. Okay. Interestingly, about 40% are only using telephones and another roughly 30%, if I add up EHR and other HIPAA compliance, are using one of the preexisting platforms that are available for doing telehealth. So far, no users of FaceTime, so that's rather surprising. And again, I'll show you those results in just a minute as soon as we wait for a few more answers to come in. All right. Now, you can see how you all responded to those questions.



## Telehealth for Family Planning Services

- Was used well before the PHE
  - Some family planning clinics
  - Many app-based telehealth companies
  - Early stages of a “disruptive innovation”
- Paramount importance now, to avoid in-person visits
- You’ll continue many services after the PHE has passed
  - There is no “going back”



11

Okay. So, to try to summarize this issue about telehealth for family planning services. We all know about the fact that this approach was used well before the onset of the public health emergency. Some family planning clinics have made telehealth services available really for years. A number of the Planned Parenthood Affiliates in the United States as well as Maine Family Planning have been the pioneers in this particular area. We also know that there are many companies that have app-based telehealth services that relate to contraceptive methods. We started seeing those about three or four years ago with a couple of initial pioneers. Now, there are about 12 different telehealth companies that will make contraceptive methods available to patients via an app-based conversation with a clinician. And really our field of family planning was in the early stage of what's called a disruptive innovation in the business world. That is to say, changing the way that we have historically done business and the way that it was primarily face-to-face and done in clinics and now more and more being done in a format of remote conversations via telehealth. And of course, having these health services available is a paramount importance now as a way of avoiding in-person visits that might be problematic either for our clients or for our staff members. Now, you've also heard about the fact that the problem of COVID-19 cases, even though they have peaked in those places and they're now starting to calm down, not everywhere, but most places in the United States. They come back again and wait. And so, what we may see in the future is a pattern of opening of clinics for a period of time, and then if there's a spike in new cases, then closing clinics again for a period of time. So, it's important to think of the use of telehealth as something which is really going to be with us for a long period of time. Number one, because of the public health emergency that may come and go, but number two, because patients and staff are getting used to this approach, and we're likely to see it continue at an even greater rate than we have so far.



### What Will Happen to Office Visits?

- Acceleration of pre-existing trend → more counselling, less physical assessment
- Most contraceptive methods require no physical exam
  - Many alternatives for determining blood pressure
  - Lab tests drawn or submitted at lab stations
- Some “problem oriented” office visits will continue, but many can (and will) be replaced with tele visits

FPNTC 12

What will happen to office visits to the face-to-face that we've historically done? well, again, this is simply accelerating a preexisting trend, where we were spending more and more time counseling and less time in physical assessment. Of course, the counseling is something that we can do with a telehealth. Second is the fact that most contraceptive methods really don't require any sort of physical examination. One of the things we commonly did for people using combined hormonal contraceptive methods was a blood pressure check in the clinic. That's something that we might be able to do at home or in other places, and we'll discuss that in a few minutes. And the same is through of laboratory tests which can be drawn or submitted at laboratory stations. So, we'll certainly continue to do some problem-oriented office visits that are related to symptoms that people have, to STD checks, even problem visits that are associated with contraceptive methods, but many visits can and likely will be replaced with telehealth visits in the future.



## Telehealth Terminology

- Telehealth
  - Infrastructure for virtual health communications
- Telemedicine
  - Virtual interaction between a patient and provider
- Synchronous (real-time) consultations
  - Audio and video (A/V)
  - Telephonic (audio-only)
- Asynchronous (delayed) visits



13

Now, as I talk a little bit more about telehealth, what I want to do is to be very clear about the terminology that I'm using. So, telehealth is a term that's used to define the whole infrastructure for virtual health communications, not only between clients and clinicians, but for a whole variety of other health interactions, health education and so on that can happen through this infrastructure of remote communication. Telemedicine is a subset of that. And that specifically refers to a virtual interaction between a patient and a provider. So, it is a part of telehealth but not its only component. Next is that there's a difference between real-time visits, which are referred to as synchronous visits as opposed to those are that are delayed. For the real-time consultations that can happen are both audio and video simultaneously. And that's kind of a classic version of a synchronous consultation. But the other is a telephonic conversation with audio only and no visual component is a type of synchronous real-time communication as well.



## Telemedicine in Medicare and Medicaid

- “Telehealth Visits”
  - Based on rules before March 6, 2020
- Communications-based Technology
  - Virtual Check-Ins
    - Short patient-initiated communications with a healthcare practitioner
  - E-visits
    - Non-face-to-face patient-initiated communication through online patient portal



The other is called an asynchronous visit, where information is uploaded to the provider and the provider looks at it in a way which is time delayed. So, that might be a photograph or a question coming from a patient. It's not evaluated real-time by the clinician, but there is some delay and then an attempt to get back in touch with the patient afterwards. Now, the Center for Medicare & Medicaid Services in Washington, which drives both the federal Medicare program as well as the Medicaid programs in the states, have some very specific definitions that have to do with telemedicine. One there's something called a telehealth visit. I'll tell you more about that in just a minute. That's based on rules that were in place before the public health emergency. Now, something which is not considered to be telehealth or telemedicine are visits by what they refer to as communications-based technologies. What is called a virtual check-in, those virtually always happened on the phone. And the other is called an e-visit. That's basically a visit with a clinician that happens by a protected email. So, patient or a client types question or a message to the clinician, the clinician evaluates that in a delayed so-called store and forward format and then gets back in touch with the patient afterwards. And by the way, in the family planning world, typically these e-visits are not covered by various payers. But we will talk about the kinds that are covered in regards to telehealth visits and the virtual check-ins.



## Telemedicine Platforms

- EHR telemedicine module
- Proprietary telemedicine products
- New telemedicine products (see NFPRHA guidance)
  - Zoom, doxy.me, eVisit, Vsee, Vidyo, Bluestream
- During PHE
  - Skype
  - Apple FaceTime
  - Facebook Messenger video chat
  - Google Hangouts video

FPNTC 15

Now, I also want to refer back to the question which we asked a few minutes ago and that is, how do you communicate with your clients using a telemedicine platform? Well, many of you use electronic health records that actually have a telemedicine module. So, Epic, eClinicalWorks, some of the others that you might be using actually give you the opportunity of using your electronic health record, which is terrific because of the fact that you don't necessarily have a telehealth sort of interaction and then have to write two separate notes, the note that's written by the clinician or the entry in the medical record that the clinician write into that same electronic health medical record. Second are proprietary telemedicine products. So, you may have been using another product which is not linked to your electronic health record to provide telemedicine services. They work well. They're HIPAA protected. The only problem with them is that sometimes you have to write one note in that proprietary telemedicine product, which then gets shifted over into your electronic medical record, it's two stuff rather than one. There are also some new telemedicine products, Zoom Healthcare, doxy.me, and so on that has kind of popped up just within the last few months, which are not quite as complex as some of the more proprietary models. And one of the references that we have for you at the back is from NFPRHA, the National Family Planning and Reproductive Health Association, which has a whole list of those various telemedicine products that are available for you, as well as sort of a compare and contrast. So you can look at things like cost, HIPAA protection and so on. Now, during the public health emergency, CMS has also made it clear that there are other kinds of audio visual formats that can be used as well between a patient and a clinician. So, Skype, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video are all things that are considered to be acceptable for now, although at some point, that recommendation may change. And of course, the problems with those is that even though they work reasonably well

as a way of communicating, they may not be as confidential and certainly, they're not HIPAA protected. That is waived for the current period that probably will not go on in the future.



### Telehealth Visit (CMS Definition)

- Real time interactive audio and video telecommunications
- Providers: MD/DO, NP, PA, CNM, CRNA
- Have an established relationship with a practitioner
  - “DHHS will not conduct audits during this PHE”
- E/M billing codes
  - 99201-99205: Office E/M visit, new
  - 99210-99215: Office E/M visit, established
    - 02: place of service
    - 95: telehealth visit



Now, during the public health emergency, CMS has also made it clear that there are other kinds of audio visual formats that can be used as well between a patient and a clinician. So, Skype, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video are all things that are considered to be acceptable for now, although at some point, that recommendation may change. And of course, the problems with those is that even though they work reasonably well as a way of communicating, they may not be as confidential and certainly, they're not HIPAA protected. That is waived for the current period that probably will not go on in the future. Now, let's talk a little bit more about that most common kind of visit called the telehealth visit as defined by CMS. So, the expectation is that would be a real-time interactive audio video communication between a clinician and a client. CMS describes the types of clinicians that can be involved in those conversations. It used to be before March of this year, that in order to bill for a telehealth visit that there had to be a preexisting relationship between the client and the clinic. In other words, you couldn't do it with a new patient, That is suspended during the time of the public health emergency. So, the Department of Health and Human Services has said that they won't conduct audits to make sure that this only happens with established patients during this time period. And then there are some ways of billings for these full audio video telehealth visits. You use the standard E/M codes that you would use for an office visit both for new patients and for established patients. But what your biller is going to have to do is to be very specific about a couple of modifiers. One is to use an 02 as the place of service, which says that this is a telehealth visit and then added on to the E/M code is a 95 modifier, again specifying that this is a telehealth visit rather than a face-to-face visit.

**Problem Oriented E/M:  
Face-to-Face Time "Midpoints"**



| New   | Time       | Established | Time       |
|-------|------------|-------------|------------|
| 99201 | ≤ 15 (10)  | 99211       | ≤ 7 (5)    |
| 99202 | 16-25 (20) | 99212       | 8-12 (10)  |
| 99203 | 26-37 (30) | 99213       | 13-20 (15) |
| 99204 | 38-53 (45) | 99214       | 21-33 (25) |
| 99205 | > 53 (60)  | 99215       | >33 (40)   |



I've included for you just a quick reminder of the fact that when the level of the E/M visit is calculated, because these are telehealth visits, there's no physical assessment involved. It's all based on time. So, your clinician should be sure to include in her note how much time was spent on the phone during the patient visit with either new patient or established patient and using these levels.

## Can Telehealth Visits Ever Be By Telephone-Only?

- This may be necessary if
  - A clinic does not have an A/V platform
  - The client doesn't have access to a computer or a smartphone
  - Internet access is unavailable or slow
- During the public health emergency
  - Considered to be “an encounter” by OPA
  - Covered by Medicare and some commercial plans
  - May (or may not) be covered by Medicaid, Medicaid managed care, or state programs *Check!*



18

Now, as I mentioned a moment ago, one of the things that we've heard from quite a number of family planning clinics is the fact that we have audio video capability for telehealth, but many of our patients don't. And what can we do in that circumstance? So, sometimes telephone-only full visits may be necessary. That could be true if you don't have an audio video platform yet, or if your client doesn't have access to a computer or to a smartphone, or if she or he lived in an area where the internet access is either unavailable or slow. So, you really lose this ability to do an audio video visit and have to do it strictly by audio, by telephone. So, that is considered to be an encounter by the Office of Population Affairs for Title X patients. These telephone-only visits filled with E/M code as if it's an office visits are covered by Medicare and some commercial health plans. But they may or may not be covered by your state Medicaid program, your state Medicaid managed care programs or your state family planning program. So, be sure to check because of the fact that even though CMS has said that this is something that is acceptable, there are some state Medicaid programs which are still sticking with the traditional definition of telehealth visits and require a video component. There are other health plans or Medicaid programs or Medicaid managed care health plans, which do not require the video components and are willing to accept telephone only. But please do not make an assumption that you can do these visits strictly by telephone because of the fact that that's going to be dependent entirely on whether or not your payer, be that Medicaid or your state family planning program, consider that to be acceptable or not. Again, something that may change over time.



### Virtual Check-In Visits

- Synchronous discussion over a telephone or through video or image *to decide whether an office visit or other service is needed*
- Initiated by the patient
- Established relationship with practice
- Not related to a medical visit within < 7 days and does not lead to a visit in <24 hours (or soonest appt)
- Patient verbally consents to receive virtual check-in
- HCPCS code G2012: 5-10 min of medical discussion



Now, one of the things that most Medicaid programs as well as Medicare or some state family planning programs have added is something called a virtual check-in visit. So, that is a discussion with the client over the telephone. It could be through an AV, like more commonly happens in a telephone conversation, to decide whether or not an office visit is needed. You can also do a short visit with the patient, let's say related to a refill on birth control pills or a question about her method. You can use the virtual check-in as well. Those calls have to be initiated by the patient. Originally, the expectation is that the patient would have an established relationship with your practice. That's also been waived, so it can be done with new patients as well. It's supposed to be when that virtual check-in visit is not related to any other visit, which has happened within the last seven days, and the patient won't be seen in the clinic within the next 24 hours. Patient should verbally consent to these virtual check-in visits. They are billable with a HCPCS code of G2012. They are intended to reflect 5 to 10 minutes of medical discussion.



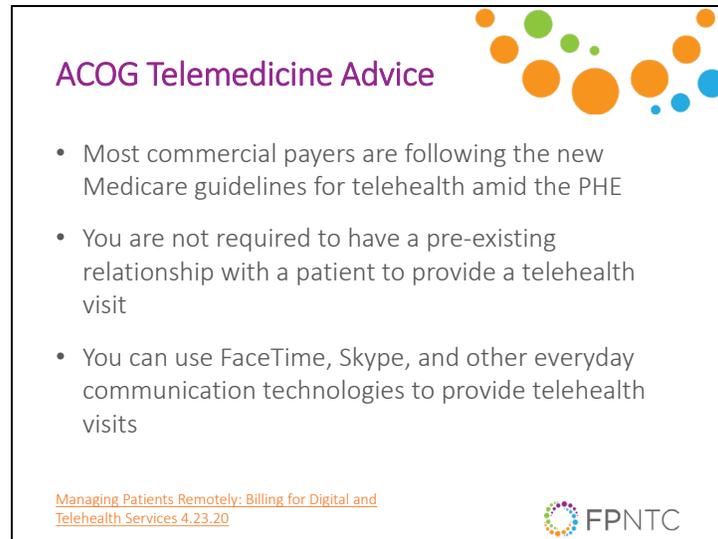
### Virtual Check In: Store & Forward

- Remote evaluation of video and/or images submitted by an established patient
  - Interpretation with follow-up in < 24 business hrs
  - Not originating from related E/M service provided <7 days or leads to E/M visit < 24 hrs (or asap)
- HCPCS Code G2010
- Example
  - Client has a genital skin lesion that s/he is willing to self-photograph and submit for evaluation



Now, there's a second type of virtual check-in visit, which is called store and forward. This is basically CMS accepting the idea of teledermatology, person taking a picture of a skin lesion, sending that to a clinician who then interprets it within 24 hours, and then gets back to the patient with their diagnosis and a recommendation of what to do. That's billed with HCPCS code G2010.

An example of that might be a client who has a genital skin lesion and she is or he is willing to self-photograph that lesion and then submit it to the clinicians for evaluation. And certainly, that could be done as part of a full E/M visit or just the evaluation of the skin lesion by itself, in which case it would be referred to as this type of virtual check-in visit.

The slide features a title 'ACOG Telemedicine Advice' in purple text at the top left. To the right of the title is a decorative graphic of several overlapping circles in orange, green, and blue. Below the title is a bulleted list of three points. At the bottom left, there is a small red link. At the bottom right, there is the FPNTC logo, which consists of a circular icon made of small colored dots followed by the text 'FPNTC'.

**ACOG Telemedicine Advice**

- Most commercial payers are following the new Medicare guidelines for telehealth amid the PHE
- You are not required to have a pre-existing relationship with a patient to provide a telehealth visit
- You can use FaceTime, Skype, and other everyday communication technologies to provide telehealth visits

[Managing Patients Remotely: Billing for Digital and Telehealth Services 4.23.20](#)

 FPNTC

Now, there is lots of other advice out there about how to both perform and bill for telemedicine visits. The American College of Obstetricians and Gynecologists on their website has quite a bit of helpful information about billing for telemedicine services. When you get the slide set, you can click on the link at the bottom of the slide, and they'll give you lots of information that they double checked with payers to make sure that this is going to be acceptable. It's also nice because it's frequently updated.



### Are HIPAA Requirements Relaxed During PHE?

- Yes. DHHS has issued a limited waiver of certain HIPAA sanctions to improve patient care during PHE
- HHS' Office for Civil Rights will not impose penalties for noncompliance that may not comply with privacy rule
- DHCS recommends you review that guidance re: providing services via telehealth + telephonic visits



Another question that comes up is, are HIPAA confidentiality requirements relaxed during the public health emergency? And the answer to that is yes. The Department of Health and Human Services has issued a limited waiver, such that HIPAA sanctions will not be leveled as long as we are providing telehealth services in good faith to improve patient care during the public health emergency.

But certainly, you can't just totally ignore confidentiality as long as you're making an honest effort, good faith effort to maintain the patient's confidentiality, then you don't have to follow all the chapter and verse of the HIPAA regulations, at least for now. You'll probably hear more about that as things changed in the future. So, there will not be penalties for noncompliance that if you don't fully comply with the privacy rule. But the Department of Health Care Services does recommend that you keep checking on just to see whether or not things are evolving over time in regard to HIPAA requirements.



## Telehealth Verbal Consent

- Obtain verbal consent and document in client's medical record. Share a digital copy with client, if possible.
  - Obtain written consent when client returns to clinic.
- Include language that explains what telehealth or phone consult is, expected benefits and possible risks associated with it, and security measures
- Example of documentation
  - “Verbal consent to treat obtained via phone, and written consent will be obtained when client comes to clinic. Consent reviewed in detail with client, digital copy shared, and client verbalized understanding.”



How about consenting to telehealth visit? CMS says that this does need to be done. So, you should obtain verbal consent and document that in the client's medical record and share a digital copy with her if that's at all possible. And in fact, the recommendation is, is that even though she doesn't have to sign online with DocuSign or some other kind of digital signature, once your clinic opens up, she's able to be seen face-to-face that she should physically sign at that point. Other parts of getting verbal consent are to make sure that you've explained what a telehealth or phone consult is, the benefits, risks, and security measures that are involved with that. Here's an example of the kind of documentation that you might do in terms of recording the fact that the patient has given verbal consent to having this visit as a telehealth visit.



## Telehealth Documentation

- Statement that the service was provided through telehealth or phone consult
- Location of the client and the provider
- Names and roles of any other persons participating in the telehealth or phone consult
- Minimum requirements to be established as a Title X client, see Administrative 1.19, Definition of a Title X Client; same as for a face-to-face encounter



And then the next thing to mention briefly is what about the way the telehealth visits need to be documented? Again, these are all part of CMS regulations that would apply in the Title X program. A statement that the service was provided through telehealth or phone consult visit should be part of the note from that patient-provider interaction. The location of where the client was, was she at home or somewhere else and the location of the provider, the names and roles of any other persons who are participating in that telehealth visit or phone consult visit. And if you want to find out more about that, here is the administrative section of Title X. And by the way, when you're billing for these visits for the most part, they are billed the same as if you were seeing a patient face-to-face, particularly with the CMS-defined telehealth visits that I was telling you about earlier.

## Telemedicine Resources for Family Planning Providers

- Plan for implementation with:
  - NFPFHA's toolkit, [Initiating Telehealth in Response to COVID-19](#).
  - AAFP's [telehealth guide](#) (includes a list of vendors)
  - Essential Access' [Telehealth Essentials for SRH Care](#).
  - AMA's [quick guide](#) to telemedicine.
- Staff workflow [best practices](#) from UCSF.
- Develop systems for billing for telehealth. See
  - NFPFHA's [Coding and Billing for Telehealth Services](#),
  - Medicare's [list of payable telehealth services](#)
  - AAFP's quick guide to [differentiate and code virtual visits](#)



25

So, here are a whole range of telemedicine resources for family planning providers. Just click on the orange links when you have time and they'll give you lots more information about how to set these up in your clinic or to enhance what you have already.



### Sample Prioritization (Triage) Template

| Postpone  | Virtual (audio only)                      | Virtual (audio and visual)  | In-person, as available   | In-person, same day (or ASAP)   |
|---|---|---|---|---|
| Well-woman visit<br>Most colposcopy ( <i>in accordance with ASCCP guidelines</i> )<br>2 <sup>nd</sup> or 3 <sup>rd</sup> dose HPV vaccine | Method refills<br>Emergency contraception | Contraceptive counseling<br>Method initiation<br>DMPA-SQ counseling, instruction<br>Syndromic tx of STD, UTI<br>Pregnancy testing and diagnosis | IUD, implant replacement or removal<br>DMPA-IM (clinic, curbside) | Urgent: vaginal bleeding, pelvic pain (PID, IUD complication)<br>IUD, implant placement |

[Prioritization of In-Person and Virtual Visits During COVID-19: A Decision Making Guide for Staff](#)

So, on the FPNTC website, you'll actually see a whole section that has to do with how you might go about prioritizing or also, we can call this triaging, of patients to either postponing their visits, having virtual remote visits or seeing them in-person. And again, I want to emphasize that this is considered to be a starting point. You can move whichever of these services you want from one column to the other as a starting point and then they certainly may change over time, as your clinic opens up. And again, the point is, is that you just don't want to create this once and live with it for the next few months. That's something that you probably should visit every week or two in deciding which visits you're going to be doing in-person as opposed to which ones you'll be doing remotely.

[ACOG, COVID-19 FAQs for Obstetrician–Gynecologists, Gynecology](https://www.acog.org/clinical-information/physician-faqs/covid19-faqs-for-ob-gyns-gynecology)

<https://www.acog.org/clinical-information/physician-faqs/covid19-faqs-for-ob-gyns-gynecology>



**FPNTC**  
FAMILY PLANNING  
NATIONAL TRAINING CENTER

How are family planning providers using curbside pickup and mail delivery to provide services?



28

Now, another question that comes up is, we've decided in our clinic either to close, had our clinicians come in, our workers are going to be there, but we're going to close to patients and try to do everything remotely. But we want to also give them the ability of being able to pick up their supplies at our clinic or being able to give them sampling tools in order to have some laboratory tests that I'll tell you about in a moment. And what sometimes we find in clinics are doing is actually developing systems of curbside pickup and drop off, as well as mail delivery, things that they might not have been doing before, but now they're capable of doing that.

## Curbside Pickup

- Appropriate PPE should be used (e.g., gloves that are changed between each interaction, and use of a face mask).
- Use procedures to use physical distancing strategies.
  - Put the medication on a table, walk away, and allow the client to get out of the car, pick it up and drive away.
  - Walk the medication or test kit to a car, place the package on the hood of the car, and have the client retrieve it.
- Medications should be clearly labeled and documented in the medical record just as if it were given in-person.
- Must be a way to verify the client's identity.
  - E.g., have the client text their auto license plate number to insure that the delivery is made to the correct person.



So, what that looks like with a curbside pickup program is the fact that patients have the opportunity to come and pick up their contraceptive supplies. They can come to the curbside and pick up a sampling kit for chlamydia or gonorrhea test for vaginal discharge, and so on. What some clinics are actually doing is offering curbside services like a curbside blood pressure check or even a curbside DMPA injection. But if that's the case, make sure that appropriate protective equipment is used by your staff members who actually go out toward the patient's car, use procedures to make sure that you practice the physical distancing strategies. What some clinics have done, for example, is that a patient will drive up in her car, a staff member of the clinic will go out and put a medication on the table, walk away, and then the patient can get out of her car, pick it up and drive away. Or a staff member can walk the medication or test kit to the car, place the package on the hood of the car, walk away, and then have the client retreat. So, there are different ways to approach this curbside pickup. Just make sure that the medications are clearly labeled and documented in the medical record, just as if you weren't getting it in clinic. And what we've heard from many clinics is that they've developed ways of verifying the client's identity. And so, one sort of clever way of doing this is that when a patient is coming in to let's say, pick up a sampling kit or to pick up their supplies, they actually text their license plate number to someone in the clinic so that when the delivery person comes out to make it available to the client, that what they can do is double check the license plate to sort of verify the identity of the client who's receiving the correct test kit or the correct medications. Because certainly, you wouldn't want to take those out for someone who just happened to be in the line for curbside pickup and you give the wrong thing to the wrong person. So, there really needs to be a way of verifying that.



## Mail Delivery

- Client has no concern with confidentiality and consents to having supplies mailed to their address.
- Medications should be clearly labeled and documented in the medical record just as if they were provided in-person.
- Family planning providers should consult their state's pharmacy regulations.
- For insured clients, family planning providers can encourage them to ask their pharmacies to deliver medications; in some communities, pharmacies are offering free or low-cost delivery during the public health emergency.
  - Some insurance companies are also offering mail-order options for clients.



30

It's also acceptable in most circumstances to do mail delivery as well. Make sure that your client has no concern with confidentiality issues in having supplies mailed to their address. Make sure that medications are clearly labeled. Look at your state's pharmacy regulations to see specifically what the policies and rules are in regard to your clinic being able to mail drugs. And for your clients who have other kinds of insurance, so it could be Medicaid managed care plan or commercial health plan, and so on, they may also have other ways of making sure that mail delivery can occur. And in fact, in most communities, pharmacies will also do curbside pickup or will do delivery to patients if this is a circumstance where people are picking up their supplies from a pharmacy rather than from the clinic. So, there are lots of ways of getting supplies to the patient without actually having her walk through the door of your clinic.



How can family planning providers obtain blood pressure (BP) when the provider is offsite?



### When Is BP Measurement Necessary?

- Hypertension is 1 of 5 risk factors for acute MI in people using estrogen-containing hormonal methods
  - Age >35, heavy smoking, diabetes, hyperlipidemia
- Severe hypertension (systolic >160 or diastolic >100 mg Hg) or HTN with vascular disease: **MEC Category 4**
- The US Selected Practice Recommendations for Contraceptive Use (SPR) states that BP should be measured before initiation of combined hormonal contraceptives



And what we're going to do in our last section is to switch over to some more clinical issues that we talked about in the Q&A on the FPNTC website. So, one of the most common questions we got is how can family planning providers obtain a blood pressure measurement when the patient is outside? In other words, patient's home doesn't want to come into the clinic or so not to come into the clinic for a blood pressure measurement. What are some of the substitutes for that? Well, first off, why is blood pressure measurement even necessary? It's because hypertension is one in five risk factors for an acute heart attack and people who were using estrogen-containing methods like the pill, patch or ring. So, what we're really concerned about are, does she have hypertension or not? The other four risk factors by the way are age older than 35, being a heavy smoker, being diabetic are having high lipid levels. Now, for those people who have severe hypertension or hypertension with vascular disease like heart problems or peripheral vascular disease or kidney disease, they shouldn't be using an estrogen-containing method at all. That's considered to be MEC Category 4. However, the US Selected Practice Recommendations for Contraceptive Use is quite explicit in saying that blood pressure should be measured before we initiate combined hormonal contraceptive methods, and in fact, periodically after that. Okay, so obviously again, the reason why is because of the fact that we want to make sure that the person doesn't have hypertension.

For combined hormonal contraception (OC, patch, ring), the *CDC US Medical Eligibility Criteria for Contraceptive Use* (<https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm>) classify multiple risk factors for atherosclerotic cardiovascular disease as MEC Category 3 / 4, depending on the individual client's history. In addition, severe hypertension (systolic >160 mmHg or

diastolic >100 mg Hg) or hypertension with vascular disease are MEC Category 4 (A condition that represents an unacceptable health risk if the contraceptive method is used)

Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-3):1–104. DOI: <http://dx.doi.org/10.15585/mmwr.rr6503a1>



### Timely BP Measurement (1/2)

- For client with documented normal BP within the last 3-5 years and no other cardiovascular disease risk factors
  - Prescribe up to 1 year supply of OC, patch, or ring
- For clients with high BP
  - Initiate treatment (by referral to PCP)
  - Client can be prescribed non-hormonal methods or progestin-only methods



So, for clients who's had a documented normal blood pressure within the last three to five years and no cardiovascular risk factors, it would be reasonable to prescribe for her up to a one-year supply of pill, patch or ring. Now, those timeframes are not arbitrary because the hypertension guidelines from the US Preventive Services Task Force say that in a person who has a normal blood pressure, no history of hypertension in the past, that they don't need to have their blood pressure checked again for the next three to five years. So, in other words, if a person is young, healthy, has a normal blood pressure, that's documented in her chart from a prior visit, there's no reason to force her to come back to get an additional blood pressure check. She can have up to a year of her combined hormonal contraceptive method. Next is for patients who have high blood pressure that obviously needs to be treated, most likely by referral to a primary care provider unless you're a federally qualified health center or a community health clinic. And until her blood pressure is under control, she can be prescribed a non-hormonal method or progestin only method where we're not worried about heart attack risk and hypertension is not a contraindication. Now, what about clients who are, let's say completely new to your clinic and they have not had any documented blood pressure within the last three to five years? What we can do is to reassure her that most reproductive aged women in fact do have a normal blood pressure. We can discuss the low but existing risks of using estrogen with untreated hypertension, and eventually come to a shared decision with her about whether or not she'd like to use the pill, patch or ring despite the fact that her blood pressure has not been documented. Another possibility is that you could have a blood pressure check at a pharmacy or some clinics are offering a drive by blood pressure checks while the patient remains in her car. And another widely used approach is to consider a limited, most commonly a three-month prescription of the pill, patch or ring, as long as the patient agrees that she'll come in at a future

appointment for a blood pressure reading. So, again, in the young, healthy patient who's not had any blood pressure documented in the last few years, as long as she doesn't have other cardiovascular risk factors, she's been counseled about potential risks, that it would be quite reasonable in that circumstance to give her a limited time prescription with the understanding that she will have a blood pressure reading done in the next three months. So, for clients who's had a documented normal blood pressure within the last three to five years and no cardiovascular risk factors, it would be reasonable to prescribe for her up to a one-year supply of pill, patch or ring. Now, those timeframes are not arbitrary because the hypertension guidelines from the US Preventive Services Task Force say that in a person who has a normal blood pressure, no history of hypertension in the past, that they don't need to have their blood pressure checked again for the next three to five years.

If a client has a recorded normal BP in your system's electronic medical record, in any clinical setting (for instance if they saw a provider for a different reason), that reading can be used. The current USPSTF recommendation (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/high-blood-pressure-in-adults-screening>) is that "adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be rescreened every 3 to 5 years," which provides an outer time limit for use of the last BP reading.



### Timely BP Measurement (2/2)

- For clients without documented BP in the past 3-5 years
  - Reassure client that most reproductive aged people have normal BP; discuss risk of estrogen with untreated hypertension
  - BP check at pharmacy or “drive by” at the clinic
  - Consider a limited (3 month) prescription per clinician discretion and future appt for BP reading
- If it is not possible to get a BP reading, consider offering the client a non-estrogen-containing contraceptive method in interim



So, in other words, if a person is young, healthy, has a normal blood pressure, that's documented in her chart from a prior visit, there's no reason to force her to come back to get an additional blood pressure check. She can have up to a year of her combined hormonal contraceptive method. Next is for patients who have high blood pressure that obviously needs to be treated, most likely by referral to a primary care provider unless you're a federally qualified health center or a community health clinic. And until her blood pressure is under control, she can be prescribed a non-hormonal method or progestin only method where we're not worried about heart attack risk and hypertension is not a contraindication. Now, what about clients who are, let's say completely new to your clinic and they have not had any documented blood pressure within the last three to five years? What we can do is to reassure her that most reproductive aged women in fact do have a normal blood pressure. We can discuss the low but existing risks of using estrogen with untreated hypertension, and eventually come to a shared decision with her about whether or not she'd like to use the pill, patch or ring despite the fact that her blood pressure has not been documented. Another possibility is that you could have a blood pressure check at a pharmacy or some clinics are offering a drive by blood pressure checks while the patient remains in her car. And another widely used approach is to consider a limited, most commonly a three-month prescription of the pill, patch or ring, as long as the patient agrees that she'll come in at a future appointment for a blood pressure reading. So, again, in the young, healthy patient who's not had any blood pressure documented in the last few years, as long as she doesn't have other cardiovascular risk factors, she's been counseled about potential risks, that it would be quite reasonable in that circumstance to give her a limited time prescription with the understanding that she will have a blood pressure reading done in the next three months.



What options can family planning providers offer clients who are due for their depot medroxyprogesterone acetate (DMPA) shot to avoid a clinic visit?





**Poll #4**

Are you offering DMPA-SQ to clients? (select one)

- Yes
- No – We do not have the knowledge and experience
- No – DMPA-SQ is not available through our distributor
- No – We are not providing any services currently
- N/A – We do not provide services directly



FPNTC 36

Now, switching to another topic that has to do with clinical management is what options can family planning providers offer to clients who are due for their next DMPA shot, Depo-Provera, in order to avoid a clinic visit. So, we're going to do another quick poll. Are you offering Depo subq DMPA subq to your clients? Select the one answer that most closely reflects what you're doing. So, with the early answers are about half of you are offering Depo subq to your clients. A third are saying that they don't provide services directly, that dropped a little bit. And almost 20% are saying that Depo subq has not been available through their distributor, something that we've actually been hearing a fair amount of that their clinics would like to be able to offer Depo subq to your patients but that you haven't been able to obtain it.

### How Does DMPA-SQ Differ from DMPA-IM

- Pre-filled and ready to use at home, so client is in control
- Uses shorter, smaller 26 gauge X 3/8-inch needle and smaller volume of liquid to inject into skin instead of muscle
  - Potentially less pain
- 30% less hormone; may reduce common side effects
- Some clients experienced local site irritation and soreness on first and second self-injection
  - This improves over time
  - According to the label, 1/100 experience dimpling at injection site



All right, so let's talk a little bit about Depo subq and how it's different from the Depo IM that you've been making available to your patients. So, DMPA subq is available from a single supplier from Pfizer. There is no generic version of it available. It is prefilled, ready to use at home so the client is in control. One of its big differences from Depo IM is that it uses a shorter, smaller needle, 3/8-inch needle and only about two thirds as much liquid is being injected into the skin instead of a muscle and therefore, it is potentially less painful. It also has a reduction of about 30% in the amount of hormones. Remember, Depo IM is 150 milligrams, Depo subq is 105 milligrams. And given that reduction in dose, there may be fewer side effects as well. However, some clients have had local site irritation and soreness if they've self-injected on the first or second injection, has a tendency to improve over time. And about 1 in 100 have itching at the skin injection site.



### DMPA-SQ for Self-Injection (1/4)

| Method of Injection | Needle Type           | Dosage           | Packaging                             | Manufacturer                 |
|---------------------|-----------------------|------------------|---------------------------------------|------------------------------|
| Subcutaneous (SQ)   | 26-gauge x 3/8-inch   | 104 mg / 0.65 mL | Single-dose prefilled syringe         | Pfizer (sole brand name)     |
| Intramuscular (IM)  | 22-gauge x 1 1/2-inch | 150 mg / 1 mL    | Vial or single-dose prefilled syringe | Pfizer<br>Teva<br>Greenstone |

[National Family Planning & Reproductive Health Association \(NFPRHA\) Health Center COVID-19 Resources](#)



So, this gives you a little more information about a comparison of the two. Again, you can see with Depo IM, it uses a longer thicker needle. It's available for a number of generic sources as well as from Pfizer. While the DMPA subq is prefilled single dose and available from a single source.

[National Family Planning & Reproductive Health Association \(NFPRHA\) Health Center COVID-19 Resources](#)

<https://www.nationalfamilyplanning.org/covid-19-resource-hub>



### DMPA-SQ for Self-Injection (2/4)

- Clients who are have chosen to initiate this method
- Clients who currently receive DMPA-IM, and who after counseling, opt to switch to this delivery route
- Good choice for those experienced in self-injection of other drugs (ovulation induction for IVF, insulin, low molecular weight heparin, or drugs for multiple sclerosis)



Now, who are the best candidates for Depo subq? Well, certainly anyone where your clinician or health educator has had a discussion with a client about the variety of methods available to her and she chooses to initiate DMPA and would like to try self-injection. Second is for your clients who are currently receiving Depo IM but who after counseling would rather switch to something that they can do at home with self-administered Depo subq. It's also a good choice for people who have had experience with self-injection of other drugs. So, a person who's used Pregnyl for ovulation induction for IVF, people with diabetes who have to inject insulin, low molecular weight heparin or even drugs for multiple sclerosis. They have experience already with self-injection and they may do just fine with using Depo subq.



**DMPA-SQ for Self-Injection (3/4)**

- Contraindications and side effects are same for DMPA-SQ and –IM
- Dosage adjustment of DMPA-SQ and –IM is not necessary for BMI
- Use clinical judgement to determine whether delivery method is appropriate for a specific client and document decision



The contraindications and side effects are the same for both Depo subq and Depo IM. There's no dosage adjustment, which is necessary for either one based on the patient's weight. However, just be sure to make sure that the clinician's clinical judgment is used to determine whether this delivery method, not only Depo subq, but specifically self-administered at home, is really the right thing for a specific client.

References:

- Burke HM, Mueller MP, Perry B, et al. Observational study of the acceptability of Sayana<sup>®</sup> Press among intramuscular DMPA users in Uganda and Senegal. *Contraception*. 2014;89(5):361-367.
- Cover J, Ba M, Drake JK, et al. Continuation of self-injected versus provider-administered contraception in Senegal: a nonrandomized, prospective cohort study. *Contraception* 2019;99:137–41.

Additionally, re BMI:

- Effect of Body Weight: Although total MPA exposure was lower in obese women, no dosage adjustment of depo-subQ provera 104 is necessary based on body weight. The effect of body weight on the pharmacokinetics of MPA following a single dose was assessed in a subset of women (n = 42, body mass index [BMI] ranged from 18.2 to 46.7 kg/m<sup>2</sup>). The AUC<sub>0–91</sub> values for MPA were 71.6, 67.9, and 46.3 ng·day/mL in women with BMI categories of ≤ 28 kg/m<sup>2</sup>, >28–38 kg/m<sup>2</sup>, and >38 kg/m<sup>2</sup>, respectively. The mean MPA C<sub>max</sub> was 1.74 ng/mL in women with BMI ≤28 kg/m<sup>2</sup>, 1.53 ng/mL in women with BMI >28–38 kg/m<sup>2</sup>, and

1.02 ng/mL in women with BMI > 38 kg/m<sup>2</sup>, respectively. The MPA trough (C<sub>min</sub>) concentrations had a tendency to be lower in women with BMI >38 kg/m<sup>2</sup>.



### DMPA-SQ for Self-Injection (4/4)

- First DMPA injection can be self administered at any time if reasonably certain that client is not pregnant
- If menstrual cycle  $\leq$  7 days, no back up needed
- If DMPA started  $>7$  days since menstruation: abstain from sex, use barrier method or Plan B for 7 days after start
- DMPA stored at room temperature—instruct client not to refrigerate, freeze or leave in warm location (like a vehicle)



There's really no difference in the traditional recommendations about when during the menstrual cycle that you've used. There are some data here from the selected practice recommendations about when to start. Of course, we need to make sure that we're reasonably sure that a person is not pregnant before she starts that first Depo subq injection and Depo subq can be stored at room temperature. It should not be refrigerated, frozen or left in a warm location, like a car.



### Client Resources on DMPA-SQ Self-Injection

- Detailed [package insert](#) instructions
- Bedsider.org: [Depo SubQ: The do-it-yourself birth control shot](#)
- Reproductive Health Access Project: [Depo-Provera Sub-Q User Guide](#) (*available in English, Spanish, Simplified Chinese, Traditional Chinese, Hindi, Vietnamese*)



Again, there is quite a lot of information out there to help us educate clients about the use of Depo subq and in particular, how to give yourself injections. And here are some sources. You will see additional sources at the end of this slide set, in particular NFPRHA has developed quite a number of resources that are available about not only the availability of Depo subq but a clinical protocol about how to use it as well.



Can family planning  
providers still safely  
provide intrauterine  
devices (IUD) and  
implants?





**Poll #5**

Which LARC services are you currently providing? (select all that apply)

- Initiation
- Removal
- Replacement
- We are not providing any LARC services
- N/A – We do not provide services directly



44

So, the next issue to get to is some other services that we need to do on site. So, can family planning providers still safely provide IUDs and implants? So, our next poll is which LARC services are you currently providing first in-person at your clinic? So, we'll wait 20 seconds or so for you to respond to that. I'm really curious about whether you're still doing either initiation, removals or implants of IUDs and Nexplanon. Okay, so we're at least seeing a trend for about half of you, a little over half of you are doing initiation, removal and replacements and those are really similar numbers, up around 55% for all three and then 25% of you are saying that you don't provide any LARC services. So, just so you get a chance to be able to see the survey results. Right, and we'll go back to our slides now.



### Safe Provision of IUDs

- Yes, some family planning providers are continuing to offer IUDs and implants.
- One of the few family planning services for which it may be appropriate to provide an in-person visit
- Family planning providers should use the [Interim CDC Guidance](#) to make decisions about face-to-face activities depending on the local level of community transmission or impact of COVID-19



Okay, so obviously half of you, over half of you are continuing to provide IUDs and implants. One of those few family planning services where we have no choice but obviously have to be able to do that in-person. And I'm going to tell you a little bit about the CDC Guidance about the kinds of accommodations that we need to make in our clinics in order to be able to do these in-person services.

- Family planning providers should use the [Interim CDC Guidance](#) to make decisions about face-to-face activities depending on the local level of community transmission or impact of COVID-19.
- See Beyond the Pill's [LARC Guidance During COVID-19](#) (<https://beyondthepill.ucsf.edu/contraceptive-care-during-covid-19>) for more information.
- During the televisit, the provider should [confirm with reasonable assurance](#) (<https://www.fpntc.org/resources/how-be-reasonably-certain-woman-not-pregnant-and-when-start-contraceptive-methods-palm>) that the woman is not pregnant and even assist the woman with taking a pregnancy test, if appropriate.
- [Interim CDC Guidance on Handling Non-COVID-19 Public Health Activities that Require Face-to-Face Interaction with Clients in the Clinic and Field in the Current COVID-19 Pandemic](#) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-covid-19-client-interaction.html>)

### Duration of Use For LARC

| LARC      | FDA-Approved Duration | Evidence-Based Duration |
|-----------|-----------------------|-------------------------|
| Nexplanon | 3 years               | 5 years                 |
| Liletta   | 6 years               | 7 years                 |
| Mirena    | 5 years               | 7 years                 |
| Skyla     | 3 years               | 3 years                 |
| Kyleena   | 5 years               | 5 years                 |
| Paragard  | 10 years              | 12 years                |
| DMPA-IM   | 12 weeks              | 15 weeks                |
| DMPA-SQ   | 12 weeks              | 14 weeks                |

Source: [McNicholas et al, AJOG, 2017](#)

 46

However, before I get to that, I do want to remind you about the fact that when a client calls in and says, "I've been using this particular IUD over a period of years. I vaguely remember that at some point, this is supposed to be switched out. Can I come into the clinic and have my IUD removed and a new one put in?" And remember that there is a difference between the FDA-approved duration for the use of the various types of IUDs and usually longer evidence-based durations of the method. The reason that I included this is because of the fact that let's say a person contacts you three years after they've been using Nexplanon, would like to have a replacement of their Nexplanon capsule. Some advice you could give her, as you know that Nexplanon actually will work through a full five years and you might think about delaying the replacement of the Nexplanon until the public health emergency is over and we can go ahead and do it then. The same is true for Liletta, which can be used up to seven years, also true with Mirena. For Skyla and Kyleena, we use the same as the FDA-approved durations because we really don't have data about how much longer they work. Paragard works all the way up to 12 years, I'm sorry, 12 years. Depo IM can be given as late as every 15 weeks and Depo subq should be given no later than every 14 weeks.

### Risk Factors for Horizontal Transmission of SARS-CoV-2

| Factor             | Higher risk                  | Lower Risk     |
|--------------------|------------------------------|----------------|
| P Proximity        | < 6 feet                     | ≥ 6 feet       |
| E Enclosure        | Small room; poor ventilation | Outdoors       |
| T Time of exposure | Longer                       | Shorter        |
| A Activity         | Singing, loud speaking       | Limit speaking |
| P Protection       | No hand washing, mask, PPE   | Consistent use |
| P Prevalence       | HR groups; C-19 symptoms     | Asymptomatic   |

 47

Now, how do we make adaptations in the healthcare environment in order to keep patients safe and in order to keep staff members safe. So, here's an important way to think about this. And these are the risk factors for horizontal transmission of the coronavirus, the SARS-CoV-2 virus from an infected person to a non-infected person. There's an acronym for remembering it, PETAPP. So, the first P is proximity. You all know that we try to stay at least six feet away from people to lower our risk. The E stands for enclosure. The virus is more likely to be transmitted when you're seeing somebody you are in the same small room, particularly if it's poorly ventilated. And it's lower risk if you're in a big room with good ventilation or of course, if you're outdoors. The next thing that's important is time of exposure. The longer you are exposed to an infected person, the more likely it is that someone else will become infected. If there's a very short time of exposure, then that lowers your risk. One of the new findings, which is just appreciated in the last really couple of weeks, is activity that when there's singing or very loud speaking, that the person who's infected is more likely to give off the droplets that are infected with the virus that can infect someone else. Okay. We know that because of case reports of kind of super spreaders happening in church choirs and the singing may have something to do with kind of spewing out the virus during the singing process. The next P is for protection, and that is for saying you're at higher risk without any of the things we do like hand washing, face mask, personal protective equipment, lower risk if you consistently you use them. And then the last P stands for prevalence. There's a higher risk of acquiring the virus if you're in contact with people in high risk groups, people who work in a meatpacking plant, people who work in a skilled nursing facility, and of course anyone who has COVID-19 symptoms. On the other hand, the risk is lower if you're in contact with someone who's asymptomatic and who's been relatively isolated.

## Minimize Exposure Risk During In-person Visits (1/2)

| Factor       | Clinical practice   |
|--------------|---|
| P Proximity  | Few staff in room; maintain distance of $\geq 6$ feet   |
| E Enclosure  | Use your largest exam room  |
| T Time       | Minimize the time the client is the exam room   |
| A Activity   | Limit loud talking  |
| P Protection | Masks for all; surface cleaning afterward   |
| P Prevalence | Pre-screen for symptoms: (client and staff)<br>SOB, cough, fever, chills, sore throat, muscle aches, new loss of taste or smell |



So, how does that relate to our clinics? Well, to minimize proximity, we want to keep as few staff as we can in the room, try to maintain a distance of at least six feet. In some cases, that's not going to be possible. But as much as possible, as much as we can do that, we try to maintain that distance. Number two for enclosure, enclosure better, use your largest exam room, especially if that exam room has good ventilation, especially negative pressure ventilation. How do you think about that? Think about going into a bathroom. You flick the switch for the ventilator, which ventilates that air outside of the room. So, in your clinic, you want to use the largest room you can that has ventilation out of the room. Okay. Next is time. So, minimize the time that the client is in the exam room. Try to limit the amount of loud talking. Everybody should be wearing a mask and of course, all surfaces cleaned afterwards. And all patients should be prescreened for symptoms. And this is true not only of clients but staff members as well. So, remember, the initial symptoms that we screen people for. For shortness of breath, cough and fever, there have been four more added by the CDC on to that list, chills, sore throat, muscle aches, and a new loss of taste and smell. So, as you screen people before their visit and once they can come in for their visit, be sure to ask about all seven of those symptoms.



### Minimize Exposure Risk During In-person Visits (2/2)

- Registration, counseling, and consents via phone or telehealth
- Screen clients prior to and at office arrival: fever, cough, SOB
- Delay any procedures if clients are symptomatic
- Have client wait in car; perform intake prior to entering facility
- Have client bring their own face mask or provide one
- Upon entry, direct immediately into an exam room (minimize moving between rooms)
- Minimize staff and support people in rooms
- All staff and clients should wear masks
- Monitor PPE supply and adjust use according to CDC guidance

[Interim CDC Guidance on Handling Non-COVID-19 Public Health Activities that Require Face-to-Face Interaction with Clients in the Clinic and Field in the Current COVID-19 Pandemic](#)

 49

So, the way that we minimize exposure risk during in-person visits is registration, counseling and consents should be done beforehand, by phone or by telehealth. What some clinics are doing is having the patient wait in their car and the intake is done over the phone before the patient comes in to the facility. Screen for symptoms in the way that I just mentioned. And if the patient is symptomatic, we should delay any procedures and of course, refer her for testing if that hasn't been done yet, as well as potentially care for her potential COVID-19 infection. All staff and clients must wear face masks. Okay. So, have the patient bring her own face mask. If she can't do that, then provide her, okay, then provide her with a face mask. And everyone in the room by the way should be wearing face masks. Minimize the number of people in the room where you're going to be doing the procedure. Limit or prohibit non-patient visitors and keep track of your supplies of provider protective equipment.



How are family planning  
providers providing  
emergency contraception  
(EC) remotely?



## Remote Provision of EC



|  |   |  |   |
|--|---|--|---|
| <p><b>Ella/ulipristal acetate (UPA)</b><br/>(Selective progesterone receptor modulator)</p>  |  | <p><b>Plan B/levonorgestrel</b><br/>(P-receptor agonist)</p>   |  |
| <ul style="list-style-type: none"><li>• 1<sup>st</sup> line for those who do not want copper IUD, as it's more effective than LNG in people with BMI over 25</li><li>• Use up to 120 hours after sex</li><li>• Avoid starting OCPs within 5 days of UPA use (lowers efficacy of UPA)</li></ul> |   | <ul style="list-style-type: none"><li>• May be effective up to 5 days after sex, but efficacy drops on days 4 and 5</li><li>• Efficacy drops for weight &gt;156 lbs (BMI &gt;25)</li><li>• Available "behind the counter" but prescription required by some payers</li></ul> |   |

 51

Now, we only have a few minutes left. So, let me just quickly hit a few of our last topics so that we can be sure to get to your questions. How are family planning providers providing emergency contraception remotely? And the answer is, is that we do that pretty much the way that we always have. With emergency contraception, probably the only thing that's a little different is the fact that we make more of an effort to prescribe ulipristal acetate, UPA because of the fact that for people who have a body mass index of 25 or who have unprotected intercourse more than 72 hours ago, it does have a higher efficacy rate than levonorgestrel does. But otherwise, that's the same. Recommendations regarding the use of levonorgestrel ECPs (LNg, Plan B<sup>®</sup>) and ulipristal acetate (UPA; Ella<sup>®</sup>) are unchanged, remembering that UPA is more effective than LNg ECPs 72-120 hours after unprotected intercourse and in women whose body mass index is 26 kg/m<sup>2</sup> or higher. Given the time-sensitivity of this service, curbside pick-up or transmission of the prescription to a pharmacy for same-day pick-up is optimal. Consider providing counseling and offering a contraceptive method that can be obtained at the time of ECP pick-up.



How can family planning providers continue to provide genital tract and STD services?





### Syndromic Management of STDs

- Treatment based upon a “best guess” of diagnosis, using symptoms and a description of physical findings, but without the use of laboratory tests
- Studies show that this approach is:
  - Fairly sensitive for making a correct diagnosis (especially BV, candida vaginitis, +/- genital herpes)
  - Not very specific (i.e., many false positives possible, resulting in over-treatment)



Next is can family planning providers continue to do genital tract and STDs surfaces? The answer to that is we can but we do that through something which is called syndromic management, which is we take the history of the patient over the phone and then make a best guess of her diagnosis based on her symptoms, maybe a photograph if she'll send us that. It's actually a fairly sensitive way of making a correct diagnosis. But it's not very specific, meaning that there are false positives that are possible and that we might overtreat the patient, but that's thought to be the better part of valor during this time period.



### Vaginal Discharge: Remote Evaluation

- Recurrence of BV or vaginal candidiasis, treat based on a telephonic or telemedicine visit
- For a new problem, obtain a thorough patient history via telehealth; consider empiric treatment
  - Malodorous discharge s/o BV or trichomoniasis, metronidazole 500 mg BID 7 days will treat either
  - Vulvar irritation/itching + white discharge, treat with fluconazole 150 mg PO or 3-day topical antifungal



So, based on guidelines, which have come from the STD branch of the Centers for Disease Control, they've basically recommended that if a person is having a recurrence of bacterial vaginosis or vaginal candidiasis, you just treat them on the basis of the fact that they're having another outbreak of that. For a new problem, we want to make sure that we get a thorough patient history and consider empiric therapy. An example of that is if a person has a malodorous vaginal discharge suggestive of bacterial vaginosis or trichomoniasis, a seven-day course and metronidazole will completely cure either of those conditions, although a single dose of metronidazole will not. And the same thing goes for someone who sounds like they have a fairly classic candidiasis in the vagina, we can just automatically treat with fluconazole or with a three-day topical antifungal drug.



### Self-Sampling and Curb-side Pick-Up/Drop-Off

- Some clinics have used curb-side for pick-up and drop-off of vaginal discharge sampling kits
  - Stopped-plastic or glass tube with 1 cc fresh saline
  - Pack of sterile cotton tipped swabs
- At home, swab vaginal walls, place the swab into the tube and cap, then drop it off at the clinic asap
- Can be used to sample for gonorrhea/ chlamydia NAAT with (separate) appropriate collection container



Now, what some clinics have done is to actually develop ways of a patient coming by picking up a sampling kit for gonorrhea, chlamydia, or even a vaginal discharge in her car, sampling herself at home and then dropping that off at the clinic. And here's a little bit of detail about how that's done. What I would say is that if a person is going to self-sample her vagina to help with the diagnosis of a vaginal discharge, that it's important to get that sample back to the clinic, hopefully within 30 to 60 minutes, just because particularly trichomoniasis doesn't live very long in that sample tube. But as I said, it can be used out as a way of doing other samples as well for STD test.

### Summary of Vaginitis Findings

|                     | Itch/ Burning          | Malodor | Frothy | Color                       |
|---------------------|------------------------|---------|--------|-----------------------------|
| Candida             | I: Yes<br>B: Sometimes | No      | No     | White                       |
| Trichomoniasis      | I: Yes<br>B: No        | Yes     | Yes    | Yellow<br>Sometimes white   |
| Bacterial vaginosis | No                     | Yes     | Yes    | White<br>"homogenized milk" |
| DIV                 | Yes                    | No      | No     | Profuse white or green      |
| Physiologic         | No                     | No      | No     | White                       |

 FPNTC

Here's an example of the kinds of things that we can do if we're doing syndromic diagnosis of vaginitis, just by asking about itching, burning, malodor, whether the discharge is frothy, what its color is, most of the time, though not always will be correct.



### Vaginal Discharge: What About GC/CT?

- CDC guidelines do not recommend empiric treatment for GC/CT in patients w/vaginal discharge
- For patients with new vaginal discharge who need evaluation, testing for GC/CT is recommended prior to treatment
  - Exception is patients with known sexual contact to GC/CT



So, we'll also be doing a gonorrhea-chlamydia test in any person who has a vaginal discharge?  
The answer to that is no.



### Vaginal Discharge with Pelvic Pain or Dyspareunia

- The patient may have pelvic inflammatory disease
- Not recommended to treat that empirically
  - Advise in-person exam and antibiotic treatment



The CDC recommends that she should be coming either to the lab or for curbside pickup of a gonorrhea-chlamydia sample kit, so if she can sample at home and then bring that back.



### Outpatient Treatment of PID (1/3)

- Ceftriaxone 250 mg IM
  - then doxycycline 100 mg PO BID for 14 days OR
- OR
- Cefoxitin 2 grams IM plus probenecid 1 gram PO,
  - then doxycycline 100 mg PO BID for 14 days
- If BV is diagnosed or to improve anaerobe coverage
- Add: Metronidazole 500 mg BID for 14 days



I'm going to skip over these slides because of our time. This is just a reminder that if you should see a patient who has complaint of lower abdominal pain, she's seen in the clinic and actually turns out to have pelvic inflammatory disease, these are the two preferred approaches.



## Outpatient Treatment of PID (2/3)

### 2015 CDC STD Treatment Guidelines

- Quinolones may be used for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up is likely
- If GC is documented, change to a medication regimen that does not include a quinolone or obtain a test of cure to ensure that the patient does not have a resistant GC infection



The trouble is they have to be injected. You may not have injected medications available.



### Outpatient Treatment of PID (3/3)

- Levofloxacin 500 mg QD for 14 days OR
- Ofloxacin 400 mg PO BID for 14 days OR
- Moxifloxacin 400 mg PO QD for 14 days

**PLUS**

- Metronidazole 500 mg PO BID for 14 days



So, there are alternatives for oral-only therapy for pelvic inflammatory disease from the CDC. These are considered to be alternatives. We'd much rather use the injectable form because of concerns about multidrug resistant gonorrhea. But if you don't have injection available, we can use this.

## Acute PID: Out-Patient Follow-up



- Schedule first follow-up visit in 48-72 hours
- Hospitalize for parenteral therapy if
  - Pelvic pain is the same or worse
  - Unable to ingest medication
  - Pelvic or adnexal mass has developed
- Examine 4-7 days after completion of treatment
  - Moderate or severe tenderness: admit
  - New adnexal or pelvic mass: admit
  - If GC culture was positive, TOC tests of cervix +anus
- Rescreen for GC/CT 6 wks after end of therapy



## Expedited Partner Therapy for GC/CT



- Can be used by writing a prescription in partner's name or doubling the dose of the patient's medications
  - Critical during the COVID-19 epidemic to avoid the need for a client, or partner, face-to-face visit
- Currently, no restrictions limiting use of EPT for certain populations



Can family planning  
providers use at-home  
test kits for STDs as an  
alternative to in-clinic  
sampling?



## Poll #6

How are you testing for STDs? (select all that apply)

- In-person visits
- Curbside pickup of sample kits
- Mail delivery of sample kits
- Empiric treatment for suspected STD
- Web-ordered at-home STD test kits

## Screening and Testing for STIs at Home

- At-home *sampling* vs. at-home *screening* test kits
  - Self-samples of vaginal fluid, urine collection, and in some cases, rectal or pharyngeal swabs (same collection technique used in clinic), are transported back to the clinic for curbside drop-off or to a contracted lab test-deposit site.
  - Vaginal swab or urine for cis females/transmales would be tested for GC/CT, +/- trichomonas.
  - Urine for cis-males and transfemales would be tested for GC/CT.
    - Rectal and pharyngeal swabs in this population would typically be tested for GC/CT.



The very last topic, just to mention very quickly, is what about at home STD testing. And what I want to point out and again, this is something which is ... I'm going to skip that last poll. That is nicely detailed for you in the FAQ on the FPNTC website is the difference between home sampling and home screen. Home sampling is what I just described, where a person self-samples vaginal fluid, or they collect urine, or in some cases, either self-sampling of the rectum or the pharynx. And then those samples are returned back to the clinic and sent to the usual laboratory. Okay. That's pretty reasonable and billable, and you shouldn't have problems with that.



### At-Home STI Testing

- At-home STI screening test kits are either point of care tests or self-sampling with specimens mailed to a lab
  - Typically are sold directly to consumers or through on-line telehealth companies or pharmacies.
- Tests can include HIV, GC/CT, syphilis, trich
- Some companies also offer throat/rectal swabs for GC/CT, as well as blood spot tests for syphilis and hepatitis C.



That is different from at home STI testing. So, there are quite a number of companies, we've included those for you in the references, or even some pharmacies, which sell at home STI screening kits. So, either they are mailed to you or you go to your pharmacy and pick it up. They are either point of care test for HIV, which can be done at home or you sample yourself-that gets sent to a laboratory and then you are notified of the results. So, those are certainly available.



## Insurance Coverage of Home STD Tests

- If the patient self-samples, returns it to the clinic or lab, then has the same test performed per clinic routine, it should be covered
- A point-of care test purchased in a pharmacy (e.g., oral HIV test; cost about \$45) usually is not covered
- On-line STD home-testing products
  - Test kits start at \$100; higher with multiple organisms
  - Interpretation of result and clinician advice included with kit
  - Often a separate charge for the lab to run the test
  - Usually not covered by third party payers



Problem is or the question is, are they going to be covered by a payer? And the answer is, is that most of the time are they are not. So, a point of care tests like an oral HIV panel can be purchased in a pharmacy. You do that at home. You get an immediate result. They cost about \$45. But that is usually not covered. So, the online STD home testing products or even those that you could buy at a commercial pharmacy, the test kits start at around \$100. They go more and more expensive when you're testing for multiple organisms. That gets sent off to a lab. And by the way, the lab may charge separately for running the test. That result is sent back to the clinician that works for this particular online company. They will have a conversation with you about your results and whether or not you need to be treated. And again, that's something which is almost never covered by insurance, sometimes by PPOs, but very rarely buy a Medicaid program.



## HPV Vaccines

- National guidelines imply that the 2nd or 3rd doses are not time sensitive and can be postponed until after the epidemic
- The CDC Pink Book
  - No maximum interval between doses
  - If schedule is interrupted, do not restart
  - If interrupted after 1st dose, the 2nd dose should be given as soon as it is safe to do so; 2nd and 3rd doses separated by at least 12 weeks
  - If 3rd dose is indicated and delayed, administer asap

Sources: [CDC Pink Book](#) and [Immunization Action Coalition](#)



Just a quick word about HPV vaccines and I won't read this for you, but I will remind you that if a person needs a second or a third dose of an HPV vaccine, it is reasonable to delay those until the time that the public health emergency is over. That person can complete their series.

## Management of Abnormal Cytology Results?

| Result                            | Timeframe  |
|-----------------------------------|--|
| LSIL:                             | Postpone diagnostic evaluations up to 6-12 months  |
| HSIL, ASC-H                       | Document attempts to contact client; diagnostic evaluation scheduled within 3 months                         |
| HG disease w/o suspected invasion | Document attempts to contact client; procedures scheduled within 3 months                                    |
| Suspected invasive disease        | Contact attempted <2 wks and evaluation within 2 of that contact (4 wks from the initial report or referral) |

Source: [ASCCP Interim Guidance During COVID-19 Pandemic](#)



What about people who are being informed of an abnormal cervical cytology result? When do they need to come in for their colposcopy? These are guidelines which come from the American Society for Colposcopy and Cervical Pathology, where unless malignancy is suspected that those visits can, for the most part, not be delayed.

## Questions?

- Find answers to these and other questions about providing family planning services during COVID-19 in the FPNTC's COVID-19 and Family Planning Services FAQ
- Frequently updated

### What other questions do you have?



[COVID-19 and Family Planning Services FAQ](#)



71

So, with that, I will go ahead and wrap up. Fortunately, we did cover all of the slides, although overtly at the end. And for as long as we can stay on the line, I am happy to hear your questions.

Katie Quimby: Thank you so much, Dr. Policar. And I hope the audience will join me in thanking you for passing in a ton of content into our time. I know in the interest of time, I think we're going to hold questions. But for those of you who have already asked questions, I would like to say, we've received them. And up on the slide here, you can see our frequently asked questions web page. So, we will be taking all of the questions we received today. And the ones we received have been great questions. We will add them to our FAQ document and get written responses.

The slide features a title 'FPNTC COVID-19 Resources' in purple text at the top left. To the right of the title is a decorative graphic of several overlapping circles in orange, green, and blue. Below the title is a bulleted list of six resource links, each underlined. At the bottom right of the slide is the FPNTC logo, which consists of a circular icon made of small colored dots followed by the text 'FPNTC' in a sans-serif font.

**FPNTC COVID-19 Resources**

- [FPNTC: COVID-19 and Family Planning Services FAQ](#)
- [FPNTC: What Family Planning Providers Can Do to Meet Client Needs During COVID-19](#)
- [FPNTC: Prioritization of In-Person and Virtual Visits During COVID-19: A Decision-Making Guide](#)
- [FPNTC: COVID-19 Social Media Toolkit for Family Planning Providers](#)
- [FPNTC: Help Staff Reduce Stress During COVID-19](#)
- [NCTCFP COVID-19 Resources](#)

 FPNTC

For those of you who don't know, all of our FPNTC resources are listed here and are being updated regularly. So, in addition to the FAQ, you also have the toolkits, the decision making guides that Dr. Policar mentioned as well as our social media toolkit and one-pager on helping staff reduce stress during COVID. Number of these have been updated since they've been launched and we will continue to do so including with those questions that we've received today.

Slide 73

FPNTC COVID-19 Toolkit

FPNTC Title X Guidelines Training Packages Events Connect with FPNTC Search Log in or Create Account

Last Reviewed 2020-05

### What Family Planning Providers Can Do to Meet Client Needs During COVID-19

Toolkit/Guide Title X Program Management Save Share

#### Welcome to the Toolkit

*"I understand it is an emergency if someone is out of family planning supplies, needs them, and is concerned about getting pregnant...The Office of Population Affairs (OPA) fully supports Title X Grantees to consider creative solutions that will work in [their] communities to ensure that clients continue to receive family planning services." - Dr. Diane Foley, Deputy Assistant Secretary for Population Affairs (DASPA)*

Listed below are suggestions to help family planning providers continue to meet clients' needs while keeping themselves and clients safe during this nationwide COVID-19 public health emergency. [See the COVID-19 and Family Planning Services FAQ for evidence-based responses to frequently asked questions.](#)

- Reduce in-person visit exposure by providing services remotely

#### In This Resource:

- Welcome
- Reduce in-person visit exposure by providing services remotely
- Reduce in-person visit exposure using other alternative delivery approaches
- Ensure family planning needs continue to be met

73

For those of you who don't know the toolkit I mentioned, it is listed here.



### More Information: Top Resources

- AAFP: [Checklist to Prepare Physician Offices for COVID-19](#)
- ACOG: General [COVID-19](#) and [FAQs for Obstetrician–Gynecologists](#)
- Futures Without Violence: [Resources to support survivors of intimate partner violence](#)
- NFPRHA: [COVID-19 Resource Hub](#)
- Reproductive Health Access Project: [Contraception in the Time of COVID-19](#)
- UCSF: [Contraceptive Care During COVID-19](#)
- Upstream USA: [Ensuring Contraceptive Access During the COVID-19 Pandemic](#)



74

Included are several dozens of strategies, including some of our favorite curated links. The toolkit itself has lots of specific action steps and links for more information for how to continue to deliver services during this time.

AAFP: [Checklist to Prepare Physician Offices for COVID-19](#)  
([https://www.aafp.org/dam/AAFP/documents/patient\\_care/public\\_health/COVID-19%20Office%20Prep%20Checklist.pdf](https://www.aafp.org/dam/AAFP/documents/patient_care/public_health/COVID-19%20Office%20Prep%20Checklist.pdf))

ACOG: General [COVID-19](#) (<https://www.acog.org/topics/covid-19>) and [FAQs for Obstetrician–Gynecologists](#) (<https://www.acog.org/en/clinical-information/physician-faqs/COVID19-FAQs-for-Ob-Gyns-Gynecology>)

Futures Without Violence: [Resources to support survivors of intimate partner violence](#)  
(<https://www.futureswithoutviolence.org/get-updates-information-covid-19/>)

NFPRHA: [COVID-19 Resource Hub](#) (<https://www.nationalfamilyplanning.org/covid-19-resource-hub>)

Reproductive Health Access Project: [Contraception in the Time of COVID-19](#)  
(<https://www.reproductiveaccess.org/resource/contraception-covid/?emci=4107d822-c86e-ea11-a94c-00155d03b1e8&emdi=b38be143-6e6f-ea11-a94c-00155d03b1e8&ceid=117536>)

UCSF: [Contraceptive Care During COVID-19](#) (<https://beyondthepill.ucsf.edu/contraceptive-care-during-covid-19>)

Upstream USA: [Ensuring Contraceptive Access During the COVID-19 Pandemic](https://upstream.org/birth-control-covid-19/)  
(<https://upstream.org/birth-control-covid-19/>)



**FPNTC**  
FAMILY PLANNING  
NATIONAL TRAINING CENTER

**Thank you!**

Email [fpntc@jsi.org](mailto:fpntc@jsi.org)

Subscribe at [www.fpntc.org/enewsletter](http://www.fpntc.org/enewsletter)

This presentation was supported by Award No. FPTPA006028-04-00 from the Office of Population Affairs (OPA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.



75

I want to say thank you so much for joining us. We've had some questions about will the slides be available? And yes, we have recorded today's webinar. We will be making the slides and recording available on [fpntc.org](http://fpntc.org) in the next few days. Please take one more minute to fill out our evaluation and tell us how you thought today's webinar went and give us other suggestions as well as questions you'd like to see on the FAQ going forward. Thank you so much for joining us everyone. Hope you have a great rest of your day. And that concludes today's webinar.

Email [fpntc@jsi.org](mailto:fpntc@jsi.org)

Subscribe at [www.fpntc.org/enewsletter](http://www.fpntc.org/enewsletter)