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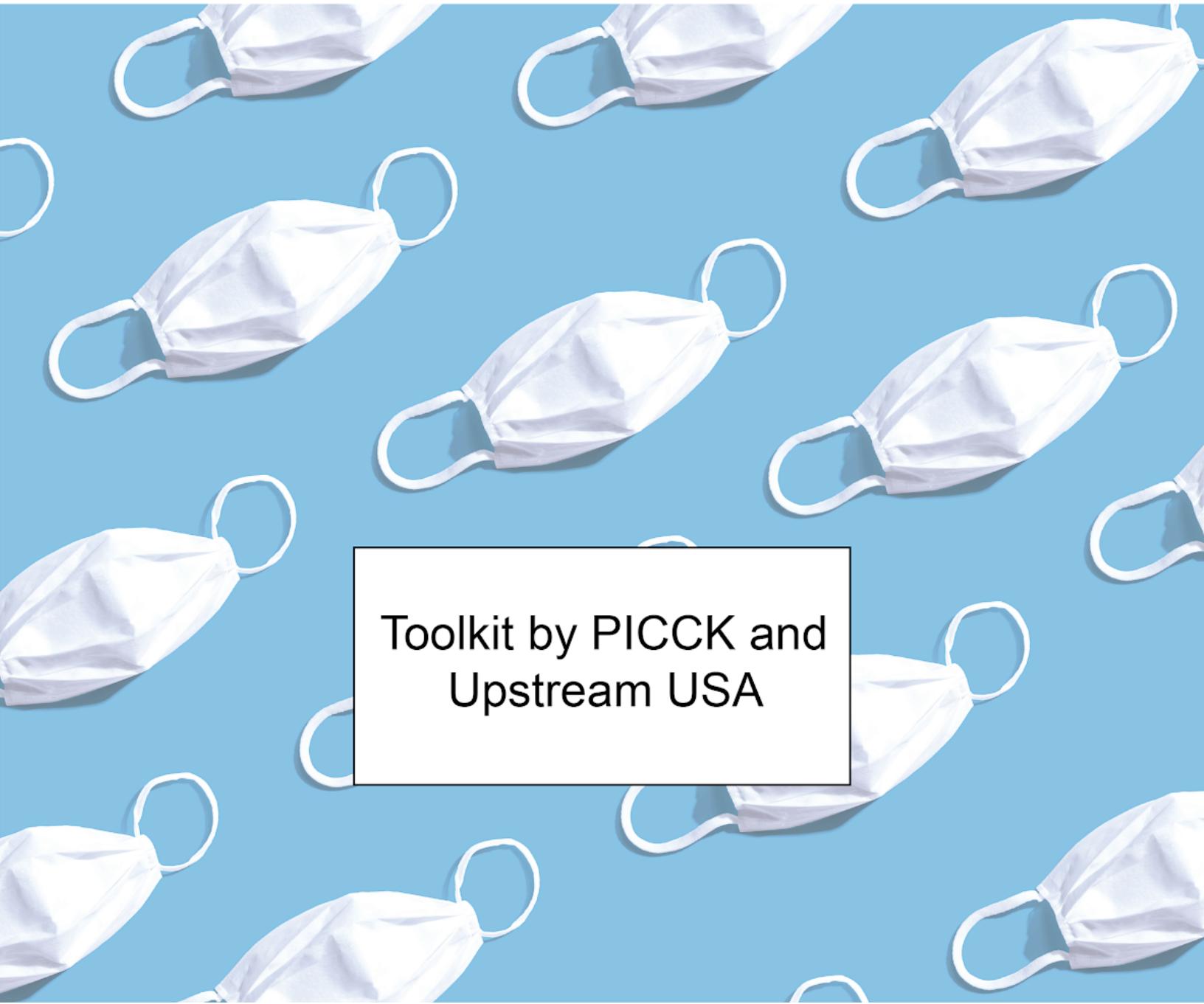
PICCK

Adapting to the New Normal: Contraceptive Care Services in the Next Phase of COVID-19



Toolkit by PICCK and Upstream USA

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Toolkit Overview

Throughout the COVID-19 public health crisis, many patients may have foregone contraceptive care despite having a desire to prevent pregnancy (Guttmacher). As your practice begins to restore some onsite clinic operations, now is an opportune time to integrate contraceptive care into in-person and remote service provision and to adapt new workflows. Partners in Contraceptive Care and Knowledge (PICCK) and Upstream USA developed this toolkit to guide your practice as you implement new clinical protocols and workflows.

How to Navigate the Toolkit:

Review the **Executive Summary** to understand the immediate steps your practice should consider when implementing your reopening protocols. For more information on each step, refer to additional explanations and tips in the expanded toolkit.

The toolkit is organized into three sections:

- **The Administrative Checklist** – This section includes recommendations for onsite capacity planning, safety and hygiene, pharmacy, and other administrative activities for the next phase of COVID-19.
    - **Clinical Prioritization of Sexual and Reproductive Health in COVID-19 Recovery** – This table includes suggestions for prioritizing sexual and reproductive health (SRH) services by COVID-19 transmission level.
    - **Risk Reduction and Personal Protective Equipment (PPE) Framework for Sexual and Reproductive Health** – This framework includes exposure risk reduction strategies and PPE recommendations for selected SRH encounters.
- **Contraceptive Counseling via Telehealth** – This section includes recommendations for how to continue integrating telemedicine into contraceptive services and create a blended care model (in-person and telehealth).
- **FAQ: Providing Full Range of Contraceptive Methods** – This section includes frequently asked questions for providing the full range of methods, such as how to use shared decision-making to counsel patients, how to offer a full range of methods given COVID-19 constraints, how to prescribe emergency contraception, and how to ensure postpartum patients access their desired method.

Executive Summary

Leadership and Operations Staff Considerations

1. **Develop a prioritization strategy for sexual and reproductive health visits.** Refer to the Clinical Prioritization Table (Appendix 1) for suggested ways to prioritize onsite patient visits by phase of recovery.
2. **Screen all patients who may have a contraceptive need regardless of visit type.** Add a pregnancy intention and contraceptive needs screening question to all intake forms and/or clinical workflows and integrate patient-centered contraceptive counseling.
3. **Leverage telemedicine alongside your prioritization strategy to ensure continuity of contraceptive care.** Contraceptive services via telemedicine can include:
    - Counseling patients on the full range of contraceptive methods and assessing for contraindications
    - Prescribing initial and refills of contraceptive methods—pill, patch, ring, diaphragm, cervical cap, emergency contraception, Depo-SubQ Provera
    - Managing contraceptive side effects
    - Discussing Depo-SubQ Provera (self-injection with prescription) as an option for patients currently using Depo-Provera or requesting to start Depo-Provera
    - Counseling on extended use of LARC devices for patients with a device reaching its FDA expiration date
    - Providing advanced emergency contraception prescriptions
4. **Monitor reimbursement and regulatory guidelines for telehealth changes**. Anticipate updates to federal and state telehealth regulations and insurance reimbursement rates.
5. **Streamline access to emergency contraception (EC).** Create standing orders for Plan B (generics available) and ella, and implement a telephone triage protocol to respond to patient requests for EC. (Resource: PICCK)

Clinic Safety and Hygiene Considerations

1. **Screen all onsite patients prior to and upon arrival for COVID-19 symptoms.** For patients with confirmed or suspected COVID-19, it is advised to limit non-emergent visits and have systems or referral pathways in place to address urgent issues. Patients that have severe pelvic pain, heavy vaginal bleeding, or concern for ectopic pregnancy need to be seen. As per Society of Family Planning (SFP) recommendations, these visits should occur in an emergency department, specially designated triage clinic, or routine outpatient clinic if appropriate PPE and recommended cleaning/decontamination is available. (Resource: SFP)

2. **Separate asymptomatic patients from patients with fever or respiratory symptoms.** Consider designating exam rooms and appointment times for symptomatic patients.
3. **Require all patients and visitors to wear a face mask during their onsite visit regardless of visit type.** Other ways to limit a patient's exposure risk are sending electronic intake and consent forms prior to the visit, expediting registration protocols, advising patients to wait in their car, when possible, and calling ahead upon arrival.
4. **Ensure exam rooms are cleaned and disinfected after each patient as per sanitation protocols and CDC guidelines**. Develop a short checklist of items to disinfect that are not part of routine equipment disinfection protocols, and post it clearly in each room (e.g. door handles, chairs and countertops). (Resource: CDC)
5. **Use recommended PPE for each procedure.** Refer to Appendix 2 for more guidance.

Provider Considerations

1. **Use shared decision-making to counsel on the full range of contraceptive methods.** As your practice increases onsite patient visits, counsel patients on the full range of methods and refer patients to an onsite provider for Depo-Provera and IUD and implant placements to reduce COVID-19 exposure risk. If your practice has limited availability, consider referring to a family planning clinic. (Resource: PICCK)
2. **If possible, provide the patient's desired method during the same visit as counseling.** The benefits of same-visit access to contraception outweigh the risks. When assessing pregnancy risk for providing same-visit hormonal contraception or copper IUDs, refer to the Quick Start algorithm for additional guidance. Offer bridge method options to patients who cannot immediately access their preferred method. (Resources: RHAP, PICCK, Upstream)
3. **Consider prescribing the maximum supply and maximum refills allowed in your state to decrease barriers to accessing future supplies for the contraceptive pill, patch and ring.** Discuss curb-side pick-up, home delivery, or mail order options covered by a patient's prescription plan. (Resource: Upstream, PICCK)
4. **Prioritize IUD and implant removals and reschedule delayed visits as soon as possible.** When patients have expiring IUDs and implants, advise patients on extended use of devices beyond the FDA expiration. If a patient prefers to have an IUD or implant removed for any reason, immediately schedule the patient or refer them to another practice or family planning clinic with immediate availability. (Resource: PICCK)
5. **If a patient's preferred method is Depo-Provera, consider counseling the patient on Depo-SubQ Provera as an option.** A nurse can provide instructions for self-injection via video conferencing. (Resource: PICCK/Upstream)

6. **Reschedule postponed tubal ligation or vasectomy procedures.** Counsel the patient in advance, via telemedicine, and discuss bridge methods of contraception the patient can use until the procedure is scheduled. (Resource: PICCK)
7. **Offer all patients using short-term or barrier methods an advance prescription for EC.** This may reduce the cost of obtaining EC compared to over-the-counter and serve as a back-up if patients experience a gap in use of their usual contraceptive method. (Resource: PICCK)
8. **Counsel all pregnant patients in the 3rd trimester about their postpartum contraception options.** Postpartum visits may be administered via telemedicine throughout the public health crisis. To support access and patient need, hospitals should consider implementing an immediate postpartum LARC program. Provide emergency contraception prescriptions for all postpartum patients who leave the hospital without LARC or permanent contraception. (Resource: PICCK)
9. **Continue to offer a staff member chaperone in the room for gynecological procedures.** To accommodate this, try to maintain as much distance as possible within the room, or move procedures to larger spaces to accommodate distancing.
10. **Check in with patients about their current living situation, if appropriate, and screen for potential violence or harm to the patient.** Screening can include reproductive coercion, contraceptive sabotage, and intimate partner/domestic violence.

Patient Communication Considerations

1. **Inform patients of changes to contraceptive services via texting, email updates, or patient portals.** Consider posting on your practice's social media profiles or website telehealth and onsite appointment options. (Resource: FPNTC)
2. **Assure patients that your practice is taking all recommended precautions to protect their health and notify them of any changes to visit procedures**. Share information about COVID-19 screening before visits, patient mask requirements, visitor limitations, expedited registration procedures, and separate waiting rooms.
3. **Offer to distribute digital patient education materials.** Information on contraceptive methods can be shared prior to onsite and telemedicine visits.
4. **If your practice has limited contraceptive options available, coach front-line staff and clinicians on how to explain limited availability.** Offer referrals to other practices for unavailable methods, including implant and IUD placements and removals.

Introduction

The COVID-19 outbreak disrupted nearly every aspect of our healthcare system and created barriers to routine healthcare services, including the delivery of contraceptive care. As your practice prepares to restore normal patient visits, it will be crucial to ensure contraceptive services are included in your prioritization strategy.

PICCK and Upstream USA created this toolkit to guide your administrative staff and clinicians as they prepare for the next phase of COVID-19. The toolkit includes administrative considerations, guidance on counseling and providing the full range of contraceptive methods, best practices for postpartum contraceptive provision, and telehealth adaptations for contraceptive care. Additionally, this toolkit offers recommendations for quality improvement activities that can inform long-term access to high-quality contraceptive care beyond COVID-19.

The Administrative Checklist

The administrative checklist outlines practice adaptations that will ensure the safety of patients and staff when increasing onsite contraceptive care.

Administrative Checklist Areas of Consideration:

Onsite visit capacity

❏ Begin with gradual reopening or expansion of services by prioritizing patients most affected by service disruption.

E.g. if the majority of visits are currently telemedicine, consider starting with 1/3 in-person visits and keep the remainder virtual visits to start.

❏ Prepare prioritization and outreach lists of patients overdue for various SRH services. Revisit and update this prioritization for your facility periodically as the pandemic

recovery continues, taking into account any local guidelines, community needs, staffing and supply availability.

See Appendix 1 for a sample clinical prioritization framework.

- ❑ Set metrics or thresholds to decrease or pause in-person services if community transmission of COVID-19 increases in your area.

  Recovery in this phase of COVID-19 may not be linear; prepare to revert back to virtual visits if cases spike in your community or if staff contract COVID-19.

- ❑ Maintain flexibility for patients and continue to offer the option of virtual visits.

  Even if in-person visits are now available at the clinic, some patients may not feel comfortable coming onsite, may have additional logistical barriers (e.g. transportation options, child care), or may prefer a virtual visit.

- ❑ Identify a multi-disciplinary team to monitor implementation of onsite visits, elicit feedback from patients and staff, and make adaptations as needed to protocols.

  Include representation of staff from all levels, including support staff, who have the most contact with patients and sanitation practices.

Call center, scheduling, and intake of patients

- ❑ While scheduling or during intake (verbal or written), screen all patients who can become pregnant for pregnancy intention and contraceptive needs regardless of visit type. By adding a universal screening question, you will ensure all patients with a contraceptive need can access their desired method at the time of their visit. (Resource: Upstream)

  Consider adding a pregnancy intention and contraceptive needs screening question to call center scripts and intake forms and protocols. (Resources: PICCK, Upstream)

- ❑ If not an OB/GYN practice, consider scheduling SRH procedures in designated clinic sessions to ensure provider and supply availability.

  E.g. group any visits for IUD/implant insertion and removal, colposcopy, endometrial biopsy, uterine evacuation, etc.

- ❑ Ensure call center and phone staff are informed of changing protocols and have clear guidelines and training to schedule and screen patients for SRH/contraceptive care.

  Consider adapting a telephone triage protocol for EC. (Resource: PICCK)

- ❏ Know where you can refer patients for in-person services if your practice is not reopening or reopening with limited capacity.

Patient communications

- ❏ Notify patients of reopening/expansion of services and what to expect when they come in for a visit, including if you would like them to bring or wear a mask.

  Depending on technology access levels of your patient population, consider using different or a combination of modalities. For example: phone call, text, email, website, or patient portal.

- ❏ Assure patients that you are taking all recommended precautions to protect their health and safety and list the key steps you are taking.

- ❏ Coach front-line staff and clinicians to explain why some contraceptive methods are not being offered during their visit.

  It is possible that your office cannot provide the full range of contraceptive methods at this time, due to stocking issues or personnel capacity. When a patient is not able to get the method of contraception they desire, patients may assume that they are being denied a method because their provider does not want them to have it.

  Providing the context of supply and other challenges during COVID-19 might help patients with their decision to use a bridge method until they are able to access their desired contraceptive method. (Resource: PICCK)

- ❏ Create and/or distribute digital patient education materials. (Refer to Contraceptive Counseling via Telehealth)

- ❏ Check in with patients about their living situation during this time, if appropriate. Screening can include reproductive coercion, contraceptive sabotage, and intimate partner violence/domestic violence.

- ❏ Check in with patients about their mental health, ask about housing instability and food insecurity, and ascertain a need for referral to social work/other resources.

Patient rights and privacy

Well-meaning infection prevention policies can sometimes limit patient autonomy and rights, such as limiting support persons allowed for labor or other sensitive procedures. For SRH services, it is imperative that patient rights and autonomy are maintained.

- ❏ Notify patients of visitor/companion policies in advance.

These policies are particularly relevant for adolescents, prenatal visits, and patients scheduling procedures.

- ❏ Notify patients in advance about the availability of interpreter services for in-person and remote visits.

  Patients should know how they will be supported to fully communicate with their provider, particularly when support persons are not allowed.

- ❏ Continue to offer a chaperone in the room for gynecological procedures.

  Though the general recommendation is to reduce the number of people in confined spaces, it is still recommended to maintain normal chaperone protocols. Try to maintain as much distance as possible within the room, or see if procedures can be moved to larger spaces to accommodate distancing.

- ❏ Prioritize patient privacy during telemedicine visits.

  It can be difficult to confirm patient privacy via telemedicine, because they could be audio/visually observed outside of your limited view. Ensure that the patient knows how to contact your office in a private manner, be it through a patient portal or email, in case they need assistance. (Refer to Contraceptive Counseling via Telehealth)

Patient flow and physical space

- ❏ Conduct remote registration when possible.

  If patients visit your facility by car, consider having them wait in their car until they are ready to be roomed; staff can perform intake prior to the patient entering the facility.

- ❏ Screen for COVID-19 symptoms prior to visit and upon arrival.

  Temperature screening is of questionable value; it misses asymptomatic and pre-symptomatic persons, is prone to inaccurate readings, and is not explicitly recommended by ACOG or CDC. (Resource: ACOG, CDC)

- ❏ Practice social distancing in all waiting areas. Consider separate waiting rooms and/or entrances for asymptomatic and symptomatic patients depending on your layout. Think about what rooms at your site contain the necessary equipment or space for SRH procedures and, if possible, ensure these are not used for patients with respiratory symptoms or patients under investigation (PUI).

As you begin to schedule more patients for in-person visits, consider how many patients can be in the waiting rooms at any given time, while maintaining social distancing precautions.

- ❏ Provide and clearly label handwashing stations for patient use and/or have hand sanitizer accessible to patients.
- ❏ Post clear signage on walls and/or floors to indicate patient pathways and restricted areas, or consider escorting patients directly to rooms. Be sure any signage is written for all literacy levels and in multiple languages, if possible.

  Particularly if your clinic has a complex layout or if patient flow has changed due to new protocols, providing clear signage or an escort can limit exposure to other facility areas. Include instructions for proper mask use.
- ❏ Have designated pens for patients to use, have patients use their own pens, or disinfect pens after patient use.

Clinical workflows

Review clinical workflows for contraceptive and other SRH services to identify needed practice changes.

- ❏ Determine what aspects of counseling or consent can be done virtually prior to the in-person visit (via telemedicine or a reminder call) to limit face-to-face time.
- ❏ Shift tasks to different care team members if staff ratios have changed due to new protocols and/or furloughs.

  If staff availability is limited due to furloughs or illness, determine what aspects of screening (e.g. pregnancy intention and contraceptive needs) or initial counseling can be done at time of scheduling and what tasks must be completed by the provider.
- ❏ Minimize staff and support people in exam or consult rooms.
- ❏ Minimize patient movement between rooms or clinical spaces.
- ❏ Review your current protocols for instrument preparation and processing, and adjust as needed to account for changes to staffing levels or clinical workflows.

Sanitation protocols

- ❏ Ensure exam rooms are cleaned and disinfected after each patient as per sanitation protocols. (Resource: CDC)

- ❏ Disinfect frequently touched surfaces, such as doorknobs and light switches, multiple times a day. Develop and post a checklist of items to disinfect in patient rooms and common areas.
- ❏ Limit the surfaces that staff and patients must touch by propping doors open or using automatic door openers, which will cut down on the need to sterilize surfaces.
- ❏ Identify who will sanitize rooms and surfaces and ensure they have proper personal protective equipment (PPE) and supplies.
- ❏ Designate additional team members to assist with sanitation tasks if typical janitorial services are insufficient for the new level of disinfecting required.

PPE

- ❏ Advise patients to bring and wear a mask at all times regardless of visit-type.

  Be sure to include this in scheduling and pre-visit communications.

- ❏ Ensure adequate supplies of PPE are available as in-person volume increases.
- ❏ In addition to ensuring sufficient supplies for staff, keep a reserve supply of surgical masks for patients who do not have masks in order to keep staff safe and reduce access barriers for patients.

See Appendix 2: Risk Reduction and PPE Framework for Sexual and Reproductive Health.

Pharmacy and supplies

- ❏ Work with pharmacy to frequently recalculate implant and IUD stocking and general supply needs based on patient lists and reports of missed visits, historic demand, and weekly trends.

  Demand is likely to be highly variable during this time; some practices may experience a surge in demand due to backlog while others may experience a slow increase as compared to previous COVID-19 patient volume levels.

- ❏ Verify supply chain and develop a contingency plan for potential disruptions.
- ❏ Consider establishing drive-through/curbside pick-up or mail options for prescription distribution or lab collection kits (e.g. self-collected samples for STI testing). (Resource: Upstream, PICCK)

  Keep confidentiality in mind when discussing mail order options with patients. Ask patient if alternate address or discrete packaging is required.

- ❏ Dispense maximum supply and refills as per state guidelines.

  *In **Massachusetts**: write contraception prescriptions for a 90 day supply on new prescriptions and 12 months supply for refills. (Resource: NARAL)*

Billing

- ❏ Review Explanation of Benefits (EOB) protocols and develop a plan for discussing options with telemedicine patients. Virtual visits may not have a "check out" step.

  *In **Massachusetts**, under the PATCH law, adolescent patients can opt-out of having an EOB sent to their policyholder. (Resource: HCFMA)*

- ❏ Check billing guidelines frequently as they are changing rapidly during this time.

  *In **Massachusetts**, refer to Upstream and PICCK telehealth guidelines for information about telehealth billing for MassHealth and Health Safety Net.*

Additional administrative resources can be found in Appendix 3.

Contraceptive Counseling via Telehealth

Defining Telehealth and Telemedicine

- ***Telehealth*** refers to the broad use of technology to provide healthcare at a distance (e.g. patient portals, text messaging, and telemedicine visits).
- ***Telemedicine*** refers to the actual conduct of a medical visit remotely via real time phone or internet (audio or video). (Resource: AAFP)

Effective March 15, 2020, The U.S. Department of Health and Human Services (HHS) temporarily relaxed enforcement of certain HIPAA regulations covering use of telehealth devices (Resource: OCR, HHS). This temporary measure granted more flexibility to providers to deliver care via telehealth amidst the COVID-19 national public health emergency.

While this measure is temporary, practices can apply lessons learned during this period to improve long-term delivery of HIPAA-compliant telehealth services and reach patients who may face barriers to accessing onsite services.

Checklist: Improving Long-term Access to Contraceptive Care via Telehealth

- ❑ Evaluate current telehealth protocols and policies.
- ❑ Monitor state and federal telehealth guidelines and ensure your telehealth platform is HIPAA compliant and accessible.
- ❑ Align telemedicine visits with designated clinic sessions and/or provider rotations.
- ❑ Include pregnancy intention and contraceptive needs screening in screening protocols.
- ❑ Use shared decision-making to counsel patients on the full range of methods and ensure patients obtain their desired method.
- ❑ Prioritize patient privacy and safety.
- ❑ Create digital patient-facing materials.
- ❑ Publicize telemedicine visits as an option for contraceptive care.

❑ **Evaluate current telehealth protocols and policies.**

- Assess the effectiveness of your current telehealth policy. Review no-show rate for contraceptive visits delivered via telemedicine and compare to your no-show rate for in-person contraceptive care visits.
- Ask providers and support staff for feedback on your telehealth policy and platform(s) to see if they have noticed any bottlenecks or technical issues.
- If you are collecting patient satisfaction metrics for contraceptive care visits, compare metrics for telemedicine visits with in-person visits.

❑ **Monitor state and federal telehealth guidelines and ensure your telehealth platform is HIPAA compliant and accessible.**

- Monitor state and federal telehealth regulations and reimbursement policies (e.g. reimbursement parity, licensure requirements, and place of service).
- Prepare to be fully compliant with the HIPAA Privacy, Security and Breach Notification Rules (HHS). If you implemented a temporary telehealth platform, prepare to migrate to a HIPAA compliant platform for long-term use.
- Conduct due diligence to ensure your vendor and staff fully comply with HIPAA regulations. (Resource: NFPRHA)
- Consider your patient population and their accessibility to different technology platforms. If your patients have limited access to a computer, smartphone,

wireless network, or data plan, check with the technology vendor to see if they offer audio-only options.

- Support remote staff in updating electronic devices and WiFi networks with appropriate security measures. (Resource: AMA)
- Update or create a patient consent form for participation in telemedicine visits, share the form in advance of the visit, and document patient's consent. (Resource: English and Spanish, CA Telehealth Resource Center)
- Ensure your telemedicine platform includes language assistance for virtual visits, such as conferencing options for remote video medical interpreters. Ensure ADA compliance for conducting telemedicine visits with a patient who is deaf or blind.

❑ **Align telemedicine visits with designated clinic sessions and/or provider rotations.**

- As onsite patient volume increases, your practice may begin to modulate provider availability and schedule non-acute visits during designated clinic sessions. If possible, consider designating at least one onsite provider, trained in providing the full range of methods, to each rotating provider team. Align telemedicine referrals with that provider's availability.
- If you are modulating clinic hours for non-COVID-19 patients, consider blocking weekly hours for family planning referrals. If you have new learners on your team, this could be an opportunity to continue precepting providers on placing and removing IUDs and implants.

❑ **Include pregnancy intention and contraceptive needs screening in screening protocols.**

- Screen all telemedicine patients who may have a contraceptive need, regardless of visit type. Since patients face greater challenges to accessing contraception during the public health crisis, increased screening will help fill this gap in care.

  > *Asking about contraceptive needs can prevent unplanned discontinuation of short-acting methods and reduce the risk of unplanned pregnancies. A universal needs assessment can also decrease the likelihood of future phone calls or appointment requests to triage.*

- When screening for COVID-19 symptoms and appropriateness for an onsite visit, consider adding a pregnancy intention and contraceptive needs screening question to assess a patients' need for contraception. (Resource: PICCK)
- Create a telemedicine triage policy specifically for contraceptive care and related appointment requests. (Resources: FPNTC, Upstream)

- Consider adding a field for the pregnancy intention and contraceptive needs screening to your electronic health record. Provide training and guidance to schedulers and call center staff to prepare staff for pregnancy intention and contraceptive needs screening and documentation delivered via telehealth.

❑ **Use shared decision-making to counsel patients on the full range of methods and ensure patients obtain their desired method.**

- Use patient-centered, shared decision-making counseling to allow patients to make an informed decision about which contraceptive method is best for them at this moment in their lives. (Resources: Upstream, PICCK, PICCK)

  Contraceptive services that can be offered via telemedicine are:

  - Counseling patients on the full range of contraceptive methods and assessing for contraindications
  - Prescribing initial and refills of contraceptive methods—pill, patch, ring, diaphragm, cervical cap, emergency contraception, Depo-SubQ Provera
  - Managing contraceptive side effects
  - Discussing Depo-SubQ Provera (self-injection with prescription) as an option for patients currently using Depo-Provera or requesting to start Depo-Provera (Resource: PICCK/Upstream)
  - Counseling on extended use of LARC devices for patients with an IUD or implant reaching its FDA expiration date (Resource: PICCK)
  - Providing advance emergency contraception prescriptions

- Send educational materials prior to the appointment and review a contraceptive decision aid during counseling by sharing your screen, when possible.

- Ensure patients can access their preferred methods as soon as possible and offer a bridge method to patients who cannot immediately access their desired method. Many methods can be provided by prescription and do not require an in-person examination. If a patient desires an implant, IUD, or Depo-Provera, complete counseling for the method during the telemedicine visit (risks, benefits, and side effects) and obtain informed consent to expedite the onsite visit. (Resources: Upstream, PICCK, PICCK)

- If your practice was not set up for same-day LARC insertion prior to the pandemic, telemedicine can also be used to facilitate access to these methods with only one in-person visit. After telemedicine counseling about the method, ensure that the device is stocked and obtain any insurance authorizations prior to the patient coming in for their procedure visit. This approach may be appealing to

patients who are hesitant about entering healthcare institutions due to concern about COVID-19 exposure.

- Consider involving nurses and medical assistants trained in patient-centered contraceptive education and counseling in screening for a patient's pregnancy intention and contraceptive needs during the administrative or "rooming" portion of the telemedicine visit. If a patient chooses a method that requires onsite care, such as an IUD, implant, or injection, the staff member can prepare the relevant consent forms and educational materials to either be sent electronically prior to the in-person visit or to be ready for signature at the in-person visit.

❑ **Prioritize patient privacy and safety.**

- It is not always possible to know a patient's privacy or safety in their environment when conducting a telemedicine visit. When delivering contraceptive education and counseling, it's important to be mindful of the setting you and the patient are in and take precautions to ensure the safety of patients, especially adolescent patients and patients at risk of intimate partner violence (IPV).
- Review recent screening measures for IPV in a patient's chart before each visit to assess the safety of the visit for each patient and look for signs of IPV during the visit. If you can communicate with the patient in a way you both know to be private, introduce a safe word that the patient can use in the conversation and instruct the patient on the quickest way to exit the platform. Suggest the patient uses headphones if they are not in a private location.
- While open-ended questions are, typically, preferred for counseling and addressing sensitive topics, check with your patients to see if they would prefer to answer close-ended (yes or no) questions. This can help ensure patient privacy if patients are not in a controlled, private location. Pay attention to non-verbal cues that may indicate a shift in the patient's environment.
- If applicable in your state, remind adolescent patients of their right to request Explanation of Benefits (EOB) forms are not mailed to their home.

> In **Massachusetts**, patients must call their insurance provider to request how and where they want their EOB sent. (Resource: HCFAMA)

❑ **Create digital patient-facing materials.**

- In lieu of print materials, consider adding links to contraception educational materials to your website or plan to share a digital version in advance of your appointment. (Resources: Upstream, PICCK)
- Publicize telemedicine visits as an option for contraceptive care.

Consider adding an announcement to your practice's social media profiles or website that lists telehealth and onsite appointment options, including family planning services. Clearly communicating the availability of services will help patients navigate changes to your practice's clinical operations. (Resource: FPNTC)

- Use existing direct patient communications channels, such as texting, email platforms, or patient portals to inform patients of your clinic's available contraceptive services.

Additional telehealth resources can be found in Appendix 3.

FAQ: Providing Full Range of Contraceptive Methods

Reproductive healthcare providers aim to offer a full range of contraceptive methods and to decrease barriers to access. COVID-19 made this provision more difficult, often limiting providers' ability to prescribe estrogen-containing methods and offer provider-controlled methods like IUDs, implants, injectables, and permanent contraception. Conversely, demand for EC increased while the United States faced ella shortages. Providers adjusted to these challenges in many ways, including shifting to telemedicine visits and offering bridge methods.

As facilities begin to increase in-person appointments, consider how your practice can ensure access to the full range of contraceptive methods, including addressing any issues of limited access over the past few months during clinic closures.

Checklist: Providing Full Range of Contraceptive Methods

- ❏ Offer to Quick Start methods of contraception whenever possible, even via telemedicine when a pregnancy test may not be available.
- ❏ Provide same-day access to LARC. If same-day LARC protocols cannot be implemented, counsel about contraceptive methods via telemedicine, so patients need only one visit to the clinic to obtain their method.
- ❏ Prioritize LARC removals and reschedule postponed LARC removal appointments as soon as possible. Counsel about extended use of LARC for patients who are satisfied with their method and want to prevent pregnancy.
- ❏ Follow-up with patients who postponed an IUD or implant placement and schedule an onsite visit. Counsel on bridge methods if appointment is delayed for any reason.
- ❏ Counsel patients about the option of self-injection of Depo-SubQ Provera; instructions can be given during a nurse visit or over video conferencing.

- ❏ Prescribe 3 or 12 months of pills, patches and rings for new and continuing users, respectively.
- ❏ Contact patients who are waiting for a tubal ligation or vasectomy procedure to confirm that they have a bridge method of contraception to use in the interim.

Quick-Start Algorithms:

Do I need to wait until the onset of menses or a negative pregnancy test before prescribing or placing a contraceptive method?

Most methods of contraception can be started on the same day a patient requests it. Refer to the Quick Start Algorithm for guidance on assessing pregnancy risk (Resource: RHAP). While protocols usually call for a urine pregnancy test prior to Quick Starting contraception, the benefits outweigh the risks of starting the method should a patient not be able to take a pregnancy test. Evidence suggests that hormonal contraception, when taken inadvertently in early pregnancy, does not harm an embryo and does not lead to pregnancy loss.

Quick Starting contraception reduces the risk of an unintended pregnancy that can occur when a patient would otherwise be waiting to start a method. Similarly, if a patient experiences a gap in their birth control (e.g. difficulty filling a prescription for oral contraceptives), they can restart their method immediately upon receiving their new supply.

Are there any risks with Quick Start?

The downside of the Quick Start approach to contraceptive initiation is that if a patient is already pregnant, they may have delayed options counseling and access to either termination or prenatal care. If a patient is unable to take a pregnancy test prior to starting their contraception, counsel them to take a pregnancy test or to call your office if they do not have a withdrawal bleed 4 weeks after beginning their method. This approach reduces the risk of inadvertent delays in care due to an unrecognized early pregnancy.

LARC (copper IUDs, hormonal IUDs, implants):

Should I provide LARC methods the same day a patient is counseled?

Same-day access to LARC is a best practice in contraceptive care. A patient should be able to get the method they choose on the day they are in the clinic, even if the visit was intended for a different purpose. Same-day access reduces potential patient and staff exposure to COVID-19 and will limit additional patient onsite visits. If indicated, STI screening can be performed at the

time of IUD insertion and should not delay the procedure unless the patient has a contraindication such as purulent cervicitis noted on exam. (Resource: FPNTC)

If I cannot provide same-day access to LARC, how can I adapt my two-visit protocol during COVID-19?

Consider conducting contraceptive counseling visits via telemedicine (Refer to Contraceptive Care via Telehealth section). If the patient desires LARC, obtain informed consent, and ensure your ability to place a LARC device (e.g. IUD or implant in stock, insurance authorization confirmed, etc.). Make sure to schedule onsite visits as soon as possible with providers who are trained in LARC placement and ensure these clinicians have sufficient availability to provide immediate access to these methods. Offer a bridge method if the onsite visit will be delayed.

I wasn't able to offer LARC insertions during the peak of COVID-19, what should I do now?

LARC insertion is an essential service, but many practices were unable to fulfill insertion requests due to COVID-19-related restrictions in clinic appointments. Patients who were counseled via telemedicine and wanted LARC were likely offered a bridge method until they could be seen in the office. Reach out to patients who received a bridge method or had interest in LARC to see if they would like to be scheduled for an insertion. (Resource: PICCK)

Should patients be scheduled for an IUD check after insertion?

In-person follow-up ("string check") visits after IUD insertion were optional even before the pandemic-related restrictions. No routine follow-up is required after IUD insertion. You may want more frequent follow-up visits for high risk patients—adolescents, patients with multiple or serious medical conditions—but check-ins can be done remotely as needed. Through telemedicine visits, providers can discuss IUD side effects or other problems, inquire if the patient wants to change their method, and discuss when it is time to remove or replace the IUD.

Should removals of LARCs be prioritized or delayed due to COVID-19?

Denying a patient the right to have a device removed from their body, thereby continuing the experience of unwanted side effects, or delaying a return to fertility, is inadvertent reproductive coercion. If any LARC removals were delayed due to COVID-19, these patients should be prioritized for appointments during rescheduling, and facilities should proactively follow-up with patients who expressed wanting a device removal.

How should I manage patients whose LARC devices are expiring during COVID-19?

For patients whose LARC device is reaching its FDA expiration date, but want to continue the method, we encourage providers to screen and counsel via telemedicine on extended use of

LARC. If a patient would like the device removed, schedule a removal appointment as soon as possible. (Resource: PICCK)

Depo-Provera:

Depo-Provera requires frequent visits. How should I schedule these appointments?

Consider scheduling Depo-Provera initiation and continuation appointments with nurses in place of advanced clinicians. You and the patient may decide to schedule the injection visit with a clinician if it is close to the time for their annual exam, or they have any health complaints that necessitate a physical exam.

Should I offer Depo-SubQ Provera as an alternative option? How do I teach self-injection?

Depo-SubQ Provera is a good alternative option to help reduce recurring onsite visits. A nurse can instruct patients on safe self-injection and needle disposal during an office visit or by a video conferencing visit. Share self-injection education materials and offer additional support over the phone if a video conferencing visit is not an option. Not all insurance carriers cover Depo-SubQ Provera. (Resource: PICCK/Upstream)

> In **Massachusetts**, insurance coverage of Depo-SubQ Provera varies widely. Refer to this PICCK/Upstream resource for a summary of insurance coverage.

Prescription Methods (pills, patch, ring):

Many prescription methods are preferred by patients and have remained accessible during COVID-19. We encourage practices to reflect upon their contraceptive prescription practices and see if this reopening is an opportunity for quality improvement.

How can I reduce in-person visits for patients who want prescription methods?

Offer methods with the maximum supply and maximum refills to decrease barriers to access and continuation. Providers should verify their local dispensing and coverage laws in their states. To reduce COVID-19 exposure risks, explore drive-through/curbside pick-up or home delivery pharmacy services, or offer mail order provision if covered by a patient's prescription plan. Consider sharing additional resources with your patients on how to access methods without an onsite visit. (Resources: Upstream, PICCK)

> In **Massachusetts**, prescription methods can be offered with an initial 90-day supply, and prescriptions for continuation can be offered with a 12-month supply.

My practice usually doesn't offer renewed prescriptions until a patient has had their annual visit. Should we change this practice during COVID-19?

Even during non-COVID-19 times, contraceptive provision should not be dependent on other health-seeking behaviors. There is no reason to withhold a prescription until a patient has received their annual visit, a pap smear, or STI testing. Instead, always offer contraception as quickly as possible to immediately meet patient demand, and use that provision as an opportunity to offer to schedule a clinic visit for other testing and care.

What about estrogen-containing methods when we do not have a recent blood pressure reading?

Under normal circumstances, best practice for prescribing contraceptive methods that contain estrogen is to confirm a recent normal blood pressure reading. During the COVID-19 pandemic response, do not limit prescriptions for estrogen-containing methods to individuals who are medically eligible for these methods but do not have a documented normal blood pressure.

For patients who do not have a documented blood pressure within the past year, the Society of Family Planning recommends the following approach (Source: SFP):

- If a patient has access to a blood pressure cuff at home or at a pharmacy, they can check their blood pressure and inform the provider of the value.
- If a patient does not have access to a blood pressure cuff, confirm no known history of blood pressure elevation and inform them of the risks of estrogen-containing methods for patients with hypertension, including stroke and myocardial infarction.
- Recommend that they schedule a non-urgent visit with a healthcare provider for blood pressure check once usual healthcare access resumes.

Non-Prescription Methods:

What other affordable contraceptive methods can patients access that do not require any interaction with providers (even telemedicine)?

Non-prescription contraceptive methods include:

- One-size diaphragm
- Internal condoms
- External condoms
- Spermicide
- Sponge
- Fertility awareness method
- Withdrawal
- Levonorgestrel emergency contraception

Many of these methods are low or no cost and may be particularly appealing to individuals who are uninsured or who have lost their insurance coverage due to COVID-19-related unemployment. (Resources: Upstream, PICCK)

Permanent Contraception:

How should permanent contraception procedures be handled in this next phase of COVID-19?

When possible, counsel male and female patients about permanent contraception (e.g. tubal ligation or vasectomy) via a telemedicine visit to avoid an additional in-person visit while observing local consent regulations. Many recent requests for postpartum tubal ligations were not fulfilled due to COVID-19 restrictions on operating room use. When reopening clinics, providers should follow-up with patients who previously expressed interest in permanent contraception or previously signed consent forms. Confirm the patient's interest in the procedure, ascertain the date of the signature on the consent form, and schedule the surgical procedure as soon as possible as operating rooms reopen. If a patient is waiting for a permanent contraception procedure, providers should offer a bridge method (pills, rings, condoms, etc.) until the procedure is scheduled. (Resource: PICCK)

MassHealth patients must sign permanent contraception consent forms 30 days before their procedure, or 30 days before their due date when pregnant; the signed forms are valid for 6 months.

Emergency Contraception:

Emergency Contraception (EC) Checklist:

- ❏ Have standing orders for Plan B and ella to streamline workflows.
- ❏ Implement a telephone triage protocol for when a patient calls needing EC.
- ❏ Train staff members who first screen these calls, whether nurses or a central call center, to understand the importance and urgency of these calls.
- ❏ Prescribe EC with maximum allowance of refills to streamline access.

  *In **Massachusetts**, clinicians are encouraged to prescribe EC with 11 refills.*
- ❏ Offer all patients not using LARC or permanent contraception an advance prescription for EC to cover the costs of over-the-counter purchasing and to serve as a back-up if patients experience a gap or failure in use of their usual contraceptive method.

- ❏ Consider implementing same-day access to copper IUD as a form of EC for patients, especially for those with a BMI over 35 kg/m^2.
- ❏ Supply chains may continue to be disrupted for the foreseeable future; exploring other sources for providing EC should be considered.
- ❏ Stock EC in the office and/or in the hospital pharmacy to increase access.
- ❏ Advocate for the need to have EC stocked at local pharmacies to increase availability. If not stocked, local chain pharmacies can usually obtain stock of ella within 24 hours.

Should I be offering patients advance prescriptions of EC or only when they need it?

All patients not using a LARC method or permanent contraception should be offered an advance prescription for EC, to defray the costs of over-the-counter purchasing and to serve as a back-up if patients experience a gap or failure in use of their usual contraceptive method.

Is EC ever appropriate as a primary form of contraception?

EC may be appropriate as a primary contraceptive method for those patients not frequently having intercourse, which may be common with social distancing restrictions. EC can also be used as a bridge method until a patient can be seen in-person for a LARC insertion.

Where can I learn more about the differences between the three forms of EC and when to prescribe each?

See PICCK EC Toolkit and PICCK EC Information Sheet.

Postpartum Contraception:

Postpartum contraception provision prior to discharge after delivery is a best practice that should be promoted during routine care. Due to COVID-19 mitigation procedures, postpartum appointments are more likely to be delivered via telemedicine, which may delay patients' access to their preferred contraceptive method. Before discharging a patient, ensure patients who desire contraception leave the hospital with a method or a clear postpartum contraception plan.

A patient can ovulate as soon as 25 days after delivery if they are not exclusively breastfeeding, and 50% of postpartum patients have intercourse prior to their 6-week postpartum visit. Unplanned, rapid, repeat pregnancies increase the risk of adverse outcomes for both the patient and their baby; to reduce this risk, counsel patients on the full range of methods and put in place a contraceptive plan at the time of delivery.

Checklist: Postpartum Contraception

- ❏ Counsel all pregnant patients in the third trimester about their postpartum contraception options.
- ❏ Consider implementation of an immediate postpartum LARC program at your hospital as postpartum visits may remain virtual.
- ❏ Provide EC prescriptions for all postpartum patients who leave the hospital without LARC or permanent contraception.

When should I counsel about postpartum contraception?

The best time to talk about postpartum contraception is during prenatal visits in the third trimester, which allows for signing of consent forms for permanent contraception and inpatient IUD and implant insertions. For patients currently pregnant, counsel about when fertility returns postpartum and the benefits of birth spacing to both the patient and infant. (Resources: PICCK)

If a contraceptive plan was not established during prenatal care, counseling can occur on postpartum day one or two to provide or set a contraception plan prior to discharge. Counseling about LARC should be avoided during labor due to concerns about informed consent and possible coercion; patients should never sign consent forms while in labor. The inpatient stay after delivery may be the last opportunity to engage patients in person during the postpartum period, especially if postpartum visits are restricted or delayed. Providing materials on postpartum contraception for patients at discharge is recommended. (Resource: PICCK)

How should I counsel about postpartum contraception?

Patients may have different short-term (first 6 weeks postpartum) and long-term postpartum contraceptive needs; clinicians are encouraged to counsel for both time periods depending on the needs and desires of each patient. For example, if a patient wants to use EC in the first 6 weeks postpartum and then wants to switch to the patch, you can discuss and prescribe both methods to the patient with clear instructions for use during discharge. This approach is important because it will allow a patient to access the method they want before they need it and helps to prevent unwanted rapid repeat pregnancies.

What should I do if my patient does not want any postpartum contraception at discharge?

Offer EC as a good short-term contraceptive plan. If desired, provide advance provision of an EC prescription at the time of discharge with the maximum refills (11) and a prescription for condoms.

Plan B and ella are both safe to use postpartum. Plan B becomes less effective with BMIs greater than 26 kg/m^2, and ella becomes less effective with BMIs greater than 35 kg/m^2. Plan B does not affect breastfeeding; ella users should discard breast milk for 24 hours after use.

Remind patients that only condoms prevent STIs, and offering free condoms or a prescription for condoms can decrease out-of-pocket costs. Offering free condoms and/or prescribing condoms, in addition to EC, will provide patients with a way to rapidly access contraception if they do become sexually active before their postpartum visit.

My hospital does not currently offer postpartum LARC, but with delayed or virtual postpartum visits during COVID-19 I am interested in starting a program. What do I do?

IUDs can be placed at any time during a patient's postpartum hospital stay, either post-placental during a vaginal or c-section delivery or on postpartum day 1-4. The implant can be placed at any time after delivery prior to hospital discharge. Due to limitations on postpartum patients' ability and willingness to come back to the hospital during COVID-19, we encourage practices to consider starting provision of inpatient contraceptive implants, if they are not already doing so. If you have providers who are trained in placing inpatient postpartum IUDs, consider offering immediate postpartum IUDs as well.

Contact PICCK here for assistance implementing an immediate postpartum LARC program at your hospital in Massachusetts. Contact Upstream here for assistance in Washington, North Carolina, or Rhode Island.

I am experiencing resistance in establishing postpartum LARC services because of device reimbursement issues. What can I do?

> In **Massachusetts**, reimbursement for IUDs and implants is unbundled from the global delivery fee for patients insured by **MassHealth** and most commercial insurers.

Contact PICCK here to discuss postpartum LARC billing in Massachusetts. Contact Upstream here for assistance in Washington, North Carolina, or Rhode Island.

My hospital is continuing to conduct postpartum visits remotely during this next phase of COVID-19. How can I ensure the best postpartum contraceptive services for my patients during this time?

Many postpartum visits were converted to telemedicine during the pandemic. If your postpartum patients are still remaining home for their visits during this transition, consider conducting a remote 2-week postpartum visit. This visit allows for inquiry about immediate postpartum recovery, screening for depression for high-risk patients, and counseling about breastfeeding challenges.

At this time, you can also confirm that patients have a birth control plan in place, even if that plan is simply condoms and a prescription for emergency contraception. Counseling around

contraception at this visit may include plans for placement of a LARC device at a 6-week in-person visit. Even if the majority of postpartum patients continue to have telemedicine visits at 6 weeks, you may want to consider patients who need an IUD or implant placed as essential in-office visits. (Resource: PICCK)

Additional contraception method resources can be found in Appendix 3.

Looking Forward

The COVID-19 outbreak has placed unprecedented strain on the healthcare system and altered how healthcare facilities deliver care to patients. As the public health crisis continues, hospitals and health centers must remain flexible and agile to the evolving needs of the outbreak. In doing so, we hope you use this opportunity to incorporate lasting protocols that promote continuity of contraceptive care throughout the crisis and beyond.

Many of the recommendations in this toolkit are applicable to normal clinic operations and may even expedite the identification of contraceptive needs and delivery of care. Contraceptive counseling via telemedicine, same-visit access to methods, universal screening for pregnancy intention and contraceptive needs, emergency contraception triage, and postpartum contraception provision are examples of procedures that not only fill gaps in care during COVID-19 but are also good practices for contraceptive care under normal circumstances.

PICCK and Upstream USA are here to support you throughout this time.

About PICCK and Upstream

Partners in Contraceptive Choice and Knowledge (PICCK) is a five-year program funded by the Executive Office of Health and Human Services, Commonwealth of Massachusetts and housed at Boston Medical Center/Boston University School of Medicine. PICCK's mission is to promote excellence and equity in contraceptive care through provider education and practice transformation.

PICCK partners with hospitals and their affiliated practices and health centers to provide customized programming as well as long-term technical assistance to onsite Champions. PICCK offers statewide and national programming that is free and available to everyone, including a monthly webinar series for CME credit, an Annual Meeting for CME/CNE credit, a media inclusivity consultation service, a biannual newsletter, and a website where all of our materials are accessible.

For more information: visit www.PICCK.org or contact PICCK here. If you would like to receive resources like this directly to your inbox, please subscribe to our mailing list here.

Upstream USA is a fast-growing, national nonprofit working to expand opportunity by reducing unplanned pregnancy across the U.S. Upstream partners with states to provide training and technical assistance to health centers, increasing equitable access to the full range of contraceptive options. Our transformative approach empowers patients to decide when and if they want to become pregnant, a critical step towards improving outcomes for parents and children.

Upstream works directly with community health centers, primary care networks, family planning agencies, and private practice groups in MA, NC, RI, and WA. A dedicated Upstream quality improvement (QI) team will work with each agency partner to conduct a baseline needs assessment, facilitate contraceptive care training, and advise on system-level administrative changes.

For more information: visit www.upstream.org or contact Upstream here. If you would like to receive resources like this directly to your inbox, please subscribe to our mailing list here.

Appendices

Appendix 1: Clinical Prioritization of Sexual and Reproductive Health in COVID-19 Recovery

- These recommendations offer a framework for decision-making, but clinical judgment should always be used as they may not apply to all individual patient considerations.
- **Considerations for shared decision-making include but are not limited to**: likelihood of delay resulting in harm to a patient; your facility's capacity for infection prevention and separation of symptomatic patients; patients' self-assessed risk, preferences and socio-cultural-economic factors.

Level of community transmission of COVID-19	**Substantial** *Large scale community transmission, including communal settings (e.g. schools, workplaces)*	**Moderate**[1] *Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases*	**Minimal - None**[1] *Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting*
Clinically urgent visits Including: acute pelvic pain, bleeding, suspected ectopic pregnancy, signs of PID or complicated UTI	**In-person, same day (or ASAP)**	**In-person, same day (or ASAP)**	**In-person, same day (or ASAP)**
IUD/Implant removal, placement or replacement	**Initial telemedicine visit** Use shared decision-making to weigh risks and benefits, offer bridge methods, discuss extended use and prioritize removals if the patient desires	**Initial telemedicine visit** Use shared decision-making to weigh risks and benefits, offer bridge methods, discuss extended use and prioritize removals if the patient desires	**In-person, same day (or ASAP)**
DMPA	**Initial telemedicine visit** Use shared decision-making to weigh risks and benefits, offer bridge methods or self-administration, and offer an injection visit if the patient desires If patient desires, offer onsite or virtual training DMPA-SQ self injection	**Initial telemedicine visit** Use shared decision-making to weigh risks and benefits, offer bridge methods or self-administration, and offer an injection visit if the patient desires If patient desires, offer onsite or virtual training DMPA-SQ self injection	**In-person visit** Begin to schedule routine **in-person** injections or continue to offer self-injection per patient preference

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Community Transmission	Substantial	Moderate	Minimal - None
Emergency contraception	**Telemedicine visit for counseling** Use shared decision-making to weigh risks and benefits of oral method vs. in-person visit for copper IUD (e.g. efficacy, BMI >35). Give advance supply and refills for oral methods	**Telemedicine visit for counseling** Use shared decision-making to weigh risks and benefits of oral method vs. in-person visit for copper IUD (e.g. efficacy,BMI >35). Give advance supply and refills for oral methods	**In-person visit** If possible continue to offer **telemedicine** option as routine **in-person** care resumes[2]
Pill, patch, ring	**Telemedicine visit** Counsel on Quick Start, shared decision-making for deferral of blood pressure screening for estrogen containing methods, prescribe maximum refills as per state regulations	**Telemedicine visit** Counsel on Quick Start, shared decision-making for option of in-person visit for higher risk patients (e.g. blood pressure screening for estrogen containing methods, confidentiality concerns for telemedicine visit), prescribe maximum refills as per state regulations	**In-person visit** Continue to offer **telemedicine** option as routine **in-person** care resumes[2]
SRH services Including: STI testing & treatment, pregnancy testing, vaginal discharge, and uncomplicated UTI	**Initial telemedicine visit for counseling** *Suspected STI*: See CDC guidelines for preferred and alternative treatment during disruption of care. Consider pharmacist dispensing of injections based on state policies. Counsel on dual protection. *Uncomplicated UTI and vaginal discharge*: Treat empirically, in-person visit for treatment failure or worsening symptoms (source: FPNTC) *Pregnancy testing & diagnosis:* Home pregnancy test acceptable If available, offer option of lab-only visit for blood draw or self-collected sample drop-off (e.g. vaginal swab, urine)	**Initial telemedicine visit for counseling** *Suspected STI*: See CDC guidelines for preferred and alternative treatment during disruption of care. Consider pharmacist dispensing of injections based on state policies. Counsel on dual protection. *Uncomplicated UTI and vaginal discharge*: Treat empirically, in-person visit for treatment failure or worsening symptoms (source: FPNTC) *Pregnancy testing & diagnosis:* Home pregnancy test acceptable If available, offer option of lab-only visit for blood draw or self-collected sample drop-off (e.g. vaginal swab, urine)	**In-person visit** Continue to offer **telemedicine** option as routine **in-person** care resumes[2] Begin to resume routine STI screening, counsel on dual protection

Community Transmission	Substantial	Moderate	Minimal - None
Breast and cervical cancer prevention	**Postpone routine screening** Telemedicine visit with shared decision making for in-person follow up of clinically urgent issues (e.g. suspected invasive cervical cancer or new breast lump found)	**Initial telemedicine visit for counseling** *Cervical cancer*: Shared decision-making for timing of in-person evaluation or follow-up Prioritization considerations as per ASCCP interim guidelines for timing and treatment for patients with abnormal screening tests *Breast cancer:* Shared decision-making of mammogram or screening for patients at high risk of breast cancer	**In-person visit** Conduct in-person visit to clear backlog of follow up for previous abnormal cervical cytology or HPV results Follow-up of abnormal cervical cancer screening as per 2019 ASCCP risk-based management guidelines Begin to resume routine screening for breast and cervical cancer
Well visits	**Postpone**	**Postpone**	Begin rescheduling **in-person** visits for after public health emergency
1. Though different metrics are used, prioritizations in CDC moderate transmission (orange) primarily aligns with Massachusetts reopening Phase: 1 and Minimal to No transmission with Phases: 2 & 3 (Source: MA EOHSS) 2. Continued availability of telemedicine may depend on billing parity (See Appendix 3 for more information) **Sources**: CDC; FPNTC; ASCCP; CDC; UCSF; ACOG.			

Sample local prioritization template:

Facility Name:		**Week of:**	
COVID-19 Status: Community transmission level: [Substantial, Moderate, Minimal] Changes to testing/screening flow:		**Facility Capacity:** # providers (location/days/visit types) # support staff	
Clinical Prioritization:			
Postpone	Telehealth Visit	Offer in-person	In-person: Same day/ASAP

Appendix 2: Risk Reduction and PPE Framework for Sexual and Reproductive Health

It is important to understand why some patient encounters and procedures represent a higher risk of exposure and require a higher level of PPE than others. Understanding the framework that has guided the recommendations can help you discern ways to reduce your exposure risk and determine the appropriate PPE for a patient encounter that has not yet been clearly addressed.

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	Aerosol activity	Singing, loud speaking	Limited speaking
P	Protection	No hand washing, mask, PPE or cough etiquette	Consistent use
P	Prevalence	HR groups; C-19 symptoms	Asymptomatic isolated people

Source: Presentation by Dr. M. Policar, 6th International Symposium on IUDs Live Stream Event, May 2020.

Pre-screening for COVID-19 symptoms:

- All patients scheduled for in-person visits for SRH services should be pre-screened for symptoms of COVID-19 and exposure risk (e.g. close contact with a known positive case) at time of scheduling and again upon arrival.
    - If a patient develops symptoms prior to their scheduled visit, refer to local testing protocols and delay visit until results are available.
    - If a patient reports concerning symptoms at the time of visit, the patient should not be seen for non-emergent care.
    - In these situations, offer a bridge method via telehealth, if possible, until the patient is well and/or meets CDC criteria for discontinuation of self isolation.
- Patients should also be advised of local policies and procedures and required to wear a mask or cloth face covering during the visit.
- All healthcare personnel should be monitored for symptoms as per institutional and CDC guidelines.

- For patients with **confirmed or suspected COVID-19** it is advised to limit non-emergent visits but have systems or referral pathways in place to address urgent issues. Possible visit types include severe pelvic pain, heavy vaginal bleeding, and a high level of concern for ectopic pregnancy.
    - As per SFP recommendations these visits should occur in an emergency department, specially designated triage clinic, or routine outpatient clinic **if appropriate PPE and recommended cleaning/decontamination is available.**

Exposure risk reduction and PPE recommendations for selected SRH encounters:

- *These guidelines offer a framework for decision-making, but local infection rates, facility capacity, supply levels, and clinical judgment should always be used as they may not apply to all individual patient considerations.*
- *Unless otherwise noted, the below recommendations apply to patients who are asymptomatic by pre-screening but are in areas of substantial or moderate community transmission where risk of asymptomatic spread remains high.*

Transmission risk	**Aerosol risk: Patient contact with higher aerosol risk**	**Droplet risk: Patient contact with lower aerosol risk**	**Limited patient contact**
Encounter type examples	● Procedure where intubation is possible ● 2nd trimester abortion ● GC pharyngeal swab	● IUD or implant insertion / removal ● Gyn procedures: colposcopy, LEEP, biopsy, 1st trimester abortion ● Close contact in exam room: contraceptive or STI counseling ● High contact care activities: dressing, preparing patient for transport	● Curbside pick-up / drop-off ● Transport of asymptomatic patient

Recommendations for reducing transmission risk			
	Aerosol risk	**Droplet risk:**	**Limited contact**
Proximity	Few staff in room; maintain distance when possible, consider physical orientation away from main aerosol when distancing not possible	Few staff in room*; maintain distance **Continue to offer chaperone for gyn procedures*	• Place items or collection bin on table and walk away, then have patient pick-up / drop-off • Walk items to patient's car and place on hood
Enclosure	Use largest room or procedure room available	Use largest exam room	Set up curbside station in open area with good ventilation
Time of exposure	Minimize time of aerosolizing procedure whenever possible	• Minimize time patient is in exam room • Perform counseling and consent via telehealth if possible, confirm during in-person visit	Minimize time in contact
Aerosol activity	Limit all non-essential aerosol risk (e.g. limit loud talking of staff)	Limit loud talking, provide pain control	Limit loud talking
Protection	**Patient:** Surgical mask (if not intubated) Consider use of surgical drapes as an additional barrier to limit exposure (e.g. during second stage of labor)	**Patient:** Surgical mask, if not available use cloth mask. Consider use of surgical drapes as an additional barrier to limit exposure	**Patient:** Surgical or cloth mask if possible or remain in car until distanced if no mask
	Healthcare worker: • N95 respirator • Face shield or goggles • Gown • Gloves* **Consider double gloves for aerosolizing procedures if patient is COVID+*	**Healthcare worker:** • Surgical mask* • Face shield or goggles • +/- Gown (if blood or body fluid exposure) • Gloves **If the patient is COVID+ use N95 respirator*	**Healthcare worker:** • Surgical mask • Gloves (changed between each encounter)

Sources: CDC, FPNTC, Protocol at Boston Medical Center

Cleaning between patients:

Cleaning high-touch surfaces is an important way to minimize the spread of COVID-19. In order to reduce the number of people exposed, and to conserve PPE, it is recommended that nursing staff be assigned cleaning and disinfection of high-touch surfaces in patient areas. Nurses who will already be in the patient room should be assigned disinfecting the high-touch surfaces in that room. Allow time for disinfectant to dry before the next patient is roomed.

In the hospital, environmental services may be called to clean a COVID+ patient room before it is assigned to a new patient. In this scenario, environmental services staff should wear a face mask, face shield or goggles, gown, and gloves for PPE. The CDC provides a chart to determine the amount of time that a room should be unoccupied before terminal cleaning following discharge of COVID+ patients. In the outpatient setting, for lower risk encounters (e.g. no coughing or sneezing, no aerosol-generating procedure, short period of time in room), any risk to HCP and subsequent patients likely dissipates over a matter of minutes.

Considerations for distribution and conservation of PPE:

PPE is both an essential and limited resource at this time. It is important to be mindful and equitable in thinking through your facility's tracking and distribution of PPE and essential disinfectant supplies. Some key considerations are:

- Store PPE and supplies in a **secure location and keep detailed records** of usage
- Ensure health care workers are **trained on best practices** for using PPE and **post clear signage and job aids** in visible areas such as outside of patient rooms.
- Review CDC Strategies to Optimize Supply of PPE and Equipment for specific recommendations including usage calculators and **prioritization for when supply** levels are at Conventional, Conditional, or Crisis capacity
- Include **clinical and support staff** such as front desk, environmental services, and transport staff as well as a limited supply for **patients** who may need a mask for source control in your calculations
- Ensure that PPE and essential **supply levels are factored into the decision to expand or re-limit services** at your facility

PPE supply conservation may be a concern for your facility now, or in the event of a surge in COVID-19 cases. To conserve PPE supplies, particularly N95 respirators, the National Institute for Occupational Safety and Health suggests implementing extended use and/or limited reuse of N95 respirators. Additionally, N95 respirators can be conserved for healthcare workers that are at the highest risk of contracting COVID-19, or that are most likely to experience complications from contracting COVID-19.

Extended use of N95 respirators

- Use the same N95 respirator continually for repeated close contact encounters
- Do not remove the respirator until all close contact encounters have been completed

Limited reuse of N95 respirators

- Doff the N95 respirator after each encounter
- Store the respirator between encounters
- Don the same N95 respirator before the next patient encounter

Appendix 3: Additional Resources

Admin Checklist Resources

Family Planning and SRH Resources:

- Society of FP: Interim Clinical Recommendations for COVID-19 Response
- FPNTC: Prioritization of In-Person and Virtual Visits During COVID-19 Guide
- ASCCP: COVID-19 Resource List
- ACOG: COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics
- Upstream: Guide to Creating a Contraceptive Access Policy
- NARAL: The Contraceptive ACCESS Law

For Massachusetts Providers:

- PICCK and Upstream: Health Safety Net & MassHealth: COVID-19 Telehealth Guidelines & Contraceptive Services
- PICCK and Upstream: Coverage of DEPO-subQ Provera in MA
- MassHealth: Coronavirus Disease 2019 (COVID-19)— Guidance for all providers
- Massachusetts Medical Society: COVID-19 Billing Guidelines for Telehealth Service
- PICCK: Guidance on LARC Billing Webinar
- Health Care for all MA (HCFAMA): Protecting Access to Confidential Health Care (PATCH) Act Resources

General Reopening Resources:

- AMA: COVID-19 Physician Practice Guide to Reopening
- CDC: Infection Control Guidance for Healthcare Professionals about Coronavirus
- CDC: COVID-19 Reopen Guidance
- American Academy of Family Physicians (AAFP): Checklist for Reopening
- Centers for Medicare & Medicaid Services (CMS): Reopening Facilities Recommendations
- ASHE: COVID-19 Recovery Guidance

Telehealth Resources

- ACOG: Implementing Telehealth in Practice
- AMA: Telehealth Implementation Playbook
- Upstream: Guidance on Telehealth and Contraceptive Care
- PICCK: Telemedicine Best Practices and Considerations
- Adolescent Health Initiative: Adolescent Health Virtual Care References & Resources
- Reproductive Health Access Project: Contraceptive Pearl: Contraception During COVID-19: E-Visit Contraceptive Template
- AMA: Guidance on Technology and Cyber Security for Remote Staff
- US Dept. of HHS: Summary of the HIPAA Security Rule
- US Dept of HHS: HIPAA and COVID-19 Bulletin
- California Telehealth Resource Center: Sample Telemedicine Consent Form English
- California Telehealth Resource Center: Sample Telemedicine Consent Form Spanish
- FPNTC: Social Media Toolkit
- National Family Planning and Reproductive Health Association (NFPRHA): Initiating Telehealth in Response to COVID-19

Contraceptive Counseling and Methods Resources

Screening and Counseling Resources

- Upstream: Contraceptive Counseling with Adolescents: Tips for Screening
- Upstream: Phone Script to Support Contraceptive Access during COVID-19
- PICCK: Shared Decision-Making Counseling and Video
- PICCK: Sample Telephone Triage Protocol for EC
- PICCK: Pregnancy Intention and Contraceptive Needs Interventions for Clinics Toolkit

Methods Resources

- Reproductive Health Access Project: Quick Start Algorithm for Hormonal Contraception
- PICCK: Extended Use of LARC Guide
- PICCK & Upstream: Guideline for DEPO-subQ PROVERA 104 Self-Injection
- PICCK: Bridge Methods of Contraception
- Society of FP: Interim Clinical Recommendations for COVID-19 Response

Emergency Contraception Resources

- PICCK: Emergency Contraception Toolkit
- PICCK: Emergency Contraception Information Sheet
- PICCK: Phone Room Guidance for Emergency Contraception
- PICCK: Sample Telephone Triage Protocol for Emergency Contraception

Postpartum Contraception Resources

- PICCK: Providing Postpartum Contraception During COVID-19
- PICCK: Collection of Postpartum Resources

Patient Access Resources

- Upstream: Online Services that Deliver Birth Control
- PICCK: Birth Control Methods You Can Get Without An In-Person Visit
- Upstream: List of Patient Education Materials
- PICCK: Patient Education and Resources Toolkit
- PICCK: Collection of Patient-Facing Resources
- PICCK: Contraception Bill of Rights