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

May 26, 2020

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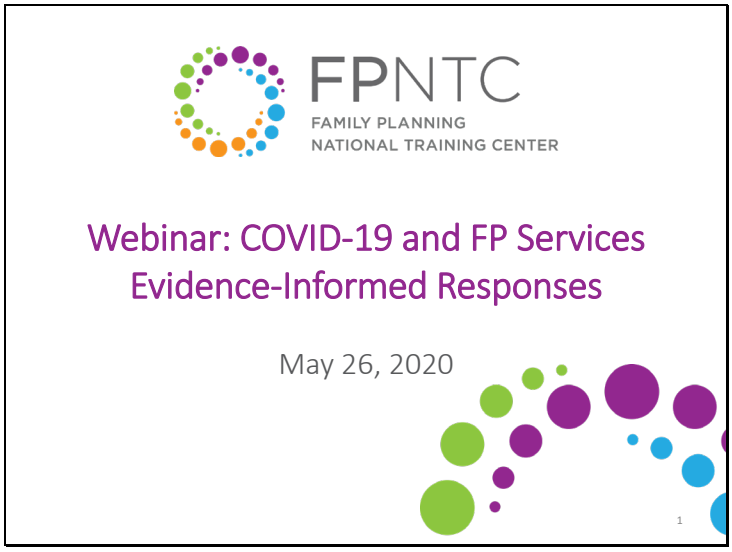

Katie Quimby: Hello, everyone. This is Katie Quimby from the Title X Family Planning National Training Center. I'm so pleased to welcome you all to today's webinar. Today, we will discuss evidence-informed responses to frequently asked questions about COVID-19 and family planning services. I have a few 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.

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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.

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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

FPNTC 3

So, our learning objectives are before you.

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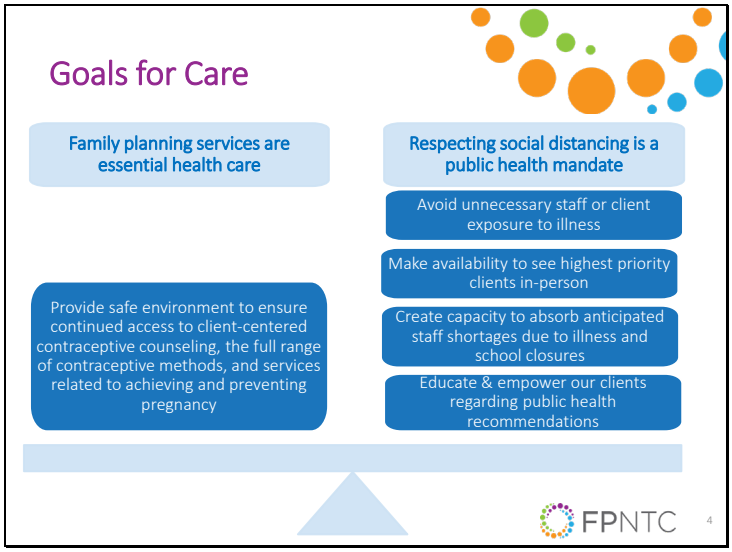

And these start by saying that the whole idea of crafting these areas responses to the public health emergency basically has to do with balancing two goals. On one side is the fact that we want to continue to deliver high quality family planning services, which the Office Population Affairs, all of us 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.

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FAMILY PLANNING
NATIONAL TRAINING CENTER
How can family planning providers use telemedicine to continue to meet client's family planning needs?
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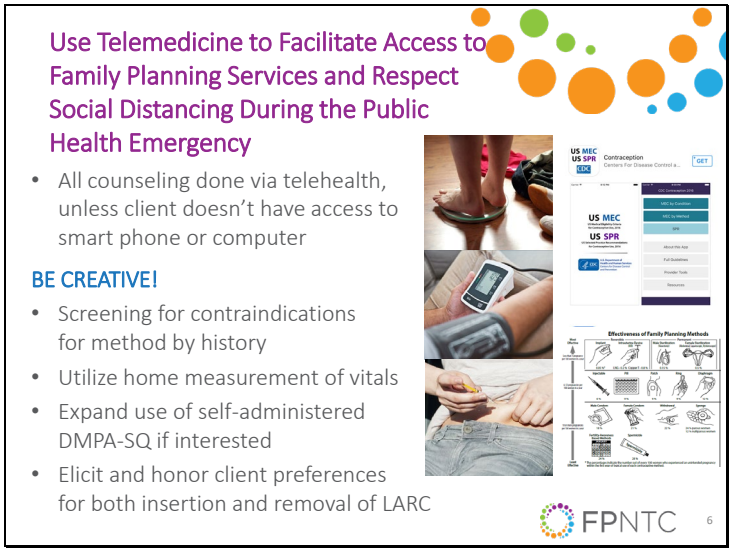

So, as I mentioned a moment ago, we're going to start with just a quick review about telemedicine and the way that it's been used in family planning. I can summarize that by saying that the large majority of what we do in family planning, particularly the counseling and shared decision-making can be 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.

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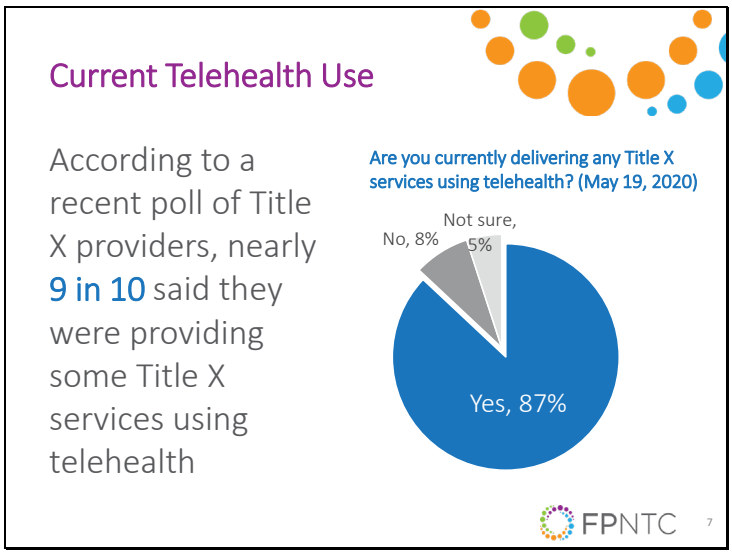

Most of us have shifted over to using telehealth. In fact, in a survey that was done on Title X providers just a few weeks ago, almost 90% of Title X providers are using some amount of telehealth services or providing all of their services by telehealth. Fewer of than 10% were not doing telehealth at 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.

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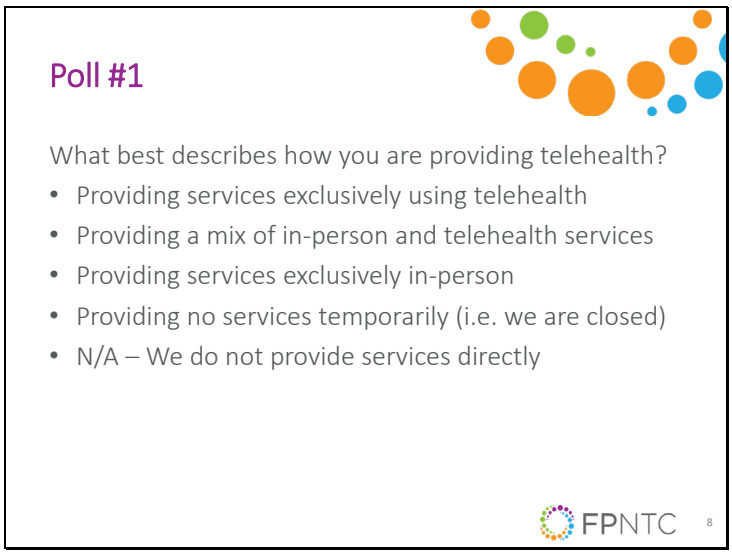

So now, what we're going to do is our first poll and we can really use this information going forward to find out more about whether or not you're providing telehealth services. So, what best describes how you're providing telehealth services in your clinic? You can see that there are five different 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.

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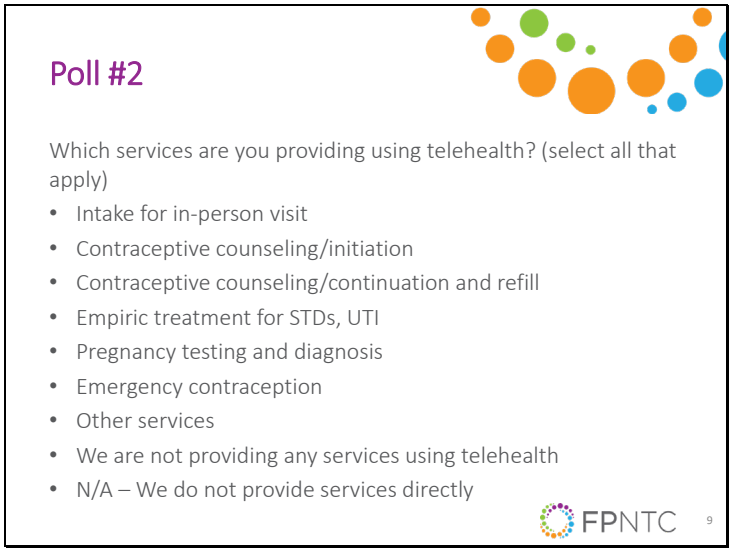

Now, the next is which services are you providing using telehealth? Again, have a look at the lists and check all of the things that apply in your clinical setting in terms of the things that you are currently doing by telehealth. Okay, there we go. Wow. Quite a variety of responses there, although we 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.

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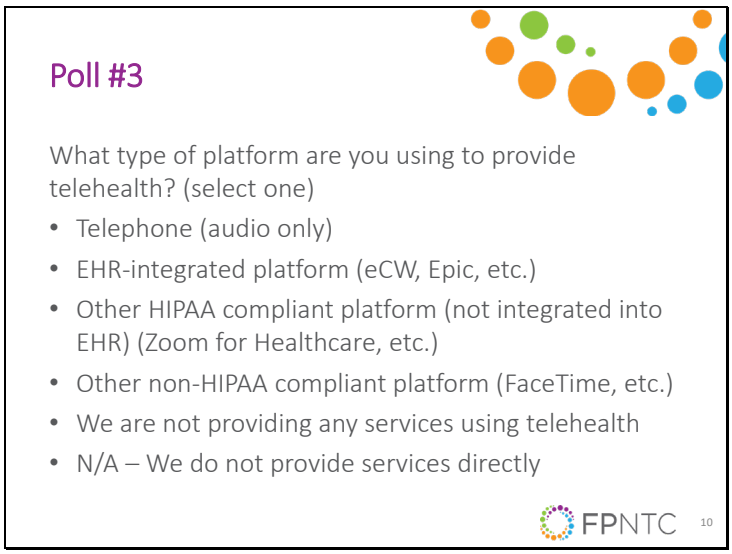

Then we have one additional question that we're curious about before I give you a little bit more of the options about the services that are available by telehealth, and that is asking you which type of platform do you use to provide telehealth services, just the telephone only? Are you using platform 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.

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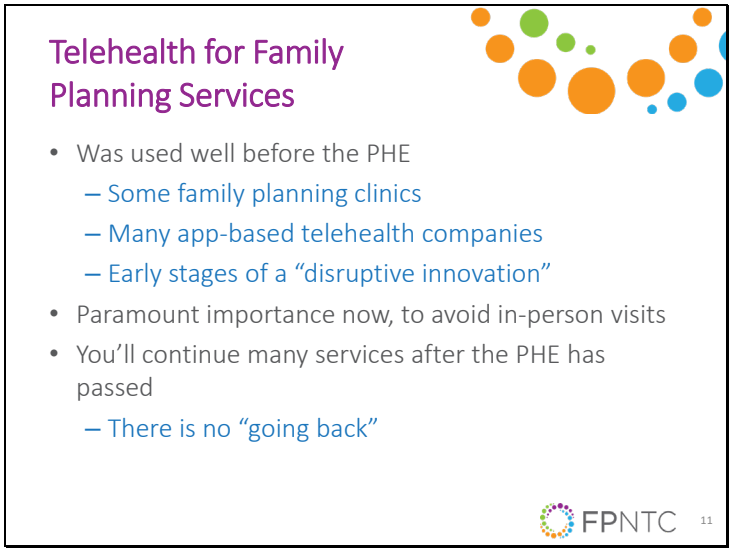

Okay. So, to try to summarize this issue about telehealth for family planning services. We all know about the fact that this approach was used well before the onset of the public health emergency. Some family planning clinics have made telehealth services available really for years. A number of the Planned 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.

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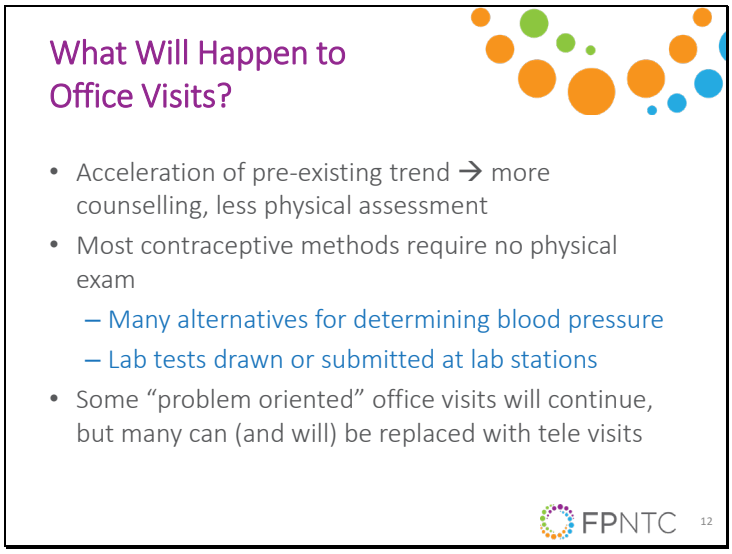

What will happen to office visits to the face-to-face that we've historically done? well, again, this is simply accelerating a preexisting trend, where we were spending more and more time counseling and less time in physical assessment. Of course, the counseling is something that we can do with a telehealth. 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.

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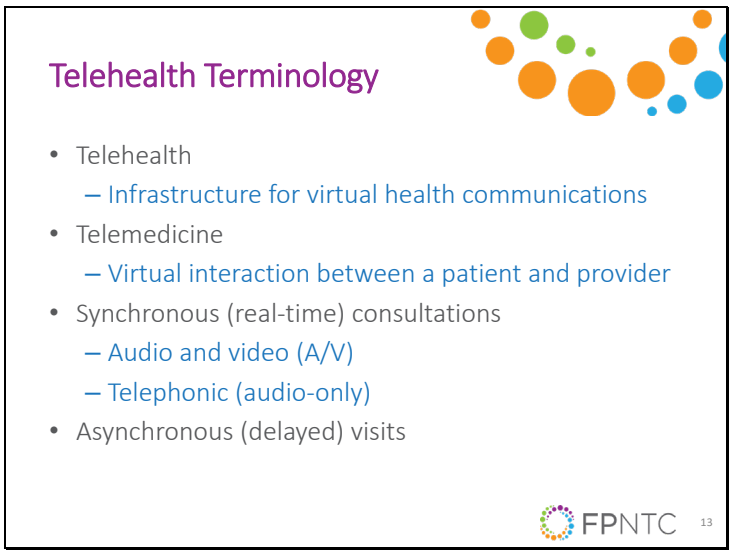

Now, as I talk a little bit more about telehealth, what I want to do is to be very clear about the terminology that I'm using. So, telehealth is a term that's used to define the whole infrastructure for virtual health communications, not only between clients and clinicians, but for a whole variety of 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.

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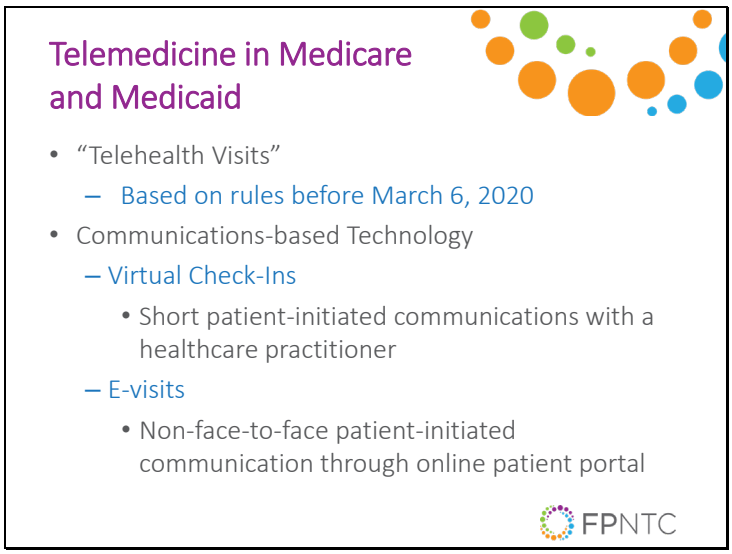

The other is called an asynchronous visit, where information is uploaded to the provider and the provider looks at it in a way which is time delayed. So, that might be a photograph or a question coming from a patient. It's not evaluated real-time by the clinician, but there is some delay and then an 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.

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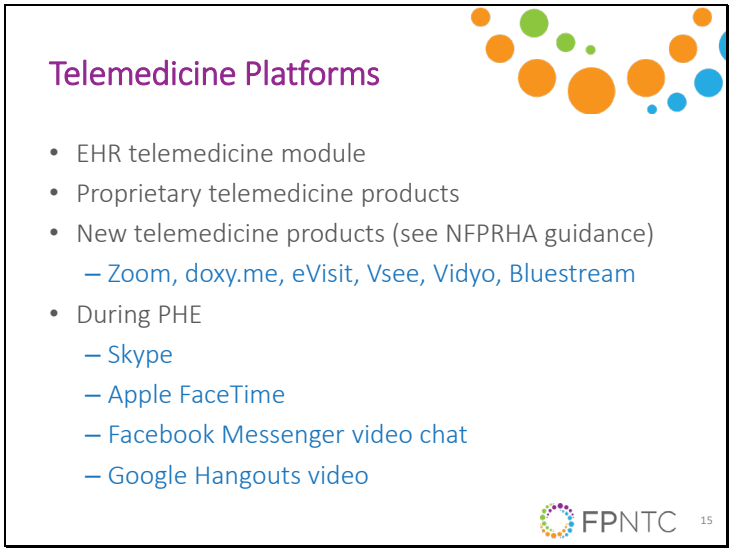

Now, I also want to refer back to the question which we asked a few minutes ago and that is, how do you communicate with your clients using a telemedicine platform? Well, many of you use electronic health records that actually have a telemedicine module. So, Epic, eClinicalWorks, some of the others that 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.

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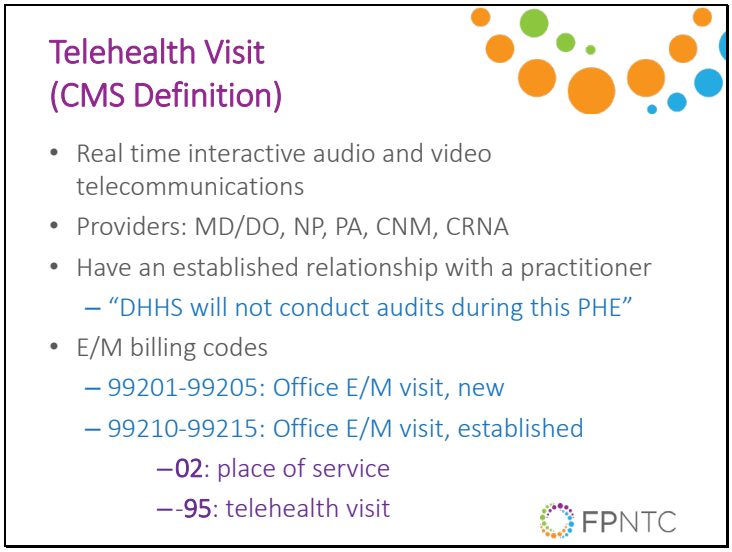

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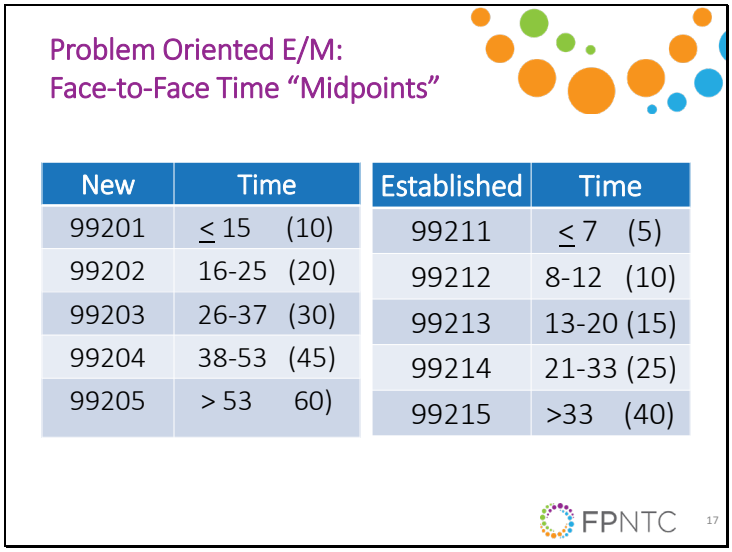

I've included for you just a quick reminder of the fact that when the level of the E/M visit is calculated, because these are telehealth visits, there's no physical assessment involved. It's all based on time. So, your clinician should be sure to include in her note how much time was spent on the phone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

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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.

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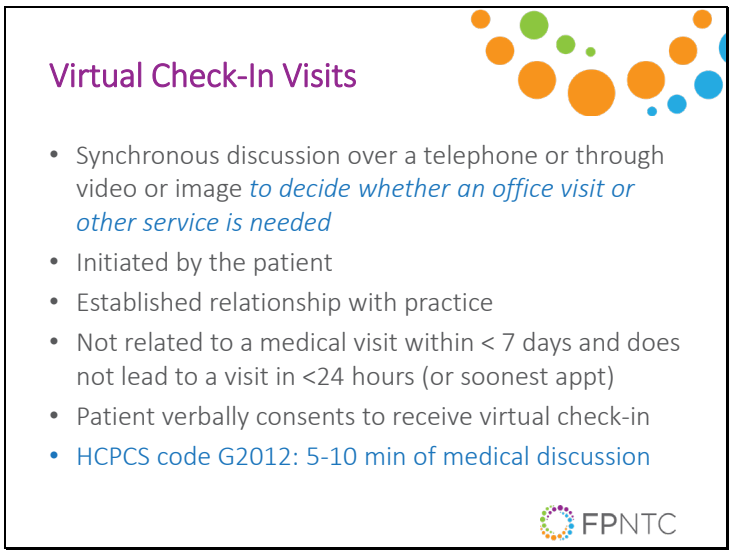

Now, one of the things that most Medicaid programs as well as Medicare or some state family planning programs have added is something called a virtual check-in visit. So, that is a discussion with the client over the telephone. It could be through an AV, like more commonly happens in a telephone conversation, 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.

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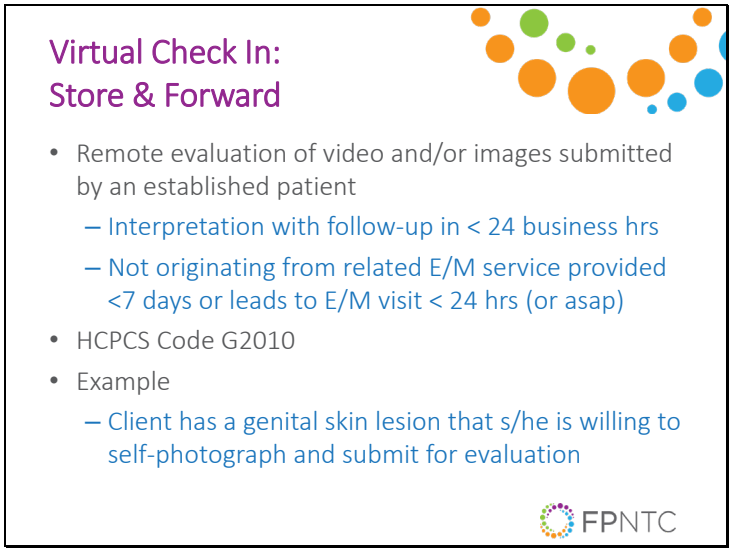

Now, there's a second type of virtual check-in visit, which is called store and forward. This is basically CMS accepting the idea of teledermatology, person taking a picture of a skin lesion, sending that to a clinician who then interprets it within 24 hours, and then gets back to the patient with their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

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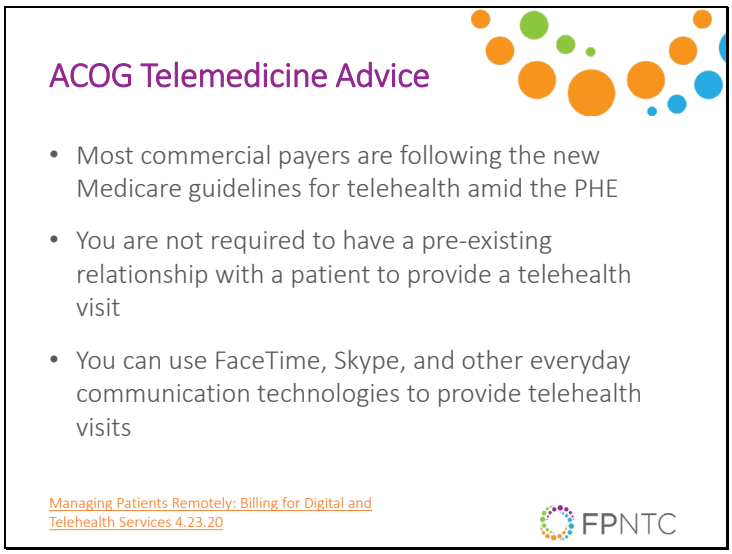

Now, there is lots of other advice out there about how to both perform and bill for telemedicine visits. The American College of Obstetricians and Gynecologists on their website has quite a bit of helpful information about billing for telemedicine services. When you get the slide set, you can click on 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.

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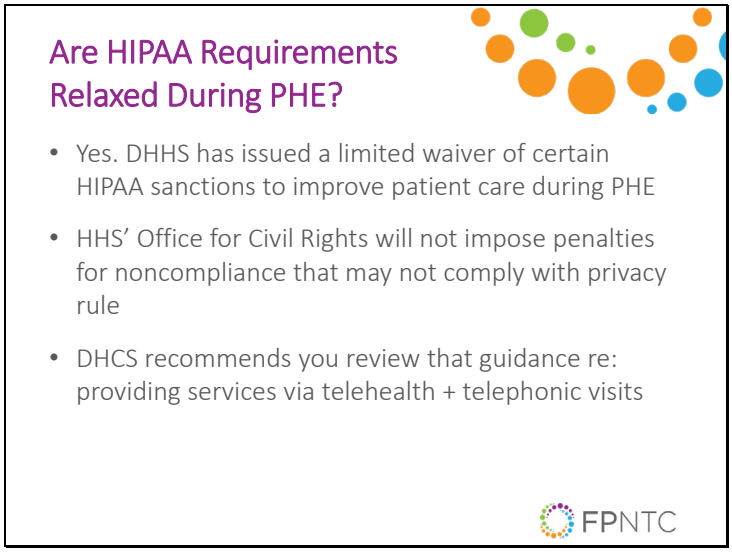

Another question that comes up is, are HIPAA confidentiality requirements relaxed during the public health emergency? And the answer to that is yes. The Department of Health and Human Services has issued a limited waiver, such that HIPAA sanctions will not be leveled as long as we are providing telehealth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

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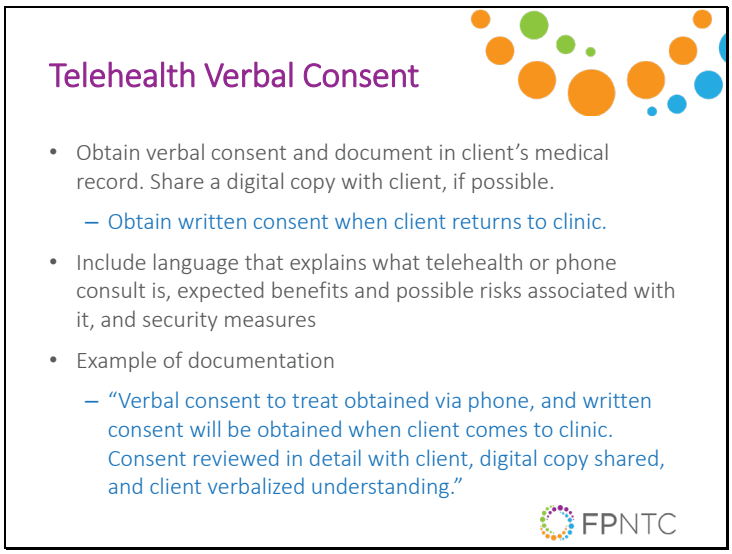
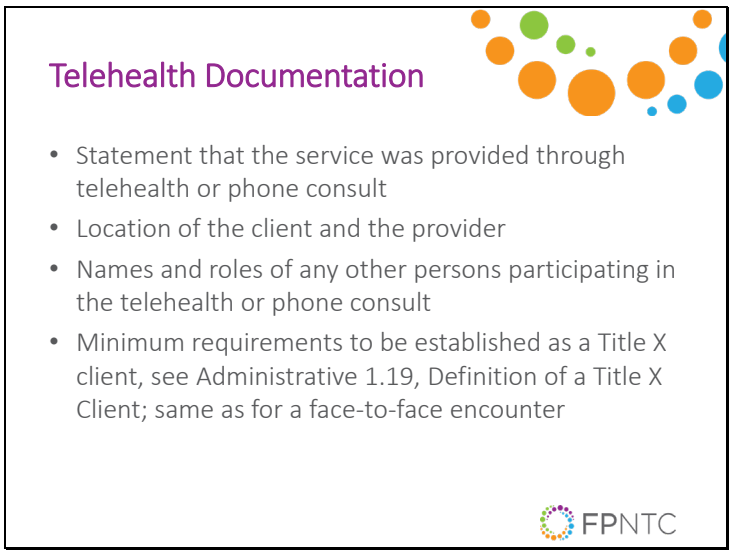


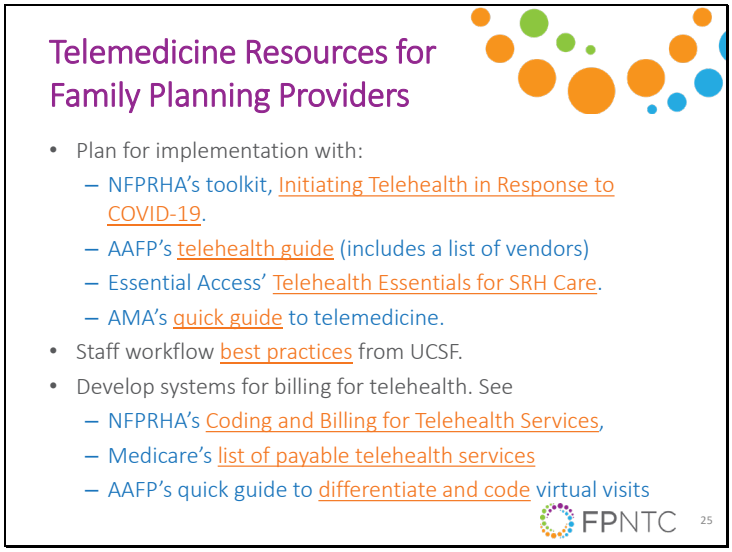
How about consenting to telehealth visit? CMS says that this does need to be done. So, you should obtain verbal consent and document that in the client's medical record and share a digital copy with her if that's at all possible. And in fact, the recommendation is, is that even though she doesn't have 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.

Slide 24



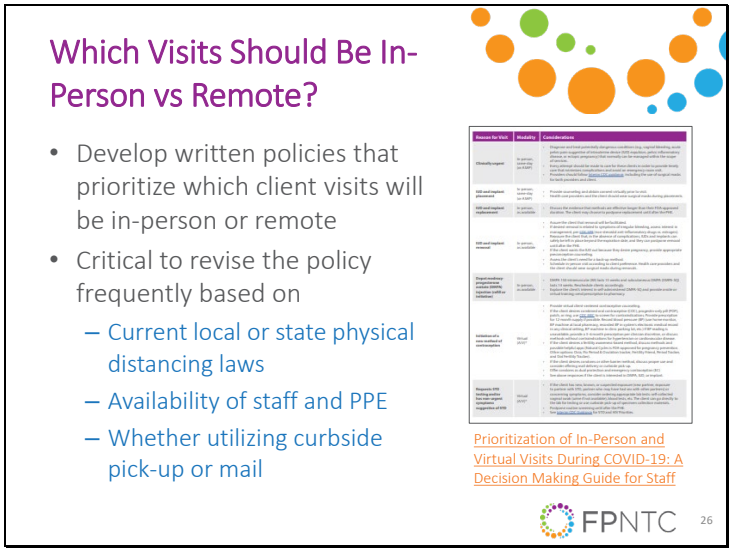
And then the next thing to mention briefly is what about the way the telehealth visits need to be documented? Again, these are all part of CMS regulations that would apply in the Title X program. A statement that the service was provided through telehealth or phone consult visit should be part of the 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.

Slide 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.

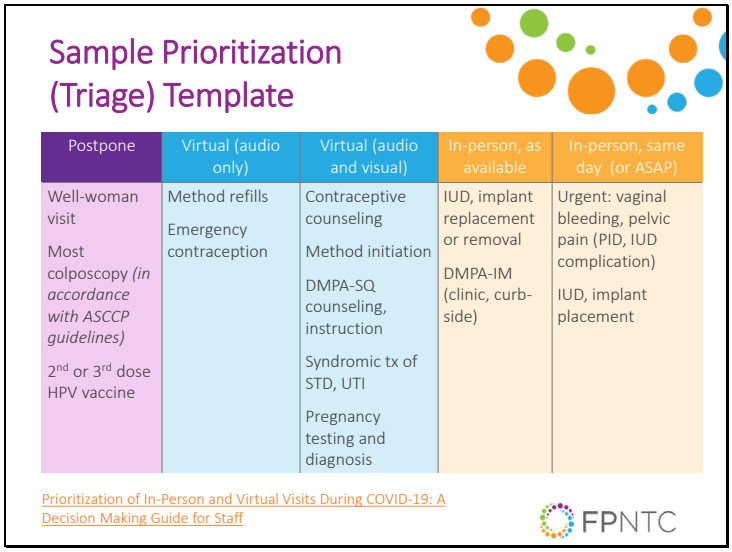
Slide 26



Now, the next question that comes up is how do you decide at your clinic which is it should be done in-person as opposed to which one should be done remotely. Again, the underlying concept being that we want to do as many of these remotely as possible. Well, what this slide intends to remind you about is that you should have written policies in your clinic that prioritize which clinic visits are going to be done immediately in-person, can be delayed that's still done in-person, as opposed to those that are going to be done remotely. But it's critical to revise that policy that you have in clinic based on what your current local or state physical distancing laws are. Number two, the availability of staff members to see patients face-to-face, as well as the personal protective equipment that you have available. And you also have to factor in whether you are offering curbside pickup for mail of test samples or contraceptive supplies.

Prioritization of In-Person and Virtual Visits During COVID-19: A Decision Making Guide for Staff
https://www.fpntc.org/resources/prioritization-person-and-virtual-visits-during-covid-19-decision-making-guide-staff

Slide 27



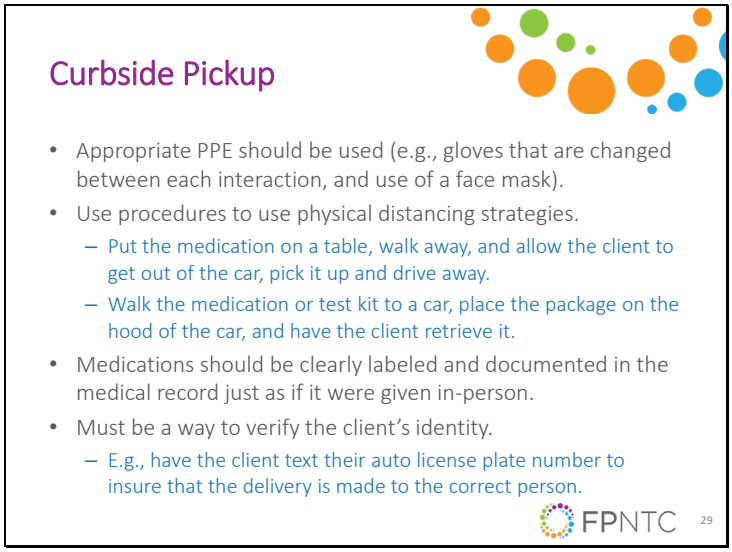
So, on the FPNTC website, you'll actually see a whole section that has to do with how you might go about prioritizing or also, we can call this triaging, of patients to either postponing their visits, having virtual remote visits or seeing them in-person. And again, I want to emphasize that this is considered 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

Slide 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.

Slide 29



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.

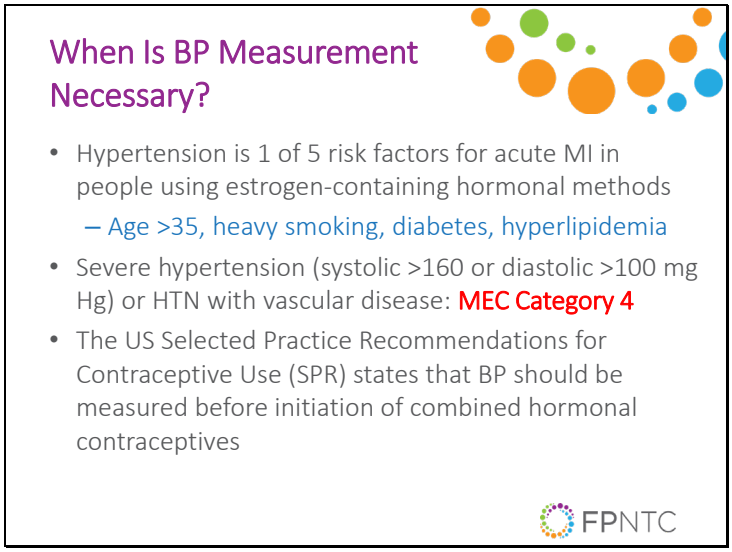
Slide 30

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.

Slide 31


FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER
How can family planning providers obtain blood pressure (BP) when the provider is offsite?
31

Slide 32



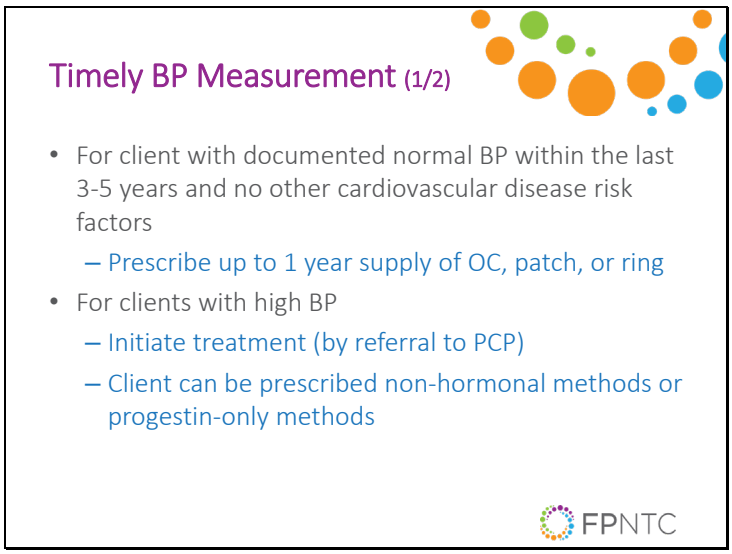
And what we're going to do in our last section is to switch over to some more clinical issues that we talked about in the Q&A on the FPNTC website. So, one of the most common questions we got is how can family planning providers obtain a blood pressure measurement when the patient is outside? In other 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

Slide 33

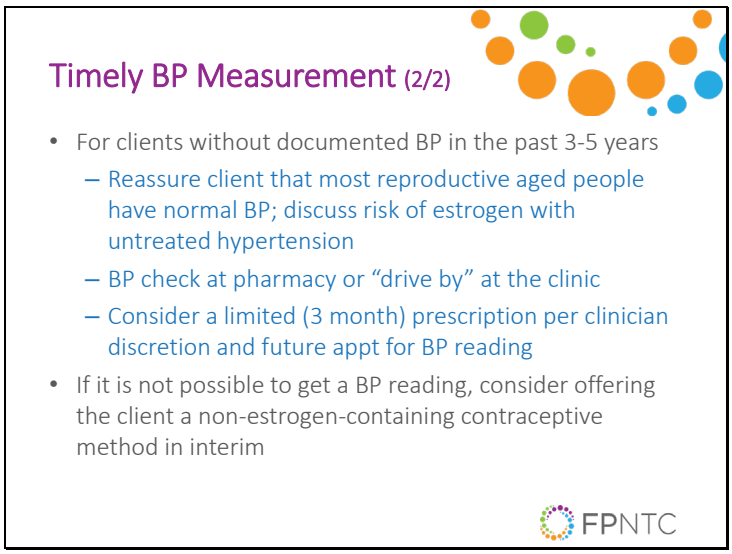


So, for clients who's had a documented normal blood pressure within the last three to five years and no cardiovascular risk factors, it would be reasonable to prescribe for her up to a one-year supply of pill, patch or ring. Now, those timeframes are not arbitrary because the hypertension guidelines 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.

Slide 34



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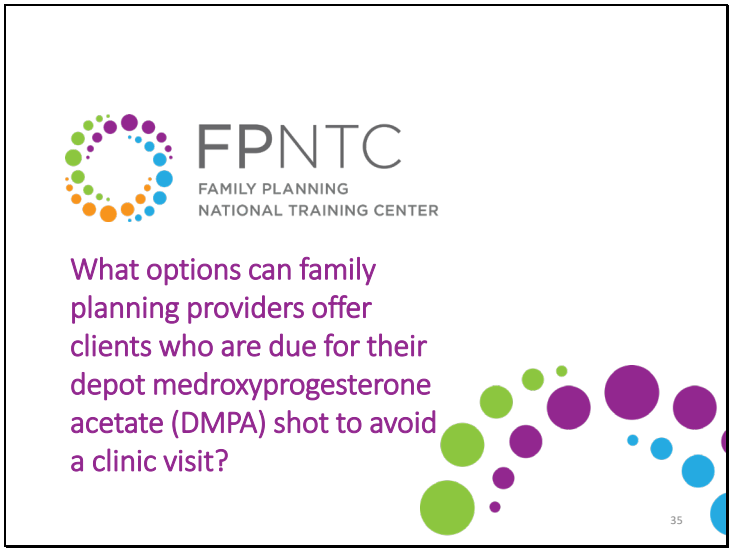
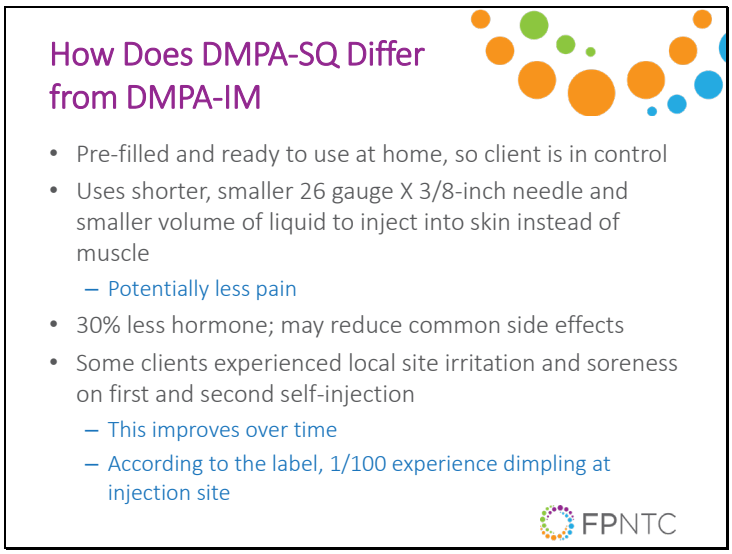
Slide 35


FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER
What options can family planning providers offer clients who are due for their depot medroxyprogesterone acetate (DMPA) shot to avoid a clinic visit?
35

Slide 36

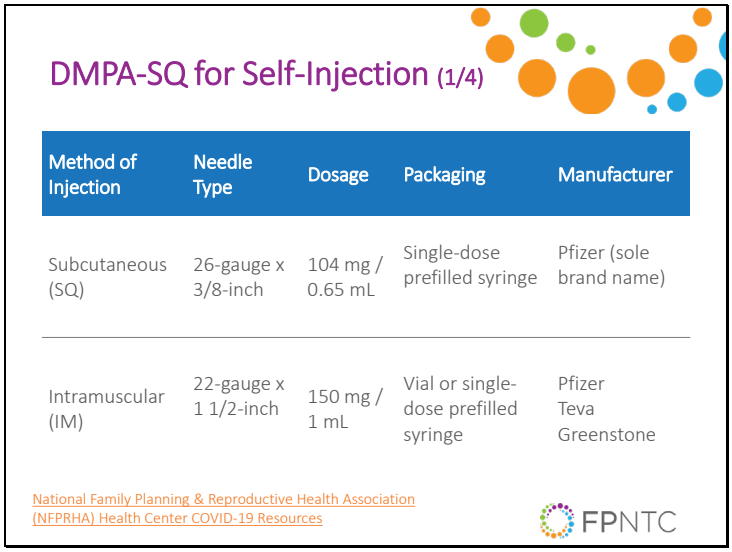
Now, switching to another topic that has to do with clinical management is what options can family planning providers offer to clients who are due for their next DMPA shot, Depo-Provera, in order to avoid a clinic visit. So, we're going to do another quick poll. Are you offering Depo subq DMPA subq to 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.

Slide 37



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.

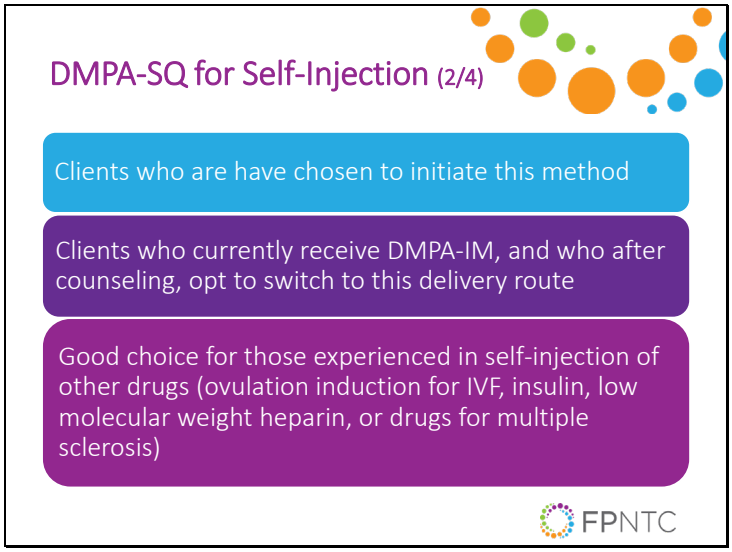
Slide 38



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.

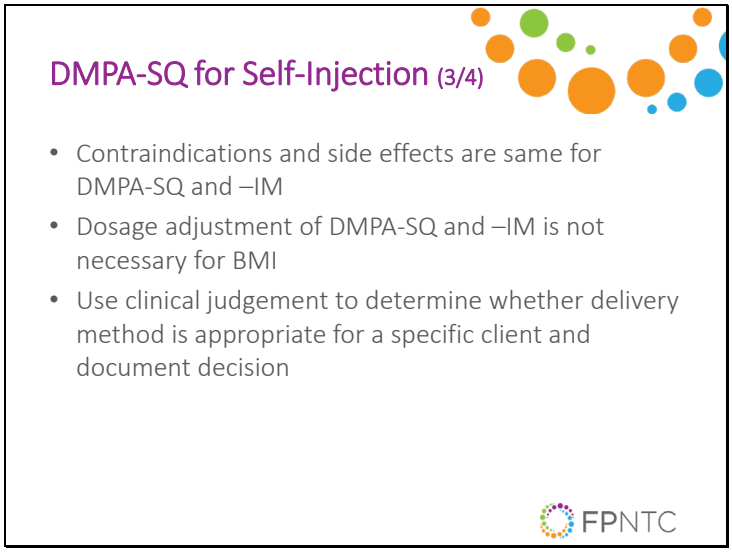
National Family Planning & Reproductive Health Association (NFPRHA) Health Center COVID-19 Resources
https://www.nationalfamilyplanning.org/covid-19-resource-hub

Slide 39



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.

Slide 40



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:

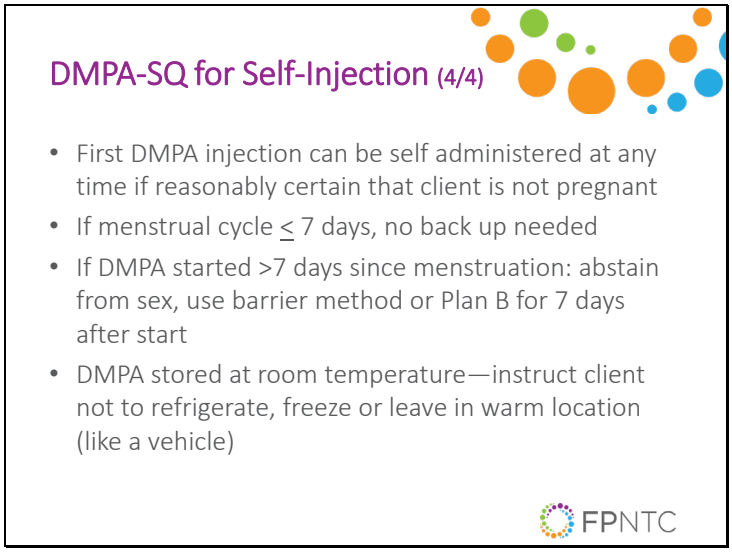
- Burke HM, Mueller MP, Perry B, et al. Observational study of the acceptability of Sayana® Press among intramuscular DMPA users in Uganda and Senegal. *Contraception.* 2014;89(5):361-367.
- Cover J, Ba M, Drake JK, et al. Continuation of self-injected versus provider-administered contraception in Senegal: 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/m2). The AUC0–91 values for MPA were 71.6, 67.9, and 46.3 ng·day/mL in women with BMI categories of ≤ 28 kg/m2, >28–38 kg/m2, and >38 kg/m2, respectively. The mean MPA Cmax was 1.74 ng/mL in women with BMI £28 kg/m2, 1.53 ng/mL in women with BMI >28–38 kg/m2, and

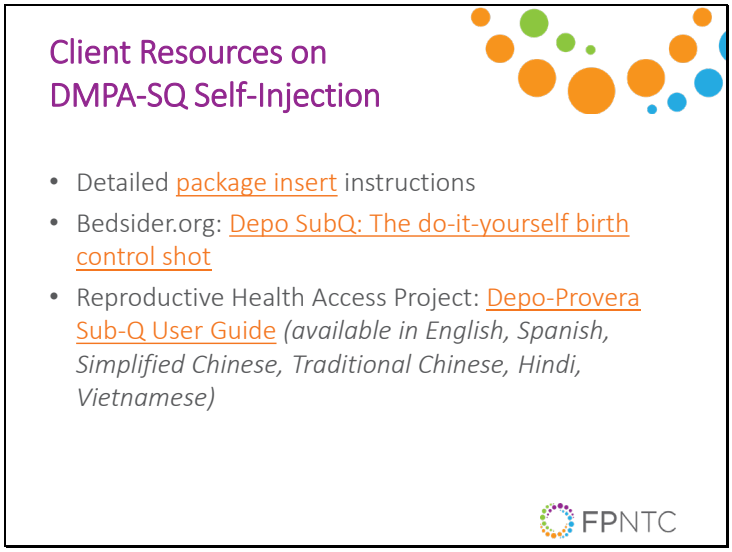
1.02 ng/mL in women with BMI > 38 kg/m2, respectively. The MPA trough (Cmin) concentrations had a tendency to be lower in women with BMI >38 kg/m2.

Slide 41



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.

Slide 42

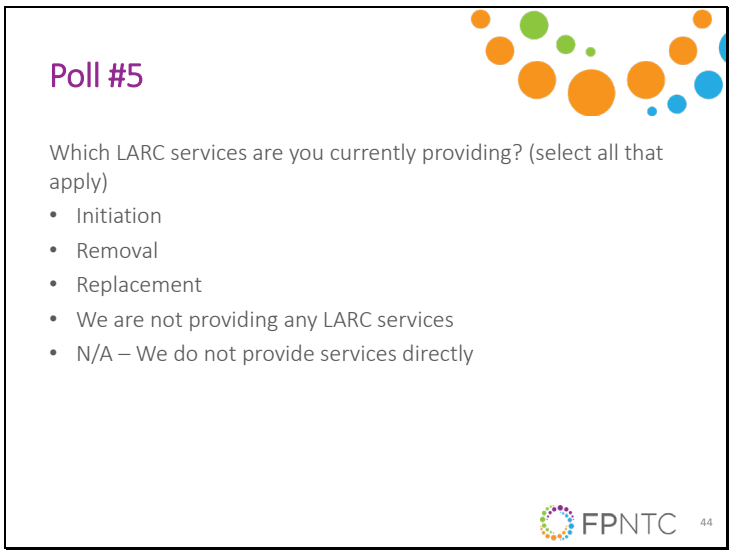


Again, there is quite a lot of information out there to help us educate clients about the use of Depo subq and in particular, how to give yourself injections. And here are some sources. You will see additional sources at the end of this slide set, in particular NFPRHA has developed quite a number of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

Slide 43

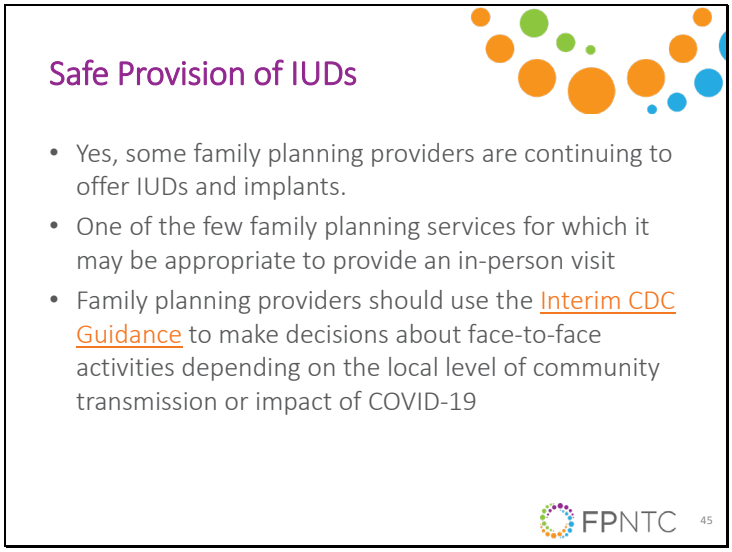

FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER
Can family planning providers still safely provide intrauterine devices (IUD) and implants?
43

Slide 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.

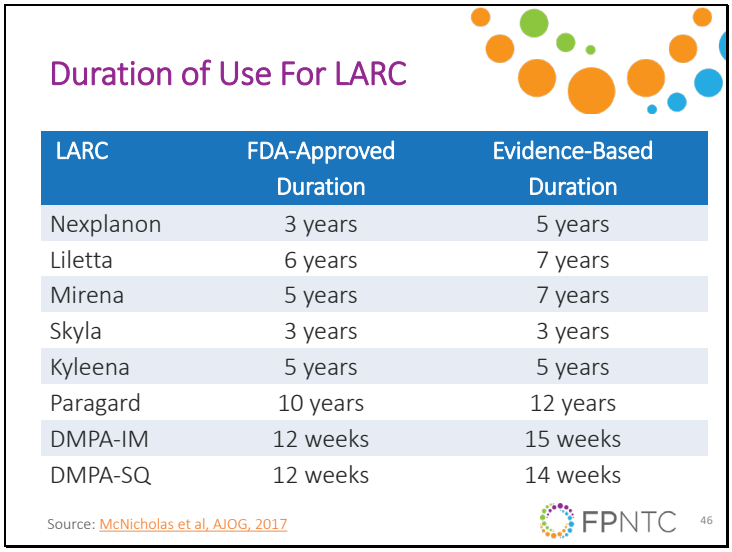
Slide 45



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.

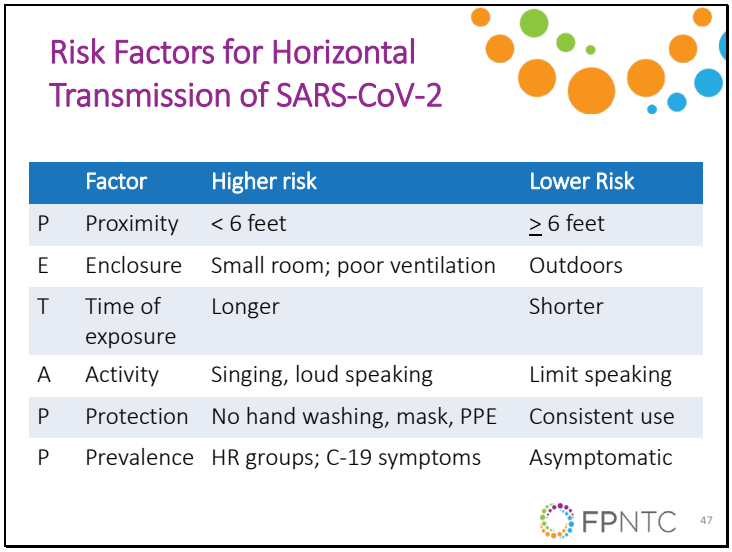
- Family planning providers should use the Interim CDC Guidance to make decisions about face-to-face activities depending on the local level of community transmission or impact of COVID-19.
- See Beyond the Pill's LARC Guidance During COVID-19 (https://beyondthepill.ucsf.edu/contraceptive-care-during-covid-19) 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)

Slide 46



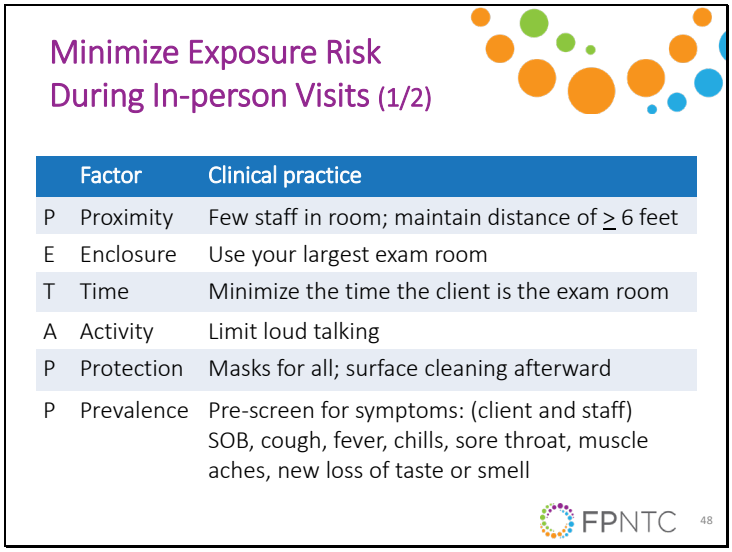
However, before I get to that, I do want to remind you about the fact that when a client calls in and says, "I've been using this particular IUD over a period of years. I vaguely remember that at some point, this is supposed to be switched out. Can I come into the clinic and have my IUD removed and a 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 weeks, 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.

Slide 47



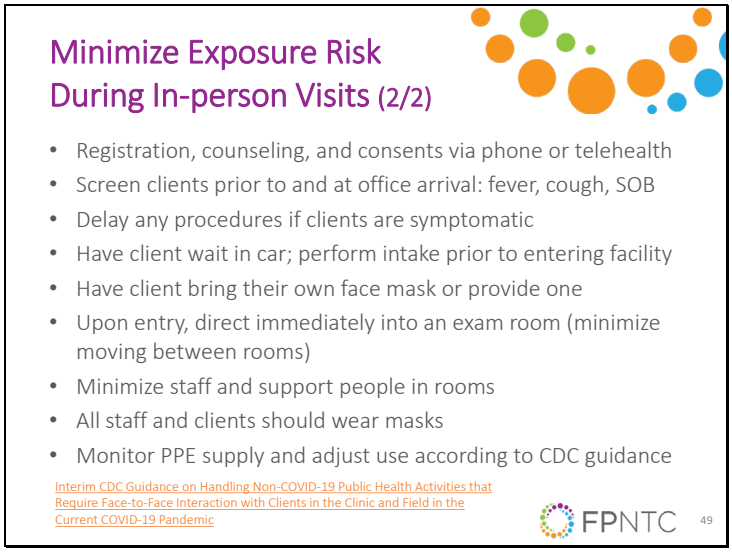
Now, how do we make adaptations in the healthcare environment in order to keep patients safe and in order to keep staff members safe. So, here's an important way to think about this. And these are the risk factors for horizontal transmission of the coronavirus, the SARS-CoV-2 virus from an infected person 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.

Slide 48



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.

Slide 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.

Slide 50


FPNTC
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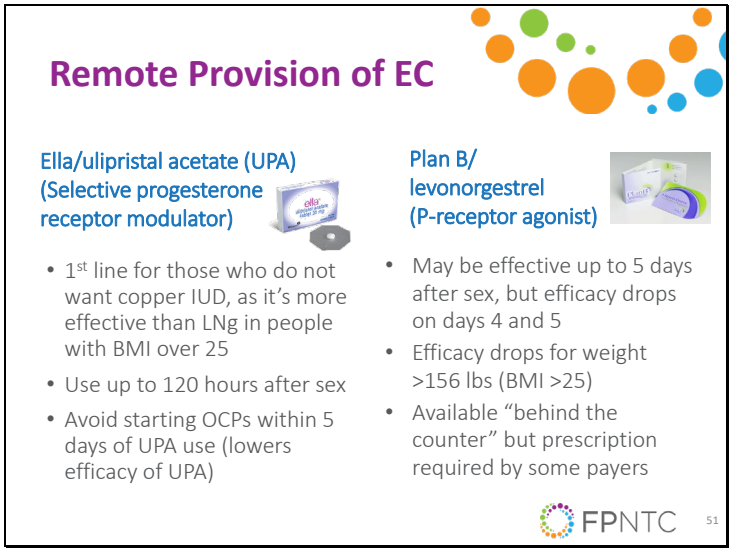
How are family planning providers providing emergency contraception (EC) remotely?
50

Slide 51

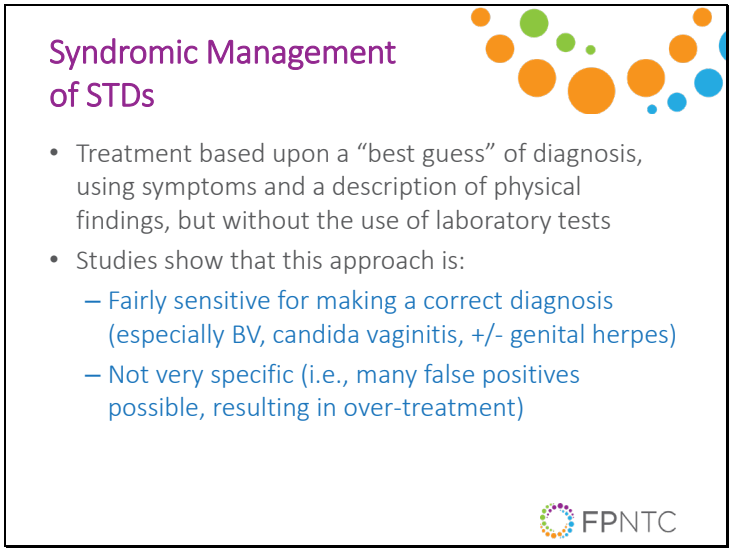


Now, we only have a few minutes left. So, let me just quickly hit a few of our last topics so that we can be sure to get to your questions. How are family planning providers providing emergency contraception remotely? And the answer is, is that we do that pretty much the way that we always have. With 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®) and ulipristal acetate (UPA; Ella®) 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/m2 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.

Slide 52

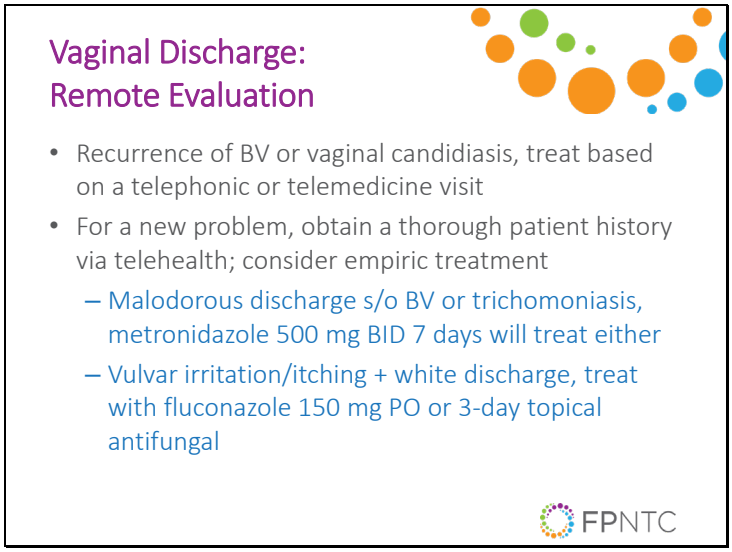

FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER
How can family planning providers continue to provide genital tract and STD services?
52

Slide 53



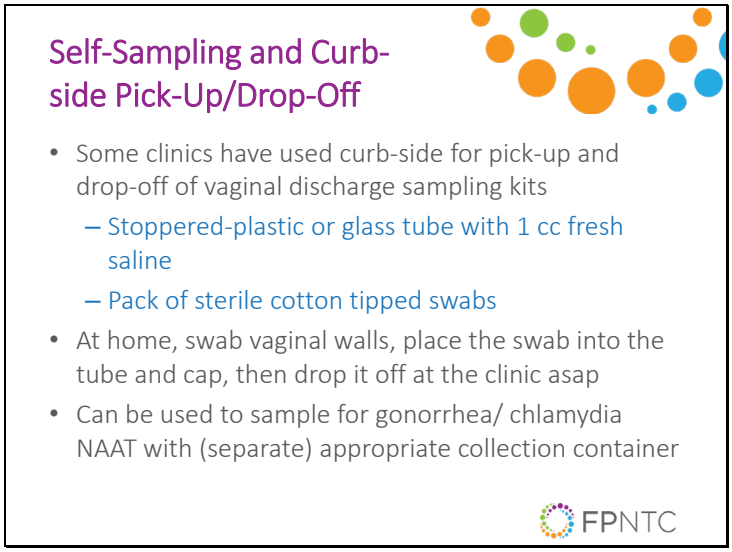
Next is can family planning providers continue to do genital tract and STDs surfaces? The answer to that is we can but we do that through something which is called syndromic management, which is we take the history of the patient over the phone and then make a best guess of her diagnosis based on her 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.

Slide 54



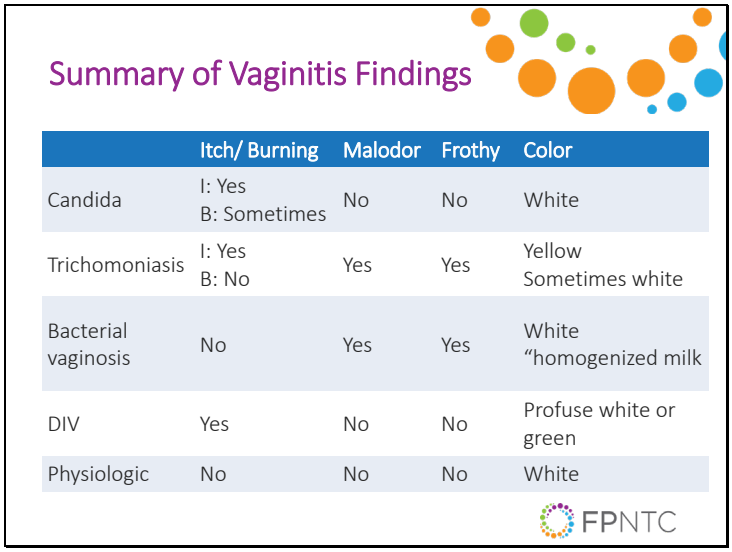
So, based on guidelines, which have come from the STD branch of the Centers for Disease Control, they've basically recommended that if a person is having a recurrence of bacterial vaginosis or vaginal candidiasis, you just treat them on the basis of the fact that they're having another outbreak of that. 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 natural 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.

Slide 55



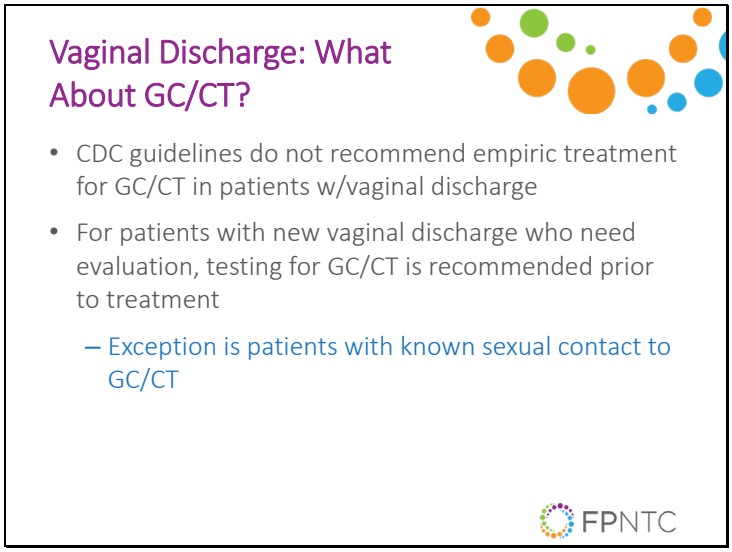
Now, what some clinics have done is to actually develop ways of a patient coming by picking up a sampling kit for gonorrhea, chlamydia, or even a vaginal discharge in her car, sampling herself- at home and then dropping that off at the clinic. And here's a little bit of detail about how that's done. 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.

Slide 56



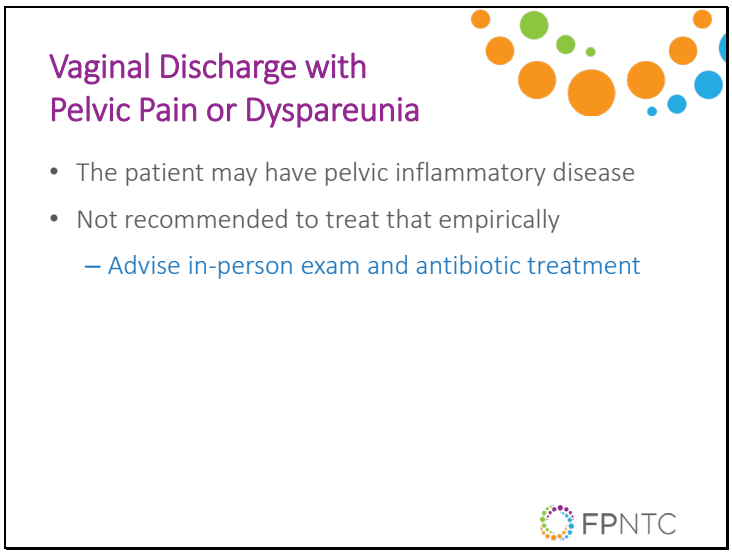
Here's an example of the kinds of things that we can do if we're doing syndromic diagnosis of vaginitis, just by asking about itching, burning, malodor, whether the discharge is frothy, what its color is, most of the time, though not always will be correct.

Slide 57



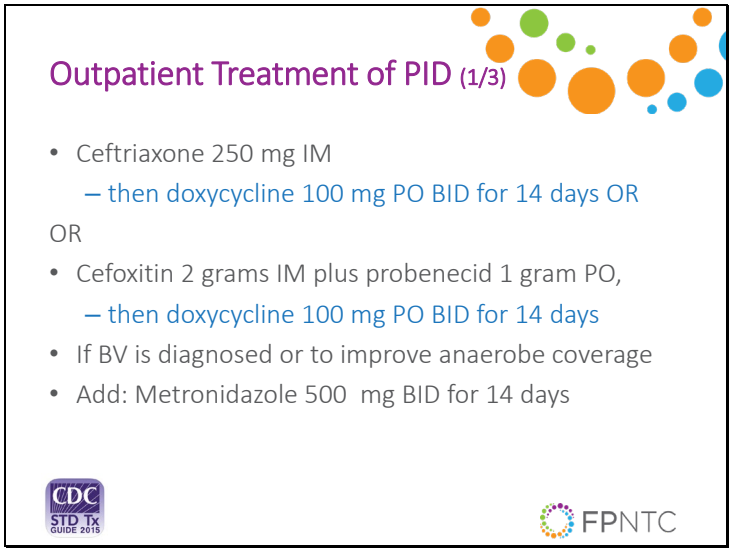
So, we'll also be doing a gonorrhea-chlamydia test in any person who has a vaginal discharge? The answer to that is no.

Slide 58



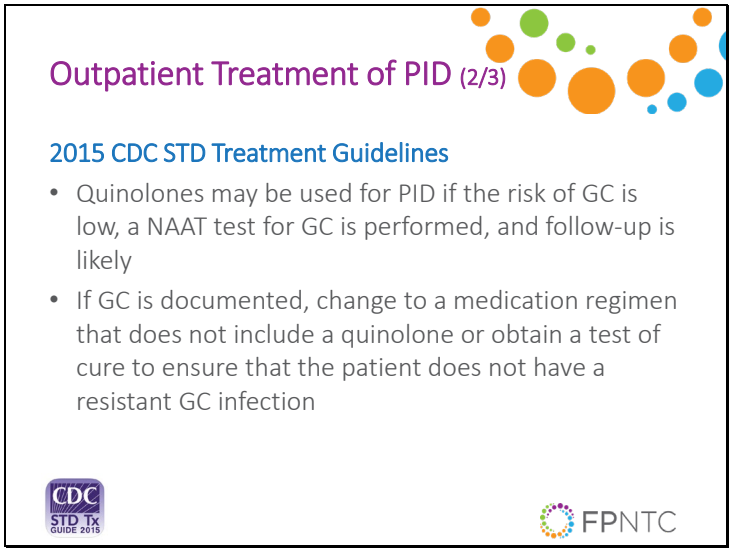
The CDC recommends that she should be coming either to the lab or for curbside pickup of a gonorrhea-chlamydia sample kit, so if she can sample at home and then bring that back.

Slide 59



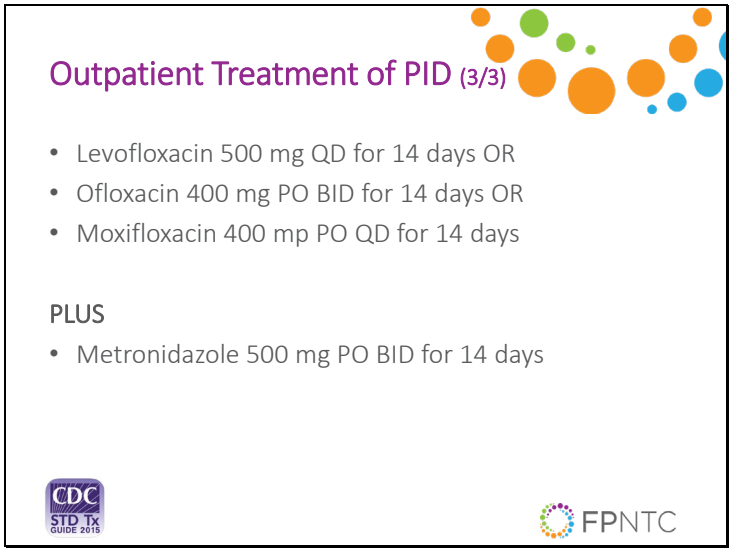
I'm going to skip over these slides because of our time. This is just a reminder that if you should see a patient who has complaint of lower abdominal pain, she's seen in the clinic and actually turns out to have pelvic inflammatory disease, these are the two preferred approaches.

Slide 60



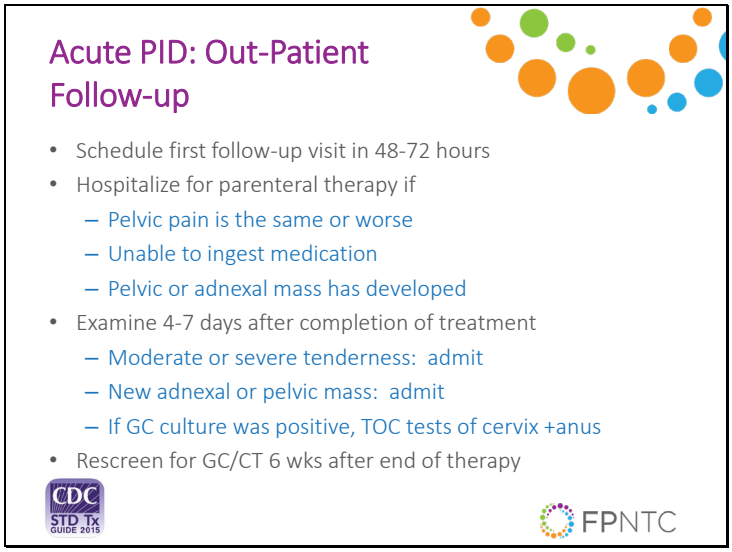
The trouble is they have to be injected. You may not have injected medications available.

Slide 61



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.

Slide 62


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
CDC STD Tx GUIDE 2015
FPNTC

Slide 63

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

FPNTC

Slide 64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FAMILY PLANNING
NATIONAL TRAINING CENTER
Can family planning providers use at-home test kits for STDs as an alternative to in-clinic sampling?
64

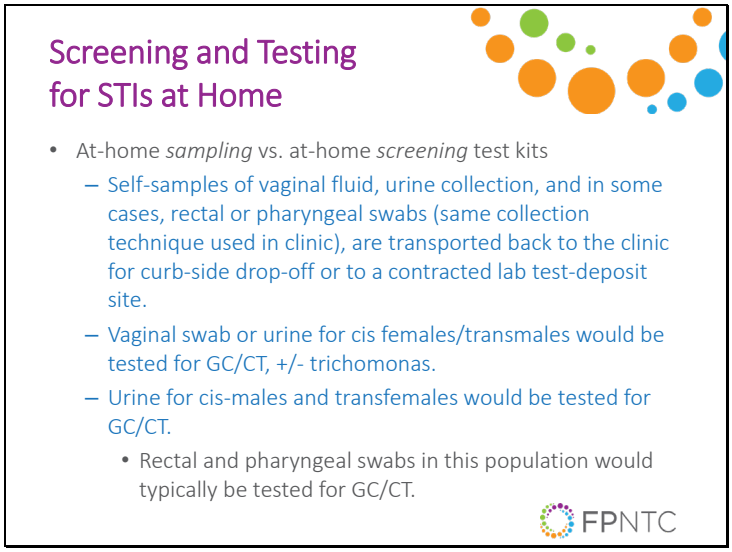
Slide 65

Poll #6

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

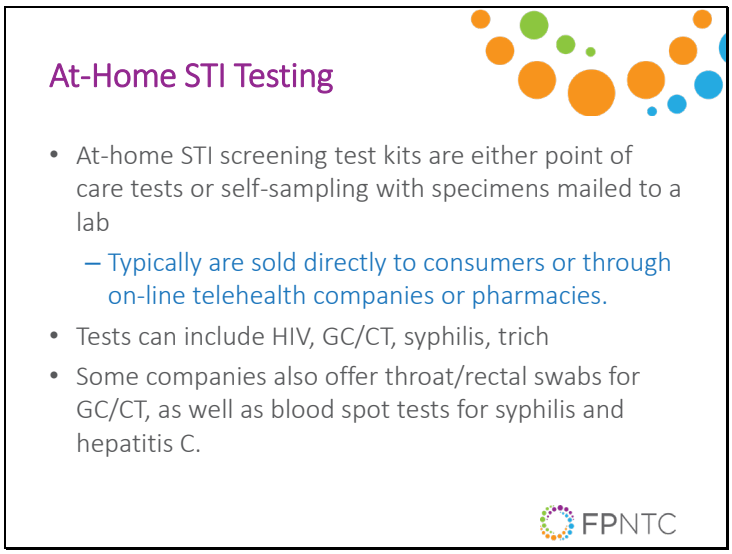
- In-person visits
- Curbside pickup of sample kits
- Mail delivery of sample kits
- Empiric treatment for suspected STD
- Web-ordered at-home STD test kits

Slide 66



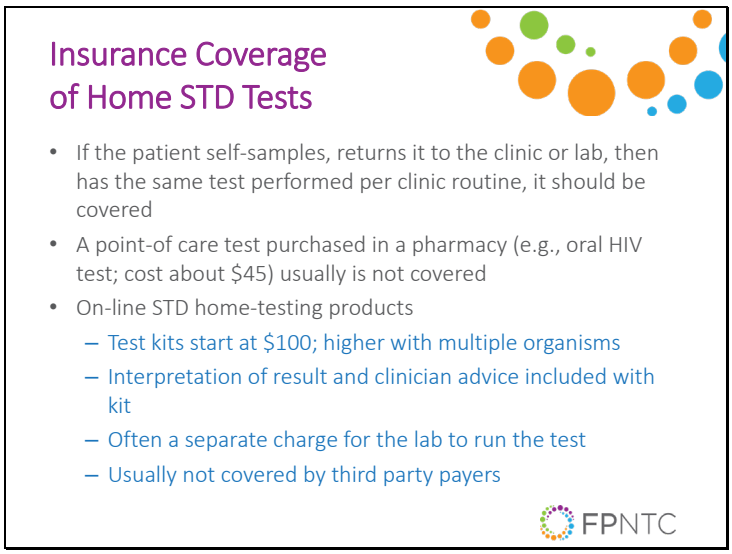
The very last topic, just to mention very quickly, is what about at home STD testing. And what I want to point out and again, this is something which is ... I'm going to skip that last poll. That is nicely detailed for you in the FAQ on the FPNTC website is the difference between home sampling and home 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.

Slide 67



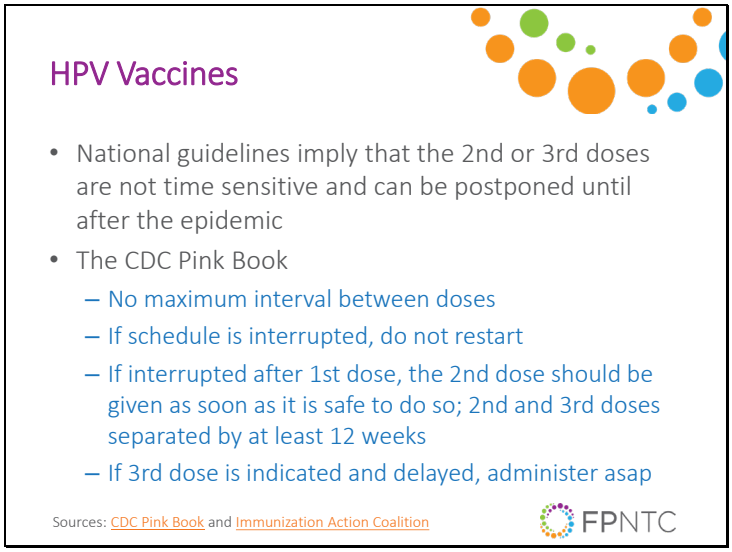
That is different from at home STI testing. So, there are quite a number of companies, we've included those for you in the references, or even some pharmacies, which sell at home STI screening kits. So, either they are mailed to you or you go to your pharmacy and pick it up. They are either point of 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.

Slide 68



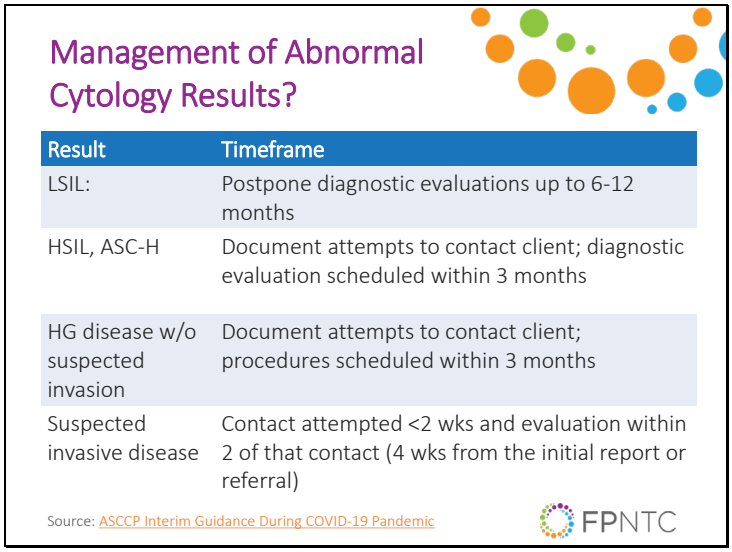
Problem is or the question is, are they going to be covered by a payer? And the answer is, is that most of the time are they are not. So, a point of care tests like an oral HIV panel can be purchased in a pharmacy. You do that at home. You get an immediate result. They cost about $45. But that is usually 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.

Slide 69



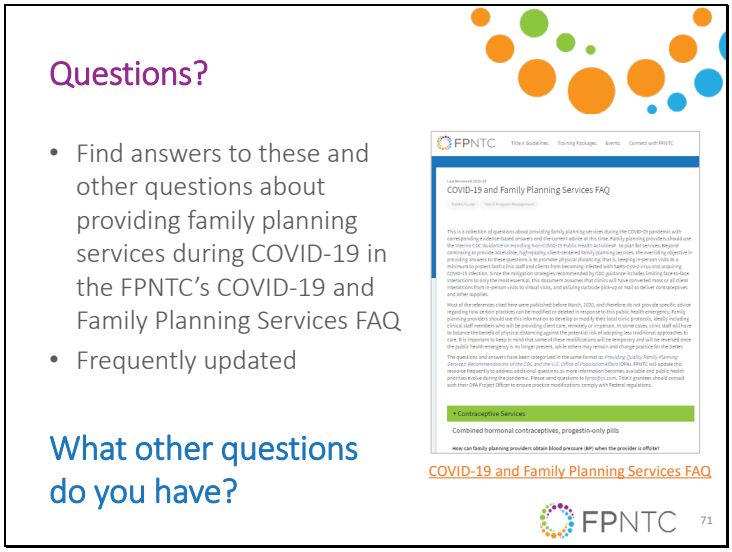
Just a quick word about HPV vaccines and I won't read this for you, but I will remind you that if a person needs a second or a third dose of an HPV vaccine, it is reasonable to delay those until the time that the public health emergency is over. That person can complete their series.

Slide 70



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.

Slide 71



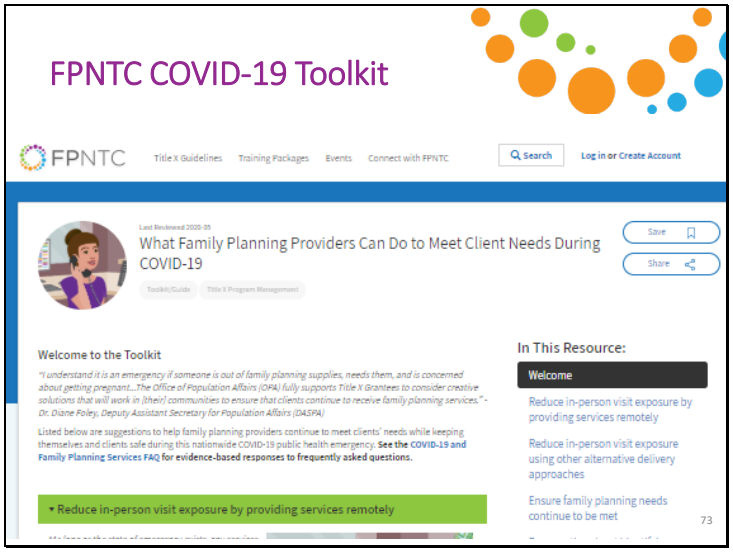
So, with that, I will go ahead and wrap up. Fortunately, we did cover all of the slides, although overtly at the end. And for as long as we can stay on the line, I am happy to hear your questions.

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.

Slide 72

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



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

Slide 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)

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/)

Slide 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 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.

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