Prioritization of In-Person and Virtual Visits During COVID-19:

A DECISION-MAKING GUIDE FOR STAFF

FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER

As a result of the COVID-19 public health emergency (PHE), family planning clinics have converted many client interactions from in-person visits to telehealth visits using audio and/or video. Family planning providers should develop written policies that prioritize which client visits will be done in-person or remotely, in accordance with 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. This policy should be revised frequently based on current local or state physical distancing laws, availability of clinician and non-clinician staff, and availability of personal protective equipment. This guidance supports the development of such a policy.

These guidelines complement—and do not replace—existing guidelines that include the Centers for Disease Control and Prevention (CDC) Medical Eligibility Criteria (MEC), CDC Selected Practice Recommendations for Contraceptive Use (SPR), CDC and Office of Population Affairs (OPA) Providing Quality Family Planning Services (QFP), and CDC Sexually Transmitted Disease (STD) Treatment Guidelines. In developing this guidance, the following was taken into consideration:

- The family planning services described here are essential health services.
- Many clinics are utilizing curbside pick-up or mail to deliver contraceptives and other supplies to clients in order to meet family planning needs.
- Return to non-emergency protocols will be gradual. Many services will be offered as they were before the PHE, but some, like telehealth visits, could be retained and even expanded.

See COVID-19 and Family Planning Services Frequently Asked Questions and What Family Planning Providers Can Do to Meet Client Needs During COVID-19 for additional guidance.

This guidance defines five modalities of visits and considerations for providing services using these modalities. It is designed to be tailored to the policies of an individual clinic and the context within which it serves clients. The five modalities of visits include:

- **In-person, same day (or as soon as possible, ASAP):** Clinically urgent visits where delay of care will put the client's health or pregnancy prevention needs in jeopardy. History, counseling and education, shared decision making, and health status pre-screening can be conducted virtually to minimize in-person visit time.
- **In-person, as available**: Visits and procedures that can only be performed in a clinical setting, but are not highly time-sensitive. History, counseling and education and shared decision making can be conducted virtually to minimize in-person visit time.
- **Virtual (audio and video (A/V))**: Visits using synchronous (real-time) audio and video. Before March 2020, most payers required the use of HIPAA-compliant platforms, but during the current PHE, other platforms, such as FaceTime or Skype, may be used temporarily. Clients must have verbal consent documented in the record.
- **Virtual (audio-only)**: Visits that are exclusively conducted via audio connection by telephone. A few payers permit billing for audio-only visits. Providers should check the payer's policy as to whether these services are benefits during the PHE.[1,2]
- **Postpone**: Visits that can be rescheduled until after the PHE has ended. These services are mainly preventive in nature and are not time-sensitive.

1 For billing: See Initiating Telehealth in Response to COVID-19: Coding and Billing for Telehealth Services from the National Family Planning and Reproductive Health Association.
2 Medicare (and most Medicaid programs) recently have added a billable visit category called a virtual check-in visit, which is defined as a synchronous (real-time) discussion over a telephone or through video or image to decide whether an office visit or other service is needed. Centers for Medicare & Medicaid Services (CMS) rules state that the call must be initiated by the client, who must have an established relationship with the practice, is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The client must also verbally consent to the virtual check-in.

Reason for Visit	Modality	Considerations
Clinically urgent	In-person, same-day (or ASAP)	• Diagnose and treat potentially dangerous conditions (e.g., vaginal bleeding, acute pelvic pain suggestive of intrauterine device (IUD) expulsion, pelvic inflammatory disease, or ectopic pregnancy) that normally can be managed within the scope of services. • Every attempt should be made to care for these clients in order to provide timely care that minimizes complications and avoid an emergency room visit. • Providers should follow Interim CDC guidance, including the use of surgical masks for both providers and client.
IUD and implant placement	In-person, same-day (or ASAP)	• Provide counseling and obtain consent virtually prior to visit. • Health care providers and the client should wear surgical masks during placements.
IUD and implant replacement	In-person, as available	• Discuss the evidence that methods are effective longer than their FDA-approved duration. The client may choose to postpone replacement until after the PHE.
IUD and implant removal	In-person, as available	• Assure the client that removal will be facilitated. • If desired removal is related to symptoms of irregular bleeding, assess interest in management, per CDC SPR (non-steroidal anti-inflammatory drugs vs. estrogen). • Reassure the client that, in the absence of complications, IUDs and implants can safely be left in place beyond the expiration date, and they can postpone removal until after the PHE. • If the client wants the IUD out because they desire pregnancy, provide appropriate preconception counseling. • Assess the client's need for a back-up method. • Schedule in-person visit according to client preference. Health care providers and the client should wear surgical masks during removals.
Depot medroxy-progesterone acetate (DMPA) injection (refill or initiation)	In-person, as available	• DMPA 150 intramuscular (IM) lasts 15 weeks and subcutaneous DMPA (DMPA-SQ) lasts 14 weeks. Reschedule clients accordingly. • Explore the client's interest in self-administered DMPA-SQ and provide onsite or virtual training; send prescription to pharmacy.
Initiation of a new method of contraception	Virtual (A/V)*	• Provide virtual client-centered contraceptive counseling. • If the client desires combined oral contraceptive (COC), progestin-only pill (POP), patch, or ring, use CDC MEC to screen for contraindications. Provide prescription for 12-month supply if possible. Record blood pressure (BP) (use home monitor, BP machine at local pharmacy, recorded BP in system's electronic medical record in any clinical setting, BP machine in clinic parking lot, etc.) If BP reading is unavailable, provide a 3–6 month prescription per clinician discretion, or discuss methods without contraindications for hypertension or cardiovascular disease. • If the client desires a fertility awareness-based method, discuss methods and possible helpful apps (Natural Cycles is FDA-approved for pregnancy prevention. Other options: Ovia, Flo Period & Ovulation tracker, Fertility Friend, Period Tracker, and Dot Fertility Tracker). • If the client desires condoms or other barrier method, discuss proper use and consider offering mail delivery or curbside pick-up. • Offer condoms as dual protection and emergency contraception (EC) • See above responses if the client is interested in DMPA, IUD, or implant.
Requests STD testing and/or has non-urgent symptoms suggestive of STD	Virtual (A/V)*	• If the client has new, known, or suspected exposure (new partner, exposure to partner with STD, partner who may have had sex with other partners) or concerning symptoms, consider ordering appropriate lab tests: self-collected vaginal swab (urine if not available), blood tests, etc. The client can go directly to the lab for testing or use curbside pick-up of specimen collection materials. • Postpone routine screening until after the PHE. • See Interim CDC Guidance for STD and HIV Priorities.

Reason for Visit	Modality	Considerations
Uncomplicated lower urinary tract infection (UTI) symptoms	Virtual (A/V)*	• Treat empirically. • In cases of questionable diagnosis, complicated UTI, or empiric treatment failure, the client can be told how to take a urine sample to the lab for testing. • If the client reports signs and symptoms of pyelonephritis, schedule in-person visit.
Vaginal discharge	Virtual (A/V)*	• If the client has recurrence of a vulvovaginal condition previously diagnosed, such as genital herpes, bacterial vaginosis, or vaginal candidiasis, prescribe treatment. • If the client has malodorous vaginal discharge suggestive of bacterial vaginosis or trichomoniasis, treat with metronidazole 500 mg orally twice a day for 7 days. • If the client has vulvovaginal itching (or burning), white discharge, no odor, treat vaginal candidiasis with one dose of fluconazole 150 mg PO or antifungal cream.
Pregnancy testing and diagnosis	Virtual (A/V)*	• The client can drop off a urine sample at the clinic (e.g., curbside) for a pregnancy test. Home pregnancy test results are acceptable during the PHE. • Provide result. If negative, explore interest in contraception. If positive, refer to prenatal care. An advanced practice clinician may also provide non-directive options counseling (or other clinical staff, if waiver has been obtained).
Refills: COCs, POPs, ring, patch, self-administered DMPA-SQ	Virtual (Audio-only)	• Mail supplies to the client, arrange for curbside pick-up, or transmit refill order to pharmacy.

Emergency contraception (EC)	Virtual (Audio-only)	• Paragard is the most effective EC; discuss pros and cons of in-person visit for placement during the PHE.
		• Ulipristal acetate (UPA; Ella®) is the next best option, but with lower effectiveness in females with BMI > 30 kg/m^2.
		  • Breastfeeding is a contraindication.
		  • Don't start oral contraceptives within 5 days of taking UPA.
		• Levonorgestrel (Plan B® and generics) less effective for BMI>26 (and less effective overall as well).
		• Given the time-sensitivity of this service, curbside pick-up or prescribing to a pharmacy for same-day pick-up is optimal.
		• Provide education about over-the-counter EC options.

Colposcopy	Postpone	American Society for Colposcopy and Cervical Pathology guidelines: • LSIL cytology: postpone diagnostic evaluations up to 6–12 months. • HSIL, ASC-H, AGC cytology: document attempts to contact and schedule diagnostic evaluation within 3 months. • High-grade cervical disease without suspected invasion: document attempts to contact and schedule procedure within 3 months. • Postpone all other visits related to low grade lesions or post treatment surveillance.
	In-person, as available	• Suspected invasive disease: attempt contact within two weeks of initial report and conduct evaluation within two weeks of that contact (four weeks from the initial report or referral).
Cervical cytology screening (alone)	Postpone	• Progression is a very slow process for most clients. Reschedule until after the PHE.
Well-woman visit	Postpone	• Reschedule until after PHE if the client has no concerns requiring urgent attention.

*Can be conducted virtually with audio only, if needed.

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