# Providing Family PACT Services During COVID-19 Part 1: Clinical Considerations
# May 8, 2020

## Nicole Nguyen:
Hi, everyone, good afternoon. And thank you for joining us on today's webinar entitled, Providing Family PACT Services During COVID-19: Clinical Considerations. We hope you're all doing well and being safe. My name is Nicole Nguyen, Health Educator at the California Prevention Training Center. The CAPTC under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event.

## Nicole Nguyen:
Before we get started, we would like to go over some housekeeping slides.

## Nicole Nguyen:
First, please check your audio and select your desired settings, join through your computer audio, or call in through your phone. If your internet connection is shaky, we recommend you call in through your phone for the best possible sound.

## Nicole Nguyen:
Second, please check that you're able to see the viewer screen with the slides on the left and the GoToWebinar control panel on the right under the Audio tab is also where you can change your audio preference at any time.

## Nicole Nguyen:
Third, please submit all your comments and questions via the questions panel. Today's webinar will be about 90 minutes and include time at the end for the presenters to answer your questions. The webinar will be recorded. Responses to questions not answered today by our presenters will be sent out to participants later along with the recording and slide deck. There is an evaluation at the end, so please fill it out, so we can get your feedback and suggestions for future content. Our webinar today will be in a frequently asked questions format where our presenters will ask each other question and discuss the answer in a more back and forth style conversation.

## Nicole Nguyen:
Now I like to present or to introduce our presenters. One of our speakers today is Dr. Michael Policar. Dr. Policar served as clinical professor of Obstetrics, Gynecology, and Reproductive Sciences at the University of California San Francisco School of Medicine. From 2005 to 2014, he was the medical director of program, support, and evaluation for the Family PACT program administered by the California Department of Healthcare Services, Office of Family Planning. He currently serves as Professor Emeritus of Obstetrics, Gynecology, and Reproductive Sciences at UCSF. For our second speaker, we are thrilled Dr. Jennifer Karlin is here with us. Dr. Karlin is finishing a family planning fellowship at UCSF and

will be starting in a faculty position at UC Davis in the Department of Family and Community Medicine this fall. Her current and previous work includes a qualitative study, which aims to understand abortions providers perspective about de-medicalizing medication abortion, a systematic review to describe what we know about patient's preferences for contraceptive counseling during the peripartum period, and a study about patient's understanding of non-dialysis options for end stage renal disease. She's hoping to begin a new project looking into the uptake and impact of self-injection of Depo-Provera on people's contraceptive autonomy in California during the COVID-19 Pandemic. And with that, Dr. Policar, Dr. Karlin, the floor is yours.

## Dr. Michael Policar:

Okay, great, thanks very much, Nicole, and thank you all for joining us today. I know that we're planning on having a very big group because of how important this particular topic is. And of course, it's related to the fact that since early March, most family planning clinics are now doing either some or even all of their services remotely, which really means significant changes in both how we perform services, and ultimately how we bill for them as well. So, what we're going to do is that Jen and I are going to address quite a number of questions that have to do with adaptations that we need to make in order to switch from mostly in-person visits to mostly remote visits but knowing that there are some circumstances where we're still going to need to see our clients or our patients face-to-face. Of course, ultimately, the goal that we're trying to achieve here is to provide high quality family planning services, but to do it in such a way that we protect both our patients and the staff in our clinics. So, I'll remind you that we have no financial disclosures to make, neither Dr. Karlin nor I, next slide.

## Dr. Michael Policar:

And the kinds of topics that we're going to cover are, first, what are some of the alternative service delivery approaches to minimize in-person care? In other words, how do you prioritize visits, rather, that need to be done in-person as opposed to those that are done remotely? Number two, how do we approach contraceptive services that are provided remotely and then later in the webinar, I'll cover symptomatic care, particularly including people who have genital tract infections, and then also review the Family PACT benefit and billing policies that have to do with telehealth, next.

## Dr. Michael Policar:

Now, it's important to mention that particularly as it relates to Family PACT and to Medi-Cal policies that they have gone through quite an evolution over the last six weeks. So many of the policies that I'll be discussing later, actually, were Family PACT policies in the PPBI before the time of the public health emergency before March 1st. Then in early March, during the first three weeks of the month, we started to see some information coming from the Office of Family Planning as well as Medi-Cal about changes in benefits and policies. And then starting on March 23rd, a whole series of policies that were published, and those, by the way, are all contained at the end of our lecture. You'll find them in the handout that you'll have access to with hot links to be able to get to the original policies. But I do want to remind you about the fact that many of these policies are going to phase out once the public health emergency is over. And of course, no one knows exactly what that date is, but at some point, you'll be hearing from the Office of Family Planning and for Medi-Cal about how the policies particularly as they relate to some of the changes in telehealth, going back to the way they were before the time of the public health

emergency. But just remember that these policies evolve frequently, and that Family PACT and Medi-Cal policies are quite similar, but they're not identical. And I'm going to do my best to tell you about the difference between the two.

## Dr. Michael Policar:

All right, so let's go ahead and get started then. And I'm going to start by asking Jen a question about whether or not there are any national guidelines on prioritizing visit types into those that really should be done in-person, those that should be done by telemedicine, or those that can be postponed until the time that the public health emergency is over.

## Dr. Jennifer Karlin:

Great, thank you, Mike. So, there's no formal national guidelines, but certainly, places across the country have been developing their own policies and guidelines based on their location. And so, we recommend that providers and clinics develop written policies and about which clients should be in-person and which should be remote. We also recommend that these policies are revised frequently, maybe once a week. This includes thinking about local and state physical distancing laws, the availability of clinician and non-clinician staff, the availability of PPE supplies, and then whether or not their specific location is able to do curbside pickup, or they're able to mail or deliver contraceptives and other supplies.

## Dr. Jennifer Karlin:

But when we think about creating these policies in general, we really recommend that we take a step back and think about our overall goals of care. And so, at our clinic at San Francisco General, once we had a sense of the specifics of our environment, we took that step back, and we started thinking about our priorities and goals of care. And so, we recognized explicitly that there were two goals of care that we really wanted to achieve. And the first is that facilitating reproductive autonomy is essential health care. And then the second was that respecting social distancing is a public health mandate. And so, both of these goals are not at odds with one another, and they can be simultaneously mapped. And so, then we broke those two goals down a little bit further, and we thought about what does facilitating reproductive autonomy mean? Well, it means providing a safe environment to offer person-centered contraceptive counseling, family planning options counseling, and access to contraceptive methods. And it also meant continuing to practice shared decision making, particularly around vulnerable topics and people who have difficulty with access to care to begin with. And then we thought about our other goal of respecting social distancing and what that meant. And that really means educating and empowering our clients regarding the public health recommendations, and avoiding unnecessary staff or client exposure to illness, making availability to see the highest priority clients in-person, and then creating capacity to absorb anticipated staff, unanticipated staff shortages due to illness and school closures. And then, keeping these goals in mind, we came up with a more specific plan of care.

## Dr. Jennifer Karlin:

And so, we use telemedicine as a tool for facilitating reproductive autonomy and respecting social distancing. And this tool can be used both in times of the pandemic and not because it's meeting our goals of care. And so, at the Family Health Center in San Francisco General specifically, we decided that

all contraceptive and family planning options counseling can be done via telehealth unless the client doesn't have access to a phone or computer, and when we're doing this, we really want to think about being creative. We want to still use those wonderful images that we have when we're doing in-person face-to-face counseling. And you can think about sending these to people through your EHR is that as possible. You could think about texting it to patients. If they have a computer, you can send them the links. And so, while you're doing the contraceptive counseling, they could still be looking at the materials that they would be looking at if you were working with them in patients, in clinic. We're going to remember to still be screening for contraindications, and we're going to do all of this, most of it is done by history. We decided that we would start utilizing home measurements of vitals, both blood pressure machines that people may have at home, or in other settings and then scales. And then we decided we would be expanding the use of self-administered subcutaneous Depo for interested clients. And lastly, we decided that it was important to continue to elicit and honor client preferences for both the insertion and removal of long-acting, reversible contraception. So, you can create in your personal settings, a grid like this that you could move the checker boxes around depending on your local environment and make triage decisions on a weekly basis. And this can be very, very helpful for everyone that's working in clinic to understand where patients should be seen. And so, this is just a sample prioritization, but you guys can make this for yourself in your own clinic.

## Dr. Michael Policar:

Okay, great, thanks, Jen. So, the next question is that there's obviously still a demand for people to have services related to intrauterine contraceptives and implants, either to have them placed or to have them removed. And of course, we've got to be able to do that in a face-to-face setting. So, what are you doing at San Francisco General? And what can you tell us about sort of the safest and most effective way to actually do the technical placements and removals of the two LARC methods?

## Dr. Jennifer Karlin:

Right, great, thank you so much. So yeah, so we are still offering IUD insertions and removal via some shared decision making about timing with the client. We are, however, using evidence-based extended use duration rather than the FDA-approved duration and I'll go more into that in one second. We're also offering advice about self-removal of IUDs. And then we have suggestions for how to minimize exposure risk during inpatient visits. So, I'll go into more detail right now about that.

## Dr. Jennifer Karlin:

In terms of the duration of use for LARC, you can see that there's differences in the FDA-approved duration and then the evidence-based duration. The main technologies that I want you to look at are the Nexplanon who's FDA-approved duration is three years, but the evidence-based duration is five years. So, we've been using five years as the upper limit for continuation of Nexplanon. Again, the other differences for IUDs are in Liletta and Mirena and Paragard. And so, for the Liletta, there's an additional year from six to seven years if you use the evidence-based duration. For Mirena, there's an additional two years, so from five years for the FDA-approved duration to seven years for the evidence-based duration. And then for Paragard, you also gain an extra two years. So, the FDA-approved duration is 10 years, and the evidence-based duration is 12 years. And then lastly for intramuscular Depo-Provera. The evidence-based duration is 15 weeks, rather than 12 weeks, which is the FDA-approved duration, and so

we have increased our injections. And for SubQ Depo, which I will talk a lot more about in a little bit, we are using, we are sending the medicines every three months so the 12 weeks, but also knowing that SubQ Depo. The evidence-based duration is 14 weeks.

## Dr. Jennifer Karlin:

So, if somebody misses their injection, they have a two-week period where they wouldn't need to take a pregnancy test again in order to reinject their Depo, and then if you are having in-person visits, these are different things that people have been doing across the country to minimize exposure risk. And so, people have been registering and counseling and doing consents via phone or telehealth. Another idea has been screening clients prior to their office arrival for any symptoms of coronavirus, so fever, cough, shortness of breath, and then delaying those procedures if clients are symptomatic. Another idea is having the client wait in the car and then performing intake prior to entering the facility. So, calling the client while they're waiting in the car if that's a possibility. We also recommend having clients either bring their own face mask or providing one for clients. And then we really want to limit movement in general within our clinics and so directly moving patients into one examining room and not moving them between rooms or between different locations if you are doing vitals to try to do that in the direct examination room and that will help minimizing staff exposure. And also, what helps minimize staff exposure is by limiting the support people in the room. And then we want to remember again to continue to monitor our PPE supply and to adjust accordingly to the CDC guidance.

## Dr. Michael Policar:

Okay, great, thanks. And just to make sure then, so let's say you're doing an IUD placement, everybody in the room then is wearing a face mask, because you said that either the patient is going to bring one or you'll supply one for her, but you as the clinician who is actually doing the IUD placement and maybe a staff member that's speaking with the patient and holding her hand, everyone has a face mask on, correct?

## Dr. Jennifer Karlin:

That is correct, and also the CDC guidance also recommend eye protection for the provider, so if you're having direct, any direct patient contact, you should be wearing both a face mask and an eye protection for yourself, which should be you should be wearing when you're placing IUD anyway.

## Dr. Michael Policar:

Would that also be true for doing an implant placement? Would you be wearing eye protection?

## Dr. Jennifer Karlin:

Yes, anytime that, the CDC recommendations are anytime someone is going to be physically in contact with a patient to be wearing eye protection and a face mask.

## Dr. Michael Policar:

Great, okay, let me just ask you one other question, we hadn't planned for this in advance, but I'm curious about what you're doing at San Francisco General. What about taking a temperature in

advance? Do you think there's any value of doing any sort of screening to see if the patient has a fever? Or is that something that's happening in the Family Health Center or in the hospital in general?

## Dr. Jennifer Karlin:

Yeah, so at all of our sites, everybody who enters our clinical sites both staff and patients are having their temperatures taken before entrance and also having a symptom check at all doors of entry.

## Dr. Michael Policar:

Great, okay, and I think that that really makes sense. It's not always part of the CDC recommendations, particularly about the temperature part. I think there's still some controversy about whether or not that's really sensitive enough, but I know that many, many clinics and certainly hospitals, but other facilities as well have adopted that practice more than others. All right, well, let's go into our next action. And that is that one of the things that we've been hearing from some family planning clinics is the fact that they've been hesitant to prescribe combined hormonal contraceptive methods that is to say, pill patch or ring to patients unless there's a documented blood pressure measurement that is available. And so, there's been quite a lot of discussion about what are the acceptable ways of being able to document blood pressure in the circumstance where you're either going to initiate the use of the combined hormonal method or, for that matter, update a person's prescription for one of the combined hormonal methods. So, when is it necessary? And what are some of the options in terms of how you can get that done?

## Dr. Jennifer Karlin:

Yeah, it's such a great question, I think. So yeah, so blood pressure measurement is necessary because hypertension is one of the five risk factors for an acute myocardial infarction or what's commonly known as heart attack in people are using estrogen containing hormonal methods. So, the other four risk factors are older age, heavy smoking, diabetes, and then abnormal lipid levels. And so, when a client has one or more of those risk factors, the risk actually increases with each. And so, so yeah, so high blood pressure is one of those five risk factors. And so, we want to then think about, well, how are we going to get that measurement for blood pressure? The other reason why this is important is because the CDC in their US Medical Eligibility Criteria for contraceptive use, which is most commonly known as the MEC, M-E-C, they classify multiple risk factors for atherosclerotic cardiovascular disease, and these risk factors are MEC category three and four, depending on the individual client history. However, severe hypertension, which is defined as systolic greater than 160, or diastolic greater than 100, or hypertension with vascular disease is automatically MEC category five, which is a condition that represents an unacceptable health risk if the contraceptive method is used, and so that's why we really want to know what someone's blood pressure is. Also, the US Selected Practice Recommendations for contraceptive use, the SPR states that blood pressure should be measured before initiation of the combined hormonal contraceptive. So how do we do that in telemedicine?

## Dr. Jennifer Karlin:

So timely blood pressure medicine, measurement. For client with documented normal blood pressure within the last three to five years and no other cardiovascular risk factors, we recommend prescribing up to a one-year supply of the combined hormonal contraceptives, so either the pill, the patch, or the

ring. And the current USPSTF recommendations are that adults aged 18 to 39 with normal blood pressure, who do not have other risk factors should be rescreened every three to five years. So that's where we're getting our upper limit of when you could have a documented blood pressure reading of normal in your medical history. And then for patients with high blood pressure, there's two things you could do. You could initiate treatment by referral to the PCP to treat the blood pressure, or the client could be prescribed a non-hormonal method or progestin-only method, but then the question comes up, okay, so what about people who don't have documented blood pressure within the last three to five years? Well, first, we think it's really important to reassure the client about why you're even asking this because as soon as we start asking lots of questions about things, people get very, very worried. And so, to set their mind at ease, we recommend that you inform them of the reason of why you're even asking about this. So, you want to discuss what the risk of estrogen is with untreated hypertension, but you also want to reassure them that most reproductive age people have normal blood pressure. And then the other options for something you might do is you might think about a blood pressure check at a pharmacy or drive-by blood pressure reading at the clinic where literally the person stays outside, and someone comes outside to do their blood pressure readings. And the other thing you could think about is just doing a three-month prescription and then a future appointment for blood pressure reading. So those are some of the things that we have been doing at San Francisco General.

## Dr. Michael Policar:

Great, okay, and then just to make sure that only applies in the case of estrogen-containing methods, right, pill, patch, ring. You wouldn't need to do that for a person using progestin-only pills or someone who's switching over to DMPA.

## Dr. Jennifer Karlin:

That is correct.

## Dr. Michael Policar:

Okay, great, all right. Let's go on to our next question that has to do with emergency contraception. So, what are some of the things that we would need to think about in terms of providing emergency contraception when we want to do that remotely in order to avoid a clinic visit?

## Dr. Jennifer Karlin:

Great, so yes, we have three options for emergency contraception, the Paragard IUD, Ella, and Plan B. And so, if we want to avoid an inpatient visit, the Paragard IUD is off the table. But we have been using Ella as our first line and the reason for that is because it is more effective than Plan B in people whose BMI is over 25. In addition, it is more effective between that window of 72 hours and 120 hours. So, between three to five days since last sexual intercourse, it's more effective. The problem with Ella is just that you have to caution the client when they are also using a progestin method, because there is a theoretical risk that the progestin can interfere with the effectiveness of Ella. So, you definitely want to talk to them about that. So, in that case, if there has been a progestin use within five days or somebody wants to start using, say, SubQ Depo immediately after taking their emergency contraceptive, then what we would recommend is Plan B. And Plan B is still effective up to five days after sexual intercourse, but its efficacy does drop on days four and five. And then again, the efficacy drops for weight above BMI of

25. There has been some off-label use of doubling the dose for Plan B for people who have elevated BMI. So that has been shown to be safe and effective, but it is not yet FDA-approved. And the other thing to note about Plan B is that it's available behind the counter. But FPACT only cover that by prescription only, so you would still have to prescribe it for your patient for them to have coverage.

## Dr. Michael Policar:

Right, exactly. In other words, in order to have Family PACT to be able to pay for it in that circumstance. Certainly, anyone could walk into a pharmacy and to be able to purchase it, it's just that Family, if they were a Family PACT enrollee, then Family PACT wouldn't pay for it. They only pay for it either when it's dispensed in a clinic or in the case when a prescription is transmitted to a pharmacy, and it's covered in that circumstance. So just as a quick reminder on the topic of emergency contraception, in Family PACT, we published a Clinical Practice Alert about the use of emergency contraceptive pills about a month and a half ago. In fact, we had a webinar on that topic. I think, roughly about two months ago, that is on the familypact.org website, both for the Clinical Practice Alert, and also if you want to hear that webinar if you didn't get a chance to hear first time around, but I just really wanted to emphasize what Jen just mentioned about the fact that if you use your ulipristal acetate or Ella and the patient wants to start a progestin containing method, but in particular wants to start oral contraceptives that we wouldn't do that until five days have passed since the time that the patient used Ella. If that sounds confusing or difficult to remember, that has been part of the patient package insert with Ella for at least three years or so based on the concern that Jennifer mentioned.

## Dr. Michael Policar:

All right let's go ahead to our next topic, and that is, since March, there's been quite a lot of interest in the subcutaneous form of DMPA for a variety of reasons. And I know that you've been very involved in this. For folks in the audience, I want you to know that Dr. Karlin is almost single handedly responsible for doing the advocacy that was necessary to have DMPA SubQ covered as both a pharmacy benefit through Medi-Cal as well as a Family PACT benefit, and she'll tell you more about the rules in terms of how that coverage works in Family PACT. So, tell us about Depo SubQ, and how it's different from DMPA given IM.

## Dr. Jennifer Karlin:

Thanks, Mike. Just to mention that I didn't quite do it single handedly. I had a really wonderful receptive partner in the Policy Division of Medi-Cal who heard the arguments and was able to write up through my literature review some very compelling reasons for Medi-Cal to be covering right now. So, I just also want to give him a lot of respect for making the time to even think about this when there's so much going on in terms of benefits of Medi-Cal right now but thank you. So yeah, so Depo-SubQ Provera 104 was approved by The United States FDA in 2004. It was actually originally developed to be self-injected, but it is currently not FDA-approved for at home use, although there has been ample evidence to show that self-injection is just as effective. And observational studies from a global setting show client preference for a SubQ formulation over IM due to some fewer side effects and less pain, especially at time points for subsequent injections. And so, as a result of the COVID-19 public health emergency, there was interested in offering Depo-Provera SubQ directly to clients for self-injection in order to reduce the need for in-person visits to health center. And so, through the 1135 Waiver, Medi-Cal and

Fam PACT have been able to pay for SubQ Depo-Provera for self-injection without requiring a PAR or what's commonly known as a prior approval. And I want to mention that this is really only a pharmacy benefit, so it is not something that you can dispense from clinic and then have it covered by FPACT. So, you can order the SubQ Depo-Provera to your clinics and then dispense SubQ Depo-Provera in that manner. It has to be paid in a pharmacy.

## Dr. Jennifer Karlin:

So, I'm going to go over a little bit about how SubQ Depo-Provera differs from IM. So, it uses a smaller, shorter 26 gauge by 3/8-inch needle and a smaller volume of liquid to inject into the skin instead of the muscle. And so, this oftentimes means potentially less pain for the client. It also comes prefilled and ready to use at home. So, the client is totally in control of this method. So, in that way, it also facilitates reproductive autonomy and empowerment. It contains 30% less hormone, and so some people find that it reduces some common side effects that they experience from IM Depo-Provera. However, it does take time to learn to use and so there have been some, so some clients experience local site irritation and soreness, especially on the first and second self-injection and this improves over time. And then according to the label, about one and 100 experience dimpling at the injection site.

## Dr. Jennifer Karlin:

So good candidates for SubQ Depo-Provera are people who are experienced in self-injection already. So, medicines that induce ovulation for IVF and insulin, or other drugs that have been used for multiple sclerosis are also SubQ formulations. But this can really be used by anyone who was interested. You want to use your clinical judgment though to determine whether this is appropriate for your specific client and you want to document this decision. Again, since prescribing it to a client for self-injection is an off-label use, you really want to document this decision in the medical record appropriately. And then the contraindications and the side effects are the same for SubQ Depo-Provera and IM Depo-Provera. And so, we want to remember to use that CDC MEC criteria for more information, and I'm not going to go into the specific side effects for both. But what I am going to mention is that there is no dose adjustment needed for BMI for both the SubQ and the IM formulations. And if you receive the webinar notes from this, we do have in the notes section information about just general side effects and contraindications for SubQ and IM Depo-Provera.

## Dr. Jennifer Karlin:

So, the use of SubQ Depo-Provera, so it can be injected at any time if it's reasonably certain that the client is not pregnant. So, the client can take a pregnancy test and report a negative result to you. If it is within the window of their last IM injection and they can be relatively certain that they are not pregnant. If their menstrual cycle is within the last seven days, there's no backup method needed. However, if it started greater than seven days since their last menstruation, they should either abstain from sex, use a barrier method, or use Plan B for seven days after start. Again, Plan B instead of Ella because the Depo would interact theoretically with Plan B during that window that we talked about. The other thing to note is that Depo-Provera should be stored at room temperature, so you want to instruct the client not to refrigerate it or freeze it or leave it in a warm location like a vehicle.

## Dr. Jennifer Karlin:

And now I'm going to go over the techniques for teaching how to do SubQ Depo-Provera to your patient. So, the first thing is you want to prepare the injection area. There's going to be three main steps that I'm going to go over. So, the first is preparing the injection area. So first you choose an injection site, and that can be either the left or right upper thigh or the abdomen. You can consider icing for five minutes prior to the injection to decrease sensation at the site. The clients' going to wash their hands, and then they're going to wipe the chosen injection site with an alcohol pad. That alcohol will dry while they're setting up the medication in the next step, so it doesn't burn when they inject. The next step is preparing the syringe. So, they're going to hold the syringe by the barrel, and they're going to pointed upwards, and they're going to shake for one minute and that's going to mix the medication. Then you're going to remove the protective cap by unscrewing it. You're going to attach the needle to the barrel, and then quickly move the safety shield away from the needle. You can see that happening in these diagrams. Then you're going to remove that plastic needle cover, and then gently push the syringe plunger up until there's liquid at the top of the syringe and this removes the air bubble. The third main step is just injecting the SubQ Depo-Provera. So, the client grasps the skin in their chosen site with their thumb and their forefingers. And then they insert the needle at a 45-degree angle, and this helps to keep the medicine in the subcutaneous area and not go into the muscular area. They're going to press that syringe slowly while counting to five. So, all the medicine gets delivered within five to seven seconds. So that's the goal of counting to five. And you want to make sure to give the entire dose. If, for some reason, a client removes the needle before giving the entire dose, you should recommend that they don't waste it and go push up more medicine and see if they didn't do enough, but just reinject themselves at the same site and finish giving it to themselves. Then they're going to remove the needle and cap the safety shield, and then dispose of it in the sharps container. And then just apply pressure to the area, but don't rub. One thing that you want to remember when talking to patients, typically the ones who are switching from IM to SubQ Depo is just remember that this is a new technique. Some of these folks have been receiving IM Depo for quite some time, and so they just assume that it should go into their arm, or they assume that it's exactly the same thing, even though you're telling them that it's subcutaneous rather than intramuscular. I found that that doesn't seem to sink in especially for people who are so used to coming into the clinic to get their IM injections. And they're just make sure that you emphasize that this is a new technique. So, it's really going to be in their belly or in their more fatty areas of their leg, and it's not going to be going into their arm or their buttock, which might be where we think of, that's where we place IM, intramuscular injections. And then the other thing I wanted to note that we've been talking to a lot of people about is they've been asking, put someone else in their family or somebody who is trained as an NEA or a nurse that they know give it to them, and the answer is yes, someone else can give that to them. And we've had a few people switch over and been really, really happy with having other friends or family members doing the SubQ injection for them.

## Dr. Jennifer Karlin:

And so, I've included many more client resources on subcutaneous self-injection, and these are both videos in English and Spanish on how to do subcutaneous injections and then written material in English and Spanish about how to do subcutaneous materials and then also have hyperlinks to the package insert.

## Dr. Michael Policar:

Jen, Jen, before we leave that topic, I wanted to make a quick comment and then ask you a question. So, the comments actually go back one slide, if you can, if you can't, that's okay. And it has to do with the sharps container, which sometimes is available in a pharmacy but it's not a Family PACT benefit. But what I've seen recommended is to take one of the heavy plastic containers that you buy laundry soap in, you know, so one of the big red containers for Tide or some other product but it has to be really very heavy plastic, and then to use that as a sharps container as soon as you filled it, if that's the case, then to put some kind of heavy tape, duct tape or something like that over the top or the original cap if you still have that. And then to be sure to put that in your garbage can and not in a recycling bin, because you don't want to recycle that plastic if it has needles in it. The question that I wanted to ask you about SubQ Depo, given the fact that you've mentioned that, at least, as a Family PACT, the Medi-Cal benefit that has to be obtained from the pharmacy. What have you been hearing about the availability of it? When Family PACT providers prescribe this, should they advise their patients that large majority of either chain pharmacies or private pharmacies are going to carry it or have there been problems in being able to obtain it at all?

## Dr. Jennifer Karlin:

Yeah, that's a great question. So actually, most pharmacies we've been calling around to the pharmacies just in our local area in San Francisco, and those pharmacies which include the outpatient pharmacy at San Francisco General itself, and then all of the Walgreens in San Francisco are able to obtain it within one to two days of it being ordered. So they weren't, they didn't have it, like in stock in their particular pharmacies but they're able to get it within a day or two. They're also providing free mailing of medications right now and also pickup so that and from the clients and from other people actually, Walgreens has been really efficient at this. They've been able to deliver within one to two days also of the order. We did have some problems with Safeway and CVS, and we've called and shared with them the 1135 Waiver and now that, in specific about the SubQ Depo, and now they are also on board in San Francisco itself. However, if you are having any trouble in getting SubQ Depo at the pharmacies, you can share with them the guidelines that are linked in this webinar and they will be able to get it. The other thing just to note about the, as you mentioned with the sharps container, that is a really good technique. Tons of people use that. In San Francisco itself, all sharps containers are free for anyone who requests them at the pharmacy. So, I don't know, so you just have to check if that is true in other counties.

## Dr. Michael Policar:

That's nice, I didn't know that.

## Dr. Jennifer Karlin:

Yeah.

## Dr. Michael Policar:

Great, okay.

## Dr. Jennifer Karlin:

Yeah, just tell your patients to ask for them. They have to provide them for free, but they are not prescribable--

## Dr. Michael Policar:

Okay

## Dr. Jennifer Karlin:

Under, like we are unable to prescribe them, but they are for free.

## Dr. Michael Policar:

Okay, all right, so advance your slide. And we'll get continue. By the way, at least one or two of the resources that you saw there are actually videos that will depict exactly the steps that Jennifer was just talking about in terms of patients learning how to do self-injection with Depo-Provera. So, even though the written instructions are available in many languages, sometimes the videos are even better in terms of helping people understand exactly how to do these self-injections.

## Dr. Jennifer Karlin:

Right.

## Dr. Michael Policar:

Okay.

## Dr. Jennifer Karlin:

I included on one video in Spanish and one video in English under those hot links.

## Dr. Michael Policar:

Great, thank you.

## Dr. Jennifer Karlin:

Okay, so, yeah, no problem. So, we've now covered the alternate service, the service delivery approaches to minimize in-person care. And I also talked about asymptomatic care, including contraceptive services. And so now we're going to move on to talk a little bit about symptomatic care, including genital tract infections, and Family PACT benefits and billing policies and how we should do that for our telehealth services.

## Dr. Michael Policar:

Okay, so we're, over me in just a moment in terms of being able to advance the slides.

## Dr. Jennifer Karlin:

Sorry, great. So, my first question for you, Mike, is can providers treat clients with symptoms of genital tract infections without a visit?

## Dr. Michael Policar:

And the answer is yes. We've known about how to do that for decades, although it primarily is related to research that has been in countries that have more limited access to healthcare services. It's something which is called syndromic management. And basically, what that means is coming up with a treatment, which is based on our best guess of the diagnosis using a person's symptoms, a description of their physical findings, but without the benefit of having laboratory tests available. So, the part of the guessing, basically is taking the symptoms and the signs that the person describes, sometimes even a photograph, coming up with their best guess of diagnosis, but of course, there's no guessing at the treatment. Once we've come up with what we think is the most likely diagnosis, then we'll treat the patient with exactly the same regimens that we're used to using. Now, most of the studies that evaluate this approach were either done back in the '80s, and the early '90s in the United States, or more recently, in low resource countries. And what it shows is that when you treat a person for a sexually transmitted infection or a genital tract infection without doing laboratory tests, that it actually is fairly sensitive for making a correct diagnosis. You really don't miss any of the people who really do have the condition that you have diagnosed. However, it's not very specific. And that is to say that also false positives are a possibility which can result in overtreatment. But given the unusual circumstances of the public health emergency, we're actually willing to sort of sacrifice some amount of specificity, knowing that we might overtreat some people just in order to make sure that everyone does receive some kind of treatment and that we're not missing anything.

## Dr. Michael Policar:

So, let me give you some examples of that. If, for example, a patient is having recurrent symptoms of something that they've had previously diagnosed, let's say, this is a female who has recurred herpes, she's had bacterial vaginosis or vaginal candidiasis before. In the conversation with this patient, it sounds like the episode that she had previously, it's completely reasonable just to add or to provide for her presumptive treatment, make the best guess of your diagnosis and then the treatment that you would otherwise offer her. On the other hand, if it's a new problem, then of course, you do need to obtain a quite thorough history using your telehealth and we'll talk more about that in just a moment. And then think about what the most appropriate empiric therapy would be in that circumstance. So, one of the examples that the CDC gives in their recent guidelines is that if a person complains of a malodorous, in other words, a fishy smelling vaginal discharge, chances are great that she either has, either vaginal trichomoniasis or bacterial vaginosis. And if we give her metronidazole 500 milligrams twice a day for a week, it'll treat either condition. So, again, in that circumstance, we're treating on the basis of the description of what she has going on, rather than necessarily looking under the microscope or having other tests available. It's also possible that some clients might actually be willing to take a cell phone photograph, let's say if they have a genital rash, for example, and submit it to you as the clinician and based on the history that they give you, what you're seeing in the photograph that's been transmitted to you that that might help in making the diagnosis as well. And in fact, I'm going to be talking about billing in just a moment. But there is a new code, which is covered both by Family PACT

and Medi-Cal that goes under the category of virtual check-in visits. This one's G2010, and you'll be paid, in addition for the evaluation of what that person's rash, rash, rather, or what their lesion looks like.

## Dr. Michael Policar:

In addition, there are some circumstances where you really just can't make the diagnosis based on a description of the patient's symptoms and what she tells you the characteristics of the discharge are, and you still want to be able to do a test to confirm what the diagnosis is. So, what some clinics have been doing is to use curbside pickup of a kit, where a person can do home sampling of their vaginal discharge. Typically, the way that that's done basically is that the client stops by the clinic. Oftentimes, there's some arrangement as to the fact that one of the staff members is going to be able to meet her outside, give her a bag that has a sampling kit that in the case of evaluating a vaginal discharge would be a stoppered plastic or glass tube that has a cc of fresh saline in it and a pack of sterile cotton tipped swabs. And what happens is that she goes home or somewhere nearby that's private, swabs her vaginal walls, immediately puts the swab back into the tube and caps it and then drops it off at the clinic as soon as possible. And it really is important that that be done quickly because if you're trying to see the motility of trichomonas, for example, they are very sensitive to light and oxygen and heat and the osmolality of the solution that they're suspended in, and they'll only live for probably a half hour or 45 minutes. So, you really want to evaluate that quickly through the microscope the way that you would if the patient was there physically. Now, it's also true that you could do that if you needed to do a gonorrhea or chlamydia in that test, for example. Of course, it's very different collection container than what I just described, whatever your lab is already using. But you can arrange for her to pick that up curbside in a paper bag or another way of being able to give it to her after you have confirmed her identity. She can then go to another site, sample her vagina for chlamydia and gonorrhea, put that back into the sample container and then drop that off at the clinic. It's very much like what you might do now in your clinic in terms of having a patient going into the bathroom self-sampling to obtain her gonorrhea and chlamydia samples within that test, and then you're sending that to the lab that you would normally use. I will just mention very quickly in the context of Family PACT. There is no policy about doing this one way or the other. I will say that that the reason I even bring it up is because there's an assumption that, basically, you're going to use the same collection materials that you do now, and you're going to send it to the same laboratory that you do now. Of course, there's no additional billing that you would do for self-sampling in comparison to a sample that you would do normally face-to-face in your clinic. But the point is, is that this is an adaptation during the public health emergency for you to be able to do these tests and send them to your lab in the way that you normally would, to have them evaluated without having to have the patient come into the clinic.

## Dr. Jennifer Karlin:

Great, those are all such great examples of being creative during this time and different things that you can do. Thanks so much, Mike. I'm wondering, can family planning providers, if we're able to treat the clients directly, are we able to use expedited partner therapy for gonorrhea or chlamydia treatment of partners?

## Dr. Michael Policar:

Sure, we can, and we can do that in the way that we have been doing that historically, that whenever we find a person who test positive for gonorrhea, chlamydia, or both, based on CDC guidelines, which have been endorsed by ACOG and a variety of other organizations, we can offer expedited partner therapy to the patients' partners either by writing a prescription in the name of the partner or doubling the dose of the medication which is dispensed to the client. Now, question oftentimes comes up in the context of Family PACT. What about expedited therapy for a partner? And at least in Family PACT, that person does have to register as being a Family PACT patient in order to have Family Pact pay for the prescription. On the other hand, remember that these medications, and I'll review which antibiotics in just a moment, are available in pharmacies, you're basically using a single pill for the treatment of gonorrhea, a different pill for the treatment of chlamydia. And in particular, if you use one of the apps like GoodRX.com, there are other companies that do the same thing. You can get really, hugely discounted access to these prescriptions, even if the medications are not going to be covered by a health plan, Medi-Cal, Family PACT, or so on. So, either of these approaches can be used. Or even more critical during the public health emergency because of the fact that we don't necessarily want partners coming into the clinic, as we did in days before where we want to evaluate the patient's partner, be able to prescribe medications face-to-face, in fact, ideally do it as directly observed therapy, but in this circumstance, we should still be doing expedited partner therapy in the best way we can make sure that partners are treated for gonorrhea and chlamydia, but without the necessity of a face-to-face visit.

## Dr. Michael Policar:

Now, one of the things that I wanted to mention to you, and in fact, this was just very recently published, in fact, this week is that the California Prevention Training Center has published interim STD treatment recommendations based on initially some CDC guidelines that have come out, but they have been embellished by the California Prevention Training Center. And what you will find in the first light blue column are the various preferred treatments for things like male urethritis, vaginal discharge without PID, genital ulcers, proctitis syndrome, and so on. So, the first column are the drugs that we would use if we could see the patient face-to-face. The middle column, which is entitled Alternative Treatments, lists strictly oral medications that would be available to patients if we are going to be treating them syndromically. So, in a single nicely done document, basically, you can see the adaptations of being able to do syndromic treatment based on oral or topical medications without having to have a patient be seen in-person in the clinic.

## Dr. Jennifer Karlin:

Awesome, so what about if providers should continue to provide later doses of HPV vaccines? Oh sorry. The next question is, how should family planning providers manage people who are found to have abnormal cytology results during this time?

## Dr. Michael Policar:

Okay, so first off, should we be doing cervical cytology screening at all? And the answer to that is no. It's something that that should be postponed until you can get patient back in to be able to see them in-person in the clinic. And that may take a while, that may take months. But the reality is, is that the development of cervical dysplasia and ultimately cervical cancer is such a slow process over the course

of years, that in the balance of personal health versus public health, it's best just to delay doing cytology. On the other hand, let's say, a person had a surgical cytology done before all of this started in March, and now you're having to deal with an abnormal result. When do you have need to get people in for colposcopy or further treatment and when is that unnecessary?

## Dr. Michael Policar:

Unfortunately, the ASCCP, the American Society for Colposcopy and Cervical Pathology has actually published interim guidance. When you get the slide deck, you can click on the link and you'll be able to see their full statement but in the table that I've included for you, it gives you the ASCCP guidelines about how long it would be reasonable to delay a diagnostic evaluation or treatment for a person who previously had an abnormal cytology, or for that matter, an abnormal biopsy result. So, in someone who had a low SIL cytology result, you can postpone that diagnostic evaluation for up to a year. If it's somewhat more worrisome like a high SIL or an ASC-H, I'd like to get those patients evaluated by colposcopy within three months. On the other hand, if she has a suspicion of high-grade disease without suspected invasion, sometimes the cytology result will actually mention the possibility of invasion. Those patients do need to be evaluated more promptly, ideally within a matter of a few weeks and have their procedure scheduled within three months. And if there's frankly suspected invasive disease, contact the patient within two weeks, and then evaluate her within two weeks after that. There is a little more detail. go straight to the ASCCP guidance at the link to find out about that.

## Dr. Jennifer Karlin:

Great, thanks so much for going over all of the symptomatic patients and what we should be thinking about when we're caring for them during this time. I think a lot of people probably have questions about the Family PACT policies, particularly around billing about telehealth services. And I'm wondering if you could tell us a little bit about that.

## Dr. Michael Policar:

Sure, let me take a few minutes to review those and then we'll go to our questions and answers, whoops. And see if I can go back, oh, yeah, great, okay. So, on the familypact.org website, you will find a number of policies and updates that have to do with Family PACT policies that have to do with the public health emergency. So, you'll see the URL down at the bottom in order for you to be able to go one-stop-shopping and to be able to actually have a look at some of the policies that I will mention next.

## Dr. Michael Policar:

First off, I'm going to assume that many of you are doing some amount of telemedicine already. I'm going to use that term rather than telehealth. But for those of you who haven't, let me just very quickly mention to you what are considered to be acceptable telemedicine visit platforms. Number one, over the last years, we have seen the advent of telehealth or telemedicine modules that are linked to your electronic health record. So, for example, if you're using Epic or one of the others, they may have telehealth capability already, which is really important because of the fact that you don't have to write two notes. One that goes into some kind of telemedicine template and then a separate one that gets transmitted over to the to the electronic health record. It all happens in one place. Second is that there are a variety of telemedicine products out there that, again, had been available for years that are HIPAA

protected, somewhat relatively more expensive but quite robust. The third is that there have been a number of new telemedicine products available. Zoom, doxy.me, eVisit, some of the others, and NFPRHA, the National Family Planning and Reproductive Health Association has a really nice guidance about the various telemedicine products that are out there as does the American Academy of Family Physicians. If you want more detail about which telehealth products that you'd be able to buy, that are somewhat less complex and less robust, but they're also quite a bit less expensive. So, these are products that you can start using very quickly if you wanted to in your clinic. In addition to that, during a public health emergency, there are other non-public facing ways of doing audio video interactions, which are considered to be acceptable, so Skype, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, are considered by CMS, the Center for Medicare, and Medicaid Services, consequently, Medi-Cal and Family PACT to be acceptable platforms for you to be able to do audio video visits with your patients. They can't be public facing, which means, that they have to be confidential between the clinician and the patient, but any of these are acceptable products.

## Dr. Michael Policar:

And this is one that you've probably been waiting to see and that is when it comes to telemedicine, what does Family PACT cover? So, I will tell you what they are first and give you a little bit more detail in just a moment. So, there are two brand new benefits and by that, I mean, starting in about mid-March, which are called virtual check-in visits, and they were first described by CMS in Washington, D.C. but they apply in Family PACT and in Medi-Cal. One is called a store and forward, that is when a photograph is emailed to the clinician. The other is called a virtual check-in visit, that's done by telephone. Next is an E-consult. So, if you want to consult an expert in family planning about a problem that your patient's having, you want to get in touch with Dr. Karlin or another expert in family planning, they can actually do a consultation for you where they will get paid for giving you advice, and that one has actually been available since August of 2019. Also, Medi-Cal and Family PACT cover what are referred to by CMS as telehealth visits. The E/M codes that you're used to using 99201 through 204 for new patients, 99212 through 214 for established patients. However, those visits have to be both audio and visual. I know you may have heard me say in an earlier webinar about the fact that a telephonic-only visit was acceptable. It turns out that that is not the case. The Medi-Cal program in California had, in fact, asked CMS for a waiver in order to allow us to do telephonic-only visits. Certain parts of that 1135 Waiver were approved, but the concept of doing telephonic-only visits for office visits was not approved. And those are not benefits of Family PACT at the moment. They have to be e-visits. So, let me tell you a little bit more about those.

## Dr. Michael Policar:

So, this virtual check-in, store and forward is defined as the remote evaluation of a video or images submitted by an established client. However, the established client part has been waived, so it could be a new patient or an established client. But it has to be just for the purpose of looking at that picture. So, what the rules are is that that can't be related to an E/M service that you've provided within the last seven days, or if you're going to see the patient within the next 24 hours. It has to be a standalone service. And there's an expectation that the clinician is going to interpret that photograph and get back to the patient within 24 business hours. The way to code for that is with G2010. An example of that I gave you earlier and that's a client who has a genital skin lesion, where she or he is willing to take photographs of the skin lesion and submit it to your clinic, or your clinician, I should say, for evaluation.

## Dr. Michael Policar:

Next is something called a virtual check-in visit, and the way that CMS defines that is as a discussion over the telephone or through video or through images to decide whether or not an office visit or another service is needed. So, CMS in Washington basically knew that a lot of patients would be communicating with clinics to have a conversation about, should I be seen in-person? Or is this something that we could handle over the phone? And that's where they came up with this particular category. That call has to be initiated by the patient. Initially, it said, that she had to have an established relationship with the practice, but again, that's been waived, so now it could be a new or an established patient. And again, it has to be something which is standalone, not related to a visit within the last seven days or doesn't lead to a visit within the next 24 hours. The client had to verbally consent to receiving this virtual check-in visit, and the way to build that one is with the HCPC code G2012, and that's described as five to 10 minutes of medical discussion. Now, in Family PACT, the way that that could be used is basically any short telephonic visit with a patient. Certainly, if you're trying to find out whether or not you need to come in, but other types of telephonic visits within this very short timeframe can be built with G2012. In addition, of course, there is an expectation that that will be recorded in the medical record.

## Dr. Michael Policar:

The next one I mentioned is an E-consult, and that is an interprofessional conversation basically between a requesting clinician and consultative clinician is going to be able to give an opinion about how to manage a particular patient. The code for that is 99541. And of course, that is a code which is going to be submitted by the consultant, takes about $35 or so.

## Dr. Michael Policar:

Next is the true telehealth visit. This is something which has been available in Family PACT since August of 2019, so it's not new but it is the way that full telehealth visit should be now billed to family PACT. It is defined as a real time interactive audio and video telecommunication using one of the platforms that I mentioned a moment ago, and there are a variety of providers who are eligible for those visits, physicians, nurse practitioners, physician's assistants, CNMs, nurse midwives, certified registered nurse anesthetist are all eligible to be able to do these telehealth visits. Now, initially, the way that CMS had described them was that it had to be in the context of a patient who already had an established relationship with the practitioner that is being waived during the public health emergency. So, it could either be a new patient or an established patient. So, as I mentioned a moment ago, these visits are built with the same E/M codes that we're used to for new patients or established patients. What's going to be different for your biller is that number one, the place of service is 01, which means an electronic interaction rather than, going to be 02 rather than 01. 01 means an office visit, 02 means a telecommunication visit. So, you use 02 is the place of service, and then that E/M code has to have a 95-modifier attached, which says that it's a telehealth visit.

## Dr. Michael Policar:

And one of the questions that commonly comes in is, do those visits if they're done by audio visual telecommunication, do they pay the same as what Family PACT would pay for an office visit? And the answer is yes, they're paid at exactly the same rate. I just include this to remind you about what the timeframe is for choosing to use a particular E/M code. And so, the way things work now is that it is the

time spent during that audio video visit that is used to decide which level of E/M code would be most appropriate for either a new patient or an established patient. It does not count the time of reviewing the chart before the visit, writing your note after the visit. The official CPT and definitions of these codes are going to change in 2021 where those factors will be included in the E/M code, but not yet, so wait until you hear that until next year.

## Dr. Michael Policar:

Now, one of the things you may have heard about is that during the time of the public health emergency, that clients can be enrolled and recertified by phone as a way of trying to keep them out of your office, and you'll find in one of the references. I'll tell you about in just a minute or two about the details of how to do this, but providers can complete both the client eligibility certification or the retro eligibility certification on behalf of the patient via a phone call. You have to obtain consent to sign on behalf of the client. Remember that this is only during the public health emergency, once the public health emergency is over with and this terminate, OFP will tell you when that is, and I've included the link to these newsflash articles that give you the details about how to do that. Now, do you need to get an electronic signature? And the answer is you can do that with something like DocuSign if you want to, but you don't necessarily have to do that. The provider that is to say someone in your office of the designee has to sign the client eligibility certification on behalf of the client that has to be maintained in the client's file. And then you have to make sure that the patient is able to receive their HAP card or the HAP number because that is necessary in order for them to be able to get prescriptions and so on. So, either they have to find a way of stopping by and picking it up curbside or you have to mail it to the client's address with their consent for you to be able to mail it to them, but it's not just enough to certify them on the phone. You have to make sure that they actually get their HAP card in addition.

## Dr. Michael Policar:

Now, just a couple have other things that I'm sure you'll ask about and then we'll wind up. How about HIPAA requirements for telemedicine? They are relaxed during the time of the public health emergency and the Department of Health and Human Services in Washington has basically said that there is a limited waiver of certain HIPAA sanctions, just to make sure that we're able to do these telehealth visits during the public health emergency. So, we do certainly pay attention to patient confidentiality, but just remember that the all the details of HIPAA will not necessarily be followed during this time period.

## Dr. Michael Policar:

Another question is do we have to get verbal consent in order to do a telehealth visit? And the answer to that until recently is that that is a good idea that we should get the patient's verbal consent to have this telehealth interaction, document that in the client’s record, share a digital copy of that consent with her when possible. Then the next time she comes into the clinic once the public health emergency is over with and give her a copy of her consent. Make sure that you have some amount of detail about what's involved with her giving consent, and this is an example of how you might document it.

## Dr. Michael Policar:

And in fact, there's a website from the federal government that actually gives you very good advice about how to obtain consent for telehealth. Remember that the AHRQ is actually the group that's

responsible for the US Preventive Services Task Force guidelines. And at this part of the website that they just recently posted, it gives you very helpful tools in order to be able to get consent, rather, for telehealth services.

## Dr. Michael Policar:

However, you've probably heard about the fact that Governor Newsom signed an executive order about a month ago which basically says that the telehealth consent requirement for Medi-Cal, and then consequently for Family PACT is suspended during the public health emergency. So, for Medi-Cal Family PACT patients, while you can certainly get consent for a telehealth visit if that's your practice and want to be able to do that, you don't have to do it in California during the time of the public health emergency, but of course that will be end dated at some point. And also remember that other payers, for example, title 10 may still require that consent be done.

## Dr. Michael Policar:

Now, you also know that registered nurses can dispense and administer hormonal contraceptives under certain circumstances in California that's been part of Family PACT for at least three years now. And so, the question has come up about whether or not RNs can do the virtual check-in visits, for example? Or if they could do the audio video visits? And the answer is yes, they can, following the rules that I just told you about a moment ago. That registered nurses, following these very specific rules of the Business and Professions Code can prescribe and dispense combined oral contraceptive progestin-only pills, patch, ring, and emergency contraceptives, as well as administer DMPA IM and they would bill for those visits as I have listed for you with a modifier-TD. So, a long-winded way of basically telling you that RNs that we're doing this before can now do this by audio video telehealth visits.

## Dr. Michael Policar:

How about pharmacists? Can they dispense hormonal contraceptives without a prescription? The answer to that is yes in both Medi-Cal and Family PACT. So, a furnishing pharmacist has to be enrolled as an ordering, referring, and prescribing provider. They are paid for the cognitive services that they do at 85% of what the rates are in clinics, and there are specific rules about that in the Family PACT PPBI.

## Dr. Michael Policar:

And this gives you an idea of what furnishing pharmacists can provide, both in terms of the billing codes for new and established patients as well as the methods that they can initiate or just giving contraceptive counseling and advice without the initiation of a method.

## Dr. Michael Policar:

Pharmacies and clinic providers can also be reimbursed for mail delivered medications as well. Medi-Cal has rules about how that's done, and it's important for you. If you're not a pharmacy, you are a clinic, to make sure that you meet those rules in terms of mailing medications, that that is something that you are capable of doing.

## Dr. Michael Policar:

So, I'm going to wrap up now just by telling you about some really important resources that are available to you. The first three are Family PACT policies for what we've just discussed. Probably the most recent and important is the Family PACT provider FAQs that were published about two weeks ago, the Depo SubQ guidelines, which Jen talked with you about, next to the Family PACT guidelines for virtual and telephonic communications.

## Dr. Michael Policar:

These are the two references that are almost identical that have to do with online eligibility certification. These are links to the corresponding Medi-Cal policies and then there are two last things that I want to tell you about.

## Dr. Michael Policar:

One is that the California telehealth Resource Center has very helpful videos instructions about how to set up a telehealth program. But this particular resource, which is free, has all of the telehealth policies, of all the Medi-Cal managed care plans in California, and it's especially helpful if you're an FQHC, to know how to bill for telehealth services.

## Dr. Michael Policar:

So, with that, I will go ahead and wrap up. Remind you that I've included Jennifer and my email addresses at UCSF if you can think of subsequent questions. But I'm going to hand the microphone back now, but for the time that we have left, we will go over some questions.

## Dr. Jennifer Karlin:

Okay, great.

## Dr. Michael Policar:

Oh, there we go.

## Dr. Jennifer Karlin:

Nicole, should I just start going through some of the questions that have been sent on over to us?

## Nicole Nguyen:

Yeah, go ahead and start it.

## Dr. Jennifer Karlin:

Okay, great. So, it looks like there are three main buckets of questions, so I'm going to go over those. And if Mike and I do not cover all of your questions, like he said, you're welcome to email us. And the first question just starting, because Mike was just talking about billing and policies. There were some questions about the 1135 Waiver and other insurances for SubQ Depo. We didn't cover that, because this is mainly, this webinar is mainly about Fam PACT providers. But I just want to be clear that the 1135 Waiver is a federal waiver. It's a federal waiver that allows flexibility for public health departments

across the country to change their benefits during the 2019 COVID pandemic. So that's what the waiver is for, and under that waiver, Medi-Cal was able to approve SubQ Depo for self-injection without requiring prior approval, which also applied to Family PACT. So, in terms of other insurances, people would have to check with their individual insurances prior to learning that this was not a covered service. I went through, for example, all of the insurances that the Family Health Center and San Francisco General take, and I looked at the individual formularies to see whether or not they were covered. And so, what I will tell you is that it was very varied, but there are, you can always do a prior approval, you can always advocate by now taking this Medi-Cal, this Medi-Cal guidance to the individual insurances and are doing that they should also be following suit. And so, I think that that goes a long way, and I will tell you that we just had a resident in our clinic talk with Anthem, Blue Cross, and got it also covered for patients. So, I think individual advocacy, if you have the time and space to advocate for your clients is always helpful.

## Dr. Jennifer Karlin:

We already discussed the disposal of the needle and how you can get that covered. Again, you'll have to look in terms of your counties about whether or not the individual pharmacies will dispense them for free. In San Francisco County, it is free. And then Mike described a really great way to use alternative types of bottles to dispose of the needle.

## Dr. Jennifer Karlin:

And then there was a bucket of questions about blood pressure. So, one of the questions was, do you accept reported normal blood pressure are documented, means your clinic has a document in normal blood pressure reading? That's a really great question. So, having a normal blood pressure documented means in any clinical setting. So, it could be in your clinical setting or through care anywhere. If somebody has a normal blood pressure documented in another clinical setting that one can be used. Again, remember the diagnosis of hypertension has to be at two different setting, two different locations. So, it's not just one elevated blood pressure reading, but it is multiple blood pressure readings. So, if you do see normal blood pressure readings in other settings, you can use that for that three to five years.

## Dr. Jennifer Karlin:

There was a question just clarifying when a patient has controlled hypertension and normal blood pressure, what about prescribing estrogen-containing methods? Again, normal controlled blood pressure is still a MEC category, like someone actually diagnosed with hypertension. So again, abnormal blood pressure at two different locations and two different time, and then they are adequately treated. According to the MEC, it is still a category three, which means theoretical or proven risks outweigh the advantages of using the method. So again, you're going to talk to your patients about that. And this is also considering that they do not have any of those other cardiovascular risk factors that we discussed.

## Dr. Jennifer Karlin:

And then the last set of questions was about isolation gowns. So, the CDC guidance guidelines do not necessarily recommend isolation gowns, even if you are physically in contact with a patient. They do recommend still gloves and proper hand washing techniques. But they've noted that, and the concern is

really that you're going to have droplets that are going either into your oral orifice. So that's why the eye protection and the mouth protection, but if you're doing an IUD insertion or removal, there are no recommendations for wearing gowns during that procedure and we're not doing that at the Family Health Center or at San Francisco General but certainly across the country, as many of you know, people are wearing scrubs and changing their clothes before they get home and doing a bunch of different things that make sense, depending on the risk that you are incurring. But for asymptomatic people, we don't think that it's necessary to wear PPE gowns. And with that, I will turn it over to Mike for his questions and Mike?

## Dr. Michael Policar:

I'm going to try to go through a whole bunch really quickly, but what were you saying?

## Dr. Jennifer Karlin:

Oh, I was just going to say that I don't know if this is going to be in your set also, but there's one last question about recommending returning to well woman exam if we have time at the end.

## Dr. Michael Policar:

Okay, all right. So, here's where we're going to go. As Jim Cramer would say the lightning round, okay, well, Family PACT pay for two packs of Plan B at one visit? I was under the impression that they only pay for one. That is correct. So, Family PACT only pays for one pack of EC at a time up to six packs per year.

## Dr. Michael Policar:

Next is, during the public health emergency, does Family PACT cover a home pregnancy test if prescribed? The answer to that is no. They haven't issued any kind of memo or anything like that. Newsbreak is what they've been doing recently that would say that that would be covered.

## Dr. Michael Policar:

Some really good questions about the billing codes that I mentioned, were telehealth services under Family PACT when billing, do we submit G2010 or G2012 as a standalone code or would the E/M codes be required as well? No, those two are definitely standalone codes. So, the G2010 is for having a look at a picture and then giving the patient a feedback about what you think is going on there. G2012 is for the virtual check-in visit which is that five or 10-minute telephone visit, but G2012 is technically the only telephonic visit that Family PACT covers. I know that really comes as a surprise. It was a surprise to me, because there were things coming for Medi-Cal in the middle of March, which certainly gave the impression that the State Department of Health Services had asked for this federal waiver to allow telephonic visits, but apparently that was not approved. And you we have seen nothing since then, from either Medi-Cal or Family PACT, which says that telephonic visits billed with an E/M code are an acceptable benefit. It might be with your MediCal managed care plan. It certainly might be with your commercial health plan. But at least with Family PACT, the only telephonic visit that's covered is a G2012, which is the virtual check-in visit.

## Dr. Michael Policar:

Let's see, I mentioned doubling the dose for expedited partner therapy for STIs. Does Family PACT cover a double dose? The answer is they don't at this point. There have been some discussions about trying to make that available at some point. The reason I even mentioned it is because of the fact that it is a CDC recommendation about doubling the dose. So yes, it can be done legally, but that doesn't necessarily mean that the payer is going to necessarily cover that.

## Dr. Michael Policar:

When presumably treating Trich and BV, does giving metronidazole two grams orally in a single dose cover both? Or does it really have to be given twice a day for seven days? The answer is twice a day for seven days. Metronidazole, two grams, of course, is a really effective treatment for Trich. It's not a very effective treatment for bacterial vaginosis. It works less than 50% of the time. So that's why the recommendation is to use the seven-day therapy if you're trying to treat both of them presumptively.

## Dr. Michael Policar:

How do we bill Family PACT for certifications and recertifications? I don't think that you do unless you have been in the future. I'm not an expert in that area. So, if that is billable, you will find that in the memo of March 20, and definitely in the frequently asked questions, but it's also contained in the Family PACT newsflash of March 26th that I mentioned to you. It has quite a lot of detail in there.

## Dr. Michael Policar:

Okay, let me see, anything else. Jen, do you have anything you want to mention. You were going to bring up something?

## Dr. Jennifer Karlin:

Oh yeah, yes. So, there are also two really great questions about if there's been any studies looking at the interests of SubQ Depo in the adolescent population, and there has, an article published in contraception in 2016 by Ushma Upadhyay and Diana Greene Foster et. al., looked at the interest of self-administration of SubQ Depo in the United States. In their patient population, they had 24% of their patients were between the ages of 15 and 19. And then 35%, were between the ages of 20 to 24. So, you get about a 50% of our patient population between the ages of 15 and 24. And overall, about 21% were interested in self-administration of SubQ Depo, and the interest was mainly driven by a desire to eliminate unnecessary return visits. We have also been at the Family Health Center calling all of our patients who are on IM Depo and seeing if they're interested in switching over to SubQ Depo. And we're getting about that same interest rate about, we're actually getting about 25% interested and it is across the board in terms of all ages. So, I wanted to answer that question.

## Dr. Jennifer Karlin:

And then there was another question about billing for and I don't know if this has been answered, but just specifically again, you can bill for teaching about SubQ Depo under the same billing code of surveillance of injectable contraception like you were doing before. So, you would still be billing for

teaching how to do SubQ Depo, and that can be done via telehealth through an RN or a provider depending on who has the capacity in your setting. And then I just hope--

## Dr. Michael Policar:

Do you remember that has to be done as a video visit, but you're exactly correct. But it just can't be done telephonically only.

## Dr. Jennifer Karlin:

Okay, and then, Mike, if you could just answer the question about Fam PACT and recommending returning to well woman visits? We don't generally have well woman visits in our practice on a yearly basis. So, I'm just wondering if you can reply to that question.

## Dr. Michael Policar:

Sure, yeah, although no one knows exactly when the answer to that is, I mean, the answer is that when the public health emergency has at least temporarily subsided, and you're starting to see patients person face-to-face in your clinic, or I should say in-person in your clinic, then you can start doing well woman visits again. And this is like strictly just conjecture, but I think that chances are fairly good that, let's say, by July, August, September, that many clinics are going to start doing more and more in-person visits, just because some of the sort of lockdown things or shelter in place that we've been seeing will be lifted to some degree. But almost certainly, later in the fall, in the end of the winter, we will probably see another wave of reports of COVID-19 infections. In which case, we may go back down into some sort of lockdown. So, the point is that we may be sort of vacillating back and forth between being open for a while, and then being closed for a while and going back to basically remote visits. But the point is, is that you're going to have to take that too basically from your local public health authorities about when you can start doing more in-person visits. And once that's the case, you can start phasing in those well woman visits again. Although I'm with Jen that for the most part, those really don't need to be done. Nor does Family PACT actually recommend them or have any expectation that they're going to be done. I know that you do need to at least have a contact with a patient at least once a year in order to update her prescriptions.

## Dr. Michael Policar:

I'm just going to say one last thing, though, that because I know that we need to wind up, we're a little over time already. But there are many, many questions. Sometimes people are really quite shocked saying, "You mean that we can't be billing Family PACT "for visits using standard E/M codes, "doing telephonic-only visits?" And the in the answer to that is, I'm really, I'm sorry to be able to say this, but no that doesn't, that idea, that policy was never approved in such a way that is considered to be an acceptable way of doing a Family PACT visit. Now, that doesn't mean you can't do telehealth visits, you can, you just have to do them with an audio-visual format, and that's why I was telling you about things like using FaceTime, Zoom, some of the others that you can hopefully very quickly get up and running. And in that circumstance, as long as there's a video component, then absolutely you can bill Family PACT for those visits, but they have to have a video component. And there's nothing in the Family PACT, either there are news flashes or there are guidelines, or the PPBI, at this point, which say that it's acceptable to do this strictly as an audio with the exception of the virtual check-in visit that I told you

about, the G2012, which, by the way, does not need a 95 modifier, and that can be done strictly on the phone. Nicole, you want to wrap things up, or?

## Nicole Nguyen:

Yeah, so it looks like all the questions were answered. And thank you so much to you both. That concludes our webinar, please fill out the survey at the end. Your feedback is extremely valuable in guiding what kind of content we provide for this and for the future. Again, the recording and the slides will be sent out in a follow up email. I want to thank you, our wonderful presenters for giving such an amazing presentation. This has been super helpful, and we hope you all enjoyed it. And then lastly, thank you to you all for joining us today. We hope you stay safe and have a wonderful weekend.