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INSIDE

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Shift to Telehealth Could Remain Trend After COVID-19

Reproductive health remains priority

Telehealth was a small part of family planning before the COVID-19 pandemic. The landscape likely will look markedly different for telemedicine strategies after the pandemic.

"If there's a silver lining to the pandemic, I hope it's that we have more ability to do telemedicine," says **Amy Paris**, MD, MS, director of family planning, Dartmouth-Hitchcock in Lebanon, NH.

Telehealth is a completely different model of healthcare that will be the new normal, said **Sophia L. Thomas**, DNP, APRN, FNP-BC, president of the American Association of Nurse Practitioners. Thomas spoke at a COVID-19 media videoconference on April 9. "I think going forward this is going to be a new shift in healthcare, the way we provide healthcare in this country," Thomas predicted. "I think we're going to be able to do more over telemedicine."

> "IF THERE'S A SILVER LINING TO THE PANDEMIC, I HOPE IT'S THAT WE HAVE MORE ABILITY TO DO TELEMEDICINE."

From a family planning perspective, telehealth visits have been a positive experience that both patients and providers favor, Paris notes. "We get consults from people all over the state of New Hampshire and Vermont, and they might have to drive two to three hours to be here," she says. "I had a woman in her 70s, who had a new ovarian cyst, referred for consult. She was just so happy to have a phone consult with a gynecologist that did not require her to make a two-hour drive."

Telehealth offers many benefits to patients, including convenience. *(See story on telehealth strategies in this issue.)*

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"When we first looked into telehealth, it was all for access and convenience," says **Evelyn Kieltyka**, senior vice president, program services, with Maine Family Planning in Augusta, ME. "Maine was an early adopter for [telemedicine] reimbursement, so it made it financially feasible, as well. Even five years ago, Maine was one of the few states that allowed you to bill for telehealth visits."

Maine Family Planning has ramped up its telehealth visits to include a wide range of services because of COVID-19, Kieltyka says. "Every day, there is a rethinking about workflow. We're making abortion care available through telehealth."

Telehealth rules were relaxed, both federally and by many states, during the COVID-19 crisis. For examples, rules requiring videoconferencing can be waived in favor of phone calls when patients do not have access to videoconferencing, Kieltyka says.

Lessons Learned from Natural Disaster

An Alaska family planning center was prepared for the telemedicine shift because of its experience during a natural disaster. "In November 2018, we had a really large earthquake in several places near Anchorage. That was enough of a wake-up call that we created a continuation of operations plan," says **Catriona Reynolds**, executive director of Kachemak Bay Family Planning Clinic in Homer, AK.

The clinic changed its personnel policy to have employees continue to work during an emergency. If there is a disruption to the clinic's daily census and practice, then staff can use their available time to catch up on things like completing all needed training and starting projects they had postponed, she says.

Kachemak Bay Family Planning Clinic worked at exploring telehealth options and navigating legal and financial barriers. In the summer of 2019, the clinic implemented a new electronic health record (EHR) that included a robust telehealth feature. The new EHR, along with the temporary government changes in telehealth during the pandemic, made it easier to move services to telehealth once the COVID-19 crisis began, Reynolds explains.

"I think that box is open," Reynolds adds. "Telehealth is going

EXECUTIVE SUMMARY

Telehealth was not widely used by family planning clinics before the COVID-19 pandemic, but it is likely to stay around post-pandemic as a more significant healthcare strategy.

- Clinics quickly shifted to phone screening and initial consultations, as well as videoconferences with patients.
- Some clinics provided contraception renewals and new prescriptions through telemedicine.
- The Office for Civil Rights said it would not impose penalties for HIPAA noncompliance against covered health providers that used telehealth during the COVID-19 national emergency.

to be here to stay for remote areas like ours."

Before the pandemic, all states provided reimbursement for some type of live video in Medicaid fee-for-service. Remote patient monitoring was covered by 22 state Medicaid programs. California and Connecticut Medicaid programs reimbursed for eConsult.[1]

Since the pandemic resulted in widespread stay-at-home orders, telemedicine rules were temporarily changed. For example, the Office for Civil Rights said it would not impose penalties for noncompliance with HIPAA rules against covered health providers that used telehealth in good faith during the COVID-19 national emergency. Both audio and video communication technology can be provided through popular applications, such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype. *(For more information on the rule change, visit: https://bit.ly/34KWqkp.)*

Also, Medicare is allowing practitioners to waive copays and deductibles for all telehealth services, and many prior authorization activities are paused. Some states will reimburse for audio-only phone calls at the same rate as in-person visits, and rural and site limitations were removed. *(For more information, visit: https://bit.ly/2XM2GXJ.)*

The Federal Communications Commission (FCC) published a final rule on April 9 to establish the COVID-19 Telehealth Program. The program helps healthcare providers offer connected care services to patients at their homes or mobile locations during the pandemic. The order provides $200 million in emergency funding, under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The federal money will help providers purchase necessary telecommunications services and devices to provide telehealth. *(The FCC rule is available at: https://bit.ly/2RMXVcA.)*

Maine Family Planning uses a HIPAA-compliant vendor for telehealth. The center also can accept electronic signatures.

"We're fortunate that patients can sign forms online and look at consent forms for treatment, and it's made it very useful to us to streamline a lot of those things," Kieltyka says. "There are other workarounds that you can do."

Maine does not require pre-abortion ultrasounds. "And there is emerging new evidence and protocols, showing that if women have a good [health] history and are under 10 weeks pregnant, it is very safe to provide them with medication abortion, using misoprostol," Kieltyka says. "We're part of a research study and can mail the [abortion] medication to those patients. Patients also can pick up the medication."

Telehealth Streamlines Care, Increases Access

As family planning centers continue to provide telehealth visits during the pandemic, they are discovering its benefits.

"I was talking to our medical director a few weeks ago, and she said, 'We're going to realize there are a lot of unnecessary things we do in healthcare, in providing good care, and we'll realize we can streamline with telehealth,'" Kieltyka recalls. "With telehealth, we'll find out retrospectively that some of the things we made people come into the office for were not necessary for good care, and patients will accept this."

If flexible telemedicine changes are maintained, family planning centers might decide to continue telehealth for most of their screening and consultation services, as well as other visits that previously were performed in the clinic.

"I hope we continue to keep some of the good parts of telemedicine even after it's over," Paris says.

In some larger, rural states, telehealth has been used to make contraceptive services more accessible to families in remote areas and to use limited medical resources more efficiently. For example, some North Dakota Title X family planning sites have limited access to advanced practice nurses, says **Jean Smith**, RN, BSN, PHN, family planning director at Richland County Health Department in Wahpeton, ND.

"We're very rural and have very few full-time advanced practice nurses on staff, so that pushed us into telemedicine," she says.

Clinics needed a full-time advanced practice practitioner on site for regulatory reasons, so the solution appeared to be telemedicine, Smith adds. "We couldn't afford to have a practitioner on site, full time, so we had to think more remotely," Smith explains. "We had to have a change to state legislation to allow Title X family planning nurses to dispense without having an advanced practice nurse on site."

This process took three years, from 2016 to 2019. The change also opened the path for more telemedicine because an advanced practice nurse can be involved, remotely, while a family planning nurse handles onsite visits.

The way the process works now is that advanced practice nurses connect through telemedicine. "We

had a contract with another family planning center that their advanced practice nurse would provide services to us," Smith says. "We added to our contract that they would do telemedicine visits on demand, when their schedule allowed, and it was a win-win."

Since the pandemic resulted in North Dakota issuing a stay-at-home order, the Richland office has operated remotely. "A lot of nurses are working from home," Smith says. "We have advertised on Facebook that we're still here. Family planning is an essential service."

Telemedicine has helped women maintain access to birth control during the pandemic.

"I think that it's more important now than ever to make sure our patients have the tools they need to plan their pregnancies or to avoid becoming pregnant, if that's their desire," Paris says. "Pregnancy right now is a very fraught time as our pregnant patients are very worried about the health of their pregnancy during the pandemic."

Dartmouth-Hitchcock has used telemedicine in an innovative way to ensure women have access to any form of contraception they choose. Contraceptive counseling, starting new contraception, and shared decision-making sessions are performed via telemedicine, Paris says. "We still bring patients into the office to start LARC [long-acting reversible contraception] methods — IUDs [intrauterine devices], implants, and injectable methods — which need to be done in person," she adds.

Their offices have postponed many gynecological visits, but not contraceptive visits, Paris adds.

"We're trying to provide the same access to contraception that they would have had without the pandemic through a telemedicine visit or inpatient when necessary," Paris says. ■

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Improve Access to Family Planning Services as Pandemic Wears On

Family planning clinics and other reproductive health providers have discovered creative ways to continue to provide contraception services to women during the COVID-19 pandemic.

Telehealth is one of the most important methods, although each facility has its own way of using remote services.

Here are some of the successful methods clinics are using:

• Telehealth consent, counseling, and screening. "Our contraceptive patients are very welcoming of any care that can be provided by telemedicine," says **Amy Paris**, MD, MS, director of family planning at Dartmouth-Hitchcock in Lebanon, NH.

When a family planning practitioner calls a patient for screening, counseling, or other services, they first obtain consent. The consent includes mention that a telemedicine visit may be appropriate, says **Jean Smith**, RN, BSN, PHN, family planning director at Richland County Health Department in Wahpeton, ND.

"We've added a telemedicine piece into contracts with our providers, since we do not have a provider on staff," Smith says.

The clinic bills insurers for telemedicine using a GT modifier, a billing code that indicates interactive audio and video telecommunications systems were used, she adds.

"There are certain criteria that have to be mentioned, identifying where the client is, where the provider is, and who is with the client," Smith says. "When a client calls and wants to start a contraceptive method, we screen her over the phone and decide whether this is an appropriate telemedicine visit. Then we contact our provider and get a time to do a telemedicine visit."

Patients are screened by phone prior to in-person visits, as well. "Before a woman comes in to the clinic, we've screened her and made sure she was asymptomatic [for COVID-19] and wants to start a contraceptive method," Smith says. "All of that is done over the phone." COVID-19 screening includes asking patients about fever, cough, and other symptoms associated with the disease.

The clinic has shortened the time the client has to be face-to-face with staff, Smith adds. "The consultation can be through telemedicine. We explain how it works and explain billing, all on the screening visit."

• Delaying services when feasible. "We have built some guidelines for our clinic, where — just like everyone else during the pandemic — we are trying to avoid sending patients to the clinic when they do not need to be there

in person," Paris says. "We have postponed many types of office visits in obstetrics and gynecology, but not contraceptive visits."

Dartmouth-Hitchcock is trying to provide the same access to contraception that would have been possible without the pandemic. This is performed through telemedicine visits when feasible, she adds.

Maine Family Planning in Augusta, ME, deferred many in-person appointments during the spring of 2020, says **Evelyn Kieltyka**, MSN, MS, FNP-BC, senior vice president of program services at Maine Family Planning.

"If someone needed more medication, we could do that, but we're not seeing anyone for nonessential reasons," Kieltyka says. "We push everyone to a telehealth visit, if possible."

Foot traffic was cut in half, at least. "We're finding that people are sheltering in place and not going anywhere, unless they absolutely need something," Kieltyka says. "We're not seeing folks come in for routine things."

Some family planning centers also are helping patients delay replacing long-term contraceptives. For example, if a patient had planned to have their five-year intrauterine device (IUD) replaced in year five, clinicians now are explaining how the contraceptive will be effective for another two years, and they can delay the replacement until after the pandemic ends, Kieltyka explains.

Dartmouth-Hitchcock also advises patients to extend use of an IUD. "If a patient calls because they want to switch out their implant because it is of three-year FDA-approved duration, we are telling them there is excellent evidence the implant is effective for at least four years, and it might even be appropriate to leave it in place for five years," Paris says.

> "CONTRACEPTION IS NOT SOMETHING THAT CAN BE POSTPONED FOR A COUPLE OF WEEKS OR A COUPLE OF MONTHS, OR UNTIL THE PEAK OF THE PANDEMIC HAS PASSED."

At first, Maine Family Planning postponed appointments for insertion of new IUDs. Women were offered a bridge method, such as birth control pills or a contraceptive injection. "We were thinking this was for a few weeks, and now we know it's much longer," Kieltyka says.

The center decided to make long-acting reversible contraception (LARC) available as an essential service for women starting this form of contraceptive. "If someone calls up and says, 'I'm having pelvic pain and abnormal bleeding,' we'll see them [in person] to figure out what's going on," she explains. "Anyone who needs to be seen based on symptoms, we consider that essential. We set up a protocol to screen people over the phone, make sure they are asymptomatic for COVID-19, and we do pre-counseling about LARC."

During the appointment for inserting the IUD, everyone wears a mask in the exam room, she adds. "We wipe down everything afterward."

• **Extending prescriptions automatically.** "If someone is already established as a patient, we automatically extend their prescription for three months, not requiring a physical, and possibly longer," Kieltyka says. "The last thing we want anyone to experience is not having access to birth control, and unintended pregnancy."

Contraception cannot be postponed until the end of the pandemic, Paris notes.

"Contraception is not something that can be postponed for a couple of weeks or a couple of months, or until the peak of the pandemic has passed," Paris says. "Contraception is urgent, an abiding principle. Not all visits need to be done in person."

Telemedicine and automatically extending prescriptions are sound tactics for ensuring contraception access during the pandemic. "Now, more than ever, it's important for patients to have the tools they need to protect themselves against unwanted pregnancies," Paris says. ■

EXECUTIVE SUMMARY

Family planning centers employ various telehealth tactics to continue to provide contraception and reproductive healthcare to their clients.

- A common telemedicine method involves consent, screening, and counseling through a phone call or videoconference.
- Facilities also could extend prescriptions via telehealth.
- Less commonly, clinics have provided telehealth counseling for use of medication abortion and test kits for sexually transmitted infections.

Family Planning Centers Find Creative Ways to Provide Services During Pandemic

Home-based testing, telemedicine are options

As elective and nonurgent procedures were cancelled or discouraged nationwide because of COVID-19, some reproductive health centers found creative ways to continue their services as safely as possible and to keep staff working during a period of low foot traffic.

Here are some of the methods they employed:

• Provide home-based testing for sexually transmitted infections (STIs). "Sexually transmitted infection testing is one of our primary focuses," says **Catriona Reynolds**, executive director of Kachemak Bay Family Planning Clinic in Homer, AK.

The clinic completed STI health history and screening through telehealth and made STI test kits available for a safe pick-up. Patients could use the vaginal swab at home and place these in a container, which they returned to the clinic's drive-through, she says.

Some of the clinic's clients already were familiar with collecting urine samples. The state laboratory epidemiologist confirmed that at-home STI testing was appropriate, Reynolds says.

"We didn't want to lose the ability to do STI testing [during the pandemic]," she adds. "We anticipate the demand for testing will go down as social distancing continues, but we still will have some demand for STI test kits."

• Continue abortion services, including telemedicine abortion. "We still offer aspiration abortion," says **Evelyn Kieltyka**, MSN, MS, FNP-BC, senior vice president of program services at Maine Family Planning.

Maine Family Planning has one office that provides these abortions, one day a week. "We don't have N95 masks, but we're screening for symptoms," she adds. Surgical masks are provided for patients.

The National Abortion Federation (NAF) held a webinar that educated clinics on how to perform abortions safely during the COVID-19 crisis. NAF also provides COVID-19 fact sheets and guidance. *(This information is available at: https://bit.ly/2xO05lp.)*

"They walked us through it with infectious disease experts, and it's all about harm reduction," Kieltyka says. "It's never going to be zero risk in a pandemic, so don't be unrealistic."

Methods include using masks and taking patients directly to exam rooms with no more than one patient in the waiting room. The patient undergoes the procedure, moves to the recovery room, and everything is wiped down with antiviral wipes, she explains.

Some family planning centers also are using telemedicine to prescribe misoprostol, the medication abortion. For example, Maine Family Planning provides no-touch telehealth abortion medication to patients who meet certain health history criteria and are fewer than 10 weeks pregnant, Kieltyka explains.

"We do all counseling through telehealth, get patients' information, and do consenting," she adds. "Our state doesn't require ultrasounds, and there are new, emerging protocols and evidence that if women have a good mental history and are under 10 weeks pregnant, it is very safe to provide them with medication abortion."

The telehealth abortion method works for patients. Family planning professionals can provide counseling, education, and obtain consent via telehealth, she adds.

• Create staffing resilience with remote work. "We're a resilient and tightly bonded group," Reynolds says.

The family planning clinic employed a robust youth education program, including visits to classrooms. When COVID-19 resulted in school closings, the clinic staff looked at moving its youth program to the virtual world. Educators and clinical staff are part of the virtual classroom experience, she notes.

"We're in such early days, but that's one of the things we're exploring," Reynolds says.

Other remote staff activities might include:

- Revising protocols;
- Revamping the site's test evaluation and feedback loop;
- Updating the website.

• Use microscope attachment for tablets. This option might work for remote areas when it is challenging to send out samples for lab testing. With a tablet and a microscope attachment, a practitioner could evaluate a swab remotely, Reynolds says.

Patients could use an STI test kit, collect their own sample, and send it to the clinic. Clinic staff could put the sample on a slide, under the tablet microscope, so the practitioner could read it, she explains.

"The practitioner could look at it and make a diagnosis in the same day," she adds. ■

Study Suggests Promise in Self-Injectables for Contraception

Subcutaneous injections work

A new study revealed that women can engage in self-care reproductive health through the use of subcutaneous injectable contraception.[1]

Adherence has long been a barrier to use of injectable contraceptives. Could the women administer the medication at the correct time and in the correct way? The authors of a new study answer that question affirmatively.

"Women are able to learn how to do this with appropriate training and support," says **Martha Brady**, MS, director of sexual and reproductive health with PATH in Washington, DC.

The study focused on self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) and the experience of women, providers, and family planning programs that adopted self-injection practices.

PATH investigators have been studying various self-care reproductive health methods employed by women who live in low-resource countries. *(See Q&A on reproductive self-care worldwide in this issue.)*

"We work in low-income countries, where a woman getting back to the clinic is challenging," Brady says. "It's a longer distance, and women have multiple daily tasks."

This barrier is more prominent in developing countries, but women in high-income countries could benefit from reproductive health self-care as well — particularly in the midst of the COVID-19 pandemic.

"In this new, COVID-19 world we're living in, we will see shifts in how health services are delivered," Brady says. "It's not just in reproductive health."

When Brady and co-authors first wrote the paper on self-care, it was based on women's empowerment. "Now, it's in a new light, given COVID," she says.

> "INDIVIDUAL CHOICE HAS ALWAYS BEEN PART OF ANY WORK WE DO IN FAMILY PLANNING. CHOICE IS THE ANSWER TO EVERY PROBLEM."

"There are a lot of blogs around this," Brady adds. "What is the impact of COVID-19 on various health services? How can you maintain quality services when people can't have access and have to do social distancing, and providers have to do other services related to COVID-19?"

In this context, the idea of self-care and self-injectable contraception is increasingly important, Brady says. Some women prefer self-injectables, rather than being given a shot by a provider.

"Individual choice has always been part of any work we do in family planning," Brady says. "Choice is the answer to every problem."

Also, there is precedent for people self-injecting medication. For example, people with diabetes self-inject insulin, she notes.

Adherence is important. Investigators have studied how well women adhere to provider instructions on how and when to self-inject.

"We've done studies in different countries," Brady says. "Women need to be trained on how to do this by a provider, and they need to understand how often they need to inject."

With a self-injection contraceptive, researchers focused on DMPA-SC, also called Depo-Provera, because it can be injected subcutaneously. An alternative DMPA injectable, as well as norethisterone enanthate, must be injected into muscle, typically in the arm or buttocks. *(More information is available at: https://bit.ly/3efStIB.)* DMPA-SC is a game-changer because it can be injected subcutaneously, Brady says.

"Its self-injection device is an auto device that you can't reuse," she adds. This feature helps to protect women from infection.

"The percentage of women continuing to use the intramuscular Depo-Provera shot at one year is 56% — the lowest adherence of all modern contraceptives, including pills, patches, rings, IUDs, and implants," says **Robert Hatcher**, MD, MPH, professor emeritus of obstetrics and gynecology at the Emory University School of Medicine in Atlanta. "This underscores the need for subcutaneous Depo-Provera. This technique can be taught to women themselves."

Women who agree to use self-injectable contraception are trained

by a provider. They are instructed to give themselves a dose of DMPA-SC every three months. Training materials are provided as reminders.

"It's doable, but women will need a lot of information and support," Brady says. "The fact that it's subcutaneous allows for a lower dose and allows for self-injection."

Intramuscular injections are physically hard for someone to do to themselves, Brady notes.

One of the chief challenges of self-care contraception is the willingness of nations to allow this practice. "We work with countries and ministries of health, and they decide whether country X will say they'll allow this idea of self-injection or not," she says. "Some say, 'Not yet.'"

From a patient's perspective, it is convenient. They do not have to return to a clinic every three months, so that obstacle is removed. And, it is empowering: "Women say, 'I can do this,'" she adds.

The challenges include ensuring people are well-trained and have access to counseling, information, and support to continue the correct behavior.

When possible, women could contact a provider online or by phone to describe issues they are experiencing or to ask questions about what they should do in a given situation, Brady says. Back-up support is important for any self-care medical practice, she adds.

"When you allow people to do things at home, if they have a question, can they have virtual contact with a provider to say, 'I'm experiencing this, and what do you say?'" Brady says. "There needs to be a mechanism to have a hotline."

Reproductive health providers always have been focused on quality of care and empowering women. Providing self-injectable contraceptives is part of this tradition.

"My feeling is that in the history of medical care, people say, 'Women can't do this,' but wait a minute — I'm going to vote for women," Brady says. ■

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Self-Care Reproductive Health Methods Employed Worldwide

Martha Brady, MS, director of sexual and reproductive health for PATH in Washington, DC, spoke to *Contraceptive Technology Update* about reproductive health self-care and how it works in other nations.

CTU: Could you explain what reproductive health self-care is? How is it being studied and used in other countries?

Brady: The World Health Organization's *Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights* defines self-care as "the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider." *(The guidelines are available at: https://bit.ly/3axyzWu.)*

Self-care allows people to become agents of their own health, leading to improved outcomes — especially in the area of sexual and reproductive health where stigma may prevent them from seeking care. Through self-care approaches, women and girls can identify their own health needs, access appropriate health technologies, and effectively manage their health conditions, including seeking health services and professional help when necessary. Exciting developments and an expanded array of user-centered sexual and reproductive health products and practices are being researched, introduced, and scaled up for use around the world, enabling women and girls to have more active participation in their health. These include phone-based applications for predicting menstrual cycles, home pregnancy tests, pericoital "on-demand" contraception, contraceptive vaginal rings, contraceptive self-injection, HIV self-testing, and human papillomavirus DNA self-sampling.

Women's sexual and reproductive health self-care also may introduce advantages from a health systems perspective, especially in low-resource settings. In some ways, self-care is the ultimate form of task-shifting — where specific tasks are moved from higher to lower levels of the system to make more efficient use of human resources for health. In this case, it is the woman who

receives the training and administers the intervention herself. This means that health workers are freed up to devote more time and resources to conditions that require medical intervention (like vaccinations or treating illnesses). Self-care is an integral part of the health system, linking to people-centered primary healthcare.

CTU: From one of PATH's reports, it appears that clients in lower-resource nations are comfortable with self-care because of previous experiences, such as immunization, HIV testing, and taking antiretroviral medication. Could you please explain how these types of self-care experiences have paved the way for reproductive health self-care strategies?

Brady: For millennia, women around the world — in both high- and low-resource settings — have managed the self-care elements of menstruation, contraception, pregnancy, and childbirth, in addition to combating illness for themselves and their families.

Currently, women in many countries and diverse economic contexts regularly use self-care approaches such as HIV self-testing, pre-exposure prophylaxis for HIV prevention, oral contraception on a routine monthly basis or in the form of emergency contraception — or, in fact, the contraceptive patch and ring, which are self-care options only available in higher-resource settings. Digital health innovations also have helped advance use of self-care strategies, as has the current COVID-19 outbreak, with its increased burden on health systems and physical distancing requirements. For example, as hospitals and clinics increasingly focus on COVID-19 patients, new medical and digital tools, products, and services are becoming available to improve individuals' ability to assess and manage their own health needs. These measures protect frontline health workers, but also ensure the most effective healthcare can be provided at scale. ■

Some Emergency Contraceptives Might Fail for Women with Higher BMIs

Ulipristal acetate is a good solution

New research revealed that some emergency contraceptives might not be effective for women at higher body weights.[1]

"There is limited research about the relationship between the efficacy of emergency contraceptive [EC] pills and body weight," says **Kelly Cleland**, MPA, MPH, researcher at Princeton University and director of the American Society for Emergency Contraception in Princeton, NJ. "The evidence we do have suggests that levonorgestrel EC may have reduced effectiveness in individuals who weigh 165 pounds or more, and possibly no effectiveness for those who weigh 176 pounds or more."

The clinical trials of ECs have limitations. For instance, there were some pregnancies, and there were fewer numbers of emergency contraception users in the higher weight categories. Also, their weight was self-reported, Cleland says.

"[Prior] studies were not designed to answer the question of weight and efficacy," she says. "But because this is a clinically important question that potentially impacts millions of people, we take this information seriously."

In 2013, European regulatory authorities approved a label change for Norlevo, an EC product, to warn that it was less effective in women weighing 165 pounds or more and ineffective in women weighing more than 176 pounds.[1]

"But European authorities reversed the labeling decision in July 2014, less than a year after this change was made," Cleland says. "And the U.S. Food and Drug Administration determined that the existing data were not compelling enough to warrant a label change."

Reproductive healthcare providers might let women know about potential drawbacks in using EC because many women may not know that their body weight could reduce the drug's effectiveness. "From what I can see, the potential lower efficacy of levonorgestrel for users with heavier body weight is not at all well-known," Cleland says. "Pharmacies, generally, do not have signage about this issue. Because it's not on the label for levonorgestrel EC products, consumers would have to find this information somewhere else."

Levonorgestrel is the easiest EC for women to obtain. Other ECs might be poorly stocked and carry additional barriers to access. "We certainly

believe that all remaining barriers should be removed," Cleland says. "At the same time, I think it's really important that people understand the limitations of the product so they can make an informed decision when they need emergency contraception."

Ulipristal acetate is a good solution, Cleland says, "although it, too, appears to have a limit to efficacy. Some research shows that it may be ineffective for users who weigh more than 195 pounds."

The main drawback to ulipristal acetate is its limited access. "It is still a prescription-only product," Cleland says. "Even though it has been approved for the U.S. market for nearly 10 years, awareness among providers and patients remains low."

Recent studies show that pharmacies do not routinely stock ulipristal acetate, so it can be difficult to obtain, she adds.

"Ulipristal acetate is an extremely safe medication, especially in the dosing used for EC. There's no reason that it should continue to be a prescription-only product," Cleland says. "In fact, ulipristal acetate is over the counter in Europe, and we hope it will be over the counter in the U.S. very soon."

Another possible option — after more research — is for women with higher body mass index (BMI) to take a double dose of levonorgestrel.

> "THE EVIDENCE WE DO HAVE SUGGESTS THAT LEVONORGESTREL EC MAY HAVE REDUCED EFFECTIVENESS IN INDIVIDUALS WHO WEIGH 165 POUNDS OR MORE."

There is some evidence that doubling the dose of levonorgestrel EC in patients with BMI greater than 30 kg/m^2 might result in similar blood levels of levonorgestrel as women with BMI less than 25 kg/m^2 who take the regular dose of 1.5 mg, Cleland says.

"But this is still preliminary pharmacokinetic research," she adds.

An alternative option, and the most effective option for everyone, is the copper intrauterine device (IUD), Cleland notes.

"It is nearly 100% effective, and its efficacy is not impacted by body weight," she says. "We think it's important to make sure providers and patients know this is an option."

IUDs are not for everyone, and no patient should be pressured into using one, she adds.

"For people who weigh more than 165 pounds, we really encourage them to call a healthcare provider or family planning clinic to get a prescription for ulipristal acetate," Cleland says. "There also are online pharmacies that ship ulipristal acetate EC after a consultation with a physician." ■

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Essential Access Health Asks Judges for Full Court Reconsideration

Earlier Title X decision was 'premature'

Essential Access Health has asked the full 9th Circuit Court of Appeals to reconsider a February 2020 decision that upheld the Trump administration's Title X regulations, issued May 22, 2018, which have had a dramatic effect on Title X family planning centers. *(For more information, see the story titled "Title X Problems Worsen with Recent Court Decision" in the May issue of* Contraceptive Technology Update *at: https://bit.ly/2VvCK0F.)*

The 9th Circuit issued its en banc panel decision in February. Essential Access Health asked for a reconsideration on April 9, 2020. The lawsuit, *Essential Access Health v. Azar*, includes co-plaintiff Melissa Marshall, MD, a family medicine doctor, who practices at a Title X-funded health center in Yolo County, CA. *(More information is available at: https://bit.ly/2UXSMR1.)*

The Trump administration's changes to Title X include a gag order that prevents healthcare providers

and staff from mentioning abortion services to patients, even if asked directly for information. The changes also require Title X sites to create separate physical space for any abortion referral or other activities.

For example, Title X sites cannot provide any brochures that mention abortion in their facility, unless there is physical separation, says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkley, CA. Essential Access Health is the statewide Title X grantee in California. Established in 1970, the organization distributes Title X funding to a statewide network of support services that include birth control, pregnancy and sexually transmitted infection tests, and cancer screenings.

"Even if the brochure doesn't have an address of where to get an abortion, you can't have the information out there," Rabinovitz says. "You can't offer abortion counseling and referral services, even if you carve that out of your title X program."

Federally qualified health facilities that perform abortions have always financially separated those services from their other healthcare services, but now they must physically separate the services, as well, she explains.

"Now, they can't do referrals, even if the staff doing referrals are not paid for by Title X," Rabinovitz adds. "They have to have separate entrances, separate waiting rooms, separate electronic medical records. It's cost-prohibitive to build a mirror health center, and nobody will do that."

The organization's decision to challenge the court decision is based on past Supreme Court decisions, which did not condone such onerous regulations.

"The panel decision issued earlier this year disregarded Supreme Court precedent and prematurely ruled on the merits of the case without review of the full administrative record," Rabinovitz said in a recent media statement on the court action. "The facts are clear. The regulations conflict with current law and medical ethics standards, and deny women complete and unbiased information about their pregnancy options. The regulations have also devastated the Title X family planning safety-net nationwide — disproportionately impacting underserved and rural areas, and communities of color."

According to the Guttmacher Institute, the Title X gag rule has cut the Title X national family planning network's capacity in half, leaving 1.6 million patients at risk of losing access. One in four Title X service sites left the network in 2019 because of the regulatory changes. *(The institute's report is available at: https://bit.ly/3a3Zl8Z.)*

The Guttmacher Institute's analysis found that the Title X network's ability to provide women with contraceptive services was cut by at least 46%, and caused a 100% reduction in Title X services in six states: Hawaii, Maine, Oregon, Utah, Vermont, and Washington. ■

CLARIFICATION

In the May issue of *Contraceptive Technology Update*, a comment by **Robin Summers**, JD, in an article, titled, "Title X Problems Worsen with Recent Court Decision," was missing the qualifier: "Title X-funded."

It should have read: "About 1.5 million people have lost access to [Title X-funded] family planning care," Summers explains. "The damage is significant." ■

CONTRACEPTIVE TECHNOLOGY UPDATE®

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CME/CE QUESTIONS

1. **Family planning centers changed their operations because of COVID-19. Which is a change that some clinic leaders say will probably continue, at least at greater levels than it was previously employed?**

   a. Mailing abortion medication to women
   b. Telemedicine consulting, counseling, and screening
   c. Sending providers to patients' homes to insert IUDs
   d. Self-injection of long-acting reversible contraception

2. **Which did some family planning centers advise patients to do regarding long-acting reversible contraception (LARC)?**

   a. Self-administer LARC patches
   b. Switch from LARC to hormonal contraceptive pills
   c. Delay replacing three- or five-year intrauterine devices for one or two years
   d. Go to a clinic drive-through to receive their three-month contraceptive injection

3. **The Trump administration's Title X changes were challenged in court recently, with Essential Access Health asking the 9th Circuit Court of Appeals to reconsider:**

   a. the order requiring a 25% cut to Title X organizations.
   b. changes prohibiting federal and state money from funding abortion services.
   c. requiring Title X services to include abstinence-only education.
   d. a gag order that prevents healthcare providers and staff in Title X programs from mentioning abortion services to patients even if requested.

4. **What did a new study reveal about emergency contraceptive (EC) effectiveness among certain populations of women reveal?**

   a. Women from lower income backgrounds experienced a higher percentage of failure rates with ECs.
   b. Levonorgestrel EC may have reduced effectiveness in individuals who weigh 165 pounds or more.
   c. Norlevo is most effective in women of Latin American descent.
   d. Women who have previously given birth showed the greatest success in using ECs.

STI QUARTERLY™

A SUPPLEMENT TO CONTRACEPTIVE TECHNOLOGY UPDATE

Young Adults Learn Some Accurate STI Information from the Internet

Parents do not always know best

Researchers predicted that when young adults received health information from medical providers, their knowledge would be superior to what other youth understood when they received information from the internet or family and friends.

To their surprise, they were only half right: A new study revealed that youth who relied on family and friends for health information are not as well-informed as those who relied on medical providers. But the young adults who rely on medical information from the internet were just as well-informed as those who talked with their doctors and other providers.[1]

The researchers found that respondents who relied on medical information from electronic media and healthcare providers tended to have better knowledge about human papillomavirus (HPV) than those who relied on healthcare information from family and friends.

Knowledge about HPV is very important and can lead to increased HPV vaccination rates, says **Gabriel Benavidez**, MPH, research assistant for the Rural and Minority Health Research Center, Arnold School of Public Health at the University of South Carolina.

"As we move into the next generation with internet, we wanted to look at the source of that knowledge and how it impacts having accurate information about HPV," Benavidez says. "We wanted to see how their knowledge was impacted by where they got their information. Where they got their information will impact whether they get the vaccine."

> "THOSE WHO GOT THEIR INFORMATION FROM FAMILY AND FRIENDS HAD HIGHER ODDS OF ANSWERING QUESTIONS WRONG THAN IF THEY GOT INFORMATION FROM A HEALTHCARE PROVIDER."

The study's respondents obtained medical information mostly from electronic or print media (56.2%), followed by 26.7% from family and friends, and 17.1% from healthcare providers.

"Most people reported getting their information from electronic or print media, and most people get their information from news articles online or internet searches," Benavidez says. "We also saw that non-Hispanic blacks, Hispanics, and Latinos had a higher proportion of seeking information from their family and friends, compared with non-Hispanic whites, who had the highest proportion of seeking information from electronic or print media."

Another demographic difference was that families with incomes of $75,000 or greater were the least likely to obtain information from healthcare providers and the most likely to learn about healthcare from the media.[1]

Investigators asked participants these questions:

- Have you ever heard of HPV?
- Do you think HPV can cause cervical cancer?

• Do you think HPV is a sexually transmitted disease?

• Have you heard of the HPV shot or vaccines?

"Those who got their information from family and friends had higher odds of answering questions wrong than if they got information from a healthcare provider," Benavidez says.

For young adults who said their information came from electronic or print media, they were more than twice as likely to have heard of HPV and to answer the other three HPV questions correctly.

"We might be able to extrapolate this to other sexually transmitted infections [STIs]," Benavidez says. "We used questions to look at their knowledge about HPV vaccination, but we could have used that to look at their knowledge about lung cancer and breast cancer."

Family and Friends Information Subjective

Researchers initiated the study to assess the effect of the media — and the internet in particular — on STI knowledge, Benavidez says. Their assumption was that people who received information from healthcare providers would have the best information, while people who sought information from family and friends or the internet and other media would be the least well-informed.

"Initially, we were thinking people who go to the internet for answers would have worse information," he explains. "But the odds of their answering a question wrong were no different than if they had gotten the information from a healthcare provider."

The only exception was that people who used the internet as their medical information source were less likely to say they knew HPV was an STI than people who received information from their healthcare provider, he adds.

"They had heard HPV might cause cervical cancer and has a vaccine, but they might not know it was sexually transmitted," Benavidez says.

"PEOPLE WHO GET THEIR INFORMATION FROM THE INTERNET PROBABLY ARE GETTING ACCURATE INFORMATION BASED ON WHAT THEY'RE SEARCHING FOR."

The researchers theorized that their original hypothesis that internet information-seekers would be less well-informed proved to be incorrect because of how sophisticated internet search algorithms are now, he notes.

"We were thinking about how Google search algorithms are very good," Benavidez says. "If you go online and search, 'What are the benefits of the HPV vaccine?' the first things that come up are information from the Centers for Disease Control and Prevention, the World Health Organization, and the National Cancer Institute."

Search methods are so sophisticated now that people will immediately find the correct information, he adds. "People who get their information from the internet probably are getting accurate information based on what they're searching for," Benavidez says. "But when they go to family and friends, it's more subjective."

From a reproductive health provider's perspective, this means that future interventions to educate young adults could include media sources, and also focus on educating patients' entire families about STIs and contraception. "Once you have educated the family, then the whole family has accurate information to share," Benavidez says. "Future information should target entire family units."

One thing to note about internet searches is that they can provide accurate information when used correctly. "The internet, if you have negative beliefs, will reinforce those beliefs," he says. "The search algorithms are so good that they will give you what you are looking for. The more you expose them to credible sources of information, the more likely they will use those sources of information."

This suggests that healthcare providers can encourage patients to seek information from respected medical sources online and to abstain from looking for medical answers on YouTube and TikTok.

"Maybe, we should have medical professionals on those platforms," Benavidez says. "There is a lot of research showing that healthcare provider information is very influential. That's why we decided to use healthcare providers as a reference category and compare everyone else to them." ■

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Tech-Driven Nursing Intervention Helps Prevent STIs, Improves Care

Text messages are positive, supportive

A technology-enhanced community health nursing intervention proved useful as a method for preventing gonorrhea and chlamydia infections. It also helped patients improve management of pelvic inflammatory disease (PID).[1]

Research shows that adolescents and young adults experience difficulty with self-care. Researchers wanted to develop an intervention that would provide them with the support they needed in an outpatient setting, says **Maria Trent**, MD, MPH, professor of pediatrics, adolescent/young adult medicine at Johns Hopkins School of Medicine in Baltimore, MD.

The theory-based intervention was designed to help people better understand their illness and to remove barriers to care. Some barriers are related to transportation and knowledge, Trent says. "We found that community health nursing is demonstrated to be an effective strategy for young people to receive care. Adolescents are largely online, and it's safe and effective to send them text messages related to their reproductive healthcare."

"We created a service package that provided community health nursing, along with text messaging, to provide support to young people dealing with illness over a 14-day treatment period," Trent explains. "Pelvic inflammatory disease treatment requires that women take medicine twice a day for 14 days, usually including one injectable and then 14 days of doxycycline."

In addition to text-messaging support, the intervention included a community health nursing visit within five days of diagnosis of the sexually transmitted infection (STI). Nurses used a Sister-to-Sister Teen Intervention, including a 20-minute skills-based sexual risk reduction and condom negotiation counseling session. Nurses also provided a PID-specific, short-term clinical follow-up visit with an abdominal examination.

The text messages, which were key to engaging with patients, were sent daily for two weeks. Participants who did not have a phone were provided a prepaid, disposable mobile phone for one month. The automated booster messages reminded patients to take their medications and asked them to give information about how many scheduled doses they had consumed each day. Each message was tailored to encourage adherence to the treatment regimen.

For example, a text message might ask, "Did you take your medicine?" If the woman answered, "no," or that she took only one of her pills, the text message would say, "Tomorrow is a new day. It's really important that you take both pills," Trent explains.

Women with PID are vulnerable to infertility issues, Trent says. "Our goal with the intervention was to address an unmet need in healthcare and help preserve future fertility of young women," she adds.

The home visits were a standard part of the intervention, unless the patient did not want a nurse to come to the home or when it was not safe for a home visit.

"We have an alternative space where community visits could occur, and that was mutually agreed upon with the nurse," Trent says. "The visits lasted 30-45 minutes, depending on the adolescent's knowledge level and whether they had concerns or questions."

The Sister-to-Sister intervention is brief and includes a short video that the nurse watches and discusses with the patient. "They discuss questions about self-efficacy, self-care, and education around PID and how to prevent it in the future by making sure the partner uses condoms," Trent says. "This being kept short is an important part of delivering that intervention in the field."

Investigators assessed participants for changes at three months. "Our biggest finding was we were able to change the rate at which women were acquiring disease," Trent says. "At baseline, one group had higher chlamydia rates than another, so we had to look at the differential rate of decrease. The intervention group's rate of decrease was higher than the control group, so they were not acquiring disease at the same rate."

Also, the absolute reductions in the prevalence of gonorrhea infection were greater in the intervention group, in which 1.5% of patients had infection at 90 days, vs. the control group, with 7.2% of patients with infection at 90 days.[1]

The study began well before the COVID-19 pandemic, but its findings are useful for this new era of more telemedicine strategies, Trent notes. "I think this pandemic we're in right now has emphasized how the use of alternative communication

strategies can transform health for people," she says. "Our research demonstrated that adolescents love to talk with people, have telemedicine visits, text with people. We have to work hard to build relationships with people."

One drawback — found in research for a separate study — is that adolescents and young adults might rely a little too heavily on text support, Trent notes.

"Text messages are great, but at the end, some of the girls' visits fell off. When a nurse asked about it, the girls would say, 'Why didn't you text me?'"

Another important feature is that participants wanted a connection with the people behind the text messages. "We had relationships with them, and our nurse and outreach worker," Trent says. "Text messages are a vehicle to further build that relationship with young people."

Future reproductive health interventions likely will use a combination of in-person visits and telemedicine. "Sometimes, people still want a doctor to lay hands on them, and it will be a mix of the two," Trent says. "Once we see patients, our ability to follow up will be enhanced by the use of telemedicine." ■

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Study Finds High Prevalence of STIs in Pregnant Adolescents

Overall prevalence is 16.5%

A new study revealed that teenagers who give birth have a higher-than-expected risk of sexually transmitted infections (STIs) and high rates of preterm births and chorioamnionitis.[1]

Researchers studied adolescents, ages 13 to 19, who had given birth, to assess their preterm birth rates and prevalence of STIs. Chorioamnionitis, which is associated with an increased risk of infant mortality, has a prevalence of less than 1% in the United States.[2] The study's cohort of adolescents had a 15.2% rate of chorioamnionitis.[1]

"We found a higher-than-expected preterm birthrate of 18.8%," says **Esther Fuchs**, MD, assistant professor of obstetrics and gynecology at UW Medicine, Harborview Medical Center in Seattle.

The overall STI infection prevalence was 16.5%. The teenage cohort had no HIV or syphilis infections, but had infections of *Chlamydia trachomatis*, *Trichomonas vaginalis*, and *Neisseria gonorrhoeae*. "The same reason teenagers got pregnant: not having birth control or condom use led to their having STIs," Fuchs says.

Researchers found a gap in screening that could help prevent chorioamnionitis problems. Pregnant patients, including higher-risk patients such as teenagers, are not screened for trichomoniasis, she says.

"Most gynecologists don't do this screening," Fuchs says. "We only screen for gonorrhea and chlamydia."

While screening for trichomoniasis is an extra expense, it would be helpful to screen teenagers, who are a high-risk group, she says. "I would like providers to add trichomoniasis testing to their existing tests for chlamydia and gonorrhea," she adds. "Every adolescent who is pregnant is possibly at risk for having an STI. We know teenagers might not be exclusive in their relationships, and that puts them more at risk."

Family planning centers that give away condoms also are helping to prevent STIs, including trichomoniasis. "Right now, in our clinic, we give out condoms for free and have them available in the clinic's bathroom, so people can serve themselves," Fuchs says.

Some pregnant women in the study were treated for an STI, cured, and were tested again later. "Several had another infection during the same pregnancy," Fuchs says.

"It's important to know that there's not enough emphasis on teenage pregnancies here in the United States," Fuchs says. "Teenagers are at higher risk of preterm birth and STIs." ■

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