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Use of Telemedicine in Family Planning Clinics during Covid-19: Providers' Perspectives on Current and Future Usage

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Perspective Article

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Precis: Healthcare providers stated that telemedicine is easily implementable for most family planning services and should continue to be used to increase access and availability for patients.

Abstract

Background: The COVID-19 pandemic decreased access to family planning services and led to restricted abortion policies. Providers have been implementing telemedicine into their practices to provide abortion and contraceptive care while limiting contact with patients.

Objective: We aimed to explore providers' and clinic administrators' perspectives and experiences utilizing telemedicine in family planning services during the COVID-19 pandemic.

Study Design: Semi-structured qualitative interviews were conducted by the Society of Family Planning to supplement a longitudinal descriptive survey asking participants about practice changes implemented as a response to the pandemic. We analyzed these 63 interviews using modified ground theory.

Results: Clinics adapted to the pandemic by utilizing telemedicine almost immediately after the pandemic if technological and financial abilities allowed. Telemedicine was most commonly used for contraception, abortion counseling and post-medication abortion follow-up allowing for contactless care. Clinics cited technology being the most limiting factor to providing telehealth care, particularly due to safety concerns with electronic medical records. State legislation preventing telemedicine abortion care also limited access in some regions. All providers agreed that telemedicine is likely to remain a mainstay method of providing family planning care where applicable.

Conclusion: Clinics have been able to successfully implement telemedicine for contraceptive and abortion care as a result of the pandemic. Telemedicine is likely to remain a modality of family planning services if reimbursement status remains. Future studies should identify if telemedicine is able to increase access to family planning services to analyze its overall impact on patients.

Introduction

The COVID-19 pandemic reduced access to family planning care in many settings across the U.S.A [1,2]. Family planning clinics have experienced significantly restricted abortion policies in some regions during the pandemic [3]. Contraceptive delivery has been equally affected, particularly in providing long-acting reversible contraceptive (LARC) methods in-person [1,2,4]. Additionally, it is projected that the COVID-19 pandemic may lead to higher rates of unintended pregnancy and unsafe abortion across the world [5]. Due to these concerns, family planning clinics rapidly pivoted practice to increase access while limiting contact with patients, notably by integrating telehealth services into their care [1,6]. Telehealth appointments are particularly useful for family planning intake appointments, contraceptive prescribing, and some pre-operative and post-operative appointments [7]. Abortion care shifted to provide medication abortions through telehealth while still maintaining access to surgical abortions in most regions [8]. Accessibility to mifepristone increased with the suspension of the Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) and allowed providers

to implement self-managed or "no touch" medication abortion [9]. Family planning recommendations were modified to allow for extended use of oral contraception and medication abortion protocols without Rh testing over the past year to increase care accessibility [1,10].

While family planning centers across the US have rapidly adapted to the COVID-19 pandemic by implementing these changes, there is little research on how providers feel about these adjustments. An improved understanding of the perspectives of family planning providers on the changes they made during the COVID-19 pandemic may inform future care. We conducted a qualitative analysis of the Society of Family Planning interviews from 2021 in which providers discussed the challenges they faced during the COVID-19 pandemic.

Methods

The Society of Family Planning (SFP) collected longitudinal data through descriptive surveys during the COVID-19 pandemic to analyze changes in family planning service delivery. Sites were recruited between April 13 and May 1 2020 through the SFP Abortion Clinical Research Network, which is comprised of 78 abortion clinics throughout the United States. Additional clinics were recruited through partner organizations, including the Abortion Care Network, the National Abortion Federation, and the Planned Parenthood Federation of America. Participating sites in the survey study were asked to complete an in-depth interview in August or September 2020, which was intended to be a retrospective review of the clinical practice delivery changes that were made up until that point to help corroborate the survey. Clinic providers and administrators alike participated in the study. The Advarra Institutional Review Board (IRB) deemed the study exempt, as sites reported data about their clinics and no personal patient health information was collected. Survey instruments are available: https://societyfp.org/research-support/abortion-clinical-research-network/network-study-family-planning-visits-during-the-covid-19-pandemic/. Our site was able to obtain access to this de-identified data and develop our own studies.

Interviews were conducted virtually by a member of the SFP research team based on a scripted interview guide. The SFP transcribed these interviews, redacting any identifying information, and provided it for study. Deidentified transcripts were imported into the qualitative data analysis software QRS International's NVivo version 12.0 for analysis. Data analysis was performed using modified grounded theory. The entire study team participated in developing an initial code dictionary. Three of the researchers (KB, RM, and ER) coded several additional interviews and discrepancies in coding were addressed with high levels of reliability (K=0.80). We coded interviews until thematic saturation was achieved.

Results

Out of seventy-four clinics participating in the surveys, 63 interviews were conducted and analyzed. Demographics of the providers and administrators were not provided. Clinics reported seeing a wide range of patients demographically. Some clinics were overwhelmingly self-pay, while others endorsed up to 70% Medicaid services. The age range of patients that these clinics care for was of reproductive age, specifically women in their 20s and 30s. There were some clinics that saw a predominantly White population, while others were exclusively Black and Hispanic populations. Very few clinics had patients seeking family planning care from out of state.

Analysis revealed five central themes regarding telemedicine services in family planning services: (1) implementation of telemedicine, (2) differentiation between in-patient and telemedicine care, (3) struggles of providing telemedicine and (4) the future of telemedicine.

Implementation of Telemedicine

Few clinics had used telemedicine in family planning practice prior to the pandemic, but in 2020 most participating clinics began using telemedicine services almost immediately as a result of social distancing measures. One participant commented that they initially "told people to not see any non-essential visits and to try to transition everything we could to telehealth" (P59). Another participant commented on limiting patient volume, stating they "started to try to do as much remotely as possible to limit the amount of time that someone could be in clinic" (P63). Some clinics used traditional video conferencing technology through their electronic medical records (EMRs), but more commonly, clinics used telephone calls as their primary method of telemedicine. Phone calls were primarily used for initial patient intake, contraception services and abortion counseling, all in an effort to reduce patient contact with office staff. One clinic would "call them from the doctor's work area and so you would do the history taking by phone. And then you would go in just to do a physical exam. And then you would call them again" (P17).

Clinics providing abortion care were able to make one significant change across the board by providing medication abortions and follow-up care primarily through telemedicine. Post-medication abortion follow-up care was addressed as a concern pre-pandemic, as many patients would not present for their in-person appointments.

Differentiation between in-person and Telemedicine Care

Using telemedicine, clinics were able to create efficiency in scheduling by creating clear differentiation between types of visits that were seen in-person and through telemedicine based on the type of family planning service that was required. Providers expressed concern about decreasing in-person contact with patients due to the pandemic. For patients who had annual exams scheduled during the onset of the pandemic, pap smears were often deemed as an immediate need and were rescheduled for later. "We see patients for procedures, exams. Otherwise… we do a lot over the phone, and we send things to pharmacies and we have them come to the lab and leave samples if they just want testing. And so they don't have to come to the clinic and have an in-person visit" (P59). Importantly, if patients requested to be seen in person for their gynecologic concerns, they were not declined by clinics.

For contraception, all clinics employed the same method of conducting contraceptive counseling through telemedicine and requesting that patients only come in for mandatory in-person visits, such as long-acting reversible contraceptive (LARC) insertion or removal. Some clinics were able to maintain in-person LARC placements and removals. Those who were unable to provide LARC had telemedicine appointments with their patients to "offer them a bridge method or some other type of method" (P27). They also expressed that contraceptive counseling visits were often cancelled and prescriptions for oral contraceptives were extended. Virtual counseling allowed for providers to assess patients' eligibility towards certain contraceptive methods and to screen them for associated risks. One provider commented on

how this increased speed of in-person appointments, saying, "We were doing all LARC insertion and contraception counseling visits via telehealth, and then that would actually make our implant insertions or removals or IUD insertions and removals quicker because then they were already counseled, had already talked through everything. They just came in, undressed, had their IUD pulled out and another one put in" (P09). Another participant stated:

"The person could come in for the LARC with only a quick in and out, get your LARC and then leave. Instead of 20 minutes of helping you decide on which LARC it is, and then get the procedure done, which would make it a longer than 15-minute visit, for safety reasons with COVID" (P53).

For abortion care, differentiation between in-person and telehealth care was more complicated. Some clinics did not have the option to conduct telemedicine for abortion care due to state laws. Like contraception care, clinics that were able to legally provide telemedicine for abortion care were utilizing it for history-taking and counseling. Patients would just have to come in person for the surgical abortion or to pick up their pills for medication abortion depending on the circumstance. One participant noted that patients were "exclusively coming in affirming that they wanted the pill, signing a piece of paper, and then taking the pill" (P49). For patients receiving dilation and evacuation (D&E), clinics commented that if patients did not require cervical preparation the day before, telemedicine was used for "H+P… and then, if they're at an appropriate gestational age when they come in for their D&E, we can give them misoprostol cervical prep[aration] if they need it" (P46). Some clinics were able to sign mandatory consents virtually through programs such as DocuSign, and others required in-person visits to sign consents. However, even with the difficulty of certain state laws, all clinics were successful in implementing contactless (telehealth or phone call) post-medication abortion follow-ups:

"They answer a series of questions. If it sounds like they passed the pregnancy, they take a home pregnancy test a month later. If the patient's concerned or if the screener is concerned, then we do make an appointment for in-person follow up" (P60).

Struggles of providing Telemedicine

Implementing telemedicine was not without its problems. Concerns were expressed regarding the heavy burden of having to implement technology and use it consistently. It was a "big learning curve… figuring out how to implement telehealth, so getting cameras… we had tablets for people to sign into the e-health system, which not all of our techs are as technologically savvy, and so that took a bit of training" (P37). The physical act of deploying computers and providing staff with adequate equipment to work-from-home was described as burdensome by many participants. Clinics that were not able to implement telemedicine successfully often cited it as being secondary to technological barriers. One participant noted that while it would be great to expand to video visits instead of just phone visits, there was a lot of behind-the-scenes to work out "especially with administrative staff trying to get that scheduled in the proper way, getting patients' email addresses or whatever linked up" (P26).

In the same vein, using existing technology through EMRs was touted as an additional barrier to implementing telemedicine by a few participants. One participant noted, "Even for the telehealth, we've gone through several different iterations of how we do telehealth in terms of the providers…we just did Doximity on our phones. Now, we've incorporated it into Epic." One participant mentioned that changing platforms allowed them to more easily utilize interpreters in telehealth visits, which initially in the pandemic had provided great difficulty. Telemedicine integration into EMRs made it easier for patients to access telemedicine appointments securely and provided hospitals and clinics with relief that HIPAA was being followed. From a workflow standpoint, it was discussed by several participants that conducting in-person visits and telemedicine at the same time was extremely difficult. They encouraged implementing dedicated in-person clinic days and telemedicine days for the highest efficiency:

"Our clinic is sort of always running like, 12 minutes behind, which is fine if the next patient knows that or she's being roomed, but if you have a telemed call at 2:00 and your 1:45 patient isn't roomed until 1:48… I personally find it very stressful when they're interspersed" (P10).

Some states did not allow for telemedicine to be used in family planning, especially for abortion care. Most of the clinics that were unable to implement telemedicine stated that this was due to these telemedicine bans and legal barriers. One participant noted "we have a complete and total telemedicine ban. Even the initial consult cannot be by telemedicine. All of these things were just significant barriers to what we thought was giving the best and safest care" (P43). Some laws were very specific, limiting clinics from circumventing them. "There's a physician only abortion law, and there's an in-person counseling law with a physician" (P74). Clinics were also limited in providing contactless care by states that required ultrasounds for all terminations.

"So, I would say if the laws were not as they are written right now, we probably would have looked for a way to do a lot of these services via telehealth. I think that was the biggest thing that got in the way of us being able to fully protect our staff and patients" (P51).

Patient access to technology was also described as a limiting factor by some participants. While telemedicine was great at increasing access for some participants, others worried that certain groups were being marginalized from receiving care, particularly those who lacked adequate broadband access to conduct video telemedicine calls. Participants also worried about patients' confidentiality, as they attended visits from home and often unsecure areas. One provider commented that "for minors they have to have a legal guardian with them with the current platform" and due to privacy concerns, they decided to use telemedicine only for patients age 18 and up (P07).

The Future of Telemedicine

Overwhelmingly, participants agreed that telemedicine is here to stay and has a great role in family planning services. Telemedicine helped increase patient access to care and ability to attend appointments due to its convenience. Participants commented on perceived patient experiences and noted that most patients really enjoyed the ability of using telemedicine for contraceptive counseling. However, all providers agreed that the future of telemedicine hinges on the continued ability of insurance companies to reimburse for telemedicine services. Participants stated that part of the reason telemedicine had been quickly implemented during the pandemic was due to insurance changes that allowed them to bill telehealth encounters at the same rate as they would office encounters. One provider

stated, "If Medicaid does not continue to recognize telehealth visits, it's going to be harder to do them and stay sustainable" (P11). Another participant whose institution was not utilizing telemedicine, commented, "If legislation changes to pay for it, the institution's going to always want to do what generates the most revenue" (P50). Navigation of telehealth post-pandemic is going to require insurance companies according to one provider, they stated that:

"Telehealth is compensated in a very heterogenous way… by the public assistance or kind of publicly funded models. And I don't know that private insurers or universally insurers are compensating it in a standardized, even way. But I think there's significant advocacy among medical groups to compensate telehealth with high parity" (P49).

Discussion

Clinics were able to implement telemedicine quickly after the onset of the pandemic. Telemedicine was most used for contraceptive and abortion counseling as well as post-medication abortion follow-up. Due to social distancing norms, most clinics only wanted patients physically in the office for procedural visits that could not be conducted via telemedicine. Abortion care was nuanced by state legislation, as some states severely restricted access to abortion care via telemedicine. Participants noted that access to technology and capabilities through electronic medical records were limiting factors to providing telemedicine. All participants agreed that telemedicine will remain a service family planning clinics will and should provide. However, the future of telemedicine rests on insurance reimbursements and ability to receive compensation for video and phone visits.

Studies have surveyed both providers and participants regarding their attitudes regarding telemedicine in family planning services, indicating the numerous advantages of telemedicine including convenience and increased comfort regarding care [11,12,13]. Our study reflected specific changes in obstetrics and gynecology practices during the pandemic, where care was shifted towards a "no-touch" method of healthcare in which virtual visits were implemented with few in-person appointments [14]. This was facilitated by changes in reimbursement models from insurance companies, particularly Medicare and Medicaid, to help encourage virtual platforms [14]. Providers in our study endorsed usage of telemedicine for contraception counseling and encouraged in-person visits for LARC insertion and removal. Prior to the pandemic, it was suggested that telemedicine should be used for contraceptive counseling, as it decreases barriers to care and improves patient education on contraception [15]. Rules have been established by the US Medical Eligibility Criteria on contraindications to contraception based on medical history, which were followed by the participants of the survey to allow contactless telemedicine [16]. One of the providers in the survey mentioned concern that telemedicine might be pushing the patient towards methods that did not require in-person visits, such as oral contraceptives, due to fear of the pandemic. This sentiment has been echoed by another survey of providers and warrants further research on telemedicine and contraceptive counseling in limited settings may perpetuate contraceptive coercion [6]. One of the significant limitations that was discussed in the survey was telemedicine accessibility in minors, which needs to be further studied and evaluated [17].

Abortion care via telemedicine varied based on the location of the provider. Telemedicine for abortion care has been identified to be safe and effective and has been offered in different settings prior to the pandemic [11,18,19,20]. Where laws allowed, participants in our study utilized telemedicine for pre-abortion counseling and no-touch medication abortions which increased access and availability to patients [21]. This became more accessible by the suspension of the Risk Evaluation and Mitigation Strategy (REMS) for mailing mifepristone by the Food and Drug Administration (FDA) [22]. Interestingly, even in states where telemedicine for abortion was banned, participants were able to conduct telemedicine for post-abortion follow-up, which has been shown to be feasible and accurate in assessing for passed pregnancy [23]. Political barriers were listed by participants as being one of the main factors to implementing telemedicine for family planning services. States like Ohio, West Virginia, and Kentucky have legally limited access to medication abortion while encouraging usage of telemedicine for other specialties [24]. Discrimination of abortion care as non-essential based on political agendas has prevented telemedicine from being accessible to patients everywhere, despite extensive research proving that it is safe, effective, and preferred by patients.

Participants widely agreed that telemedicine should remain as a method of providing care in family planning if reimbursements will allow. While 32 states currently have laws in place that require private insurers to reimburse telemedicine services the same as in-person visits, these regulations do not apply to phone visits. Expanding this rule will increase access to care for all patients as there are still discrepancies in reimbursements despite these rules [25,26]. The pandemic has accelerated changes to telemedicine, a positive change out of what has otherwise been a difficult time for healthcare workers around the world. However, in a world where many are trying to return to normal practice, it is up to policy makers to determine the path forward on reimbursements for telemedicine visits [27].

This study has several limitations, the largest being that the study was conducted through a convenience sample of clinics that participate with the Society of Family Planning and may not be representative of all providers' experiences during the pandemic. Clinics that responded were largely academic centers or hospital-affiliated practices in urban areas. It is possible that social desirability bias played a role, where negative experiences might not have been shared with survey administrators. The surveys were conducted around six months after the start of the pandemic, leaving a small role for recall bias regarding the initiation of telemedicine in practice.

While it is difficult to predict the future of telemedicine due to policy and legal changes, family planning providers have successfully utilized the use of telemedicine for contraceptive and abortion care. Infrastructure was quickly implemented to provide these services, and providers believe it has been a successful shift for both clinics and patients alike. Future studies should identify potential healthcare disparities and access to technology to identify if telemedicine increases access to family planning services.

Conclusion

Clinics were able to implement telemedicine for abortion, particularly post-medication abortion follow-up, and contraceptive counseling when the pandemic began. Implementation was limited by state legislation, access to technology, and electronic medical records capability. Providers agreed that telemedicine should be continued after the pandemic as it is appreciated by providers and patients alike.

Disclosures

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References

1. Stanton T, Bateson D. Effects of the COVID-19 pandemic on family planning services. Curr Opin Obstet Gynecol 2021 Oct 1;33(5):425-30.
2. Bateson DJ, Lohr PA, Norman WV, Moreau C, Gemzell-Danielsson K, Blumenthal PD, et al. The impact of COVID-19 on contraception and abortion care policy and practice: experiences from selected countries. BMJ Sex Reprod Health 2020 10;46(4):241-3.
3. Kaller S, Munoz MGI, Sharma S, Tayel S, Ahlbach C, Cook C, et al. Abortion service availability during the COVID-19 pandemic: Results from a national census of abortion facilities in the U.S. Contracept X 2021;3:100067.
4. Weinberger M, Hayes B, White J, Skibiak J. Doing Things Differently: What It Would Take to Ensure Continued Access to Contraception During COVID-19. Glob Health Sci Pract 2020 06 30;8(2):169-75.
5. Riley T, Sully E, Ahmed Z, Biddlecom A. Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health In Low- and Middle-Income Countries. Int Perspect Sex Reprod Health 2020 Apr 16;46:73-6.
6. Stifani BM, Smith A, Avila K, Boos EW, Ng J, Levi EE, et al. Telemedicine for contraceptive counseling: Patient experiences during the early phase of the COVID-19 pandemic in New York City. Contraception 2021 Sep;104(3):254-61.
7. Lee S, Hitt WC. Clinical Applications of Telemedicine in Gynecology and Women's Health. Obstet Gynecol Clin North Am 2020 Jun;47(2):259-70.
8. Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. BJOG 2019 Aug;126(9):1094-102.
9. Dragoman M, Fofie C, Bergen S, Chavkin W. Integrating self-managed medication abortion with medical care. Contraception 2021 Dec 28.
10. Nanda K, Lebetkin E, Steiner MJ, Yacobson I, Dorflinger LJ. Contraception in the Era of COVID-19. Glob Health Sci Pract 2020 Jun 30;8(2):166-8.
11. Grindlay K, Lane K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. Womens Health Issues 2013 Mar-Apr;23(2):e117-22.
12. Ehrenreich K, Marston C. Spatial dimensions of telemedicine and abortion access: a qualitative study of women's experiences. Reprod Health 2019 Jul 3;16(1):94.
13. Stifani BM, Avila K, Levi EE. Telemedicine for contraceptive counseling: An exploratory survey of US family planning providers following rapid adoption of services during the COVID-19 pandemic. Contraception 2021 Mar;103(3):157-62.
14. Fryer K, Delgado A, Foti T, Reid CN, Marshall J. Implementation of Obstetric Telehealth During COVID-19 and Beyond. Matern Child Health J 2020 Sep;24(9):1104-10.
15. Lohr PA, Aiken ARA, Forsyth T, Trussell J. Telephone or integrated contraception counselling before abortion: impact on method choice and receipt. BMJ sexual & reproductive health 2018;44(2):114-21.
16. Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016 Jul 29;65(3):1-103.
17. Wilkinson TA, Kottke MJ, Berlan ED. Providing Contraception for Young People During a Pandemic Is Essential Health Care. JAMA Pediatr 2020 Sep 1;174(9):823-4.
18. Upadhyay UD, Grossman D. Telemedicine for medication abortion. Contraception 2019 Nov;100(5):351-3.
19. Gomperts RJ, Jelinska K, Davies S, Gemzell-Danielsson K, Kleiverda G. Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. BJOG 2008 Aug;115(9):1171-5; discussion 5-8.
20. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and acceptability of medical abortion provided through telemedicine. Obstet Gynecol 2011 Aug;118(2 Pt 1):296-303.
21. Raymond E, Chong E, Winikoff B, Platais I, Mary M, Lotarevich T, et al. TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States. Contraception 2019 Sep;100(3):173-7.
22. Fuleihan C. American College of Obstetricians and Gynecologists v. United States Food & Drug Administration: Restricted Access to Medical Abortion Threatens Reproductive Rights during the COVID-19 Pandemic. Am J Law Med 2020 Nov;46(4):507-17.
23. Perriera LK, Reeves MF, Chen BA, Hohmann HL, Hayes J, Creinin MD. Feasibility of telephone follow-up after medical abortion. Contraception 2010 Feb;81(2):143-9.
24. Mello K, Smith MH, Hill BJ, Chakraborty P, Rivlin K, Bessett D, et al. Federal, state, and institutional barriers to the expansion of medication and telemedicine abortion services in Ohio, Kentucky, and West Virginia during the COVID-19 pandemic. Contraception 2021 Jul;104(1):111-6.
25. Greiner AL. Telemedicine Applications in Obstetrics and Gynecology. Clin Obstet Gynecol 2017 Dec;60(4):853-66.
26. Okoroh EM, Kroelinger CD, Smith AM, Goodman DA, Barfield WD. US and territory telemedicine policies: identifying gaps in perinatal care. Am J Obstet Gynecol 2016 Dec;215(6):772 e1- e6.
27. Mehrotra A, Bhatia RS, Snoswell CL. Paying for Telemedicine After the Pandemic. JAMA 2021 Feb 2;325(5):431-2.

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