Bixby Center for Global Reproductive Health

UCSF University of California San Francisco

Beyond the Pill

Bringing the best science to contraceptive care

Protocol for the Provision of Contraceptive Services via Telehealth

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Abbreviations

AI	Artificial Intelligence
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease of 2019
EHR	Electronic Health Record
FCC	Federal Communications Commission
HIPAA	Health Insurance Portability and Accountability Act
iOS	iPhone Operating System
PHE	Public Health Emergency for COVID-19
SMS	Short Message Service (or text)

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Telehealth Basics

Telehealth has become an important way to deliver contraceptive services. The COVID-19 pandemic dramatically impacted the provision of essential health services across the U.S., prompting contraceptive health providers to rapidly pivot to integrate telehealth into their service offerings,[1-3] including for counseling, eligibility screening for contraceptive methods, prescription of new methods and refills.[4] Providers also pivoted to minimal contact and reduced testing where appropriate. Described telehealth benefits include remote access to contraceptive services, accommodating patients who live at a distance or who face challenges attending in-person office visits. Telehealth can also be helpful for patients in restrictive reproductive health environments.[5] Telehealth challenges include disparities in access and confidentiality.[1] Having staff and clinicians available for telehealth can help to:

- Avoid delays in access.
- Provide comprehensive person-centered contraceptive counseling, method initiation and continuation, and method switching.
- Manage side effects.
- Discuss options for patients currently using Depo or requesting to start Depo.
- Teach self-administration of DMPA-SQ.
- Facilitate prescriptions for time-sensitive emergency contraceptive pills.
- Support abortion services or facilitate post-abortion contraceptive care.
- Empower patients regarding social distancing.
- Avoid unnecessary exposure to illness and preserve staff availability to see high priority patients.

This protocol will review telehealth basics, candidates and contraindications, considerations for privacy, safety, and accessibility, best telehealth practices, and suggestions for clinic operations.

Three recommended steps to quickly implement telehealth services

The American Medical Association (AMA)[6] recommends the following steps:

1. Set up a team that will help facilitate the implementation of telemedicine services and make decisions quickly to ensure launch as soon as possible.
2. Check with your malpractice insurance carrier to ensure your policy covers providing care via telemedicine.
3. Familiarize yourself with payment and policy guidelines for various telemedicine services.

Nomenclature

Telehealth and Telemedicine

The terms telehealth and telemedicine are often used interchangeably to describe the practice of healthcare delivery when a patient and clinician are at a distance, with real-time audio, video, and / or

texting. The Federal Communications Commission (FCC) differentiates the two by describing telemedicine as using telecommunications technology for medical diagnosis, treatment, and management by clinicians, whereas telehealth employs a "wider variety of remote healthcare services beyond the doctor-patient relationship." Despite this differentiation by the FCC, CMS uses these terms interchangeably and describes telehealth as, "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. At one time, telehealth in Medicaid had been referred to as telemedicine."

In practice, there is minimal utility in differentiating between remote care and/or education delivered by clinicians vs. other remote healthcare services. We primarily refer to the term telehealth in this document.

Telehealth can be delivered using video, telephone, or text chat to facilitate health related communication when individuals are not in the same room together.

Direct-to-Patient Telehealth

Direct-to-patient telehealth is when the visit is at the patient's chosen location, not in a clinical setting, generally involving the patient's own device (phone, tablet, or computer).

Clinic-to-Clinic

As opposed to direct-to-patient, clinic-to-clinic telehealth involves the patient showing up to one clinical setting and receiving telehealth care or consultation from a clinician at another location. This method is commonly employed at hospitals without certain in-house clinician consultants so a specialty consult can still be offered. Similarly, a clinic-to-clinic telehealth consult might happen between two clinics in a large network.

Synchronous

Synchronous telehealth visits happen in real-time, where the patient and clinician are speaking directly to each other, at the same time, using audio, video, or chat. While synchronous video telemedicine visits might be crucial for the diagnosis and management of some medical conditions, generally a synchronous video visit is not necessary for initiation, management, or trouble-shooting contraceptive care.

Asynchronous / E-visits

Asynchronous telehealth visits are when chats, patient portal messages, photos, or videos are exchanged between patients and clinicians, not in real-time. Both synchronous and asynchronous telehealth models are appropriate for most contraception care. These visits may include evaluation and management.

Virtual Check-Ins

Virtual check-ins are assessments by telephone or other telecommunication device to determine whether an in-office encounter is needed for the patient's concern.

Federal Guidance

Many changes to federal regulations on telehealth care and telehealth billing exceptions were made during the COVID-19 Public Health Emergency, relaxing privacy regulations and expanding payment to cover telehealth. For more information on exceptions continued after the Public Health Emergency, see HHS updates and the CMS toolkit.

Telehealth Platforms

A variety of telehealth platforms are available to help deliver remote healthcare. Deciding the best for your practice will depend on the states you practice in, your payor mix, and the needs of your patients. If you won't bill insurance, the platform will be less important from a billing standpoint. However, if you plan to bill insurance, it's important to understand your state laws regarding telehealth. Some states require video-based platforms in order to bill for a visit, while others accept both telephone and video encounters. Additionally, some payers may not reimburse for chatting or text / SMS, but they will for video or telephone encounters. Depending on the communities you care for, some people may prefer to see their clinician over a video visit or have the option for closed captioning in the video encounter, while others may not have a stable enough internet connection to support a video call, or may view video visits as intimidating or an invasion of privacy.

The simplest telehealth platform is telephone (mobile or landline). Contraceptive care can be delivered synchronously via a phone call or both synchronously or asynchronously through text / SMS. While a landline phone without the need for an additional platform can be used for a telephone visit, providers should consider patient security and data privacy if choosing to deliver synchronous or asynchronous care using text / SMS or other chat features. Increased privacy can be achieved through encrypted messaging services such as the Signal application.

With the increased use of smartphones, providers now have the ability to provide live video care to patients through applications that are end-to-end encrypted such as:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

It should be noted that Facebook Live, Twitch, TikTok, and similar video applications are not acceptable applications for telehealth services.

Additional technology platforms:[7]

- Doxy.me - Telehealth platform that can assist providers and clinics to set up telehealth services
- Doximity: A platform that allows clinicians to call patients using their cell phone, while displaying office/clinic number.
- CareMessage - A mobile texting platform for FQHCs offering:
    - FREE use of CareMessage for at least 60 days (Webinar) : CareMessage has released a COVID-19-only version of its texting platform, made available at no cost for 60 days to any health center not already using CareMessage.
    - One-hour setup: No EMR or PHM integration is required to use this version of the platform and setup takes one hour.

Frequently Asked Questions in Considering Video Telehealth Platforms

Does your EHR already have an integrated video telehealth platform?

Over recent years, several electronic health record vendors have integrated video telehealth as an option in their platforms. Some include this in the base package for their platform, while others require adding it. An integrated video platform streamlines telehealth visits both for patients and providers.

They can automatically track visit time with the patient, to easily enter into the note for time-based billing. They can display the video call within the same window as the patient chart, so the clinician can document and see the patient without toggling between windows or tabs. They will typically offer a simple link that patients and providers can use to access the visit within the appointment reminder system or calendar, to enter the virtual room. If you are not using an integrated telehealth platform, there will be a few additional steps to integrate your virtual exam room link into materials electronically sent to the patient.

Is the platform HIPAA secure?

If your EHR does not have video integration, or you do not have an EHR, you should confirm that your video platform is HIPPA secure. Although the COVID-19 PHE loosened security requirements of video conferencing platforms, it is best practice for patient safety and practice longevity to choose a video platform offering robust privacy protections. Important features to evaluate are a) if video calls can be observed or entered by third parties without your knowledge, b) if the visit or chat is recorded and saved somewhere, and c) where scheduling data is stored and displayed. For example, if the video platform you choose creates a calendar link for the provider or practice, it's important to evaluate who can view that calendar link and where it will be displayed.

Is the platform web-based or app-based?

Some video platforms allow the patient to simply click on a link to enter the virtual exam room from the web, while others require the download of an app to enter the virtual exam room. A web-based platform provides a simpler, more streamlined process for patients. Benefits of an app-based platform include the potential for push notifications on the patient's device, which can offer reminders for taking medication, appointments, or refills. However, app-based programs require app download, which can be confusing, or require extra device storage.

Is the platform mobile friendly or does it require a computer to use? Does the platform support both Android and iOS devices?

Choosing a platform that is mobile device friendly not only ensures that patients without computers can log-in to visits from their cell phones, but also, the ability to connect using mobile data vs requiring a stable Wi-Fi connection. Currently, most telehealth video platforms are mobile device friendly for patients, but less often for hosting providers. Depending on your practice setting, choosing a platform that is mobile friendly for both patients and providers can ensure ease of use and flexibility for both. Additionally, ensure the platform supports both Android and iOS mobile devices for video streaming.

Does the platform provide real-time closed captioning?

Real-time closed captioning in a telehealth platform allows the provider to speak normally and have their speech simultaneously captioned for the patient to read. Choosing a platform with closed captioning is critical to ensuring access for Deaf and Hard-of-hearing patients, as well those with a diversity of learning styles.

Does the platform allow screen sharing?

There are several decision aides that can help during a contraceptive counseling visit. Being able to use a screen share function allows the provider to clearly share the decision aid or slide deck for the patient to review during the conversation. An alternative to screen sharing would be to securely email the document to the patient, but this may be challenging in real-time and requires screen toggling.

Technology Set-Up Recommendations

For telehealth video-based platforms you will need:

1) A computer or phone with either a built-in camera and microphone, or an external camera and microphone.
2) A quiet, private room. Your space should not have open windows or doors behind you, to reduce glare from the sun, and prevent others from looking at your screen.
3) For shared office or workspace, we recommend additional privacy measures like headphones and a privacy screen for your computer.
4) The specific technology needed will depend on the platform you decide to use.

Licensure and Location Confirmation

Currently, physicians and clinicians are required to be licensed in the state where the patient is receiving the healthcare and comply with the laws of that state. Some states have temporary practice laws to support existing provider-patient relationships and minimize gaps in care.

To meet appropriate standards of care, providers should: (1) verify the state where the patient is located before each telehealth appointment; (2) disclose their location and applicable credentials; and (3) obtain consent from patient after describing the telehealth delivery models and treatment methods or limitations.[8]

While some practices request a driver's license, home address, or utility bill for location confirmation, this may be unnecessarily restrictive for patients who must cross state lines and call-in from another state due to bans and other reproductive health restrictions. We recommend against using patient geolocation included with some EHR platforms to confirm location. Geolocation is not a current legal requirement and unnecessarily risks patient privacy and security without benefit to the patient or the practice. If the practice uses geolocation, advanced warning should be given to patients including the potential privacy risks associated with it.

If additional steps are required by state policy, this should be laid out the telehealth practice policy and communicated to patients prior to starting the telehealth visit.

Contraception & Telehealth Best Practices

Candidates for Telehealth Services

For all telehealth services, providers should obtain consent (verbally at minimum) and should alert their patients of potential privacy risks. All people who want to can receive contraceptive counseling via telehealth, and there is no medical reason someone must be seen in-person for a contraceptive counseling visit. Utilizing video platform tools like screenshare can allow for the easy use of contraceptive decision aides, and providers can be equipped with other contraceptive models in their office or at their home to show patients as they consider their options.

Provide patient-centered counseling on a range of methods & patient priorities when using telehealth, as in any visit type. Clearly, provider-dependent methods like an IUD, implant, or sterilization will require an in-person visit for initiation. However, telehealth could be used to streamline these visits prior to the patient's arrival. Medical eligibility, coverage, and informed consent for the method of choice can be reviewed via telehealth. Consent documents can also be signed electronically during a telehealth visit and simply confirmed once the patient arrives in the office.

For almost all people, synchronous telehealth visits can be used to initiate any non-provider dependent method. Patients can either fill out a pre-visit intake form specifically asking about certain medical conditions that can be contraindications to estrogen-containing methods, or providers can simply ask about medical history during the synchronous visit. As a general practice, all patients should be asked about medical history, medical conditions, and current medications. In addition, patients should be directly asked about medical conditions that are absolute contraindications for the use of estrogen-containing methods.

An example of how this question could be asked:

"I know you stated you don't have any medical conditions, but I want to ask you about some questions specifically about your medical history:

- *Do you have high blood pressure?*
- *Do you smoke? (verify age, number of cigarettes)*
- *Did you recently have a baby? (verify timing)*
- *Have you ever had breast cancer?*
- *Have you ever had a blood clot in your legs or lungs or had a stroke?*
- *Do you have Lupus or any conditions that cause blood clotting? (Verify +/known anti-phospholipid antibodies?)*
- *Do you have diabetes? (verify severity, duration, any end-organ effects)*
- *Do you have any heart conditions or have you ever had a heart attack?*
- *Have you ever had a tumor in your liver or any issues with your liver?"*

During a synchronous telehealth visit (telephone or video), positive answers to any of these questions can be explored more deeply to evaluate if they are true contraindications or not. For asynchronous telehealth visits, if a positive answer is given for any of these questions, a real-time phone or video call might be necessary to elucidate if there is truly a contraindication present.

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Contraception Initiation

- Avoid delays by sending prescriptions to pharmacy, mailing or pre-packing supplies for pick up.
- Assess risk of pregnancy using CDC criteria presented in the U.S. SPR, Box 2.
- Assess safety and eligibility for a method using the CDC Medical Eligibility Criteria. Make in-person visits needed for IUD, implant, sterilization, and / or DMPA-IM (DMPA-SQ is available for home administration). Initiate a bridging method as needed.
- Delay in-person visit if COVID-19 symptoms, pending test results, or recent asymptomatic contact.

Contraception Continuation

- Use evidence-based extended use for all methods.
- Advise condoms, initiate bridging methods.
- IUD and Implants using extended durations.
- Review risks & benefits of ongoing effectiveness of IUD beyond evidence.

Contraceptive Change or Discontinuation

- IUD and implant removals are essential reproductive health services. Ensure that removal on request will be facilitated.
- Discuss IUD self-removal, when appropriate.

Contraceptive Provision Tips

Combined Hormonal Contraceptives:

- Generally, provide a 12-month supply if no hypertension in last 3-5 years.
- If initial visit is e-visit, provide 12-month supply, and request BP report (clinic, pharmacy, or home blood pressure cuff) within 3 months.
- If history of hypertension, consider other methods. However, if hypertension was only during prior pregnancy and blood pressure has been normal since then, CHC prescription is fine.

Progestin-Only Pills:

- Generally, provide a 12-month supply.
- Consider over-the-counter Norgestrel (Opill) option, FDA approved July 2023, with expected availability in 2024. It has a 3-hour missed pill window and should be taken at the same time every day to maintain effectiveness.
- By prescription, consider Norethindrone (28 active pills / pack; with 3 hour missed pill window, i.e. should be taken near the same time every day to maintain effectiveness) or newer Drosperinone (24 active pills / 4 inert, with a 24-hour missed pill window, but may have limited insurance coverage).

DMPA:

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- For DMPA-IM, consider pharmacy or in-person visit (unless patient has experience with IM self-administration).
- Consider DMPA-SQ for self-administration for potential benefits of autonomy, continuation, and satisfaction (see Beyond the Pill's Protocol for the Provision of DMPA-SQ).

IUD & Implant:

In-person clinician visit is needed.

- Initiate a bridging method as needed.
- Education, consent, and payment can be done via telehealth.
- Consider contraceptive provision, placements and removals on request to be essential services.
- Provide IUD self-removal instruction, as appropriate.
- 1 in 5 who wished to remove IUD was successful,[9] with improved likelihood to recommend.[9,10]
- Advise evidence-based extended durations for all methods.

Emergency Contraception (EC):

- Provide routine counseling on all EC methods (EC pills and IUDs).
- Provide advanced prescriptions with refills.
    - Consider UPA EC pills (as more effective; especially for BMI >25) or LNG EC pills.
- Offer same-day IUD placement, when possible, and if not possible, provide and facilitate rapid access referrals for patients desiring IUD as EC.

Post-Abortion Contraception Telehealth Tips:

- Many patients do not want contraceptive counseling on the day of an abortion or in the abortion setting,[11-14] raising telehealth opportunities in post-abortion care.
- Advance notice of method availability is acceptable and provides abortion patients more time and knowledge for decision-making.[14]
- Those who do desire contraceptive counseling often want to hear about methods that are easier to use and more effective than previous methods and may want to leave the clinic with a method,[11] or get a method soon after abortion care.
- Results show fewer patients get contraception in the setting of medication abortion compared to aspiration abortion.[15]
- IUD insertion at in-person follow-up for medication abortion is safe, and without increased expulsions or complications.[16]
- Implant insertion at in-person medication abortion initiation is safe, effective, & more satisfactory to patients.[17,18] Implant can be provided in-person after telehealth medication abortion.

Postpartum Contraception Telehealth Tips:

- Many people do not attend routine postpartum visits, which is a crucial period when contraception would be initiated.[19]
- Telehealth postpartum visits have been shown to increase the odds of attending a postpartum visit by 90% with similar numbers of people making a contraceptive decision at their in-person visit compared to a telehealth visit.[20]

- Telehealth postpartum care might be associated with a decrease in racial disparities in postpartum visit attendance.[21]
- Progestin-only methods (such as POP or DMPA) and peri-coital methods (such as barriers or pH modulating gel) can be initiated at any time in the postpartum period, so an early postpartum telehealth visit (1-2 weeks postpartum) could be employed to discuss options, potentially initiate a method, and make a plan to bridge to an estrogen containing method in the coming weeks (or months if breastfeeding), as desired.

Online Contraceptive Pharmacy and Telehealth Visit Resources

Online telehealth contraceptive services for patients seeking short-acting methods, condoms, or emergency contraceptive pills:

- Bedsider's "Where To Get It" search engine includes online prescription and delivery services for birth control.
- Several online services prescribe and/or deliver birth control to patients, including:
    - PillPack: a full-service online pharmacy that delivers medication separated into daily packets (available in most U.S. states).
    - PRJKT RUBY: allows patients to order birth control online without a provider visit (available in most U.S. states).
    - Planned Parenthood Direct: telehealth birth control visits through app (available in some U.S. states).

Pharmacist-prescribed birth control:

- Pharmacist-prescribed birth control now in 7 states: CA, CO, HI, NM, OR, TN, WA.
- See map of participating pharmacies.

Telehealth Best Practices in Medication Abortion Care

Minimal contact and no-test medication abortion protocols, with demonstrated safety and efficacy,[21, 22] were increasingly used during the COVID-19 pandemic and following the Dobb's decision and resulting abortion bans. Essential components include:

- Dating by last menstrual period with home urine pregnancy test.
- Lab tests as needed for Rh, Hgb, STI tests, Ultrasound, urine pregnancy tests.
- Education, consent, and payment by telehealth.
- Evidence-based protocols for estimated GA up to 77 days, including 2nd dose misoprostol.
- Medications can be mailed, sent via mail order pharmacy, or prepared for drive-by pick up.
- Telehealth follow-up (symptom check, and follow-up home urine pregnancy tests).
- In settings with mifepristone restrictions, https://www.plancpills.org can be consulted for additional mailing options.
- Evidence demonstrates safety and efficacy of self-managed medication abortion.[23]
- Patients traveling outside of their state for abortion services should consider using encrypted platforms for communicating with clinics.

Privacy, Safety, and Accessibility

Privacy

Ensuring patient privacy is critical for any healthcare visit. For telehealth visits, ensuring privacy becomes the responsibility of both the provider and the patient. Ultimately, patients can decide to engage in a telehealth visit from any location they prefer. Best practice is to suggest headphones if there may be others in the room (home, coffee shop, library, etc.), but lack of a completely private patient location should not be a barrier to initiating a telehealth visit, if the patient chooses this type of visit.

Best practice is to use an exam room with the door closed for telehealth visits. For shared office spaces or cubicles, it is recommended to use headphones and a privacy screen and to ensure the camera is not facing windows or open doors so no one can inadvertently look at the screen. If taking telehealth visits from a provider's home or another location, similar precautions should be taken.

Screening for Family / Intimate Partner Violence with Telehealth

- When initiating a telehealth visit, scan your room and introduce any other staff that are in the room and then ask the patient who else may be in the room with them.
- Include a standard screening question on IPV, and give standard instruction to alert provider if they can't safely continue conversation (chat feature, safe word, hand gesture, etc.).
- Consider intake forms patients can complete privately.
- Futures Without Violence COVID-19 resource list.

Language Interpretation

Although most healthcare providers use telephone language interpretation services, few have utilized this service for video telehealth visits. For synchronous telephone visits, providers can typically use their same interpretation service and include them in a three-way call with the patient.

Most major language interpretation services also offer telehealth interpreters for video visits. Before launching your video telehealth practice, contact your current language interpretation service to confirm this, and determine how the interpreter will be added to video calls. Assess with patients before an interpreter is invited into a video call if they will be comfortable including a male-presenting person on a contraception video call or not, and facilitate any request.

Interpretation services for asynchronous visits can be more challenging. Although AI translation programs or services like Google Translate are tempting to use, they have not been validated as an accurate translation tool in medical settings and raise some serious privacy concerns. If a clinician is not available to translate over chat, consideration should be given to convert the visit to a telephone or video call where a medical translator can be used.

Closed Captioning

Closed captioning is when text is displayed in real-time on a video to help all people understand what is being said. This is an especially crucial service for Deaf and Hard-of-hearing communities and can also be very useful in comprehension for all people.

Confidentiality and Mandated Reporting

Patient information should be confidential and only shared with people directly involved in the person's care, if permission was given to do so, or by exception, such as to comply with:

- Insurance company (if patient consents to submitting claim)
- Health department laws about required infectious disease reporting
- Mandated reporting of suspected child abuse
- Mandated reporting of domestic violence
- A formal subpoena

Caution should be used submitting insurance claims, keeping in mind that the claim could be made visible or mailed to the home of other members on the insurance plan. Medications mailed to the home may jeopardize confidentiality and should be considered with patients ahead of time.[24-25]

It is important when submitting mandated reporting to consider risk of criminalization to patients, providers, and anyone involved in abortion care in your state. To date, there is no mandated reporting state law or policy to report an abortion to law enforcement and doing so could be a HIPAA violation.

Clinical Operations

Telehealth Clinic Workflow Best Practices

Below are some best practices for telehealth workflow.

AAFP Virtual Visit Algorithm provides guidance on virtual visits.

Registration / Billing

- Call patients to verify insurance and obtain any documentation in advance.
- Allow patients to show ID and insurance card over video chat or electronically.
- Allow payment online in advance or post telehealth session at clinic if patient picking up medications from clinic site.

Scheduling / Triage

- Call in advance to inform patients of changes (i.e., hour changes, cancellations, screening protocol, accompanying individuals, telemedicine visits, and COVID-19 precautions).
- Post signs regarding walk-in appointments and triage.
- Have masks available for patients.

Counselor / Medical Assistant / Intake

- Maintain roles allowing staff to complete visit check-in, intake, screening, and medical history in advance.
- Use online tools to allow patients to complete forms and sign electronically (i.e., DocuSign).

Consent and Protocols

- Consent the patient verbally if electronic or written consent cannot be obtained. Include documentation for verbal consent.
- Print protocols so that staff can easily provide the correct information.
- Use teleconference feature to bring provider or other staff into visit in real time (i.e billing person for coverage question, rather than patient making another call).

Manager / Staffing / Flow

- Monitor staffing, sick leave, childcare needs, back-up staffing, and the ability of staff to come to work.
- Monitor staff traveling between sites to reduce risk of infection transmission.
- Allow staff to work from home if possible.
- Huddle with staff 1-2 times daily to update workflows.
- Consider utilizing a secure instant-messaging system (like Microsoft Teams or if practice's EHR system has one) to allow for real-time communication like triaging patients or calling patients back, as well as huddles.
- Streamline activities (i.e., complete lab orders in advance so the patient can just leave specimens).

- Ideally a nurse, provider or flow manager is available to assist staff in the triage screening process, to troubleshoot workflows in real time.
- Use the same documentation for telehealth visits as face-to-face visits, with the same requirements.

Contraceptive e-Visit Templates, Dot Phrases

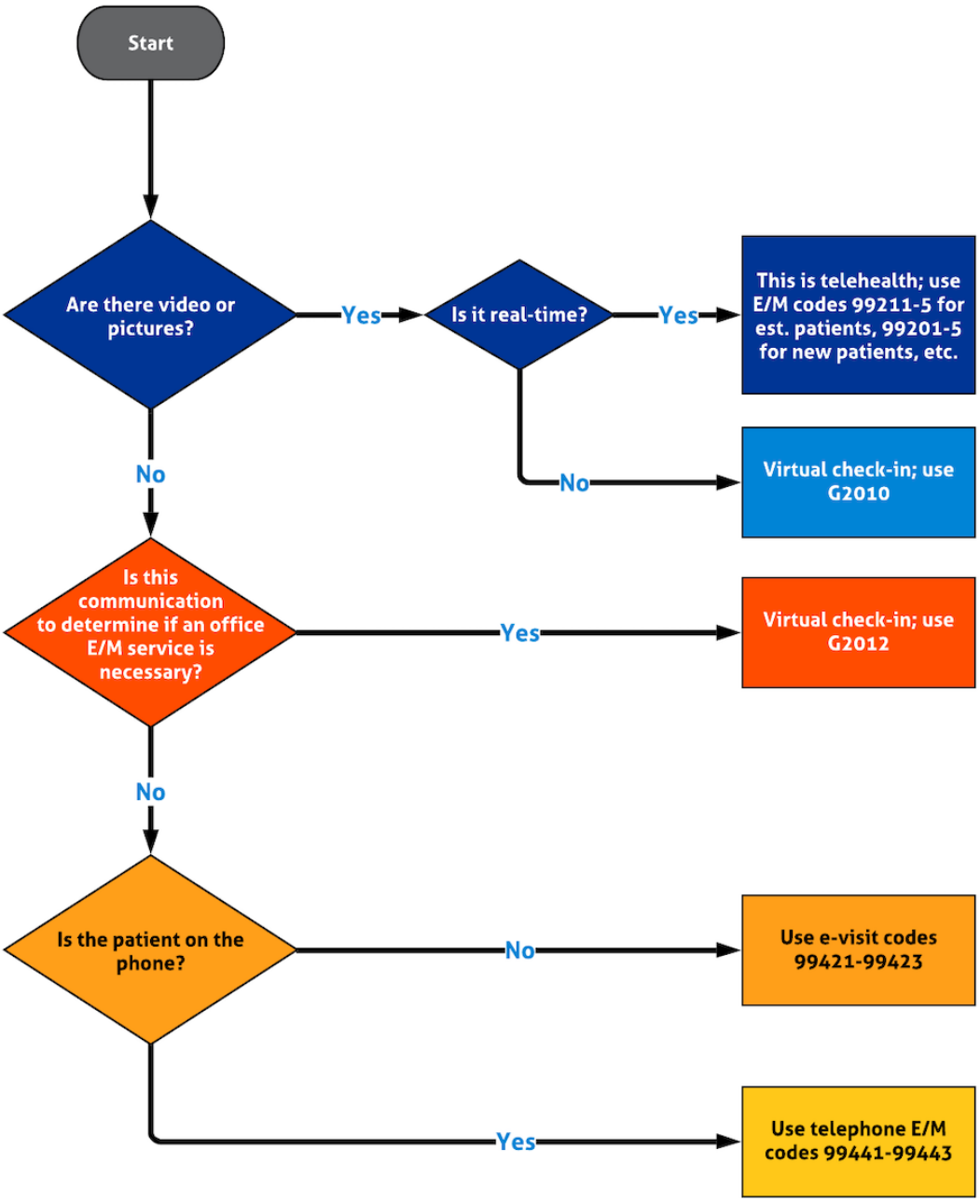
- See contraceptive e-visit template (RHAP).
- See virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins (AAFP).

Telehealth and Billing

There are various coding and billing resources below, and a Virtual Visit Algorithm on the next page providing a simple, useful coding guide. Guides to facilitate implementing telemedicine capabilities and detailed billing guides:

- AMA – Telehealth Quick Guide
- AAFP – Telehealth and Telemedicine website
- ACOG – Managing Patients Remotely: Billing for Digital and Telehealth Services
- AMA – Special Coding Advice During COVID-19 Public Health Emergency
- CCHPA – website with latest links to federal guidelines, state legislation, major insurers

Virtual Visit Algorithm



Developed by James Dom Dera, MD, FAAFP. Source: Four algorithms that answer four key questions about COVID-19. *FPM*. May 18, 2020. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/covid_algorithms.html

References

1. Comfort AB, Rao L, Goodman S, Raine-Bennett T, Barney A, Mengesha B, Harper CC. Assessing differences in contraceptive provision through telemedicine among reproductive health providers during the COVID-19 pandemic in the United States. Reprod Health. 2022 Apr 22;19(1):99.
2. Steenland MW, Geiger CK, Chen L, et al. Declines in contraceptive visits in the United States during the COVID-19 pandemic. Contraception. 2021 Dec;104(6):593-599.
3. Wosik J, Fudim M, Cameron B, et al. Telehealth transformation: COVID-19 and the rise of virtual care. Journal of the American Medical Informatics Association. 2020;27:957–962.
4. Nanda K, Lebetkin E, Steiner MJ, et al. Contraception in the Era of COVID-19. Glob Health Sci Pract. 2020 Jun 30;8(2):166-168.
5. Stifani BM, Smith A, Avila K, et al. Telemedicine for contraceptive counseling: Patient experiences during the early phase of the COVID-19 pandemic in New York City. Contraception. 2021;103:157–162.
6. AMA Telehealth Quick Guide. Updated May 2023.
7. Upstream Guidance on Telehealth and Contraceptive Care. Updated June 2020.
8. HHS: Licensing Across State-lines. Updated May 11, 2023.
9. Foster DG, Grossman D, Turok DK, et al. Interest in and experience with IUD self-removal. Contraception. 2014 Jul;90(1):54-9.
10. Raifman S, Barar R, Foster D. Effect of Knowledge of Self-removability of Intrauterine Contraceptives on Uptake, Continuation, and Satisfaction. Womens Health Issues. 2018 Jan-Feb;28(1):68-74.
11. Matulich M, Cansino C, Culwell KR,et al. Understanding women's desires for contraceptive counseling at the time of first-trimester surgical abortion. Contraception. 2014; 89; 36-41.
12. Kavanaugh M, Carlin EE, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Contraception. 2011; 84; 583-593.
13. Purcell C, Cameron S, Lawton J, et al. Contraceptive care at the time of medical abortion: experience of women and health professionals in a hospital or community sexual and reproductive health context. Contraception. 2016; 93; 170-7.
14. Roe AH, Fortin J, Gelfand D, et al. Advance notice of contraceptive availability at surgical abortion: a pilot RCT. BMJ Sex Reprod Health. 2018. July; 44(3): 187-193.
15. Rocca CH, Goodman S, Grossman D, et al. Contraception after medication abortion in the United States: results from a cluster randomized trial. Am J Obstet Gynecol. 2018 Jan;218(1):107.e1-107.e8.
16. Sääv I, Stephansson O, Gemzell-Danielsson K.Early versus Delayed Insertion of Intrauterine Contraception after Medical Abortion — A Randomized Controlled Trial. PLoS One. 2012;7(11):e48948.

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17. Raymond EG, Weaver MA, Tan YL, et. al. Effect of Immediate Compared With Delayed Insertion of Etonogestrel Implants on Medical Abortion Efficacy and Repeat Pregnancy: A RCT. Obstetrics & Gynecology Feb 2016;127(2):306–312.
18. Sonalkar S, Hou MY, Borgatta L. Administration of the etonogestrel contraceptive implant on the day of mifepristone for medical abortion: a pilot study. Contraception Nov 2013:88(5),671–673.
19. Attanasio LB, Ranchoff BL, Cooper MI, Geissler KH. Postpartum Visit Attendance in the United States: A Systematic Review. Womens Health Issues. 2022 Jul-Aug;32(4):369-375. doi: 10.1016/j.whi.2022.02.002. Epub 2022 Mar 15. PMID: 35304034; PMCID: PMC9283204.
20. Arias MP, Wang E, Leitner K, Sannah T, Keegan M, Delferro J, Iluore C, Arimoro F, Streaty T, Hamm RF. The impact on postpartum care by telehealth: a retrospective cohort study. Am J Obstet Gynecol MFM. 2022 May;4(3):100611. doi: 10.1016/j.ajogmf.2022.100611. Epub 2022 Mar 22. PMID: 35331971; PMCID: PMC10134102.
21. Kumar NR, Arias MP, Leitner K, Wang E, Clement EG, Hamm RF. Assessing the impact of telehealth implementation on postpartum outcomes for Black birthing people. Am J Obstet Gynecol MFM. 2023 Feb;5(2):100831. doi: 10.1016/j.ajogmf.2022.100831. Epub 2022 Dec 7. PMID: 36496115; PMCID: PMC9726646.
22. Aiken A, Lohr PA, Lord J, et al. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. BJOG. 2021 Aug;128(9):1464-1474.
23. Upadhyay UD, Raymond EG, Koenig LR, et al. Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study. JAMA Intern Med. 2022 May 1;182(5):482-491.
24. WHO Abortion Care Guidelines, 2022.
25. ACOG Policy. Opposition to Criminalization of Individuals during Pregnancy and the Post-partum Period. December 2020.

Additional Resources:

- https://www.fcc.gov/general/telehealth-telemedicine-and-telecare-whats-what
- https://www.medicaid.gov/medicaid/benefits/telehealth/index.html
- Center for Connected Health Policy: Telehealth Coverage Policies in the Time of COVID-19 To Date: COVID-19 Related State Actions
- Health Insurance Providers Respond to Coronavirus (COVID-19) – outlines the steps private insurers have taken in light of COVID-19
- AMA quick guide to telemedicine in practice: Policy, coding & payment
- ACOG has compiled information on proper billing and coding for the provision of contraceptive care services through telehealth in their resource Managing Patients Remotely: Billing Guidance for Digital and Telehealth Services.
- American Academy of Family Physicians: A virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins

- The Family Planning National Training Center (FPNTC) has created a toolkit entitled What Family Planning Providers Can Do to Meet Client Needs During COVID-19, which provides guidance on reducing in-patient visit exposure, ensuring family planning needs are continuing to be met, and how to keep both staff and clients safe onsite.
- Partners in Contraceptive Choice and Knowledge (PICCK) COVID-19 Resources: Telemedicine Best Practices and Considerations
- UCSF Telemedicine guidelines for contraceptive provision during COVID-19
- The National Consortium of Telehealth Resource Center provides assistance, education, and information to organizations and individuals who are actively providing or interested in providing health care at a distance. They have created a toolkit on Telehealth and COVID-19.
- CMS General Provider Telehealth and Telemedicine Toolkit
- National Family Planning and Reproductive Health Association (NFPRHA): Initiating Telehealth in Response to COVID-19: Initial Considerations and Resources
- National Association of Community Health Centers: Telehealth Resources
- Reproductive Health Access Project:
    - Contraceptive Care via Telehealth
    - Birth Control Choices Fact Sheet
    - Contraception Resource Guides
- UCSF Beyond the Pill "How Well Does Birth Control Work?" Chart
- CDC Medical Eligibility Criteria for Contraceptive Use