# Protocol for the Provision of Contraceptive Services via Telehealth

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# Acknowledgements

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This publication is designed for use by licensed medical providers. Individuals who wish to provide any of the medical services described herein should obtain appropriate training prior to initiating services. This resource is not intended to provide legal, medical or professional advice. It is not a substitute for consultation with a healthcare provider or for independent judgment by healthcare providers or other professionals regarding individual conditions and situations.

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# Abbreviations

| | |
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| **AI** | Artificial Intelligence |
| **AMA** | American Medical Association |
| **CDC** | Centers for Disease Control |
| **CMS** | Centers for Medicare and Medicaid Services |
| **COVID-19** | Coronavirus Disease of 2019 |
| **DMPA** | Depo medroxyprogesterone acetate |
| **DMPA-IM** | Depo medroxyprogesterone acetate intramuscular |
| **DMPA-SQ** | Depo medroxyprogesterone acetate subcutaneous; aka DMPA-SC or “Depo sub-q” |
| **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 |
| **PHI** | Protected Health Information |
| **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,[1,2,3] 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 DMPA or requesting to start DMPA.
- 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 to access contraceptive services without the logistical barriers of in-clinic care.
- 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 telehealth services and make decisions quickly to ensure a timely launch.
2) Check with your malpractice insurance carrier to ensure your policy covers providing care via telehealth.
3) Familiarize yourself with payment and policy guidelines for various telehealth services and modalities.

## 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."[7] 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 telehealth 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, videos, or questionnaires 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. Virtual check-ins may be initiated by clinic staff trained in initial screening who have access to licensed providers for official triage, or they can be facilitated by providers directly.


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## 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 at similar reimbursement rates to in-office care. 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 platform for your practice will depend on the states you practice in, your billing needs, and the needs of your patients. If you plan to bill insurance, it's important to understand your state laws regarding telehealth and evaluate potential platform billing capabilities. 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 chat-based communication or text/SMS, but they will for video and/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 or a capable device to support a video call or may view video visits as intimidating or an invasion of privacy.

The simplest telehealth platform is mobile or landline telephone. Contraceptive care can be delivered synchronously through a clinic's established landline. This offers a stable option without the need for an additional platform and is often the starting point for burgeoning telehealth services. If choosing to use a mobile phone for synchronous care, providers should mask their cell-phone number for security purposes using applications such as Google® Voice, Doxy.Me, or iPlum®.

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 end-to-end encryption, which is an important security standard that allows two-way communication only between sender and recipient, barring third party access to transmitted data.

Video platform options that can be used via phone or computer apps that are end-to-end encrypted:

- Apple® FaceTime, Facebook Messenger® video chat, Google Hangouts® video, Skype®[8]
- Zoom®, as one of the most popular videoconferencing platforms, does include standard end-to-end encryption; however, some online reviews state that it is required that a provider have the paid version of Zoom® for additional encryption security which could be a barrier to care.

Asynchronous encrypted texting platforms include: Signal®, Jabber®, WhatsApp®, or iMessage®[8]

It should be noted that public-facing applications such as Facebook Live®, Twitch®, TikTok®, and similar video applications are not acceptable applications for telehealth services.

Additional platforms specifically designed for telehealth delivery:[9]

- Doxy.me: A comprehensive telehealth platform that can assist providers and clinics to set up telehealth services.
- Doximity: A free platform that allows clinicians to video or audio call and/or send texts to patients using their cell phone, while displaying an office/clinic number.
- CareMessage: A mobile texting platform for FQHCs and other non-profit organizations.

## 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 into their platforms or have associated telehealth platforms with some limited integration. Depending on the vendor and plan, features can be included in base packages, while others require adding it. An integrated video platform streamlines telehealth visits both for patients and providers and can include features like automatically tracking visit time with the patient for time-based billing or displaying 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 typically offer a simple link that patients and providers can use to access the virtual visit room within the appointment reminder system or calendar. If you are not using an integrated telehealth platform, additional steps are needed to include 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, 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 and if so, the security of where it is being saved, and c) where scheduling data that contains patient PHI 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, barriers to app-based programs include requiring app download, which can be confusing, or require a capable smart device and adequate 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 a computer can log-in to visits from a smart phone, 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 parties. Additionally, ensure the platform supports both Android and iOS mobile devices.

***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 video-based telehealth platforms medical staff 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. Visits should never be conducted in public spaces.
4) Any other specific technology needed will depend on the platform you decide to use.

You can offer similar instructions to a patient prior to an initial telehealth visit. One study demonstrated that user experience improved when patients received clear instruction on how to join the visit ahead of time.[10]

## Licensure and Location Confirmation

Currently, physicians and clinicians are required to be licensed in the state where the patient is located and 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) confirm their ability to practice in the patient's state; and (3) obtain verbal or written consent from patient after describing the telehealth delivery models and treatment methods or limitations.[11,12]

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 associated potential privacy risks, with the option to opt-out or decide not to proceed with the visit.

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

# Contraception and Telehealth Best Practices

## Telehealth Contraceptive Counseling and Initiation

For all telehealth services, providers should obtain verbal or written consent and should alert their patients of potential privacy risks. Anyone can receive contraceptive counseling via telehealth, and there is no medical indication requiring an in-person contraceptive counseling visit, though patient preference for visit type should be honored.[13] In fact, the choice to self-select preferred modality (in-person vs telehealth) is an important factor in patient assessment of the quality of contraceptive counseling.[14] 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 and patient priorities when using telehealth, as in any visit type. While provider-dependent methods like an IUD, implant, or sterilization will require an in-person visit for initiation, 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. A telehealth consultation visit should not be required or lead to a delay in in-person care when a patient is confident in their desire to proceed with a provider-dependent contraceptive method.

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

An example of how this question could be asked:

*"Thanks for sharing your medical history with me. I want to ask you some additional questions to confirm any history of specific medical conditions that can interact with some contraception methods:*

- *Do you have high blood pressure?*
- *Do you smoke cigarettes? (verify age, number of cigarettes)*
- *Have you recently been pregnant? (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 or been told you need to take a blood thinner? (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, positive answers to any of these screening questions can be explored to evaluate if a true contraindication exists. For asynchronous telehealth visits, if a positive

answer is given for any of these questions, a real-time phone or video call rather than text-based communication might uncover any true contraindications.

## Contraception Initiation

- Assess likelihood of current pregnancy using CDC criteria presented in the U.S. SPR, Box 3.
- Assess safety and eligibility for a method using the CDC Medical Eligibility Criteria.
- Make in-person visits as needed for IUD, implant, sterilization, and/or DMPA-IM (DMPA-SQ is available for home administration). Initiate a bridging method as needed.
- Send prescriptions to a local pharmacy, or pre-pack supplies for mail or pick up without delay.

## Contraception Continuation

- Use evidence-based extended use for all methods, including IUDs and implants, and review risks and benefits of ongoing effectiveness beyond evidence-based durations.[15]
- Advise condoms for dual pregnancy and STI prevention.
- Initiate bridging methods, including offering prescriptions for the over-the-counter progestin-only pill or advance provision of emergency contraception pills.
- Extend prescriptions for combined hormonal contraceptives beyond 12 months to allow flexibility in receiving blood pressure report from patients.
- Assessment and management of contraceptive side effects, such as bleeding irregularities, can be facilitated via telehealth.

## Contraceptive Change or Discontinuation

- Telehealth may offer patients increased opportunity to consider their options, discuss how to manage side effects, or explore method changes, which can alleviate the pressure to make an immediate decision.[5,13,14,16]
- IUD and implant removals are essential reproductive health services. Ensure that removal on request will be facilitated.[17]
- Discuss IUD self-removal, when appropriate.[18]
    - In one study, 1 in 5 who wished to remove their IUD were successful and study participants, regardless of success, would recommend the IUD to a friend knowing that IUD self-removal is an option.[19]
    - In another study, regardless of success, most participants would recommend the method of IUD self-removal to a friend.[20]

## Contraceptive Provision Tips

**Combined Hormonal Contraceptives:**

- Generally, provide a 12-month supply if no history of hypertension in last 3-5 years.


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- Provide 12-month supply at initial telehealth visit, and request blood pressure report (clinic, pharmacy, or home blood pressure cuff) within 3 months of initiation.
- If history of hypertension (not including gestational hypertension with subsequent normal blood pressure), consider other methods.
- Depending on the state, Registered Nurses (RNs) can prescribe combined pills, patches, and rings.

**Progestin-Only Pills:**

- Provide a 12-month supply at initial and subsequent annual telehealth visits.
- Patients may consider over-the-counter Norgestrel (Opill®), FDA approved July 2023 and now available at most retail pharmacies, for self-directed use. 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 Drospirenone (24 active pills/4 inert, with a 24-hour missed pill window, but may have limited insurance coverage).
- Depending on the state, RNs can prescribe progestin-only pills.

**DMPA:**

- For DMPA-IM, consider pharmacy or in-person administration (unless patient has experience with IM self-administration). Depending on the state, RNs can prescribe DMPA-IM.
- 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 and Implant:**

In-person clinician visit is needed.

- Initiate a bridging method as needed.
- Education, consent, payment, and prescription for bridging method can be done ahead via telehealth.
- Consider contraceptive provision, placements and removals on request to be essential services.
- Provide IUD self-removal instruction, as appropriate.
- 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 a first-line option (more effective, especially for weight over 165 pounds) over LNG EC pills[21,22]. However, UPA may be more cost-prohibitive for those without insurance coverage.
- Offer same-day IUD placement, when possible, and if not possible, provide and facilitate rapid access referrals for patients desiring IUD as EC.
- Depending on your state, Registered Nurses (RNs) can prescribe EC pills.

**Post-Abortion Contraception:**

- Many patients do not want contraceptive counseling on the day of an abortion or in the abortion setting,[23,24,25] 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.[26]
- Those who do desire contraceptive counseling within the abortion setting 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,[23] or get a method soon after abortion care.
- Results show fewer patients get IUDs in the setting of medication abortion compared to aspiration abortion, due to the need to return for follow-up for these methods.[27]
- IUD placement at in-person follow-up for medication abortion is safe, without increased expulsions or complications.[28]
- Implant insertion at in-person medication abortion initiation is safe and effective, and more satisfactory[29,30] Implant can also be provided in-person after telehealth medication abortion as long as it is reasonably certain the patient is not pregnant.

For patients who reside in abortion-hostile states or in situations where pregnancy disclosure is unsafe, counsel patients who plan to receive an IUD or implant outside of your organization that there is a possibility of a urine pregnancy test being performed prior to placement. High sensitivity urine pregnancy tests can stay positive up to up to 4-6 weeks after an abortion.[31]

**Postpartum Contraception:**

- Many people do not attend routine postpartum visits, which is an ideal period for contraception initiation.[32]
- 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.[33]
- Telehealth postpartum care might be associated with a decrease in racial disparities in postpartum visit attendance.[34]
- 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 Telehealth and Pharmacy 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 contraception 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 in an asynchronous manner (available in most U.S. states).
- Planned Parenthood Direct: Telehealth birth control visits through an app (available in some U.S. states).

Pharmacist-prescribed birth control:

- Pharmacist-prescribed birth control now in over 25 states, but not every pharmacy in those states may be participating.
- See map of participating pharmacies and state-by-state coverage for pharmacist-dispensed contraception.

# 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 patients use headphones if there may be others in the room (home, coffee shop, library, etc.)[35], but lack of a completely private patient location should not be a barrier to initiating a telehealth visit. If a patient decides to have their appointment in a public space, it's important for them to understand that the conversation may involve discussing sensitive medical and sexual history questions.

Best practice for providers and clinic staff 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 resource list for getting help now.

## Language Interpretation

Although most healthcare providers use telephone language interpretation services, barriers remain to utilize this service for video telehealth visits.[36] For synchronous telephone visits, providers can typically use the same interpretation service 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 the availability of video interpretation, and their usual process for joining video calls. Confirm with patients during visit scheduling if they would be comfortable with a male-presenting interpreter for a contraception visit and facilitate any requests or preferences ahead of the visit.

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 significant privacy concerns. If a bilingual clinician is not available to converse with the patient over chat, consideration should be given to convert the visit to a telephone or video call where a medical interpreter can be used.

Remember that some health insurance plans will cover translation for their insured patients. Research your payers for instruction on how to utilize these services and create job aides to support telehealth staff.

## 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

Per HIPAA regulations, patient information should be confidential and only shared with people directly involved in the person's care, if explicit 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 via an Explanation of Benefit report. Medications mailed to the home may jeopardize confidentiality and should be considered with patients ahead of time.[37,38]

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

### Registration/Billing

- Allow trained call center, clinic staff or coordinators to offer and initially screen patients for telehealth services and eligibility.
- Staff can call patients to verify insurance and obtain any documentation or consents 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 or text in advance to inform patients of appointment times, telehealth requirements and visit expectations.
- Post signs about telehealth options and services throughout the clinic.

### 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.
- Create 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 having the patient make another call.

### Manager/Staffing/Flow

- Allow staff to work from home if possible, for days in which no in-clinic care is being provided.
- Huddle with staff 1-2 times daily to respond to any flow issues that arise during the clinic session.
- Consider utilizing a secure instant-messaging system (like Microsoft Teams® or via EHR messaging if available) to allow for real-time communication like triaging patients or calling patients back, as well as huddles.
- Ideally a nurse, provider or flow manager is available to assist staff in the triage screening process, to troubleshoot workflows in real time.
- Streamline activities. If lab orders are required for STI testing or other screening, create orders in advance so patients can simply leave specimens or be referred to Quest® or Labcorp® locations.
- Follow same documentation requirements for telehealth visits as in-person visits.

## Contraceptive e-Visit Templates, Dot Phrases

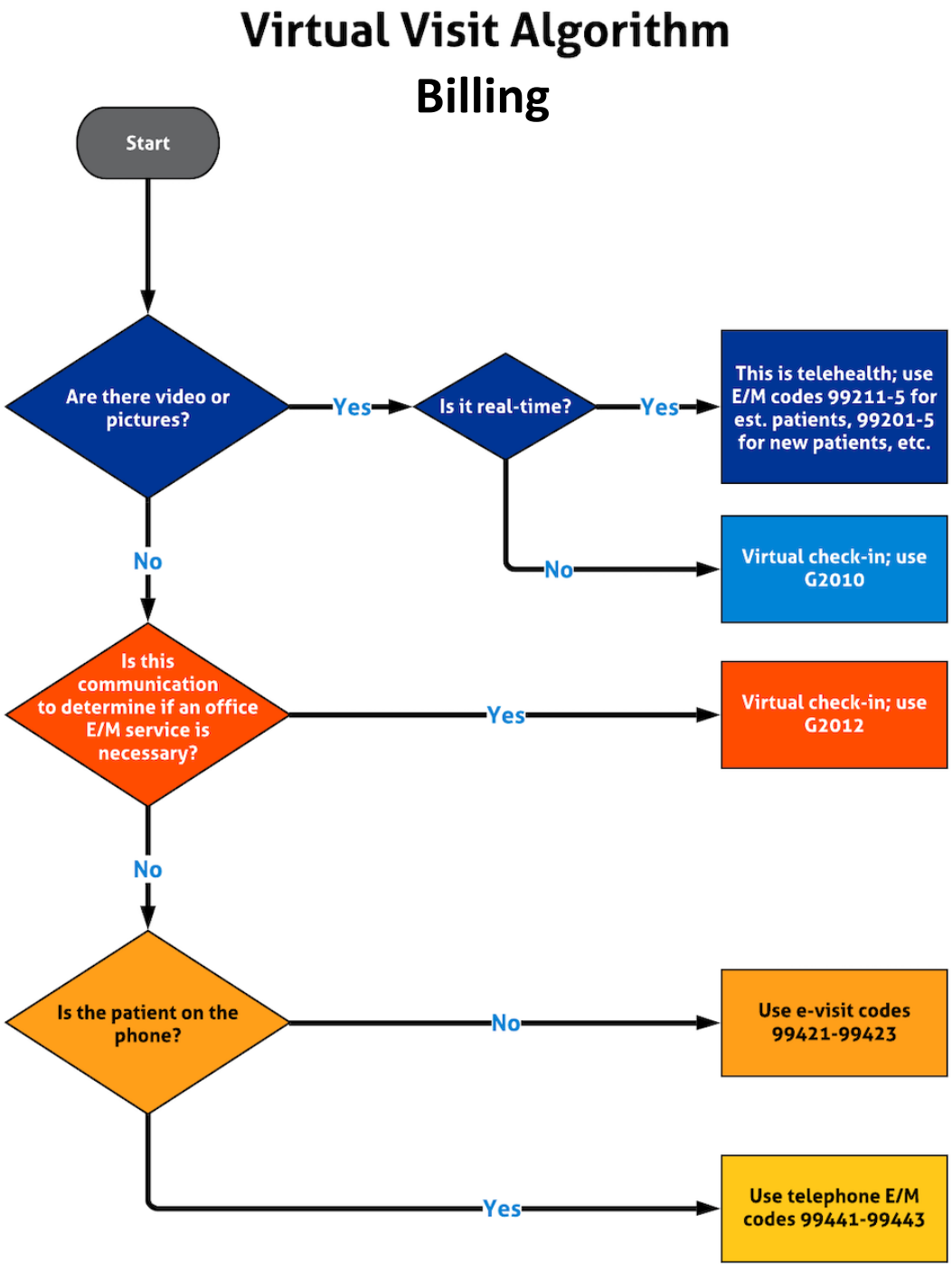
- See contraceptive e-visit template (RHAP). *Last updated March 2024. Note that it may include outdated counseling information such as LARC duration.*
- See virtual visit algorithm which outlines how to differentiate and code telehealth visits, e-visits, and virtual check-ins (AAFP).

## Telehealth and Billing

There are various coding and billing resources below, and the AAFP 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
- CCHPA – website with latest links to federal guidelines, state legislation, major insurers




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

# Additional Telehealth Resources

- https://www.fcc.gov/general/telehealth-telemedicine-and-telecare-whats-what
- https://www.medicaid.gov/medicaid/benefits/telehealth/index.html
- 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
- Birth Control Pharmacist
- CDC Medical Eligibility Criteria for Contraceptive Use, 2024
- CDC MEC Summary Chart, Color
- CDC Selected Practice Recommendations, 2024
- Converge: Partners in Access Provision of Person-Centered Reproductive Health Care via Telemedicine
- CMS General Provider Telehealth and Telemedicine Toolkit
- 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.
- 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.
- 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
- Partners in Contraceptive Choice and Knowledge (PICCK) COVID-19 Resources: Telemedicine Best Practices and Considerations
- Power To Decide State Reproductive Health Access Policies Map
- Providing Quality Family Planning Services in the US: Recommendations of the US Office of Population Affairs, 2024
- Reproductive Health Access Project:
    - Contraceptive Care via Telehealth
    - Birth Control Choices Fact Sheet
    - Contraception Resource Guides
    - IUD Self Removal Patient Guide
- Reproductive Health Initiative for Telehealth Equity & Solutions (RHITES) Sexual and

Reproductive Access for People with Disabilities Summary Sheet

- UCSF Beyond the Pill "How Well Does Birth Control Work?" Chart
- UCSF Beyond the Pill Protocol for the Provision of Subcutaneous Depo Medroxyprogesterone Acetate (DMPA)
- UCSF Telemedicine guidelines for contraceptive provision during COVID-19

Thank you for reviewing Beyond the Pill's *Protocol for the Provision of Contraception via Telehealth.* To leave feedback, offer suggestions, or to share how you've used this protocol in your practice, you can email us at beyondthepill@ucsf.edu

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