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Special Article

Society of Family Planning Committee Statement: Telemedicine in family planning care part 1 – Background and overarching principles☆,☆☆

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ABSTRACT

Telemedicine is an effective modality for remote family planning care delivery. Telemedicine increases reach, reduces barriers to care, and facilitates person-centered care. As the demand for telemedicine increases, evidence-based guidance is crucial for optimal practice. This clinical guidance series offers evidence-informed, person-centered, and equity-driven recommendations to enhance telemedicine delivery of contraceptive services and medication abortion in the US. Providing care via telemedicine may not be for everyone, and thus, clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care. Ensuring that telemedicine remains accessible, regardless of whether a person also requires in-person clinical services, is essential to person-centered family planning care. Telemedicine family planning services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible. Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access. Telemedicine family planning care should address the privacy and confidentiality of the person receiving care. Telemedicine family planning care clinicians should be familiar with their state, regional, and institutional laws or regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care. The companion documents, *Society of Family Planning Clinical Recommendation: Telemedicine for abortion and contraception part 2 – Contraception* and *Society of Family Planning Clinical Recommendation: Telemedicine for abortion and contraception part 3 – Abortion*, build upon this document and focus on actionable clinical recommendations.

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Disclaimer: This publication is designed as a resource to assist clinicians in providing family planning care. It should not be considered inclusive of all proper treatments or serve as the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations, considering individual circumstances, may be appropriate. This publication reflects the best-available evidence at the time of publication, recognizing that continued research or major changes in the practice environment may impact future recommendations and should be evaluated for incorporation into care. Clinical guidance, grounded in evidence-based research, is distinct from legal requirements and restrictions governing family planning care. Medical recommendations do not vary based on practice location. However, abortion is not legal in all states and circumstances, and this document is not intended to aid in or otherwise advocate for unlawful care. Any updates to this document can be found on https://societyfp.org/clinical/clinical-guidance-library/. SFP and its contributors provide the information contained in this publication "as is" and without any representations or warranties, express or implied, of any kind, whether of accuracy, reliability, or otherwise.

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1. Background

1.1. Purpose

Telemedicine is an effective modality for remote family planning care delivery. While telemedicine may not be suitable for all family planning needs, when appropriate, telemedicine increases reach, reduces barriers to care, and facilitates person-centered care. It enables health care facilities to respond to the growing demand for services while maintaining access to in-person care [1–3]. Clinicians who provide abortion care via telemedicine appreciate its scheduling flexibility, increased patient access, reduced scheduling delays and cancellations, and seeing persons earlier in pregnancy [4]. Telemedicine also reaches people who live farther away from abortion facilities, thereby increasing service access in more rural areas of the US [3,5–11].

Telemedicine medication abortion has demonstrated significant benefits by reducing the burdens of cost, travel, time, and the stigma associated with abortion, particularly for those living in rural areas or in states requiring two appointments for abortion care [9,11,12]. Remote follow-up for medication abortion decreases the average estimated cost per person by 39%, mostly due to forgoing ultrasonography [13]. Telemedicine can address barriers related to initiating or refilling contraception prescriptions, especially for individuals who have difficulty accessing or affording clinic appointments or are unable to take time off from work or school [14]. For postpartum persons, telemedicine improves attendance rates for postpartum visits, which increases the likelihood of obtaining postpartum contraception [15]. Moreover, persons receiving contraceptive counseling via telemedicine are equally likely to choose a contraceptive method as those seeking in-person care [16,17].

Telemedicine can enhance person-centered care. Satisfaction rates among persons receiving care for telemedicine abortion are high, ranging from 80–100%, with dissatisfaction rates under 2.5% [4,13,18–27]. For abortion care, satisfaction stems from the removal of barriers, enhancement of the relationship between the clinician and the person receiving care, autonomy, and a sense of control over the process [1,11,13,18,19,22,24,26,28–35]. For contraceptive care, persons from diverse backgrounds and with unique needs are highly satisfied with the availability of telemedicine contraceptive care [36–45]. Persons feel that they have more time with the clinician to consider contraceptive options, address side effects, switch methods, and feel less pressure to make an immediate decision [46,47].

Telemedicine in family planning care has increased significantly in recent years due in part to the COVID-19 pandemic, which led to rapid innovation in health care delivery models to reduce in-person visits [48,49]. During COVID-19, 71% of independent abortion facilities chose telemedicine for abortion follow-up and 41% for pre-abortion consultation [50]. Many facilities adopted no-test medication abortion protocols, omitting in-person exams, ultrasonography, and pre-abortion testing, such as Rh testing. Others introduced curbside and mail-order delivery of abortion medications [50,51]. Similarly, the percentage of US-based reproductive health care clinicians offering telemedicine contraceptive care rose from 11% pre-pandemic to nearly 80% during the pandemic [52]. Telemedicine in family planning care continues to rise post-pandemic, making evidence-based guidance essential for optimal practice [53].

This clinical guidance series provides evidence-informed, person-centered, and equity-driven recommendations to enhance the management of and access to contraceptive services and medication abortion via telemedicine within the US. It's companion documents, *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 2 – Contraception* and *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 3 – Abortion*, build upon this document and focus on actionable clinical recommendations [54,55].

1.2. Definitions

The exact definitions of telemedicine and telehealth vary. *Telemedicine* falls under *telehealth,* which includes a broad range of virtual nonclinical services such as contraceptive reminder programs or mobile health (mHealth) [56]. This guidance defines *telemedicine* as providing clinical care virtually via synchronous and asynchronous approaches within the formal health care system. In synchronous care, persons receiving care and clinicians engage in a virtual visit simultaneously, either "direct-to-clinic" (also known as "site-to-site"), where a person goes to a clinical facility and communicates with a clinician who is off-site via teleconference, or "direct-to-patient", in which persons receive care in their home or another place of their choosing [57]. Both audio-video and audio-only visits are acceptable for virtual synchronous care. Clinicians may use them to provide care according to the preference of the person receiving care. An audio-only option should be available if technical difficulties with video conferencing arise [58,59]. In asynchronous care, persons first provide the relevant medical information via a questionnaire. A clinician then reviews this information and provides treatment virtually if the person receiving care is eligible. Asynchronous telemedicine services can enhance access, offering greater convenience and timeliness by eliminating the need for synchronous phone or video calls [60–62]. *Telemedicine care* can be entirely virtual or a hybrid of virtual and in-person. Clinicians providing this care include licensed physicians, nurses, and advanced practice clinicians.

Telemedicine medication abortion differs from self-managed abortion, in which a person ends a pregnancy outside of the formal health care system and may involve a range of interactions with community support, clinicians, or both [63,64]. Please see the *Society of Family Planning Interim Clinical Recommendations: Self-managed abortion* for further information on this topic [63].

2. Committee statements

2.1. Clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care.

Although telemedicine family planning satisfaction rates are high, clinicians should understand individual preferences, acceptability, and needs to deliver person-centered care. Successful telemedicine contraceptive care should align with best-practices, accommodating a person's complex and nuanced views and framing each method according to their overall health and well-being [65]. Overall people greatly value their choice in service modality and consider it an important aspect of meeting their healthcare needs [66].

For telemedicine medication abortion, remote consultations that omit pretreatment ultrasonography and exam are considered acceptable and trustworthy due to time and cost savings, privacy, avoiding uncomfortable procedures, and not having to view ultrasound images [19,67–69]. Remote follow-up is also highly acceptable [70–73]. However, some express anxiety about not having ultrasonography confirmation of the pregnancy [19].

Some persons value being in the same room as the clinician for abortion visits, while others experience stigma or uncomfortable power dynamics with the clinician in an in-person clinical setting [19,38]. Those undergoing a telemedicine medication abortion are likely to choose it again for a future abortion and recommend it to a friend [21,22,68]. Studies comparing in-person and telemedicine medication abortion experiences show no overall difference in preparedness of the person receiving care, including their expectations for pain and bleeding. In some studies, the telemedicine experience exceeds expectations [25,68,74].

For telemedicine contraceptive care, persons prefer having multiple options for obtaining contraception, including in-person, telemedicine, direct-to-patient telemedicine, and pharmacies, when

clinically appropriate (Table 1) [75]. Despite the preference of persons receiving care for and the appropriateness of telephone-only telemedicine for prescribing contraception, some health care systems require video visits due to system regulations, clinical preferences, and higher insurance reimbursement rates [39,46]. Where permissible, clinician preferences for video visits should be balanced against the broader accessibility of telephone-based care [36,37,46]. Preferences can vary by community setting. For example, some school-based health center studies show a preference for telemedicine, while others prefer in-person care [76,77]. The content of the counseling visit may also impact preferences. One study from New York reports a preference for telemedicine for "basic" contraception options counseling but in-person care for more "complex" topics like pregnancy and preconception [38].

It is important to consider the unique needs of different populations, such as persons seeking contraception postabortion, pregnant and postpartum persons, adolescent and young adults (AYA), persons with disabilities, and those living in rural areas, when providing contraceptive counseling. Contraception counseling is often offered during in-person abortion visits (i.e. "integrated counseling"), which can be challenging due to operational and time constraints. The person receiving care may not want to discuss contraception at the time of their abortion [78]. Virtual individual or group contraceptive counseling sessions scheduled ahead of an in-person abortion visit are feasible and acceptable [79,80]. One study found persons opting for telemedicine contraceptive counseling separate from the abortion encounter were more likely to be non-White, have had difficulty obtaining contraception in the past, and not be using contraception at the time of conception [80]. Telemedicine counseling before in-person abortion care is more strongly associated with choosing and receiving a desired long-acting reversible contraceptive (LARC) method at the time of in-person abortion care compared to integrated counseling. However, one study indicates that persons who chose LARC during telemedicine medication abortion may be less likely to obtain a LARC method after completing the abortion, while another study shows no difference [17,81]. These differences in outcomes of contraceptive choice and provision between in-person and telemedicine medication abortion care underscores the importance of providing both telemedicine and in-person options for those seeking contraception at the time of abortion.

Most AYA perceive synchronous video-based telemedicine care for contraceptive services as acceptable and accessible, and their high levels of digital competency may make them particularly well-suited to telemedicine [42,82]. Screening protocols can help identify AYA at risk of sexual abuse or exploitation in remote contraception services [83]. However, access to a private space to discuss sexual and reproductive health needs is crucial and may lead to a preference for asynchronous or in-person care [42,43,84]. Insurance status can also limit AYA access to telemedicine contraceptive care [85].

The diversity of preferences across populations, clinical contexts, and care modalities highlights the importance of adaptable service models. In this context, ensuring that telemedicine remains accessible, regardless of whether a person also requires in-person clinical services, is essential to person-centered family planning care.

2.2. Telemedicine abortion and contraceptive services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible.

Facilities that already use telemedicine technology for different appointment types can readily apply this technology for telemedicine medication abortion [86]. Facilities not already using telemedicine may require additional training with the technology and guidelines for online consultations [30]. Facilities should use platforms that support obtaining patient signatures to meet the Risk Evaluation and Mitigation Strategy (REMS) requirements for mifepristone administration [86]. For contraceptive visits, self-selection of the encounter type is an important factor in care quality assessments [36,47]. Telemedicine appointments are more successful when persons receive instructions on how to join their visit before the telemedicine visit [87].

Key factors for successful implementation include a supportive institution [88], a facility champion, formal or informal mentoring by organizations within and outside the facility who can help overcome challenges such as meeting regulatory compliance and current standards of care [89,90], and creating standing operating procedures with clear guidelines [30,91]. Challenges include effectively marketing the telemedicine services and raising awareness about their availability [1].

Language is a critical consideration for telemedicine care globally, as linguistic diversity poses challenges across many countries. In the US, almost 10% of the population has limited English proficiency [92]. Most platforms require a degree of English proficiency to navigate scheduling and accessing the visit [1,93]. Cultural values and beliefs around health care also influence how persons and communities prefer to access reproductive health care and may limit telemedicine's benefit [94]. To ensure equitable access, health care facilities should codesign telemedicine care during the implementation process with persons receiving care [95].

Table 1
Summary of contraceptive services suitable for telemedicine versus services that typically require in-person visits

Contraceptive services that are suitable for telemedicine provision	Contraceptive services that typically require in-person visits
Counseling about IUD self-removal; video or telephone coaching for IUD self-removal	IUD removal (if patient is unable to or unwilling to attempt self-removal)
Prescription (initiation or continuation) of oral contraceptive pills, transdermal patch, or vaginal ring	Contraceptive implant removal
Provision of oral emergency contraception	Contraceptive implant or IUD insertion
Prescription (initiation or continuation) of self-administered subcutaneous DMPA-SC, possible video coaching for DMPA-SC self-administration	Administration of DMPA-IM
Prescription of barrier and other pericoital methods (including diaphragm, spermicides, contraceptive sponge, condoms, vaginal pH regulator gel)	Symptoms concerning for ectopic pregnancy, including pregnancy with IUD in situ
Counseling before IUD and contraceptive implant insertion, removal, or replacement, including counseling about extended use of IUDs and contraceptive implants	Suspected IUD expulsion or nonpalpable contraceptive implant (if symptomatic and/or if there is concern for pregnancy)
Evaluation and potential management of some contraceptive issues or side effects (e.g., heavy or unscheduled bleeding)	Some contraceptive issues or side effects (if severe symptoms)
Consultation for permanent contraception	Initiation of permanent contraception
Contraceptive counseling, including counseling about fertility-awareness-based methods	

DMPA-IM, depot medroxyprogesterone acetate - intramuscular; DMPA-SC, depot medroxyprogesterone acetate – subcutaneous; IUD, intrauterine device.
Reprinted from Society of Family Planning Clinical Recommendations: Contraceptive care in the context of pandemic response [58].

2.3. Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access.

State-level abortion bans are not evidence-based and do not improve the safety or efficacy of clinical care [96,97]; However, they have severely limited in-person abortion care, forcing farther travel to obtain an abortion. Telemedicine family planning care has the potential to increase access for those who must travel the longest distances and who face the most barriers, including people of color; those without insurance, with low income, facing food insecurity, or living in rural locations; AYA; incarcerated individuals; people with disabilities; immigrants; and gender diverse individuals [8,98].

Research suggests persons who are younger, have at least one medical condition, whose first language is not English, who identify as Black, and others from under-resourced and rural communities have limited access to and are less likely to use telemedicine services for abortion care and contraceptive counseling [5,99-103]. Over 50% of abortions in the US are provided to Black and Latine/X individuals, more than 70% are to people under 30%, and 75% are to people with low incomes [104,105]. This demonstrates the disproportionate impact that challenges to telemedicine medication abortion access may have on these groups [106]. Internet access and digital literacy challenges also reduce telemedicine access and usability [107-111]. Connectivity issues remain barriers for some [37,47,112]. Up to 30% of Americans still experience internet connectivity problems, and those with lower incomes or less formal education are less likely to have reliable internet access [113]. AYAs, who account for 6% of all abortions in the US, encounter additional obstacles when trying to use telemedicine services [105]. These barriers include lack of awareness, stigma, financial and insurance constraints, and confidentiality concerns related to parental notification and consent requirements [85,114,115].

Despite the rapid adoption and innovation of telemedicine by many health care clinicians, facilities in under-resourced areas still face significant implementation barriers, exacerbating the inequity in telemedicine care provision [116]. Smaller outpatient facilities and those serving many persons with publicly-funded health insurance often do not offer telemedicine due to lower reimbursement rates compared to in-person visits, as well as the higher costs and effort required to establish the necessary infrastructure [93,117-120].

2.4. Telemedicine family planning care should address the privacy and confidentiality of the person receiving care.

Privacy. Clinicians should conduct telemedicine visits in a private space and address confidentiality and privacy concerns, especially for vulnerable populations such as AYAs or those experiencing intimate partner violence. Access to a safe and private space for persons receiving care to discuss sexual and reproductive health needs is crucial and may lead to a preference for asynchronous or in-person care [42–44,61].

Confidentiality. Persons receiving care and clinicians express concern about confidentiality in telemedicine [9,38,121]. Concerns about the security of personal health data when utilizing telemedicine services are especially significant for individuals residing in states with restrictive abortion laws who seek abortion care in other states [122]. Clinicians should document only clinically relevant information to minimize risk to the person receiving care and make notes confidential. Digital encryption is a crucial security measure to safeguard protected health information (PHI). Telemedicine providers should use Health Insurance Portability and Accountability Act (HIPAA)-compliant platforms that limit or prohibit automatic medical record sharing with other health systems.

Additional confidentiality considerations for AYAs must account for local laws on parental notification and consent for family planning services. Clinicians may find these requirements more uncertain in a telemedicine context [84,123]. While many states allow for confidential contraceptive services without parental consent or notification, insurance factors may limit confidentiality [84,124]. Laws for abortion care are more complex, with many states requiring parental involvement, though most allow a judicial bypass for court-approved abortion decisions [125].

2.5. Clinicians should be familiar with their state, regional, and institutional laws and regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care.

Some states specifically prohibit the use of telemedicine for abortion care despite its demonstrated safety, efficacy, and acceptability [126]. Other states that protect abortion access have instituted “shield laws”, which provide certain protections for clinicians in that state to provide abortion care to persons living in other states, including states that ban or restrict abortion. Some shield laws provide protections for telemedicine care rendered across state lines to persons who are in states that ban abortions. Other shield laws strictly apply to clinicians providing care for persons who have traveled from banned states to receive an abortion in a state where it is legal [127].

When providing telemedicine across state lines, clinicians render care in the state where the person receiving care is physically located. Therefore, they must practice under the laws of and, generally, be licensed in the state where the person receiving care is located, unless there is a cross-state waiver or a shield law allowing them to prescribe medication abortion in states where they are not licensed. Waivers providing exceptions for licensing requirements for most states have ended, since they were primarily in place during the COVID-19 Public Health Emergency [128].

3. Continued discussion

During the development of this document, we identified multiple areas where further discussion, research and consensus are needed, and we invite further exploration:

- Insurance coverage of and policy barriers to telemedicine for contraception and abortion care.
- Evaluation of barriers and facilitators to telemedicine to address health care access inequity, particularly among adolescents and young adults (including parental consent and privacy concerns) and rural and underserved communities.
- Development and evaluation of culturally and linguistically appropriate telemedicine services.
- Exploration of emerging technologies (AI, mobile health apps) to enhance telemedicine contraceptive care.
- Patient preferences for and satisfaction with counseling and education methods for telemedicine medication abortion.

4. Summary of statements

- Clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care.
- Telemedicine abortion and contraceptive services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible.
- Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access.

- Telemedicine family planning care systems should address the privacy and confidentiality of the person receiving care.
- Clinicians should be familiar with their state, regional, and institutional laws and regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care.

5. Sources

A series of clinical questions was developed by the authors and reviewed by representatives from the Society of Family Planning's (SFP) Clinical Affairs Committee. We searched PubMed, Ovid Medline, Cochrane Library of Clinical Trials, Embase, and the Turning Research Into Practice (TRIP) database to identify relevant articles published between 2003 and July 2024. Search terms included, but were not limited to abortion, contraception, family planning, telehealth, telephone, telemedicine, video, and virtual. The search was restricted to articles published in the English language. We also identified studies by reviewing the references of relevant articles and clinical guidelines published by organizations or institutions with related recommendations, such as the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, and SFP. The content of and references cited in relevant product labels and Food and Drug Administration (FDA) prescribing information were also considered when developing critical statements on topics involving medications. When relevant evidence was not available or too limited to inform practice, the expert opinion of clinicians with complex family planning expertise was used to develop the critical statements.

6. Intended audience

This Committee Statement is intended for SFP members, family planning and sexual and reproductive health service clinicians, family planning and reproductive health researchers, consumers of family planning care, advocates, and policymakers.

Authorship

This Committee Statement was prepared by Rajita Patil, MD; Divya Dethier, MD; Montida Fleming, MD; Emily Godfrey, MD, MPH; and Julia E. Kohn, PhD, MPA, with the assistance of Jennifer Chin, MD, MS; Bhavik Kumar, MD, MPH; Jennifer Lesko, MD, MPH; April Lockley, DO; Shawana S. Moore, PhD, DNP, APRN, WHNP-BC, FNAP, FAAN, FNPWH; and Laurie Ray, DNP, WHNP-BC on behalf of the Clinical Affairs Committee, and Robert Johnson. It was reviewed and approved by Clinical Affairs Committee members on behalf of the SFP Board of Directors.

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