UAMS Health

Women's Health Telemedicine Toolkit

COVID-19

IMPACT Arkansas: A Complete Women's Health Toolkit for Implementation of Access to Care via Telemedicine during the COVID-19 Pandemic

Provided by the UAMS Department of Obstetrics and Gynecology

GOALS/OBJECTIVES

The primary goal of this toolkit is to continue to provide excellent care to our patients while simultaneously reducing exposure to COVID-19. UAMS Women's Health Clinic was able to institute this new telemedicine process in just 48 hours.

Our secondary goal is to maintain the expansion of telemedicine infrastructure in order to continue remote care to our patients in some capacity in the future.

TELEMEDICINE PREPARATIONS

Splitting the Workforce

All elective surgical procedures have been postponed. Additionally, we encourage patients to delay routine visits such as annual well woman exams until after the pandemic ends. In the meantime, we will refill existing prescriptions.

As clinical obligations have decreased, we were able to split the provider group in half - one group to be the "active" or "exposed" group, and the other to be the "reserve" or "non-exposed" group. These groups will alternate weekly for the duration of the pandemic. The active group is responsible for hospital and traditional ambulatory clinical duties. The reserved group will engage patients in telemedicine visits.

Recruiting Patients

Patients previously scheduled for traditional ambulatory visits should be contacted and informed of the new telemedicine platform. It has been our experience that nearly all patients are willing to convert to a telemedicine visit. Patients are reassured that a telemedicine platform is being adopted for their safety and that they will still have face-to-face interaction with their provider during the video visit.

Obstetric and gynecologic visits which we consider to be appropriate for telemedicine is available in Appendix A. This is intended as guidance; please adapt to your own practice.

Our providers review their clinic day and mark visits that should be converted to telemedicine. Nursing and office staff contacts patients to notify them of the new platform, obtains consent to use telemedicine, and then converts the patient to a telemedicine visit. Patients have been responding in a positive manner and most visits have already been converted to telemedicine.

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Creating the Telemedicine Workspace

Since we expect to see fewer patients in-person, the total number of active clinic rooms has been reduced. The UAMS Center for Gynecology clinic was closed to traditional ambulatory visits. Computers in each exam room were upgraded with webcams, speakers and microphones. Most telemedicine platforms can also function from portable devices, such as phones and tablets, so new hardware installation may not be necessary for your needs.

Selecting a Telemedicine Platform

During the pandemic, HIPAA regulations have been relaxed. Any video platform may be utilized in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Popular video chat applications include Apple FaceTime, Facebook messenger video chat, Google Hangouts video, and Skype. Providers are encouraged to notify patients that these third party applications potentially introduce privacy concerns. The following applications are HIPAA compliant: Skype for Business, Updox, VSee, Zoom for Healthcare, Doxy.me and Google G Suite Hangouts Meet. Public facing applications such as Facebook Live, Twitch and TikTok are explicitly forbidden.

For our purposes, UAMS Women's selected Doxy.me. In addition to HIPAA compliance, we found the interface to be exceptionally easy for both providers and patients. Upon registration, each provider is given a personalized link to their virtual exam room. That link can then be shared with the patient. We sent invitation emails from an unmonitored email account in order to eliminate patients' expectations of a response. The template for the invitation email can be found in Appendix B. Doxy.me has both paid and free services; we have had sufficient success with the free version.

Type of Telemedicine Visit

Video and audio visits must take place in real time in order to qualify for reimbursement. Video visits are preferred over telephone encounters as they allow face-to-face interaction and they are billed in the same manner as an in person visit. Telephone visits are useful for quick check-ins (as in the case of rescheduling a routine annual visit) and for patients who do not have reliable internet access. Billing guidelines for each type of visit are available in Appendix C.

General structure for gynecologic and obstetric visits is outlined below. In addition to routine patient care, plan to answer important questions regarding the COVID-19 pandemic while offering reassurance and up-to-date information.

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GYNECOLOGY

General Structure of Gynecologic Care

Gynecology care typically involves a focused physical exam. This is important to thoroughly evaluate abnormal uterine bleeding, vaginal discharge, and other complaints. However, health departments have already shown that some visits do not always necessitate such exams, such as STD evaluations. Instead, thorough historical evaluations can be conducted followed by ordering necessary lab work and treating empirically.

Modifications for Gynecologic Visits

It is appropriate to utilize telemedicine visits for many gynecologic complaints.

Routine well woman visits can be delayed until the pandemic has abated. Checking in with the patient via telephone is now billable with appropriate documentation. Provide appropriate refills and order lab evaluations as indicated.

Other issues can be addressed as a typical problem visit, utilizing the typical billing codes and charging for time. Video visits are paid at the usual rates so long as they occur in real time. This may include adjusting birth control prescriptions and empiric treatment of vaginal discharge or dysuria, for example.

For abnormal uterine bleeding, empiric treatment with progestins can be safely initiated in many cases at your discretion. Ultrasounds can be delayed.

Procedures such as colposcopy can typically be delayed, especially for low-grade indications. Please refer to ASCCP guidelines found here: https://www.asccp.org/covid-19

More complicated issues can be handled in-person only if absolutely necessary or if empiric treatment has failed.

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OBSTETRICS

General Structure of Obstetric Care

Prenatal care in low risk populations has traditionally included 12-14 in-person prenatal visits. At these check-ins, vital signs and basic labs are evaluated and fetal status is assessed. These visits are often brief, and much of the interaction is spent on education and reassurance. This is precisely the opportunity to reduce exposure by providing this important provider-patient interaction via telemedicine and encouraging patients to be more personally involved in their own prenatal care.

Maternal Status

The first priority is assessing maternal health. Initial assessment stratifies patients according to risk (see Appendix A). Blood pressure cuffs are issued or prescribed as indicated. Important education regarding self-monitoring is given to the patient (see Patient Guide: Virtual Prenatal Visits). High-risk patients are seen in coordination with perinatal specialists and visit reduction is individualized, if possible.

The goal is fewer in-person visits, occurring only when it is absolutely necessary to be seen at the office (e.g. ultrasound, lab draws, etc).

Fetal Status

One measurement of fetal status that is routinely monitored is the presence of a fetal heart rate via a Doppler fetal monitor. We propose that in the spirit of social distancing, there are alternatives to assessing fetal status that do not require an in-person visit. For the purposes of evaluating the fetus, instructions for monitoring kick counts will be given to the patients.

Fetal growth will be monitored with fundal height at in-person visits and follow-up ultrasonography as indicated. Efforts to have ultrasound and in-person visit on the same day should be made to reduce the number of exposures.

WRAPPING UP THE ENCOUNTER

Documentation

Documentation should be consistent with standards for traditional in-person visits. The progress notes should clearly state that the visit was performed in "real time." It should also clearly document the communication modality, "telephone" vs "video." Obviously, the exam will be limited to generalized findings such as mood and affect.

Billing

These are time-based visits, and an attestation should be attached to every progress note detailing the amount of time that was spent during the telemedicine visit.

Video visits are billed using the usual E&M codes with a -GT modifier. Telephone visits have their own E&M codes. Coding guidance can be found in appendix C.

FUTURE DEVELOPMENT

In order to further limit risk of exposure, we are investigating the possibility of drive-thru labs and injections. Once successful, we will update the toolkit to reflect current practice.

LIST OF APPENDICES AND RESOURCES

Appendix A: Prenatal Telemedicine Visit Structure
Appendix B: Doxy.me protocol
Telemedicine Tip Sheets for Physicians
Patient Guide: COVID-19 in Pregnancy
Patient Guide: Virtual Prenatal Visit
Patient Guide: COVID-10 in Pregnancy - Spanish
Patient Guide: Virtual Patient Visit - Spanish

Appendix A: Prenatal Telemedicine Visit Structure

Initiation of Care and Risk Assessment		
8 weeks Current patient	TM	Return GYN, diagnosis of missed period or amenorrhea
12 weeks Current patient	Trad	New OB Visit (Prenatal labs, Pap smear if indicated, dating ultrasound, discuss quad screen, Risk Assessment, flu vaccine, etc)
OR		
8-12 weeks New patient	Trad	New OB visit (Prenatal labs, Pap smear if indicated, dating ultrasound, discuss quad screen, Risk Assessment, flu vaccine, etc)

For patients who screen into **Moderate or High Risk** for any issues, give them a prescription for a blood pressure cuff for home monitoring and instruct them to keep a log.

Low Risk (including previous cesareans and class 1 obesity)		
16-18 weeks	TM	Add a lab draw for quad screen if desired
20-22 weeks	Trad	Anatomy ultrasound
24 weeks	TM	
28 weeks	Trad	Glucose screening, Tdap, 3rd trimester labs, Rhogam if indicated
32 weeks	TM	
34 weeks	TM	
36 weeks	Trad	GBS screening
37 weeks	TM	
38 weeks	Trad	
39 weeks	Trad	
40 weeks	Trad	
PP	TM	

Moderate Risk (including well controlled chronic hypertension, well controlled diabetes, advanced maternal age, gestational diabetes, class 2-3 obesity, diamniotic-dichorionic twin pregnancy, history of late 2nd trimester or 3rd trimester preterm labor)		
16-18 weeks	TM	Add a lab draw for quad screen if desired, BP check
20-22 weeks	Trad	Anatomy ultrasound
24 weeks	TM	
28 weeks	Trad	Glucose screening, Tdap, 3rd trimester labs, Rhogam if indicated
30 weeks	TM	
32 weeks	TM	
34 weeks	TM	
36 weeks	Trad	GBS screening
37 weeks	Trad	
38 weeks	Trad	
39 weeks	Trad	
40 weeks	Trad	
PP	TM	
If a patient meets criteria for follow-up ultrasound, coordinate with traditional in-person visit OR schedule for ultrasound only in order to avoid adding an additional in-person visit. Limit traditional in-person visits as much as possible without compromising patient care. Consider performing bedside ultrasounds at 28 and 36 week visits for growth and fluid, if indicated. Space antenatal testing if possible.		

High Risk (including poorly controlled chronic hypertension, poorly controlled or Type 1 diabetes, SLE, maternal cardiac disease, fetal anomalies, IUGR, multiple gestation pregnancies (other than di-di), history of early 2nd trimester preterm labor, or a combination of moderate risk problems)
Structure visits according to the provider in consultation with MFM. Attempt to limit traditional visits without compromising care. Space antenatal testing if possible.

Appendix B: Doxy.me protocol

Log into DOXY.ME through the CHROME browser.

At the patient's appointment time, you will see them pop into your patient queue on the left of the screen. To start the visit, simply click on their name. If you do not see your patient log in to the queue by 15 minutes past their appointment time, call them by phone. If you cannot easily help them log in, perform a phone visit rather than a video visit. If the patient does not answer their phone, they will be marked as "no show."

Message from unmonitored email account to patient:

> Hello, this is Dr. ***. At your scheduled time, please use this link to join me for a secure video call:
>
> **LINK**
>
> You will need a computer with a good internet connection and webcam or a tablet or smartphone.
> If you run into issues connecting, restart your computer or check out http://help.doxy.me If you have not joined your video visit within 15 minutes of your scheduled time, your physician will contact you at the phone number on file.
>
> ****This email was sent from an unmonitored account. Please direct questions about your health to your provider through **your clinic's usual channels.** For medical emergencies, please call 9-1-1.**