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TELEHEALTH EQUITY & MEDICATION ABORTION CARE

OVERVIEW & TOOLKIT

RHITES
REPRODUCTIVE HEALTH INITIATIVE FOR TELEHEALTH EQUITY & SOLUTIONS

Waxman

This guide is part of RHITES' (Reproductive Health Initiative for Telehealth Equity & Solutions) efforts to expand access to reproductive health care using telehealth and strengthen collaboration across communities to encourage policies which improve equitable access to telehealth. We recognize that people should have access to all forms of reproductive health care, including abortion and including, but not limited to, medication abortion via telehealth, although our scope is focused on medication abortion care delivered using telehealth. In service of our work, we conducted a series of stakeholder interviews and released a survey to experts in the fields of telehealth, reproductive health, rights, and justice, and health equity. While this document is intended to be a useful foundational tool for advocates, there was no way to capture all the tremendous data gathered or all the data that exists on these topics. To our partners, interviewees, and survey participants, and those who have given feedback on prior versions of this report, we extend our deepest thanks.[1]

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1 Those who have assisted with this project include, and are not limited to the following: National Health Law Program, Carafem, Ushma Upadhyay, PhD, MPH, Rhia Ventures, Reproductive Health Access Project, Ibis Reproductive Health, Kristyn Brandi, MD, MPH, All* Above All, National Partnership for Women & Families, the American Medical Women's Association, and the Na ional Abortion Federation.

TABLE OF CONTENTS

MAIN TAKEAWAYS 4

HOW TO USE THIS GUIDE 4

A NOTE ON EQUITY 4

BACKGROUND AND PURPOSE 5

- So, what is telehealth? 5
- A brief history of telehealth 6
- A brief history of medication abortion care 6

HOW DOES CENTERING EQUITY IMPROVE ACCESS TO TELEHEALTH AND MEDICATION ABORTION CARE? 7

WHAT ARE BARRIERS AND OPPORTUNITIES TO USING TELEHEALTH TO ADVANCE EQUITABLE ACCESS TO MEDICATION ABORTION CARE? 7

CHECKLIST & RESOURCES 11

GLOSSARY 14

MAIN TAKEAWAYS

- Access to telehealth and access to abortion are linked—in order for people to meaningfully have access to telehealth, they must have access to abortion using telehealth.
- There is an abundance of misinformation abounds about telehealth, medication abortion care, and the types of policies that advance equitable access to telehealth. Addressing information and knowledge gaps is a vital early step to arm advocates with tools to support policy change. This guide is intended to begin filling these gaps.
- Technology and telehealth show promise to advance access, but only if they are developed and implemented using principles that meaningfully center equity. Some of the most common barriers to adoption of telehealth include lack of broadband access, lack of patient access to information and devices, cultural competency, and literacy barriers.
- A lack of investment in both telehealth and reproductive health care is a significant barrier to equitable experience of telehealth for medication abortion care. This includes policy and financial disincentives from investing in abortion technology, and a lack of investment in training and infrastructure particularly for safety-net provision of medication abortion care via telehealth.
- Coverage is key. Medicaid coverage for abortion is limited by the Hyde amendment, which prohibits the use of federal funds on abortion care except under specific circumstances, although some states do pay for abortion services using state Medicaid funds. Allowing Medicaid coverage for abortion is vital to advancing equitable access to care.
- Reimbursement for medication abortion care is complicated, but it is tremendously impactful for advancing individual access. Complex structures that limit Medicaid reimbursement can make these services prohibitive or difficult for safety-net providers, limiting access to people who already experience intersecting barriers to care.

HOW TO USE THIS GUIDE

As highlighted above, this guide is intended to support advocates with a range of interests and expertise. This is also meant to assist lawmakers by providing background information and evidence to help them understand how these issues intersect and better support their constituents. Based on your own background, certain sections may be more relevant than others—for example, if you are an expert in abortion policy but would like to learn more about telehealth, then we recommend going to the telehealth sections on pages 5 and 8. If you are a telehealth expert hoping to learn more about abortion, please see pages 6 and 8. At the bottom of this guide, we also include a list of resources and a glossary which could be of use to all readers.

A NOTE ON EQUITY

Equitable care recognizes that every person has unique individual needs that must be satisfied to reach an equal outcome. Equity in health care, or "health equity" is achieved when all people are able to reach their full health potential regardless of factors including race, class, gender, sexuality, ability, citizenship status, etc.[1] Advocates have long touted telehealth as a potential tool used to help achieve health equity, especially given the opportunity to support providers reaching patients who previously would be unable to receive treatment in an in-person setting. However, that promise has not yet been met. Operational considerations including internet access, technological ability, language barriers, physical barriers, and state policy limitations intersect with other social and systemic injustices related to race, income, and gender as primary factors to consider to ensure that telehealth does not further exacerbate existing inequities in health care.[2,3,4] As advocates look to build the case for policies which expand telehealth access, centering equity is critical—and that must include equitable access to medication abortion care.

BACKGROUND AND PURPOSE

For some, health care has never been easier to access: a cell phone or laptop can be an access point to a trusted medical provider, and many small or large worries can be easily resolved through chatbot exchanges or virtual visits. However, as noted above, the promise of increased access *for everyone* using technology and telehealth has not yet been met.

As is so often the case, these reflections are similarly true as they pertain to access to abortion. Abortion "access" in the United States right now is complicated—it is experienced (or not) based on an intersection of cobbled together state laws, a vastly underfunded safety net, and intersecting social, political, and systemic barriers to physical access. The 2022 midterm elections illustrated that abortion is an important issue for voters including with statewide ballot measures that came out supporting abortion rights even in red states.[5] With that said, it can be no surprise that despite changing federal policies (which would in theory accommodate access to abortion using telehealth), additional work is needed to ensure that the promise of sexual and reproductive health care and telehealth is equitably experienced. Due in part to pervasive societal injustices that systemically impede people of color's comprehensive health education, access to contraception, access to primary care, and more, they are more likely to seek an abortion than their white counterparts. In 2019 (prior to the pandemic and the *Dobbs v. Jackson Women's Health* Supreme Court decision) abortion rates were 3.6 times higher among Black women compared to white women.[6] Even in states where abortion services are not banned, communities who often experience the most barriers to care such as people of color, those struggling to make ends meet, and people who identify as LGBTQ+ may experience less equitable access to telehealth care.

Access to telehealth and access to abortion are linked—in order for telehealth to be truly equitable, people must have access to abortion using telehealth. Given the changes to health care delivery in the past several years, this resource was created as an opportunity to provide foundational information about the ways that telehealth policy and abortion policy can be used to improve equity, with definitions and recommendations for ways to use policy levers to improve access. Since both abortion and telehealth policy are heavily state driven, this guide will primarily focus on state policy. Our goal is to assist policymakers at large and advocates who work on telehealth, reproductive rights, and/or equity to better understand these synergies, and to provide examples of hhow to support equitable access to telehealth for medication abortion care.

So, what is telehealth?

Telehealth encompasses the broad range of ways a patient receives health services from a distance using a variety of devices such as a computer, phone, or tablet from a provider. Certain state policies impact the specifics of telehealth utilization, including whether care can be delivered across state lines, or by different types of providers including physicians, nurses, and psychologists.[7] Normally telehealth services require limited follow up and modalities fall into four categories: live video or audio-only calls (synchronous care), asynchronous care (also called store-and-forward), remote patient monitoring, and mobile health.

While not all care can be delivered via telehealth, and full expansion will not solve all inequities inherent in our healthcare system, many forms of care, including conducting virtual visits, prescribing medications, and remotely monitoring patients health status' can tremendously improve convenience and access to care for patients. As some may be surprised to learn: medication abortion care falls into the above categories, making its delivery one of the most natural fits for equitable telehealth services. See below for more details.

Although public awareness and usage of telehealth has dramatically risen in the past few years due to the COVID-19 pandemic, this type of service has actually been used by health professionals for decades, with roots in innovation and equitable access.

A brief history of telehealth

As an outgrowth of a National Aeronautics and Space Administration (NASA) program, in the 1970s, the federal government invested in telemedicine research and development particularly to help people in rural areas who faced geographic barriers to access.[8] Some of those geographic barriers include having to travel longer distances to reach care and less public transportation than in urban areas.[9] Telehealth allows providers were able to leverage the technology that was initially developed for space travel to remotely monitor the health of people in hard-to-reach areas. Patients were able to reach providers via video calls and audio calls to assess their needs and provide health services without the logistical hassles of finding transportation and providers with the resources and time available to help them. Because of these outcomes, telehealth was, and still is, really intended to be used to address inequities in health care delivery by addressing certain barriers which make health care harder to attain for communities experiencing intersecting injustices. Telehealth bridges gaps in access to care.

The COVID-19 pandemic, there has led to an exponential surge in telehealth usage. As a result of social distancing to reduce the spread of COVID-19 and with the goals of supporting communities experiencing barriers to care due to the pandemic, many health providers turned to delivering their services remotely, resulting from and in federal and state policy changes. In 2020, Medicare suspended their restrictions on the types of telehealth services that it covered, and states expanded telehealth access through licensing and payment changes.[10,11,12] The pandemic pushed many health care consumers and patients to better understand telehealth, with increased patient and provider willingness to use it and policy changes that led to greater access and reimbursement. Since the onset of the COVID-19 pandemic, telehealth usage has stabilized at levels that are 30 times higher than before the pandemic.[13] Telehealth utilization once again illustrates that as people struggle to find care, access is crucial to centering equity and shows that when it is important enough to us, it can happen quickly.

A brief history of medication abortion care

Medication abortion care is an abortion method that uses a Food and Drug Administration (FDA) approved regimen combination (mifepristone and misoprostol) to terminate a pregnancy and can be completed in a setting of the patient's choosing. Robust research has shown that this regimen is extremely safe and effective, including via telehealth.[14] Mifepristone, which is the first medication that is taken in the regimen, was first approved by the FDA in 2000. Misoprostol, the second medication that is taken about 24–48 hours after Mifepristone, was initially approved in the late 1980s.[15,16]

Medication abortion care now accounts for more than half of the abortions in the United States.[17] Although the medication abortion care regimen has been approved by the FDA for more than 20 years, and adopted by many providers, the delivery of medication abortion care remains challenging. The FDA recently announced an update to federal requirements on mifepristone, to allow mail-order and in-person pharmacy distribution.[18] This change will allow for direct-to patient or hybrid models of telehealth.

Medically unnecessary and unscientific restrictions at the state level will continue to present barriers to patients, despite the proven safety and efficacy of telehealth for medication abortion care.[19] Some of these restrictions are based on in-person distribution requirements thereby preventing providers from administering medication abortions via telehealth.

The recent *Dobbs v. Jackson Women's Health* Supreme Court decision can only further exacerbate the impact of these restrictions, as states are now able to enact broad abortion bans. Approximately half of all U.S. states are anticipated to enact bans on abortion or gestational limits—as of November 23, 2022, 18 states have enacted some form of ban.[20] Other states which do not have restrictions based on gestational limits or fetal viability, may still have state laws prohibiting state funds from being used to cover an abortion.[21] This is reflective of how abortion policy often diverges

from other types of care which lend themselves to telehealth—unscientific and medically unnecessary requirements get in the way of health care delivery and access, adding another layer of complication to the equitable experience of telehealth.

Similar to the way telehealth generally was developed, telehealth for medication abortion care was initiated by providers to address staffing shortages and access challenges in rural areas. In many states, especially states where there are significant restrictions and lack of resources or investment, staff and provider shortages create insurmountable barriers. With so many challenges and such complex reimbursement, developing the tools to understand how to implement telehealth for medication abortion care can be tremendously difficult. Telehealth was conceived of as an opportunity to bring providers to patients in different states without physically moving them, to increase access while also saving patient costs. Actualizing these priorities depends on state provider restrictions and licensure.

HOW DOES CENTERING EQUITY IMPROVE ACCESS TO TELEHEALTH AND MEDICATION ABORTION CARE?

Equity-centered and effective telehealth policy has potential promise for individuals who seek healthcare, including abortion, by:

- Reducing logistical barriers including travel, childcare, and taking time off from work,
- Saving patient costs while demonstrating similar clinical outcomes as in-person visits,[22]
- Utilizing non-MD clinicians such as physician assistants and nurse practitioners to provide care via telehealth,
- Leveraging multiple modalities including chat-only and audio features to reduce technology barriers and increase patient comfort,
- Removing friction that people experience in the health care system, including clinic protesters and lack of provider choice,
- Creating more opportunities for language inclusivity and closed captioning, and
- Growing investments in the field to advance the current telehealth and abortion care infrastructure.

As medication abortion care becomes an increasingly common method of abortion, and especially as the landscape for access to surgical abortion evolves following the recent Supreme Court decision undermining the right to abortion, the ability to provide abortion care virtually is even more important to improve equity and access.

WHAT ARE BARRIERS AND OPPORTUNITIES TO USING TELEHEALTH TO ADVANCE EQUITABLE ACCESS TO CARE, INCLUDING MEDICATION ABORTION CARE?

Political and structural barriers have affected the operationalization of telehealth achieving its promise writ large, especially as it pertains to abortion. The impact of the *Dobbs* decision diminishing the right to abortion cannot be understated, and yet it is worth noting that even prior to the decision, abortion was never accessible for many people due to structural inequities and systemic racism exacerbated by restrictive policies. The Dobbs decision, resulting abortion bans, and other medication abortion-specific bans are the most obvious and critical barriers to improving the accessibility of abortion using telehealth.[23] One fundamental misconception is that telehealth access policy differs from telehealth abortion policy. This is based on a false perception that abortion policy is separate from, or unrelated to, telehealth policy, as opposed to a fundamental public health component of equitable telehealth access. Recent data shows that states with abortion bans tend to have higher uninsured rates, higher child poverty rates, and higher shares of people living in maternity care deserts compared to states without bans.[24] However, the following chart reflects some key challenges and opportunities to advance equity-centered policies that impact access to abortion using telehealth.

BARRIERS	RECOMMENDATIONS
Medically unnecessary abortion restrictions – These show up in many ways: as bans on the entire service, criminalization of providers delivering the service, bans tied to specific dates, medication abortion bans, or requirements for waiting periods, medically unnecessary ultrasounds, or other testing.	 Significant work exists to fight back against abortion bans. Lend your energy and voice to existing efforts to fight harmful and unscientific bans. For too long this work has been siloed from other forms of health care advocacy; entrenching advocates across industries and expertise into the conversation around abortion access and bans is crucial.
Coverage – This is one of the most fundamental components to equity-centered access. With less than fifty percent of births covered by Medicaid, ensuring equitable policies for abortion coverage is critical to ensuring that abortion access is equitably experienced.[25] The most significant barrier to coverage equity is the Hyde amendment, which bans using federal funds to cover most abortions. There are key telehealth-related components to coverage as well, including the *modality* (or type of service) which is covered by Medicaid, and which types of providers can deliver covered telehealth services.	 Consider the most comprehensive coverage of telehealth *and* abortion care services possible. This includes identifying if there is permanent Medicaid coverage of all relevant types of telehealth services (audio-only, remote patient monitoring, etc.), and if Medicaid covers abortion services using state funds.
Reimbursement – Ensuring adequate reimbursement for telehealth services is a vital piece of the puzzle. Structural changes to the delivery of health care will have an outsized impact on already underfunded safety net providers of care, and abortion providers who service large geographic areas due to provider shortages. Ensuring that telehealth services are adequately reimbursed by all insurers, including public insurers, is critical to maintaining the abortion safety net.	 Ensure that conversations related to telehealth reimbursement do not further stigmatize abortion services by partnering with local and state medical advocates, and telehealth advocates.
Provider shortages – Addressing rural and specialist provider shortages was one of the primary goals of the adoption of telehealth. These concerns are even more acute in the abortion setting, where a unique confluence of safety concerns, reimbursement issues, and training limitations create significant shortages.	 No one recommendation could address the intersecting factors which result in abortion provider shortages. Expanding access to telehealth and ensuring ease in provider licensure are key tools to addressing these shortages. Other options include opposing state limitations on teaching abortion services at public universities and advocating for policies which reduce abortion restrictions and limitations on abortion training.

BARRIERS	RECOMMENDATIONS
Technology and access challenges – Digital access challenges, including lack of access to or knowledge of broadband, cell signal, and technology, and failure to invest in access to these services for many urban and rural communities. This "digital divide" may encompass gaps experienced between demographics or geographical regions.	 There have been broadband education and access campaigns implemented to varying degrees of success. Ensure that providers of all types of services can access relevant trainings and funding streams. Additionally, partnering with community leaders who focus on abortion and comprehensive sexual and reproductive health service access will ensure that those with deep understanding of the abortion access ecosystem can help develop relevant materials and trainings for patients.
Insufficient investment – Funding and resources are needed at the intersection of telehealth and abortion care at all levels. For investors, complex state laws and insufficient knowledge of future financial returns make investment seem unattractive despite the significant impact. For abortion providers who are already stretched incredibly thin, lack of bandwidth and knowledge makes investing in new platforms untenable, although this problem could be mitigated by the initiation of state funding streams for telehealth adoption.	 Support the equitable delivery of telehealth services by investing in telehealth infrastructure grants for providers with significant experience in the provision of care to communities experiencing disproportionate barriers to care. These funding streams should require high standards of care delivery and could be an opportunity for states to model best practices in the provision of services using telehealth.
Data accessibility – While researchers have compiled data on challenges related to the equitable delivery and experience of telehealth and abortion access, these studies can be difficult to translate to practice. To create meaningful change based in scientific principles, data must be accessible to advocates. In addition to making sure data exists, data accessibility also addresses other barriers such as comprehension and paywalls. Accessibility is further complicated by state abortion bans and a lack of funding for abortion research.	 Researchers and community organizations can collaborate to develop and share digestible materials about equitable delivery and experience of abortion using telehealth.
Language access – Ensuring that platforms are inclusive to non-English speakers or speakers with limited English proficiency is vital to the equitable experience of telehealth, and especially as it pertains to abortion. Requiring translators or interpreters to a form of care which may already include unnecessary stigma and bias creates new challenges and potentially insurmountable barriers.	 Consider whether any existing funding for telehealth infrastructure is tied to language access. Where possible and appropriate, support investment in telehealth and technology education which is tied to expanded language access.

BARRIERS	RECOMMENDATIONS
Data privacy – Given the increased criminalization of abortion and other sexual and reproductive health services, robust privacy protections are critical to ensure that a patient's experience of telehealth cannot be used against them in a court of law.	 Work across coalitions to support protections for abortion providers to all patients, including patients from states which have criminalized abortions. Educate policymakers on the risks at the intersection of health technology, data privacy, and abortion access.
Health Literacy – To effectively make appropriate decisions about telehealth care, patients and providers must be able to receive and understand health information. Health literacy may be impacted by a variety of factors, including appropriate written health materials, accurate interpretation of health information, and quality communication with health providers. Disparities may exist based on patient circumstances such as education level, age, disability, and poverty.	 Work to make culturally competent telehealth materials and information available in accessible formats. This could mean materials in different languages, information delivered verbally, and assistance in using and understanding digital tools.
Knowledge gaps – Despite significant research and relevant access points, many patients and some providers are still unfamiliar with the safety and efficacy of telehealth, especially telehealth for medication abortion. The use of telehealth for medication abortion delivery increased significantly during the COVID-19 pandemic, when providers (and patients!) had many other priorities, and often limited bandwidth to understand how to adopt and respond to evolving laws.	 Consider education efforts to ensure that the most up to date materials highlighting the safety and efficacy of telehealth generally, including medication abortion via telehealth are readily available.

CHECKLIST & RESOURCES

As you continue or begin to center equity related to access to telehealth, including for medication abortion care, here are some questions to consider:

• ABORTION BANS

- ☐ Are there currently any medically unnecessary restrictions on abortion?
- ☐ Are people seeking abortion able to obtain accurate information on abortion access and efficacy?
- ☐ Are people seeking abortion able to find and understand their legal rights and protections?

• COVERAGE

- ☐ What types of telehealth services are covered by state Medicaid programs? By private insurers? Are audio-only services covered or is there a requirement for live video for reimbursement? Can a patient-provider relationship be established using telehealth or are there medically unnecessary in-person requirements?
- ☐ Are Medicaid policies permanent or connected to the COVID-19 public health emergency?
- ☐ Does state Medicaid cover abortion using state funds? Does the state restrict private insurance coverage of abortion?
  - ○ Does payment parity exist or is coverage mandated for telehealth services (as opposed to simply covered) under both private and public plans, including for medication abortion care?
  - ○ Are interpreters required and are their services reimbursable under public and private insurance plans?
  - ○ Is the mailing of medications allowed and the cost reimbursable by public and private insurance plans?
- ☐ Are major employers including telehealth and abortion access in their internal policies and healthcare plans, including paid sick/family leave, emergency assistance, reimbursed travel/childcare costs, etc.?

• LICENSURE

- ☐ Are providers from other states allowed to practice telehealth?
  - ○ If so, are the licensure requirements burdensome? Does licensure depend on types of care that can be provided?
- ☐ Are providers allowed to dispense mifepristone without an in person visit, as per FDA guidelines?
- ☐ Are non-MD practitioners, such as physician's assistants and nurse practitioners, allowed to prescribe mifepristone?

- **INFRASTRUCTURE AND INVESTMENT**
  - ☐ Are there investments in any infrastructure to support patients and safety net providers with telehealth services?
    - ○ If so, do these investments include any restrictions based on service delivery?
- **TRAINING**
  - ☐ Are there telehealth trainings available for providers?
    - ○ If so, are these trainings available to and inclusive of abortion providers?
  - ☐ Does public education include the uses and benefits of telehealth?
    - ○ If so, is there specific information available about telehealth care for abortion?
- **LANGUAGE ACCESS**
  - ☐ Are there any informational abortion or telehealth resources available?
    - ○ If so, are they accessible in languages other than English?
- **DATA PRIVACY**
  - ☐ Are there protections for providers delivering services which have been criminalized in some states?
  - ☐ Are there requirements for providers to collect sensitive patient information such as residence/location?
  - ☐ Are there investments in infrastructure and security for virtual data protection for providers?
- **PARTNERSHIPS**
  - ☐ What medical societies or associations advocate or have statements supporting telehealth expansion?
    - ○ If so, do they have a position on abortion restrictions to telehealth expansion?
  - ☐ Are there reproductive health, rights, or justice organizations advocating for increased abortion access?
    - ○ If so, do they have a position on telehealth expansion?

To learn or share more, here are resources that can be useful to advocates:

- American Telemedicine Association: Telehealth Basics_Center for Connected Health Policy
- The EMAA Project: Improving Access to Telehealth for Medication Abortion Care
- University of California, San Francisco: Association of Travel Distance to Nearest Abortion Facility With Rates of Abortion
- Health and Human Services: Telehealth licensing requirements and interstate compacts
- Kaiser Family Foundation: Medication Abortion Via Telehealth: What You Need to Know About State Regulations
- Power to Decide: Telehealth and Income Survey
- National Public Radio: States With Toughest Abortion Laws Have Weakest Maternal Supports
- In Our Own Voice: Black Reproductive Justice Policy Agenda
- Liberate Abortion: Policy Strategies for States with Expanded Access to Abortion
- Telehealth Equity Coalition: Digital Health & Literacy Policy Outline

GLOSSARY

TELEHEALTH	
TERM	**DEFINITION**
Asynchronous Communication	• A form of communication in which patients may use a method such as pictures, dynamic intake forms, or direct messaging to receive care in non-real time. • This is also known as "Store and Forward" communication. • This can be compared most closely to the practice of emailing someone and waiting for a response.
Synchronous Communication	• Communication that is happening in real time, most commonly via video conferencing or phone calls
Direct to Patient Services	• Care delivered from a provider to a patient at another location such as in the patient's home, office, or location of choice.
Site to Site	• Care delivered from a provider at one medical facility to a patient in a different medical facility
Hybrid Telehealth	• Healthcare that is delivered to a single patient over both a virtual telehealth method and in an in person setting, allowing some care over video/audio and some care in a provider office
Modality	• A method of treatment, for example a drug therapy or a digital therapy delivered by telehealth.
Parity (Coverage/ Service and Payment)	• Parity requirements force health payers (like insurers) to treat telehealth services similarly to in-person services. Coverage and service parity is more common and requires payers to cover the same services via telehealth as those covered in-person. However, payers may not pay the same rates to providers for services delivered via one or the other. Payment parity is less common and requires payers to pay the same rates to providers for care delivered via telehealth as they would if the care was delivered in-person.
Live Video	• Live and two-way interaction between a provider and a patient using video telecommunications technology that transmits a picture and audio.
Audio Only	• Live and two-way interaction between a provider and a patient using only audio technology without a visual image
Remote Patient Monitoring (Telemonitoring)	• The use of information technology to monitor patients' health from a distance.
Mobile Health (mhealth)	• The use of devices such as phones and tablets, and the health-based apps developed for these devices, for health care
Licensure Compacts	• An agreement among some states to streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify.

REPRODUCTIVE HEALTH	
TERM	**DEFINITION**
Medication Abortion Care	• A safe and effective abortion method that uses a combination of drugs (mifepristone and misoprostol) to terminate a pregnancy.
Risk Evaluation and Mitigation Strategies (REMS)	• A Risk Evaluation and Mitigation Strategy (REMS) is a drug safety program that the FDA can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. • Mifepristone has been subject to REMS since 2000 despite robust health and safety evidence of its use.
Health/Care Navigation	• A health/care navigator is a member of a health care team who helps individuals overcome barriers to quality care.
Quality Family Planning (QFP)	• Developed by the CDC and HHS to help reproductive health and primary care providers to reflect the highest standard of care for patients who need services related to preventing or for achieving pregnancy.

ENDNOTES

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REPRODUCTIVE HEALTH INITIATIVE
FOR TELEHEALTH EQUITY & SOLUTIONS

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