



Telehealth Service Recommendations

Clinical best practice guidance for adult primary care

April 2021

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INTRODUCTION

Purpose & Intent

The recommendations in this document are meant to provide guidance to primary care providers in determining whether an adult patient's condition is clinically appropriate for telehealth care. They were developed from available evidence-based literature and expert opinion. The goal is to ensure the quality and safety of services delivered remotely.

Evidence pertaining to the effectiveness of telehealth is not yet available for many health conditions and patient populations. This document is meant to provide information to assist practitioners in developing their own practice standards. Providers should continue to exercise their own clinical judgement in determining whether telehealth services are appropriate. We plan to revisit these recommendations as research evolves and we learn more about successful telehealth practices.

We advocate for the continued use of telehealth as an effective platform to deliver high quality health care services. The hope is that these recommendations help facilitate safe and effective remote care and build strong patient-provider relationships. We recognize that significant inequities in accessing telehealth care exist among different sociodemographic populations. Broadband and video equipment is not available to all patients due to geographic and cost limitations, and those who are older or non-English speaking may have barriers to utilizing telehealth technology.¹ It is recommended that a high priority is placed on ensuring access to vulnerable patients, to prevent furthering the already existing health inequities in these populations. Lastly, we support permanent reimbursement for all modes of telehealth delivery, which is essential to the development of an innovative, stable telehealth infrastructure.

Telehealth

"Telehealth" is a mode of delivering healthcare services or medical information from one physical location to another through the use of telecommunications technologies. Services may be delivered asynchronously or synchronously, via audio, visual, and/or written communications.

This document utilizes the following definitions for telehealth platforms:

Video: Synchronous audio and video capabilities, through smartphone, tablet, or computer

Telephone: Synchronous audio-only communication

Remote Monitoring: Use of digital technologies to collect patient health data and transmit it electronically to a provider

E-Visit: Asynchronous communication between an established patient and provider through a secure online messaging portal

Virtual Check-In: A brief discussion by phone or video with a patient to determine whether an office visit or other service is needed

Providers should utilize the most comprehensive telehealth platform feasible. Therefore, telephone visits should be used only when audio/video platforms are unachievable or declined by the patient. It is recommended that E-visits are primarily used for established patients, for symptom-specific evaluation, when the condition is of low-acuity, low-risk, and not time-sensitive.²

Organizations providing telehealth services must abide by all state and federal regulations, including privacy and security requirements.

INTRODUCTION

When In-Person Visits are Necessary

Providers should continue to exercise clinical judgement, taking into account clinical considerations such as cognitive capacity of the patient, geographic distance to the nearest emergency facility, patient's support system, potential for disease exposure, and patient's current medical status.

Certain conditions necessitate in-person visits. In general, these include:²

- Need for a physical examination in which a provider must lay hands on a patient
- Need for protocol-driven procedures
- Need for aggressive interventions
- Poorly controlled conditions at risk for acute complications
- Patients who do not have the requisite technology to complete a telehealth visit
- Patients who prefer to receive in-person health care

If there is uncertainty regarding the appropriateness of a telehealth visit, providers may conduct a **virtual check-in** – a brief (5-10 min) communication with the patient to determine if a hands-on assessment will be necessary. These virtual check-ins may be compensated, depending on the payer.

Telehealth Principles

It is recommended that organizations providing telehealth services abide by the following principles, adapted from the telehealth principles agreed upon by the West Coast Compact:³

1. **Access:** Telehealth will be used as a means to promote adequate and equitable access to health care.
2. **Confidentiality:** Patient confidentiality, including interactions and patient records, will be protected; and patients should provide informed consent verbally or in writing about both care and the specific technology used to provide it.
3. **Equity:** Telehealth will be available to every patient, regardless of race, ethnicity, sex, gender identify, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Telehealth services will comply with civil rights law.
4. **Standard of Care:** Standard of care requirements will apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.
5. **Stewardship:** Providers will employ the use of evidence-based strategies, deliver quality care, and will continue to take steps to mitigate and address fraud, waste, and abuse.
6. **Patient choice:** Patients, in conjunction with their providers, should be offered their choice of service delivery mode. Patients will retain the right to receive health care in person.

Payment and Benefits

Benefits for telehealth vary by type of service and health plan. Additionally, telehealth coverage has changed significantly during the COVID-19 pandemic, and it remains unclear whether (or for how long) expanded payments will continue. **These recommendations pertain to clinical use of telehealth services, regardless of benefit coverage.** We attempted to align recommended services with those that are currently covered by Medicare (CMS) and the Oregon Health Plan (OHP). However, coverage should always be confirmed prior to providing any telehealth services.

PRIMARY CARE – ADULTS

Chronic Condition Management

General Recommendations for Chronic Conditions

These recommendations are applicable to adult patients with one or more **established chronic condition** diagnoses.

During the course of a telehealth visit, if it becomes clear to the provider that an in-person visit is necessary based on clinical need or acuity, the provider should take responsibility for ensuring a visit is scheduled and transportation is arranged.

Recommended Telehealth Uses:

1. Routine follow up in established, stable patients
2. New patients, after comprehensive screening to ensure they do not meet any in-person visit criteria (below)
3. New or worsening symptomology that does not require hands on or urgent/emergent assessment

Consider in-person visits for patients who meet any of the following criteria:

1. Poorly controlled condition with risk for acute complications
2. Lack of access to necessary monitoring devices either at home or at a satellite clinic location (i.e., blood pressure cuff)
3. Due for routine care that requires hands on assessment by a provider (i.e., foot exam)
4. Condition requires a physical assessment to determine a diagnosis or plan of care
5. Lack of access to telehealth technology or lack of necessary telehealth technical skills
6. Preference to visit provider in person
7. Most recent visit(s) were performed via telehealth and provider deems an in-person visit necessary based on patient risk and time elapsed since last in-person visit.

Note: Patients who are due for ancillary services such as lab work, radiology exams, vaccinations, or infusions may receive those in-person services without a face-to-face visit to their primary care provider.

Condition Specific Recommendations for Chronic Conditions

In addition to the general recommendations above, consider the condition specific recommendations below when determining clinical appropriateness for telehealth services for **established** chronic conditions.

Reason for visit	Telehealth Appropriate?	Platforms	Recommended Telehealth Services	In addition to general recommendations above, consider in-person visit for the following:	References
Allergies	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral Injectable epinephrine training 	<ul style="list-style-type: none"> Need for allergy testing Need for office administered allergy injections 	1,2,3,4
Asthma	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring – may be used for home spirometry, peak flow readings, asthma diaries, or digital inhalers	<ul style="list-style-type: none"> Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral Develop/review asthma action plan, perform validated questionnaire to monitor asthma control Observe/review inhaler technique and peak flow testing 	<ul style="list-style-type: none"> Need for spirometry Need for evaluation of lung sounds 	2,5,6
Back Pain/ Musculoskeletal Pain (Chronic)	Yes	Video – preferred Telephone – not recommended	<ul style="list-style-type: none"> Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral Query and review Prescription Drug Monitoring Program portal (PDMP), if applicable 	<ul style="list-style-type: none"> New or worsening pain which necessitates a physical exam 	7,8,9,10
Chronic kidney disease (CKD)	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring - may be used as adjunct to virtual visits	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	<ul style="list-style-type: none"> New patient with urgent issue and clinically significant liver disease Patient does not have access to remote blood pressure measurement Patient is due for recommended labs or vaccinations 	11,12,13,14,15

Congestive Heart Failure (CHF)	Yes	Video – preferred Telephone – not recommended Remote Monitoring – symptom monitoring available as adjunct to virtual visits (efficacy evidence is mixed)	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, medication management, education, assessment for specialist referral • Advance care planning • Urgent assessment of new or worsening symptoms • Full range of HF patients (all stages, HFrEF or HFpEF, all stages, with LVAD, with heart transplant) can be seen via video 	<ul style="list-style-type: none"> • Urgent visit that requires hands on assessment • Patient does not have access to remote blood pressure or weight measurement 	16,17,18,19
Chronic Obstructive Pulmonary Disease (COPD)	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring - may be used as adjunct to virtual visits	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, assessment for referral to specialist or pulmonary rehabilitation • Smoking cessation advise/assistance 	<ul style="list-style-type: none"> • Acute exacerbation • Patient does not have access to remote pulse oximetry measurement • Patient is due for spirometry • Patient is due for recommended vaccinations 	20,21,22
Cognitive Impairment/ Dementia	Yes	Video – preferred Telephone – if video is not possible. Not recommended if there is a need to perform cognitive testing or assess home environment	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, patient and caregiver education, medication management/monitoring, assessment for referral to specialist or case management • As appropriate, assess social and or/caregiver needs, discuss advance care planning, home safety • Cognitive testing (i.e., Mini-Mental State Exam) to assess stability/decline in mild to moderate impairment 	<ul style="list-style-type: none"> • Need for cognitive testing to establish a diagnosis or assess stability/decline in patients with advanced illness • Family/caregiver is unable to join remotely 	23,24,25,26
Coronary Artery Disease (CAD)	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral • Smoking cessation advise/assistance 	<ul style="list-style-type: none"> • Patient is due for recommended labs • Patient does not have access to remote blood pressure or heart rate measurement 	27,28,29

Diabetes Type II	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring – CBG monitoring recommended as adjunct to virtual visits	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	<ul style="list-style-type: none"> • Patient has not been seen in person in 1 year or more • Condition is uncontrolled • Patient is due for foot exam or neuropathy screening • Height, weight, or BP cannot be measured remotely and has not been obtained in 1 year or more (or more frequently if appropriate) • Patient is due for cognitive screening 	30,31,32
Gastroesophageal Reflux Disease (GERD)	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	Patient meets criteria for endoscopy, esophageal impedance, and/or esophageal manometry	33,34
Headache/ Migraine (Chronic)	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	<ul style="list-style-type: none"> • Need for routine or acute injectable treatments • New or high-risk symptoms indicate need for imaging or complete neurological exam 	35,36,37,38, 39,40
Hepatitis C	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral • Advance care planning • Alcohol/substance abuse screening • Monitor for new or worsening psychiatric illness 	<ul style="list-style-type: none"> • Initial evaluation and treatment initiation • Concerns for treatment intolerance • Patient is due for recommended labs, imaging, and/or vaccines 	41,42,43
Hyperlipidemia	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	<ul style="list-style-type: none"> • Patient is due for recommended labs • Patient has not been seen in person for 1 year or more and needs to be screened for other CVD risk factors 	44,45

Hypertension	Yes	Video – preferred Telephone – If video is not possible Remote Monitoring – BP monitoring recommended as adjunct to virtual visits	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education	<ul style="list-style-type: none"> • Initial evaluation and treatment initiation • Patient does not have remote access to accurate blood pressure measurement • Patient is due for recommended labs 	46,47
Hyperthyroid Disorders	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, education, medication management, assessment for specialist referral	Patient is due for recommended labs	48,49
Hypothyroid Disorders	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral	<ul style="list-style-type: none"> • Patient is due for recommended labs • Patient has not been seen in person for 1 year or more 	50,51
Inflammatory Bowel Disease/Irritable Bowel Syndrome	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring – symptom monitoring available as adjunct to virtual visits	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education, assessment for specialist referral • Smoking cessation counseling/assistance 	<ul style="list-style-type: none"> • Initial evaluation and treatment initiation • Patient is due for recommended labs • Patient is due for IV medication infusion • Patient is due for recommended cancer screenings 	52,53,54,55,56,57
Osteoarthritis	Yes	Video – preferred Telephone – if video is not possible	Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist/PT/OT referral	<ul style="list-style-type: none"> • Need for cane, brace, or orthotic fitting • Need for intraarticular injection 	58,59,60
Osteoporosis	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, nutrition therapy/education • Smoking cessation advise/assistance • Fall prevention education 	<ul style="list-style-type: none"> • Patient is due for bone density screening • Patient is due for IV medication infusion • Patient is due for recommended labs 	61,62,63

Pre-Diabetes	Yes	Video – preferred Telephone – if video is not possible Remote Monitoring – Recommended for goal setting, weight tracking, physical activity tracking	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management/adherence, nutrition therapy/education, assessment for specialist referral • Lifestyle coaching, education, and interventions (cooking, exercise, weight management) to groups or individuals 	<ul style="list-style-type: none"> • Life threatening obesity • Metabolic syndrome 	64,65,66,67,68
Psoriasis/ Psoriatic Arthritis	Yes	Video – preferred Telephone – not recommended	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral 	<ul style="list-style-type: none"> • Need for phototherapy • Need for infusion • Need for PPD testing prior to medication initiation 	69,70,71,72
Rheumatoid Arthritis	Yes	Video – preferred Telephone – not recommended Remote Monitoring – symptom monitoring available as adjunct to virtual visits	<ul style="list-style-type: none"> • Routine clinical status evaluation, self-management support, education, medication management, assessment for specialist referral • Functional status assessment and/or disease activity measurement 	<ul style="list-style-type: none"> • Patient is due for recommended labs • Need for PPD testing prior to medication initiation • Need for infusion 	73,74,75,76
Testosterone Deficiency	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Routine clinical status evaluation, medication management/adherence, education • Psychologic counseling • Erectile dysfunction treatment • Discuss related men’s health conditions (i.e., hair loss) 	<ul style="list-style-type: none"> • Periodic visits as required by state/DEA for controlled substance prescribing • Patient is due for recommended labs • Patient is due for in-office injection 	77,78,79

PRIMARY CARE – ADULTS

Routine Care

General Recommendations for Routine Care

These recommendations are applicable to adult patients due for **non-urgent, routine recommended** care.

During the course of a telehealth visit, if it becomes clear to the provider that an in-person visit is necessary based on clinical need or acuity, the provider should take responsibility for ensuring a visit is scheduled and transportation is arranged.

Recommended Telehealth Uses:

1. Routine scheduled and follow-up care in established, stable patients
2. New patients, after comprehensive screening to ensure they do not meet any in-person visit criteria (below)

E-Visits are appropriate for the following scenarios:

1. Established patients in need of evaluation, education, or clinical guidance for an issue or condition that is not time sensitive

Consider in-person visits for patients who meet any of the following criteria:

1. History or triage findings warrant a physical assessment to determine a diagnosis or management
2. High risk due to comorbid condition(s)
3. Lack of access to necessary monitoring devices either at home or at a satellite clinic location (i.e., blood pressure cuff)
4. Lack of access to telehealth technology or lack of necessary telehealth technical skills
5. Preference to visit provider in person

Note: Patients who require ancillary services such as lab work or radiology exams may receive those in-person services without a face-to-face visit to their primary care provider.

Condition Specific Recommendations for Routine Care

In addition to the general recommendations above, consider the condition specific recommendations below when determining clinical appropriateness for telehealth services for **non-urgent routine care**.

Reason for visit	Telehealth Appropriate?	Platforms	Recommended Telehealth Services	In addition to general recommendations above, consider in-person visit for the following:	References
Advance Care Planning (ACP)	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • ACP discussions with patient, family, and/or surrogate • Completion of POLST and/or Advance Directive forms 	No additional considerations	80
Annual Wellness Visit (Medicare)	Yes	Video – preferred Telephone – if video is not possible	Health risk assessment, medical history, behavioral health assessment, functional assessment, prevention planning, advance care planning	Patient does not have access to remote blood pressure or weight measurement	81
Birth Control	Yes	Video – preferred Telephone – if video is not possible	Obtain history and assessment, provide education, contraceptive counseling, medication management	Need for in-office contraceptive placement (i.e., implant, IUD, injection)	82,83
Hospital/ED Follow Up	Yes	Video – preferred Telephone – if video is not possible. Not recommended for patients that require visual assessment of wounds, swelling, range of motion, etc.	<ul style="list-style-type: none"> • Obtain history and assessment. Provide education, medication reconciliation, medication management, self-management support • As appropriate, provide caregiver counseling, social needs screening, nutrition screening, advance care planning • Ensure needed supplies, medical equipment, in-home support, and specialist/ancillary follow up care are arranged 	<ul style="list-style-type: none"> • Vital signs are warranted, and patient does not have access to remote monitoring • Patient’s condition has worsened since discharge • Patient is unstable or at high risk for readmission • Patient requires follow up labs, imaging, or other diagnostics 	84,85
Prostate Exam	No	N/A	N/A	N/A	
Results Follow-up	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Explanation of results, education, counseling • As appropriate, development of care plan, specialist referrals, medication management 	Additional in-office diagnostics are warranted	

Routine Physical	No	N/A	N/A	N/A	
Skin Check	Yes	<p>Video – preferred</p> <p>Telephone – not recommended</p> <p>E-Visit – high quality images may be shared asynchronously. Dermoscopic images are preferred. May be an adjunct to video visit or stand-alone. Not recommended for full body exams, patients at high risk for melanoma, or if lesions are in hair-bearing areas</p>	History, visualization of lesions, education, counseling, medication management, assessment for specialist referral	<ul style="list-style-type: none"> • Need for biopsy or palpation • Any potentially malignant lesions are identified • Assessment of areas of hair-bearing skin are needed • Presence of mucosal lesions • Skin color makes virtual assessment difficult 	86,87,88,89,90
Women’s wellness exam	Yes	<p>Video – preferred</p> <p>Telephone – if video is not possible</p>	<ul style="list-style-type: none"> • General assessments such as alcohol, anxiety, depression, obesity, tobacco and other substance use, and urinary incontinence screenings • Counseling for medications, contraception, fall prevention, nutrition and supplements, exercise, skin cancer, and tobacco cessation • Infectious disease risk assessment and counseling • BRCA testing risk assessment • Interpersonal and domestic violence screening and resources • Preeclampsia screening and prevention 	<ul style="list-style-type: none"> • Patient is due for recommended labs • Need for infectious disease testing • Need for osteoporosis screening • Due for mammogram, PAP, or other cancer screening • Due for immunizations • Need for contraceptive device insertion or removal • Need for pelvic exam 	91,92
Women’s Medicare gynecological exam	No	N/A – Pap test, pelvic exams and breast exams require an in-person visit	N/A	N/A	93

PRIMARY CARE – ADULTS

Acute Symptoms

General Recommendations for Acute Symptoms

These recommendations are applicable to adult patients with **low-acuity** symptoms. Prior to a telehealth visit, patients with acute complaints should be **screened carefully** to identify the need for emergent care or any red flag symptoms such as chest pain, sudden vision changes, weakness/dizziness, leg swelling, etc.

During the course of a telehealth visit, if it becomes clear to the provider that an in-person visit is necessary based on clinical need or acuity, the provider should take responsibility for ensuring a visit is scheduled and transportation is arranged.

Recommended Telehealth Uses:

1. Established patients who are at low risk for complications
2. New patients, after comprehensive screening to ensure they do not meet any in-person visit criteria (below)
3. New symptomology that does not require hands on or urgent/emergent assessment

E-Visits are appropriate for the following scenarios:

1. Established patients in need of symptom-specific evaluation, when the condition is low-acuity, low-risk, and not time sensitive

Consider in-person visits for patients who meet any of the following criteria:

1. History or triage findings warrant a physical assessment to determine a diagnosis or management
2. High risk due to comorbid condition(s)
3. Symptoms of systemic illness (constitutional symptoms)
4. Lack of access to necessary monitoring devices either at home or at a satellite clinic location (i.e., blood pressure cuff)
5. Lack of access to telehealth technology or lack of necessary telehealth technical skills
6. Preference to visit provider in person

Note: Patients who require ancillary services such as lab work or radiology exams may receive those in-person services without a face-to-face visit to their primary care provider.

Condition Specific Recommendations for Acute Symptoms

In addition to the general recommendations above, consider the condition specific recommendations below when determining clinical appropriateness for telehealth services.

Reason for visit	Telehealth Appropriate?	Platforms	Recommended Telehealth Services	In addition to general recommendations above, consider in-person visit for the following:	References
Abdominal Pain	Yes	Video – preferred Telephone – if video is not possible	Obtain history and assess acuity. For benign presentations, provide self-management support, education, medication management, nutrition education, assess for specialist referral	Red flags are present, such as severe pain, fever, sudden onset, hematochezia, hematemesis, pregnancy, intractable vomiting, lightheadedness with standing, trauma, intensifying pain, distended abdomen, diaphoresis, abdominal pain with walking, or pulsatile mass	94
Conjunctivitis	Yes	Video – preferred Telephone – not recommended	History, assessment, diagnosis, self-management education, medication management, assess need for specialist referral	<ul style="list-style-type: none"> • Need for culture testing • Red flags are present, such as severe pain, vision loss, copious purulent discharge, corneal involvement, traumatic eye injury, recent ocular surgery, distorted pupil, herpes infection, or recurrent infections 	95
Constipation	Yes	Video – preferred Telephone – if video is not possible	Obtain history and assess acuity. For benign presentations, provide self-management support, education, medication management, nutrition education, assess for specialist referral	<ul style="list-style-type: none"> • Need for rectal exam or additional diagnostic studies • Need for lab work • Red flags are present, such as severe pain, nausea, cramping, vomiting, weight loss, melena, rectal bleeding, rectal pain, or fever 	96
Diarrhea	Yes	Video – preferred Telephone – if video is not possible	Obtain history and assessment, provide education, discuss nutrition, oral rehydration, medication management	<ul style="list-style-type: none"> • Need for stool culture/microbiological assessment • Need for IV fluids • Non-improving or persistent symptoms • Red flag symptoms are present, such as fever, bloody stools, or dehydration 	97,98,99

Dizziness/Vertigo	Yes	Video – preferred Telephone – not recommended	<ul style="list-style-type: none"> • Obtain history and assessment, provide self-management support, education, medication management, assess for specialist referral • Teach BPPV positioning maneuvers, if applicable • Fall prevention education 	<ul style="list-style-type: none"> • Need for vestibular testing or imaging studies • Red flags are present, such as loss of consciousness, falls, or sensory/motor disturbances of the face or extremities 	100,101
Erectile Dysfunction	Yes	Video – preferred Telephone – not recommended	<ul style="list-style-type: none"> • Obtain medical/sexual/psychosocial history and assessment • Perform validated questionnaire to determine severity • Provide education, medication management, assess for referral to specialist, including mental health professional 	<ul style="list-style-type: none"> • Need for lab work • Patient does not have access to remote blood pressure measurement 	102
Falls/Fall Risk	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> • Obtain history and assessment. Provide education, self-management support, medication review, medication management • Assess for referral to specialist, physical or occupational therapy, exercise program, or community support • Perform home safety assessment 	<ul style="list-style-type: none"> • Need for in -person multifactorial risk assessment, including gait, balance, visual acuity, muscle strength, cardiovascular status, postural hypotension, foot/footwear, or neurologic testing. • Family/caregiver is unable to join remotely 	103,104,105
Headache/Migraine (Acute)	Yes	Video – preferred Telephone – if video is not possible	Obtain history and assessment. For features typical of low-risk primary headaches, provide medication management, education, self-management support, discuss non-pharmacological management, assess for specialist referral	<ul style="list-style-type: none"> • History or symptoms warrant neuroimaging, labs, lumbar puncture, etc. • Red flag symptoms are present, such focal neurological signs, papilledema, neck stiffness, an immunocompromised state, sudden onset of severe headache, personality changes, headache after trauma, or headache worse with exercise 	106

Rash/Skin Disorder	Yes	Video – preferred Telephone – not recommended E-Visit – high quality images may be shared asynchronously	Obtain history and assessment, provide education, medication management, self-management support, assess for specialist referral	<ul style="list-style-type: none"> • Assessment of areas of hair-bearing skin are needed • Assessment of pigmented lesions where a dermatoscope is required • Presence of mucosal lesions • Presence of non-blanching petechial lesions • Skin color makes virtual assessment difficult • History or symptoms of arthritis • Need for biopsy, labs, or diagnostic imaging 	86,89,90
STI Symptoms	Yes	Video – preferred Telephone – if video is not possible E-Visit – high quality images may be shared asynchronously	Obtain history and assessment, provide education/counseling, medication management, self-management support, assess for specialist referral	<ul style="list-style-type: none"> • Need for labs, culture, or biopsy • Need for pelvic exam • Need for parenteral medication • Need for cryotherapy or surgical lesion removal 	107
URI Symptoms (congestion, cough, fever, etc.)	Yes	Video – preferred Telephone – if video is not possible	Obtain history and triage for acuity. For non-concerning presentations, provide self-management support, education, medication management	<ul style="list-style-type: none"> • Need for radiology exam or lung auscultation • Need for labs or culture 	108,109,110, 111
UTI Symptoms	Yes	Video – preferred Telephone – if video is not possible E-Visit – may be used per RN protocol	<ul style="list-style-type: none"> • Management of uncomplicated UTI • History, assessment, prevention education, medication management 	<ul style="list-style-type: none"> • Need for urinalysis or culture • Male patient 	112,113

PRIMARY CARE – ADULTS

Behavioral Health

General Recommendations for Behavioral Health

These recommendations are applicable to adult patients with **non-emergent** symptoms. Prior to a telehealth visit, high risk patients should be screened carefully to rule out any possible need for emergent care.

During the course of a telehealth visit, if it becomes clear to the provider that an in-person visit is necessary based on clinical need or acuity, the provider should take responsibility for ensuring a visit is scheduled and transportation is arranged.

Recommended Telehealth Uses:

1. Established patients who are at low risk for acute adverse outcomes, in need of treatment and monitoring of common mental health or substance use conditions
2. New patients, after comprehensive screening to ensure they do not meet any in-person visit criteria (below)
3. Any patient who is not in need of urgent or emergent care, that would not otherwise have access to care or is more comfortable speaking about behavioral health issues via a telehealth platform

Consider in-person visits for patients who meet any of the following criteria:

1. Provider feels that an in-person visit is necessary to assess full clinical picture and appreciate more subtle nuances of interpersonal communication
2. Privacy/safety is not possible at home
3. Lack of access to telehealth technology or lack of necessary telehealth technical skills
4. Preference to visit provider in person

Connect patient with a behavioral health provider or emergency services for anyone experiencing a mental health emergency or crisis such as acute suicidality, psychosis, acute intoxication, delirium, drug withdrawal, or aggression

Note: Patients who require ancillary services such as lab work may receive those in-person services without a face-to-face visit to their primary care provider.

Condition Specific Recommendations for Behavioral Health

In addition to the general recommendations above, consider the condition specific recommendations below when determining clinical appropriateness for telehealth services.

Reason for visit	Telehealth Appropriate?	Platforms	Recommended Telehealth Services	In addition to general recommendations above, consider in-person visit for the following:	References
Alcohol, Tobacco or Other Drug Use or Dependence	Yes	Video – preferred Telephone – if video is not possible	<ul style="list-style-type: none"> Assessment, education, self-management support, counseling, medication management, and/or Medication for Addiction Treatment services, including high risk patients such those with a history of non-fatal overdose, co-occurring mental illness, and pregnant patients Assess need and refer to psychotherapy, group therapy, case management, crisis support, and community support as needed 	Need for UA or other labs	114,115,116, 117
Anxiety or Depression	Yes	Video – preferred Telephone – if video is not possible	Assessment and screening, medication management, counseling, education, self-management support, assess for referral to psychiatry or other community supports	No additional considerations	118,119,120, 121

OPERATIONAL CONSIDERATIONS

Resources for successful telehealth integration

How can I implement telehealth in my practice?

- American Medical Association Telehealth Implementation Playbook
<https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf>
- American Academy of Family Physicians – A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice
https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
- AMA Steps Forward – Telemedicine: Facilitate access to care for your patients
<https://edhub.ama-assn.org/steps-forward/module/2702689>
- Health and Human Services (HHS) – Telehealth resources for health care providers
<https://telehealth.hhs.gov/providers/>
- Northwest Regional Telehealth Resource Center
<https://nrtrc.org/about/region/oregon.shtml>

What telehealth services are covered by insurance?

- Medicare
 - Centers for Medicare and Medicaid Services (CMS) – General Provider Telehealth and Telemedicine Toolkit
<https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>
 - Centers for Medicare and Medicaid Services (CMS) – List of Telehealth Services
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- Medicaid
 - Oregon Health Authority, Health Systems Division – Oregon Medicaid COVID-19 Provider Guide
<https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20COVID-19%20Provider%20Guide.pdf>
- Commercial
 - Center for Connected Health Policy
<https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies>

Can I provide care to an out-of-state patient?

- Physicians and Physician Assistants: <https://www.oregon.gov/omb/Topics-of-Interest/Pages/Telemedicine.aspx>
- Naturopathic Physicians: <https://www.oregon.gov/obnm/Documents/Rules/TelemedicineGuidelines.pdf>

METHODS

These recommendations were developed by the OHLC Telehealth Workgroup, with the guidance and support of OHLC's Best Practice Committee. These groups are comprised of providers, clinical leaders, and telehealth experts representing health systems, clinics, and health plans throughout Oregon. More information about the Best Practice Committee can be found here:

<http://www.orhealthleadershipcouncil.org/ebbp/>

The guidance in this document was collected via comprehensive evidence-based literature searches, as well as expert opinion from Telehealth Workgroup members and their colleagues. The conditions listed within each condition specific guideline section were derived from the most common reasons for visits in the primary care setting.

Future Telehealth Workgroup projects include Service Recommendations for pediatric primary care, behavioral health, and oral health.

FOOTNOTES

1. Eberly, L. A., Kallan, M. J., Julien, H. M., Haynes, N., Khatana, S., Nathan, A. S., Snider, C., Chokshi, N. P., Eneanya, N. D., Takvorian, S. U., Anastos-Wallen, R., Chaiyachati, K., Ambrose, M., O'Quinn, R., Seigerman, M., Goldberg, L. R., Leri, D., Choi, K., Gitelman, Y., Kolansky, D. M., ... Adusumalli, S. (2020). Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. *JAMA network open*, 3(12), e2031640. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488>
2. CareOregon telemedicine technical assistance guide. <http://careoregon.org/docs/default-source/covid-19/cor-covid-19-telehealth-ta-guide.pdf>
3. West Coast Compact Telehealth Principles. <https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=53256>

REFERENCES

1. Krishna, M.T., Knibb, R., & Huissoon, A. (2016). Is there a role for telemedicine in adult allergy services? *Clinical & Experimental Allergy*, 46, 668 - 677. <https://onlinelibrary.wiley.com/doi/abs/10.1111/cea.12701>
2. Elliott, T., Shih, J., Dinakar, C., Portnoy, J., & Fineman, S. (2017). American College of Allergy, Asthma & Immunology position paper on the use of telemedicine for allergists. *Annals of Allergy, Asthma, and Immunology*, 119(6), 512-517. [https://www.annallergy.org/article/S1081-1206\(17\)31047-5/fulltext](https://www.annallergy.org/article/S1081-1206(17)31047-5/fulltext)
3. Kurowski, K. & Boxer, R. (2008). Food Allergies: Detection and Management. *American Family Physician*, 77(12), 1678-1686. <https://www.aafp.org/afp/2008/0615/p1678.html>
4. American Academy of Family Physicians. (2018). Treatment of seasonal allergic rhinitis: A guideline from the AAAAI/ACAAI joint task force on practice parameters. *Am Fam Physician*, 87(11), 756-757. <https://www.aafp.org/afp/2018/0601/p756.html>
5. National Institute for Health and Care Excellence. (2017). *Asthma: diagnosis, monitoring, and chronic asthma management*. <https://www.nice.org.uk/guidance/ng80/resources/asthma-diagnosis-monitoring-and-chronic-asthma-management-pdf-1837687975621>
6. Persaud, Y. K., & Portnoy, J. M. (2021). Ten Rules for Implementation of a Telemedicine Program to Care for Patients with Asthma. *The journal of allergy and clinical immunology. In practice*, 9(1), 13–21. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7543924/>
7. Tauben, D.J., Langford, D.J., Sturgeon, J.A., Rundell, S.D., Towle, C., Bockman, C. & Nicholas, M. (2020) Optimizing telehealth pain care after COVID-19, *PAIN*, 161(11), 2437-2445. https://journals.lww.com/pain/Fulltext/2020/11000/Optimizing_telehealth_pain_care_after_COVID_19.3.aspx
8. Eccleston, C., Blyth, F.M., Dear, B.F., Fisher, E.A., Keefe, F.J., Lynch, M.E., Palermo, T.M., Carrington Reid, M., & Williams, A.C. (2020). Managing patients with chronic pain during the COVID-19 outbreak: considerations for the rapid introduction of remotely supported (eHealth) pain management services. *PAIN*, 161(5), 889-89. https://journals.lww.com/pain/Citation/2020/05000/Managing_patients_with_chronic_pain_during_the.3.aspx#JCL-P-15
9. Lambert, M. (2010). ICSI Releases guideline on chronic pain assessment and management. *Am Fam Physician*, 82(4), 434-439. <https://www.aafp.org/afp/2010/0815/p434.html>
10. American Academy of Family Physicians. (2017). Management of chronic pain and opioid misuse: A position paper from the AAFP. *American Family Physician*, 95(7), 458-459. <https://www.aafp.org/afp/2017/0401/p458.html>
11. Narva, A. S., Romancito, G., Faber, T., Steele, M. E., & Kempner, K. M. (2017). Managing CKD by Telemedicine: The Zuni Telenephrology Clinic. *Advances in chronic kidney disease*, 24(1), 6–11. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5325060/>
12. Koraihy, F.M. & Rohatgi, R. (2020). Telenephrology: An emerging platform for delivering renal health care. *American Journal of Kidney Diseases*, 76(3), 417-426. [https://www.ajkd.org/article/S0272-6386\(20\)30613-2/fulltext](https://www.ajkd.org/article/S0272-6386(20)30613-2/fulltext)
13. He, T., Liu, X., Li, Y., Wu, Q., Liu, M., & Yuan, H. (2017). Remote home management for chronic kidney disease: A systematic review. *Journal of telemedicine and telecare*, 23(1), 3–13. <https://pubmed.ncbi.nlm.nih.gov/27269795/>
14. Jain, G., Ahmad, M. & Wallace, E.L. (2020). Technology, telehealth, and nephrology: The time is now. *Kidney360*, 1(8), 834-836. <https://kidney360.asnjournals.org/content/1/8/834>
15. Department of Veterans Affairs. (2019). *VA/DoD clinical practice guideline for the management of chronic kidney disease* (Version 4.0). <https://www.healthquality.va.gov/guidelines/CD/ckd/VADoDCKDCPGProviderSummaryFinal5082142020.pdf>
16. American College of Cardiology Foundation/American Heart Association. (2013). 2013 ACCF/AHA guideline for the management of heart failure. *Journal of the American College of Cardiology*, 62(16), e147-e239. <https://www.jacc.org/doi/pdf/10.1016/j.jacc.2013.05.019>
17. Gorodeski, E. Z., Goyal, P., Cox, Z. L., Thibodeau, J. T., Reay, R. E., Rasmussen, K., Rogers, J. G., & Starling, R. C. (2020). Virtual Visits for Care of Patients with Heart Failure in the Era of COVID-19: A Statement from the Heart Failure Society of America. *Journal of cardiac failure*, 26(6), 448–456. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7166039/>
18. American Heart Association. (2019). Using remote patient monitoring technologies for better cardiovascular disease outcomes. <https://www.heart.org/-/media/files/about-us/policy-research/policy-positions/clinical-care/remote-patient-monitoring-guidance-2019.pdf?la=en>
19. Brahmabhatt, D. H., & Cowie, M. R. (2019). Remote Management of Heart Failure: An Overview of Telemonitoring Technologies. *Cardiac failure review*, 5(2), 86–92. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6545972/>
20. Ambrosino, N., Vaghegini, G., Mazzoleni, S., & Vitacca, M. (2016). Telemedicine in chronic obstructive pulmonary disease. *Breathe (Sheffield, England)*, 12(4), 350–356. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5297949/>

21. Gentry, S., & Gentry, B. (2017). Chronic Obstructive Pulmonary Disease: Diagnosis and Management. *American family physician*, 95(7), 433–441. <https://www.aafp.org/afp/2017/0401/p433.html>
22. Barbosa, M. T., Sousa, C. S., Morais-Almeida, M., Simões, M. J., & Mendes, P. (2020). Telemedicine in COPD: An Overview by Topics. *COPD*, 17(5), 601–617. <https://pubmed.ncbi.nlm.nih.gov/32892650/>
23. Dang, S., Gomez-Orozco, C. A., van Zuilen, M. H., & Levis, S. (2018). Providing Dementia Consultations to Veterans Using Clinical Video Telehealth: Results from a Clinical Demonstration Project. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 24(3), 203–209. <https://pubmed.ncbi.nlm.nih.gov/28686082/>
24. Carotenuto, A., Rea, R., Traini, E., Ricci, G., Fasanaro, A.M. & Amenta, F. (2018). Cognitive Assessment of Patients With Alzheimer's Disease by Telemedicine: Pilot Study. *JMIR Ment Health*, 5(2), e31. https://mental.jmir.org/2018/2/e31/?utm_source=TrendMD&utm_medium=cpc&utm_campaign=JMIR_TrendMD_1
25. Laver, K., Liu, E., Clemson, L., Davies, O., Gray, L., Gitlin, L.N., Crotty, M. (2020). Does Telehealth Delivery of a Dyadic Dementia Care Program Provide a Noninferior Alternative to Face-To-Face Delivery of the Same Program? A Randomized, Controlled Trial. *The American Journal of Geriatric Psychiatry*, 28(6), 673-682. <https://www.sciencedirect.com/science/article/pii/S1064748120302402>
26. Ciemins, E.L., Holloway, B., Coon, P.J., McClosky-Armstrong, T. & Min, S.J. (2009). Telemedicine and the mini-mental state examination: assessment from a distance. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association*, 15(5), 476–478. <https://europepmc.org/article/med/19548827#free-full-text>
27. Turan Kavradim, S., Özer, Z., & Boz, İ. (2020). Effectiveness of telehealth interventions as a part of secondary prevention in coronary artery disease: a systematic review and meta-analysis. *Scandinavian journal of caring sciences*, 34(3), 585–603.
28. Ruschel, K. B., Rados, D. R., Furtado, M. V., Batista, J., Katz, N., Harzheim, E., & Polanczyk, C. A. (2020). Transition of care of stable ischaemic heart disease patients from tertiary to primary care with telemedicine support: Randomized noninferiority clinical trial. *Journal of telemedicine and telecare*, 1357633X20906648. Advance online publication. <https://journals.sagepub.com/doi/abs/10.1177/1357633X20906648>
29. Braun, M.M., Stevens, W.A & Barstow, C.H. (2018). Stable coronary artery disease: treatment. *Am Fam Physician*, 97(6), 376-384. <https://www.aafp.org/afp/2018/0315/p376.html>
30. Wu, C., Wu, Z., Yang, L., Zhu, W., Zhang, M., Zhu, Q., Chen, X., & Pan, Y. (2018). Evaluation of the clinical outcomes of telehealth for managing diabetes: A PRISMA-compliant meta-analysis. *Medicine*, 97(43), e12962. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6221638/>
31. Appuswamy, A.V. & Desimone, M.E. (2020). Managing diabetes in hard to reach populations: A review of telehealth interventions. *Current Diabetes Reports*, 20(28). <https://link.springer.com/article/10.1007%2Fs11892-020-01310-2>
32. American Diabetes Association. (2020). Standards of medical care in diabetes – 2020 abridged for primary care providers. *Clinical Diabetes*, 38(1), 10-38. <https://clinical.diabetesjournals.org/content/38/1/10>
33. Sandhu, D. S., & Fass, R. (2018). Current Trends in the Management of Gastroesophageal Reflux Disease. *Gut and liver*, 12(1), 7–16. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753679/>
34. Iwakiri, K., Kinoshita, Y., Habu, Y. et al. (2016). Evidence-based clinical practice guidelines for gastroesophageal reflux disease 2015. *Journal of Gastroenterology*, 51, 751–767. <https://link.springer.com/article/10.1007%2Fs00535-016-1227-8>
35. Friedman, D. I., Rajan, B., & Seidmann, A. (2019). A randomized trial of telemedicine for migraine management. *Cephalalgia : an international journal of headache*, 39(12), 1577–1585. <https://pubmed.ncbi.nlm.nih.gov/31450969/>
36. Müller, K.I., Alstadhaug, K.B. & Bekkelund, S.I. (2016). Acceptability, Feasibility, and Cost of Telemedicine for Nonacute Headaches: A Randomized Study Comparing Video and Traditional Consultations. *Journal of Medical Internet Research*, 18(5), e140. <https://www.jmir.org/2016/5/e140/>
37. Müller, K. I., Alstadhaug, K. B., & Bekkelund, S. I. (2017). Telemedicine in the management of non-acute headaches: A prospective, open-labelled non-inferiority, randomised clinical trial. *Cephalalgia : an international journal of headache*, 37(9), 855–863. <https://pubmed.ncbi.nlm.nih.gov/27301460/>
38. American Headache Society. (2018). The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache*, 59(1), 1-18. <https://headachejournal.onlinelibrary.wiley.com/doi/10.1111/head.13456>
39. Ebell, M.H. (2006). Diagnosis of migraine headache. *American Family Physician*, 72(12), 2087-2088. <https://www.aafp.org/afp/2006/1215/p2087.html>
40. Yancey, J.R., Sheridan, R. & Koren, K.G. (2014). Chronic daily headache: diagnosis and management. *American Family Physician*, 89(8), 642-648. <https://www.aafp.org/afp/2014/0415/p642.html>
41. Piao, C., Terrault, N.A. & Sarkar, S. (2019). Telemedicine: an evolving field in hepatology. *Hepatology Communications*, 3(5), 716-721. <https://aasldpubs.onlinelibrary.wiley.com/doi/full/10.1002/hep4.1340>
42. Schulz, T. R., Kanhutu, K., Sasadeusz, J., Watkinson, S., & Biggs, B. A. (2020). Using telehealth to improve access to hepatitis C treatment in the direct-acting antiviral therapy era. *Journal of telemedicine and telecare*, 26(3), 180–185. <https://journals.sagepub.com/doi/abs/10.1177/1357633X18806651>

43. Wilkins, T., Akhtar, M., Gititu, E., Jalluri, C. & Ramirez, J. (2015). Diagnosis and management of hepatitis c. *American Family Physician*, 81(12), 835-842. <https://journals.sagepub.com/doi/abs/10.1177/1357633X18806651>
44. Arnett, D. K., Blumenthal, R. S., Albert, M. A., Buroker, A. B., Goldberger, Z. D., Hahn, E. J., Himmelfarb, C. D., Khera, A., Lloyd-Jones, D., McEvoy, J. W., Michos, E. D., Miedema, M. D., Muñoz, D., Smith, S. C., Jr, Virani, S. S., Williams, K. A., Sr, Yeboah, J., & Ziaeian, B. (2019). 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*, 140(11), e563–e595. <https://www.ahajournals.org/doi/10.1161/CIR.0000000000000677>
45. Stanford Hospital and Clinics. (2013). Hyperlipidemia management protocol: Stanford coordinated care. <https://med.stanford.edu/content/dam/sm/cerc/documents/Hyperlipidemia%20Management%20Protocol.pdf>
46. Omboni, S., McManus, R. J., Bosworth, H. B., Chappell, L. C., Green, B. B., Kario, K., Logan, A. G., Magid, D. J., Mckinstry, B., Margolis, K. L., Parati, G., & Wakefield, B. J. (2020). Evidence and Recommendations on the Use of Telemedicine for the Management of Arterial Hypertension: An International Expert Position Paper. *Hypertension (Dallas, Tex. : 1979)*, 76(5), 1368–1383. <https://www.ahajournals.org/doi/full/10.1161/HYPERTENSIONAHA.120.15873>
47. Omboni, S., & Ferrari, R. (2015). The role of telemedicine in hypertension management: focus on blood pressure telemonitoring. *Current hypertension reports*, 17(4), 535. <https://pubmed.ncbi.nlm.nih.gov/25790799/>
48. Kaur, D., Galloway, G. K., & Oyibo, S. O. (2020). Patient Satisfaction With the Use of Telemedicine in the Management of Hyperthyroidism. *Cureus*, 12(8), e9859. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7437122/>
49. Kravets, I. (2016). Hyperthyroidism: diagnosis and treatment. *American Family Physician*, 93(5), 363-370. <https://www.aafp.org/afp/2016/0301/p363.html>
50. Gaitonde, D.Y., Rowly, K.D. & Sweeney, L.B. (2012). Hypothyroidism: An update. *American Family Physician*, 86(3), 244-251. <https://www.aafp.org/afp/2012/0801/p244.html>
51. Lakhani, O.J., Lathia, T., Bhattacharya, S. & Shaikh, A. (2020). “Telethyroidology”: Managing thyroid disorders through telemedicine. *Thyroid Research & Practice*, 17(2), 56-61. <https://www.thetrp.net/article.asp?issn=0973-0354;year=2020;volume=17;issue=2;page=56;epage=61;aulast=Lakhani>
52. Bhattacharya, S., Wong, U. & Cross, R.K. (2020). Telemedicine in the management of inflammatory bowel disease: An update. *Smart Homecare Technology and TeleHealth*, 7, 9-17. <https://www.dovepress.com/telemedicine-in-the-management-of-inflammatory-bowel-disease-an-update-peer-reviewed-fulltext-article-SHTT>
53. Helsel, B. C., Williams, J. E., Lawson, K., Liang, J., & Markowitz, J. (2018). Telemedicine and Mobile Health Technology Are Effective in the Management of Digestive Diseases: A Systematic Review. *Digestive diseases and sciences*, 63(6), 1392–1408. <https://link.springer.com/article/10.1007/s10620-018-5054-z>
54. Yin, A.L., Hachuel, D., Pollak, J.P., Scherl, E.J. & Estrin, D. (2019). Digital Health Apps in the Clinical Care of Inflammatory Bowel Disease: Scoping Review. *Journal of Medical Internet Research*, 21(8), e14630. <https://www.imir.org/2019/8/e14630/>
55. Veauthier, B., & Hornecker, J. R. (2018). Crohn's Disease: Diagnosis and Management. *American family physician*, 98(11), 661–669. <https://www.aafp.org/afp/2018/1201/p661.html>
56. Langan, R. C., Gotsch, P. B., Krafczyk, M. A., & Skillinge, D. D. (2007). Ulcerative colitis: diagnosis and treatment. *American family physician*, 76(9), 1323–1330. <https://www.aafp.org/afp/2007/1101/p1323.html>
57. Wilkins, T., Pepitone, C., Alex, B., & Schade, R. R. (2012). Diagnosis and management of IBS in adults. *American family physician*, 86(5), 419–426. <https://www.aafp.org/afp/2012/0901/p419.html>
58. Cuperus, N., Hoogeboom, T. J., Kersten, C. C., den Broeder, A. A., Vlieland, T. P., & van den Ende, C. H. (2015). Randomized trial of the effectiveness of a non-pharmacological multidisciplinary face-to-face treatment program on daily function compared to a telephone-based treatment program in patients with generalized osteoarthritis. *Osteoarthritis and cartilage*, 23(8), 1267–1275. [https://www.oarsijournal.com/article/S1063-4584\(15\)01127-9/fulltext](https://www.oarsijournal.com/article/S1063-4584(15)01127-9/fulltext)
59. Rezaian, M. M., Brent, L. H., Roshani, S., Ziaee, M., Sobhani, F., Dorbeigi, A., Fatehi, Z., Hardy, J., Ragati Haghi, Y., Maghsoudi, T., & Beinaghi, F. (2020). Rheumatology Care Using Telemedicine. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 26(3), 335–340. <https://www.liebertpub.com/doi/full/10.1089/tmj.2018.0256>
60. Kolasinski, S. L., Neogi, T., Hochberg, M. C., Oatis, C., Guyatt, G., Block, J., Callahan, L., Copenhaver, C., Dodge, C., Felson, D., Gellar, K., Harvey, W. F., Hawker, G., Herzig, E., Kwoh, C. K., Nelson, A. E., Samuels, J., Scanzello, C., White, D., Wise, B., ... Reston, J. (2020). 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee. *Arthritis care & research*, 72(2), 149–162. <https://www.rheumatology.org/Portals/0/Files/Osteoarthritis-Guideline-Early-View-2019.pdf>
61. Dickson, L., Cameron, C., Hawker, G., Ratansi, A., Radziunas, I., Bansod, V., & Jaglal, S. (2008). Development of a multidisciplinary osteoporosis telehealth program. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 14(5), 473–478. <https://www.liebertpub.com/doi/pdf/10.1089/tmj.2007.0079>
62. Yu, E. W., Tsourdi, E., Clarke, B. L., Bauer, D. C., & Drake, M. T. (2020). Osteoporosis Management in the Era of COVID-19. *Journal of bone and mineral research : the official journal of the American Society for Bone and Mineral Research*, 35(6), 1009–1013. <https://asbmr.onlinelibrary.wiley.com/doi/full/10.1002/jbmr.4049>
63. Camacho, P. M., Petak, S. M., Binkley, N., Diab, D. L., Eldeiry, L. S., Farooki, A., Harris, S. T., Hurley, D. L., Kelly, J., Lewiecki, E. M., Pessah-Pollack, R., McClung, M., Wimalawansa, S. J., & Watts, N. B. (2020). AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS/AMERICAN COLLEGE OF ENDOCRINOLOGY CLINICAL PRACTICE GUIDELINES FOR THE DIAGNOSIS AND TREATMENT OF

- POSTMENOPAUSAL OSTEOPOROSIS-2020 UPDATE. *Endocrine practice : official journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists*, 26(Suppl 1), 1–46. <https://www.sciencedirect.com/science/article/pii/S1530891X20428277>
64. Vadheim, L. M., Patch, K., Brokaw, S. M., Carpenedo, D., Butcher, M. K., Helgeson, S. D., & Harwell, T. S. (2017). Telehealth delivery of the diabetes prevention program to rural communities. *Translational behavioral medicine*, 7(2), 286–291. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5526819/>
 65. Everett, E., Kane, B., Yoo, A., Dobs, A., & Mathioudakis, N. (2018). A Novel Approach for Fully Automated, Personalized Health Coaching for Adults with Prediabetes: Pilot Clinical Trial. *Journal of medical Internet research*, 20(2), e72. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5849796/>
 66. Grock, S., Ku, J. H., Kim, J., & Moin, T. (2017). A Review of Technology-Assisted Interventions for Diabetes Prevention. *Current diabetes reports*, 17(11), 107. <https://pubmed.ncbi.nlm.nih.gov/28942537/>
 67. Reedy-Cooper, A., Helm, L. & Lee, D. (2020). Metformin to prevent diabetes in patients at increased risk. *American Family Physician*, 102(9), 531-532. <https://www.aafp.org/afp/2020/1101/p531.html>
 68. Crawford-Faucher A. Preventing or Delaying Type 2 Diabetes Mellitus with Diet and Exercise. *Am Fam Physician*. 2018 Dec 1;98(11):643-644. <https://www.aafp.org/afp/2018/1201/p643.html>
 69. Dahy, A., El-Qushayri, A. E., Mahmoud, A. R., Al-Kelany, T. A., & Salman, S. (2020). Telemedicine approach for psoriasis management, time for application? A systematic review of published studies. *Dermatologic therapy*, 33(6), e13908. <https://onlinelibrary.wiley.com/doi/full/10.1111/dth.13908>
 70. Armstrong, A. W., Chambers, C. J., Maverakis, E., Cheng, M. Y., Dunnick, C. A., Chren, M. M., Gelfand, J. M., Wong, D. J., Gibbons, B. M., Gibbons, C. M., Torres, J., Steel, A. C., Wang, E. A., Clark, C. M., Singh, S., Kornmehl, H. A., Wilken, R., Florek, A. G., Ford, A. R., Ma, C., ... Lane, C. J. (2018). Effectiveness of Online vs In-Person Care for Adults With Psoriasis: A Randomized Clinical Trial. *JAMA network open*, 1(6), e183062. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2705854>
 71. Weigle, N., & McBane, S. (2013). Psoriasis. *American family physician*, 87(9), 626–633. <https://www.aafp.org/afp/2013/0501/p626.html>
 72. Beer, J., Haderler, E., Calume, A., Gitlow, H., & Nouri, K. (2021). Teledermatology: current indications and considerations for future use. *Archives of dermatological research*, 313(1), 11–15. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7570421/>
 73. Ferucci, E. D., Day, G. M., Choromanski, T. L., & Freeman, S. L. (2020). Outcomes and quality of care in rheumatoid arthritis with or without video telemedicine follow-up visits. *Arthritis care & research*, 10.1002/acr.24485. Advance online publication. <https://onlinelibrary.wiley.com/doi/epdf/10.1002/acr.24485>
 74. Rezaian, M. M., Brent, L. H., Roshani, S., Ziaee, M., Sobhani, F., Dorbeigi, A., Fatehi, Z., Hardy, J., Ragati Haghi, Y., Maghsoudi, T., & Beinaghi, F. (2020). Rheumatology Care Using Telemedicine. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 26(3), 335–340. <https://pubmed.ncbi.nlm.nih.gov/31084537/>
 75. McDougall, J. A., Ferucci, E. D., Glover, J., & Fraenkel, L. (2017). Telerheumatology: A Systematic Review. *Arthritis care & research*, 69(10), 1546–1557. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5436947/>
 76. Singh, J. A., Saag, K. G., Bridges, S. L., Jr, Akl, E. A., Bannuru, R. R., Sullivan, M. C., Vaysbrot, E., McNaughton, C., Osani, M., Shmerling, R. H., Curtis, J. R., Furst, D. E., Parks, D., Kavanaugh, A., O'Dell, J., King, C., Leong, A., Matteson, E. L., Schousboe, J. T., Drevlow, B., ... McAlindon, T. (2016). 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis & rheumatology (Hoboken, N.J.)*, 68(1), 1–26. <https://www.rheumatology.org/Portals/0/Files/ACR%202015%20RA%20Guideline.pdf>
 77. Houman, J. J., Eleswarapu, S. V., & Mills, J. N. (2020). Current and future trends in men's health clinics. *Translational andrology and urology*, 9(Suppl 2), S116–S122. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7108990/>
 78. Shahinyan, R. H., Amighi, A., Carey, A. N., Yoffe, D. A., Hodge, D. C., Pollard, M. E., Nork, J. J., Mills, J. N., & Eleswarapu, S. V. (2020). Direct-To-Consumer Internet Prescription Platforms Overlook Crucial Pathology Found During Traditional Office Evaluation of Young Men With Erectile Dysfunction. *Urology*, 143, 165–172. <https://pubmed.ncbi.nlm.nih.gov/32535075/>
 79. Qaseem A, Horwitch CA, Vijan S, Etxeandia-Ikobaltzeta I, Kansagara D; Clinical Guidelines Committee of the American College of Physicians. Testosterone Treatment in Adult Men With Age-Related Low Testosterone: A Clinical Guideline From the American College of Physicians. *Ann Intern Med*. 2020 Jan 21;172(2):126-133. <https://www.acpjournals.org/doi/10.7326/M19-0882>
 80. Powers, J.S. & Abraham, L. (2020). Outpatient-focused advance care planning: Telehealth consultation for geriatric primary care patients. *Palliative Medicine and Hospice Care*, 6(1), 1-4. https://www.academia.edu/44119311/Outpatient_Focused_Advance_Care_Planning_Telehealth_Consultation_for_Geriatric_Primary_Care_Patients
 81. American Academy of Family Physicians. (2020). *Annual wellness visit*. <https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/annual-wellness-visits.html>
 82. Stifani, B.M., Avila, K. & Levi, E.E. (2020). Telemedicine for contraceptive counseling: An exploratory survey of US family planning providers following rapid adoption of services during the COVID-19 pandemic. *Contraception*, S0010-7824(20)30416-9. Advance online publication. <https://www.sciencedirect.com/science/article/abs/pii/S0010782420304169>
 83. Sundstrom, B., DeMaria, A. L., Ferrara, M., Meier, S., & Billings, D. (2019). "The Closer, the Better:" The Role of Telehealth in Increasing Contraceptive Access Among Women in Rural South Carolina. *Maternal and child health journal*, 23(9), 1196–1205. <http://website60s.com/upload/files/maternal-and-child-health-journal-v23-iss9-a7.pdf>
 84. Wakefield, B. J., Ward, M. M., Holman, J. E., Ray, A., Scherubel, M., Burns, T. L., Kienzle, M. G., & Rosenthal, G. E. (2008). Evaluation of home telehealth following hospitalization for heart failure: a randomized trial. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 14(8), 753–761. <https://www.liebertpub.com/doi/pdf/10.1089/tmj.2007.0131>

85. Khairat, S., Tirtanadi, K., Ottmar, P., Gudhe, R., & Austin, C. A. (2019). Would Geriatric Patients Accept Using a Telemedicine Platform for Post ICU-Discharge Follow-Up Visits?. *Studies in health technology and informatics*, 264, 1233–1237. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6756478/>
86. Pala, P., Bergler-Czop, B. S., & Gwiżdż, J. M. (2020). Teledermatology: idea, benefits and risks of modern age - a systematic review based on melanoma. *Advances in dermatology and allergology*, 37(2), 159–167. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7262815/>
87. Ferrándiz, L., Ojeda-Vila, T., Corrales, A., Martín-Gutiérrez, F. J., Ruíz-de-Casas, A., Galdeano, R., Álvarez-Torralba, I., Sánchez-Ibáñez, F., Domínguez-Toro, J. M., Encina, F., Narbona, F. J., Herreras-Esteban, J. M., & Moreno-Ramírez, D. (2017). Internet-based skin cancer screening using clinical images alone or in conjunction with dermoscopic images: A randomized teledermoscopy trial. *Journal of the American Academy of Dermatology*, 76(4), 676–682. [https://www.jaad.org/article/S0190-9622\(16\)31017-9/fulltext](https://www.jaad.org/article/S0190-9622(16)31017-9/fulltext)
88. Piccolo, D., Smolle, J., Wolf, I. H., Peris, K., Hofmann-Wellenhof, R., Dell'Eva, G., Burroni, M., Chimenti, S., Kerl, H., & Soyer, H. P. (1999). Face-to-face diagnosis vs telediagnosis of pigmented skin tumors: a teledermoscopic study. *Archives of dermatology*, 135(12), 1467–1471. <https://jamanetwork.com/journals/jamadermatology/fullarticle/478128>
89. Beer, J., Hadelner, E., Calume, A., Gitlow, H., & Nouri, K. (2021). Teledermatology: current indications and considerations for future use. *Archives of dermatological research*, 313(1), 11–15. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7570421/>
90. American Telemedicine Association. (2016). *Practice guidelines for dermatology*. <https://www.americantelemed.org/resources/practice-guidelines-for-teledermatology/>
91. Women's Preventative Services Initiative & The American College of Obstetricians and Gynecologists. (2020). *Telehealth FAQ for preventative care*. <https://www.womenspreventivehealth.org/faqs/>
92. Women's Preventative Services Initiative & The American College of Obstetricians and Gynecologists. (2020). *Well-woman chart: Recommendations for well-woman care*. <https://www.womenspreventivehealth.org/wellwomanchart/>
93. U.S. Centers for Medicare & Medicaid Services. *Cervical & vaginal cancer screenings*. <https://www.medicare.gov/coverage/cervical-vaginal-cancer-screenings>
94. Branstetter, M. & Garrett-Wright, D. (2017). Practice Matters: Red Flags in Evaluating Adult Abdominal Pain. *International Journal of Faith Community Nursing*, 3(1), Article 5. <http://digitalcommons.wku.edu/ijfcn/vol3/iss1/5>
95. Cronau, H., Kankanala, R. R., & Mauger, T. (2010). Diagnosis and management of red eye in primary care. *American family physician*, 81(2), 137–144. <https://www.aafp.org/afp/2010/0115/p137.html>
96. Arce, D. A., Ermocilla, C. A., & Costa, H. (2002). Evaluation of constipation. *American family physician*, 65(11), 2283–2290. <https://www.aafp.org/afp/2002/0601/p2283.html#afp20020601p2283-f1>
97. Dobrusin, A., Hawa, F., Gladsheteyn, M., Corsello, P., Harlen, K., Walsh, C. X., Alaparthy, L., Weinstein, M., Baig, N., Sousa, A., & Gunaratnam, N. T. (2020). Gastroenterologists and Patients Report High Satisfaction Rates With Telehealth Services During the Novel Coronavirus 2019 Pandemic. *Clinical gastroenterology and hepatology : the official clinical practice journal of the American Gastroenterological Association*, 18(11), 2393–2397.e2. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7352104/>
98. Riddle, M. S., DuPont, H. L., & Connor, B. A. (2016). ACG Clinical Guideline: Diagnosis, Treatment, and Prevention of Acute Diarrheal Infections in Adults. *The American journal of gastroenterology*, 111(5), 602–622. https://journals.lww.com/ajg/Fulltext/2016/05000/ACG_Clinical_Guideline_Diagnosis_Treatment_and.14.aspx
99. Shane, A.L., Mody, R.K., Crump, J.A., Tarr, P.I., Steiner, T.S., Kotloff, K., Langley, J.M., Wanke, C., Warren, C.A., Cheng, A.C., Cantey, J. & Pickering, L.K. (2017) Infectious Diseases Society of America Clinical Practice Guidelines for the Diagnosis and Management of Infectious Diarrhea. *Clinical Infectious Diseases*, 65(12), e45–e80. <https://academic.oup.com/cid/article/65/12/e45/4557073>
100. Chari, D. A., Wu, M. J., Crowson, M. G., Kozin, E. D., & Rauch, S. D. (2020). Telemedicine Algorithm for the Management of Dizzy Patients. *Otolaryngology--head and neck surgery : official journal of American Academy of Otolaryngology-Head and Neck Surgery*, 163(5), 857–859. <https://journals.sagepub.com/doi/full/10.1177/0194599820935859>
101. Bhattacharyya, N., Gubbels, S. P., Schwartz, S. R., Edlow, J. A., El-Kashlan, H., Fife, T., Holmberg, J. M., Mahoney, K., Hollingsworth, D. B., Roberts, R., Seidman, M. D., Steiner, R. W., Do, B. T., Voelker, C. C., Waguespack, R. W., & Corrigan, M. D. (2017). Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update). *Otolaryngology--head and neck surgery : official journal of American Academy of Otolaryngology-Head and Neck Surgery*, 156(3_suppl), S1–S47. https://journals.sagepub.com/doi/10.1177/0194599816689667?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%20%20pubmed
102. Burnett, A. L., Nehra, A., Breau, R. H., Culkin, D. J., Faraday, M. M., Hakim, L. S., Heidelbaugh, J., Khera, M., McVary, K. T., Miner, M. M., Nelson, C. J., Sadeghi-Nejad, H., Seftel, A. D., & Shindel, A. W. (2018). Erectile Dysfunction: AUA Guideline. *The Journal of urology*, 200(3), 633–641. [https://www.auanet.org/guidelines/erectile-dysfunction-\(ed\)-guideline](https://www.auanet.org/guidelines/erectile-dysfunction-(ed)-guideline)
103. Bernocchi, P., Giordano, A., Pintavalle, G., Galli, T., Ballini Spoglia, E., Baratti, D., & Scalvini, S. (2019). Feasibility and Clinical Efficacy of a Multidisciplinary Home-Telehealth Program to Prevent Falls in Older Adults: A Randomized Controlled Trial. *Journal of the American Medical Directors Association*, 20(3), 340–346. <https://www.sciencedirect.com/science/article/abs/pii/S1525861018304948>
104. Vance J. (2012). The clinical practice guideline for falls and fall risk. *Translational behavioral medicine*, 2(2), 241–243. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717891/>

105. Phelan, E. A., Mahoney, J. E., Voit, J. C., & Stevens, J. A. (2015). Assessment and management of fall risk in primary care settings. *The Medical clinics of North America*, 99(2), 281–293. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707663/>
106. Hainer, B. L., & Matheson, E. M. (2013). Approach to acute headache in adults. *American family physician*, 87(10), 682–687. <https://www.aafp.org/afp/2013/0515/p682.html>
107. Centers for Disease Control and Prevention. (2015). Morbidity and Mortality Weekly Report. *Sexually transmitted disease treatment guidelines, 2015*, 64(3). <https://www.cdc.gov/std/tg2015/tg-2015-print.pdf>
108. Frid, S. A., Ratti, M., Pedretti, A., Pollan, J., Martínez, B., Abreu, A. L., Diodati, G., López, G., Sommer, J., Luna, D., & Plazzotta, F. (2019). Telemedicine for Upper Respiratory Tract Infections During 2018 Epidemiological Outbreak in South America. *Studies in health technology and informatics*, 264, 586–590. [https://www.hospitalitaliano.org.ar/multimedia/archivos/servicios_attachs/12756_SHTI-264-SHTI190290_\(1\).pdf](https://www.hospitalitaliano.org.ar/multimedia/archivos/servicios_attachs/12756_SHTI-264-SHTI190290_(1).pdf)
109. Centers for Disease Control and Prevention. (2017). Antibiotic prescribing and use in doctor’s offices. *Adult treatment recommendations*. <https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/adult-treatment-rec.html>
110. Kinkade, S., & Long, N. A. (2016). Acute Bronchitis. *American family physician*, 94(7), 560–565. <https://www.aafp.org/afp/2016/1001/p560.html>
111. Aring, A. M., & Chan, M. M. (2016). Current Concepts in Adult Acute Rhinosinusitis. *American family physician*, 94(2), 97–105. <https://www.aafp.org/afp/2016/0715/p97.html>
112. Novara, G., Checcucci, E., Crestani, A., Abrate, A., Esperto, F., Pavan, N., De Nunzio, C., Galfano, A., Giannarini, G., Gregori, A., Liguori, G., Bartoletti, R., Porphiglia, F., Scarpa, R. M., Simonato, A., Trombetta, C., Tubaro, A., Ficarra, V., & Research Urology Network (RUN) (2020). Telehealth in Urology: A Systematic Review of the Literature. How Much Can Telemedicine Be Useful During and After the COVID-19 Pandemic?. *European urology*, 78(6), 786–811. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7301090/>
113. Murray, M. A., Penza, K. S., Myers, J. F., Furst, J. W., & Pecina, J. L. (2020). Comparison of eVisit Management of Urinary Symptoms and Urinary Tract Infections with Standard Care. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 26(5), 639–644. <https://www.liebertpub.com/doi/full/10.1089/tmj.2019.0044>
114. Lin L., Fernandez A.C. & Bonar E.E. (2020). Telehealth for Substance-Using Populations in the Age of Coronavirus Disease 2019: Recommendations to Enhance Adoption. *JAMA Psychiatry*, 77(12), 1209–1210. <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2767300#vvp200026r9>
115. Kruse, C. S., Lee, K., Watson, J. B., Lobo, L. G., Stoppelmoor, A. G., & Oyibo, S. E. (2020). Measures of Effectiveness, Efficiency, and Quality of Telemedicine in the Management of Alcohol Abuse, Addiction, and Rehabilitation: Systematic Review. *Journal of medical Internet research*, 22(1), e13252. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7055825/>
116. Lin, L. A., Casteel, D., Shigekawa, E., Weyrich, M. S., Roby, D. H., & McMenamain, S. B. (2019). Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. *Journal of substance abuse treatment*, 101, 38–49. https://www.researchgate.net/publication/331943000_Telemedicine-delivered_treatment_interventions_for_substance_use_disorders_A_systematic_review
117. Centers for Medicare and Medicaid Services, Department of Health and Human Services. (2020). CMCS Informational Bulletin. *Rural health care and Medicaid telehealth flexibilities, and guidance regarding section 1009 of the substance use-disorder prevention that promotes opioid recovery and treatment (SUPPORT) for patients and communities act (pub. L. 115-271)*, entitled *Medicaid substance use disorder treatment via telehealth*. <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf>
118. Oregon Health Authority, Public Health Division. (2020). Public Health recommendations for community behavioral health services. *Risk benefit assessment of in-person mental health, problem gambling, and substance use disorder*. <https://sharingsystems.dhsoha.state.or.us/DHSForms/Served/1e3224.pdf>
119. Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*, 19(6), 444–454. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662387/>
120. Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review. *Acta informatica medica : AIM : journal of the Society for Medical Informatics of Bosnia & Herzegovina*, 25(4), 240–246. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/>
121. Locke, A. B., Kirst, N., & Shultz, C. G. (2015). Diagnosis and management of generalized anxiety disorder and panic disorder in adults. *American family physician*, 91(9), 617–624. <https://www.aafp.org/afp/2015/0501/p617.html>