MIFE BY MAIL: FINDINGS FROM A TELEMEDICINE ABORTION SERVICE IN THE U.S.

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14 September 2018

13th FIAPAC Conference

TelAbortion
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HEALTH PROJECTS

Background

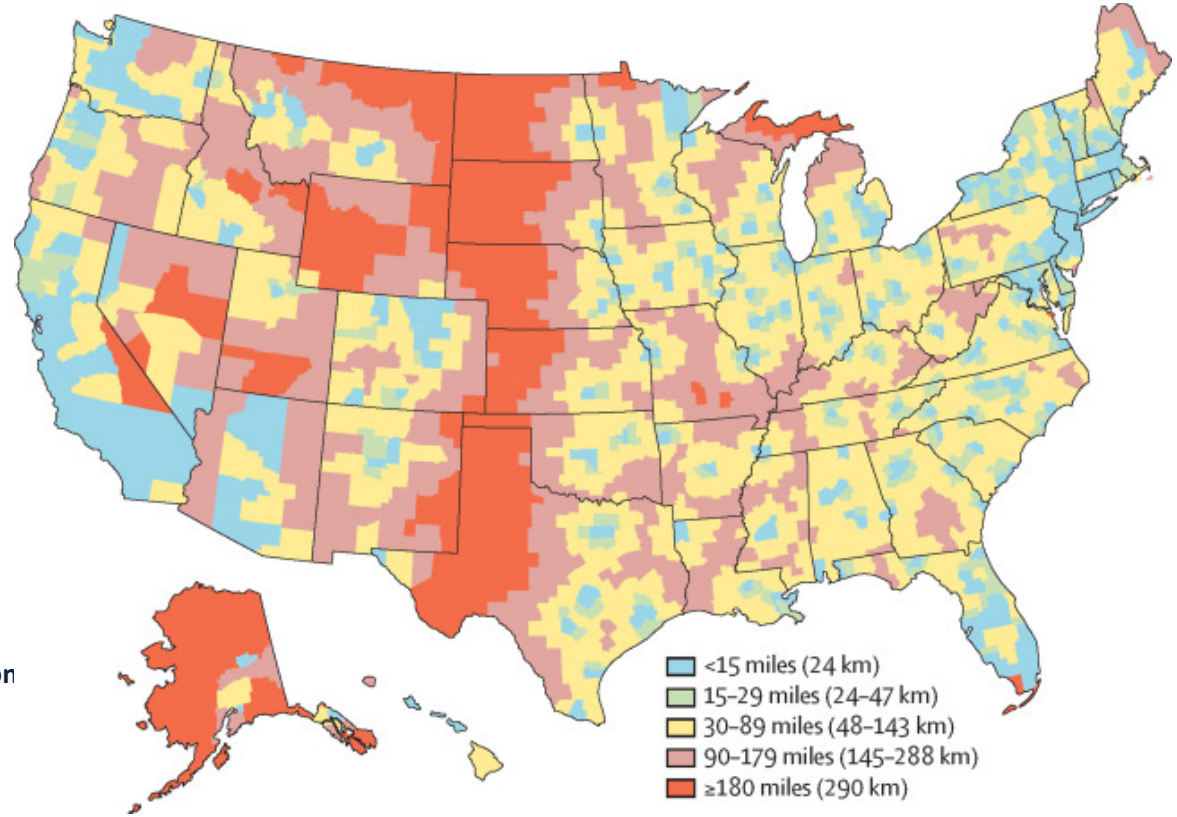
- Due to high efficacy and safety of medical abortion, the pills are increasingly being accessed via telemedicine (TM)
- Several online services (including WoW, WHW) mail pills to women but they do not ship to U.S.
- Countries like Australia have successful TM abortion programs

U.S. Context

Encouraging conditions to try a direct-to-patient (DTP) model

- Safety and acceptability of site-to-site models established
- Mifepristone label revised in March 2016, allowed mifepristone to be taken outside of clinic/office
- DTP models used for other RH indications

Urgent need for DTP model



Median distance to the nearest abortion provider by county, 2014
Bearak, Burke, and Jones, Lancet Public Health 2017.

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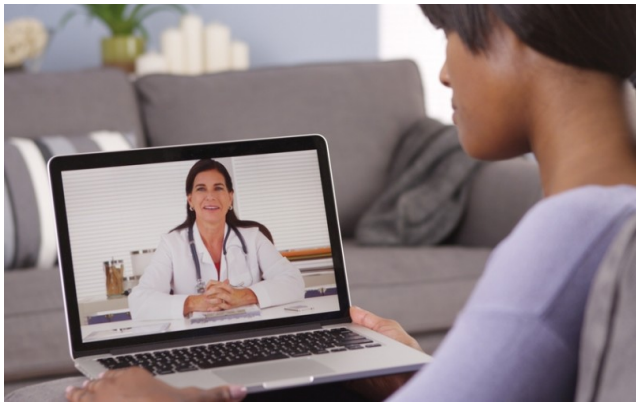
Patient has Video Evaluation with abortion provider, e-signs consent forms, obtains screening tests locally and results sent to provider

↓

Provider reviews results of screening tests, if eligible, provider sends pills to her by mail

↓

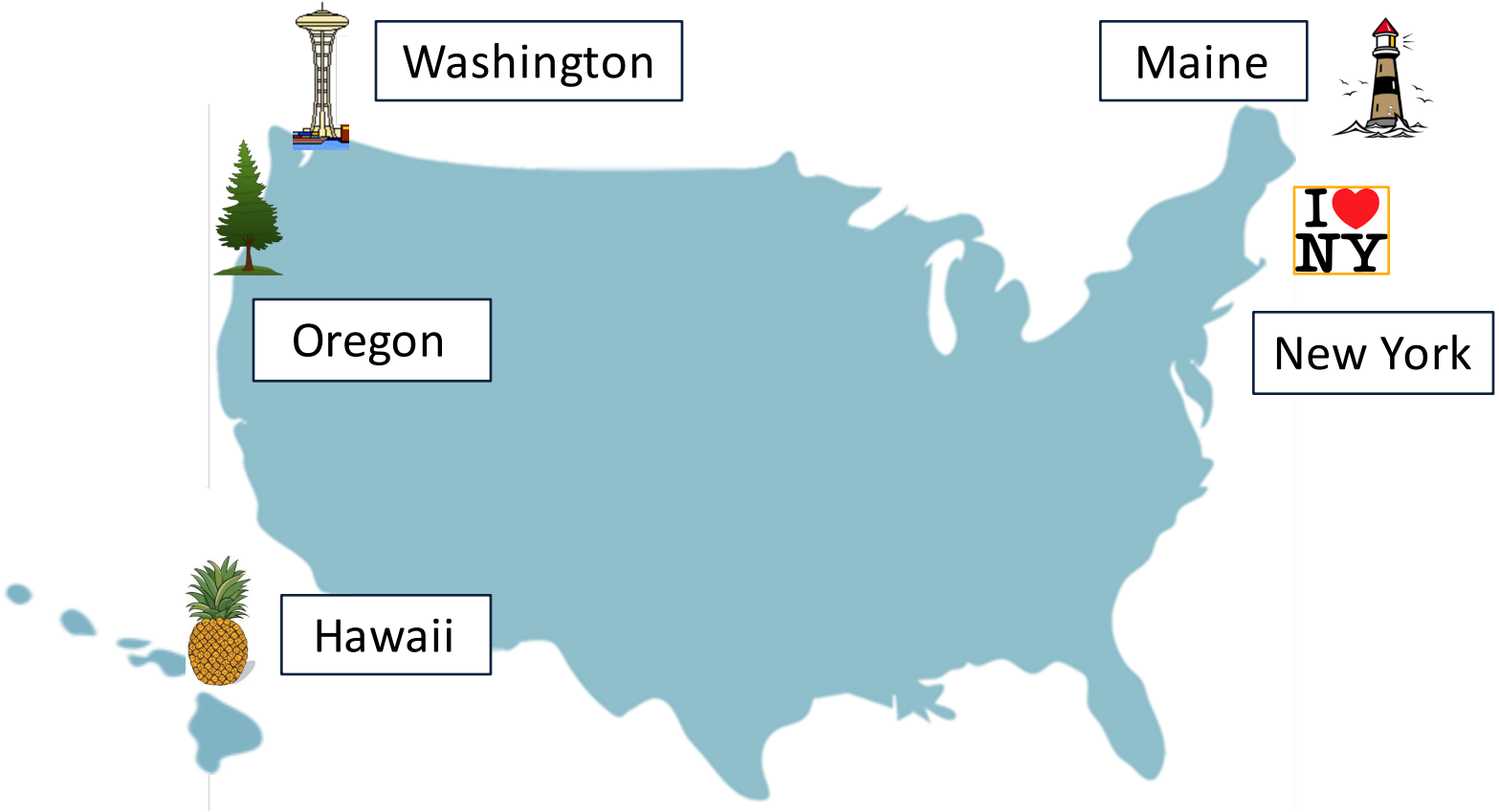
Patient takes medications, obtains F/U tests locally. Follow up consultation 7-14 days



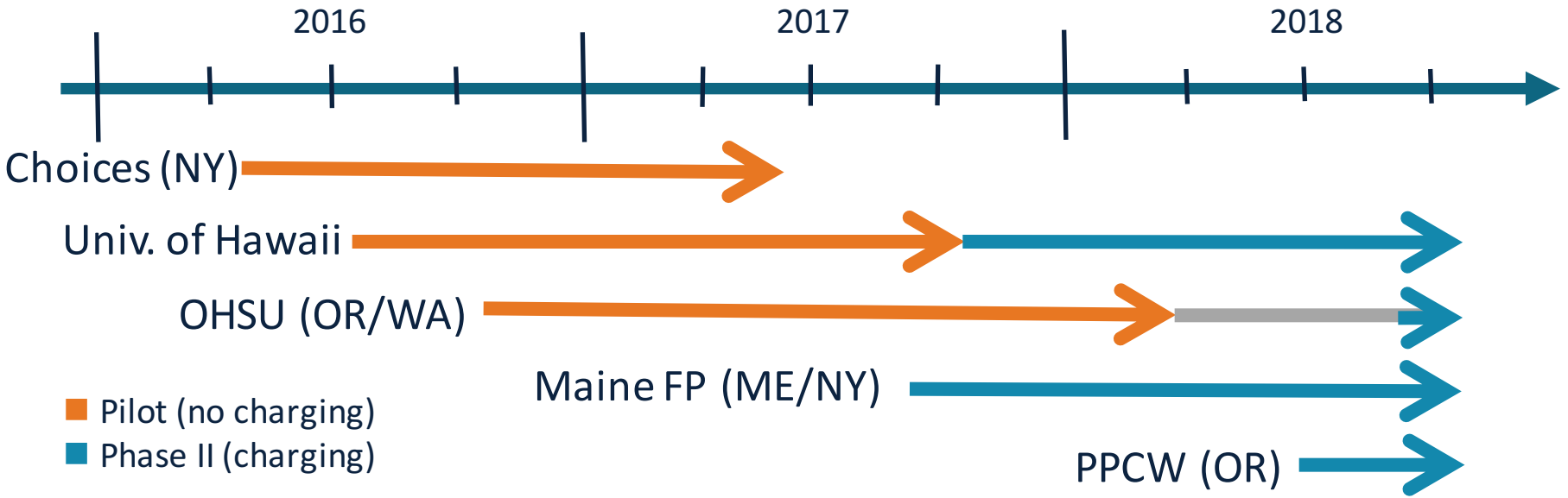
The TelAbortion Study

- Objectives: to study the safety, feasibility, and acceptability of the service
- Sample size: 1000
- Study filed with FDA

Current States

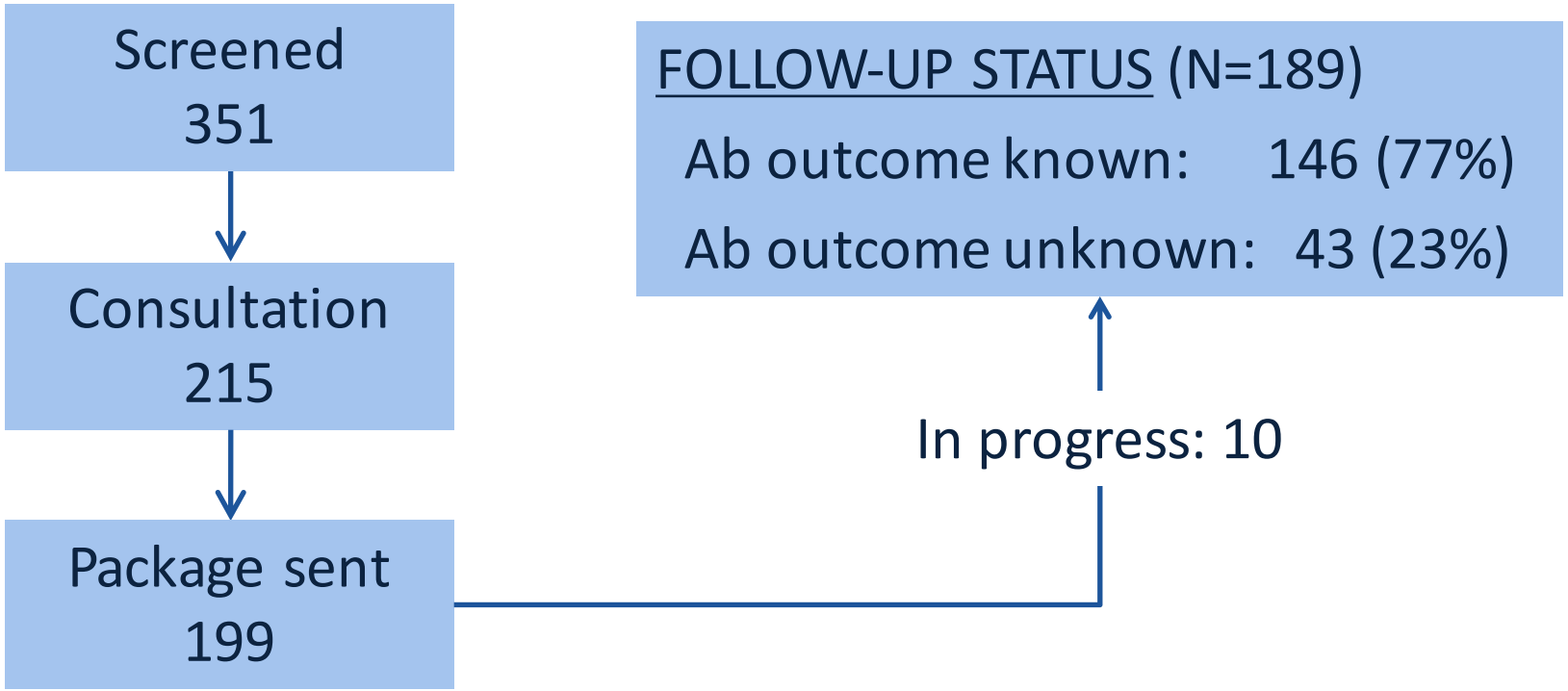


Project Timeline

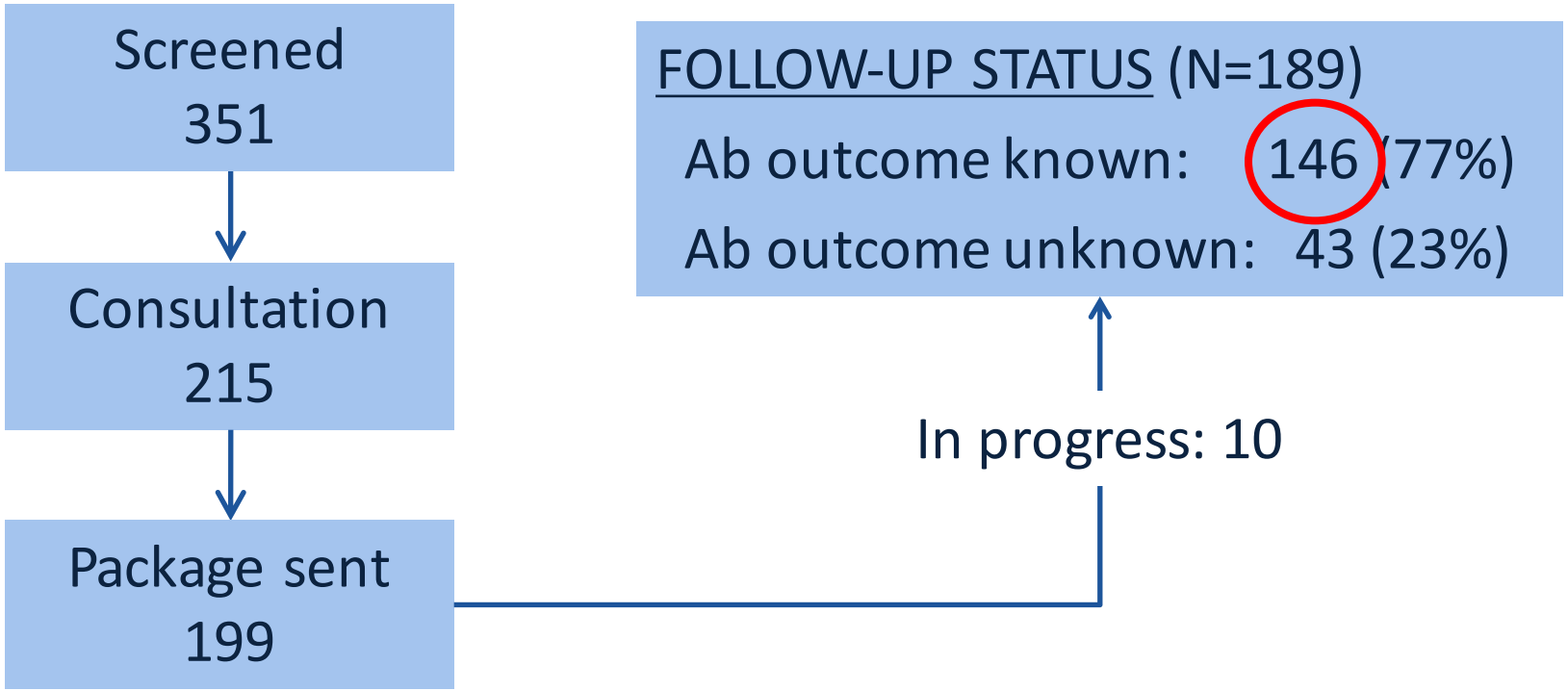


CLINICAL FINDINGS as of September 10

Enrollment and Follow-up



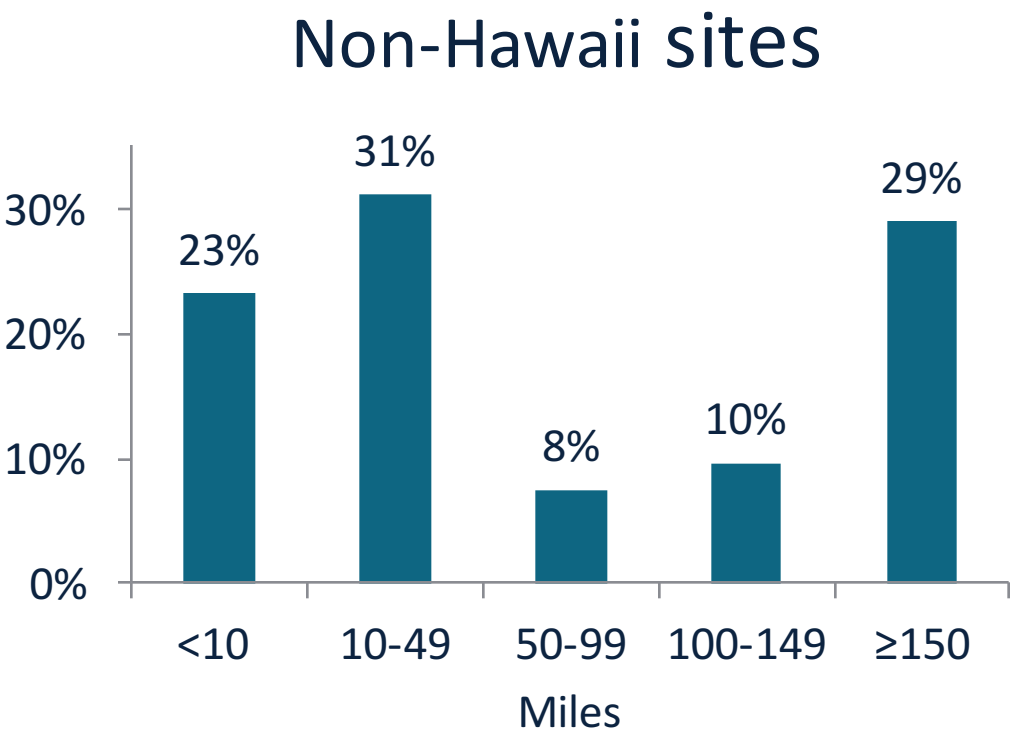
Enrollment and Follow-up



Patient Characteristics at Consultation

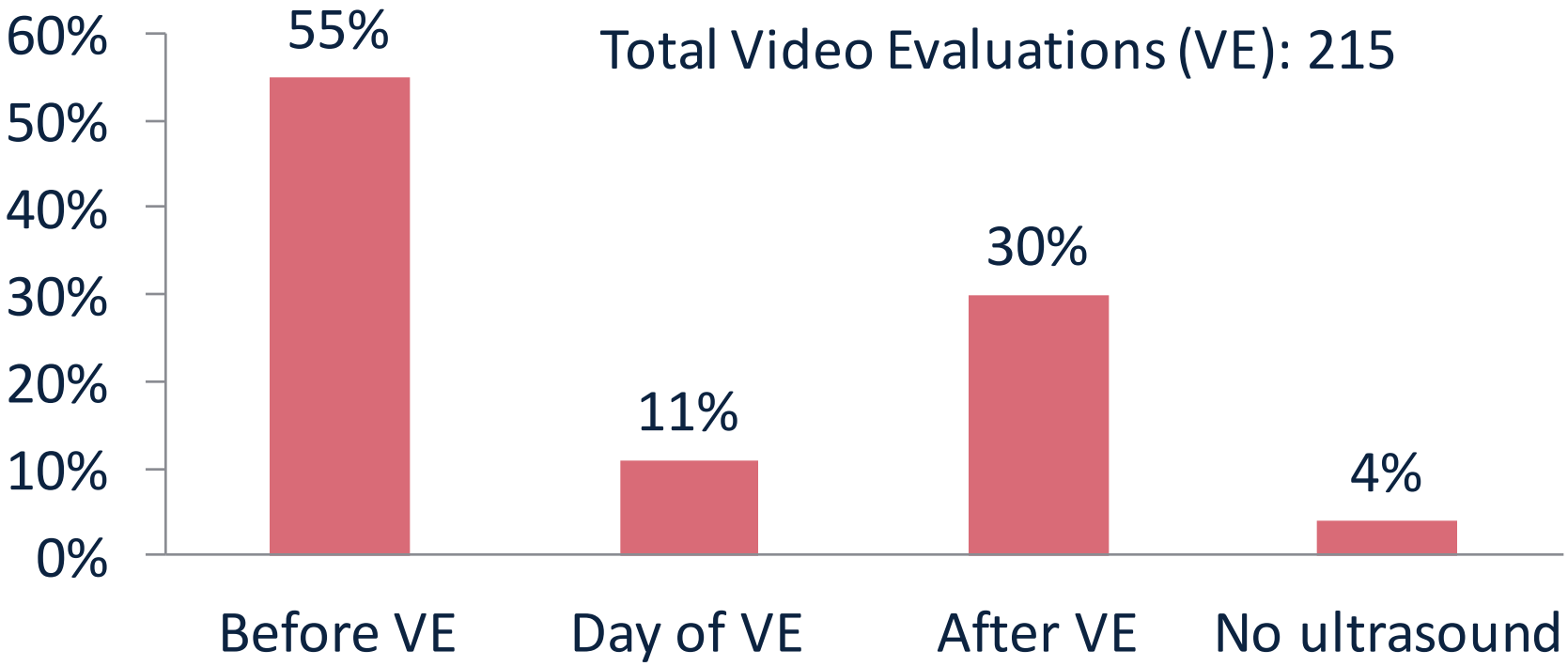
- Age range: 15-45 (median 28)
- Completed more than HS education: 64%
- Had previous MA: 17%
- GA at Video Evaluation: 26-68 days (median 48 days)

Distance from Site



61% lived on island other than Oahu

Timing of Ultrasound



Abortion Outcomes

	N=146
Complete without surgery	137 (94%)
Complete with surgery	8 (6%)
Continuing pregnancy	1 (1%)

1 chose surgical Ab
2 (at least) had ongoing pgs
5 had bleeding/incomplete Ab

Documentation of Complete MA

	N=137*
Ultrasound	68 (50%)
Serum HCGs	45 (33%)
Urine pregnancy test	27 (20%)
None of the above	5 (4%)

78% had US or HCGs

2 confirmed by outside clinician
1 HCG=184 mIU/ml 10 d after mife
1 miscarried before taking mife
1 incomplete data

*Some had >1 test

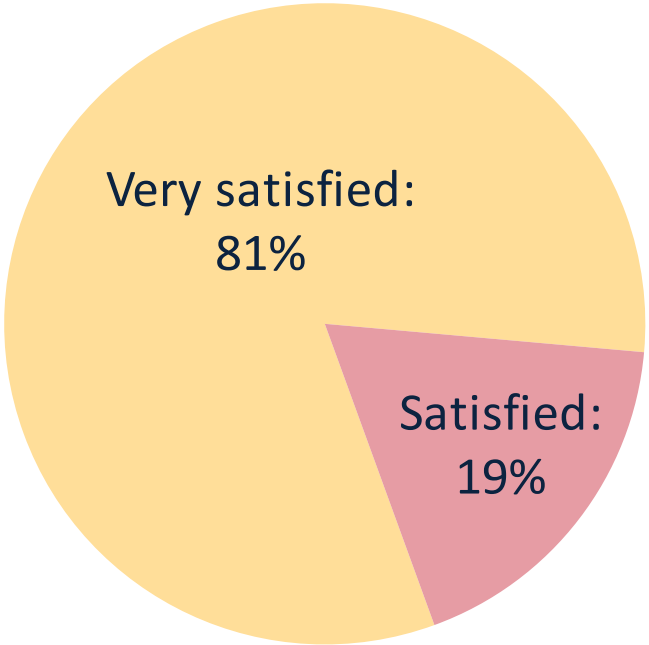
Feasibility

- 87% of packages were sent within 2 weeks after initial study contact (range 0-30 days)
- No packages were lost
- All women took mife at GA ≤ 72 days
- 5 of 7 Rh-negative women who took mife got Rh immune globulin

Complications

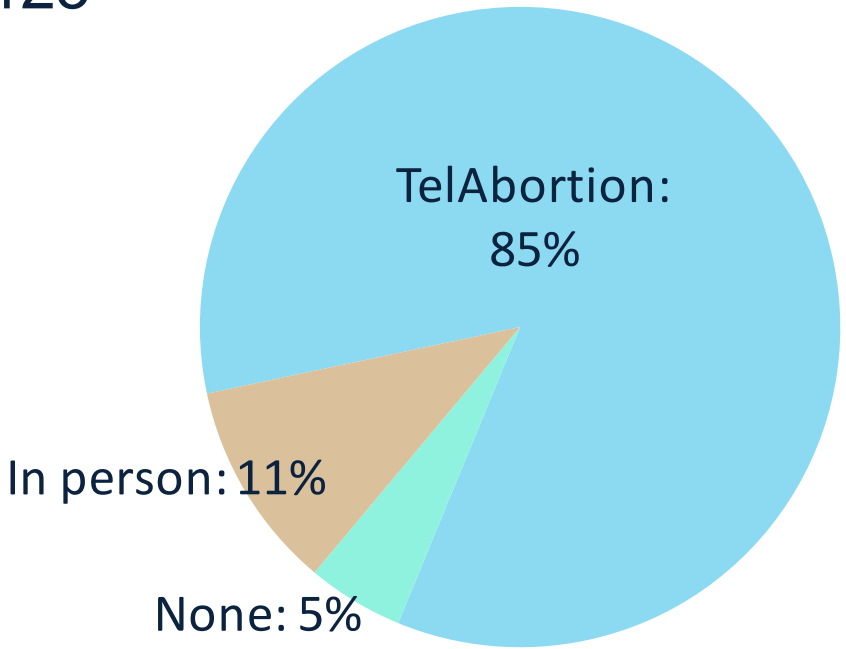
- No related significant complications
- 1 hospitalization for seizure after aspiration
- 15 emergency department visits
  - 1 to get RhIg
  - 1 for flank pain unrelated to abortion
  - 13 for bleeding/cramping

Satisfaction

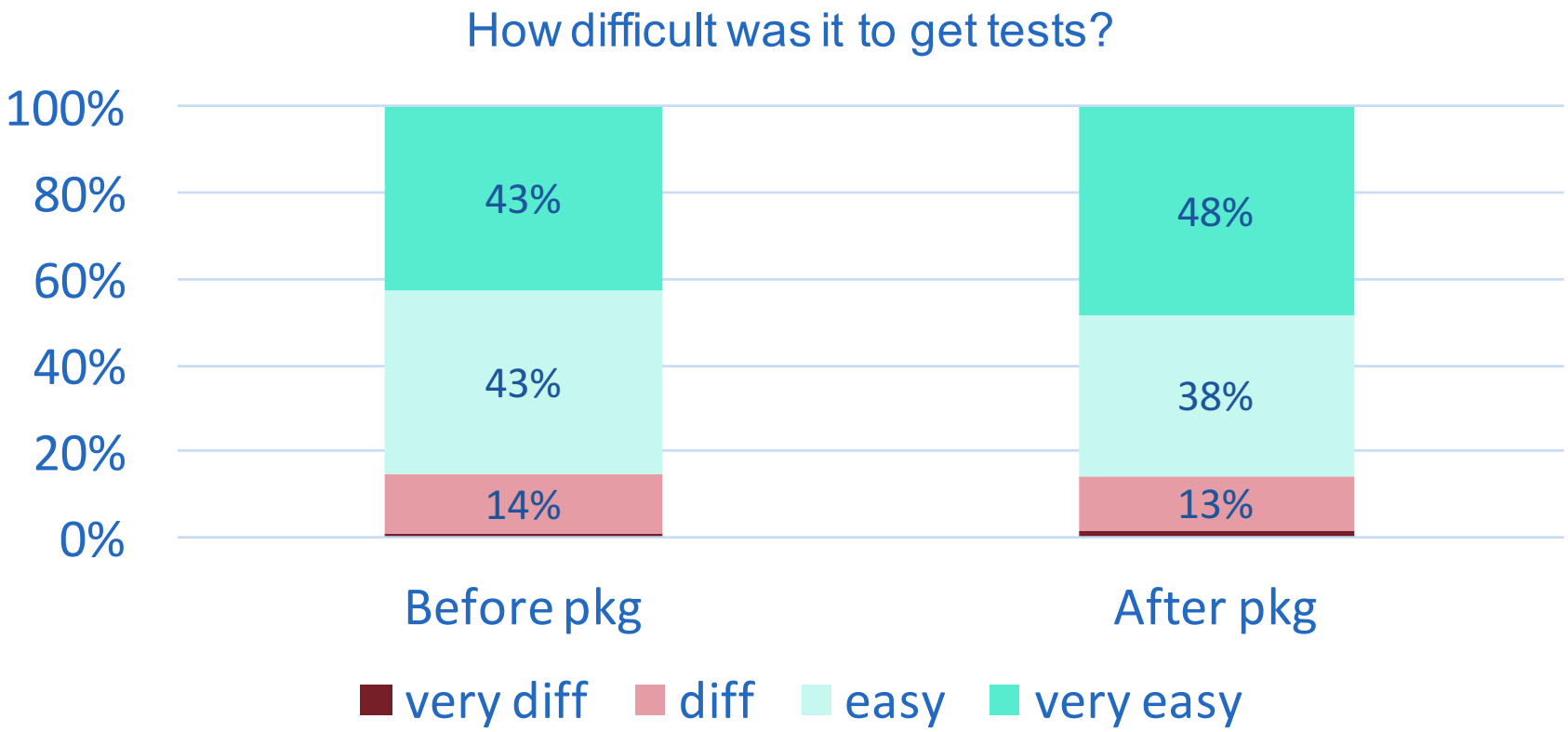


Future Preference

N=123



Pre- and post-abortion tests



Why Choose TA Again?

Protests at the clinic – too intense

Privacy, separate from usual doctor system

Convenience, better than sitting in an office all day

Valuable to be at home due to it being an emotional process

No abortion services on island. Would do it in clinic if it were available

Why Prefer In Person Abortion?

I would prefer to do a surgical abortion instead to have it over with quicker

Due to pain of medical abortion

There were a lot of steps required to get the package

I would prefer to see someone face to face

Conclusions

- Success rates among TelAbortion patients are comparable to that reported among in-clinic patients
- Direct-to-patient provision is highly acceptable to both patients and providers
- Allowing more flexibility in how patients are screened and followed up would add convenience and reduce cost to the patient

Future Plans

- Expand to new states (new sites or cross-state provision)
- Simplify abortion procedures
- Provide data to support changes to restrictions on mifepristone
- Develop strategies to reach disadvantaged populations that might particularly benefit from this model

Collaborators

University of Hawaii
- Bliss Kaneshiro

Maine Family Planning
- Leah Coplon

Choices Women's Medical Center
- George McMillan

Planned Parenthood Columbia Willamette
- Paula Bednarek

Oregon Health & Science University
- Maureen Baldwin

Gynuity Health Projects
- Elizabeth Raymond, Inga Platais, Tanya Lotarevich, Roxanne Martin, Andrea Lopez, Beverly Winikoff

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www.telabortion.org

Thank you!!

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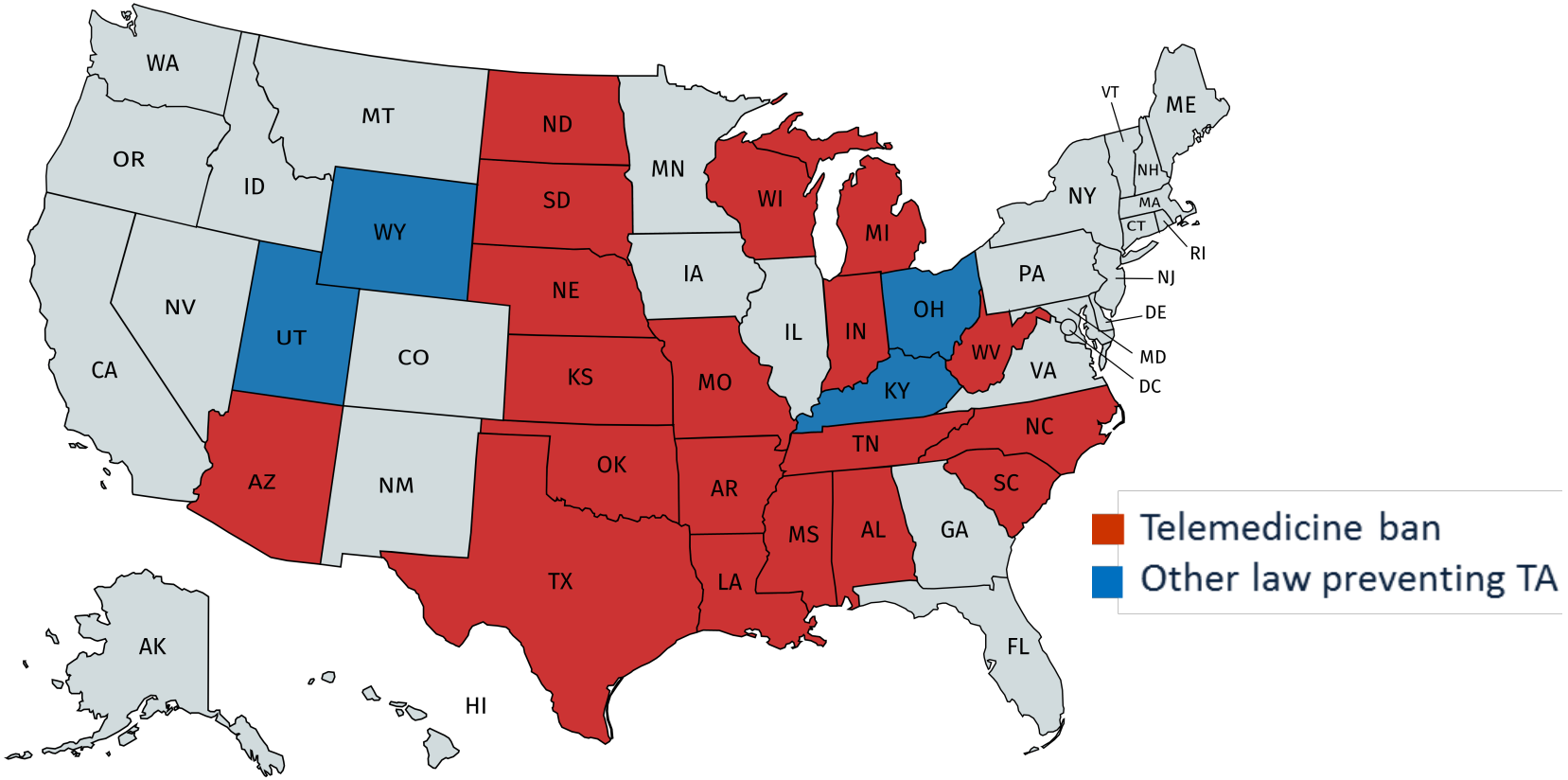
Gynuity HEALTH PROJECTS

www.gynuity.org

States that Prohibit Telemedicine Abortion

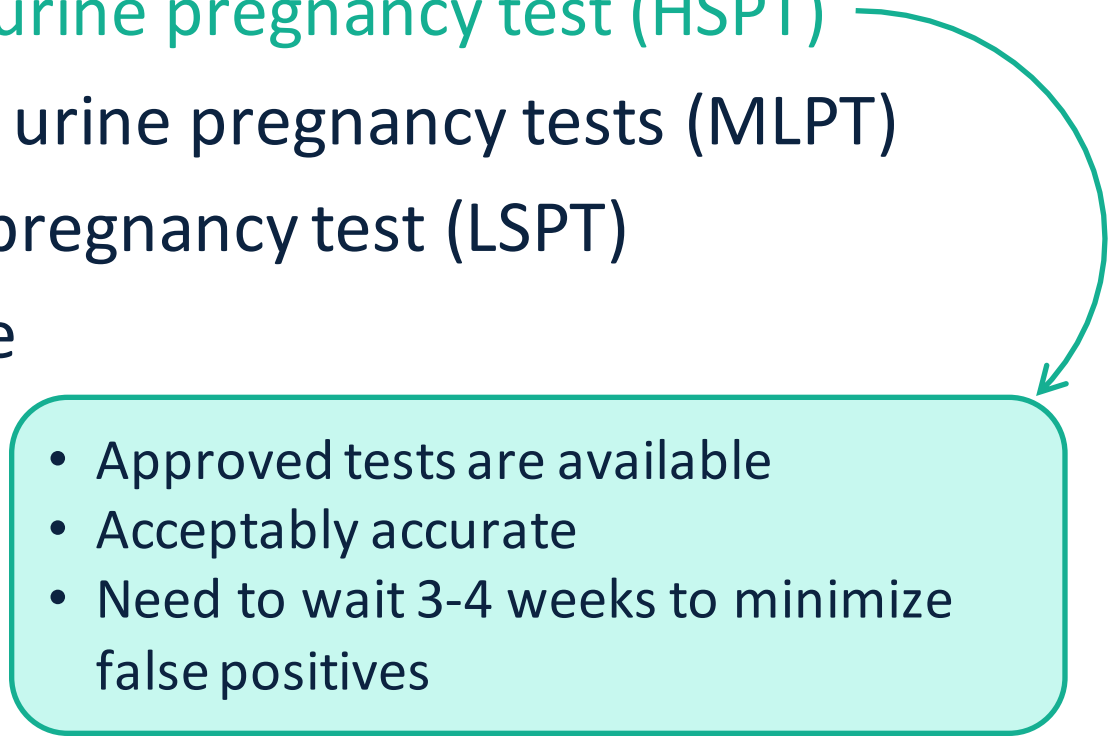


3. Home-Based Follow-Up

- Ultrasound and serum HCGs are costly, invasive, inconvenient
- Currently using urine tests mostly as a backup
  - 18% of pts were assessed only with urine test

Options

- High sensitivity urine pregnancy test (HSPT)
- Serial multilevel urine pregnancy tests (MLPT)
- Low-sensitivity pregnancy test (LSPT)
- Symptoms alone



Summary of Considerations

All would be more convenient and cheaper, and enhance autonomy

But!

	HSPT	2 MLPTs	LSPT	Symptoms
Delayed detection of failure	x		x	x
Increased loss to follow-up?	x	x	x	x
False results			x	x
Non standard approach		x	x	x
Uses “investigational product”		x	x	

4. Rh Testing and Rh Ig

Problems with Rh testing and Rh Ig

- Patient: Getting test/drug is inconvenient and costly
- Provider: Connecting pt with source of Rh Ig is onerous

Not clear that Rh Ig Is needed in early abortion

Current protocol requires neither Rh testing nor Rh Ig if Rh-negative

Our Study

7/180 (4%) of women who got pkg were Rh-negative

- 5 got Rh Ig, all at a doctor's office
- 1 was referred but apparently opted out due to cost
- 1 planned to opt out of Rh Ig but was lost

1 nulligravid patient (a surgeon!) opted out of Rh typing and RhIg

Rationale for Simplified Screening

- Lots of data indicate that LMP alone is sufficient to confirm GA in most women
- Ectopic pregnancy is very rare

1. Reducing Cost to Patient

To date, cost has not appeared to be a major barrier for TA

- Only 13% of women who declined VE cited cost as a factor
- 65% paid <$100 out of pocket (as of exit interview date)
- In pilot, 76% said they would have paid $350 above what they had already paid out of pocket

<u>BUT</u>

- 61% of patients were in pilot, so study paid for site care
- Nationally, most abortion patients pay out of pocket

Our Charging Policy

	Pilot	Phase II
Site care	Study	Insurance or self
Outside care (tests, etc.)	Insurance or self	Insurance or self

Planned Payment for Outside Tests

	Choices N=6	UH N=118	OHSU N=59	MFP N=19	PPCW N=4
Private insurance	67%	47%	76%	16%	50%
Medicaid	33%	33%	10%	42%	50%
Self only		18%	14%	37%	
Undecided		2%			
No data				5%	

Planned Payment for Site Care (Phase II)

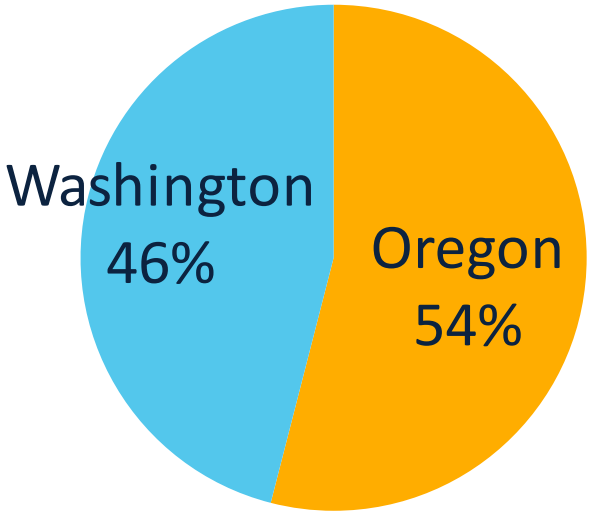
	UH N=42	MFP N=19	PPCW N=24
Private insurance	31%		
Medicaid	40%		50%
Ab fund		53%	
Self only	29%	47%	50%

Cross State Prescribing

Challenges

- Outreach
- Helping pts find facilities
- Retrieving results
- Time zones
- Others??

Total VEs at OHSU: 59



Cross-Border Pickup

Patient in state where TelAbortion is illegal crosses border to pick up meds in state where it is legal

Ex: Patient in Amarillo, Texas

Cross-Border Pickup

3. Developing Referral Networks

Referrals to our service

- Abortion providers who may have long wait times or logistically difficult for woman to get to clinic
- Clinicians who want to provide “everything but abortion”
- Other clinicians who see patients needing abortion
- Reaching beyond ob/gyns and family med docs to midwives, pediatricians, social workers, student health networks, others?

4. Outreach to Women

We want to serve all women, but especially those with the most limited abortion access:

- Rural women
- Low-income women
- Women of color
- Immigrants
- Adolescents
- LGBTQ people
- Incarcerated people
- Women with federal insurance
  - Native Americans
  - Military women and families
  - Other federal employees

How Our Patients Heard about TA

Source	N=330
Clinic staff or website	45%
Another provider	26%
TelAbortion website	13%
Women on Web, etc.	5%
Other	12%