Does Travel Distance Determine Telemedicine Abortion Interest?

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ABSTRACT (152 words)

***Background*:** In the United States, nearly half of all pregnancies are unintended,[1] and women terminate nearly half of unintended pregnancies[2]. We describe barriers abortion patients face, and gauge their interest in utilizing telemedicine abortion practices.

***Methods*:** We conducted 19 patient interviews and surveys, and three interviews of abortion providers at clinics. We designed patient interviews to understand barriers to access and interest in telemedicine abortions. We asked providers about the possibility of telemedicine abortions.

Results: Women reported four common barriers to accessing the abortion: travel, transportation, child care, and cost. They had diverse responses to telemedicine abortions. Overall, eight felt comfortable having their abortion appointment over a video call, and 17 felt comfortable obtaining abortion pills by telemedicine. All providers felt telemedicine abortions were feasible and necessary.

Conclusion: Patients reported barriers to abortions and nearly all felt comfortable with telemedicine. Clinics that add telemedicine services might improve access to abortion for women living in rural communities.

EXTENDED ABSTRACT

***Background*:** In the United States nearly half of all pregnancies are unintended[1] and women terminate nearly half of unintended pregnancies.[2] Women—especially those in low income settings, face diverse barriers to access. Those falling on or below the poverty line are five times more likely to experience unintended pregnancy, and have subsequent abortions.[3] Barriers to access strongly influence disparities in abortion rates. For women in low income settings, the cost of an abortion can seem daunting. Women without Medicaid coverage, or in states where Medicaid coverage is prohibited from being allocated to abortions, are forced to pay an average of 575 dollars out of pocket in abortion related costs.[4] Traveling to the clinic provides an additional barrier for these women. A recent study found that around 10% of women traveled over 100 miles, and another 19% of women traveled 50-100 miles to an abortion providing facility.[5] Previous research shows that rural women are underrepresented in terms of overall abortion patients, which may indicate that these women have less access to abortions.[5] Telemedicine abortions are a proposed solution to geographic barriers. About 19.3% of the United States Population, or 60 million people, live in rural areas, while only 9% of United States physicians practice in rural areas.[6] Telemedicine works to increase access to providers. In 19 states, including Kansas and Oklahoma, telemedicine abortions are illegal.[7] While other states have no legal limitations on telemedicine abortions, only three states, Alaska, Minnesota, and Iowa, provided this service in 2018.[8]

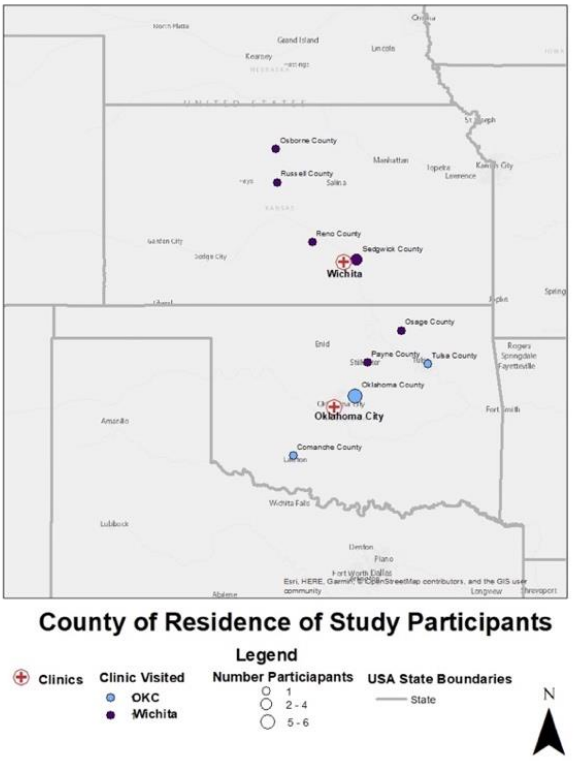
Trust Women's first clinic opened its doors in April of 2013, in Wichita, Kansas. The clinic is located where Dr. George Tiller once practiced before his assassination in 2009, while he was working as the only abortion provider in Wichita. Trust Women opened its second clinic in September of 2016, in Oklahoma City, Oklahoma. In June of 2017, Trust Women assumed operations at a clinic in Seattle, Washington.[9] By utilizing technology Trust Women can allow physicians to communicate with patients via video chat to discuss their abortion care. Telemedicine will also allow Trust Women to provide the medication abortion in a way that does

not require patients to travel great distances to the clinic. While the implementation of telemedicine practices has started in the Washington clinic, Oklahoma and Kansas clinics must overcome legal obstacles before implementation can occur. In this mixed methods study, we interviewed and surveyed patients and providers at the Trust Women Clinics of Wichita, Kansas and Oklahoma City, Oklahoma. We interviewed patients in order to understand barriers abortion patients in face and to gauge their interest in utilizing telemedicine abortion practices.

***Methods*:** We conducted 19 patient interviews and surveys, and 3 interviews of abortion providers at the Trust Women Clinics of Wichita, Kansas and Oklahoma City, Oklahoma. We recruited patients at the clinic during their abortion procedure appointment or their two-week follow-up appointment. Patients were asked about interest in participating after check-in and were interviewed prior to their abortion procedure. In order to be eligible to participate in the study, individuals must be female, over 18, and receiving or received an abortion in the last month, from the Trust Women clinic. We designed semi-structured patient interviews to gain an in-depth understanding of their past reproductive healthcare, their experience at the clinic, barriers to access, and interest in telemedicine abortions. Patient participants also completed a survey with demographic information including, age, education, race, number of children, and distance traveled, and questions about interest in telemedicine practices. In provider interviews, we asked their perspective and experience providing abortion services, and the possibility of providing telemedicine abortions. Data analysis was completed utilizing a modified grounded theory approach. Interview transcriptions were coded individually using NVivo software with a standardized codebook. Survey results were analyzed with SPSS software, specifically looking at means, frequencies and chi-square tests.

Results: Of the 19 participants interviewed and surveyed, nine occurred at the Wichita, Kansas clinic and ten took place in the Oklahoma City, Oklahoma (Figure 1). The mean age of the women was 25.89 years old. Within the sample, about half of the participants identified as white. Three fourths of the women attended some level of college. Additionally, 11 of the 19 women were either in a relationship or married, and four of the women reported cohabitation with their partner. In terms of insurance status, 13 had either private insurance or Medicaid, while six women were uninsured. More than half of the women traveled over 20 miles to receive their abortion, and four of these women traveled over 100 miles (Table 1).

Figure 1: Map of study participants by county



Overall, women reported four common barriers to accessing the abortion: travel, transportation, child care, and cost. Cost was the most prominent barrier as numerous women discussed saving, dipping into savings, and making sacrifices in order to pay for the procedure. While many women described barriers to obtaining their abortion, others described experiences that some may consider to be barrier, but they remained unbothered by this perceived barrier.

Table 1: Participant demographic information

Location of interview (n=19)	
Wichita, Kansas	9
Oklahoma City, Oklahoma	10
Abortion Type (n=19)	
Medication	16
Surgical	3
Race (n=19)	
White	9
Black or African American	3
Hispanic or LatinX	2
Asian	2
American Indiana or Alaskan Native	1
Other	2
Highest level education (n=19)	
Some high school	1
High school or GED	4
Some college	6
Associates Degree	2
Bachelors Degree	4
Master's Degree or higher	2
Average Age (sd) (n=19)	25.89 (4.78)
Relationship Status (n=19)	
In-relationship	10
Married	1
Single	8
Living Situation (n=19)	
Partner	3
Roommate	3
Alone	4
Parents	4
Partner and Roommate	1
Other	1
Insurance Status (n=18)	
Private Insurance	10
Medicaid	3
None	6
Distance Traveled to clinic (n=19)	
0-20 miles	9
21-50 miles	3
51-100 miles	3
100+ miles	4

These women had diverse responses to telemedicine abortions. When asked about interest in receiving a telemedicine abortion instead of coming to the clinic, a participant says, "if I could go and pick it up at a pharmacy, I would be way happier and less embarrassed." Some showed a bit of apprehension, as one said she would be, "not exceedingly comfortable with that, but comfortable." When asked about interest video chat appointments for telemedicine abortions, some felt very comfortable. A participant says, "that wouldn't be a problem for me, even if it was over the phone, I still just have questions for the doctor." Another woman was less interested in video chat appointments when she said, "in person is so different from video chat because video chat, you go through something. In person you can see that person, their face, their emotion, how they act."

Overall, 17 felt comfortable gaining access to the abortion pills by some means of telemedicine and eight felt comfortable having their abortion appointment over a video call. We found a statistically significant relationship (x^2=4.23, df=1, p=0.04) between traveling less than 20 miles to the clinic and interest in video chat appointments. Those who traveled less than 20 miles were more interested in video chat appointments than those who traveled more than 20 miles.

Providers recognized similar barriers to access for the women. One provider described the barrier of cost by saying, "often times even when they know they are pregnant early on, it takes some time to save money, which then delays their care, which then increases the cost of their care. So, there's a cycle of economic inaccessibility." Another provider makes the argument that we are likely unaware of most of the barriers these women have faced because, "they don't even bother mentioning to us 'oh well it took me a week and a half to figure out how I was even going to get here.' You know, they've gone ahead and gotten here so they don't even bother telling us." In regards to telemedicine, all three of the providers felt that telemedicine abortions were feasible and necessary. A provider says, "I think anything we could do to make the process easier and more efficient for them, they would be appreciative of."

Discussion: We found that women continue to face a number of barriers when attempting to access an abortion. Many of the mentioned barriers could be addressed with the introduction of telemedicine abortions. Based on the results of both the interviews and survey responses, interest in telemedicine varied amongst the participants. Some participants were interested in certain aspects of telemedicine, but had reservations about the process as a whole. Surprisingly, although patients appeared interested in video chat telemedicine appointments, survey analysis indicated that there was greater interest in video call technology in those patients traveling shorter distances—20 miles or less. We considered three possible reasons for this. First, individuals

living closer to the clinic may be more concerned with privacy at the clinic. Patients and providers commonly discussed privacy in interviews, and some may worry that since their home is near the clinic, they may meet someone they know. Second, reasons for disinterest in telemedicine services may be a result of the lack of personal experience with telemedicine abortion. Finally, respondents may lack understanding of how the process would work. Researchers attempted to explain the process of receiving a telemedicine abortion, but some patients had a hard time understanding the logistics of the process, possibly deterring their interest. All providers were extremely optimistic about the potential for telemedicine abortions within the states of Oklahoma and Kansas. They discussed the many barriers the process would alleviate, including: travel costs, privacy, support, and indirect costs. From a provider perspective, all believed that the process is feasible and would not change the level of care received by the patients.

As a result of general interest amongst patients and providers, and previous literature, clinics should consider ways to add telemedicine services. Both patients and providers acknowledge the great number of potential positives associated with telemedicine abortions. As telemedicine abortions will not eliminate the option for in-person medication abortions, patients who expressed no interest in telemedicine practices will not be negatively impacted by this implementation.

Conclusion: Patients commonly reported logistic barriers to obtaining abortion and nearly all felt comfortable with telemedicine, but half would like a face to face clinic visit. As a result of general interest amongst patients and providers, and previous literature, clinics should consider ways to add telemedicine services. As telemedicine abortions will not eliminate the option for in-person medication abortions, patients who expressed no interest in telemedicine practices will not be negatively impacted by this implementation. Law permitting, clinics which add telemedicine service might help women living in rural communities gain easier access to abortion services.

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