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

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13th FIAPAC Conference
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
TelAbortion

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

Washington

Oregon

Maine

New York

Hawaii
Project Timeline

2016

Choices (NY)

Univ. of Hawaii

OHSU (OR/WA)

2017

Maine FP (ME/NY)

2018

PPCW (OR)

- Pilot (no charging)
- Phase II (charging)
CLINICAL FINDINGS
as of September 10
Enrollment and Follow-up

**Screened**: 351

**Consultation**: 215

**Package sent**: 199

**FOLLOW-UP STATUS (N=189)**
- Ab outcome known: 146 (77%)
- Ab outcome unknown: 43 (23%)

In progress: 10
Enrollment and Follow-up

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FOLLOW-UP STATUS (N=189)
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- Ab outcome unknown: 43 (23%)

In progress: 10
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

Non-Hawaii sites

61% lived on island other than Oahu
Timing of Ultrasound

Total Video Evaluations (VE): 215

- **Before VE**: 55%
- **Day of VE**: 11%
- **After VE**: 30%
- **No ultrasound**: 4%
Abortion Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete without surgery</td>
<td>137</td>
<td>94%</td>
</tr>
<tr>
<td>Complete with surgery</td>
<td>8</td>
<td>6%</td>
</tr>
<tr>
<td>Continuing pregnancy</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

N=146

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

<table>
<thead>
<tr>
<th>Test</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>68</td>
<td>(50%)</td>
</tr>
<tr>
<td>Serum HCGs</td>
<td>45</td>
<td>(33%)</td>
</tr>
<tr>
<td>Urine pregnancy test</td>
<td>27</td>
<td>(20%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>5</td>
<td>(4%)</td>
</tr>
</tbody>
</table>

N=137*  
*Some had >1 test

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
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

Very satisfied: 81%
Satisfied: 19%

Future Preference

N=123

TelAbortion: 85%
In person: 11%
None: 5%
Pre- and post-abortion tests

How difficult was it to get tests?

<table>
<thead>
<tr>
<th></th>
<th>Before pkg</th>
<th>After pkg</th>
</tr>
</thead>
<tbody>
<tr>
<td>very diff</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>diff</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>easy</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td>very easy</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

very diff   diff   easy   very easy
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

Oregon Health & Science University

- Maureen Baldwin

Gynuity Health Projects

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

Choices Women’s Medical Center

- George McMillan

Planned Parenthood Columbia Willamette

- Paula Bednarek
www.telabortion.org

Thank you!!

eychong@gynuity.org  (Erica Chong)
erymond@gynuity.org  (Beth Raymond)
States that Prohibit Telemedicine Abortion

- Telemedicine ban
- Other law preventing TA
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

- Approved tests are available
- Acceptably accurate
- Need to wait 3-4 weeks to minimize false positives
Summary of Considerations

All would be more convenient and cheaper, and enhance autonomy

But!

<table>
<thead>
<tr>
<th></th>
<th>HSPT</th>
<th>2 MLPTs</th>
<th>LSPT</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed detection of failure</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Increased loss to follow-up?</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>False results</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Non standard approach</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Uses “investigational product”</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
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

FDA doesn’t require ultrasound
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

BUT

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

<table>
<thead>
<tr>
<th></th>
<th>Pilot</th>
<th>Phase II</th>
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</thead>
<tbody>
<tr>
<td>Site care</td>
<td>Study</td>
<td>Insurance or self</td>
</tr>
<tr>
<td>Outside care</td>
<td>Insurance or self</td>
<td>Insurance or self</td>
</tr>
<tr>
<td>(tests, etc.)</td>
<td></td>
<td></td>
</tr>
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</table>
## Planned Payment for Outside Tests

<table>
<thead>
<tr>
<th></th>
<th>Choices N=6</th>
<th>UH N=118</th>
<th>OHSU N=59</th>
<th>MFP N=19</th>
<th>PPCW N=4</th>
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</thead>
<tbody>
<tr>
<td>Private insurance</td>
<td>67%</td>
<td>47%</td>
<td>76%</td>
<td>16%</td>
<td>50%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>33%</td>
<td>33%</td>
<td>10%</td>
<td>42%</td>
<td>50%</td>
</tr>
<tr>
<td>Self only</td>
<td>18%</td>
<td>14%</td>
<td>37%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undecided</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
</tr>
</tbody>
</table>
Planned Payment for Site Care (Phase II)

<table>
<thead>
<tr>
<th></th>
<th>UH N=42</th>
<th>MFP N=19</th>
<th>PPCW N=24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private insurance</td>
<td>31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>40%</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Ab fund</td>
<td></td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Self only</td>
<td>29%</td>
<td>47%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Cross State Prescribing

Challenges

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

Total VEs at OHSU: 59
- Washington 46%
- Oregon 54%
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

- 288mi
- 260mi
- 339mi
- 106mi!!
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

<table>
<thead>
<tr>
<th>Source</th>
<th>N=330</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic staff or website</td>
<td>45%</td>
</tr>
<tr>
<td>Another provider</td>
<td>26%</td>
</tr>
<tr>
<td>TelAbortion website</td>
<td>13%</td>
</tr>
<tr>
<td>Women on Web, etc.</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
</tr>
</tbody>
</table>