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Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study

Kate Grindlay, MSPH [a,*], Kathleen Lane, CN [b], Daniel Grossman, MD [c]

[a] *Ibis Reproductive Health, Cambridge, Massachusetts*
[b] *Provide, Cedar Rapids, Iowa*
[c] *Ibis Reproductive Health, Oakland, California; Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco*

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A B S T R A C T

Background: In states requiring physicians to dispense mifepristone, the small number of providers offering the method limits its uptake. In 2008, Planned Parenthood of the Heartland in Iowa began providing medical abortion via telemedicine at clinics without an on-site physician. The purpose of this study was to evaluate patients' and providers' experiences with telemedicine provision of medical abortion.
Methods: Between October 2009 and February 2010, in-depth interviews were conducted at Planned Parenthood clinics with 25 women receiving medical abortion services (20 telemedicine patients and 5 in-person patients) and 15 clinic staff. Data were analyzed qualitatively for themes related to acceptability of the telemedicine service delivery model.
Findings: Patients and providers cited numerous advantages of telemedicine, including decreased travel for patients and physicians and greater availability of locations and appointment times compared with in-person provision. Overall, patients were positive or indifferent about having the conversation with the doctor take place via telemedicine, with most reporting it felt private/secure and in some cases even more comfortable than an in-person visit. However, other women preferred being in the same room with the physician, highlighting the importance of informing women about their options so they can choose their preferred service modality.
Conclusions: The findings from this study indicate that telemedicine can be used to provide medical abortion in a manner that is highly acceptable to patients and providers with minimal impact on the clinic.
Practice Implications: This information demonstrates the feasibility of telemedicine to extend the reach of physicians and improve abortion access in rural settings.
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Introduction and Background

The number of abortion providers has declined over the last three decades in the United States (Jones & Kooistra, 2011), resulting in greater distances and higher costs for some women to obtain care. Today, 87% of counties lack an abortion provider, and women in rural areas are the hardest hit by this shortage; 97% of nonmetropolitan counties do not have an abortion provider (Jones & Kooistra, 2011).

When the U.S. Food and Drug Administration approved mifepristone for early medical abortion over a decade ago, many anticipated that it would increase access to abortion because it could be offered by a wide range of providers without the need for surgical facilities (Finer & Wei, 2009; Yarnall, Swica, & Winikoff, 2009). However, only about one quarter of eligible abortions in the United States are medical abortions (Jones & Kooistra, 2011), and the hoped-for increase in provision of the method by family medicine doctors or in private obstetrician–gynecologist offices has not taken place. The majority of states require physicians to dispense mifepristone (Berer, 2009), and the small number of providers offering the method in many of these states limits its uptake.

In rural states, where a single physician may be the only abortion provider within a several hundred mile radius, lack of access to abortion is acutely felt. In Iowa, abortion access for rural women is particularly difficult. Before 2008, physicians at Planned Parenthood of the Heartland in Iowa traveled up to 400

* Correspondence to: Kate Grindlay, MSPH, Ibis Reproductive Health, 17 Dunster Street, Suite 201, Cambridge, MA 02138. Phone: 617-349-0053; Fax: 617-349-0041.
E-mail address: kgrindlay@ibisreproductivehealth.org (K. Grindlay).

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miles roundtrip to provide abortion care at smaller sites, and patients often traveled similar distances from an opposite direction to receive care. Although medical abortion allowed Planned Parenthood to expand the number of locations where patients could obtain an early abortion, limited physician time still restricted the availability of services.

Telemedicine, which involves using information and communication technology to provide a health service or consultation at a distance, has been used in many fields of medicine to improve access to care for rural populations (Wade, Karnon, Elshaug, & Hiller, 2010). In June 2008, Planned Parenthood of the Heartland in Iowa began providing medical abortion via telemedicine at clinics without an on-site physician to improve access to early abortion and reduce physician and patient travel. This telemedicine model providing medical abortion has been described previously, and it was evaluated in a recent prospective cohort study and shown to be equally safe and effective as an in-person physician visit (Grossman, Grindlay, Buchacker, Lane, & Blanchard, 2011). Some measures of acceptability were higher among women who received services via telemedicine, with telemedicine patients having a higher odds of saying they would recommend the service to a friend compared with in-person patients, adjusting for sociodemographic characteristics (odds ratio, 1.72; 95% confidence interval, 1.26–2.34; Grossman, et al., 2011). Another analysis found that after the telemedicine program was launched at Planned Parenthood of the Heartland, women were significantly more likely to have a medical abortion and to have a first-trimester abortion, and women in more rural areas of the state were more likely to access abortion care, especially early medical abortion (Grossman, Grindlay, Buchacker, Potter, & Schmertmann, 2013).

The purpose of this study was to evaluate women's and providers' experiences with telemedicine provision of medical abortion qualitatively. In particular, we aimed to learn more about the acceptability of the telemedicine abortion service and the impact that it has on patients, staff, and clinic operations.

Methods

Between October 2009 and February 2010, in-depth interviews were conducted at Planned Parenthood of the Heartland clinics in Iowa with women receiving telemedicine ($n = 20$) or in-person ($n = 5$) medical abortion services. Women seeking abortion at Planned Parenthood called a central call center, which gave them information about the nearest clinic and soonest appointment and informed them whether the service would be provided by telemedicine or not, and women selected the appointment they preferred. We planned to perform fewer in-depth interviews with women undergoing the standard provision model because of the large amount of published data on women's experiences with this model (Fielding, Edmunds, & Schaff, 2002; Lafaurie, Grossman, Troncoso, Billings, & Chavez, 2005). In addition, we conducted in-depth interviews with 15 clinic staff, including those who were involved with the standard method of providing medical abortion and those involved with the telemedicine model.

Women who chose medical abortion and were eligible for the method (including being pregnant at ≤63 days gestation and not having other standard contraindications), were at least 18 years of age, able to speak English, willing to participate, and able to give informed consent were eligible to participate in the in-depth interviews. The eligibility criteria for clinic staff were that they were a doctor, advanced practice clinician, nurse, medical assistant, or clinic manager on staff at a Planned Parenthood of the Heartland clinic; willing to participate; and able to give informed consent.

At their initial clinic visit, women seeking medical abortion were invited to participate in an in-depth interview about the acceptability of the medical abortion they were undergoing. The interview was performed at the completion of the visit in a private location at the clinic. The interview guide was semi-structured and included open-ended questions about access to health care services generally, decision making about abortion and where to have the procedure, and experience with and opinions of the service. Clinical information was also obtained by the interviewer. Patients received a $25 gift card for their participation.

Clinic staff were invited to participate in the in-depth interview by a study team member, and they were told that their participation was voluntary and confidential. Staff were interviewed in a private location at the clinic or by telephone. No compensation was given to clinic staff for their participation.

All study participants provided written, informed consent to participate in the study and have their interview audio recorded. On average interviews took 45 minutes to 1 hour to complete. The study was approved by Allendale Investigational Review Board.

All interviews were digitally recorded and transcribed verbatim. Data were analyzed qualitatively with inductive coding using grounded theory methods (Charmaz, 2006). All analyses were performed with ATLAS-ti 6.2 (ATLAS-ti GmbH, Berlin, Germany) for themes related to acceptability of the telemedicine service delivery model.

Results

Participant Characteristics

Twenty-five women receiving medical abortion services (20 telemedicine patients and 5 in-person patients) and 15 clinic staff (six medical assistants, five clinic managers, two physicians, and two nurses) participated in the study.

The majority of patients were under 25 years old (64%), had a high school education or less (56%), and were single (68%). Three quarters (76%) identified as White, 12% as African-American/Black, and 12% as other race (Native American, Native American/White, African American/White). Forty-four percent of women had at least one prior birth, and 48% reported at least one prior abortion (Table 1).

Perspectives of Telemedicine Patients before the Visit

When women called to make an appointment, they spoke with a call center that provided information about several clinics that they could choose from, allowing women to weigh their options of whether to have a telemedicine or in-person visit with other considerations such as travel distance, appointment date, or other factors. Women reported having mixed reactions when they first learned about telemedicine. One woman reported initially feeling nervous about telemedicine, but said that it was more important for her to go to the closest clinic. Another woman described thinking that it was "different," but that she had enough trust in the clinic that it would not impact the quality of care.

The telemedicine patients in our sample overwhelmingly selected the clinic based on logistical concerns, citing that even if

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