

Alison H. Norris, MD, PhD
Interested Party Testimony
Senate Bill 260
Ohio Senate Health, Human Services and Medicaid Committee

I appreciate Members of the Ohio Senate Health, Human Services, and Medicaid Committee for considering my testimony as an interested party.

My name is Dr. Alison Norris. I earned my MD from Yale University in 2008 and my PhD in epidemiology from Yale University in 2006. I was a postdoctoral fellow at the Johns Hopkins Bloomberg School of Public Health from 2008-2011. Since that time I have been a faculty member at the Ohio State University. I am a tenured associate professor in the College of Public Health and the College of Medicine.

Today I am representing myself as a private citizen of Ohio. My testimony is based on my expertise as a scholar and researcher, and on the epidemiologic scientific literature. I am not representing Ohio State or any other organization.

Telemedicine uses communication technologies to deliver healthcare services and information remotely. **Telemedicine has been used to great success to *reduce the burdens* in providing health care to people throughout the world for many different health conditions. Banning telemedicine risks *increasing* the burdens.**

Abortion is one of the most common and safe kinds of care that women receive. Telemedicine for abortion care has been shown to be safe and effective, and, if we consider what is best for women and families in Ohio, telemedicine abortion should continue to be available in Ohio. **My concern, as a public health doctor, is for the safety of patients and for improving their access to high quality health care. Telemedicine for abortion is safe, increases access, and maintains excellent quality of care.** Telemedicine is used throughout the world by doctors and advance practice clinicians to provide patient assessment, counseling, medication distribution, and clinical guidance.^{1,2,3}

The provision of telemedicine varies by location – in some places, like Ohio, a clinic-to-clinic telemedicine model is available for abortion care; in others, a direct-to-patient model is available. In the clinic-to-clinic model, a patient goes to a health care center to receive tests and then has a videoconference with an off-site physician who prescribes medication that is dispensed to the patient at the clinic. Follow up care usually occurs at the same clinic. In the direct-to-patient model, a patient receives necessary testing at a health care center, videoconferences with a remote provider from home, fills their prescription for medication from a pharmacy, and completes follow up care at a health care center. **Both are safe.**

The use of telemedicine in abortion care is currently allowed in Ohio, a state with serious geographic barriers to abortion and other reproductive health care. (The Appalachian region of the state has particularly few sites for comprehensive reproductive health care).⁴ Because

Ohio law requires that patients undergo state-directed in-person counseling at least 24 hours prior to an abortion, telemedicine cannot be used for initial counseling. Telemedicine can be used for subsequent abortion medication distribution. At least 24 hours after an in-person visit with a physician, two Ohio abortion clinics provide care whereby patients access abortion medications at a remote clinic site that could otherwise not provide abortion services. This means that those locations can dispense medication abortion to patients without a physician on site. Physicians located at other sites in Ohio use video communication to answer questions and to oversee medication administration. Follow up occurs in the same way that in-clinic abortion care occurs.

In January of 2020, State Bill 260 was introduced; if this becomes law, physicians would be required to be present for medication administration, thus prohibiting telemedicine in abortion as it is currently practiced in Ohio.^{5,6}

As an epidemiologist and a doctor, I am qualified to tell you that Medical abortion via telemedicine is safe, effective, highly acceptable to both patients and providers.^{7,8,9,10,11,12}
The best evidence we have says that bans on telemedicine abortion are medically unjustified¹³. Like all of us considering this bill, I care about women in Ohio having the highest quality of care, and the most fair access to care.

Telemedicine improves access to quality care. Telemedicine lowers the barriers to access, so it can serve to lower the gestational age at which patients obtain their abortion.¹⁴ Clinical outcomes for telemedicine abortion have the same excellent safety profiles as in-person models of care.⁹ Both in-person abortion and telemedicine abortion are among the safest medical procedures performed in America.¹⁵ Both clinic-to-clinic⁹ and direct-to-patient¹⁶ telemedicine abortion models for care are safe, effective, efficient and satisfactory for patients.⁷

Because telemedicine abortion is so safe and cost-effective, it has the potential to improve service delivery and quality of care. Telemedicine abortion offers convenience and confidentiality. Other researchers have found that telemedicine abortion can improve “safety, patient-centeredness, timeliness and geographic equity” in care.⁸ In other countries, like Australia which have **broadly implemented telemedicine for abortion provision, doctors have found that these services are “effective, safe, inexpensive and satisfactory” and particularly beneficial to people in rural areas of the country.**¹⁷ **Telemedicine can increase access to safe and affordable health care.**

¹ Drovetta, R. I. (2015). Safe abortion information hotlines: An effective strategy for increasing women’s access to safe abortions in latin america. *Reproductive Health Matters*, 23(45), 47-57. doi:10.1016/j.rhm.2015.06.004

² Merino-Garcia, N., Meléndez, W., & Taype-Rondan, A. (2016). Abortion services offered via the internet in lima, peru: Methods and prices. *Journal of Family Planning and Reproductive Health Care*, 42(1), 77-78. doi:10.1136/jfprhc-2015-101332

-
- ³ World Health Organization. Ryu, S. (2012). Telemedicine: Opportunities and developments in member states: Report on the second global survey on eHealth 2009 (global observatory for eHealth series, volume 2). *Healthcare Informatics Research*, 18(2), 153-155. doi:10.4258/hir.2012.18.2.153
- ⁴ Jones, R. K., & Jerman, J. (2017). Abortion incidence and service availability in the united states, 2014. *Perspectives on Sexual and Reproductive Health*, 49(1), 17-27. doi:10.1363/psrh.12015
- ⁵ Wicklund E. Ohio Legislator Files New Bill to Prevent Telemedicine Abortions. mHealth Intelligence (2020). Available at: <https://mhealthintelligence.com/news/ohio-legislator-files-new-bill-to-prevent-telemedicine-abortions>
- ⁶ Hancock L. Ohio Senate would ban abortions performed through telemedicine. Cleveland.com. Available at: <https://www.cleveland.com/open/2020/01/ohio-senate-bill-would-ban-abortions-performed-through-telemedicine.html>.
- ⁷ Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., & Gemzell-Danielsson, K. (2019). Telemedicine for medical abortion: A systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, 126(9), 1094-1102. doi:10.1111/1471-0528.15684
- ⁸ Grossman, D., & Grindlay, K. (2017). Safety of medical abortion provided through telemedicine compared with in person. *Obstetrics and Gynecology*, 130(4), 778-782. doi:10.1097/AOG.0000000000002212
- ⁹ Grossman, D., Grossman, D., Grindlay, K., Grindlay, K., Buchacker, T., Buchacker, T., . . . Blanchard, K. (2011). Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics and Gynecology*, 118(2), 296-303. doi:10.1097/AOG.0b013e318224d110
- ¹⁰ Grindlay, K., MSPH, Lane, K., CN, & Grossman, D., MD. (2013). Women's and providers' experiences with medical abortion provided through telemedicine: A qualitative study. *Women's Health Issues*, 23(2), e117-e122. doi:10.1016/j.whi.2012.12.002
- ¹¹ Grindlay, K., & Grossman, D. (2017). Telemedicine provision of medical abortion in alaska: Through the provider's lens. *Journal of Telemedicine and Telecare*, 23(7), 680-685. doi:10.1177/1357633X16659166
- ¹² Kohn, J. E., Snow, J. L., Simons, H. R., Seymour, J. W., Thompson, T., & Grossman, D. (2019). Medication abortion provided through telemedicine in four U.S. states. *Obstetrics & Gynecology*, 134(2), 343-350. doi:10.1097/AOG.0000000000003357
- ¹³ Upadhyay, U. D., & Grossman, D. (2019). Telemedicine for medication abortion. *Contraception*, 100(5), 351-353. doi:10.1016/j.contraception.2019.07.005
- ¹⁴ Grossman, D. A., Grindlay, K., Buchacker, T., Potter, J. E., & Schmertmann, C. P. (2013). Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in iowa. *American Journal of Public Health*, 103(1), 73-78. doi:10.2105/AJPH.2012.301097
- ¹⁵ Kapp, N., & Lohr, P. A. (2020). Modern methods to induce abortion: Safety, efficacy and choice. *Best Practice & Research. Clinical Obstetrics & Gynaecology*, doi:10.1016/j.bpobgyn.2019.11.008
- ¹⁶ Raymond, E., Chong, E., Winikoff, B., Platais, I., Mary, M., Lotarevich, T., . . . Priegue, E. (2019). TelAbortion: Evaluation of a direct to patient telemedicine abortion service in the United States. *Contraception*, 100(3), 173-177. doi:10.1016/j.contraception.2019.05.013
- ¹⁷ Hyland, P., Raymond, E. G., & Chong, E. (2018). A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 58(3), 335-340. doi:10.1111/ajo.12800