

Expanding access to later abortion care in Maine: Improving in-state clinic referral systems

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Access to later abortion care

Researchers have demonstrated that access to legal abortion care after the first trimester in the United States can be challenging and, at times, impossible for many people.¹⁻³ In addition to state regulations that seek to curb access to later abortion (e.g. bans on later abortion surgical methods and gestational age [GA] bans),⁴ barriers to abortion care after the first trimester include a lack of trained providers, the need to travel longer distances to a clinic, and higher out-of-pocket costs.¹⁻³ In order to minimize the logistical and financial burdens facing later abortion clients, it is essential that healthcare workers provide timely and appropriate referrals for clients who need to travel to receive services.

Abortion landscape in Maine

In 2017, 31% of Maine’s counties did not have clinics that provided abortions,⁵ and 24% of the state’s women lived in those counties.⁵ Maine does not mandate a specific gestational age limit on abortion services; instead, the state’s law imposes the federal standard that permits abortions up to the point of fetal viability.⁵ Abortions can be provided at or after viability if the pregnancy threatens the life or health of the pregnant person.⁵ In 2016, Maine had three freestanding ambulatory clinics (ASCs) and one hospital that provided abortion care after the first trimester, up to various gestational ages (Figure A; Table 1). During this time, no clear referral process existed among the clinics in Maine, which resulted in out-of-state referrals for many clients whose pregnancies exceeded the gestational age limits of the facilities or who had special health conditions. Researchers have found that traveling greater distances to abortion care is associated with a myriad of logistical and financial challenges, including delays in accessing care,⁶ greater difficulties getting to a clinic,⁷ and higher out-of-pocket costs.⁷

This brief describes a project spearheaded by the Later Abortion Initiative (LAI)[†] of Ibis Reproductive Health that sought to improve access to later abortion by piloting an in-state referral intervention for abortion providers in Maine.

Figure A: Counties with freestanding ambulatory centers, health centers, and hospitals that provide abortions as of 2016



Table 1. Maine facility offerings as of 2016

	Location	Facility type	Gestational age limit	Abortion Services [†]				
				MAB	EVA	MVA	D&E	Labor induction
Mabel Wadsworth Center (MWC)	Bangor	ASC	14 weeks, 3 days	×	×	×		
Maine Family planning (MFP)	Augusta	ASC	14 weeks	×	×	×		
Maine Medical Center (MMC)	Portland	Hospital	24 weeks*	×	×	×	×	×
Planned Parenthood of Northern New England Portland Health Center (PPNNE)	Portland	Health Center	19 weeks, 6 days	×	×	×	×	

* MMC has a gestational age limit of 24 weeks unless there is a lethal fetal anomaly, in which case there is no limit

† Medication abortion (MAB), Electric Vacuum Aspiration (EVA), Manual Vacuum Aspiration (MVA), Dilation and evacuation (D&E)

* Maine Family Planning provided medication abortion via telehealth during this time to some counties.

† The Later Abortion Initiative (LAI), a project of Ibis Reproductive Health, seeks to change the conversation around abortion after the first trimester and the people who need this service. LAI particularly focuses on the increased stigma, challenges and barriers for clients who need abortions after 18 weeks. LAI supports the development of innovative activities and new leadership on later abortion, and supports efforts to preserve and expand access to later abortion care.



Project Components

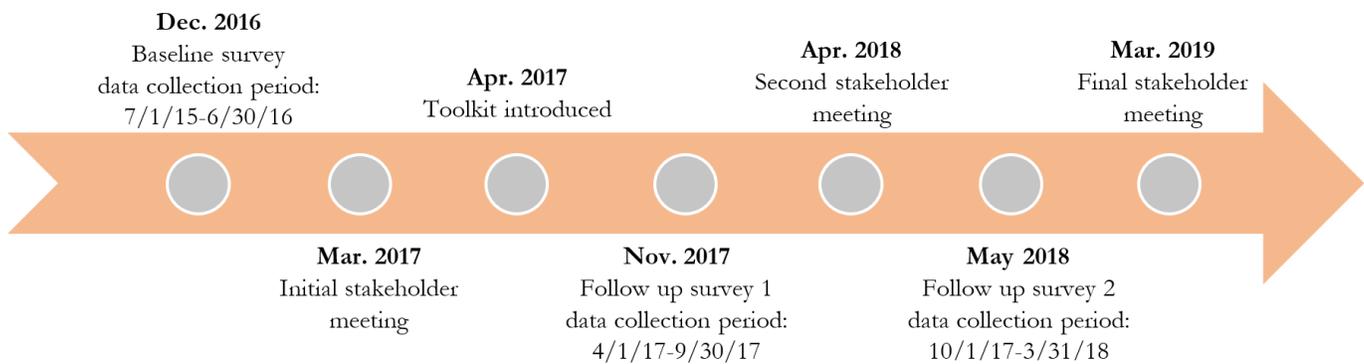
Formative research

In 2016, LAI conducted informal interviews with leadership representatives from each of the four sites in Maine that provided abortion care—three clinics/health centers and one hospital: Maine Family Planning (MFP), Maine Medical Center (MMC), Mabel Wadsworth Center (MWC), and Planned Parenthood of Northern New England (PPNNE). These conversations sought to introduce the project, learn about each clinic’s perspective and interest in expanding abortion services, and seek participation in a survey to document Maine’s current abortion referral patterns.

In December 2016, we launched the baseline survey. Questions primarily focused on four areas: the types of abortion services offered; the gestational age limits at each clinic; interest in/steps necessary to expand abortion services; and referral practices for clients beyond the clinic’s gestational age limit, including those with medical conditions that need a more specialized setting and those with known fetal complications. We also collected data on the number of abortions provided by participating facilities and the number of client referrals to facilities inside and outside of Maine by gestational age, for the 12-month period from July 1, 2015 to June 30, 2016.

LAI convened an initial stakeholder meeting to share results from the survey, build relationships among stakeholders, and generate strategies to improve abortion referrals. In addition to representatives from the four abortion provider sites, key advocates from the American Civil Liberties Union, Maine Women’s Lobby, and Safe Fund also attended.

Figure B: Project timeline



Development of the referral toolkit

REFERRAL TOOLKIT

Discussions among stakeholders about how to improve referrals within Maine sparked the development of a referral toolkit by the Maine stakeholders. The toolkit consisted of a provider contact sheet, which listed key contact information to ensure that referring clinicians could make a direct call to the receiving health care team, and a patient checklist, which listed all the medical information or documents needed for referrals to each of the participating clinics. The group also agreed to schedule quarterly calls to discuss and refine the tools. The toolkit was implemented in April 2017. We convened annual stakeholder meetings throughout the project to continue to build relationships among the Maine clinics, share updates about relevant political and advocacy developments, discuss progress on expanding services and improving referrals, and generate strategies to further improve access to later abortion services. The final stakeholder meeting convened by LAI was in March 2019. Providers continued to meet on their own after that point.

TOOLKIT ASSESSMENT

Following implementation of the toolkit, we conducted follow-up surveys in November 2017 and May 2018 to collect data on service provision and referral patterns during the project period. The survey also included open-ended questions to assess the impact of the referral tools, quarterly calls, and the annual stakeholder meetings.



Findings

Service delivery findings

IN-STATE PROVISION

At baseline, the four abortion sites in Maine provided a total of 105 abortions between 14–24 weeks last menstrual period (LMP). At endline, we observed an overall increase of 29% in total abortion volume (Table 2).

Table 2. Number and percent change in abortions provided within Maine by gestational age

Gestational age (LMP)	Baseline 7/1/2015 – 6/30/2016	Endline 4/1/2017 – 3/31/2018	Percent change
14–15.6 weeks	46	44	-4%
16–18.6 weeks	45	57	27%
19–20.6 weeks	8	21	163%
21–23.6 weeks	6	12	100%
24 weeks	0	1	N/A
Total	105	135	29%

OUT-OF-STATE REFERRALS

At baseline, the four sites referred 17% of clients between 14–24 weeks (LMP) outside of Maine. At endline, only ten percent of clients were referred out of state, a 40% decrease (Table 3).

Table 3. Proportion of clients referred outside of Maine by gestational age

Gestational age (LMP)	Baseline* 7/1/2015 – 6/30/2016	Endline* 4/1/2017 – 3/31/2018	Percent change
14–15.6 weeks	4/50	1/45	-75%
16–18.6 weeks	0/45	2/59	N/A
19–20.6 weeks	10/18	6/27	-60%
21–23.6 weeks	7/13	5/17	-46%
24 weeks	0/0	1/2	N/A
Total	21/126	15/150	-40%

*Denominator listed for baseline and endline equals total number of clients who obtained abortions in Maine and clients referred to an out-of-state provider

CHANGES IN REFERRAL PATTERNS

In the survey, we asked providers to report which facilities they referred clients to under different circumstances. At baseline, many facilities were referring clients outside of Maine. At endline, when possible, clinics referred clients within the state of Maine. This shift to in-state referrals potentially reduced client travel by 110–238 miles.[‡] Figure C presents a visual representation of referral patterns at baseline and endline.

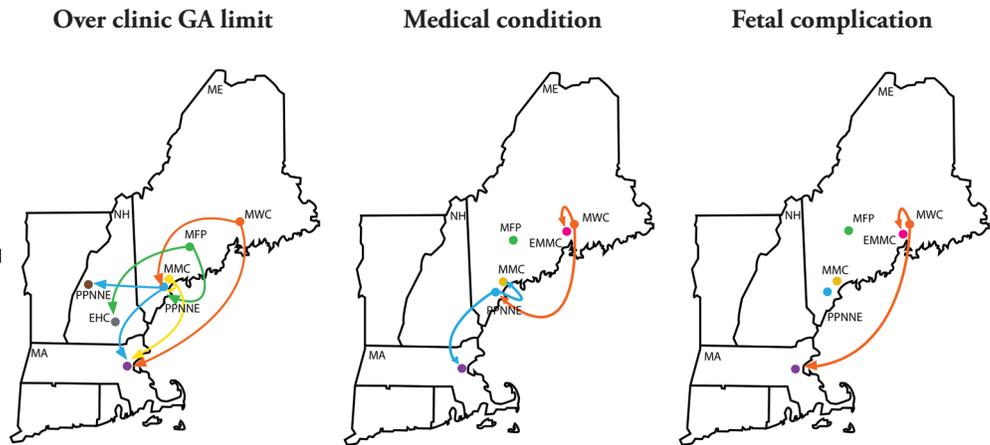
[‡] Travel mileage was obtained by calculating the driving distance between the originating clinic and referral clinic via Google maps



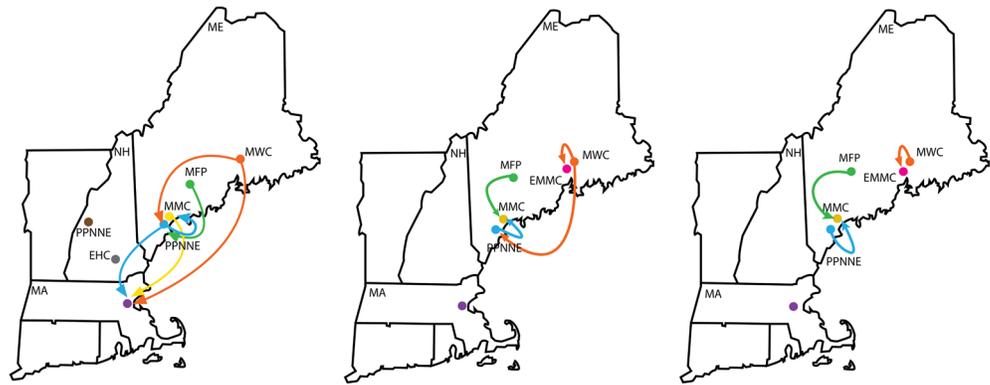
Figure C: Visual representation of changes in referral patterns

- Boston facility
- Equality Health Center
- Eastern Maine Medical Center
- Maine Family Planning
- Maine Medical Center
- Mabel Wadsworth Center
- Planned Parenthood, Portland, ME
- Planned Parenthood, Lebanon, NH

Referral period
7/1/2015–6/30/2016



Referral period
4/1/2017–3/31/2018



GESTATIONAL AGE EXPANSION

After the intervention, all clinics had started discussions around increasing their gestational age limit, but no changes were made during the study period. In the survey, providers identified several barriers to increasing gestational age such as buy-in among key facility stakeholders, provider training, equipment for pain and sedation management, and hospital backup services. Respondents also noted a need for funding support and values clarification work with staff and their medical board.

USE OF REFERRAL TOOLS

The endline surveys revealed that all four facilities used the developed referral tools. Providers shared that the tools positively impacted their practice by creating a streamlined referral process. Tools also allowed providers to establish a clear referral policy, foster better communication between abortion providing facilities, and allowed providers to build rapport with peer colleagues. When asked to share how the tools impacted clients, some respondents noted that the tools supported a much more efficient referral process, allowing clients to be seen with fewer delays and made a potentially stressful situation easier for clients.

“The referral process is much more efficient since the addition of the checklist, allowing clients to receive referral care in a quicker fashion than in the past.”
— Provider A

Some respondents identified the face-to-face time, quarterly calls, and connections with other providers as a key factor in improving referrals. Respondents shared:

Additional referral pattern changes

GESTATIONAL AGE

Pre-intervention, MFP reported referring to New Hampshire (~165 miles away). Post-intervention, they reported referring within Maine (~58 miles away) which could reduce client travel by ~107 miles.

MEDICAL CONDITIONS

Pre-intervention, PPNNE reported referring to Boston (~112 miles away). Post-intervention, they reported referring within Maine (~5 miles away) which could reduce client travel by ~100+ miles.

FETAL COMPLICATIONS

Pre-intervention, MWC reported referring to Boston (~238 miles away). Post-intervention, they reported referring within Maine (~2 miles away) which could reduce client travel by ~200+ miles.



“The face-to-face [meetings], calls, [and] connections [are] the most important part. While the details still need to be worked out at times, knowing who I can call, and really understanding what each facility offers so that I can be better informed for clients is great.” — Provider B

“Being connected in this way has been helpful to better understanding the role each provider plays in our region” — Provider C

Discussion

The collaborative implementation of a referral toolkit had a positive impact on abortion referral patterns in Maine. Our baseline assessment revealed the absence of a clear referral process among in-state providers, resulting in out-of-state travel for abortion care. After implementation of our referral intervention, in-state access to abortion care improved substantially, particularly for clients needing later abortion services. The relationships cultivated among providers acted as a catalyst in the development, implementation, and upkeep of the referral toolkit.

This study has several limitations. First, we collected service provision data on client referrals in aggregate. We asked clinics to share where they generally referred clients under various circumstances, so we were unable to track where each individual client was referred. Second, we collected pre-post data and cannot disentangle the impact of the referral toolkit from the improved communication and collaboration that occurred during the study period; however, participants shared that both factors played important roles in improving referral patterns. Third, we only collected clinic-level data and are unable to speak to the client experience for those who received in-state care. Finally, we do not know if referred clients successfully obtained their procedure at the clinic to which they were referred.

Our project provides a model that could be replicated in other states or regions where there are multiple non-affiliated clinics willing to collaborate to expand abortion access and improve referrals. When referral processes are streamlined, clients may be able to receive services sooner, travel shorter distances, and experience fewer logistical barriers.

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