Objectives: Despite an absence of evidence that Rho(D) immune globulin is necessary before first-trimester abortion, current US guidelines are mixed regarding whether routine Rh testing and Rho(D) immune globulin are required. We sought to assess knowledge of blood type, interest in Rh testing, and Rho(D) immune globulin received if Rh-negative among patients receiving direct-to-patient telehealth for medication abortion care and who would not otherwise need to travel to a clinic for care.
Methods: We analyzed survey data from patients obtaining medication abortion through telehealth in 21 states and Washington, DC as part of the California Home Abortion by Telehealth Study between October 2020 and January 2021. The survey included questions about patients' blood type, interest in receiving Rh testing, and whether Rh-negative patients have received Rho(D) immune globulin. Clinics counseled patients about low risks of Rh sensitization early in pregnancy.
Results: Among all 1,378 respondents who answered survey questions on Rh, 713 (51.7%) patients knew their blood type and among these, 172 (24.1%) reported they were Rh-negative. One clinic asked all patients with unknown blood types (n=202) about their interest in Rh testing, among whom 201 (99.5%) were not interested in Rh testing. Among Rh-negative patients, 2.91% did obtain Rho(D) immune globulin.
Conclusions: Most patients who choose telehealth services for medication abortion are not interested in Rh testing or have not received Rho(D) immune globulin. Guidelines that continue to mandate Rh testing and Rho(D) immune globulin for first-trimester abortions should be reconsidered based on low patient interest and lack of demonstrated clinical necessity in the existing literature.

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P031
MIFEPRISTONE AS A NORMAL PRESCRIPTION RAPIDLY INCREASED RURAL AND URBAN PROVIDERS
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Objectives: Before mifepristone became available in January 2017 in Canada, only physicians provided abortion, and most abortions were surgical and in the largest cities. Risk Evaluation and Mitigation Strategy (REMS)-like restrictions were removed in November 2017, so that mifepristone became a normal prescription. We hypothesized this would increase the size and distribution of the workforce.
Methods: We used interrupted time series analyses on Ontario's population-based administrative data to compare abortion workforce trends before mifepristone (January 2012–December 2016) to when mifepristone was a normal prescription (November 7, 2017–March 10, 2020). We defined a most responsible provider (MRP) for each abortion and calculated MRPs per 100,000 females aged 15–49, with Risk Differences (RD) and 95% CI.
Results: We identified MRPs for 98.3% (311,742/315,447) of all abortions. Compared to the expected trend, the number of MRPs increased from 11.1 to 45.3 per 100,000 reproductive-aged females (RD, 34.3; 95% CI, 29.3–39.2). This increase was greatest in rural areas, rising from 1.8 to 48.7 (RD46.9, CI42.0-51.8). By 2019, most MRPs were GPs (66.5%) providing >80% of abortions, with 23.2% obstetrician-gynecologists, and 9.1% nurse practitioners. MRPs providing fewer than 10 abortions per year rose from <120 to over 600, while the number of MRPs in all categories providing over 30 annual abortions was unchanged.
Conclusions: When mifepristone was available without REMS-like restrictions, physicians and nurse practitioners rapidly implemented mifepristone medication abortion in both urban and rural primary care. The abortion workforce in Ontario quadrupled within two years of the policy change, including more providers per reproductive-age female in rural than in urban locations. This policy improved access to confidential abortion care closer to home.

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P032
COVID-19 ABORTION EXPERIENCES ON REDDIT: A QUALITATIVE STUDY
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Objectives: We sought to document the effects of COVID-19 pandemic restrictions on people seeking abortion by analyzing posts on Reddit, a popular social media website.
Methods: We compiled 528 anonymous posts on the abortion subreddit from March 20, 2020 to April 12, 2020 and applied deductive qualitative methods to identify codes and themes.
Results: In the first of four themes, posters reported several COVID-19-related barriers to abortion services: reduced in-person access due to clinic closures, mail delivery delays of self-managed medication abortion, and pandemic-related financial barriers to both self-managed and in-clinic abortion. The second theme encompassed quarantine-driven privacy challenges, primarily challenges with concealing an abortion from household members. Third, posters detailed how the pandemic constrained their pregnancy decision making, including time pressure from impending clinic closures. Finally, posters reported COVID-19-related changes to service delivery that negatively affected their abortion experiences — for example, being unable to bring a support person into the clinic due to pandemic visitor restrictions.
Conclusions: This analysis of real-time social media posts reveals multiple ways that the COVID-19 pandemic limited people's abortion access and affected their termination decisions and experiences. Findings shed light on the consequences of sudden changes, whether pandemic- or policy-related, on abortion service delivery.

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P033
PATIENT ACCEPTABILITY OF ASYNCHRONOUS VS SYNCHRONOUS TELEHEALTH MEDICATION ABORTION CARE IN THE US
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Objectives: Despite its recent expansion in the US, little is known about patient experiences with direct-to-patient telehealth abortion care and its role in addressing inequities in access to care.
Methods: We analyzed surveys from patients of three US virtual abortion clinics — Choix, Hey Jane, and Abortion on Demand — who received care between April 2021 and January 2022. We described telehealth abortion experiences and used logistic regression to evaluate inequities by race/ethnicity and by whether the patient communicated with the provider by video (synchronous) or messaging (asynchronous).
Results: Across the 1,306 included participants, nearly all (98%) felt they could trust the telehealth provider, 95% said that telehealth abortion was the right experience for them, and 89% were very satisfied. Participants cited privacy (93%) and the ability to get the abortion pills quickly (91%) as benefits. The most common drawbacks were concerns about whether the service was legitimate (37%), not confirming the abortion outcome at a clinic (23%), and not having a screening ultrasound (21%). Compared to white participants, Asian participants were less likely to be very satisfied with their care (OR, 0.5; 95% CI, 0.3–1.0). We found no other differences by race/ethnicity. While patients who received synchronous care were more likely to report that telehealth was right for them (OR, 2.6; 95% CI, 1.0–6.3), we found no differences in satisfaction and trust by communication method.
Conclusions: Telehealth abortion care is highly acceptable, and its benefits include privacy and expediency. However, there may be some differences by race/ethnicity that warrant further exploration.

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P034
WHO FAILS TO OBTAIN ABORTION CARE IN INDIANA? RESULTS FROM A LONGITUDINAL ONLINE SURVEY
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Objectives: We aimed to measure barriers to accessing abortion care in Indiana, a state with hostile abortion policies that is anticipated to become even more restrictive.
Methods: Between June 2021 and April 2022, we recruited pregnant Indiana residents seeking abortion via Google advertisements and other online posts, as well as through abortion clinic waiting rooms and callers to local abortion funds. Participants completed a self-administered, online survey at baseline, and a follow-up survey approximately one month later to ascertain outcomes. We compared the proportion of people who reported an abortion at endline by recruitment method and social and economic barriers experienced, using chi-square tests of independence and multivariable logistic regression models.
Results: Overall, 351 participants completed the baseline survey and 205 (58%) participants completed endline. Among those recruited from Google ads, 46% had an abortion compared to 91% and 94% of participants recruited from an abortion fund or a clinic ($p<0.01$). Participants who reported experiencing abortion stigma — specifically, their family opposed abortion or they feared clinic protestors — (76% vs. 87%), who did not have paid jobs (76% vs. 88%), and were uninsured (65% vs. 86%) were less likely to have received an abortion than were those who did not report these experiences.
Conclusions: Anti-abortion sentiment and financial barriers prevented people from obtaining abortion care in Indiana, while abortion funds facilitated access. As abor-