Peer Review File

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Reviewer A

This is an important contribution as TeleMAB grows, for future provision of care and TeleMAB research. Some clarity and tighter organization will better serve authors' ideas and analysis.

Comment 1: This paper could benefit from a tighter framing. The findings and implications are important, but the importance could be more evident with a tighter analysis. For example, ln 46: Authors should explain in more detail how TeleMAB mitigates the stated obstacles to abortion care, either by reasoning through the factors or providing evidence. Does offering TeleMAB allow clinicians to offer services closer to patients who otherwise would be too far from an abortion provider to access care? Does TeleMAB allow a single clinician to serve more patients by reducing their commute time? This may seem obvious but an explanation would strengthen the overall analysis. Authors could consider focusing on specific types of barriers (eg related to travel and to provider shortage) and how they were specifically mitigated by TeleMAB.

Reply: Thank you for this helpful feedback concerning the framework for this paper. We agree with your assessment that we could explicitly state the ways in which the site-to-site model can improve access to care. Although our data cannot speak to the point of reducing commute time, we can provide additional evidence to the ways in which the site-to-site model may offer services closer to where some patients' live.

Changes in text: We have added more context and evidence regarding access and the site-to-site telehealth model in the Introduction (pg. 3, lines 63-66), which now reads: "*The site-to-site TeleMAB model can mitigate some obstacles to accessing abortion care by increasing the availability of medication abortion in facilities that would otherwise not have services or have only limited availability,(11,12) thereby enabling some patients to obtain care closer to home.(12)*"

Comment 2: Ln 91: What determined eligibility related to gestational age? Protocols by the PP health centers?

Reply 2: The Planned Parenthood health centers set the gestational age limit for medication abortion, in accordance with research evidence and the United States' Food and Drug Administration's approved regimen for medication abortion.

Changes in text: We have clarified this on page 5, lines 108-109, which now reads: "*The gestational age limit for medication abortion was set by the Planned Parenthood health*

centers."

Comment 3: Ln 103: Authors note interviews were conducted over the time period "due to staggered implementation of TeleMAB across health centers over a period of time". It's unclear how these are related: Is it that the staggered implantation resulted in a longer time period than readers would expect? I'm unclear on what, exactly, is "due to staggered implementation…"

Reply 3: Thank you for flagging the need for clarity around the data collection period. The site-to-site telehealth services were introduced at different time points across the clinic network over the course of 30 months. We initiated recruitment at each health center as telehealth services were launched there. As a result, the data collection period overall was long.

Changes in text: We have re-phrased this sentence to articulate the data collection process clearly on page 6, lines 126-128. The line now reads: *"We initiated recruitment for interviews on a rolling basis as site-to-site TeleMAB services were implemented at different health centers between August 2016 and January 2019."*

Comment 4: Ln 170: More comfortable than…? Either omit the explanation of the quote altogether (eg "including one person who said, 'I think I felt…") or note they felt more comfortable than they would have with an in-person visit.

Reply 4: Thank you for noting the incomplete thought in this sentence. We have updated this statement (p. 9, lines 206-207) to indicate the client's report of greater comfort speaking to the doctor via telehealth rather than in person. This line now reads: "*Many participants reported feeling comfortable during the telehealth visit, including one person who said that they felt more comfortable than they would have in an in-person visit, "I think I felt more comfortable speaking to her on the screen then I would be in person.""*

Comment 5: Ln 174: Repeated use of "those" interrupts the flow of the sentence.

Reply 5: We appreciate this editorial feedback. We re-phrased these findings on page 9, in lines 209-212. The line now reads: *"Several participants reported that they would have felt more comfortable during an in-person visit, and of those participants, some reported a preference for in-person care. However, the telehealth participants who reported a preference for in-person care reflected that they still felt comfortable during the site-to-site TeleMAB visit."*

Comment 6: Ln 207: Is "brushed" supposed to be "rushed"?

Reply 6: The audio file from this interview confirms that the interviewee used the word "brushed" and not "rushed."

Changes in text: We have changed the word from *"brushed"* to *"[rushed]"* for the reader's clarity in line 243 on page 10.

Comment 7: At the start of the paper, authors should offer context regarding existing

research on experiences with TeleMAB and the significance of these findings—perhaps state the info in ln 343-344 at the outset.

Reply 7: Thank you for this feedback. We agree that it would be helpful for the reader to have more context about previous studies and the significance of these findings.

Changes in text: We have added more information about existing TeleMAB research on page 4 in lines 78-81, which now read: "*In 2011, an evaluation of site-to-site TeleMAB services in Iowa demonstrated that both patients and providers found the service to be highly acceptable, and most patients reported feeling positive or indifferent about meeting with the provider over videoconference. (14) In addition, a 2013 study of provider experiences with a TeleMAB service at Planned Parenthood health centers in Alaska found that the service allowed the clinic to increase the number of medication abortion appointments, which supported patients in receiving care sooner and at earlier gestational ages.(13)"*

We also state the significance of our findings on page 5, lines 92-94, which now read: *"The findings presented below fill a gap in the literature by providing evidence about experiences using the site-to-site TeleMAB model across multiple locations in the United States."*

Comment 8: Similar to my initial comment, consider placing the analysis of the interviews in terms of addressing specific barriers/issues in abortion care rather than "access" more generally.

Reply 8: We agree that the framework for this paper could benefit from more specific examples of how the site-to-site model can address specific barriers to care.

Changes in text: As stated above, more context about the ways the site-to-site telehealth model can address issues in access to abortion care has been added to the Introduction (pg. 3, lines 63-66). The line now reads: "*The site-to-site TeleMAB model can mitigate some obstacles to accessing abortion care by increasing the availability of medication abortion in facilities that would otherwise not have services or have only limited availability,(11,12) thereby enabling some patients to obtain care closer to home.(12)"*

We also added more details to the discussion about how our findings highlighted the ways in which the site-to-site model could expand access by increasing medication abortion availability. On page 16, lines 362-369 now read: *"Providers in this study reported that site-to-site TeleMAB benefited people who lived far away from the clinic, and that the services helped increase medication abortion availability in states where abortion care options are limited. Their experiences align with findings from a recent study that found that the introduction of site-to-site TeleMAB in Montana and Nevada led to an increase in the uptake of medication abortion in both states.(11) Providers also reported that the site-to-site TeleMAB model may have helped patients get to the health center earlier, and the populations who may benefit the most from the site-to-site TeleMAB services include those who prefer medication abortion over aspiration abortion and are close to the gestational age limit for medication abortion."*

Lastly, we suggest that to equitably expand access to telehealth for medication abortion services,

there is more work to be done to uproot structural systems that make access to telehealth services inequitable, especially for communities of color. These changes are on pages 18-19, lines 422-429, and read: *"Although both the direct-to-patient and the site-to-site model offer opportunities to expand access to abortion care in the United States, more work is needed to dismantle the structural systems that prevent access to telehealth.(31) Digital redlining, for example, has resulted in a lack of internet access for communities of color compared to wealthier, white communities.(32) Studies evaluating the use of telehealth during the COVID-19 pandemic demonstrated that the use of telehealth was lower among communities of color, rural populations, and those using Medicare or Medicaid (33,34). These findings underscore the need to address inequitable policies in order to maximize the potential of telehealth."*

Comment 9: Related to the final paragraph, could authors be more clear in the overall paper on what quality of care measures were employed for this study? The authors offer a QoC conceptual framework on p. 2 but don't clearly use this framing in the analysis—are the authors using patients' experiences to define QoC? This should be clearer if so.

Reply 9: Thank you for this feedback. In this study we aimed to capture various aspects of perceived quality of care experienced.

Changes in text: We have added additional clarity about how we aimed to capture acceptability through client's perceptions of quality of care. We cited the Agency of Healthcare Research and Quality's Six Domains of Health Care Quality to define quality of care because it encompasses patient-centered care as a measure of quality, in addition to safety and efficiency. Page 6, lines 131-137 reads: *"We aimed to assess acceptability of services by asking participants about various aspects of perceived quality of care,(19) such as how they were treated in the clinic and if they felt comfortable in the exam room. We also asked site-to-site TeleMAB patients about their comfort level meeting with the doctor remotely, if they had all of their questions answered, the level of privacy, the sound quality of the videoconference, and things they liked and disliked about the experience. We also asked both site-to-site TeleMAB and MAB patients whether they would recommend site-to-site TeleMAB services or the standard in-clinic MAB services to a friend."*

I appreciate the opportunity to review! Overall (in keeping with my comments) I suspect there remain key connections that are well understood by authors, but not yet clearly explained in the paper.

Reviewer B

This is a very timely intervention, given the recent FDA decision on Mifepristone.

Comment 1: On page 7 line 218-225, the authors may consider quantifying the qualitative data. Instead of saying "Some participants highlighted things they disliked..", they can tell us how many participants disliked. Similarly, when they say "One person" and followed with "One person" it is not clear if we are talking about the same person. They could say "Another person" if and where applicable.

Reply 1: Thank you for this feedback. To clarify, participants were asked to describe specific aspects of the services that they liked and disliked, and many participants described both things they liked and disliked. While we have not attempted to quantify the specific number of comments that touched upon a given them, we have clarified the comments that come from another individual as you suggest for clarity.

Changes in text: We have clarified the comments in on page 11, lines 256-258, which now read: *"One participant expressed a negative experience discussing birth control options, and two participants, as mentioned above, shared concerns about privacy because of a door left ajar. Another person, also mentioned above, had technical issues that resulted in a longer-than-anticipated wait time."*

Comment 2: In methods, the authors should note how long the interviews lasted.

Reply 2: The authors agree it would be informative for the reader to know the duration of the interviews.

Changes in text: We added the range of the interview times in minutes for patient interviews and for providers. The duration of the patient interviews is now on page 7, line 143 and reads *"Patient interviews lasted from 15 to 50 minutes."* The duration of the provider interviews is now on page 8, line 166 and reads *"Provider interviews lasted from 30 to 60 minutes."*

Comment 3: Since the study involves different states, it may be interesting to mention if there have been any differences in the experience of TeleMAB abortion depending on the state. The same question is also interesting for providers.

Reply 3: Thank you for this suggestion. We looked across states, however, did not see any differences in patient and provider responses. This is likely in part because there are only a few participants included per state. Therefore, it is unlikely that we could confidently identify trends in experiences by state.

Changes in text: We did not make any changes to the text because we did not identify any differences in responses, however, we did address this as a limitation in the Discussion. Page 17, lines 386-388 now read: "*Lastly, the small number of participants per state did not allow us to immediately identify any trends or differences in experiences across states."*

Comment 4: The authors do not really resume the findings and leave out some of the

elements in the discussion session. Here it is good to mention that while majority felt comfortable, some concerns around privacy, negative interactions with staff and technical difficulties were addressed by study participants.

Reply 4: Thank you for your suggestion to add more details from the Results to the Discussion.

Changes in text: We added more details about participants' concerns around privacy, the technical issues experienced, and the negative interactions with staff on page 15, lines 338-345 now read: *"Our findings indicate that most TeleMAB patients felt comfortable using the telehealth service, and that providers thought that TeleMAB made medication abortion more accessible. Although the majority of the TeleMAB patients reported feeling comfortable, some respondents reported a preference for meeting with the physician in-person, rather than over videoconference. A few TeleMAB patients discussed concerns around privacy during their conversation with the doctor, and some patients reported encountering technical difficulties. Two participants noted negative interactions with staff."*

We also added additional detail about where concerns around privacy have shown up in previous literature on page 16, lines 355-357: "*Reasons for privacy-related concerns , including not being able to tell if anyone else was in the room with the remote physician, have been documented in a previous study.(14)"*

Comment 5: The providers' opinion on who can benefit from telemedicine is also worthy of discussion and can be expanded-this may be of particular importance for the US context where access remains unequal and even contested (because of protestors in front of clinics) across the country. The literature shows that telemedicine can extend access to rural areas and underserved populations, and can enable individuals to mitigate stigma.

Reply 5: Thank you for this suggestion, we agree that the findings around who can benefit most from TeleMAB is worthy of further discussion. These findings also align with the provider perceptions about the ways in which the site-to-site model can impact access to abortion care in the United States.

Changes in text: We have expanded the discussion so that the text on page 16, lines 361-374 now reads: "*Providers in this study highlighted the ways in which the site-to-site TeleMAB model could address some of the disparities in abortion access in the United States. Providers in this study reported that site-to-site TeleMAB benefited people who lived far away from the clinic, and that the services helped increase medication abortion availability in states where abortion care options are limited. Their experiences align with findings from a recent study that found that the introduction of site-to-site TeleMAB in Montana and Nevada led to an increase in the uptake of medication abortion in both states.(11) Providers also reported that the site-to-site TeleMAB model may have helped patients get to the health center earlier, and the populations who may benefit the most from the site-to-site TeleMAB services include those who prefer medication abortion over aspiration abortion and are close to the gestational age limit for medication abortion. Current evidence suggests that many abortion patients who express a preference for medication abortion encounter delays in accessing care, and are*

beyond the gestational age limit for medication abortion, making them ineligible for the procedure.(24) This underscores the importance of increasing overall availability of MAB, as well as reducing delays in access."

Comment 6: The discussion can also expand on overall and in light of these findings to what extent and in what ways teleMAB is different than in-person care and also talk specifically what teleMAB can bring to the abortion care provision in the US. One could argue that telemedicine provides an acceptable alternative to in-person care and can meet the needs, demands and preferences of some abortion seekers.

Reply 6: We agree that we can add depth to the Discussion by illustrating how the site-to-site TeleMAB model can address some of the challenges in accessing abortion care in US, and that the findings in this study support that TeleMAB is an acceptable method of care. However, given that the findings also illustrate that some people prefer in-person care, it is important to highlight that the site-to-site TeleMAB model should be one option among a range of safe and acceptable options for care, rather than an alternative.

Changes in text: We have added more detail about what the site-to-site model can bring to abortion provision in the US on pages 19, lines 436-439, the text reads: "*The high-level of acceptability for the site-to-site TeleMAB services demonstrated in this study and others, suggests that the service should be offered as part of a range of safe and acceptable service models available to patients to ensure they receive care in the way they prefer."*

Comment 7: I see the interviews were done prior to COVID-19, but perhaps in the discussion the authors can discuss how the pandemic has changed the abortion landscape globally and different telemedicine models were applied, in direct-to-patient form elsewhere notably in the UK and France. Several mixed-method studies conducted in these countries evaluate these models and these results can be useful to include in the final discussion.

Reply 7: Thank you for this suggestion, we agree that it would be beneficial to add findings from recent studies evaluating patient experiences using direct-to-patient models during the height of the pandemic in 2020.

Changes in text: We have added the following text on page 18, lines 410-417: *During the onset of the COVID-19 pandemic, in-clinic requirements for medication abortion were lifted in some countries, including the United States, in order to mitigate the risks associated with in-person care. As a result, abortion providers were able to implement direct-to-patient medication abortion using telehealth. Studies in the United States found that the direct-to-patient models implemented during the pandemic were safe, effective,(26,27) and acceptable to patients.(27) These findings were also echoed in studies examining patient experiences using direct-to-patient models during the pandemic in 2020 in the United Kingdom(28-30) and France.(31)*

Comment 8: Authors may want to refer to the latest 2022 WHO Safe Abortion Guidance

which has an extensive section on telemedicine abortion.

Reply: Thank you for noting the recent 2022 WHO Safe Abortion Guidance, which was published after we submitted the original manuscript. We agree that the inclusion of telehealth in the WHO guidelines offers additional evidence for the safety, efficiency, and acceptability of telehealth.

Changes in text: We have cited the new WHO guidelines in on page 4, line 67, which reads, *"Site-to-site TeleMAB is safe, effective, and comparable to in-person care (11,13–17)."*

Reviewer C

Overview:

The topic of telemed abortion is very timely. The idea that people have to travel to a health center to meet with a clinician will likely fall out of favor, making this study less generalizable. However, given the uncertainty regarding how services are offered and that traveling to a clinic to talk to a clinician via video may be desired by some patients, I believe it is important to publish this study.

This study is unique because it includes both patient and provider experiences of site to site telemedicine.

Comment 1: The authors defined TeleMAB as site-to-site care that is associated with "diagnostic testing, such as an ultrasound". This level of care is not what many currently think of TeleMAB, which does not require a visit to a clinic and diagnostic testing. Thus, the use of "TeleMAB" in this paper is confusing and technically misleading. Please find another term to describe an in-clinic visit with part of the visit being video consultation with mife prescriber.

Reply 1: Thank you for flagging the potentially misleading use of the term "TeleMAB" for the site-to-site model.

Changes in text: We have replaced the use of the term "*TeleMAB"* with *"site-to-site TeleMAB"* throughout.

INTRODUCTION: Discuss introduction: Does it clearly define the main aspects of the topic being investigated and explain the aim of the study?

Comment 2: Pg 2, ll 58-59. The authors use the Price and Hawkins social analysis framework – need to explain better how this framework fits with the study. Was it used to shape the research questions/interview guide?

Reply 2: In the introduction, we use the Price and Hawkins framework to justify the assessment of the telehealth site-to-site model beyond the measures of safety and effectiveness. As noted in the changes to the Methods section, the research questions and interview guide were developed based on previously published studies on the site-to-site model for telehealth.

Changes in text: We have added more context about the use of the Price and Hawkins framework on page 4 in lines 74-79, which now read: "*Price and Hawkins' approach to evaluating reproductive health services provides an important basis for examining the acceptability of the site-to-site telehealth model for patients and providers. Ibis Reproductive Health (Ibis) has partnered with Planned Parenthood Federation of America to assess the acceptability of the site-to-site telehealth services for patients and providers and identify areas for improvement."*

Comment 3: Pg 2, ll73-75: The authors define the purpose of the study which is not in line

with aims noted in the Methods.
Reply 3: We apologize for any confusion with the objectives of the study. We have clarified the aims of the study in the introduction. As noted below, we have also edited the Methods section to give more clarity around the aims of the study documented in this paper.
Changes in the text: The aims stated in the Introduction, on pages 4-5 lines 90-94, now read: *"This study sought to document the experiences of patients and providers using site-to-site TeleMAB with a focus on acceptability and perceptions of access. The findings presented below fill a gap in the literature by providing evidence about experiences using of the site-to-site TeleMAB model across multiple locations in the United States."*

METHODS:

Comment 4: Pg 3, ll81-82: this sentence suggests that the in-depth interviews were conducted to evaluate patient satisfaction. But in the Introduction, the authors state that the study "sought to document the experiences…with focus on acceptability and perceptions of access." The authors need to be consistent and clear about the aims of the study, why qualitative methodology was the best method to meet the aims of the study.
Reply 4: Thank you for flagging the need for clarity around the aims of the study. The interviews were conducted as part of a larger study that aimed to measure patient acceptability with the medication abortion services they received at Planned Parenthood health centers, which includes their satisfaction with the services. However, we understand how the term "satisfaction" may seem inconsistent with the purpose of the study.
Changes in text: We have added more consistent language in the Methods by changing *"satisfaction"* on page 5, line 99 which now reads, "*We conducted in-depth interviews with 29 abortion patients as part of a larger study that aimed to evaluate patient acceptability of medication abortion services received at Planned Parenthood affiliate health centers in five states: Alaska, New York, Maryland, Montana, and Nevada*. We also clarified the aims of the larger study on page 5 in lines and 109 to 114, the line now reads: "*As part of the larger medication abortion acceptability study among Planned Parenthood patients, eligible patients were invited to complete an online survey two weeks after the appointment where they received the medication abortion pills. We recruited interview participants from the pool of patients who completed the online survey; upon completing the survey, participants interested in interviewing were redirected to an anonymous online interview interest form where they could provide their contact information."*

Comment 4: Pg 3, ll 95-97: It is unclear if this study sought to "evaluate patient satisfaction…." And patients completed a survey about satisfaction, why none of the findings from the survey were reported in this paper? It is also not clear why the authors did not link the survey responses with those who chose to participate in the in-depth interviews?
Reply 4: Results from the patient survey are being prepared for a forthcoming publication. We

did not link patient responses to their surveys because the study team wanted to assure participant confidentiality, and potentially increase the candidness of participant responses.
Changes in text: We have added more details around the decision to not link the participant's survey and interview responses on page 6 in lines 120-122: "*We did not link participant survey responses to the interview interest form or subsequent interview responses to ensure confidentiality and to increase the candidness of the interviewee's responses.*"

Comment 5: Pg 5, ll133-135: qualitative analysis methodology is poorly described and should be grounded in a theoretical framework and referenced. The authors should also explain why they are choosing their particular approach to analysis and not another approach.
Reply 5: Thank you for noting the need for more clarity around our analytic approach. We used a modified grounded theory approach for analysis to better understand factors that impacted patient's perspectives of acceptability.
Changes in text: We have added details and citations for choosing grounded theory methods on page 8, lines172-174: *"A modified grounded theory approach was applied to our analysis to assess the factors that impacted participants' perspectives of acceptability and impact on access.(21,22)"*

Comment 6: Pg 4, ll105-111 – There is little insight into the interview script – how was it developed. Did a framework guide the development of questions? Of note, it seems like the interview script questions are listed more in the Results section, rather than Methods. I think for this particular study, it would be helpful to list the questions in the methods with a rationale as to why those questions were asked. Often, questions are asked to meet a specific aim of the study, and it would help if that is clarified in the Methods section.
Reply 6: Thank you for noting the need for more details regarding the development of the in-depth interview guides. We agree with your suggestions to add more details about what was asked in the interviews in the Methods, rather than the Results.
Changes in text: We added more details about the development of the patient guides in lines on page 6 in lines 129-138, which now read: "*Patient interviews were conducted by telephone using a semi-structured interview guide adapted from a previously published study assessing patient acceptability of site-to-site TeleMAB services in Iowa.(14) We aimed to assess acceptability of services by asking participants about various aspects of perceived quality of care,(19) such as how they were treated in the clinic and if they felt comfortable in the exam room. We also asked site-to-site TeleMAB patients about their comfort level meeting with the doctor remotely, if they had all of their questions answered, the level of privacy, the sound quality of the videoconference, and things they liked and disliked about the experience. We also asked both site-to-site TeleMAB and MAB patients whether they would recommend site-to-site TeleMAB services or the standard in-clinic MAB services to a friend.*"

We also added more details about the creation of the provider interview guide on pages 7-8, lines 156-163: "*The provider interview guide was adapted from a previously published study examining provider acceptability and perspectives of a site-to-site teleMAB model in Alaska.(12) In order to capture provider acceptability of the site-to-site TeleMAB services, we asked providers to share their opinions about the services, including benefits and challenges. We also asked providers to share their perspectives of site-to-site TeleMAB's impact on abortion access, who benefitted the most from the site-to-site TeleMAB services, and if there were patients who might be better served by an in-person visit."*

Comment 7: It may be helpful to note which clinics were offering site to site telemed longer than others? I wonder if a more experienced clinic may have different outcomes than those that just started offering services?

Reply 7: Thank you for this feedback. Other than some in Alaska, sites were not previously providing site-to-site TeleMAB services before the study, so while this comment is noted, we did not make any changes to the text.

Comment 8: It would help if the authors could describe the part of the clinical visit that requires meeting with a clinician via video. Do the patients use their own phone to meet with the clinician via video? Does the clinical site where the patient is sitting set up the video and make sure it works for the patient?

Reply 8: We appreciate this feedback about the need for clarity around the videoconference platform. The videoconference platform was accessed from the clinic's computers, set up in a private room. The clinic staff set up the system and ensured that all of the sound and visual functions were working.

Changes in text: We added these details on page 3 in lines 57-61, which now read: *"Instead of meeting with the physician in-person, patients meet with the physician via a videoconference platform on a clinic computer in a private room. Prior to the physician-patient encounter, clinic staff set up the videoconference platform and ensure that the audio and video functions are working."*

RESULTS:

Comment 9: P 6, ll 161: the term "comfort level" seems like a new term that wasn't specifically outlined in the Methods. As stated earlier, it would be helpful if the authors were clearer about what they are measuring in this study. Between the intro, methods and results, it seems like they are measuring "acceptability, perceptions of access, satisfaction, "yet the results list "comfort." If the authors can better tie in how "comfort" is related to "satisfaction?" or "acceptability of access?" the findings will appear to be more relevant.

Reply 9: We appreciate this feedback for the need for clarity around the measures addressed in this study. As stated above, we have added more details in the Methods to better explain how we assessed acceptability in this study, which includes aspects of perceived quality of care.

Changes in text: As mentioned above, we have added details about how we aimed to assess acceptability on page 6, lines 131-133, which reads: *"We aimed to assess acceptability of services by asking participants about various aspects of perceived quality of care,(19) such as how they were treated in the clinic and if they felt comfortable in the exam room."*

Comment 10: Pg 6, ll169-170: I find it a bit odd that the interviewers are asking about the video sound quality, especially if the clinics where the patient is sitting is in charge of that equipment. It seems like the findings related to the video sound quality for this study is more a QI component for the clinical sites, and not applicable to "real world" telemedicine where patients have to figure out how to get onto the video themselves. To keep this study more generalizable, the authors could shorten by removing information about the sound quality?
Reply 10: We appreciate this perspective and feedback about the findings related to sound quality. We agree that this finding could be more presented more concisely. However, even if the clinic staff is responsible for setting up and troubleshooting the telehealth equipment, the client's ability to hear the physician during their appointment would impact their perspective of the service.
Changes in text: We have condensed the findings around audio quality on page 10, lines 231-232, which now reads: *"The majority of site-to-site TeleMAB participants said that the sound quality was good, and one person said there was a slight delay in the audio."*

Comment 11:Pg 7, ll 215: Can the authors clarify "shorter wait time"? Im assuming that patients who chose TeleMAB did so because the appointment was sooner than being in clinic. But it is not clear whether the patient is referring to how long they had to wait to get the appointment versus how long they sat in the clinic. If "shorter wait time" is the latter, it begs the question regarding how a patient would know that people with in-person visits wait longer than those in-clinic and have a video consultation with a mife prescriber?
Reply 11: Thank you for flagging the need for clarity around this participant's response. This participant thought that the TeleMAB service facilitated a shorter wait-time in the clinic, specifically when waiting to meet with the physician.
Changes in text: We have clarified this finding on page 11, lines 248-251, which reads: "*Other positive aspects of the site-to-site TeleMAB visit described by patients included that it was a more personal experience than an in-person visit with a shorter wait time for meeting with the physician, and that the virtual waiting room gave them time to acclimate to the visit."*

DISCUSSION:

Comment 12: Pg 11-12, ll347-360. I appreciate the authors' attempt to convey future work, but it isn't clear what is informing all of these suggestions? For example the suggestion about those who experience intimate partner violence is a good one, but the authors should provide a rationale, like # of patients who may be in this situation or how victims

of violence may be more prone to seek abortion services.

Reply 12: Thank you for noting the need for my clarity around the recommendations for future work. We agree that this section could benefit from more details about what is informing these suggestions, including the rationale for better understanding experiences of privacy.

Changes in text: We added these additional details on pages 17-18, lines 392-408, which now read: *"Future studies of telehealth for medication abortion services should incorporate additional quality of care measures to gain deeper insight into how telehealth for medication abortion is meeting the care needs of patients. Researchers should include measures such as accessibility of accurate and unbiased information about abortion care and telehealth in order to better understand patient care decision-making. In addition, future quality of care measures should also assess how patients from groups that are targeted by systems of oppression experience telehealth for medication abortion; for example, how provider use of gendered terminology and other cultural competencies can impact patient-provider interactions. Lastly, our study did not evaluate differences in feelings about privacy for site-to-site TeleMAB and MAB patients, however, this information would be valuable for identifying ways to ensure patient confidence in the privacy and security of TeleMAB and MAB appointments, especially for those who are experiencing intimate partner violence, which is common among people seeking abortion."*