This chapter is designed to aid primary care clinicians interested in integrating abortion services into their own practice. In recognizing the range of our audience - different states, training backgrounds, and political environments - we have aimed to provide a breadth of tools that may be useful to you as you proceed. Additional tools and/or handouts are downloadable (with links underlined) throughout this chapter. They are also available online at http://www.teachtraining.org/Workbook.html

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

☐ Discuss important initial steps for introducing services into a practice.
☐ Learn pertinent aspects of medical documentation, quality assurance
☐ Understand security precautions important for abortion provision.
☐ Know legal and reporting restrictions for your state.
☐ Know malpractice and financial opportunities and restrictions for your setting.
☐ Understand where you can find support locally, regionally, and nationally.

READINGS / RESOURCES

  • Chapter 23: Ensuring quality care in abortion services
  • Appendix: Resources for Abortion Providers
SUMMARY POINTS

SKILL

- Integration of services into your primary care setting helps to normalize abortion as a part of your patients’ regular health care.

- Clinical experience is easier to attain during residency when your credentialing and malpractice are covered, although those who have endeavored to obtain training after residency have been more likely to provide

SAFETY

- Train staff to handle medical emergencies and security-related situations.

- Make arrangements for hospital backup that you may occasionally need.

ROLE

- Be patient and persistent as the process of integrating skills may take some time.

- While you may find yourself the most knowledgeable person regarding abortion care at your practice, don’t assume you have to know everything. Use the local and national networks to build a sense of collaborative community, find answers to questions (medical and administrative), and challenge yourself to learning best practices.
ABORTION IN PRIMARY CARE

Below are two examples of primary care providers who have successfully integrated abortion care into their primary care practice:

**Urban Provider**

“I work at a private family practice office in an urban suburb. It’s a small office, with only 2 providers working at any time, and we see a culturally-diverse mix of insured, under-insured and non-insured patients. When I started there, the owner was already providing medication abortions (MABs). He says he was always interested in providing full-spectrum women’s health care (and until recently when he had difficulties finding obstetric back-up, he was also doing deliveries). And so he called the maker of Mifeprex, who made it very easy -- they sent him all the information one would need to get set up. The main things he had to do were decide to follow the evidence-based protocol then find a physician who would perform the aspiration procedure if necessary. The process is simple: patients are counseled about options during the visit and, if they choose a MAB, we do a pelvic exam and confirm dates (if there is any doubt about dates or ectopic by history or exam we send the patient for a formal ultrasound) and do the rest of the usual evaluation. We check a serum hCG before and after the procedure to confirm; no ultrasounds. I have given patients my number to call if there are any questions, but we also have a formal call system. It is a great part of the practice. The first time I did a MAB there it was with a teenage woman whose father, also a patient in the practice, had recently and unexpectedly died. It felt great to be able to help her through this time in an office where she and her family were known and comfortable.

We are now interested in also providing aspiration procedures. Two of us are completing training with MVA so that hopefully we can help his office to set up for this. While there will be challenges, I know there will be invaluable rewards to providing this procedure in a known, comfortable primary care setting.”

**Rural Provider**

“I am an FNP sharing a primary medical care practice with a physician. We integrate abortions into our everyday schedule via walk-in appointments. We find this a more relaxing way to schedule and it sets a better tone from the start. Every day has walk-in appointments unless we are just too slammed. The receptionist takes money, gives the woman literature to read on her choices (we offer medication method up to 9 weeks, MVA or electrical suction, and IV vs. PO pain meds. Our nurse takes the woman back and we do an ultrasound even while seeing our other patients, and then the nurse proceeds with the intake. We go back to review the information and have the consent signed. If the suction procedure is wanted, then we do schedule that usually for another day as we like to prep with vaginal misoprostol and often the woman needs a driver (if she chooses IV meds). For the medication method, we give the meds and will do a walk-in follow-up in 7-14 days at which time we do a contraceptive visit as well.
We are the primary site of abortion care in the southern half of our state and we find it fits into our primary care setting perfectly. Most of our patients do not know we even do abortions. The local Planned Parenthood’s get picketed by anti-abortionists and they don’t do abortions. About 8 years ago in our little town, a doc who did only abortions had his office bombed and totally destroyed. We are therefore somewhat secretive and thus our abortion patients can blend into our primary care setting and this is good."

The best abortion services take time to build. Incorporating abortion services into your practice is a process during which you may need to explore core values and attitudes of your staff, while simultaneously attending to the more concrete tasks of ordering new medications and implementing new protocols. Approaching this process with a commitment to open dialogue is fundamental to a successful outcome.

GETTING STARTED

This section addresses fundamental questions about training your staff, setting up your facilities, and ordering supplies for abortion care.

Be realistic and patient about the amount of work time this process will take. It will take time to integrate abortion and may require various staff meetings and trainings. It will help to clearly articulate the reasons you decided to include abortions in your practice. You may be asked to defend your decisions if, for example, you are faced with an unhappy staff person or realize you have spent more than you made your first month. Returning to your core beliefs about the importance of caring for your patients will be valuable.

GETTING STAFF INTERESTED

Everyone on staff should be considered in the groundwork for expanding reproductive health and abortion care, including preparing, training, and offering abortion services. Specifically, they should be exposed to the principles of values clarification and non-judgmental language. Experience has shown that even those staff who may not believe in abortion are more likely to be involved if their feelings and beliefs are acknowledged early on and respected. How to begin:

1. Conduct a Values Clarification Workshop (available at http://www.reproductiveaccess.org/integrating_reprohealth/values_clar.htm. This is an invaluable process that can be used in many settings to:
   - Address anxiety around change.
   - Identify and dispel myths.
   - Separate personal beliefs from professional roles.

2. Offer lunchtime trainings or discussions to:
   - Introduce updates in contraception, unintended pregnancy, and early abortion, as well as the public health impact of limited access to abortion services. Some helpful slide presentations on abortion can be found on the Guttmacher Institute website at http://www.guttmacher.org or PRCH website at http://www.prch.org.
• Some have used the papaya workshop for MVA training as an orientation and icebreaker.
• Role-play options counseling and information sessions (refer to Chapter 2).
• Answer questions over the phone
• Explore what is entailed in informed consent for abortion (see Chapter 2 and the Medical Documentation section in this chapter).
• Learn verbal and non-verbal tips to build rapport with patients (Chapter 2).
• Assist during and after procedure (see Quality Management section of this chapter).
• Prepare for potential negative reactions from friends and family about being involved in abortion care (see excerpts from “Abortion and Options Counseling,” Anne Baker from the Hope Clinic).
• Have a plan for integrating staff that do not wish to be involved in all aspects of abortion care. For instance, answering phones, making appointments, or providing contraceptive counseling, instead of assisting in the procedure room.

3. Identify and include key staff to participate in conversations and decisions around the following:
• How are you going to integrate/schedule abortion services into the practice?
• What will your fees will be? (see Financial Issues in this chapter)
• How much information will you give over the phone?
• Will you have childcare available?
• Can support persons be present throughout the entire process?
• Will you require your patient to have a ride home (important if you are going to offer IV sedation)
• Will you accept abortion patients who are not already in your practice?
• Will you advertise?
• How will you let your patients know you will offer abortion services?
• Does your malpractice insurance cover abortion?

**MAKING APPOINTMENTS AND SCHEDULING ISSUES**

Consider making “every effort to minimize the time between the patient’s request for an appointment and her procedure, as well as the number of visits required to complete the process” (Henshaw, 1995). We know from patient satisfaction data, that women prefer a one-day abortion procedure and want an immediate appointment (within 3 days of calling). Based on patient forecast consider setting aside procedure-specific time slots to accommodate patients quickly.

“Patients often measure the clinic’s diligence in pursuing their best interest based simply on their perception of the clinic’s efforts in explaining and scheduling their appointment,” Striving for Excellence in Abortion Care: A Self-Assessment Tool. The CAPS Project.

Abortion services can be integrated into practice in a variety of ways. Some clinicians build abortion appointments into their primary care clinic schedule, thereby interspersing appointments throughout the week. Others prefer to establish a “procedure day” during which they offer abortions and perhaps other procedures.

As you know, medication abortion requires a shorter visit than aspiration abortion. Both require lab work, counseling, and an informed consent process. Aspiration abortion will
also require procedure and recovery time. The visit may also include an ultrasound. Most clinicians can facilitate a medication abortion within a routine visit, whereas many clinicians will require a double appointment slot to accommodate patients wanting an aspiration abortion. Remember that your time spent going over information and handling forms will improve with familiarity.

Refer to the Phone Script to help your receptionist handle various abortion inquiries.

IMPORTANCE OF CONFIRMATION CALLS

While confirmation calls may be a regular part of your existing practice, it has a particular importance with abortion patients. Beyond the reminder of their appointment, you are calling to:

- Show concern, answer questions, and demystify fears
- Address concerns about transportation or payment
- Give important reminders (e.g. wear 2-piece clothing, underwear for a pad, be sure to have a ride home)

Some argue that there is a risk of breaking confidentiality; however the confirmation call can be done using a code name, calling your self the doctor’s office, or not being made if the client refuses to be contacted.

Where services are more available, patients shop around for abortion care. They may have an appointment with you and still plan to go elsewhere. Contacting them may ensure that you are the preferred provider or alert you to a cancellation.

NO SHOWS

There are many factors that may feed into a “no show” patient: uncertainty, fear of the procedure, lack of funds, transportation, pressure from friends/family, or ambivalence.

You may want to call your patients who fail to show that day. Ask them if they would like to reschedule their appointment to a more convenient time, or if there is any other service that they need. This continues to show concern during what may be a difficult time for them.

Your no show rate is not an immediate measure of success or failure, but rather a reality in even the most successful dedicated abortion clinics. Do use the information gathered from patient comments during your confirmation and follow-up calls to tailor your service to better meet patient needs.

REFERRALS

Occasionally, you may have a patient you cannot help. She may be too far into the pregnancy, request or need general anesthesia, or require counseling beyond your scope. Have referral numbers for the nearest:

- Abortion providers (be familiar with their fees, anesthesia options, gestational limits)
- Adoption services: open and closed
- Counseling
- Domestic Violence
• Sexual Abuse
• Child Protective Services
• Translator services
• Crisis lines (suicide, overdose, etc)
• After abortion counseling referrals

AFTER HOUR CALLS

It is critical to provide your abortion patients with an after-hours contact number. Counseling patients on what to expect will help decrease the number of calls, but in the majority of cases, a phone call can save your patients a trip to the emergency room. According to the National Abortion Federation (NAF), abortion providers “must provide an emergency contact service on a 24-hour basis where calls are triaged in accordance with appropriate law. The facility must assure physician referral if indicated (NAF Clinical Policy Guidelines 2011.

It will help to have your after hours number printed on your written aftercare instructions. Let your on-call service know you are now offering abortion services

STOCKING YOUR CLINIC: MEDICATIONS

Refer to Chapter 4 in this Workbook for a listing of basic medications. Here are a few medications you will need to stock, or write prescriptions for:

For aspiration abortion:
• Ibuprofen
• Doxycycline
• Lidocaine +/- bicarbonate +/- vasopressin
• Anti-emetic rectal suppositories
• Methergine/ergonovine (PO/IM)
• Misoprostol
• Atropine
• Benadryl
• Epinephrine
• Ammonium “smelling salts”
• Rhogam (50ug dose sufficient through 12 weeks’ gestation)
• Contraceptive methods

For medication abortion:
• Mifepristone
• Misoprostol
• Ibuprofen
• Hydrocodone with acetaminophen
• Rhogam (50ug dose sufficient through 12 weeks’ gestation)
• Contraceptive methods

Refer to the Spreadsheet Tool in the Financial Issues section of this chapter for a comprehensive list of medications and equipment that you will need for your service.
STOCKING YOUR CLINIC: SUPPLIES

Front Desk
- Pregnancy wheels
- Insurance and fee information
- Phone Scripts for abortion questions, as needed
- Referral numbers

Exam Room
- Ultrasound machine (not required)
- Vaginal probe (not required)
- Drape sheets
- BP cuff
- Kleenex
- Chux
- Flashlight
- Knee stirrups or soft padding on foot stirrups
- Emesis basins or bags for vomiting
- Extra sterile medical equipment (small and large spec, tenaculum, MVA parts, set of dilators)

Exam Room
- Cannulas
- Needle extenders (with 1.5 inch, 22 gauge needles) or 20 x 3 ½ Spinal needles, if applicable
- Syringes (control top, preferable)
- Pillow for exam table
- Pitcher of water and cups for mifepristone
- Maxi-pads
- Indirect lighting
- Hooks for clothes
- Chair for support person

Tip: You can make your exam room more comfortable for patients during the procedure by considering the following:
- Indirect lighting will avoid overhead fluorescent lighting shining into the patient’s eyes. This is easy to do by turning an exam light against the wall.
- Hanging a calming mobile or poster over the exam table will help the patient focus.
- You may want to have music in the room.

Recovery Room (or place where patients will recover)
- Mirror
- Patient information handouts
- Patient referrals
- Brown bags for supplies/contraception
- Condom basket
- Emergency contraception (pack or prescription)
- Birth control samples
- Gingerale
- Crackers
- Patient journal (for comments/sharing experiences with other patients)

Lab (or where you will check products of conception)
- Red biohazard bags
- Strainer
- Shallow clear glass or plastic bowl (Pyrex dish)
- Light source, back light (a slide light box)
- Running water to rinse POC
- Tweezers or tissue forceps
- Handheld magnifying lens
- Rhogam in the lab refrigerator
- Containers with fixative for sending tissue to pathology

Tip: Find a laboratory where you can send tissue and blood for hCG.
Emergency

The following is, according to the NAF Guidelines 2011 the minimum equipment and medications that must be available to handle medical emergencies:

- O₂ delivery system
- Oral airways
- Uterotonics
- Epinephrine

STOCKING YOUR CLINIC: VENDORS

Below is a list of supply vendors to help you get started. We do not endorse one company over the other and suggest you call around for competitive prices and services.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Pharm Partners</td>
<td>Vasopressin, oxytocin, and cefoxitin.</td>
</tr>
<tr>
<td>1-888-386-1300</td>
<td></td>
</tr>
<tr>
<td>Berkeley Medevices</td>
<td>Cannulas, vacuum aspirators and accessories.</td>
</tr>
<tr>
<td>1-510-231-2474</td>
<td></td>
</tr>
<tr>
<td>Henry Schein</td>
<td>General medical supplies, including Rhogram and methergine.</td>
</tr>
<tr>
<td>1-800-772-4346</td>
<td></td>
</tr>
<tr>
<td>HPS Rx Enterprises</td>
<td>A distributor for Ipas manual vacuum aspirator and general medical supplies.</td>
</tr>
<tr>
<td>1-800-850-1657</td>
<td></td>
</tr>
<tr>
<td>Pharmapax</td>
<td>Will re-package medications into patient-friendly dosage, with instructions.</td>
</tr>
<tr>
<td>1-800-547-6315</td>
<td></td>
</tr>
<tr>
<td>McKesson</td>
<td>General medical supplies, including Rhogram and methergine.</td>
</tr>
<tr>
<td>1-800-366-8990</td>
<td></td>
</tr>
<tr>
<td>MedGyn Products, Inc.</td>
<td>Forceps, curettes, specula, and tenacula.</td>
</tr>
<tr>
<td>1-800-451-9667</td>
<td></td>
</tr>
<tr>
<td>Medline</td>
<td>General medical supplies.</td>
</tr>
<tr>
<td>1-800-633-5463</td>
<td></td>
</tr>
<tr>
<td>Pie Medical</td>
<td>Ultrasound machines and equipment.</td>
</tr>
<tr>
<td>732-245-0091</td>
<td></td>
</tr>
<tr>
<td>Shimadzu Medical Systems</td>
<td>Ultrasound machines and equipment.</td>
</tr>
<tr>
<td>1-800-228-1429</td>
<td></td>
</tr>
<tr>
<td>Smith Medical</td>
<td>The only U.S. distributor for mifepristone. Only the physician (not pharmacy) can order mifepristone.</td>
</tr>
<tr>
<td>1-800-292-9653</td>
<td></td>
</tr>
<tr>
<td>WomanCare Global</td>
<td>Manufactures manual vacuum aspirator (contact HPS Rx, below, to order)</td>
</tr>
<tr>
<td>1-800-850-1657</td>
<td></td>
</tr>
</tbody>
</table>
FETAL TISSUE QUESTIONS AND DISPOSAL

Patients often have questions about embryo-fetal development, want to see the tissue, or know what happens to the POC. Please refer to Chapter 2 of this Workbook for ideas on how to handle these questions.

One great resource for staff and patients on embryo-fetal development was developed by Center For Choice in Toledo, Ohio. These books provide detailed information about embryo-fetal development throughout pregnancy. Each week of development is described separately and includes a line drawing showing the actual size of the embryo/fetus. On the back of the fetal development page is a photograph of tissue removed during an abortion. Call for order information 419.255.7769.

According to the 2004 NAF Guidelines, page 51, “all surgically removed tissue must be considered biohazardous and be disposed of in accordance with applicable local, state, and federal regulations. A proper protocol for tissue disposal must be in place.” Contact your local Department of Health to find out current regulations.

MEDICAL DOCUMENTATION

Medical documentation is fundamental to patient care, follow up, and risk management. Customized forms that allow you to document quickly and thoroughly will help with the successful integration of abortion care into your practice.

The main forms that you will need include informed consent, operative or procedure note, discharge note, after care instructions, and follow up visit. Consider having fact sheets on comparison of medication versus aspiration abortion, ectopic precautions, Rh factor, contraceptive options and emergency contraception. Examples are available on the website.

In this section, we will review important points to include in staff training.

INFORMED CONSENT

In Chapter 2 of this Workbook you will find information to help train your staff about the issues specific to abortion when obtaining informed consent. It is important for staff to understand the informed consent process – even if they are never formally obtaining it – because they have contact with patients that the provider does not. Staff should feel empowered to bring any concerns to the provider’s attention (e.g. staff witnesses an overbearing partner telling a patient that she has to “go through with this.”).

The goal of informed consent is to assure that the woman’s decision is voluntary and informed and to obtain legal permission for an abortion. Informed consent is a process, not a just signing a form. It is an opportunity to establish a relationship with your patient, ensure the decision is her own, and explore her understanding of the procedure.
ABORTION PROCEDURE NOTES

For medication or aspiration abortion, document and verify:
- Pertinent medical history.
- Confirmation of pregnancy (by urine hCG or US).
- Gestational age, ultrasound results (if performed).
- Completion of procedure (by POC exam, hCG or US).
- Rh testing and immune globulin, if indicated (NAF Clinical Guidelines 2011).

For aspiration abortion, you should also include:
- Pre and post procedure vital signs.
- Comments section – special findings or problems.
- Time (e.g. start and end of procedure, medication given).
- Tissue exam results.
- Allergies.
- Physical exam, as indicated.
- Medications given for pain control, bleeding, or antibiotic prophylaxis.
- Birth control choice including offer of Emergency Contraception.
- Referrals as indicated.
- A note on patient’s tolerance to procedure.
- Scheduled follow-up visit, if applicable.

DISCHARGE NOTES

For aspiration abortion, assure that you have documented that:
- Patient is ambulatory with documented stable BP and pulse.
- Bleeding and pain are controlled.
- Patient understands instructions outlining signs and symptoms of post-abortion complications and after-hours contact number.
- Post op vitals immediately following procedure.
- Final discharge vital signs.

AFTERCARE INSTRUCTIONS

For examples, see Chapter 6 for aspiration abortion and Chapter 7 for medication abortion aftercare. Include the following in your written aftercare instructions:
- Symptoms of possible complications (fever, severe cramps, heavy bleeding).
- What to expect (cramping, bleeding).
- Limitations (sex, exercise, bathing, swimming, heavy lifting).
- After hours phone number.
- When to return for follow-up.

WORKING WITH INTERPRETERS

If your patient does not speak English, and you do not have bilingual staff available, you must have someone who can interpret. A professional interpreter services is best. However, if you must rely on a friend or family member, be sensitive to the possible limitations.
SAMPLE FORMS, FACT SHEETS, and TOOLS

Samples to help you in developing forms for your practice are available on the Website at teachtraining.org/Workbook.html. These include:

- MVA Pre Procedure Note
- MVA Procedure Note
- MVA Consent
- Medication Abortion Consent
- Medication Abortion Log
- Medication Abortion Follow-Up Log
- Medication Abortion Visit (Screening Checklist)
- Post-Abortion Patient Instructions
- Aftercare Instructions – medication abortion
- Aftercare Instructions – aspiration abortion
- Interpreter Agreement
- Working With An Interpreter Training Tool
- Rh Information
- Comparison of Medical and Surgical Abortion
- Ectopic Pregnancy Fact Sheet

ENSURING QUALITY

This section will highlight a few areas in quality management that will help you assess and monitor the integration of abortion into your practice, using a 4-Point Quality Management Approach:

A) Training of staff, documentation, and medical emergencies;
B) Data and audit processes;
C) Patient Satisfaction and Complaint processes;
D) Trend Analysis.

A. TRAINING OF STAFF, DOCUMENTATION, AND MEDICAL EMERGENCIES

Evaluate the training needs of your staff in the following four areas.

1. Sterilization and Disinfection

We have included easy-to-follow training posters on the following techniques from Consortium of Abortion Providers (CAPS):

- Wrapping Instruments and Trays for Sterilization
- Unwrapping Sterile Packages, Using Aseptic Technique
- Decontaminating IPAS Syringe
- Cleaning IPAS Syringe
- Drying, Disinfecting, and Storing the IPAS Syringe
- Reprocessing Vaginal Ultrasound Probe
2. Assisting in Procedure Room

Just as you went through your training to learn appropriate procedure room support techniques, you will train your support staff in many of the same techniques. You may want to review with your staff the information included in Chapter 2 of this Workbook.

We have included a checklist for staff when they are in the procedure room with a patient.

**During the procedure:**

- Address the patient by name and introduce yourself upon entering the room.
- Show empathy and warmth both verbally and non-verbally toward the patient. Look her in the eye and stand near her.
- Indicate that you understand her needs.
- Enlist patient input rather than taking a dominant role during the procedure (offer to hold her hand, if that would be comforting, but do not assume she wants a hand to hold).
- Talk to the patient during the procedure, specifically using relaxation and breathing techniques.
- Explain what is happening during the procedure in simple terms, and relay patient reactions to the provider.

**After the procedure:**

- A staff or support person should stay in the room with the patient while she is recovering (if recovery is in same room).
- Help her into a comfortable supine position.
- Document post procedure vitals while she is lying down.
- Clean up the immediate area before she sits up so that she does not see the instruments or any blood.
- Monitor until she is stable for discharge.
- Have her put on underwear with a pad before she gets off the table. Allow her some privacy with out leaving the room while she dresses.
- Document another set of vitals with her dressed and sitting. These will be the discharge vitals unless she is unstable.
- Check in with your patient about how she is feeling.

Having a support person in the room may allow your staff to have more flexibility with monitoring the patient. Staff may be able to leave the room if the patient has a support person present. The door should be left slightly ajar if staff has to leave. Another option may be to move the patient from the exam room to a semi-private recovery area allowing the patient to be monitored by staff as they continue routine tasks. Consider a recliner chair tucked into the end of a hallway.

**Tip:** After IV pain medications, patients may be groggier and have more nausea than with local anesthesia, therefore requiring more observation and longer recovery time. If you have a separate recovery area, you may want to consider having a wheel chair to transport patient.
3. Documentation

In addition to the standards you already follow for medical charting, here are some things that may be pertinent to abortion care.

- Document who assisted in the procedure.
- Record initials by each set of vitals.
- Use non-judgmental statements in records.
- MD should sign off on ultrasounds, unless performed by a certified radiologist.
- Document allergies, specifically latex, iodine, shellfish, and medications.
- Document any changes in patient status during recovery (e.g. patient states, “I feel dizzy.”), and have provider sign the discharge note.

4. Preparing for Medical Emergencies

Preparedness is the key to managing any medical emergency effectively. You may already do emergency drills for your office, but we have included drills on two scenarios that may occur during an abortion. Further Emergency Drills are available at [http://www.teachtraining.org/resources/Emergency_Scenarios_by_Topic_PDFs/](http://www.teachtraining.org/resources/Emergency_Scenarios_by_Topic_PDFs/).

Scenarios work best when they are acted out. Include all staff. It is helpful to break staff into 2 teams. One observes and later critiques, while the other does the drill.

Role-playing: Have staff go to the places where they would normally be. Monitor:

- Communication
- Response (and time it took to respond)
- Preparedness
- Documentation
- Accessibility of medications and equipment

Medical emergencies will go more smoothly if the staff work well together as a team. Spend some time working on how to communicate with one another during an emergency. Remember to practice documenting in the chart what is happening to the patient. Review where and what medications you will need (e.g. methergine in the refrigerator, ammonia inhaler in the drawer, and O2 tank is in the hall).

**Drill 1: Patient “Feels Faint”**

Scenario: Medical assistant is cleaning room just after an abortion. Patient sits up, states she feels woozy, and appears pale and sweaty.

Set Up: Pick one person to be the patient and another to be the medical assistant.

Action: Each drill should be conducted twice. The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:

- Immediate steps to take: have patient lie down, cool cloth on head or neck, feet up, record vitals.
- Always ask for help.
- Determine who is in charge.
- Know where atropine is kept.
- Know where your ammonia inhalants are kept.
- Discuss how long you want to monitor the patient.
- Review appropriate and timely documentation.
- Discuss actions taken for follow-up.

Perform the drill a second time
- Review staff performance and improvements.

Follow-up
- Discuss preventive measures (e.g. avoid leaving patient unattended and recognize symptoms of a vasovagal reaction).
- Offer positive feedback on improvements.

**Drill 2: Hemorrhage**

Scenario: After presumed completion of the procedure the patient begins to bleed heavily.

Set Up: Assign one person to be the patient. An MD and a medical assistant are in the room with the patient.

Action: Each drill should be conducted twice: The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:
- Did MD communicate clearly to staff how she wants to manage the bleeding?
- If MD needs uterotonics, did the assistant leave briefly or not at all to retrieve it?
- Document vitals signs every few minutes until emergency is resolved

For purposes of the drill, practice managing a hospital transfer:
- MD instructs someone to call to 911/ambulance service
- Designate a staff person to copy entire medical chart to accompany patient, including up-to-date notes and vital signs
- If necessary, designate someone to accompany patient to the hospital
- Designate staff to contact or speak to support person
- Consider if and what to tell other patients
- MD calls ER or hospital doctor ahead of time to discuss the case

Perform the drill a second time:
- Review staff performance and improvements

Follow-up:
- After the emergency is resolved, encourage the staff to debrief about what worked

**B. USING DATA AND AUDIT PROCESSES**

Gathering data and performing audits periodically will allow you to measure how well your newly integrated services are operating. It is important to measure from the patient perspective and to measure systems, not the performance of individuals. Having staff and patients involved in identifying necessary improvements will facilitate positive change.
1. Using Data to Evaluate New Services

To undertake an audit of abortion care in your practice, we suggest you gather data on the following indicators:

- Length of visit
- Patient wait time
- Length of time between first call and appointment date
- Patient perception of pain and pain management
- Ease of scheduling follow-up appointments

Here is a simple but useful methodology for measuring your service indicators:

- Identify criteria
- Set performance goals
- Collect data
- Analyze data
- Identify areas of improvement
- Implement improvement activities
- Evaluate both desired and undesired outcomes

Example: Measuring the Total Time of a Visit

1. Identify criteria: Time from check-in to discharge. It is helpful to note the significant or distinct parts of a visit (start and end times for: completing paperwork, ultrasound, time with provider for counseling and procedure, and recovery).
2. Set performance goals: No more than 1 ½ to 2 hours for visit.
3. Collect data: Create a small sheet where you can collect patient name, date, and above mentioned times. Decide to collect for 2 weeks or a month.
4. Analyze data: Find out where the bottlenecks are within the visit and why they are happening.
5. Identify areas of improvement: Is service taking longer than you thought? Are you taking too many ultrasound pictures? Could you create an FAQ Sheet to help with your patient’s most commonly asked questions? Are there ways to streamline counseling, consents or procedure? Are there necessary and ample instruments in room?
6. Implement improvement activities: Implement the solutions identified for the above problems.
7. Evaluate: Collect data again to see that you made the right improvements. Or, did you create different bottlenecks?

2. Audits to Evaluate your Services

An important part of managing the quality of your services is to review charts for completion and accuracy. This enables you to determine what sort of improvements and training is needed.

We suggest auditing approximately every 3 months after beginning your abortion service, and at least twice a year. National quality standards suggest reviewing 30 charts each time, or 10% of your total visits.
Refer to the sample chart review tools at www.reproductiveaccess.org for auditing medication and aspiration abortion charts: MVA Chart Review, and MAB Chart Review.

We suggest you also conduct audits of the following:
- Medication Abortion follow-up rate
- Any abortion complication (see NAF textbook for complication definitions)
- Number and type of after-hours calls
- Coding practices and actual reimbursement

C. PATIENT SURVEY PROCESSES

In a patient-centered practice having consistent and useful patient feedback is crucial to offering excellent care. This information creates opportunities for reflection, enriches learning, and ultimately helps to improve the patient’s experience.

1. Using Patient Satisfaction Surveys

In collecting patient feedback, it is important to create and maintain an environment where criticism and feedback (both positive and negative) are used for improvement of systems to benefit the patient, not as punishment of individuals.

The following questions come from the 1999 Picker Institute Abortion Study, which identified these as the 22 most important criteria for patients. Consider obtaining patient feedback through the use of surveys on an intermittent regular basis.
We are interested in your opinions about your visit today and about the care you received from your doctor and the staff. Please rate each of the following things about this visit. (Mark one answer for each item).

For the questions below, circle a number from 1 to 5 to indicate how much you agree or disagree with each statement.

1=Strongly Disagree     2=Disagree     3=Neutral     4=Agree     5=Strongly Agree

The person on the phone put me at ease
The person on the phone was knowledgeable
The person on the phone was courteous
The amount of time that I waited to see a staff person was acceptable
In the waiting areas of the clinic, staff was very sensitive regarding my confidentiality
During the procedure, clinic staff showed respect for my privacy
The amount of time with the doctor during the procedure was acceptable
The medications I received for pain management were adequate
The staff did enough to make me feel comfortable in the recovery room
I had enough privacy in the recovery room
I received as much attention from the staff that I wanted in the recovery room
I would rate my overall experience as positive

Please circle “Yes” or “No” to answer the questions below.

I received all of the information that I wanted about the procedure
I was given the opportunity to discuss all of my concerns and fears
I received information about emotions or physical reactions I may have after my procedure
I received information on birth control methods
I received information on sexually transmitted diseases
I received as much information and counseling as I wanted
The doctor who performed the procedure made me feel comfortable
During the procedure, the pain was less than I expected
When I left to go home, I felt physically ready
I was told what problems to watch for after I left the clinic

2. Complaints

In a patient-centered environment, concerns and complaints are not a measure of failure, but an opportunity for improvement. There should be no punishment for surfacing and discussing problems.

A patient with a complaint is frequently satisfied to know that someone has listened to her issue and that action is being taken to resolve the situation. Concerns and complaints are not a measure of failure, but an opportunity for improvement. In addressing complaints, the following steps should take place:
• Acknowledge the problem being described and reflect it back, letting the patient know that you take her comments seriously.
• Take responsibility for the problem instead of shifting blame. Find out what you can do to resolve the situation for this patient. Ask her what she would like. Do not assume or make suggestions for her.
• Thank her for bringing the issue to your attention. Let her know that her willingness to voice her concerns helps improve services for everyone.
• Be committed to respond in a timely (usually 48 hours) manner.
• Document complaints, including date, time, and type of complaint.
• Consider reviewing complaints intermittently to identify improvement opportunities.

D. TRACKING TRENDS IN YOUR PRACTICE (TREND ANALYSIS)

You may already undertake a process of trending and analyzing risk management information. If so, you know that it can help identify problems, and potential problems, in a timely manner. Looking at trends can be more helpful than looking at statistics alone, by allowing you to look at data over time. You may experience a rash of complaints or complications all at once, and then none for many months. Looking at data quarterly and annually will give you a better overall picture of your service, rather than looking at data in shorter intervals.

We suggest you perform trend analysis on the following indicators:
• Utilization of services (how many patients did you see for a specific service)
• Completion rate (how many medication abortion patients come for follow-up)
• Complications
• Complaints
• Worker’s Comp claims
• Medication errors

Consider maintaining and reviewing logs for each indicator above. When creating logs, the simpler the better.
LEGAL AND REPORTING CONSIDERATIONS

This section will provide a brief overview of the laws and reporting requirements specific to abortion care in different states. We are only mentioning laws that pertain to first trimester aspiration and medication abortion. For the most up-to-date information, go to http://www.guttmacher.org, http://www.naral.org, or http://www.prochoice.org.

Your practice will already have reporting procedures for statutory rape or abuse and sexually transmitted diseases. Be aware that certain states require reporting of abortion complications and hospitalization. Consult your Department of Health for more information and reporting procedures.

TITLE X FUNDING

In 1993 President Clinton rescinded the domestic Title X gag rule. Section 1008 of Title X states, “women who request options counseling must be given information about carrying a pregnancy to term, adoption, and abortion, and a referral to an abortion provider if requested.”

The discussion for options of an unplanned pregnancy must be non-directive. Title X clinics may provide “as much factual, neutral information about any option including abortion, as they consider warranted by the circumstances, but may not steer or direct clients towards selecting any option including abortion in providing options counseling.” 65 Federal Register, Section 41270.

The Department of Health and Human Services has not prohibited “self-referral” for abortion services to date.

For more information go to www.prochoice.org to read their “Abortion and Title X: What Health Care Providers Need To Know” fact sheet.

INSURANCE COVERAGE PROHIBITION

Nineteen states restrict abortion in plans that will be offered through the insurance exchanges. Fifteen states restrict abortion coverage for public employees. Eight states restrict coverage of abortion in all private insurance plans, including those that will be offered through the health insurance exchanges; most often limiting coverage to life endangerment, allowing purchase of additional abortion coverage at an additional cost.

PHYSICIAN AND HOSPITAL REQUIREMENTS

Thirty-nine states require an abortion to be performed by a licensed physician. Twenty-one require an abortion to be performed in a hospital after a specified point in the pregnancy, and 20 require the involvement of a second physician after a specified point.

PROTECTION AGAINST CLINIC VIOLENCE

The Freedom of Access to Clinic Entrances (FACE) Act is a federal law that was enacted in 1994 to protect medical personnel and women seeking reproductive health
care against blockades and violence. Sixteen states and the District of Columbia have passed similar laws in order to increase their options for enforcement.

REFUSAL CLAUSES

Forty-six states allow individual health care providers to refuse to participate in an abortion. Forty-three states allow institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions.

TARGETED REGULATION OF ABORTION PROVIDERS (TRAP)

Forty-five and the District of Columbia impose onerous restriction and regulations on abortion providers that are not imposed on other health care providers. All of these states prohibit certain qualified health care professionals from performing abortions. Twenty-five of these states restrict the provision of abortion care, often even in the early stages of pregnancy, to hospitals or other specialized facilities. Sixteen of these laws are at least partially unenforceable.

See Chapter 1 for information on biased counseling, mandatory waiting periods, parental consent or notification, and public funding availability and restriction.

MALPRACTICE INSURANCE

Obtaining affordable malpractice coverage is currently a challenge for clinicians in every area of medicine, and abortion services in particular. Although the financial risk to the insurer for abortion services is approximately one third that of obstetric services, insurance companies often “bundle” abortion with general Ob-Gyn coverage, in spite of much lower complication rates. In addition, many insurance companies do not yet recognize abortion as a service that falls safely within the scope of practice of primary care providers, in spite of significant safety and efficacy data.

The good news about malpractice is that federal and state lawmakers are moving toward considering legislation to help resolve this issue within the next few years. There have been a series of recent physician-led community efforts to help insurance companies understand the safety of covering abortion services, and others have identified sources of law that may limit insurers’ ability to deny coverage or charge high premiums for medical abortion. However, for most providers in private or small group practice there remains no easy, affordable solution. We therefore provide a list of options, along with the potential advantages and disadvantages of each.
<table>
<thead>
<tr>
<th>Malpractice Option</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| NAF Group coverage in progress (contact NAF for update or to join plan) | • Large group of physicians ensures bargaining power.                                                                                                                                                                                                                                                                                     • Cost is unknown at this time.  
• Clinic coverage only  
• Must be NAF member. |
| Risk Retention Group                                    | • Allows providers to decide what to charge the group for premiums, what policies to adhere to, and what level of risk is acceptable.  
• Profit can be put back into premiums.                                                                                                                                                                                                                                                                                               • Physicians within the group must be like-minded and share a similar level of risk.  
• Still may need to attract a secondary (excess) carrier. |
| Commercially purchased insurance (potential carriers include companies such as Chubb, Evinston, and Admiral) | • Risk is individually assessed, which may be helpful for some.  
• Does not require organizing with other physicians.                                                                                                                                                                                                                                                                               • Most likely to be high-cost. |
| Going without (going "bare")                           | • No insurance premiums.  
• Does not require organizing with other physicians.                                                                                                                                                                                                                                                                                  • May put personal assets at risk.  
• This option may not be legal in your state. |
| Gap coverage                                            | • Covers services such as abortion that are not covered by Federal Tort Coverage (FTCA) – FQHC 330 sites                                                                                                                                                                                                                                    • May be expensive |
| Part-time policy                                        | • Less expensive in some cases than gap coverage, because it only covers the % time the physician is performing abortions.  
• May be particularly helpful for Federally Qualified Health Centers                                                                                                                                                                                                                                                                   • Safest to purchase alongside "entity coverage" that covers the clinic at all times. |

No matter which option you choose, it is important to check first with the insurance commissioner of your state to ensure the coverage is adequate for your services. There is currently no uniform code for insurance coverage. Not only do states differ in terms of whether they require you to have insurance coverage, but they also differ in which insurance companies they consider to be legitimate. Especially if you plan to purchase individual insurance, make sure to check that your carrier is on the approved list.

A targeted, short-term fundraising campaign may be an option for raising the fee required for a rider. See fundraising suggestions on www.grassrootsfundraising.org.

Contact Allen Labadorf of Sobel Associates to discuss Gap Coverage: (516) 745-1111
SECURITY

Many of you already have security plans in place in your practice setting. This section is intended to help coordinate some of those plans with some preparedness training for any new security concerns you may have to consider while providing abortion care. Security is an issue for any medical setting, and this is really no different, but if you do not have some sort of structured security training or preparedness training, than perhaps this section can help.

The very thought of this issue conjures visions of clinic blockades and invasions, or worse. Certainly there was a time when this was more the norm at abortion clinics. The main factors contributing to the decrease in clinic violence are: stronger federal and state laws protecting clinics, a move towards more “mainstream” action from those opposed to abortion, and changes in public tolerance towards violent behavior. In fact, well-executed TRAP (Targeted Regulations of Abortion Providers) laws and restrictive legislation are more of a threat to integrating abortion services today. For the most current information on incidence of violence and disruption, go to www.prochoice.org.

While the instances may be rare, as with any good risk management program, security preparedness and violence prevention are the best steps towards protecting your staff and patients. It is important to document any incident. A sample Incident Report Form (Disruption/Violence Report) sample is available online.

When working with your staff it may be helpful to put security into a larger framework (e.g. all clinics need to be prepared to handle fires or disruptive patient behavior, not just those that offer abortion services).

DRILLS

We have included drills on four different scenarios. One drill is outlined here and the other three can be found online as Security Drills. These drills help prepare staff to handle critical situations. They also help staff express concerns, know their fears are taken seriously, and understand their role in keeping their workplace safe.

The best preparedness training is achieved when scenarios are acted out and staff has to actually respond.

Begin by telling staff you are going to run drills on a certain day. Include all staff. If you are in a larger practice it is helpful to break staff into 2 teams. One observes and later critiques, while the other does the drill.

Role-playing: Have staff go to the places where they would normally be on a given day (e.g. lab, front desk, rooming patients). You will want to monitor:

- Communication
- Response (and time it took to respond)
- Preparedness
Emergencies will go more smoothly if staff communicates well. Spend some time working on how to communicate with one another during an emergency. We recommend that the following drills be practiced every six months. They don’t all have to be done at the same time. With practice, a drill can take as little as ten minutes. Drills include:

- Manageable Fire
- Unmanageable Fire
- Bomb Threat
- Patient or visitor disruption (included here)

**Patient or Visitor Disruption or Violence**

Scenario: The patient is in an exam room with her boyfriend, waiting for the MD to return with some forms. Patient’s boyfriend begins screaming, threatening her.

Set Up: Choose to act as either boyfriend or patient. Designate a staff member to play other role. Begin yelling and making threatening gestures.

Action: Each drill should be conducted twice. The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:

- Ask the patient/visitor to change behavior immediately.
- Tell the patient/visitor to leave the clinic. Let them know the police have been called.
- Instruct someone to call 911 and inform them that you have disruptive or violent people in the clinic that need to be removed immediately.
- Do not get involved in their fight.
- Do not get in between this person and the exit. You do not want to be trapped and you want to encourage them to leave.
- Do not physically get in between the patient and boyfriend.
- Assign staff to move other patients away from incident.
- Document on an Incident Report Form (see sample Disruption/Violence Report).

Perform the drill a second time to:

- Review staff performance and improvements.
- Debrief. These drills may bring up a lot of emotions for you and your staff.

Things to think about:

1) Understandably, staff feel that it is their job to make sure the patients are safe. However, emphasize that it is not their responsibility to intervene in these situations, and that doing so may make the situation worse.

2) Consider contacting local law enforcement to solicit their suggestions for this situation, and what their response time would be. This gives you an idea of how long you will need to manage the patient and contain the situation.
MAIL HANDLING

While mail handling is an important security measure to review, it really does not work as a role-play scenario. Instead, please review with your staff the important salient points about handling mail.

When handling mail, there are a few ways to identify a suspicious letter or package:

- Excessive or no postage.
- Inaccurate or misspelled names and addresses.
- Lack of return address or return address and postmark are from different areas.
- Noticeable messiness or discoloration, unusual odors, or unprofessional wrapping.
- Drawing, unusual statements, poor typing, or handwritten address.
- Statements such as “Open Addressee Only,” “Special Delivery,” or “Personal and Confidential”.

What to do:

- Trust your instincts. If package doesn’t “feel” right, do not handle it!
- Isolate the package.
- Notify the in-charge person.
- Notify the police and follow evacuation procedures if necessary.

What not to do:

- Do not shake a suspicious package.
- Do not open a suspicious article.
- Do not place a suspicious article in a confined space such as a cabinet or a drawer.
<table>
<thead>
<tr>
<th>PHONE NUMBERS AND CONTACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Here is a security phone list for you and your staff to fill in:</td>
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</table>

<table>
<thead>
<tr>
<th>Local Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>(contact name: ________________________)</td>
</tr>
<tr>
<td>Local FBI</td>
</tr>
<tr>
<td>Local ATF</td>
</tr>
<tr>
<td>(Bureau of Alcohol Tobacco and Firearms)</td>
</tr>
<tr>
<td>U.S. Marshals</td>
</tr>
<tr>
<td>Postal Inspector</td>
</tr>
<tr>
<td>Fire Department</td>
</tr>
<tr>
<td>Bomb squad</td>
</tr>
<tr>
<td>Hazardous materials team</td>
</tr>
<tr>
<td>Alarm company</td>
</tr>
<tr>
<td>Fire alarm company</td>
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<tr>
<td>Phone company</td>
</tr>
<tr>
<td>Electric/utilities company</td>
</tr>
<tr>
<td>Landlord/Management Office</td>
</tr>
<tr>
<td>EPA Chemical Emergency Response</td>
</tr>
</tbody>
</table>
FINANCIAL ISSUES

If done well, adding abortion into your practice should not cost you money. In time, all costs should be recoverable through proper billing and appropriate setting of cash fees. But the information may help you make sure of this.

There are three main components of financial analysis for integration of abortion services, including cost, revenue, and profit or loss. As you know, there are also many intangible benefits of integrating these services, including improved continuity of care, patient retention, and enhanced relationships with your patients.

Because of many one-time expenses, you may not be able to show a profit in the first year of services, especially if you are seeing a low volume of patients. However, over time – maybe 2 to 3 years – the variable supply costs should be very low, especially if you take advantage of group purchasing programs.

COST

Like any service, the first thing you will do is cost out what it will take to provide an abortion, then identify your revenue sources (e.g. cash, state funds), and research what your competitive market will bear.

Please see Spreadsheet Tool online. You can input your own variable and fixed costs and patient volume to determine your approximate cost per procedure.

REVENUE

Knowing who will pay for abortion services is another important step. In 17 states, Medicaid will reimburse for abortion services in most circumstances.

In other states, patients most often have to pay cash (See Fee Setting below).

Because many of your patients are already insured, It will be beneficial to research if any of those insurance plans will cover abortion services. If not, then consider negotiating contracts with those insurance companies with which you already have relationships. Be prepared to dedicate staff time to building these relationships and establishing new contracts. Although some of your patients may be insured, it is important to note that approximately 40% of women who have insurance decline to use it for abortion services.

Tool: See FP Insurance Letter to use as blue print for contacting an insurance company.

When billing Medicaid or private insurance, using proper billing codes is very important to getting accurate reimbursement. Billing codes differ from state to state. The www.reproductiveaccess.org has a list of billing codes for aspiration and medication abortion. In the state of California, please see the ANSIRH website for a listing of Abortion Reimbursement Rates.
There are three considerations when setting your fee:

1) What are your actual costs?

2) What are your competitors charging?

3) What is the value placed on it by patients?

In setting your fees, include:

- Rhogam
- Pain medication
- One month of birth control
- The follow-up exam
- Emergency contraception

The receptionist making the appointment should be able to articulate all the services included in this bundled fee.

The median charge for an abortion at < 10 weeks in the United States in 2009 was $470.00. Medication abortion fees vary significantly. Fee differences may impact on a woman’s choice or make her preferred procedure inaccessible. Therefore consider setting the same fee for aspiration and medication abortion.

**PROFIT OR LOSS**

For the first year, due to capital purchases, and assuming a low volume of patients, there may not be much profit, and may even be some loss. We suggest a three year forecast to show a trend of breaking even, and eventual profitability. Be patient.

Often we hear that the controversy that comes with offering abortion services is not worth the minimal profits. A simple cost and expense analysis may not be enough to refute this argument. Be prepared to respond to these obstacles with your reasons for learning the procedure in the first place.

**FINDING SUPPORT**

**DEVELOPING A NETWORK**

Building a supportive community may be the key element to helping you sustain your abortion services. Building community support requires some advance planning, creativity, and courage.

Think of your support network in three key groups: your Core group, Usual Suspects, and Unusual Suspects. Your Core Group might be made up of those people working with you to implement the services (perhaps a supportive receptionist or nurse, a mentor, board members, the person who referred you to your training program). Think of these people as your key stakeholders.
The Usual Suspects might be the other local abortion providers, local Planned Parenthood, reproductive health care providers known to refer for abortion (this may be a list that other abortion providers can help generate), and political organizations (NOW, NARAL, PRCH League of Women Voters).

Identifying your Usual Suspects requires creativity and is specific to your community. This might include faculty at a university women’s studies department, women-owned businesses, community health care providers, community educators, advocacy groups, high school nurses or guidance counselors.

Start with what is easy, and be encouraged whenever you make useful contacts. After identifying your Core Group, meet to decide what your goals or needs are in terms of support. If it seems that broader community support will be beneficial, identify and contact your Usual Suspects, inviting them to an informal discussion group. Consider inviting each person to talk about:

- The services or programs they offer.
- The patients they see.
- How abortion touches the lives of their patients or their day-to-day work.
- What kind of support they have needed and what kind they can offer.

This is an important networking opportunity. Be sure to gather everyone’s contact information. Discuss ways in which you can continue to support each other in the future.

The local Planned Parenthood or political group might host this, to reduce your workload and to limit your exposure.

You may want to go further in your search for community support. One suggestion would be to work with Planned Parenthood or another feminist group to set a panel discussion aimed at demystifying and normalizing abortion. Inviting your Core and Usual Suspects along with some identified Unusual Suspect would be appropriate.

When you are trying to start an abortion service, don’t be surprised that people within and outside your practice may throw you curveballs. For instance, if your head administrator or CEO is continuing to stall the initiation of abortion services, you may want to use some of the techniques in the Values Clarification Tool to discover her or his underlying concerns. Integrating abortion is much more than adding a service, or learning a new technique. It will require patience and determination to overcome obstacles at various steps of the way. Such barriers will vary with the existing culture of the practice, the level of knowledge and skill, as well as the attitudes and feelings of the staff.

Integration of broader reproductive health and abortion services is a process. As you move through it, your health center staff will also begin to gain a more balanced understanding of pregnancy options and abortion access, as well as an enhanced ability to handle divisive issues in a positive, patient-centered manner. Your patients will also gain greater access to these services in a safe, more private and familiar environment.
## Medical and Professional Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of Reproductive Health Professionals</td>
<td>This site provides excellent information on reproductive health in an easy to understand and fun format.</td>
</tr>
<tr>
<td><a href="http://www.arhp.org">www.arhp.org</a></td>
<td></td>
</tr>
<tr>
<td>National Abortion Federation (NAF)</td>
<td>With membership you have access to:</td>
</tr>
<tr>
<td><a href="http://www.prochoice.org">www.prochoice.org</a></td>
<td>* Medical abortion technical assistant</td>
</tr>
<tr>
<td>202-667-5881</td>
<td>* Access to ultrasound training</td>
</tr>
<tr>
<td></td>
<td>* Educational conferences</td>
</tr>
<tr>
<td></td>
<td>* Archived tools and forms</td>
</tr>
<tr>
<td>Planned Parenthood Federation of America</td>
<td>A national umbrella organization for all local Planned Parenthood affiliates. The website has position papers and fact sheets, as well as numerous FAQs about abortion.</td>
</tr>
<tr>
<td><a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a></td>
<td></td>
</tr>
<tr>
<td>Physicians for Reproductive Choice and Health (PRCH)</td>
<td>Educational assistance and opportunities. Regional meetings to network with fellow abortion providers, as well as other non-abortion providing doctors who are supportive of choice</td>
</tr>
<tr>
<td><a href="http://www.prch.org">www.prch.org</a></td>
<td></td>
</tr>
<tr>
<td>Reproductive Health Access Project</td>
<td>Training, advocacy, mentoring, fact sheets, clinical algorithms – for integrating early abortion, evidenced-based contraceptive care, and management of miscarriage into primary care settings.</td>
</tr>
<tr>
<td><a href="http://www.reproductiveaccess.org">www.reproductiveaccess.org</a></td>
<td></td>
</tr>
<tr>
<td>RHEDI: Center for Reproductive Health Education in Family Medicine</td>
<td>Contacts, support, tools, and forms for starting or continuing abortion services in Family Medicine Residencies or in primary care practice. Expanding the scope of Family Medicine to include abortion care.</td>
</tr>
<tr>
<td><a href="http://www.rhedi.org">www.rhedi.org</a></td>
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## Listservs

<table>
<thead>
<tr>
<th>Listserv</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>NAFbytes Listserv <a href="mailto:robinred@hotrock.com">robinred@hotrock.com</a></td>
<td>Email listserv offering access to the shared experience, knowledge, support, and resources of hundreds of NAF members and abortion providers, immediate answers to real time problems, community to combat feelings of isolation or frustration, and archived tools/forms.</td>
</tr>
<tr>
<td>STFM Access Listserv <a href="mailto:techmanager@rhedi.org">techmanager@rhedi.org</a></td>
<td>Email listserv created to help family practice doctors integrate medication and early aspiration abortion in their practice. Enrollment requires nomination by current member for security purposes.</td>
</tr>
</tbody>
</table>

## Hotlines

<table>
<thead>
<tr>
<th>Hotline</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Emergency Contraception Hotline 800-584-9911</td>
<td>Provides information emergency contraception and referrals to providers</td>
</tr>
<tr>
<td>Exhale <a href="http://www.4exhale.org">www.4exhale.org</a> 866-4-EXHALE</td>
<td>Toll-free after-abortion talkline to provide support for women and their support people after an abortion</td>
</tr>
<tr>
<td>NAF Hotline 800-772-9100</td>
<td>Abortion referrals</td>
</tr>
</tbody>
</table>

## Legal

<table>
<thead>
<tr>
<th>Organization</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACLU Reproductive Freedom Project <a href="http://www.aclu.org">www.aclu.org</a></td>
<td>Local chapters can provide referrals to pro-choice lawyers</td>
</tr>
<tr>
<td>Center for Reproductive Rights <a href="http://www.reproductiverights.org">www.reproductiverights.org</a></td>
<td>Clearinghouse for information on federal and state laws and policy regarding abortion and reproductive health care issues. Legal advocacy organization dedicated to promoting reproductive rights.</td>
</tr>
<tr>
<td>Jane’s Due Process <a href="http://www.janesdueprocess.org">www.janesdueprocess.org</a></td>
<td>Texas-based organization working to help minors seeking abortions. They are an excellent resource for forms and advocacy regardless of where you practice.</td>
</tr>
</tbody>
</table>
### Research

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guttmacher Institute</td>
<td>Conducts research and publishes extensively on abortion and reproductive health issues.</td>
</tr>
<tr>
<td>Centers For Disease Control and Prevention (CDC)</td>
<td>The CDC works to promote health and quality of life by preventing and controlling disease, injury, and disability. Great source for fact sheets.</td>
</tr>
</tbody>
</table>

### Advocacy

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Abortion Access Project</td>
<td>Seeks to ensure access to abortion for all women by increasing abortion services, training new providers, and raising awareness about the critical importance of abortion access to women's lives.</td>
</tr>
<tr>
<td>Catholics For A Free Choice</td>
<td>Information and advocacy for patients, providers, and activists on abortion and reproductive health care issues within a catholic framework.</td>
</tr>
<tr>
<td>Center for Reproductive Health Education in Family Medicine at Montefiore Medical Center</td>
<td>Tools and forms for family practice physicians starting or continuing abortion services, including sample charts, billing codes, and audits.</td>
</tr>
<tr>
<td>Choice USA</td>
<td>Mobilizes and supports the diverse upcoming generation of leaders in reproductive justice.</td>
</tr>
<tr>
<td>Feminist Majority Foundation</td>
<td>National organization working to advance women’s equality and empower women and girls in all sectors of society.</td>
</tr>
<tr>
<td>Indigenous Women’s Reproductive Rights and Pro-Choice Page</td>
<td>The purpose of this page is to provide information concerning Indigenous women's reproductive health and their perspectives on pro-choice issues.</td>
</tr>
<tr>
<td>NARAL-ProChoice America</td>
<td>Provides information and political action around issues of abortion and reproductive health care issues.</td>
</tr>
<tr>
<td>National Asian Women’s Health Organization</td>
<td>NAWHO was founded in 1993 to improve the health status of Asian American women and families.</td>
</tr>
<tr>
<td>National Latina Institute for Reproductive Health</td>
<td>The mission of NLIRH is to ensure the fundamental human right to reproductive health for Latinas, their families and their communities through education, advocacy and coalition building.</td>
</tr>
<tr>
<td>National Network of Abortion Funds</td>
<td>Network of independent organizations that provide financial assistance to women to pay for abortions.</td>
</tr>
<tr>
<td>Religious Coalition For ReproductiveChoice</td>
<td>National organization of pro-choice clergy and churches. Can provide spiritual counseling</td>
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### Sexuality Education

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Advocates for Youth</td>
<td>Champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health.</td>
</tr>
<tr>
<td>Coalition for Positive Sexuality</td>
<td>Information about all aspects of sexuality along with information about parental involvement laws.</td>
</tr>
<tr>
<td>Go Ask Alice!</td>
<td>This site is run by Columbia University’s Health Education Program and provides accurate and non-judgmental information.</td>
</tr>
<tr>
<td>My Sistahs</td>
<td>Information about sexual health run by and for young women of color.</td>
</tr>
<tr>
<td>Scarleteen</td>
<td>Sex education for the real world with a section for men as well.</td>
</tr>
<tr>
<td>Sexuality Information and Education Council of the US</td>
<td>SIECUS develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates the right of individuals to make responsible sexual choices.</td>
</tr>
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</table>
EXERCISES: OFFICE PRACTICE INTEGRATION

EXERCISE 13.1

1. List 3 barriers that you think you may encounter in trying to integrate abortion services in your practice. How would you address them?

2. In a future job site, who are the key stakeholders in starting an abortion service? How would you approach getting buy-in from your stakeholders or staff?

3. What might you do if you have a complication in your clinical site? How will you secure OB or hospital back up? How would you cover call?
REFERENCES


TEACHING POINTS FOR CHAPTER 13:
OFFICE PRACTICE INTEGRATION EXERCISES

EXERCISE 13.1

1. List 3 barriers that you think you may encounter in trying to integrate abortion services in your practice. How would you address them?

   Expense of malpractice/unable to obtain malpractice coverage.
   (See Malpractice section for possible solutions and support)

   Capital equipment cost
   There are ways to bring abortion services on without investing too much early on. One way to do this is to start with medication abortion. If the ultrasound is the most daunting expense, you can find other alternatives: You can rely more on your expertise in pelvic sizing, refer out for ultrasound when necessary, and use serial beta hCGs instead of ultrasound to ensure the abortion is complete. Investing in a manual vacuum aspiration (MVA) system is between $16 - 43 (depending on valve-type, and single-use vs. autoclavable), and a tray or two of dilators and tenacula may cost around $500.

   Reimbursement
   Limited reimbursement may be more of an issue in states where there is no Medicaid funding of abortion.

   Controversy
   There will always be controversy where there is change. The most important step is to find the root cause of the controversy and try to directly address that issue.

   • If the problem is that staff may object to the very idea of including abortion in your service, refer to the tools included here for working through values clarification.
   • If the controversy is about "turning into an abortion clinic", the statistics in family practice settings suggest that most integrated clinics are likely to perform 1-2 abortions per week
   • If the fear is security, there are many resources and people to help assess the actual risk, and determine if there are any areas that may need additional security re-enforcement. Also going through the security drills included here should help staff feel prepared.

   The most compelling response to these issues is the experience of the patient. Being able to offer comprehensive care is the most important reason to start abortion services, and will benefit the practice in terms of client retention.

   "No one ever asks for an abortion here. It’s not a needed service"
   Consider that by age 45, 35% of women will have had an abortion (Guttmacher 2007). Half of pregnancies are unintended, and if you care for pregnant women in your practice, about 1 of every 4 pregnant patients will choose to have an
abortion. Women will make different choices at different points in their lives. About 60% of women seeking an abortion have had at least one child. You can safely project that a certain percentage of the women in your practice will seek abortion services. Offering your patients balanced options counseling and abortion care may increase both comfort and access for your patients.

**Fear of complications**
According to the CDC from 2002, serious complications arising from surgical abortions performed before 13 weeks are quite unusual. About 88% of the women who obtain abortions are less than 13 weeks pregnant. Guttmacher Institute reports that of these women 97% report no complications; 2.5% have minor complications that can be handled at the medical office or abortion facility; and less than 0.5% have more serious complications that require some additional surgical procedure or hospitalization (1996).

**Myths about abortion (only poor women need abortion services, none of our patients have unintended pregnancies)**
Obviously, these types of arguments are stereotypes that have very little to do with the real information about which type of women seek abortion care. The answer is that women from every age group, every socio-economic background, and who use every type of contraception, seek out abortion services. When faced with these myths, the goal is to move the discussion away from punishing the woman who may need services to focus on the bias the speaker may have about abortion in general.

**There are other providers in the area, why do we have to take this on?** There are many areas where there are multiple services being offered - management of hypertension, management of diabetes, dentistry. The reason to offer the services is to meet the needs of your patients, not to compete with other providers. The idea that abortion is just part of the spectrum of comprehensive care for women is the most compelling argument.

**Abortion is out of our scope of practice.**
Early pregnancy termination is within the scope of practice of Primary Care Physicians, and Advanced Practice Clinicians in some settings. In the Maternity and Gynecologic Care Guidelines for Family Physicians that were developed jointly by ACOG & AAFP, "voluntary interruption of pregnancy up to 10 weeks gestation" is specifically noted as an advance skill for Family Practice Physicians.

Appropriate training in abortion care and demonstrated competency are the key issues. Clinicians from many specialties have excelled at abortion provision and furthermore, have come to make significant advances in the reproductive health field.
2. In a future job site, who are the key stakeholders in starting an abortion service? How would you approach getting buy-in from your stakeholders or staff?

Depending on type of practice stakeholders may include:
- CEO
- CFO
- Medical Director
- Board of Directors
- The partners in a practice
- Clinic or practice owner (and family)
- Students, Residents, or Colleagues in a nearby training program
- ER/hospital
- Patients

These parties may be swayed by the broadened services for women, increased patient retention, the cost-effectiveness of minimizing referrals or getting services out of the OR, or the training or faculty development options associated with training.

In incorporating staff, first, allow time for this process and room for initial negative and mixed reactions. You may never get everyone to be enthusiastic, or even okay with providing abortions. That does not mean you will not be able to offer abortion services. Try the following tactics to encourage their participation:

Model:
- Commitment to patient centered care
- Confidence in your technical skills and your ability to assist staff in transition to offering this service.

Train – offer formal and informal staff meetings on the following:
- Q&A about abortion (safety of, who has them, types of abortion services)
- Values Clarification exercises
- Shared experience from your TEACH training

Reassure:
- Offering abortion will not disrupt but rather enhance services
- Do not intend to become an “abortion clinic”, but rather help our patients who trust us already
- We will begin slowly and have all the training and support that we require

Personalize:
- “I would want my sister or friend to be cared for by a staff like this.”
- Share success stories from your TEACH training of specific patients.
3. **What might you do if you have a complication in your clinical site? How will you secure OB back up? How would you cover call?**

Despite careful planning, systems development, and staff training, complications will occur. Prescreening and sound medical practices will minimize their severity. Your first priority is to stabilize the patient and adhere to her needs.

Remain calm and clear. Let your other patients know there may be a delay. Document clearly and completely. Pay attention to the details. Allow time for staff to ask questions and debrief, particularly if the complication required a hospital transfer. Send complete notes, and communicate directly with your referral MD. Meet all state and local reporting requirements.

Keep in mind that most complications can be cared for by the primary care doctor on either an outpatient or inpatient basis, as appropriate. Primary care doctors can do aspirations for retained products or hematometra, treat most hemorrhages (as they would in OB patients), and treat pelvic infections (even if the patient needs hospital admission and IV antibiotics) (Prine 2003).

Talk with other doctors in your practice to see if they know of MDs for referral. Ask the nearest abortion provider who provides their back up. Contact Access Project to see if they can help you identify an abortion-friendly hospital and then contact their OB Department.

Most early perforations are benign and can be managed conservatively. The rare occurrence that would require OB-Gyn backup is the major perforation requiring surgery or a ruptured ectopic.