# EARLY ABORTION TRAINING CURRICULUM
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10. OFFICE PRACTICE INTEGRATION

Updated June 2016 by Danit Brahver MD & Lisa Maldonado MA MPH

This chapter is designed to aid primary care clinicians interested in integrating early pregnancy loss (EPL) and abortion care 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 throughout this chapter and also available online at TEACH Office Practice Tools.

LEARNING OBJECTIVES

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

• Discuss important initial steps for introducing services into a practice
• Find allies and build buy-in among staff and key-stakeholders
• Learn pertinent aspects of medical documentation and quality assurance
• Know how to find current legal and reporting restrictions for your state
• Know malpractice and financial opportunities and restrictions for your setting
• Understand security precautions important for abortion provision
• Understand where you can find ongoing support locally, regionally, and nationally

VIDEOS

• Abortion in Primary Care Settings (IERH): https://bit.ly/2MMDbi6
• Practice Integration of EPL Services (IERH): https://bit.ly/30YMCmT
  o (Password protected: Request to see at info@innovating-education.org)

READINGS / RESOURCES

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

SKILLS

• Integrating services into your practice setting will help to normalize abortion as a part of your patients’ regular health care.
• Finding and working with additional champions in your organization will spread the mission and maximize your efforts.
• Involving various stakeholders is critical to the service’s success and sustainability.
• Providing a safe, respectful opportunity for staff to voice feelings (positive as well as concerning) about participating in abortion care will help support their involvement.
• Using and infusing huddles, debriefs, and staff meetings with an emphasis on problem solving over blame can help facilitate gradual change in clinic culture.
• Achieving rapid appointment access, staff courtesy, and ready information to patient questions are the most commonly reported factors affecting patient’s satisfaction with their abortion experience (Tilles 2016).

SAFETY

• Preparing for medical and security-related emergencies, while rarely needed, is important for making staff feel secure, and should be carried out on a recurrent basis.
• Maintaining necessary medications and equipment for abortion related emergencies, as well as hospital back-up arrangements, will prepare for patients’ rare needs.

ROLE

• Being patient and persistent with the process of integrating services is critical, as it may take some time.
• Being familiar with practice improvement methodologies used in other parts of your practice, such as small tests of change, or readiness to scale and spread.
• Using your the local and national networks will build a sense of collaborative community, help answer your medical and administrative questions, and challenge you to learn best practices.
GETTING STARTED

New services take time to build. Incorporating reproductive health services into your practice is a process during which you will need to explore core values of your staff, while attending to the more concrete tasks of ordering supplies and implementing new protocols. Approaching this process with a commitment to open dialogue is fundamental to a successful outcome.

Be realistic and patient about the amount of time this process will take to integrate new services, and the number of staff meetings and trainings it may require. Be strategic. If you are working in a practice that has yet to offer all contraceptive options or miscarriage management, it may be helpful to start by integrating new contraception services, then management of EPL. If you are introducing abortion services, start with medical abortion before uterine aspiration. This may get staff on board and set the stage logistically for offering aspiration later.

This section addresses fundamental questions about the initial steps of integrating abortion and miscarriage care services.

ASSEMBLING A PLANNING COMMITTEE

Start by identifying other providers, administrators and staff who might be allies in providing reproductive services. Initiate informal discussions and begin to develop a Planning Committee, which can meet regularly to discuss tasks, timeline, potential obstacles and solutions.

Some initial considerations will be to consider which services should be integrated first, what strategies will be best for gauging staff interest, and a model for training staff in various skills (e.g., counseling, assisting in the procedure room, etc.).

Other tasks could include developing clinical protocols and policies, deciding a schedule for how to integrate services, and assigning administrative roles to research state regulations, order supplies, develop forms for consent and the medical record, set up protocols with the billing department, and research the cost of additional malpractice for abortion coverage.

For providers working in FQHCs and/or Title X clinics, research will be needed to figure out how to fiscally separate supplies and time to provide abortion services from Title X and 330 funds. Because many clinicians mistakenly believe that it is not possible to provide abortion care at FQHCs and/or Title X clinics, it may be important to do some education about this early in the process.

The committee could address other questions like:

- Who will take call for abortion patients?
- Who will provide suction back up if only medication abortion is provided?
- Will ultrasound be available onsite? If yes, how will clinicians be trained? If no, how can you ensure smooth referrals and educate radiology staff?
- Will services be advertised?
- Will you accept abortion patients who are not already in your practice?

REACHING OUT TO KEY STAKEHOLDERS

In planning to introduce new reproductive services, consider the “key players” in your institution, what interests to address to assure their support, and what collateral support will be helpful to demonstrate to them. Potential stakeholders and interests may include:
EARLY ABORTION TRAINING CURRICULUM

- CEO (impact on relationships, bottom line, overall game plan, efficiency)
- Medical or OB Director (need, expected volume, service organization, back-up)
- The partners in a practice (call sharing)
- Training Director / Trainees (nearby residents, nurses, students)
- CFO, Billing Manager (billing strategy, anticipated expenses / income)
- Operations or Nursing Director (nursing responsibilities, sedation, efficiency)
- ED/hospital (how rare referral issues will be handled, if not already arranged)
- Radiology Director (if hospital setting) for ultrasound needs and credentialing
- Patients (public health impact, needs, preferences)

For those centers looking to integrate medication abortion only, finding back up for uterine aspiration is an important early step. For primary care providers working within a healthcare organization, this can be as simple as reaching out to the heads of the OB/GYN and Emergency Departments to let them know that you will be starting to offer medication abortion.

- If you are outside of a network, is there a local abortion clinic for unofficial back up to refer stable patients with complications outside of your system?
- While getting their support for managing rare emergent cases may be challenging in politically conservative areas, their “support” is not absolutely necessary, as this care cannot legally be withheld in EDs. Fortunately, these complications are rare.
- In provider shortage areas where is limited or unsupportive, it may be in the best interest of your patients to offer both medication and uterine aspiration on site.

GETTING STAFF INTERESTED

Consider the variety of staff in the groundwork for reproductive health expansion, as patients interact with staff throughout their experience. Staff will need exposure to the principles of values clarification and non-judgmental language. Experience has shown that even those who may not support abortion are more likely to be involved if their feelings and beliefs are acknowledged and respected early on.

1. Consider distributing anonymous staff attitude surveys to gauge people’s thoughts and feelings [Staff Attitude Survey (RHAP)].

2. Offer a Values Clarification Workshop (at NAF or RHAP) to provide a broader public health framework for the benefits of service provision. This invaluable process can help address anxiety around change, identify and dispel myths, and separate personal beliefs from professional roles and responsibilities. Working with an outside facilitator can help avoid the impression of pushing an agenda.

3. Offer lunchtime trainings or discussions to:
   - Introduce updates in contraception, unintended pregnancy, miscarriage management, and public health impact of limited access to reproductive health services including abortion. Helpful presentations can be found at http://www.guttmacher.org or http://www.prh.org.
   - Use a Papaya MVA Workshop to serve as an orientation and icebreaker.
   - Present data on regional needs or results of a patient attitude survey [available at Patient Attitude Survey (RHAP)] to counter potential resistance.
   - Role-play options counseling and consent process (see Chapter 2).
   - Practice answering common telephone questions abortion and EPL.
   - This Phone Script (TEACH) is a helpful reference.

More information can be found at Integrating Early Abortion into Primary Care (RHAP).
DEVELOPING CLINICAL POLICIES
Once support is in place from key stakeholders, begin developing protocols that define and standardize clinical workflows around reproductive health services you will provide. These protocols standardize, for example, how many office visits are needed for the service, what pre-procedure lab work is needed, what supplies and medications are required onsite vs. by prescription, who is identified emergency back-up, etc.

Sample clinical policies can be found here:
Medical Management of Miscarriage Policy (RHAP)
MVA for Miscarriage Policy & Procedure (RHAP)
Medication Abortion Protocol Using Mifepristone & Misoprostol (RHAP)
Medication Abortion Protocol Using Misoprostol Alone (RHAP)
Medication Abortion Protocol Using Methotrexate and Misoprostol (RHAP)
MVA for Therapeutic Abortion Policy & Procedure (RHAP)
Nursing Policy & Procedure for MVA (RHAP)

Develop a policy for pre-abortion early dating US referrals (e.g., indications, location of US on-site vs. off-site, etc.). Develop clinical policies that standardize the provision of services while considering Targeted Regulation of Abortion Providers (TRAP) laws.

TRAINING STAFF FOR NEW SERVICES
Having a structure for training current staff and onboarding new staff will help ensure consistence of care to your patients. Evaluate staff training needs in the following areas:

• Scheduling appointments and telephone triage
• Counseling and consent
• Ultrasound training
• Assisting in the procedure room for uterine aspiration
• Emergency preparedness
• Sterilization and disinfection
• Fetal tissue questions and disposal

Scheduling Appointments
“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. CAPS, 2001).

Make every effort to minimize the time between the patient’s request for an appointment and the appointment, as well as the number of visits required to complete the process. This is among the most important factors associated with patient satisfaction in abortion care (Tilles 2016). Patient data show that women prefer a one-day abortion procedure and want an immediate appointment (within 3 days of calling). Based on patient forecasting, consider setting aside procedure-specific time slots to accommodate patients quickly, and using no-show slots to accommodate walk-in pregnancy test patients who may be clear about their decision and would like an abortion that day, if permitted by law.
Providers working in states where TRAP laws mandate waiting periods will struggle more with expediting care. Many providers working in heavily regulated areas have indicated that TRAP laws may cause mistrust within the provider-patient relationship. Most have developed verbal strategies for mitigating the emotional impacts for patients (Mercier 2015). For example, they may say “the state requires me to say... but as a physician / clinician, I will tell you the scientific evidence does not support that.”

If staff can be trained for the counseling and consent process, clinicians can facilitate a medication abortion or offer misoprostol for EPL within a routine visit. A less ideal option is to use two slots, or to provide a visit for counseling, US and / or lab work prior to the medication abortion visit. Again, mandated waiting periods and US ordinances may dictate the timing of these abortion-related visits. Visit Guttmacher’s State Laws and Policies center.

Uterine aspiration for EPL or abortion can be integrated into practice in a variety of ways. Some clinicians build procedural appointments into their primary care clinic schedule, to intersperse appointments throughout the week. Others schedule appointments into a “procedure session” during which they offer uterine aspiration along with other procedures. Providers may schedule a double slot, or require a separate visit for counseling, US and lab work prior to the procedural visit. Here is a sample Abortion Scheduling Template (TEACH) available for use.

**Importance of Confirmation Calls**

Confirmation calls are particularly important with abortion patients, as making appointments may be a part of their decision-making process while they assess funds, transportation, privacy, support from friends/family, or ambivalence. Where services are more available, patients also 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. 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 instructions (e.g. wear 2-piece clothing and underwear for a pad, plan a ride home)

To address confidentiality concerns, the confirmation call can be done non-specifically or by using a code name. It is best to ask the patient whether and how they prefer to be contacted.

**No Shows**

You may want to call your patients promptly who fail to show that day to ask if they would like to reschedule to a more convenient time, or if another service is needed. This continues to show concern during what may be a difficult time for them.

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

**Referral Making**

Occasionally, you may have a patient you cannot help. They may be too far into the pregnancy, need general anesthesia, or require counseling beyond your scope. Have referral numbers available for a variety of patient needs (See Chapter 2: Referral Making). Taking an active role in care coordination is even more important in areas where services are restricted and stigma greater (Zurek 2014). This can help dispel misperceptions or deliberate misinformation about legality and safety of abortion, or overcome complex social issues patients face.
After Hours Calls
If not already part of your practice, it is critical to provide your EPL or abortion patients with 24-hour contact number to triage questions and assure physician referral if indicated (NAF CPGs 2016). Counseling patients thoroughly con what to expect will help decrease the number of calls, but often a phone call can save your patients an ED visit. Print after-hours number on your written aftercare instructions. (See Chapter 13 Medical Documentation for sample aftercare instructions.) Let your on-call service know you are now offering EPL, medication or aspiration abortion services. You can find a helpful Algorithm for Triaging Bleeding After Medication Abortion (RHAP) here.

Counseling and Consent
In many primary care settings, the provider does most of the counseling, but occasionally a lead counselor may take that on. In addition to having staff members review Chapter 2 of this Workbook, consider having lead counselors visit a high-volume abortion site to get a thorough understanding of workflows and counseling styles.

Counseling around early pregnancy loss (EPL) can differ substantially from options counseling for an abortion visit (see Chapter 8 and providecare.org).

Ultrasound (US) Training
US training for early dating is hard to come by! Consider starting with the Ultrasound Lecture Series: Obstetrics and Gynecology (AUIM). There is a 5-day intensive US course offered for CME credit for providers and health workers at Planned Parenthood of the Rocky Mountains (PPRM) in Denver, CO. Contact PPRM for more details. If you train or work in a Planned Parenthood environment, you may have access to the interactive online curriculum Ultrasound in Abortion Care (ARMS 2007). If US is available on site, it is also helpful to train staff on US guidance to assist with the occasional challenging procedure.

Assisting in the Procedure Room
Just as you went through your individual training to learn appropriate procedural support techniques for providers, your support staff will need training in many of the same techniques and language, and Chapter 6 of this Workbook is a good resource for them.

A Training Checklist for Staff Assisting in the Procedure Room (TEACH) may be a useful training tool.

Preparing for Medical and Security Emergencies
Preparedness is the key to managing any medical emergency effectively. Limited patient encounters and heightened focus on safety have led to training that increasingly involves simulated complication scenarios. Simulation and drills build communication, improve stress readiness during a crisis, and decrease risk to patients. Many medical Emergency Simulation Drills (TEACH) and Security Drills (TEACH) are available and can be carried out on a quarterly or recurrent basis. In addition, a sample Incident Report Form is available. For current information on incidence, go to NAF Violence Statistics and History.
Sterilization and Disinfection
We have included easy-to-follow training posters on the following techniques:

- Wrapping Instruments and Trays for Sterilization (TEACH)
- Unwrapping Sterile Packages, Using Aseptic Technique (TEACH)
- Decontaminating, Cleaning & Disinfecting the IPAS Syringe (Ipas, pg. 15)
- Reprocessing Vaginal Ultrasound Probe (TEACH)

Fetal Tissue Questions and Disposal
Patients often have questions about fetal development and want to see or know what happens to the tissue. See Chapter 2 for how to answer these questions. All surgically removed tissue must be considered biohazard and be handled, stored, and disposed of in a manner that minimizes the risk of exposure (NAF CPGs 2016). A protocol for tissue handling, storage, and disposal must be in place. Contact your local Department of Health to find out current regulations or use this guide for general tissue disposal.

SETTING UP YOUR FACILITIES
It may take some time and up-front cost to order necessary medications and supplies. A comprehensive list of medications, supplies, and vendors necessary to provide medical and aspiration management of EPL and abortion can be found here, and in Chapter 5. For sites already doing IUD insertions, adding a set of dilators and manual vacuum aspirators to an IUD set up may be all that you need. A step-by-step guide for ordering mifepristone for medical abortion is available at Mifepristone Ordering Guide (RHAP).

MEDICAL DOCUMENTATION
Medical documentation is fundamental to patient care, follow up, and risk management. Customizing your electronic health record (EHR) or forms to allow quick and thorough documentation will help with successful integration of abortion care into your practice.

The main forms that you will need include: informed consent, operative or procedure note, medications, discharge note, aftercare instructions, and follow up visit. Consider having fact sheets that compare medication vs. aspiration abortion, ectopic precautions, Rh factor, contraceptive options and emergency contraception (RHAP). Examples and templates of all chart forms are available in Office Practice Tools. In this section, we will review important points to include in staff training.

INFORMED CONSENT
In Chapter 2: Counseling and Informed Consent, you will find information to review and train your staff about the counseling and informed consent issues specific to uterine aspiration for abortion or miscarriage. Even if they are never formally counseling or obtaining consent, it is important for staff understand the process – because they have contact with patients that the provider does not. Staff should feel empowered to bring any concerns to the provider’s attention (such as witnessing an overbearing partner telling a patient they must “go through with this”).
The goal of informed consent is to assure that the patient's decision is voluntary and informed and to obtain legal permission for the procedure. Informed consent is a process, not just signing a form. It is an opportunity to establish a relationship with your patient, explore their understanding of the procedure, answer questions, and ensure the decision is their own.

PROCEDURE NOTES
For medication abortion, document and verify:

- Pertinent medical history
- Confirmation of pregnancy (by urine hCG or US)
- Gestational age by clinical dating or ultrasound results (if performed)
- Rh testing and immune globulin, if indicated (NAF CPGs 2015)
- Hemoglobin or hematocrit (if indicated)
- Abortion success (by POC exam, history, US, and / or hCG fall from baseline)
- Choice of post abortion contraception, if de, unless required by insurer to document in a separate note

For uterine aspiration for abortion or miscarriage management, you should also include:

- Pertinent medical history review
- Allergies, specifically including latex, iodine, shellfish, and medications.
- Physical exam, as indicated
- Pre and post procedure vital signs
- Time (e.g. start and end of procedure, medication given)
- Tissue exam results
- Comments section – special findings or problems
- A comment on patient's tolerance to procedure
- Medications given for pain control, bleeding, or antibiotic prophylaxis
- Estimated blood loss
- Referrals and follow-up visit, if applicable

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
- Sign off ultrasounds by the provider, unless performed by another certified clinician or radiologist
- Document any changes in patient status during recovery (e.g. patient states, “I feel dizzy.”)

For medication abortion, you should also include:

- Manufacturer’s Patient Agreement and Medication Guide

DISCHARGE NOTES
For discharge after uterine aspiration procedures, assure you have documented that:

- Patient is ambulatory
- Bleeding and pain are controlled
• Patient understands instructions outlining signs and symptoms of post-abortion complications and after-hours contact number
• Post op vitals following the procedure
• Choice of post abortion contraception, if desired

AFTERCARE INSTRUCTIONS
For examples, see Chapter 4 for medication abortion aftercare and Chapter 6 for uterine aspiration aftercare. Include the following in your written aftercare instructions:
• What to expect (cramping, bleeding)
• Symptoms of possible complications (fever, severe cramps, heavy bleeding)
• Limitations, as needed (exercise, bathing, heavy lifting, sex) – no evidence
• After hours phone number
• If, and when, to return for follow-up

WORKING WITH INTERPRETERS
For your patients that speak limited or no English, use the resources for interpretation that you already use in your practice. Utilizing bilingual staff or professional interpreter services are best, although telephone interpreter services have become more readily available in many languages. These resources should provide basic and accurate language skills, neutrality and confidentiality. If you must rely on a friend or family member, be sensitive to these limitations.

ENSURING QUALITY
This section will highlight a few areas to help you assess the integration of abortion into your practice, and can be folded into assessments you already do for new services.

USING DATA AND AUDIT PROCESSES
Gathering data and performing audits periodically will allow you to measure how well your newly integrated services are operating and assess the patient experience. This is to evaluate systems, not the performance of individuals. Involving staff and patients in identifying necessary improvements will facilitate positive change. Consider using the PDSA (Plan Do Study Act) model that has been endorsed by the Agency for Health Care Quality and Research.

To undertake an audit of reproductive services such as abortion care in your practice, consider gathering data on the following indicators:
• Length of time between first call and appointment date; willingness to refer
• Patient wait time
• Patient perception of pain and pain management and overall experience
• Abortion volume (utilization of resources)
• Complications and after-hours calls
• Coding practices and actual reimbursement
Below is a simple but useful methodology for measuring your service indicators:

• Identify criteria and set performance goals
• Collect and analyze data
• Identify areas of improvement and solutions
• Evaluate both desired and undesired outcomes

PATIENT SURVEY PROCESSES
Having consistent and useful patient feedback is crucial to offering excellent care in a patient-centered practice. This information creates opportunities for reflection, enriches learning, and ultimately helps to improve the patient’s experience. You might utilize patient satisfaction surveys and complaint forms already in use by your practice.

In collecting patient feedback, it is important to create and maintain an environment where feedback and criticism (both positive and negative) are used for improvement of systems to benefit the patient, not as punishment of individuals. A patient with a complaint is frequently satisfied to know that someone has listened to their issue and that action is being taken to resolve the situation.

LEGAL AND REPORTING CONSIDERATIONS
For a brief overview of the laws and reporting requirements specific to abortion in different states see Chapter 1: Overview of Abortion Law, and for the most up-to-date information, go to the Guttmacher Overview of Abortion Law. Be aware that certain states require reporting of abortion complications and hospitalization. Consult your Department of Health for more information and reporting procedures.

For reporting for statutory rape, abuse or incest, see https://rainn.org/statelaws.
For child abuse and neglect, see https://www.childwelfare.gov/pubPDFs/manda.pdf.

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 (Dehlendorf 2008). 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. Advocacy for improved regulation of the insurance industry could help ensure that clinicians trained and willing to provide services to their patients are not limited by the decisions of liability insurers.
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.

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 with the insurance commissioner of your state that your carrier is on the approved list. No matter which option you choose, it is important to check that the coverage is adequate for your services.

A targeted, short-term fundraising campaign may be an option for raising the fee required for a rider. See fundraising suggestions on [http://www.grassrootsfundraising.org](http://www.grassrootsfundraising.org).

<table>
<thead>
<tr>
<th>Malpractice Option</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAF Group coverage in progress (contact NAF for update or to join plan)</td>
<td>Large group of physicians ensures bargaining power. Membership cost is pro-rated to procedure number performed.</td>
<td>Clinic coverage only Must be NAF member.</td>
</tr>
<tr>
<td>Risk Retention Group</td>
<td>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.</td>
<td>Physicians within the group must be like-minded and share a similar level of risk. Still may need to attract a secondary (excess) carrier.</td>
</tr>
<tr>
<td>Commercially purchased insurance (potential carriers include companies such as Chubb, Evanston, and Admiral)</td>
<td>Risk is individually assessed, which may be helpful for some. Does not require organizing with other physicians.</td>
<td>Most likely to be high-cost.</td>
</tr>
<tr>
<td>Going without (going “bare”)</td>
<td>No insurance premiums. Does not require organizing with other physicians.</td>
<td>May put personal assets at risk. This option may not be legal in your state.</td>
</tr>
<tr>
<td>Gap coverage</td>
<td>Covers services such as abortion that are not covered by Federal Tort Claims Act (FTCA) – FQHC 330 sites. May already have in place for other services, like L&amp;D or hospital rounding.</td>
<td>May be expensive</td>
</tr>
<tr>
<td>Part-time policy</td>
<td>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</td>
<td>Safest to purchase alongside “entity coverage” that covers the clinic at all times.</td>
</tr>
</tbody>
</table>
SECURITY

New providers should consider personal and online security precautions before beginning to provide services. See Chapter 9: Personal Security Section.

Security is an issue for any medical setting. You may already have security plans in place in your practice setting. This section is intended to help coordinate those plans with additional security concerns you may have for providing abortion care. 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). If you do not have structured security preparedness training, then this section can help.

As with any good risk management program, security preparedness and violence prevention are important steps towards protecting your staff and patients. It is important to document any incident. A sample Incident Report Form (TEACH) sample is available online. For the most current information on incidence, go to NAF Violence Statistics and History.

DRILLS

Security drills help prepare staff to handle critical situations. They also help staff understand their role in keeping their workplace safe, express concerns, and know their fears are taken seriously.

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, often in the roles they usually play on a given day. If you are in a larger practice it is helpful to break staff into two teams. One observes and later critiques, while the other does the drill. Observers can monitor communication, response, time it took to respond, and preparedness.

There is new emphasis on closed-loop communications during emergencies. This is a technique used to avoid misunderstandings, such that when the sender gives a message, the receiver repeats it back.

During the debriefing, the whole team can assess what went well and areas for improvement, with attention spent on successful communication.

We have included on five different security drills online.

FINANCIAL ISSUES

If done well, adding EPL, medication or aspiration abortion into your practice should not cost you money in the long term. In time, all costs should be recoverable through proper billing and appropriate fee setting. But this information will help you make sure of this.

There are three main components of financial analysis for integration of EPL and abortion services: cost, revenue, and profit or loss. In addition, 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 service, 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 (for example through NAF membership, or HRSA 340b pricing for contraceptive supplies).
Facilities that receive federal funding, such as Title X or Section 330 funding (Federally Qualified Health Centers), are prohibited from using federal funds for abortion care. These facilities need to establish clear financial and administrative systems to ensure that abortion expenses and revenues are properly segregated from their federally funded services. An administrative guide outlines the key administrative and financial issues that federally funded facilities must take into account as they integrate abortion services.

COST
Like any new service, you will need to cost out what it will take to provide an EPL or abortion care, then identify your revenue sources (e.g. cash, insurance revenue, state funds), and research what your competitive market will bear. Please refer to the Spreadsheet Tool. You can input your own variable and fixed costs and patient volume to determine your approximate cost per procedure.

REVENUE
Knowing how much you can expect to be paid for EPL and abortion services is another important step in developing your budget. EPL services should be reimbursed by all payors, including Medicaid. 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 and Guttmacher State Policy Guide).

Because many of your patients are already insured, it will be beneficial to research if and how much those insurance plans will reimburse for EPL and abortion services. If you encounter plans that will not reimburse, consider negotiating contracts with those insurance companies with which you already have relationships. Be prepared to dedicate staff time to identifying and establishing new contracts. See FP Insurance Letter to use as blueprint for contacting an insurance company.

With respect to abortion services, while 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 for privacy reasons.

BILLING
When billing Medicaid or private insurance, use of proper billing codes is very important to getting accurate reimbursement. A list of the most common ICD-10 codes used for diagnosing and billing for early pregnancy loss, manual vacuum aspiration for abortion and medication abortion can be found here.

FEE SETTING
There are three considerations when setting your fee:

- What are your actual costs?
- What are your competitors charging?
- What is the value placed on it by patients?
- In setting your fees, make sure to include:
  - Lab tests (if using)
  - Pain medication and contraception (if using)
  - Follow-up exam for medication abortion patients (if using office follow up)
The staff making the appointment should be able to articulate all the services in the visit. Evaluate whether patients can be separately covered for short and long acting birth control methods and emergency contraception. You can bulk bill for the office visit that includes abortion, or you can bill each item. For medication abortion, this especially makes sense because most primary care offices will be offering additional services on top of the abortion pill: contraceptive counseling, pap test, STI screening, even flu and HPV vaccination. So, in this case, some practices just bill the abortion pill ($90) and part of the provider time as the abortion part of the visit, and the rest as they would any primary care visit.

The average amount paid for a nonhospital abortion with local anesthesia at 10 weeks’ gestation was $480 in 2011-2012. The average amount paid for an early medication abortion before 10 weeks was $504. (Jerman 2014) Fee differences may impact on a woman’s choice or make her preferred procedure inaccessible. Therefore, it is strongly advised to consider setting the same fee for aspiration and medication abortion.

**PROFIT OR LOSS**

While abortion provision is rarely motivated by finances, having an understanding of fiscal issues may help make the case for expanding services to your administration. 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. Be patient; we suggest a three-year forecast to show a trend of breaking even, and eventual profitability.

While offering abortion services may only provide a health center with minimal profits, there are many non-financial reasons why offering the service may be worthwhile. 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.

**HELPING PATIENTS PAY FOR THEIR ABORTION**

In many states Medicaid will not cover abortion care. Eleven states limit private insurance abortion coverage. Clinics can legally ask for payment at time of service, but cannot bill individual patients after the services are provided at a different rate than the standard billing rate set by the clinic. Paying at time of service for abortion services can be a financial challenge for some patients. Providers can connect with local and national abortion funds to help women pay for their abortion care. The National Network of Abortion Funds maintains a complete listing of state-based abortion funds. Planned Parenthood and the National Abortion Federation also offer patients financial support to cover their cost of their abortion.

**FINDING SUPPORT**

**DEVELOPING A NETWORK**

Building a supportive community may be the key element to helping you build and 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. Think of these people as your key stakeholders. Recall that stigma is an important predictor of satisfaction, burnout and compassion fatigue among abortion care providers (Martin 2014). So strengthening human resources for abortion care will help require stigma reduction efforts. An example, are the promising results from Provider Share Workshops showing reductions in stigma over time (Martin 2014).

The usual suspects might be the other local abortion providers, helpful listservs, 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, PRH, League of Women Voters). See Chapter 9 for additional resource organizations.

Identifying your unusual 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 EPL or abortion services, 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 (at NAF or RHAP) 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 and community.

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.
## ORGANIZATIONAL RESOURCES *

### Hotlines

<table>
<thead>
<tr>
<th>Hotline</th>
<th>Website/Phone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Options</td>
<td><a href="https://www.all-options.org">https://www.all-options.org</a> 888.493.0092</td>
<td>Toll-free after-abortion talkline to provide support for women and their support people after an abortion</td>
</tr>
<tr>
<td>Exhale</td>
<td><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</td>
<td><a href="https://prochoice.org">https://prochoice.org</a> 800-772-9100</td>
<td>Abortion referrals</td>
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### Legal

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<tr>
<th>Organization</th>
<th>Website</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACLU Reproductive Freedom Project</td>
<td><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</td>
<td><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</td>
<td><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>Website/URL</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guttmacher Institute</td>
<td><a href="http://www.guttmacher.org">www.guttmacher.org</a></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><a href="http://www.cdc.gov">www.cdc.gov</a></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>

### Sexuality Education

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website/URL</th>
<th>Description</th>
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<tbody>
<tr>
<td>Advocates for Youth</td>
<td><a href="http://www.advocatesforyouth.org">http://www.advocatesforyouth.org</a></td>
<td>Champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health.</td>
</tr>
<tr>
<td>Bedsider</td>
<td><a href="https://bedsider.org">https://bedsider.org</a> <a href="http://providers.bedsider.org">http://providers.bedsider.org</a></td>
<td>An online birth control support network to help women find birth control that’s right for them and learn how to use it consistently and effectively. Great interactive tools for patients and providers.</td>
</tr>
<tr>
<td>Coalition for Positive Sexuality</td>
<td><a href="http://www.positive.org">www.positive.org</a></td>
<td>Information about all aspects of sexuality along with information about parental involvement laws.</td>
</tr>
<tr>
<td>Go Ask Alice!</td>
<td><a href="http://www.goaskalice.columbia.edu">www.goaskalice.columbia.edu</a></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><a href="http://www.mysistahs.org">www.mysistahs.org</a></td>
<td>Information about sexual health run by and for young women of color.</td>
</tr>
<tr>
<td>Scarleteen</td>
<td><a href="http://www.scarleteen.com">http://www.scarleteen.com</a></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><a href="http://www.siecus.org">http://www.siecus.org</a></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>
</tbody>
</table>

*See Chapter 9 for a) Medical and Professional Organizations b) Training and Employment c) Listservs d) Advocacy.
CHAPTER 10 EXERCISES: OFFICE PRACTICE INTEGRATION

EXERCISE 10.1
Purpose: These exercises will help you consider potential barriers and strategies for integrating reproductive health services into practice. Although they refer to abortion and miscarriage services, they could be used for other services you may be planning.

1. List 3 barriers that you think you may encounter in trying to integrate the reproductive health service you are considering in your practice. How would you address them?

2. Who are the key stakeholders in starting this 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 appropriate OB or hospital back up? How would you cover call?
CHAPTER 10 TEACHING POINTS:
OFFICE PRACTICE INTEGRATION EXERCISES

EXERCISE 10.1

Purpose: These exercises will help you consider potential barriers and strategies for integrating reproductive health services into practice. Although they refer to abortion and miscarriage services, they could be used for other services you may be planning.

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

Controversy
There will tend 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.

• Work gradually on building support for reproductive services, so staff might first understand the benefits to patients of offering comprehensive contraception and miscarriage services.
• If staff objects to the idea of including abortion in your service, refer to the tools included for working through values clarification.
• If the controversy is about “turning into an abortion clinic”, the statistics in primary care settings suggest that most integrated clinics perform 1-2 abortions per week, and rarely draw such attention.
• 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.
• Talk to other sites that have done the same thing for a “reality check.”

The most compelling response to these issues is the experience of patients. 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”
“We can just send our miscarriage patients to the ER.”

Consider that nearly half of pregnancies are unintended, and if you care for pregnant women in your practice, approximately 1 in 5 pregnancies end in miscarriage, and 1 of 4 pregnant patients choose to have an abortion. Women will make different choices at different points in their lives. You can safely project that a certain percentage of the women in your practice will seek these services. Offering your patients balanced options counseling and care may increase both access and comfort for your patients. Studies show that offering these services in a primary care setting is more cost-effective and, especially with respect to miscarriage care, better for women’s emotional well-being (Dalton 2006).

Fear of complications
First trimester abortion is one of the safest medical procedures, with minimal risk of major complication, less than .05% might need hospital care. About 89% of the women who obtain abortions are less than 13 weeks pregnant (Guttmacher 2016).
Myths about abortion (none of our patients have unintended pregnancies)

Women from every reproductive 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 patient who may need services to focus on the bias the speaker may have about abortion in general. Share this video with staff and use it to debunk myths about who has abortions in the U.S..

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, as well as advanced practice clinicians in certain states. Early abortion safety, efficacy and acceptability are found to be equivalent between physicians and most cadres of advanced practice clinicians (Bernard 2015). The similarity of safety and efficacy is true for both experienced and newly trained providers. Appropriate training in abortion care and demonstrated competency are the key issues. Clinicians from many specialties have excelled at abortion provision and have come to make significant advances in the reproductive health field.

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 and miscarriage services on without investing too much early on. One is to start with medication abortion. Medication abortion success may be assessed by clinical means in the office or by telephone, hCG testing, or ultrasound (NAF CPG 2020). You can refer out for ultrasound as needed. 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 a tenaculum may cost around $500. Some organizations may help provide funding to offset start-up costs for abortion and miscarriage services.

Reimbursement

Limited reimbursement will be more of an issue in states where there is no Medicaid funding of abortion. Connecting to local or national abortion funds can help patients cover the cost of services. Miscarriage care should be covered by Medicaid and other insurers as a standard component of prenatal care.

2. Who are the key stakeholders in starting this service? How would you approach getting buy-in from your stakeholders or staff?

See Key Stakeholders Section for likely players. 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 operating room, 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
- Commitment to prevention of unintended pregnancies within a public health framework
- Commitment to addressing patient’s sexual and reproductive health care needs
- 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 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 training of specific patients.

3. What might you do if you have a complication in your clinical site? How will you secure appropriate OB or hospital 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.

When a complication arises, 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)

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.

For clinics looking to integrate medication abortion only, finding surgical back up is an important early step. For primary care providers working within a healthcare organization, this can be as simple as reaching out to the heads of the OB/GYN and Emergency Medicine departments to let them know that you will be starting to offer medication abortion. If no back up is available within network, a local surgical abortion clinic can serve as unofficial back up. The Reproductive Health Access Project can help identify abortion-friendly hospitals if none are available locally. (See Key Stakeholders Section for details.)
CHAPTER 10 REFERENCES


Freedman L. Willing and Unable: Doctors’ Constraints in Abortion Care..Vanderbilt Press; 2010.


11. BECOMING A TRAINER

Updated June 2016 by Sarah McNeil MD

This chapter is designed to help you train clinicians to competence in early abortion care and miscarriage management. It presents techniques for efficiency in training as well as integration of training into the clinical setting.

CHAPTER LEARNING OBJECTIVES

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

• Maintain balance between patient-centered care, safety, clinic flow, and training
• Ask trainees for self-assessment and give effective feedback to trainees
• Assess competence in abortion provision
• Respond appropriately to difficult training situations
• Integrate training seamlessly into a busy clinical setting

VIDEOS

• This is How I Teach Series: helpful video series on teaching techniques (IERH): https://bit.ly/2YvsrKm

READINGS / RESOURCES

• Clinic flow strategies for training clinics
• Conscientious refusal in reproductive medicine: an educational intervention (Lupi 2009)
**SUMMARY POINTS**

**SKILLS**

- Expose each trainee to the process of values clarification prior to, or early in patient contact, and individualize a learning plan for each trainee. Log issues encountered that trainees want help deciphering and revisit their learning plan throughout the training experience.
- Teach opt-out trainees to gain core skills including pregnancy dating, ultrasound, options and contraceptive counseling, referral skills, miscarriage and complication management.
- Make learning expectations clear. Each skill can be broken into distinct steps with observable competencies for learners and for trainers-in-training.
- Distinguish recommendations based on evidence versus those based on provider preference.
- Introduce yourselves as a team to maintain the patient’s confidence.
- Learn to manage competing priorities in a busy clinic, including patient support and safety, clinic flow, and training learners with different skills and interest.
- Give the trainee the first opportunity at self-evaluation, and offer positive reinforcement before constructive criticism in a specific and timely fashion.

**SAFETY**

- Prioritize patient safety; review plans for communication that would prompt a trainee to allow you to take over.
- Progressively involve a new trainee in the procedure as they gain more confidence.
- Take every opportunity to discuss the management of potential complications ahead of time, which will help prepare trainees for the challenges they may encounter.

**ROLE**

- Train new providers as part of a collaborative national effort aimed to normalize abortion within the healthcare system and address the abortion provider shortage.
TRAINING SKILLS

Becoming a trainer can be exciting, challenging, and most of all, rewarding. As you help learners to develop and refine important clinical skills, you also have the opportunity to teach about other critical aspects of reproductive health, such as the public health context of unintended pregnancy, the nuances of patient-centered care, word choice, and cultural humility. As a trainer, you will also build relationships within the reproductive health community and help address stigma associated with abortion provision.

VALUES CLARIFICATION AND PROFESSIONAL RESPONSIBILITIES

It is best to introduce the process of values clarification with each learner before, or soon after having begun patient contact in the abortion care setting.

- Have new trainees read Chapters 1 and 2 before training to clarify their personal values about pregnancy options and abortion in the context of professional judgments they will be called upon to make.
- Remind trainees of their professional responsibility to, and opportunity to support patients by, provide appropriate referrals regardless of their own beliefs.
- Relay how literature recognizes the “conscience” in abortion provision, and not just refusal to participate. Teach how provision can address stigma, as well as impact clinical practice, law and bioethics (Harris 2012).
- Offer each trainee to shadow a patient all the way through the counseling and abortion process, to illuminate the experience from a patient’s perspective before getting into the specifics of clinical care.
- Continue to revisit your own values as you work with patients and trainees, as these interactions may shed new light on your experiences.
- And remember that stigma is an important predictor of satisfaction, burnout and compassion fatigue among abortion care providers (Martin 2014). Therefore, strengthening human resources for abortion care requires stigma reduction efforts. Participants in the PSWs show reductions in stigma over time.

OPT-OUT TRAINEES

A thoughtfully implemented opt-out policy is key to the success of an integrated abortion training program. Significantly more trainees receive abortion training when it is incorporated as a routine part of the curriculum with opt-out provisions, compared to when it is elective only. In addition, training opt-out trainees is likely to help reduce abortion stigma, by making both patients and providers more human to them.

In addition to training future providers, we hope this curriculum broadens the perspective of opt-out trainees to provide unbiased evidence-based care. Gaining skills to provide balanced options counseling, referral and follow-up, miscarriage management, and contraceptive care is critical for all learners. By tailoring the program content to focus on individual interest, trainees ambivalent about abortion still gain critical reproductive health skills.

Studies show that trainees opting-out of some or all abortions valued the ability to partially participate in the family planning training. Many identified specific aspects of their training that impact future patient care, including those addressing core competencies in medical knowledge, exam and procedural skills, counseling skills, appropriate referrals and professionalism. (Steinauer 2014, Freedman 2010, Nothnagle 2008).
For opt-out trainees, we recommend that you:

- Respect varying opinions, which can help defuse polarity
- Express interest in how a trainee developed their point of view
- Reinforce that even trainees ambivalent about abortion have important knowledge and patient-care skills to gain from this rotational experience
- Be explicit about not forcing anyone to perform procedures; there is plenty more to learn
- Consider sharing part of your own experience, such as the first time you looked at fetal parts or used intra-operative ultrasound
- Tailor the program using the Partial Participation or Opt-Out Curriculum in Chapter 1.
- Refer to them to online modules like Physicians for Reproductive Health’s LEARN (Lessons to Enhance Awareness of Reproductive Needs) and ARSH (Adolescent Reproductive and Sexual Health)

As learners realize that choices to provide abortion services are not black and white for providers, opt-out trainees often expand their participation through the rotation.

PRACTICE WITH SIMULATION MODELS PRIOR TO PATIENT CARE

A growing body of literature supports the use of simulation models in medical education (Lofaso 2011, Okuda 2009, Ziv 2003). Limited patient encounters, demands on training hours, and heightened focus on safety have all lead to the increasing use of models and simulated complication scenarios. Simulation can help learners with procedural comfort, complication management, and stress-readiness during a crisis.

Existing simulation models for uterine aspiration include low-cost fruit models such as the papaya (Paul 2005) and pitaya (Goodman 2015); both enable trainees to practice cervical anesthesia, aspiration, pelvic exams, or IUD placement. In addition, a number of anatomic models are available to help new learners with pelvic exams and gynecologic procedures.

Programs and trainers should consider require comfort with a model BEFORE a real patient, to set a learner up for success during an actual procedure. The model can be very simple—for example using the trainer’s fisted hand as a pretend cervix if no other model is available—but comfort should be obtained prior to doing the procedure itself.

MODELING HIGH QUALITY PATIENT-CENTERED CARE

Remember that in the role of trainer, our own interactions with patients and staff communicate our underlying philosophy. Given the sensitivity of this work, we encourage you to specifically consider the following resources to:

- Incorporate patient-centered counseling techniques and word choices
  - Chapters 2 and 7
- Explore implicit bias
  - Dehlendorf 2010, UCSF Office of Diversity Website
- Promote inclusiveness and cultural humility
  - Kutob 2013, Loudon 1999

It is helpful to differentiate evidence-based recommendations from provider preference or style.

- Stay current with the growing body of abortion and contraceptive literature
- Expose trainees to the styles of various providers
COMPETENCY-BASED SKILLS

Rather than focus on trainees achieving specific procedural numbers or specialty training, there have been concerted efforts in reproductive health training to help learners attain clinical knowledge and skill-based competencies in line with health professional education standards (e.g. ACGME Family Medicine Milestones, AACN, ACNM, NONPF). Each skill can be delineated into clear steps with observable competencies for learners and for trainers-in-training (Cappiello, 2016).

In one clinician training model (Levi 2012), competencies were monitored by both the trainer and the trainee. Both groups used daily and final competency assessments in areas of a) patient comfort, b) procedural completeness, c) speed, and d) ability to identify problems, while review of complications was used to identify concerns about clinician safety.

Abortion safety, efficacy and acceptability are found to be equivalent between most cadres of advanced practice clinicians and physicians (Bernard 2015; Weitz 2013). And the similarity in safety and efficacy is true for both experienced and newly trained providers (Jejeebhoy 2011, Warriner 2006). This supports the adoption of policies allowing more providers to perform early aspiration abortions, and in turn, helps to expand patient access to abortion care.

MEETING INDIVIDUALIZED NEEDS OF YOUR LEARNER

Use a step-wise approach to involving new trainees

- Start slowly on earlier cases, and build involvement with each case. Trainees may progress at differing paces. For some trainees, they may build up to doing most steps of a case in the first session or so. For faster learners, the trainee can do the pelvic exam and observe the first procedure, help aspirate the uterus with the second, help dilate and place the cannula on the third, and be involved in the entire abortion on the fourth.
- To best support learning, stay aware of the trainee’s skill advancement. At first, stand behind a trainee, so you can assist with your hands, and see what they are seeing. As the learner gains competence, move back or to the side.
- Consider agreeing ahead of time on a time limit after which the trainer intervenes (for example, if cases go on longer than 5 minutes). This helps depersonalize the need for the trainer to intervene, and ensures patient comfort and flow maintenance.
- With time, trainees should also take command of communication with the patient.
- Consider having a trainee work independently at the end of the rotation, especially for earlier gestational ages, while you stay within earshot if they need your assistance.

TEACHING DURING THE PROCEDURE

Prioritize patient safety

At the beginning of the training session, ask the trainee what their priorities are for the day, and review plans for communicating during procedures so it is patient-centered. For example:

- Introduce yourselves as a team, and initially lead the patient conversation, allowing a trainee to focus on new procedural skills.
- Don’t hesitate to step in when you are concerned about patient comfort or safety.
- Consider having a signal for “trading places” such as a tap on the shoulder if the situation becomes challenging.
- Encourage trainees to stop for assistance if the procedure does not feel right (i.e. they feel resistance with dilation or instruments pass further than usual).
Play an active role in clinic flow (particularly in a high-volume clinic)

- Set reasonable goals for procedure times with trainees. Emphasize that longer procedures may be uncomfortable for patients and increase waiting for other patients. A first trimester abortion should rarely take longer than 5-10 minutes of speculum time.
- Prior to seeing the first patient, review more challenging steps of the procedure, such as accurate bimanual exam, efficient speculum placement, the first dilator pass, and the final check for completion.
- Plan special needs for a case before entering the procedure room to minimize trips out.
- Review tray set-up to adhere to the no-touch technique.
- Tell trainees that part of your communication with them will be through speaking with the patient. For example, you may prompt a new learner to inject anesthetic by saying to the patient, “Next is numbing medicine; you may feel a cramp or nothing at all.”
- Rely on a medical assistant or doula to support the patient, which can distract from the teaching process.
- If a trainee is taking a long time for any one step (e.g.: speculum placement or dilation), assist with your hands or step in, and offer helpful tips before the next patient, when the trainee can try again.
- Communicate early and often with the clinic or flow manager.
- Provide the majority of teaching and feedback between cases, or bookmark them for the end of the day.
- For additional ideas, see Clinic flow strategies.

GIVING EFFECTIVE FEEDBACK

Feedback helps keep an individual on target to achieve learning goals. Data show that learners appreciate feedback early and often (Cantillon 2008). Providing this information can increase a learner’s rate of improvement, and inspire higher levels of performance.

- Provide feedback in private.
- Invite a trainee to take the first shot at self-evaluation. Ask, “How do you think that case went?” or “What else might you try in this situation?”
- Give better feedback using a simple five step model captured in the acronym SMART: giving feedback that is Specific, Measurable, Achievable, Relevant and Time-based.
- Offer feedback that reinforces good clinical skills before constructive criticism, to soften the delivery and avoid discouragement.
- Share observations about non-verbal communication, wording, and tone.
- Feedback should include an action plan for what to try next.
- Remember that all learners benefit from constructive feedback, even experienced providers.

Consider varying the types of feedback you provide.

- Sharing your observation: “You used a number of open-ended questions with that client.” “Your pelvic assessment was accurate, as we see from the angle the dilator entered.”
- Reacting at a personal level: “I liked your reassuring tone; it really seemed to calm her down.” “I appreciate how you asked for help with cannula placement.”
- Predicting the outcome of a situation and emphasizing the consequences of an incorrect practice: “One risk of continuing to push against resistance is creating a false tract or perforation. You avoided that by stopping to confirm the patient’s uterine position.”
MASTERING AND TEACHING ULTRASOUND (US)

As you become more proficient as a provider and trainer, continue to master your own US skills, for dating and intra-operative guidance. Where available, try to provide your trainees with US experience at multiple gestational ages. In addition to reviewing basic US principles from Chapter 3, encourage learners to take advantage of interactive online curriculum that may be available in your setting. If you have other staff members proctoring trainees, consider observing a trainee sonogram yourself to assess skill level. Resources include:

- Ultrasound in Abortion Care (Interactive Online Curriculum), ARMS 2007
- Ultrasound Lecture Series – Obstetrics and Gynecology, AUIM.
- Early Pregnancy Ultrasound Skills Evaluation (NEW TRAINER SKILLS EVALUATION, page 31)

HELPING TO PREPARE FOR TRANSITIONS TO PRACTICE

It is valuable to ask trainees how they might integrate this material into their future careers, Reinforce the stories and benefits of being able to offer services in one’s own practice.

- Compare a primary care office to a high-volume setting, which has more ancillary staff to provide counseling, lab work, ultrasound, or recovery support.
- Point out areas where different practice standards exist (i.e. routine vs. selective US).
- Encourage trainees to consider how they will adapt to these differences.

Reinforce the expectation that the trainee should be able to provide multiple aspects of care by the end of their training. On the last day of training, consider completing all steps (US, counseling, pre-medication, procedure, recovery) in one room, to simulate a primary care practice experience.

BUILDING STAFF SUPPORT

When establishing a training program, it is invaluable to build and maintain staff support and involvement. The following strategies have been useful:

- Develop and foster multidisciplinary, team-based care
- Discuss how patients benefit (i.e.: public health implications of improved access)
- Cultivate interest in contraceptive advances
- Use appropriately timed staff surveys and values clarification workshops
- Bring speakers (with an outside opinion) to attest and legitimize the value of services.

NEGOTIATING THE TRAINING RELATIONSHIP WITH STAFF AND PATIENTS

There are various ways to present the training arrangement to staff and patients, reminding them that this is part of the national process of professional education.

- Prior to training initiation, discuss ways for your staff to talk about the training with patients and provide a script. They should feel comfortable presenting it.
  - Training can be described as an initiative to address patient access to reproductive health services, extending expertise to more providers.
  - Staff can explain, “You will be seen by two doctors / providers today; one from our clinic and one from the university.”
• Consider posting information explaining the training partnership in waiting rooms. One example is “A partnership has been established with the (university, hospital or residency) to expand access to services by training more clinicians in reproductive health. This is a center of training and excellence.”
• Consider including training in a general consent form for care and services.
• Consider introducing yourselves by saying, “We’ll be doing your procedure together today.” Depending on who is undertaking the hands-on role, the trainer could alternatively say, “I’ll be assisting with your procedure today.”
• Emphasize the team approach to care (instead who has more or less experience).
• Allow the trainees to describe the details of their procedural background as needed, focusing on the fact that they do many procedures of this complexity.

PREPARING FOR AND SUPPORTING CHANGE
We all appreciate that change is not easy. Incorporation of new and controversial programs like abortion training is likely to require significant institutional change. Steps might include:

• Building the case for change
• Creating a plan and enrolling others to champion the change
• Identifying and preparing for resistance
• Recognizing the strengths your setting already has to support the change
• Considering small steps that can be made toward change
• Supporting, recognizing and maintaining the momentum
• Evaluating and openly addressing unanticipated problems
• Redirecting to stay the course

Embracing the concept on ongoing improvement sets a positive tone in a clinic, where trainers, trainees, and staff alike may be part of the learning process. Assure that there an outlet for staff and patient concerns and suggestions regarding the training program.

• Help reinforce the value of staff contribution in training new abortion providers
• Encourage leadership by creating roles for particular staff to be involved with demonstrating counseling, ultrasound, recovery or discharge teaching
• Encourage staff to give feedback to trainees
• Offer periodical updates to staff to broaden their knowledge and buy-in
• Encourage periodic discussion of clinic flow issues, strategies, and patient care with your staff, including huddles, debriefs, and staff meetings
• Share cumulative results of the training program with staff

EVALUATING NEW TRAINERS
Ideally new trainers have the opportunity to work alongside seasoned trainers to gradually obtain the many skills important to quality training. Timing of evaluation and approval to train independently may vary with experience providing and teaching in other environments, as well as needs of the program, but the following will assist in this assessment.

• New Trainer Skills Evaluation: A competency evaluation for new trainers (see below)

CONTINUING COMMITMENT
We hope that the above suggestions can help you to more seamlessly integrate training into your practice and to make it a fulfilling means to address disparities in access to abortion and reproductive health regionally and throughout the country. Please don’t hesitate to reach out to us and other colleagues with any questions!
NEW TRAINER SKILLS EVALUATION  New Trainer being evaluated

Faculty Evaluator

Number of training sessions observed

In addition to meeting the criteria for competency as an abortion provider, a trainer must be able to:

<table>
<thead>
<tr>
<th>Training Skills</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
<th>Did not experience</th>
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</thead>
<tbody>
<tr>
<td>Assesses trainee’s skills and learning needs</td>
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<tr>
<td>Engages trainee in learning experience</td>
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<tr>
<td>States objectives for each training day</td>
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<tr>
<td>Encourages trainee to ask questions</td>
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<tr>
<td>Answers questions clearly and completely</td>
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<tr>
<td>Demonstrates strong knowledge of subject matter</td>
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<tr>
<td>Gives appropriate evidence and resources</td>
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<tr>
<td>Uses variety of teaching methods including cases, role plays, “what if” scenarios, didactics</td>
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<tr>
<td>Discusses various approaches to the procedure</td>
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<tr>
<td>Demonstrates knowledge of site specific protocols</td>
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<tr>
<td>Reviews chart and informed consent</td>
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<tr>
<td>Reviews / interprets US, labs, and medical history w/ trainee</td>
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<tr>
<td>Demonstrates establishing rapport with the patient</td>
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<tr>
<td>Demonstrates non-judgmental attitude towards the patient</td>
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<tr>
<td>Demonstrates clear communication with the patient regarding procedure and management</td>
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<tr>
<td>Allows trainee to solicit and answers patient questions</td>
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<tr>
<td>Confirms physical exam findings</td>
<td></td>
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<tr>
<td>Gives feedback about no touch technique</td>
<td></td>
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<tr>
<td>Gives feedback about trainee’s attention to patient comfort during procedure</td>
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<tr>
<td>Can take over a case when appropriate without disturbing the patient or undermining the trainee</td>
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<tr>
<td>Provides feedback to the trainee after each procedure, and at the end of session</td>
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<tr>
<td>Reviews elements of tissue exam with trainee</td>
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<tr>
<td>Reviews appropriate post operative orders with the trainee</td>
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<tr>
<td>Reviews patient’s contraceptive needs (including EC) and contraindications w/ trainee</td>
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<tr>
<td>Models respectful attitude towards staff</td>
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<tr>
<td>Is receptive to feedback from trainee / peers</td>
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<tr>
<td>Models and teaches trainee attention to clinic flow</td>
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Additional Comments:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Evaluation by Trainer:  □ Approved    □ Further orientation and observation suggested/required

SIGNATURE OF EVALUATOR:  ___________________________ DATE:  ___________________________
**EARLY PREGNANCY ULTRASOUND SKILLS EVALUATION**

Trainer: ___________________________ Date: ___________________________

Number of Sonograms Observed: __________________________________________

<table>
<thead>
<tr>
<th>TRAINING SKILLS</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
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</thead>
<tbody>
<tr>
<td><strong>INTERPERSONAL SKILLS</strong></td>
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<tr>
<td>Introduces self to patient and establishes rapport</td>
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<tr>
<td>Explains sonogram procedure to client, and routinely asks about LMP, latex allergy, desire to hear about twins, etc.</td>
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<tr>
<td>Pays attention to patient comfort</td>
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<tr>
<td>Uses appropriate language to discuss ultrasound findings in presence of patient</td>
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<tr>
<td>Solicits and answers patient questions appropriately</td>
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<tr>
<td><strong>CLINICAL SKILLS</strong></td>
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<tr>
<td>Prepares ultrasound probe properly for use</td>
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<tr>
<td>Uses keyboard and screen functions properly</td>
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<tr>
<td>Keeps uterus in center of screen, zooming as needed</td>
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<tr>
<td>Systematically identifies uterus in longitudinal and transverse views, taking appropriate images</td>
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<tr>
<td>Systematically scans across pelvis, requesting help as needed.</td>
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<tr>
<td>Measures gestational sac in 3 planes; able to explain how and why</td>
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<tr>
<td>Identifies yolk sac</td>
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<tr>
<td>Identifies fetal pole and cardiac activity</td>
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<tr>
<td>Measures CRL in longest view (without limbs or yolk sac)</td>
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<tr>
<td>Assures location of pregnancy is intrauterine</td>
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<tr>
<td>Perform post procedural or post medical abortion US to establish no evidence of gestational sac, embryo or fetus</td>
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<tr>
<td>Ensures transducer(s) cleaned between exams</td>
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<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
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<tr>
<td>Able to name key US characteristics of pseudo vs. true gestational sac (identify if possible)</td>
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<tr>
<td>Accurately calculates GA with gestational sac measurements</td>
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<tr>
<td>Accurately calculates GA with CRL measurement</td>
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<tr>
<td>Knows when to switch to BPD measurement, and elements of an optimal BPD measurement</td>
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</table>

Additional Comments:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Evaluation by Trainer: ☐ Approved    ☐ Further orientation and observation suggested/required

SIGNATURE OF EVALUATOR: ___________________________ DATE: _________________
CHAPTER 11 EXERCISES: BECOMING A TRAINER

Challenging Training Situations

Purpose: For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training.

1. A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions “I felt some obstruction and a tearing feeling.”

2. A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. They tend to sit back and avoid saying much, making assessment of skill difficult.

3. You start off with the values clarification exercises with a trainee who is shy but friendly. After a brief introduction, they tell you that they are struggling over whether or not to provide abortions. They feel it is hard to “help someone commit a sin.” They would feel better if only they could spend a lot of time with each patient to make sure that they thought abortion was the right decision for that patient. They especially wanted to avoid doing abortions for those who use it as birth control. The trainee states, “Clearly some patients make bad decisions for themselves, so I cannot trust that they are making the right decision about this.”
4. A trainee shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

5. The last couple days in your training clinic, you’ve noticed the clinic flow seems to be less than optimal, with longer patient waiting times, and your staff becoming mildly inpatient with training. How might you approach this problem?

6. You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. The patient then becomes more active on the table, withdrawing from each cervical dilation by the trainee, and starts crying loudly in the middle of the dilation. How do you proceed?
CHAPTER 11 TEACHING POINTS:
BECOMING A TRAINER EXERCISES

Challenging Training Situations

Purpose: For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training.

1. A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions, “I felt some obstruction and a tearing feeling.”
   • You need to assess what the trainee has done, making the transition as smooth as possible to preserve safety, and not to alarm the patient.
   • Subtly communicate the need to switch places.
   • Help reassure the patient if there is a change in her procedure.
   • Have a low threshold to use ultrasound guidance if available.
   • Consider the following preventative steps:
     o Practice with simulation models like the papaya, an IUD model, or even a trainer’s fisted hand as a pretend cervix if no other model is available.
     o Consider requiring comfort with a model BEFORE a real patient, to set a learner up for success during an actual procedure.
     o Introduce the trainee gradually to the procedure.
     o Prepare the trainee for “moments of caution” including the first dilation.
     o Work very closely next to a trainee, assisting with your hands, until you gradually gain confidence in his/her skill level.
   • Give feedback after the case, starting with the opportunity for self-assessment.
   • Recognize the trainee for having asked for help when feeling resistance, which contributed to the patient’s safety.
   • Give ideas for improvement, and steps to take to either prevent or manage this challenge if it arises again.

2. A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. They tend to sit back and avoid saying much, making assessment of skill difficult.
   • Engage the trainee with values clarification work and counseling exercises.
   • Ask the trainee for specific contributions or actions.
   • Ask for their assistance in making this a meaningful experience. “How can I make this training more useful for you?”
   • Consider asking other trainers if they have had a similar experience with this learner.
   • If the behavior continues, ask the trainee about her apparent lack of enthusiasm, and focus on basic expectations of the rotation.
   • Evaluate the trainee honestly.
3. You start off with the values clarification exercises with a trainee who is shy but friendly. After a brief introduction, they tell you that they are struggling over whether or not to provide abortions. They feel it is hard to “help someone commit a sin.” They would feel better if only they could spend a lot of time with each patient to make sure that they thought abortion was the right decision for that patient. They especially wanted to avoid doing abortions for those patients who use it as birth control. The trainee states, “Clearly some women make bad decisions for themselves, so I can not trust that they are making the right decision about this.”

- Consider asking more about how they perceive sin and forgiveness, and how they weigh the relative difficulty of decisions in this realm.
- Consider asking if they believe in broader platform such as the importance of respecting patient autonomy, reduction of stigma, or a clinician’s duty to ensure a patient receives care.
- “Broaden” the approach to explore other scenarios that might evoke physician bias in relation to childbearing or not (e.g. alcoholism, drug-use, HIV, refusal of blood transfusion, or refusal of a C-section).
- Do values clarification, some counseling observations, and then reassess.
- It’s important to give them the space to work it through in a way that doesn’t adversely affect the care of your patients.
- We recommend evaluating trainees on their ability to render non-judgmental care. When trainees are unable to do so, we need to give an honest evaluation and let the residency faculty know what areas still need work.

4. A trainee shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

- Do counseling exercises and role-play early. Ask the trainee to play the patient at times, and see which tone they prefer as a patient.
- Review alternative ways to say things.
- Ask the trainee to do the procedure while you talk to the patient and see if they can glean from your word-choice.
- Give feedback after every case.
- Reinforce the benefits gained by the things they tried.
- Reinforce their strong procedural skills, and potential to provide support.
5. The last couple days in your training clinic, you’ve noticed the clinic flow seems less than optimal, with longer patient waiting times, and your staff becoming mildly inpatient with training. How might you approach this?

- Acknowledge that training can slow down the clinic, and remind the staff of the long-term benefits. Enlist their support in its success.
- ‘Bookmark’ topics to finish reviewing at the end of the clinic day.
- Use a debriefing session after clinic to ask staff to share their perspectives and brainstorm strategies for improvement. See Clinic flow strategies.
- Help keep the case moving by helping with that or the next step (for example, if the trainee is struggling to put adequate pressure on the dilator, add the additional pressure on their hands, so they appreciate the appropriate pressure needed).
- Agree ahead of time with trainee/team on a time limit after which the trainer intervenes (for example, if the case is going on longer than 10 minutes). This can helpful depersonalize things when the trainer intervenes if a case is taking too long, and it also ensures that concerns about flow are addressed in an ongoing way.
- Consider having one trainer whose focus is the learner, and another practitioner whose focus is flow and keeping waiting times minimized.
- Consider other options that may work in your own practice setting.

6. You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. The patient then becomes more active on the table, withdrawing from each cervical dilation by the trainee, and starts crying loudly in the middle of the dilation. How do you proceed?

- Have the trainee pause during the procedure so you can assess the situation clinically and check in with the patient.
- If you feel the procedure is safe, help reinforce the techniques of relaxation including breath, stabilizing her hips into the table, visualization, and talking her through the procedure. Assess whether more local, oral or IV medication might be helpful.
- Ask for a medical assistant to be more active or step into the doula role yourself. Making eye contact with the patient, holding the patient’s hands, walking through a guided meditation as distraction, and breathing with the patient can all make a huge difference.
- Sometimes, just getting the case done as quickly as possible, though, is necessary, and you will have to complete the procedure. Make this transition using a subtle signal so the patient doesn’t become alarmed.
- Discuss the case after you finish, giving the trainee the first opportunity to assess and problem-solve, and explain why it was important if you needed to take over the case. Offer positive and then constructive feedback.
CHAPTER 11 REFERENCES


12. Training Evaluation

Updated 2016 by Suzan Goodman MD MPH

Evaluation and feedback are among the most important tools in effective learning. The ACGME and the American Board of Medical Specialties (ABMS) provide information about the validity and feasibility of a variety of evaluation methods that may be used to assess performance and skills.

The following instruments, developed for use with this Training Workbook, are based on ACGME-recommended methods. They include specialty competencies for primary care clinicians providing early abortion care, regardless of setting. They include essential knowledge, behaviors, and skills that primary care clinicians should be able to demonstrate upon application for practice in abortion care and the prevention of unintended pregnancy. These instruments are designed to assist in the evaluation of participants, faculty, staff, and the overall rotation. All forms may be used or adapted for the professional training program or high-volume training setting. These and various alternative evaluation forms can be downloaded separately at either TEACH or RHEDI.

- Skills and Experience Inventory: To assess experience prior to the rotation
- Trainee Agreement and Consent Form: To consent to training
- Procedure Log: To record all trainee procedural experience.
- Training Program Evaluation: For trainees to review the overall training program
- Daily Evaluation Card: Designed for faculty to evaluate trainees on a daily basis
- Observed Performance Assessment: For faculty to evaluate trainees
- Core Competencies for First Trimester Aspiration Abortion by Primary Care Clinicians: Entry-level specialty competencies for providing early abortion care, regardless of setting
- Clinician Feedback Form for Clinic Staff: For training site staff to review the trainee’s performance, with regards to patient care and professionalism
- Clinic Services Satisfaction Survey: A patient satisfaction survey to use in training sites

For Advanced Skills evaluation, this section includes:

- Early Pregnancy Ultrasound Skills Evaluation: A competency evaluation for early pregnancy ultrasound
SKILLS & EXPERIENCE INVENTORY

Name: ___________________________________  Training Program _______________________________________

1. TRAINING - Have you ever had training in:
   a. Family Planning/Contraception □ Yes □ No Hours _______
   b. Unintended Pregnancy & Options Counseling □ Yes □ No Hours _______
   c. Miscarriage Management □ Yes □ No Hours _______
   d. Public Health Aspects of Abortion Access □ Yes □ No Hours _______

2. EXPERIENCE – check all of which apply:

   NUMBER OF PROCEDURES/SESSIONS:

   Electric Vacuum Aspiration (EVA) □ 1-10 □ 11-20 □ 21-30 □ >30
   Manual Vacuum Aspiration (MVA) □ 1-10 □ 11-20 □ 21-30 □ >30
   Dilation & Curettage □ 1-10 □ 11-20 □ 21-30 □ >30
   Ultrasound dating □ 1-10 □ 11-20 □ 21-30 □ >30
   Medical management of miscarriage □ 1-10 □ 11-20 □ 21-30 □ >30
   IUD insertion □ 1-10 □ 11-20 □ 21-30 □ >30
   Contraceptive implant insertion □ 1-10 □ 11-20 □ 21-30 □ >30
   Prenatal care □ 1-10 □ 11-20 □ 21-30 □ >30
   Early pregnancy dating exams □ 1-10 □ 11-20 □ 21-30 □ >30
   Endometrial biopsy □ 1-10 □ 11-20 □ 21-30 □ >30

3. ADDITIONAL INFORMATION

   I. Could you give me three reasons why you decided to participate in this Training Program?

   __________________________________________________________________________________________

   __________________________________________________________________________________________

   II. Do you have any hesitations (fears) about participating in this Training Program or providing abortions? □ Yes □ No

   III. Aside from technical skills, do you anticipate any other benefits from completing this training?

   __________________________________________________________________________________________

   __________________________________________________________________________________________

   IV. Do you anticipate offering abortions in future practice? □ Yes □ No
TRAINEE AGREEMENT AND CONSENT FORM

This is a consent to participate in reproductive health training available through your residency or professional training program. In addition to training, we hope to evaluate and improve the reproductive health curriculum for all participants.

Every learner eligible to participate in reproductive health training will be asked to evaluate the program, regardless of the level at which they opt to participate. Questions will involve your evaluation of the training, the competence you have gained, and the influence of the training on your future practice plans.

Your participation is voluntary, and you can decide not to participate in the evaluation.

As a participant in the Training Program, you will be asked to review and comply with the medical standards and mandated reporting for the training site, maintain confidentiality, and follow the clinical protocols of the training site.

You will also be asked to keep a record of your procedural experience (including ultrasounds, counseling, aspiration procedures, medication abortions, and any complications) during the rotation and in the subsequent two years. Note: Keeping a log and follow-up information will help you monitor your own practice. Training staff may also use this information on an anonymous basis in evaluating the effectiveness of training.

We will ensure that personal information gathered for this evaluation study is kept private and confidential. If information from this study is published or presented at scientific meetings, no names and personal information will be used.

If you have any questions, you may ask your faculty.

CONSENT: You can print a copy of this consent form if you choose.

Signature ____________________________ Date __________________________

Witness ______________________________ Date __________________________


# PROCEDURE LOG

Trainee: ____________________________________________________________

Residency / Professional Training Program: _____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Pt/Case #</th>
<th>Type</th>
<th>Weeks Gest.</th>
<th>Trainer Comments and Initials</th>
</tr>
</thead>
<tbody>
<tr>
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<td>MVA / EVA / MED</td>
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</tbody>
</table>
**TRAINING PROGRAM EVALUATION FORM**

For completion by training participants.

Be sure to complete any additional evaluation required by your residency or training program.

Name: ___________________________ Training Program ___________________________

Program Year: ______________________ Date: __________________________

1. Please evaluate the following aspects of your rotation training experience by circling the appropriate response:

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Did not experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Didactic teaching</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>b Syllabus</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>c Clinic orientation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>d Abortion counseling experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>e Medical screening/management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>f Pelvic examination / sizing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>g Pain management techniques.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>h Vacuum aspiration technique</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>i Use of ultrasound</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>j Routine post-abortion care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>k Opportunities to ask questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>l Opportunities to interact with clinic staff</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>m Initial Program Orientation (didactic session at residency or professional training program)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

2. What did you like most about the training?

3. What did you like least about the training?

4. In your opinion, the length of your training was: □ adequate □ too short □ too long

5. Did the abortion training rotation adequately prepare you to:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No, need more</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Counsel patients about pregnancy options</td>
<td></td>
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<tr>
<td>b Counsel patients choosing abortion</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>c Counsel patients about contraceptive options</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>d Obtain informed consent for abortion</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>e Perform accurate pelvic sizing</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>f Perform aspiration procedures under local anesthesia</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>g Perform 1st trimester aspiration abortions with confidence</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>h Manage common abortion complications</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
<tr>
<td>i Integrate abortion with other health services in your regular practice</td>
<td>Yes</td>
<td>No, need more</td>
</tr>
</tbody>
</table>

6. What additional abortion training opportunities would you like your residency or training program to provide, if any?
7. Please evaluate the following training faculty by circling the appropriate responses:

<table>
<thead>
<tr>
<th>Name of Trainer</th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Did not experience</th>
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<td>NA</td>
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<td>NA</td>
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<tr>
<td>Other:</td>
<td>1</td>
<td>2</td>
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<td>NA</td>
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</table>

8. What are your immediate career plans following graduation from this training program?

9. What are your long-term career plans?

10. Where do you hope to practice after graduating?
    - □ In this state
    - □ In another US state (specify: ________________________________)
    - □ Outside the US (specify: ________________________________)
    - □ Don't know yet

11. Do you plan to pursue additional abortion training during or after your residency or training program?  
    If “Yes,” what additional training? ________________________________

12. Do you anticipate providing aspiration abortions in your post-graduate practice?

13. Do you anticipate providing early medication abortions (mifepristone or methotrexate) in your post-graduate practice?

14. Since completing the abortion training rotation, has your interest in or commitment to providing abortion services:  □ Increased  □ Decreased  □ Remained the same

15. Has the abortion training rotation influenced your attitudes or opinions about abortion in any positive or negative way? Please explain:

16. What suggestions do you have for improving the training program?

17. Other comments:
OBSERVED PERFORMANCE ASSESSMENT

Trainee _________________________________  Evaluator _____________________________  Date ________________

Indicate the rating that best describes the clinician’s performance:

**Beginner**: close observation/monitoring and supervision; Demonstrates limited fund of knowledge or significant gaps

**Developing Competence**: developing independent thinking and needs intermittent assistance/supervision; knows limitations and seeks guidance when needed; Demonstrates improving fund of knowledge with some gaps

**Competent**: independent; need for assistance and direct supervision is occasional; knows limitations and seeks guidance when needed; asks appropriate questions to attending; approaches task of supervision of peers; demonstrates solid fund of knowledge with rare gaps

<table>
<thead>
<tr>
<th>A: Patient Care</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews history thoroughly; asks additional questions as indicated</td>
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<tr>
<td>Confirms patient consent</td>
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<tr>
<td>Accurately estimates uterine size and position from pelvic examination</td>
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<tr>
<td>Able to interpret sonogram findings for dating and completion of abortion</td>
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<tr>
<td>Asks and answers questions in a patient-centered manner (one that is free of personal judgments and is focused on meeting the patient’s expressed needs)</td>
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<tr>
<td>Discusses post abortion contraceptive options and prescribes as necessary</td>
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<tr>
<td><strong>ASPIRATION for Abortion or EPL</strong></td>
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<tr>
<td>Administers analgesics/sedatives in appropriate doses</td>
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<tr>
<td>Provides effective paracervical block</td>
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<tr>
<td>Safely dilates cervix to correct size for gestational age</td>
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<tr>
<td>Consistently uses no-touch technique</td>
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<tr>
<td>Communicates with patient during the procedure with attention to her comfort and expectations</td>
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<tr>
<td>Safely assimilates landmarks for uterine aspiration (flexion, fibroids, etc.)</td>
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<tr>
<td>Accurately assesses when uterus is empty</td>
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<tr>
<td>Maintains adequate speed performing procedure</td>
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<tr>
<td>Examines POCs for appropriate elements and consistency with gestational age</td>
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<tr>
<td>Prescribes appropriate post-procedure medications as needed</td>
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<tr>
<td>Provides anticipatory guidance for post-procedure course</td>
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<tr>
<td>Effectively manages difficulties encountered during procedure (ex. dilation, cervical laceration, anatomical variations)</td>
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<tr>
<td><strong>MEDICATION for Abortion or EPL</strong></td>
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<tr>
<td>Prescribes and administers medications according to protocol</td>
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<tr>
<td>Appropriately counsels patient about procedure taking into account life circumstances</td>
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<tr>
<td>Provides patient centered counseling</td>
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<tr>
<td>Provides anticipatory guidance to distinguish expected side effects from complications</td>
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<tr>
<td>Appropriately assess for completion of abortion</td>
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<tr>
<td>Demonstrates appropriate management of complications of medication abortion</td>
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</table>
## B: Communication and Interpersonal Skills

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently introduces him/herself to patients</td>
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<td></td>
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<tr>
<td>Consistently uses open-ended questions when counseling patients</td>
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<tr>
<td>Establishes rapport with the patient</td>
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<tr>
<td>Provides patient-centered options-counseling</td>
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</table>

## C. Professionalism

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrives at clinic on time</td>
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<tr>
<td>Demonstrates respect for patients and staff</td>
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<tr>
<td>Maintains strict patient confidentiality</td>
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<td></td>
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<tr>
<td>Is receptive to constructive feedback</td>
<td></td>
<td></td>
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<tr>
<td>Documents all relevant patient data</td>
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<tr>
<td>Is aware of his/her limitations</td>
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</tbody>
</table>

## D. Systems-Based Practice

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to compare and contrast the delivery of reproductive services provided in family practice setting with that in family planning clinic system</td>
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<tr>
<td>Demonstrates knowledge of range of access issues related to abortion services including billing and insurance</td>
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</tbody>
</table>

## E. Practice-Based Learning and Improvement

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assimilates feedback from evaluation to improve patient care practices</td>
<td></td>
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</tr>
<tr>
<td>Demonstrates ability to appraise and assimilate evidence from scientific studies to support patient care decisions</td>
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</tbody>
</table>

## F. Medical Knowledge

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the differences between medication and aspiration abortion</td>
<td></td>
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<tr>
<td>Identifies factors pertinent to abortion care during patient history review</td>
<td></td>
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<tr>
<td>Describes the expected process of an uterine aspiration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describes the expected process of a medication abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies contraindications to medication abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows appropriate use of medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows appropriate use and interpretation of laboratory tests</td>
<td></td>
<td></td>
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<tr>
<td>Identifies features of ectopic pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows contraceptive options and contraindications to specific methods</td>
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<td></td>
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<tr>
<td>Knows indications for sonography</td>
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</table>

## ADDITIONAL COMMENTS:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

SIGNATURE OF EVALUATOR: ___________________________ DATE: ___________________________
Primary, secondary and tertiary prevention of unintended pregnancy (Taylor 2011) is an essential element of sexual and reproductive health care, a specialty of primary medical care and public health services. Early abortion care is considered one component of secondary prevention of unintended pregnancy.

This document describes the entry-level specialty competencies for primary care clinicians providing early abortion care, regardless of setting. These specialty competencies are the essential knowledge, behaviors, and skills that primary care clinicians should be able to demonstrate upon application for practice in abortion care and secondary prevention of unintended pregnancy. They are intended to supplement the health-professional core competencies for primary-care clinicians (e.g. CNM, DO, MD, NP, PA) as well as population-focused competencies (e.g. women’s health care, family practice) (Informed by HWPP 171, TEACH 2020, and UK SRH 2012 Curricula).

1. Competence Level Descriptors: Measurement of achievement and progression
Competence is a baseline level for safe independent practice, with further (post-training) exposure and experience leading to proficiency and subsequent expertise. Attainment and assessment of any competency should progress through all three of the following stages.

Level 1 (observation or indirect methods)
- Demonstrate thorough understanding of the principles of the competency/clinical skill/situation, including the indication for the procedure and common complications
- Observe the procedure on a number of occasions before direct supervision of clinical skill
- Use other methodologies (e.g. drills, simulation, e-learning, case-based discussion assessments) if direct experience is not possible

Level 2 (direct supervision across different clinical situations)
- Perform the clinical skill/manage case under supervision
  The number of times the competency/clinical skill/situation needs to be supervised depends on the complexity of the case and individual aptitude
- No limit to the number of times the procedure can be supervised; both trainee and trainer must be certain that the procedure can be safely performed in a number of different clinical situations and levels of complexity
- Be able to manage any unexpected complication and know when to summon senior help

Level 3 (independent practice)
- Ability and confidence to perform the clinical skill/situation competently when senior staff is not immediately available
- Willingness to move on to experiential learning with further case exposure
  Keep a record of the numbers of cases/procedures subsequently managed (including any complications and their resolution)
2. Specific competencies to be attained

Pre-requisite to training: Unintended Pregnancy Care Competencies

- Perform comprehensive pregnancy options counseling and care coordination (for adoption, prenatal care, abortion)
- Effectively communicate with patients and accompanying persons, respecting diversity of beliefs
- Effectively counsel the psychosocially complex patient (e.g. ambivalence, mental health conditions, religious belief conflicts)
- Perform pregnancy test, including appropriate type (urine v. serum), interpret results and deliver results neutrally
  - If positive, calculate estimated gestational age and discuss pregnancy options in an unbiased, non-directional manner
- If patient indicates desire to continue: Initiate antenatal/adoption care pathways/clinical guidelines
- If patient indicates desire to terminate: Initiate abortion care pathways/clinical guidelines
- Assess and manage identified clinical and non-clinical risks
- Perform STI risk assessment and manage positive responses appropriately by performing relevant screening, providing risk reduction counseling and referrals as necessary
- Provide contraceptive education and counseling and provide selected method, or refer, as appropriate
- Provide supportive counseling and education (written, verbal, electronic) to promote closure of encounter, including follow-up & care coordination or referral

Pre-Procedure Assessment Competencies

- Perform pre-abortion clinical history including complete medical, reproductive and sexual and social history and risk assessment
- Manage positive responses appropriately by providing necessary screenings, counseling and referrals and partner notification if positive STI screening results
- Perform appropriate clinical examination including assessment of gestation
  - Arrange/perform laboratory and ultrasound investigations, and specific investigations as prompted by history and examination
  - Conduct assessment to determine/confirm gestational age (ultrasound for pregnancy elements, bimanual exam for uterine size)
- Manage unexpected findings from routine assessment as per clinical guidelines (e.g. miscarriage, ectopic gestation, molar pregnancy)
- Communicate effectively with patients and accompanying persons they wish to have present
  - Explain clearly and without bias—treatment regimens, potential side effects of drugs and complications of procedures
  - Demonstrate consistent respect for diversity of beliefs and values
  - Counsel the psychosocially complex patient (e.g. ambivalence, mental health conditions, family conflicts) and engage other health professionals as needed (e.g. therapist, social worker) to ensure effective communication and management plan
• Arrange abortion procedure or refer to another agency, including cervical priming and follow-up as necessary
  o Arrange interpreter/signer if required
• Prescribe drugs required for chosen procedure including cervical priming/local antibiotic prophylaxis policy/contraception as per clinical guidelines
• Formulate, implement and, if necessary, modify management plans in consultation with patient
• Complete documentation including consent
  o Seek informed consent after assessment of cognitive competency
  o Document episode accurately
• Provide contraceptive and sexual health advice and supplies

First-Trimester Aspiration Abortion Procedure Competencies
To 14 weeks, by manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA)
• Verify absence of changes in health
• Confirm consent for procedure and post-abortion contraceptive plan choice since pre-procedure assessment
• Confirm all medications prescribed and administered/taken including cervical priming, antibiotics and contraception
• Check equipment and supplies for procedure including for analgesia, sedation
• Manage pain appropriately using local anesthesia and analgesia
• Manage pain using moderate/conscious sedation – optional depending on institutional guidelines
• Complete abortion procedure by MVA and/or EVA
  o Position patient
  o Use ‘no-touch’ clean technique throughout procedure
  o Perform:
    • Bimanual examination (empty bladder)
    • Speculum examination
    • Stabilization of cervix
    • Application of local anesthetic to cervix
    • Cervical dilation
    • Aspiration of uterine contents
    • Use of ultrasound during the aspiration procedure
    • Gross identification of products of conception and disposal of same with due regard to respect and dignity
• Manage if inadequate products of conception (i.e. incomplete or failed abortion, rule out ectopic or molar pregnancy)
• Manage immediate complications including: dilation difficulties, poor aspiration of uterine contents, blockage of cannula, excessive bleeding/hemorrhage, uterine atony, incomplete abortion, continuing pregnancy, vasovagal reaction, allergic reaction, uterine false passage/perforation, cervical laceration, air embolism, acute hematometra
• Provide immediate post-abortion contraception (including IUDs, implants, DMPA)
Post-Procedure Assessment and Follow-up Competencies

- Perform immediate post-procedure clinical assessment and routine follow-up.
  - Conduct investigations with ultrasound and/or laboratory assessments to confirm resolution of pregnancy (e.g. beta HCG, hemoglobin) as necessary
- Confirm procedure complete by gross or additional examination of uterine contents (i.e. products of conception examination) by identifying pregnancy elements consistently and accurately
- Assess physical and psychological wellbeing of patient; review counseling and support needs
- Review needs for social support and assistance following procedure with special attention to patients with particular vulnerability (e.g. minors; those with psychiatric conditions/mood disorders, limited social support, or high risk for intimate partner violence, repeat unintended pregnancy or STI)
- Contact patient after discharge to assess problems and/or to determine return to primary prevention methods of unintended pregnancy or reproductive life plan
- Manage delayed complications including bleeding, infection, retained products of conception, ongoing pregnancy, and emotional distress
- Complete documentation
**CLINIC SERVICES SATISFACTION SURVEY**

We are interested in your opinions about your visit today and about the care you received from the health professionals (the doctors and nurses) and staff. Please rate each of the following things about this visit. (Mark one answer for each item).

<table>
<thead>
<tr>
<th></th>
<th>Not at all satisfied</th>
<th>Somewhat satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>The courtesy of the staff</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<td>b</td>
<td>The staff’s flexibility in scheduling my appointment around my needs</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<td>c</td>
<td>Privacy when talking with staff or health professionals</td>
<td>O</td>
<td>O</td>
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<tr>
<td>d</td>
<td>The amount of time I spent in the waiting room today</td>
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<tr>
<td>e</td>
<td>The amount of time I had to talk with my abortion provider</td>
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<tr>
<td>f</td>
<td>My abortion provider’s ability to answer questions in a sensitive and caring way</td>
<td>O</td>
<td>O</td>
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<td>g</td>
<td>My abortion provider’s ability to explain things clearly</td>
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<td>h</td>
<td>My abortion provider’s ability to help me feel comfortable talking about my concerns</td>
<td>O</td>
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<tr>
<td>i</td>
<td>The chance to ask all of my questions</td>
<td>O</td>
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<tr>
<td>j</td>
<td>My abortion provider’s willingness to explain different options for my care</td>
<td>O</td>
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<tr>
<td>k</td>
<td>My abortion provider’s effort to make my medical services as comfortable as possible</td>
<td>O</td>
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</tbody>
</table>

Do you have any suggestions for us?
TRAINEE FEEDBACK FORM FOR CLINIC STAFF

Clinic: ___________________________________________ Date: ____________________
Name of Trainee: __________________________________________

1. Please rate the trainee on the following:

<table>
<thead>
<tr>
<th>Category</th>
<th>Always</th>
<th>Usually</th>
<th>Rarely</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>a. Makes patients feel comfortable</td>
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<tr>
<td>b. Explains procedures in patient friendly manner</td>
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<tr>
<td>c. Answers patient questions appropriately</td>
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<tr>
<td>d. Maintains patient confidentiality</td>
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<tr>
<td>e. Treats me respectfully</td>
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<tr>
<td>f. Manages time effectively</td>
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<tr>
<td>g. Charting is legible and complete</td>
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</table>

2. What are this trainee’s strengths?

3. How might this trainee provide better reproductive health services to our patients?
FOR TRAINERS AND CLINIC STAFF

Please consider writing a message below to provide feedback to the clinicians and clinic staff at your training site that you would like them to review directly, or to thank them for their assistance. This page will be detached and sent to the clinic with other trainee responses, so it will be anonymous unless you choose to sign your name.

Name (Optional) _____________________________________________________________
Residency / Training Program (Optional) _______________________________________

Name (Optional) _______________________________________________________________________
Residency / Training Program (Optional) ___________________________________________________________________
# EARLY PREGNANCY ULTRASOUND SKILLS EVALUATION

**Trainer:** _______________________  **Date:** ________________

Number of Sonograms Observed: ______________________________________

<table>
<thead>
<tr>
<th>TRAINING SKILLS</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERPERSONAL SKILLS</strong></td>
<td></td>
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<tr>
<td>Introduces self to patient and establishes rapport</td>
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<tr>
<td>Explains sonogram procedure to client, and routinely asks about LMP, latex allergy, desire to hear about twins, etc.</td>
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<tr>
<td>Pays attention to patient comfort</td>
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<tr>
<td>Uses appropriate language to discuss ultrasound findings in presence of patient</td>
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<tr>
<td>Solicits and answers patient questions appropriately</td>
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<tr>
<td><strong>CLINICAL SKILLS</strong></td>
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<tr>
<td>Prepares ultrasound probe properly for use</td>
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<tr>
<td>Uses keyboard and screen functions properly</td>
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<tr>
<td>Keeps uterus in center of screen, zooming as needed</td>
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<tr>
<td>Systematically identifies uterus in longitudinal and transverse views, taking appropriate images</td>
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<tr>
<td>Systematically scans across pelvis, requesting help as needed</td>
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<tr>
<td>Measures gestational sac in at least 3 planes; able to explain how and why</td>
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<tr>
<td>Identifies yolk sac</td>
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<tr>
<td>Identifies fetal pole and cardiac activity</td>
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<tr>
<td>Measures CRL in longest view (without limbs or yolk sac)</td>
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<tr>
<td>Assures location of pregnancy is intrauterine</td>
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<tr>
<td>Perform post procedural or post medical abortion US to establish no evidence of gestational sac, embryo or fetus</td>
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<tr>
<td>Ensures transducer(s) cleaned between exams</td>
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<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
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<tr>
<td>Able to name key US characteristics of pseudo vs. true gestational sac (identify if possible)</td>
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<tr>
<td>Accurately calculates GA with gestational sac measurements</td>
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<tr>
<td>Accurately calculates GA with CRL measurement</td>
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<tr>
<td>Knows when to switch to BPD measurement, and elements of an optimal BPD measurement</td>
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</table>

Additional Comments: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Evaluation by Trainer: ☐ Approved  ☐ Further orientation and observation suggested/required

**SIGNATURE OF EVALUATOR:** ___________________________  **DATE:** ________________

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**EARLY ABORTION TRAINING CURRICULUM**

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54
NEW TRAINER SKILLS EVALUATION

New Trainer being evaluated __________________________________________

Faculty Evaluator ________________________________________________

Number of training sessions observed ________________________________

In addition to meeting the criteria for competency as an abortion provider, a trainer must be able to:

<table>
<thead>
<tr>
<th>TRAINING SKILLS</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
<th>Did not experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assesses trainee’s skills and learning needs</td>
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<tr>
<td>Engages trainee in learning experience</td>
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<tr>
<td>States objectives for each training day</td>
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<tr>
<td>Encourages trainee to ask questions</td>
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<tr>
<td>Answers questions clearly and completely</td>
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<tr>
<td>Demonstrates strong knowledge of subject matter</td>
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<tr>
<td>Gives appropriate evidence and resources</td>
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<tr>
<td>Uses variety of teaching methods including cases, role plays, “what if” scenarios, didactics</td>
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<tr>
<td>Discusses various approaches to the procedure</td>
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<tr>
<td>Demonstrates knowledge of site specific protocols</td>
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<tr>
<td>Reviews chart and informed consent</td>
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<tr>
<td>Reviews / interprets US, labs, and medical history with trainee</td>
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<tr>
<td>Demonstrates establishing rapport with the patient</td>
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<tr>
<td>Demonstrates non-judgmental attitude towards the patient</td>
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<tr>
<td>Demonstrates clear communication with the patient regarding procedure and management</td>
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<tr>
<td>Allows trainee to solicit and answers patient questions</td>
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<tr>
<td>Confirms physical exam findings</td>
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<tr>
<td>Gives feedback about no touch technique</td>
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<tr>
<td>Gives feedback about trainee’s attention to patient comfort</td>
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<tr>
<td>Can take over a case when appropriate without disturbing the patient or undermining the trainee</td>
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<tr>
<td>Provides feedback to the trainee after each procedure, and at the end of session</td>
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<tr>
<td>Reviews elements of tissue exam with trainee</td>
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<tr>
<td>Reviews appropriate post operative orders with the trainee</td>
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<tr>
<td>Reviews patient’s contraceptive needs (including EC) and contraindications with trainee</td>
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<tr>
<td>Models respectful attitude towards staff</td>
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<tr>
<td>Is receptive to feedback from trainee / peers</td>
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<tr>
<td>Models and teaches trainee attention to clinic flow</td>
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</tbody>
</table>

Additional Comments: ______________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Evaluation by Trainer:  □ Approved  □ Further orientation and observation suggested/required

SIGNATURE OF EVALUATOR: _____________________________________________ DATE: _____________________
CHAPTER 12 REFERENCES

