Contents

11. OFFICE PRACTICE INTEGRATION

This full chapter can be found online only or as an separate download from our website.

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 (with links in blue) throughout this chapter and also available online at http://www.teachtraining.org/Workbook.html

CHAPTER LEARNING OBJECTIVES

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

- Discuss important initial steps for introducing services into a practice
- 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

READINGS / RESOURCES

- Paul et al (eds). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care (Wiley-Blackwell, 2009)
  - Chapter 23: Ensuring quality care in abortion services
  - Appendix: Resources for Abortion Providers

SUMMARY POINTS

SKILL

- 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

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:

- 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 your 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**.**

How to begin:

1. Consider distributing anonymous staff attitude surveys to gauge people's thoughts and feelings [Staff Attitude Survey (RHAP)].
2. Offer a Values Clarification Workshop (NAF or RHAP) to provide a broader public health framework for the benefits of service provision. This 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, www.arhp.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 provider, 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.

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. Taking an active role in care coordination is even more important in areas where services are restricted and stigma greater (Zurek 2015). 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 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 linked Training Resources (Provide)].

Ultrasound (US) Training

US training for early dating is hard to come by! 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 2 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 4. 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 a fact sheets that compares medication vs. aspiration abortion, 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 2016)
- 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 6 for uterine aspiration aftercare and Chapter 7 for medication abortion 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 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.
- For sexually transmitted diseases, see http://www.cdc.gov/std/program/final-std-statutesall-states-5june-2014.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.

Malpractice Option	Advantages	Disadvantages
NAF Group coverage in progress (contact NAF for update or to join plan)	Large group of physicians ensures bargaining power. Membership cost is pro-rated to procedure number performed.	Clinic coverage only Must be NAF member.
Risk Retention Group	Allows providers to decide what to charge the group for premiums, what policies to adhere to, and what level of risk is acceptable. Profit can be put back into premiums.	Physicians within the group must be like-minded and share a similar level of risk. Still may need to attract a secondary (excess) carrier.
Commercially purchased insurance (potential carriers include companies such as Chubb, Evanston, and Admiral)	Risk is individually assessed, which may be helpful for some. Does not require organizing with other physicians.	Most likely to be high-cost.
Going without (going “bare”)	No insurance premiums. Does not require organizing with other physicians.	May put personal assets at risk. This option may not be legal in your state.
Gap coverage	Covers services such as abortion that are not covered by Federal Tort Claims Act (FTCA) – FQHC 330 sites. May already have in place for other services, like L&D or hospital rounding.	May be expensive
Part-time policy	Less expensive in some cases than gap coverage, because it only covers the % time the physician is performing abortions. May be particularly helpful for Federally Qualified Health Centers	Safest to purchase alongside “entity coverage” that covers the clinic at all times.

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 (RHAP) 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 blue print 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:

- Rhogam
- Pain medication
- The follow-up exam for medication abortion patients (if using office follow up)
- Contraception

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: core, 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, Physicians, 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 and 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 to 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 you 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 (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 begin to gain a more balanced understanding of pregnancy options and abortion access; enhancing their 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
Backline 888.493.0092 Toll-free after-abortion talkline to provide support for women and their support people after an abortion
Exhale 866-4-EXHALE Toll-free after-abortion talkline to provide support for women and their support people after an abortion
NAF Hotline 800-772-9100 Abortion referrals
Legal
ACLU Reproductive Freedom Project Local chapters can provide referrals to pro-choice lawyers
Center for Reproductive Rights 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.
Jane's Due Process Texas-based organization working to help minors seeking abortions. They are an excellent resource for forms and advocacy regardless of where you practice.
Research
Guttmacher Institute Conducts research and publishes extensively on abortion and reproductive health issues.
Centers For Disease Control and Prevention (CDC) The CDC works to promote health and quality of life by preventing and controlling disease, injury, and disability. Great source for fact sheets.
Sexuality Education
Advocates for Youth Champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health.
Bedsider 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.
Coalition for Positive Sexuality Information about all aspects of sexuality along with information about parental involvement laws.
Go Ask Alice! This site is run by Columbia University's Health Education Program and provides accurate and non-judgmental information.
My Sistahs Information about sexual health run by and for young women of color.
Scarleteen Sex education for the real world with a section for men as well.
Sexuality Information and Education Council of the US SIECUS develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates the right of individuals to make responsible sexual choices.

*See Chapter 9 for a) Medical and Professional Organizations, b) Training and Employment, c) Listservs, d) Advocacy.

EXERCISES: OFFICE PRACTICE INTEGRATION

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.

EXERCISE 11.1

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

Teaching Points

11. TEACHING POINTS: OFFICE PRACTICE INTEGRATION

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.

EXERCISE 11.1

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 (GI 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 (GI 2011) 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 2016). 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.

Return to Exercise

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.)

Return to Exercise

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