

Integrating Medication Abortion in Primary Care

Table of Contents

INTRODUCTION 2

I. ESTABLISHING A PLANNING COMMITTEE..... 2

II. GETTING STAKEHOLDER BUY-IN..... 5

III. PREPARING STAFF 7

IV. PATIENT EDUCATION 10

V. ADMINISTRATIVE LOGISTICS 10

VI. MEDICATION ABORTION AND FEDERAL FUNDING 14

VII. TRAINING MATERIALS & CLINICAL RESOURCES 15

VIII. RESOURCE INDEX 16

Introduction

The Reproductive Health Access Project strives to integrate early abortion into primary care so that patients can receive abortion care in the same health care setting where they get their general medical care. Incorporating abortion care is a process requiring thoughtful planning, sensitivity, and ongoing dialogue. It is a change that can take months or even years.

Integrating **medication abortion** care into a primary care setting is not just a matter of adding a new medication or procedure; it requires an exploration of core attitudes and values, and the support of everyone at a health center. At the end of this process, patients gain access to abortion care in a safe, private, familiar environment, and health center staff members at all levels gain a deeper understanding of reproductive health, rights, and justice, as well as an enhanced ability to handle difficult conversations in a positive, patient-centered manner.

Integrating medication abortion care requires sensitivity and determination to overcome obstacles and barriers. Barriers depend on the existing culture of the practice, clinicians' level of knowledge and skill, state laws and regulations, as well as the attitudes and feelings of the administration and staff—everyone from the folks at the front desk and those who purchase medical equipment and supplies, to the medical assistants and the nurses and various other staff members. In order to effectively integrate medication abortion care, concerns from any and all of these stakeholders need to be identified and addressed.

No single strategy will work for all health centers; cultural, geographic, and political differences call for individualized approaches. This toolkit outlines a range of approaches and key considerations for integrating medication abortion into primary care settings and community health centers (CHCs), including federally qualified health centers (FQHCs).

I. Establishing a Planning Committee

Adding a reproductive health service to an existing community health center involves more than just adding clinical services; it involves changing the clinical culture. This requires at *least* one committed individual to serve as the organizing champion and change agent. RHAP has found that it is preferable to begin the push for medication abortion care with at least two champions who can support one another in the face of various challenges to providing care.

1. Start by identifying other clinicians, administrators, and/or staff within your setting who might be allies and committed to providing medication abortion care. Initiate an

informal discussion with these colleagues and then invite those interested to meet as a Planning Committee.

2. Determine which members of the clinic staff and administration must be involved in the process of integrating medication abortion—namely, those who manage insurance, ordering medication and medical supplies, billing, and contracts, as well as the medical director and nursing director. Assembling a multidisciplinary team is critical. If these colleagues are not already interested in joining the Planning Committee, consider ways to approach them about becoming part of the effort to integrate medication abortion. Relationship-building with these colleagues will be critical to implementing change.
3. Develop a plan for regular meetings of this Planning Committee. The Planning Committee will discuss tasks, timelines, potential obstacles, and solutions. A few possible questions to think about as a Planning Committee include:
 - What [state and federal regulations](#) impact our ability to provide abortion care?
 - Does our malpractice insurance cover abortion care?
 - Who will be “on-call” to receive calls from abortion care patients?
 - Who will provide aspiration back up if only medication abortion is provided?
 - Will ultrasound be available onsite? If yes, how will clinicians be trained? If no, how can smooth referrals be ensured, when necessary?
 - Will services be promoted to the patient community? How so?
 - Will abortion patients who are not already patients be accepted?
 - How will potential complications be managed?
 - How will abortion care be integrated into the clinic flow?

For those working in FQHCs (or in sites that receive federal funding), additional questions to ask may include:

- How will abortion services be fiscally separated from federal funds?
 - How will we financially sustain abortion provision?
 - Did our FQHC receive federal funding to construct or renovate building sites? (contact RHAP at programs@reproductiveaccess.org if you need more information on this topic)
4. Schedule regular meetings of the Planning Committee. At each meeting, assign concrete tasks that will help you move forward. Make sure that a detailed summary of the meeting is sent to each Committee member. Assign one person to take and share minutes regularly and to send reminders about meetings and conference calls. Possible tasks for the Committee could include:

- Meeting with key administrators to gauge attitudes and levels of support
 - Conducting a needs assessment to determine what changes to appointments, telephone triage, and clinic flow may need to be made
 - [Surveying staff](#) to ascertain how they feel about providing medication abortion
 - Conducting a [values clarification exercise](#) to offer staff the opportunity to explore their beliefs and values around abortion.
 - Organizing [site-specific clinical trainings](#) for all staff who will be involved in medication abortion
 - Reviewing or developing site-specific protocols for the service, including whether you provide telehealth care and if mifepristone and/or misoprostol will be provided on-site or prescribed
 - Developing forms for charts
 - [Ordering mifepristone](#)
 - Making insurance coverage calls for medication abortion patients
 - Connecting with local and national [abortion funds](#) to help patients pay for care.
 - Developing a referral protocol for services you do not offer, like aspiration abortion in rare cases of medication failure or ultrasound if needed.
 - Identifying stakeholders (i.e. who are key “players” who need to support this effort?)
 - Researching malpractice options if current professional liability insurance does not cover abortion care
 - Educating your site’s billing department, sharing [coding information](#), and working with them to set up systems to separate abortion expenses and revenues from federal funds.
 - Letting patients know medication abortion is available by placing informational materials around your site, like [posters](#), patient education materials, or [zines](#).
 - Enrolling in referral lines (“warm lines”) for medication abortion providers to easily access support and guidance from other experienced abortion providers
5. Find out about other health centers or clinicians who have successfully integrated medication abortion care into their practice. Invite them to meet with the Planning Committee so they can share their experiences and lessons learned. Connect with clinicians in the [Reproductive Health Access Network](#) for peer support and mentorship on integrating medication abortion into practice.
 6. Identify and attend training programs relating to early abortion care. RHAP offers medication abortion and early pregnancy loss workshops for continuing education

credit. Contact info@reproductiveaccess.org for more information or to organize one for your staff.

7. Alert staff members that you are considering implementing medication abortion care at the health center. Consider distributing an anonymous [Staff Attitude Survey](#) to gauge their thoughts and feelings about this change.
8. Establish regular meetings with staff (possibly in sub-groups, depending on the size of the health center) to provide information and address concerns. Elicit staff members' input to shape the agendas for meetings. Include values clarification exercises here. This invaluable process can help address anxiety around this change, debunk myths, and separate personal beliefs from professional responsibilities.
9. Present information on early abortion care, including options counseling, medication abortion, manual vacuum aspiration (MVA), and self-managed abortion (SMA) to all staff. This includes medical providers, nurses, and ancillary staff. It is important to avoid the assumption that everyone has the facts straight about abortion. RHAP can help facilitate presentations on these topics. Contact info@reproductiveaccess.org for more information.
10. Consider implementing an anonymous [Patient Attitude Survey](#). In some settings, demonstrating patient support for a service can help foster staff support. Inform staff of survey results, and address staff and patient concerns based on these results.
11. In collaboration with nursing and administrative leaders, develop a policy regarding staff members who feel they are unable to participate in providing abortion services. In discussing these issues, it is important to clarify the differences between participating in the service delivery itself (i.e. counseling, administering medication, providing on-call services), from customary health center functions (such as answering telephones, drawing blood, etc.) Be clear on the message that staff members will be giving to patients regarding these decisions.
12. When interviewing applicants for staff vacancies, discuss abortion care. Applicants should discuss how comfortable they would feel working in an office that provides medication abortion care.

II. Getting Stakeholder Buy-In

Health centers will face varying levels of difficulty securing the leadership support necessary to integrate medication abortion. The Planning Committee and outside allies—like RHAP staff

and abortion providers at other clinics—can offer support throughout the pitching, planning, and implementation process. Consider the “key players” in your institution and what priorities and perspectives to address to ensure their support. Do they care about money, funding, equity, patient-centeredness, something else? Potential stakeholders include:

- Patients
- CEO
- CHC/FQHC Board
- Medical Director
- Other clinicians, including OBGYNs
- Partners
- Training Director, Residency Director, Trainees
- CFO, Billing Manager
- Operations or Nursing Director
- ED/Hospital Partner

CHCs and FQHCs have often had to grapple with the concerns of their Health Center Boards. CHC guidelines require that Boards be made up of community representatives and include patients, adding a different dimension to securing medication abortion support. The Planning Committee should research the Board and find out who the members are. Find a way to connect with a Board member—who can then become an ally. This can get you on the path to presenting your case for offering medication abortion care. Additionally, the Planning Committee can also work together to identify allied community members who might run for the Board.

Not all health centers allow their Boards to determine the clinic’s scope of services. Many health centers believe these decisions are medical and best left in the hands of the center’s medical director; indeed, it is well within the medical director’s purview to make the final call. If you hear that your health center’s Board is to debate the provision of medication abortion, be sure to confirm it is a usual and customary practice for the Board to determine the scope of medical care. Did the administration go to the Board when colposcopy services were added? Or might this be an anti-abortion roadblock?

If the decision to offer medication abortion care does go to the Board, ensure that patient and clinician voices are heard. RHAP can assist in crafting a compelling presentation for the Board about why it is critical to patients and the health center’s community to provide this care.

For advice on responding to stakeholders’ frequently asked questions and concerns about medication abortion, refer to RHAP’s [FAQs on Integrating Medication Abortion Care into Community Health Centers](#).

III. Preparing Staff

To integrate medication abortion successfully, it is critical that all clinic staff—from the person answering the phones to the person writing prescriptions—are prepared to perform their jobs, irrespective of the care patients have chosen. Clinicians who want to add medication abortion care to their health center’s practice often wonder how to discuss this subject with staff and colleagues whose views on abortion are unknown. One starting point is a [Values Clarification Workshop](#), to reinforce that all patients deserve respectful medical care in all situations. From the workshop, staff should be able to:

1. Identify the myths and reality surrounding the provision of abortion care in the US and the patients who have abortions
2. Identify their own beliefs and attitudes toward the provision of abortion care and toward patients who have abortions
3. Separate their personal beliefs from their professional role in the provision of abortion services

RHAP has also found it useful to bring up the subject in the context of a hypothetical or real patient case. In addition to focusing on specific examples, there are a number of other reasons patients could benefit from going to their primary care clinician for a medication abortion that might resonate with clinic staff:

- Patients will not face picketers or harassment outside the clinic
- Patients with an unwanted pregnancy can make their health care decisions with a known, trusted health care system/clinician who knows their medical and social history
- Some studies show that many patients prefer receiving abortion care through their primary care clinician, citing comfort as a key reason
- Patients will have increased continuity of and access to care – every time a referral is made to another system, some patients will fall through the cracks
- Patients won’t have to travel for abortion care, spending time and money on childcare, taking off from work, and coordinating logistics
- There will be decreased marginalization of and stigma towards patients and abortion providers as abortion is further integrated into primary care services

Hosting lunchtime trainings, conversations, or Grand Rounds that invite all clinic staff to attend are helpful strategies to introduce and continue conversations about abortion care and to train staff. RHAP can also help facilitate presentations on these topics. Potential topics include:

- Updates in contraception, unintended pregnancy, early pregnancy loss (EPL) management, and abortion.

- Public health impacts of limited access to reproductive health services and the [safety of abortion](#). Helpful maps, charts, infographics, and evidence can be accessed through the [Guttmacher Institute](#) to help develop presentations.
- Findings from your patient attitude survey or staff attitude survey to guide conversation about medication abortion care at your health center.
- Information on Early Abortion, including medication abortion and manual vacuum aspiration (MVA). This initial overview can help de-mystify the process, support staff in realizing the benefits of abortion access, and help to embrace the possibility of abortion integrated into one's practice. [Innovating Education in Reproductive Health](#) offers online, video-based courses in abortion and is easily accessible to all levels of clinical and non-clinical staff.
- [Role-play sessions](#) on abortion options counseling, the consent process, and answering common telephone questions. Even if all staff are never formally counseling or obtaining consent, it is important for staff to 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.
- Gender-affirming abortion care: how can your health center reflect and adapt to become a more inclusive space for non-binary and trans people also seeking abortion care?
- Facilitate a [Papaya Workshop](#) with this accompanying [role-play](#) to offer staff an orientation and icebreaker to demystify MVA. You can also [request](#) RHAP to host a Papaya Workshop at your site.

Having a structure for training current staff and onboarding new staff will help ensure the consistency and quality of care for all patients. Assess staff training needs in the following areas:

- Scheduling appointments and telephone triage
- Telehealth coordination
- Counseling and consent
- Ultrasound training, if needed
- Emergency preparedness and safety
- Sterilization and disinfection
- Fetal tissue questions and disposal, where applicable

Case Study: Talking with Staff – How to Begin a Conversation About Abortion with Office Staff

Here is an example of a case discussion that helped a provider begin the conversation about integrating abortion into clinical practice.

The case that hit home for my staff was a 26-year-old woman who had intermittently lost custody of her first two children because of suspected abuse and neglect. Because she had a consistently depressed affect, I had been trying for some time to get her into psychotherapy. Her husband was also our patient. He did most of the daytime childcare while she worked, and then he worked night shifts. He was clearly exhausted by this schedule. All of the staff knew the family, because they often arrived late or missed and had to be rescheduled for appointments. The children were always behind in their immunizations and were in our “children of concern” file. We had referred them to the social worker and to early intervention services. Everyone who knew them agreed that another child was the last thing this couple needed. The mother then came to us with another unplanned pregnancy, asking for an abortion. We referred her to the local Planned Parenthood and did not see her again until she returned in her sixth month of pregnancy. When I began her prenatal care, I asked her about the planned abortion. She said she just could not go to “one of those clinics.” I asked if she would have been able to go through with an abortion from me, in our office. She said, “Of course. Are you going to be able to do that?” Her case helped to inspire me to provide abortion services in our family health center.

During a team meeting in the health center, this story gave everyone pause. The discussion quickly became heated, with some staff members sympathizing and others condemning this patient for having become pregnant. The conversation allowed us to use a concrete example to examine staff members’ objections. (A nurse said, “If abortion were readily available, some women might use it for birth control”; and a receptionist countered, “Well, which is preferable: another child for this family, or an abortion as birth control?”) This case allowed us to discuss the importance of children being born wanted, not just as accidents of sexual activity. We talked about parenthood as a life-long responsibility, to be undertaken intentionally, not just because birth control failed.

Other points to consider when talking to staff about abortion:

- Discuss abortion care in the context of reproductive autonomy and justice, family planning, the concept of helping all people to have children when and how they feel is best for them, and your health center’s commitment to primary care.
- Educate staff to the reality of the [abortion provider shortage](#), heavily restrictive state laws and their impacts, and the [potential impact on patients and burden on stand-alone abortion clinics in states experiencing a surge of out-of-state patients](#).

- Acknowledge that people on both sides of this issue have strong feelings. Offer all staff the space to talk about how they feel and demonstrate respect for powerful feelings, even if they are hard to understand.
- Use gender-inclusive language. Non-binary and transgender people also seek abortion care.

IV. Promoting Services

Once a health center decides to implement medication abortion, administrators might remain concerned about promoting abortion care. There are other ways clinicians can indicate to patients that they offer medication abortion care without being overtly public about it. And, there are ways to create a clinical environment where patients feel comfortable discussing abortion care with their providers:

- Consider putting up posters that promote respect of patients' pregnancy options, along with all the other health information posters and patient-friendly artwork on the walls of your exam room.
- Place stickers and buttons on your bulletin boards with slogans such as, "Abortion is Essential Health Care" or "Ask Me About Abortion Care". See this compendium of [Pro-Choice Posters](#) from various reputable organizations.
- Print and pin RHAP's [zines](#) on abortion care to your bulletin board, or have them available for patients to read while waiting.
- While asking patients about contraceptive practices or sexual history, clinicians can also ask or say something like: "If you ever have an unwanted pregnancy, you can make an appointment with me to talk through all your options, including abortion care if that is what you want."

V. Administrative Logistics

For medical settings that are not currently offering abortion care, adding medication abortion can raise both clinical and administrative issues, of which the latter tend to be more complex. Administrative issues requiring particular attention include staff development (i.e. values clarification, myth-busting), review of professional liability insurance coverage, back-up for aspiration procedures, after hours on-call coverage, and compliance with legal and regulatory issues.

Financial Considerations

There are particular financial and billing issues for healthcare organizations that receive Title X and/or Section 330 funding. Since these government funds restrict abortion care, while permitting pre-abortion counseling and contraceptive services, special attention needs to be paid to diagnostic and procedure codes and billing among facilities that receive these funds. RHAP's [Administrative Billing Guide](#) supports health centers in addressing these administrative challenges. See this guide and our [Guidelines for General Ledger Record Keeping](#) for in-depth assistance on administrative challenges, including suggested billing models.

Download RHAP's [Coding for Medication Abortion using Mifepristone and Misoprostol](#) resource for CPT, ICD-10, out-patient procedure, medication administration, and other codes to use for documenting and billing medication abortion services. The TEACH Workbook chapter on [Reimbursement Considerations](#) also outlines the main components of financial analysis to help you consider costs, revenues, and profit or loss when integrating abortion care into practice.

Billing State Medicaid for Abortion

Under the Hyde Amendment, federal Medicaid funds cannot be used for abortion except in cases of rape, incest, or life endangerment. All state Medicaid programs must cover abortions under these circumstances; states have the option to cover abortions using their own [funds](#). Most states only follow the federal standard, but [16 states](#) use their own Medicaid funds to provide coverage for all or most medically necessary abortions.

Hospital systems, abortion clinics, health centers receiving Title X funding, and other community health centers have successfully been able to bill state Medicaid to cover abortion for their Medicaid patients. However, Federally Qualified Health Centers (FQHCs) in these states may not have a mechanism to bill state Medicaid for abortion. FQHCs receive federal funding for health care services through [section 330](#) of the Public Health Services Act to cover specific services outlined in the FQHC 330 grant application. Federal 330 funds may be expended only for the FQHC's specific scope of project, which does not include abortion services. FQHCs are able to take advantage of a special [Prospective Payment System \(PPS\) Medicaid reimbursement rate](#), which allows them to bill for services within their 330 scope of project at a higher rate than the traditional fee for service (FFS) Medicaid rate. As abortion does not fall within the 330 scope of project, there *may not* be a mechanism within each state for FQHCs to bill state Medicaid at the lower FFS rate. **RHAP and other allies are working to understand and address this issue state-by-state to ensure FQHCs have a mechanism to bill outside of their 330 PPS Medicaid reimbursement rate.** This requires advocacy within each state's primary care associations and Departments of Health. Effective October 1, 2022, [California's Medi-Cal program](#) has resolved this issue and provides FQHCs, Rural Health Clinics, Indian Health Services, and Tribal FQHCs a new option to be reimbursed at a fee-for-service rate for abortion services.

Protocols and Procedures

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 as an emergency back-up, etc. Below are several sample clinical policies for medication abortion:

- [Protocol for Medication Abortion Using Mifepristone and Misoprostol](#)– includes regimens for various routes of misoprostol and guidance on providing medication abortion care without ultrasound.
- [Protocol for Medication Abortion Using Misoprostol Alone](#) (by Gynuity Health Projects, Ibis Reproductive Health, and the World Health Organization)
- [Telehealth Care for Medication Abortion Protocol](#)

Make sure to develop a policy for pre-abortion early dating ultrasound referrals if needed (i.e. indications, location of ultrasound on-site versus off-site, etc.) Ensure clinical policies standardize the provision of services while considering state laws and regulations in place. [Guttmacher Institute](#) provides detailed and up-to-date information on abortion restrictions in every state.

It is not necessary for a health center to have an ultrasound machine to offer medication abortion. In cases where a clinic does have a machine on site, it is important to ensure clinicians are properly trained for medication abortion. The [Evaluation of Ultrasound Skills](#) form can be used for training to assess a learner’s grasp of basic early pregnancy ultrasound skills. When there is not appropriate equipment on site, health centers should reach out to sonography staff at nearby facilities to support a smooth referral process for patients who might need an ultrasound. This RHAP resource on [Indications for Sonography for Medication Abortion](#) provides a list of absolute indications for using an ultrasound for medication abortion.

Ordering

To order and dispense mifepristone, you must register as a certified prescriber with a mifepristone distributor. Use RHAP’s step-by-step guide on [How to Order Mifepristone](#). [Danco](#) and [GenBioPro](#) are currently the only distributors of mifepristone (branded mifepristone by Danco called Mifeprex®) in the US. Mifepristone can be ordered through each distributor’s website: Danco and GenBioPro. The first time a provider places an order for Mifeprex®, they must read and sign the Prescriber’s Agreement with [Danco](#) or [GenBioPro](#).

In states that permit telehealth for medication abortion care, mifepristone can be dispensed via mail order pharmacy. There are currently two mail order pharmacies that can work with you to send mifepristone to your patients (as well as misoprostol, pain medicine, pregnancy tests, and

heating pads, if desired): American Mail Order Pharmacy (bob@hpsrx.com) and Honeybee Health (prescribers@honeybeehealth.com). You must still register with a mifepristone distributor, but will also enter into an agreement with the online mail order pharmacy. This will allow the distributor to ship mifepristone directly to the online pharmacy, rather than only your office. The steps to set this up include:

- [Register](#) as a certified prescriber with a mifepristone distributor
- Indicate the collaborating online pharmacy as a secondary shipping address (if you are *only* providing mifepristone by mail, then the online pharmacy would be the primary shipping address).
- Set up an account with the online pharmacy. Confirm this agreement with the mifepristone distributor.
- Order and pay for mifepristone through the distributor, who will then deliver mifepristone to the online pharmacy.

See more details about this process in the [Access, Delivered Provider Toolkit](#).

Professional Liability Insurance

Obtaining affordable malpractice coverage is currently a challenge for clinicians in every area of medicine, and abortion care in particular. Although the financial risk to the insurer for abortion care is much less than that of obstetric services, insurance companies often “bundle” abortion with general Ob-Gyn coverage ([Dehlendorf 2008](#)). There is currently no uniform rule for insurance coverage: states differ with requirements and which insurance companies they consider to be legitimate. If you plan to purchase individual insurance, check with the insurance commissioner of your state that your carrier is on the approved list. It is important to ensure that the coverage option is adequate for your services.

The TEACH Early Abortion Options Workbook section on [Reimbursement Considerations](#) contains a chart detailing malpractice insurance coverage options and their advantages and disadvantages.

Your business office should be able to give you a copy of your clinic’s malpractice policy. If your CHC is an FQHC AND purchases FQHC insurance from the federal government (such as through FTCA), your malpractice policy specifically excludes abortion care. However, “add-on” or “wraparound” policies are available. Your health center may have already purchased a wraparound policy for other areas of care that the Federal malpractice insurance does not cover, such as hospital medicine or obstetrics. Some providers who are also employed by non-religiously-affiliated hospital systems and have their professional liability insurance through the hospital are likely to have abortion care covered. You may also ask your state primary care association for recommended options of wraparound coverage.

RHAP offers a number of [administrative resources](#) to support all levels of clinic staff in implementing and managing medication abortion care, including but not limited to consent forms, electronic health record templates, and guides to ordering medication.

VI. Medication Abortion & Federal Funding

For administrators at many federally qualified health centers (FQHCs), concerns about integrating medication abortion care have less to do with objections to the service, and instead focus on the feasibility of implementation. **It is possible to offer medication abortion at a FQHC and maintain federal funding.** However, Title X and Section 330 federal funding restrict abortion care while permitting pre-abortion counseling and contraceptive services. As such, clinic staff must be prepared to pay special attention to diagnostic and procedure codes and billing for facilities that receive these funds should they wish to add medical abortion to their services.

While Title X or other federally funds can't be used for abortion services, clinics have other revenue streams that do not restrict the type of services they can provide to patients, like insurance reimbursements, self-pay, and/or grant funding. FQHCs may provide abortion services so long as no Title X or 330 funds directly or indirectly support the provision of the abortion services. Although federal regulations require neither the complete physical separation between abortion services and federally funded ones nor a separate organizational framework, they do mandate that clinics use separate supplies for providing medication abortion services. At health care facilities that receive restricted federal funds, staff time spent accounting, billing, and filing insurance claims must be pro-rated and properly allocated. The [Administrative Billing Guide and Guidelines for General Ledger Keeping has more guidance on billing for and financially segregating abortion services.](#)

Costs to provide medication abortion in a CHC are minimal. The original mifepristone pill costs about \$90 each (the generic is cheaper). Beyond that, the other medications needed for medication abortion (misoprostol, ibuprofen, and codeine or hydrocodone) are inexpensive.

Paying at the time of service for an abortion can be a financial challenge for some patients. In many states Medicaid will not cover abortion care and some states limit private insurance abortion coverage. Providers can connect with local and national abortion funds to help patients pay for their abortion care. The National Network of Abortion Funds maintains a [complete listing of state-based abortion funds.](#)

For additional information on federal statutes and rules regarding FQHCs and abortion care, we recommend consulting the [Federal Law Requirements for Women's Reproductive Health Services at Health Centers](#) and/or the [Women's Reproductive Health Services: Sample Policy](#)

[and Procedure Document](#). Reach out to RHAP if you have specific legal questions for your FQHC.

VII. Training Materials & Clinical Resources

Special certification is not required to prescribe mifepristone and misoprostol, though clinical training is necessary just like any clinical care. In all states except Mississippi, physicians can provide medication abortion care. In some states, advanced practice clinicians (APCs: physician assistants, nurse midwives, and nurse practitioners) can provide medication abortion too.

RHAP provides various types of support for health centers who want to implement medication abortion, from in-person or virtual trainings, technical assistance, and hosting an array of resources online. RHAP has compiled a wealth of [clinical training materials and guidance](#) that can serve as a standing resource for clinicians as they begin to offer medication abortion. Many invaluable resources from partner organizations exist for clinicians and health center staff who want to learn about and provide medication abortion care.

- TEACH's [Early Abortion Training Workbook](#), an exhaustive curriculum for training providers in medication abortion and uterine aspiration, which can be used individually, in small groups, or in a clinical setting with a qualified trainer. TEACH also offers an exhaustive list of [Office Practice Tools](#) designed to aid primary care clinicians to integrate reproductive health services into their own practice
- [Innovating Education in Reproductive Health](#) offers an online, video-based course in abortion and is easily accessible to all levels of clinical and non-clinical staff.
- [Access, Delivered Toolkit for Clinicians Offering Medication Abortion](#) provides a step-by-step guide for initiating medication abortion services within primary care practices.
- [Abortion Provider Toolkit](#) supports APCs compile evidence to support integration of early abortion care into their practices.

Each health center can and should develop their own medication abortion clinic materials that meet each site's standards, expectations, and norms as well. Additional resources are also available on RHAP's [website](#).

VIII. Resource Index

This index is organized by section and provides quick access to all of the resources linked or mentioned in this toolkit, as well as additional resources from other reputable organizations. All of RHAP’s medication abortion resources are available [here](#).

I. Establishing a Planning Committee

[Staff Attitude Survey](#)

[Patient Attitude Survey](#)

[TEACH Early Abortion Training Workbook: “Getting Started”](#)

II. Getting Administrative Buy-In

[FAQs on Integrating Medication Abortion Care into Community Health Centers](#)

III. Suggestions for Preparing Staff

[Values Clarification Workshop](#)

[The Abortion Option: A Values Clarification Guide for Health Professionals](#)

[Abortion: Complete Course](#)

[The Safety and Quality of Abortion Care in the United States](#)

[Papaya Workshop](#) and [Role Play Script](#)

[Guttmacher Institute](#)

[Role-Play Script for Training in Administration of Medication Abortion](#)

IV. Patient Education

[Pro-Choice Posters](#)

[Early Pregnancy Options Counseling Model](#)

[Early Abortion Options Fact Sheet](#)

[Medication Abortion vs. Emergency Contraception Fact Sheet](#)

[How to Use Abortion Pills: Mifepristone & Misoprostol](#)

[How to Use Abortion Pills: Misoprostol Alone](#)

[Sam’s Medication Abortion Zine](#)

V. Administrative Logistics

[Administrative Billing Guide](#)

[Guide to Coding for Medication Abortion Using Mifepristone and Misoprostol](#)

[Delineation of Abortion Privileges](#)

[Medication Abortion Protocol](#)
[Protocol for Early Abortion with Mifepristone and Misoprostol](#) (NAF)
[How to Order Mifepristone](#)
[Prescriber's Agreement/Account Setup Form](#) (Danco Laboratories)
[Medication Guide](#) (Danco Laboratories)
[Patient Agreement Form](#) (Danco Laboratories)
[Electronic Health Record Template for Medication Abortion](#)
Consent Forms: [Medication Abortion](#), [Mifepristone Patient Agreement](#)
[Evaluation of Ultrasound Skills](#)
[Sonography for Medication Abortion](#)
[Office Practice Tools](#)
[Manual Vacuum Aspiration Resources](#)
[Start-Up Kit for Integrating Manual Vacuum Aspiration \(MVA\) for Early Pregnancy Loss into Women's Reproductive Health-care Services](#) (IPAS)

VI. Medication Abortion & Federal Funding

[Federal Law Requirements for Women's Reproductive Health Services at Health Centers](#)
[Women's Reproductive Health Services: Sample Policy and Procedure Document](#)
[Guidelines for General Ledger Record Keeping for FOHCs Providing Abortion Services](#)

VII. Training Materials & Clinical Resources

[Medication Abortion FAQs](#)
Protocol for Medication Abortion: [Mifepristone + Misoprostol](#), [Misoprostol alone](#), or [Methotrexate + Misoprostol](#)
Medication Abortion Aftercare Instructions: [Vaginal](#) or [Buccal](#)
[Algorithm for Phone Triage of Bleeding](#)
[Algorithm for Clinical Management When Ultrasound Shows No IUP](#)
[Options for Clinical Management of Ongoing Pregnancy or Retained Gestational Sac After Medication Abortion](#)
[TEACH Early Abortion Workbook](#)
[The Abortion Provider Toolkit](#) (National Abortion Federation)
[Abortion: A Complete Course](#) (Innovating Education in Reproductive Health)
[NAF 2022 Clinical Policy Guidelines for Abortion Care](#)
[Mifepristone Log](#)
[Medication Abortion Charting Form](#)
[Medication Abortion Precepting Checklist](#)
[Ultrasound Chart Form](#)
[Simulation Workshops](#)
[Patient-Centered Options Counseling](#)
[Medication Abortion in Early Pregnancy Teaching Tool PowerPoint](#)
[Insights](#)

[Clinical Protocol for Telehealth for Medication Abortion Care](#)
[Telehealth for Medication Abortion Care Workflow](#)