

Frequently Asked Questions about Integrating Medication Abortion Care into Community Health Centers

1. Our CHC gets Title X and/or 330 funds. Does that mean we can't provide abortions?

No. While Title X or other federally restricted funds can't be used for abortion services, your clinic has many revenue streams that do not restrict the type of services you can provide to your patients. FQHCs may provide abortion services so long as no Title X or 330 funds, directly or indirectly, support the provision of the abortion services. Several federal statutes and rules dictate this conclusion and provide guidance as to how FQHCs may offer abortion services consistent with their federal 330 grant (read more about this on page 6 of the National Association of Community Health Center's [Federal Law Requirements for Women's Reproductive Health Services at Health centers](#)). You will need to fiscally separate out supplies and time used to provide abortions services. There are several resources that can assist your administrative/billing department to facilitate this. Two to explore as you get started are the [Administrative Billing Guide](#) and the [Guidelines for General Ledger Recordkeeping for FQHCs](#).

2. I've been told that our CHC malpractice won't cover abortions. How do I find out if that is true?

Your business office should be able to give you a copy of your clinic's malpractice policy. If your CHC is a Federally Qualified Health Center AND obtains its liability insurance through the federal government's Federal Tort Claims Act (FTCA) program, your malpractice policy will only cover the services that your FQHC is federally funded to provide. Abortion is explicitly excluded. However, "add-on" or "wrap around" policies are available and some health centers have already purchased a wraparound policy for other areas of care that the Federal insurance does not cover (hospital medicine, obstetric deliveries); contact us at program@reproductiveaccess.org for more information. You can review the TEACH Workbook table on other malpractice options [here](#).

3. We want to add manual vacuum aspiration (MVA) for early pregnancy loss (EPL) management to the services we provide. We are an FQHC with FQHC malpractice insurance which excludes abortions; can we still provide EPL management?

Yes. EPL management does not involve a viable pregnancy. Therefore it is not an abortion and can be treated like any other minor surgical procedure that you routinely provide. EPL care in FQHCs should be covered under the

FTCA as part of prenatal care. And, EPL management should be covered by Medicaid and other insurers as a standard component of prenatal care.

4. Our administrators are worried about increased security risks if we provide abortions. What can I tell them?

CHCs already deal with issues of patient and staff security on a regular basis. For example, you see patients with mental illness, substance abuse disorder, and issues of domestic violence. All CHCs should have good security protocols in place for the protection of patients and staff. The threat of violence from an anti-abortion protestor is significantly less likely than from the other patients you already see regularly. RHAP can also provide a security consultation to ensure that the protocols in place are appropriate.

5. Why should our CHC provide abortion services when we can refer our patients to Planned Parenthood or another clinic?

Your patients count on you for quality primary health care services. There are many reasons why early abortion services are important for the health of your patients:

- You are a known and trusted health care system/health care provider. This familiarity means your patients trust you with their health care and may feel more comfortable than going to an unknown, unfamiliar place.
- Providing abortion care at the CHC enhances continuity of care. Every time a referral is made to another system, some of your patients will fall through the cracks. Continuity means better care for your patients.
- At many high-volume abortion clinics, patients must deal with protesters or harassment.
- Some patients have complex feelings about having an abortion. Being able to talk it through with their own clinician, without judgment and with support and understanding, can make all the difference.
- Referral to an independent abortion clinic could require additional appointments, time off work, coordination, and travel for your patient, delaying needed care. Delays in abortion care can lead to greater costs for the patient, slightly higher risks of complications, and greater stress on the patient. These delays will be compounded as many patients in states that ban abortion care will likely travel to states where abortion care is legal and protected. Creating more access points in primary care can alleviate this stress on independent abortion clinics.

- By providing abortion care as an integrated part of primary health care, you are increasing access to this care. You are providing dignity and a sense of autonomy for all people, especially for those with the greatest barriers and costs to accessing abortion care. Abortion care in primary care decreases the marginalization of patients who need this service and the clinicians who provide it.

6. Our administration is somewhat supportive of adding abortion care, but they say that the Board will never allow it. What can we do?

Not all health centers allow their Board to determine their scope of services. Many health centers believe these decisions are medical and are best left in the hands of the medical director of the health center. Make sure that, if you hear that the provision of abortion services is to be debated by the Board, that it is a usual and customary practice for the Board to be determining the scope of the medical care. Did they go to the Board when colposcopy services were added? Or is this just an anti-choice or ambivalent administrator putting up roadblocks?

However, if the decision to provide abortion care does go to your Board, it is important that clinicians' and patients' voices be heard. RHAP can help you make a very compelling presentation to your Board about why your patients need this service. This kind of presentation should also incorporate values clarification ([NAF](#) or [RHAP](#) workshop). Values clarification can help address anxiety around change, identify and dispel myths, and separate personal beliefs from professional responsibilities in medicine.

It is important to research your Board and find out who the members are. You can work with your health center's CEO, or other leaders, to do a power map to help you understand who is on the Board and who can be your allies. CHC guidelines require that the Health Center Board be made up of community representatives, including patients. It will take some legwork, but you should find someone who knows a Board member who can become an ally and help you make a presentation to the Board about why abortion care is so critical to your community.

If there is significant resistance from those in positions of power that determine your CHC's scope of services, consider starting to integrate other new reproductive health services – like full-scope contraception or EPL care. Consider starting with medication abortion before aspiration abortion. These

steps may help get Leadership on board and set the stage logistically for offering comprehensive early abortion care later on.

7. Can our nurse practitioner provide medication abortion? How about our midwives and physician assistants?

In many states, advanced practice clinicians (physician assistants, nurse midwives, and nurse practitioners) can provide medication abortion. Visit the [Guttmacher Institute](#) for updated information on abortion legislation, including Physician-only laws. Contact RHAP at program@reproductiveaccess.org for information about the status of APC scope of practice in your state. Learn more at the [abortion provider toolkit](#) website.

8. Some of our nursing and administrative staff may be uncomfortable with abortion. We are a smooth team – how can I raise the issue of providing abortions at our CHC?

Clinicians who want to add abortion care services to their health center's practice often wonder how to discuss this subject with staff and colleagues whose views on abortion are unknown. It is useful to bring up the subject in the context of a case discussion. The ideal case involves a patient well known to the staff who clearly needs an abortion – so much so that anyone but the most dogmatic "anti" would understand their need – but faces difficulty in getting the procedure done elsewhere. "If only they had been able to obtain this service from their own clinician, in the privacy and trust of their clinician's office." Once the conversation has started, involving the entire staff in values clarification exercises is often extremely helpful. You can find samples on the RHAP website:

[How to Begin a Conversation about Abortion With Office Staff](#)
[Staff Attitude Survey](#)
[Values Clarification Workshop](#)

Some talking points to consider:

- It is important to discuss abortion care delivery 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 CHC's commitment to primary care. Ask staff members: what do our patients do when faced with an unwanted pregnancy? How do we counsel them, and where do we refer them? How might this process change if we offered abortion care here?
- Educate staff to the reality of the abortion provider shortage, heavily restrictive

[state laws](#), and the potential impact of primary care abortion provision for patients.

- Discuss the lack of access to legal abortion care in states where abortion is banned. This lack of access will lead to increased stress on your local abortion clinics with many patients traveling out of state for care. Your practice can help alleviate some of that excess demand by caring for your own patients within your health center.
- Acknowledge that people on both sides of this issue have strong feelings.
- Allow staff members to talk about how they feel and demonstrate respect for powerful feelings, even if they are hard to understand. Our experience shows that even those who may not support abortion are more likely to be involved if their feelings, beliefs, and concerns are acknowledged and respected early on.
- Use gender-inclusive language. Non-binary and transgender people also seek abortion care.
- And, very important: Help staff to stay focused on the needs of patients!

9. Our administration doesn't want our CHC to be known as an "abortion provider". If we introduce abortion care, how can I let my patients know about the availability of services without advertising?

When you take a sexual history of a new patient, or when you are doing an annual exam, you no doubt ask about contraceptive practices and reproductive health needs. It is quite natural to say something along the lines of, "As you know, contraception fails sometimes. If you ever have an unplanned pregnancy, you can make an appointment with me so that we can discuss *all* of your options. We can provide you with whatever care you may need."

While office visits are short, patients often sit in the exam room for 10 or 15 minutes waiting for the clinician. Consider putting up prochoice posters along with all the other informational posters or patient-friendly artwork on the walls of your exam room. You can also place bumper stickers and buttons on your bulletin boards with slogans such as "Ask me about abortion" or "Abortion is essential health care." You can also keep RHAP's abortion themed [zines](#) in your exam room for patients to read while they wait for you. For other ideas, [click here](#).

10. What can I tell our billing department about coding for medication abortion?

There are standard billing codes for medication abortion. [Click here](#) for

information on these codes. You'll also need to review [mifepristone ordering information](#).

11. Where can our staff get trained to provide medication abortion?

Though special certification is not required to prescribe mifepristone and misoprostol, clinical training is necessary, just as it would be for any clinical care you provide. RHAP can help organize a virtual or in-person CE Medication Abortion Training for your staff on the clinical elements of providing medication abortion care. [TEACH](#) also offers a self-paced, virtual medication abortion training for CME credit. [NAF members](#) have access to online CE courses on abortion care. You can also watch video lectures through [Innovating Education](#). Additionally, contact RHAP at program@reproductiveaccess.org to explore options for observing medication abortion counseling.

12. We don't have an ultrasound machine. Does this mean we can't provide abortion services?

While many clinicians are trained to use an ultrasound machine, it is not essential to providing high quality abortion care. In fact, RHAP and other major organizations like NAF, and Society of Family Planning endorse an "ultrasound only as needed" protocol. You can review RHAP's protocol [here](#). The majority of patients will not need an ultrasound, but you should have access to a nearby ultrasound service for those times when the need does arise. It is important to make sure that the sonographers are sensitive and respectful to your patients and do not make assumptions that the patient is happy to be pregnant. Consult RHAP's website to review additional protocols and join the [Reproductive Health Access Network](#) to be part of a community of likeminded clinicians who can help support and mentor you on providing the latest evidence-based, person-centered care.

13. How expensive is it to provide an abortion? Will our patients be able to afford it?

Costs to the CHC are minimal. The mifepristone pill costs less than \$50 each. Beyond that, the other medications that are needed for medication abortion - misoprostol, ibuprofen, and codeine or hydrocodone - are very inexpensive. For an MVA, there are no direct costs once the MVA supplies are purchased. For more information about how to bill out the office visits while keeping abortion expenses and revenues appropriately separated from federally-funded services,

see our [Billing Guide](#) and [Guidelines for General Ledger Record Keeping](#).

If you work in a CHC, your site probably has a sliding fee scale for uninsured patients. This sliding scale is partially supported with federal funding so it CANNOT be used for abortion care, unless your CHC has identified a separate funding stream to underwrite abortion care.

As part of your planning process, it is important to review your health center's payor mix. Commercial insurance usually covers abortion care. In some states, [Medicaid](#) also covers abortion care (though some work will need to be done for FQHCs to have an appropriate mechanism to bill abortion Medicaid visits. Contact RHAP at program@reproductiveaccess.org for more information. Abortion funds also provide financial support to uninsured and underinsured people seeking abortion care.