Integrating Medication Abortion in Primary Care

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Introduction

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

Integrating **medication abortion** services 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 both a deeper understanding of reproductive health, as well as an enhanced ability to handle controversial issues in a positive, patient-centered manner. With the addition of medication abortion in particular, patients can end a pregnancy in the privacy of their own homes.

Providing medication abortion requires sensitivity and determination to overcome obstacles and barriers. Barriers depend on the existing culture of the practice, the level of knowledge and skill, 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 services, 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).

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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 advocate and change agent. RHAP has found that it is preferable to begin the push for medication abortion services with two change agents who can support one another in the face of various challenges to providing care.

1. Start by identifying other medical providers, administrators, and/or staff within your setting who might be interested in and committed to providing medication abortion services. Initiate an informal discussion with colleagues about offering the service 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. 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. They 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 to those obstacles. A few possible questions to think about include:

    - Does our malpractice insurance cover abortion provision?
    - Who will answer calls for abortion 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 services be integrated into the clinic flow?
    - For those working in FQHCs and/or Title X clinics, how will abortion services be fiscally separated from Title X and 330 funds?

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 disseminate 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 ensure all staff will take a patient-centered approach to providing this care
    - Organizing site-specific trainings for all staff who will be involved in medication abortion
    - Reviewing or developing site-specific protocols for the service, including whether misoprostol will be provided on-site or prescribed
    - Developing forms for charts
    - Ordering mifepristone
    - Making insurance coverage calls for medication abortion patients
    - Identifying providers of aspiration abortion in rare case of medication failure
    - Arranging clinician training for on-site ultrasounds or developing smooth referrals for sonography off-site when necessary
    - Building administrative support (i.e. who are key “players” who need to support this effort?)

- Educating your site's billing department and sharing coding information
- Letting patients know medication abortion is available by placing informational materials around your site
- 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 local health centers or medical providers who have successfully integrated medication abortion services into their practice. Invite them to a meeting of the Planning Committee so they can share their experiences and lessons learned.

6. Identify and attend training programs relating to early abortion methods. RHAP and the Institute for Family Health offer medication abortion training sessions that are open to community health center clinicians. Contact info@reproductiveaccess.org for more information.

7. Advise staff members that you are considering implementing medication abortion 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.

9. Present information on early abortion, including medication abortion and manual vacuum aspiration (MVA), 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 onsite. 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 the issue of abortion. Applicants should assess how comfortable they would feel working in an office that provides medication abortion care.

II. Getting Administrative Buy-In

Health centers will face varying levels of difficulty securing the administrative 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. This support can be especially useful for CHCs, which often have 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.

A CHC Planning Committee should make it a priority to research the Board and find out who the members are. It will take some legwork, but finding a way to connect with a Board member—who can then become an ally—can get clinicians on a path to presenting their case for offering medication abortion to the Board. Additionally, the Planning Committee can also work together to identify allied community members who might run for the Board. RHAP can provide support to CHCs to identify potential candidates.

It is important to note that not all health centers allow their Boards to determine what the clinic's scope of services will be. 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 are a clinician who hears 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 does go to the Board, it is important that clinicians' voices—and, where possible, their patients' voices—be 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 the service. For more information about the process of integrating medication abortion at a CHC, refer to RHAP's FAQs on Integrating Medication Abortion Care into Community Health Centers.

III. Suggestions for Preparing Staff

In order to integrate medication abortion successfully, it is critical to ensure 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 services 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 services in this country and the patients who have abortions

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

RHAP staff have also found it useful to bring up the subject in the context of a case discussion. The ideal case involves a patient who is well-known to the staff. This patient clearly needs an abortion – so much so that anyone but the most dogmatic "anti" would understand the need – but faces difficulty in getting the procedure done elsewhere. The sentiment around the patient's case might be, "If only she had been able to obtain this service from her own primary care clinician, in the privacy of her provider's office."

In addition to focusing on specific examples, there are a number of other reasons patients could benefit from going to their primary care provider 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 health care system/provider who knows their medical and social history
- Patients will have increased continuity of 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 services
- 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 and discussions or Grand Rounds that invite all clinic staff to attend are helpful strategies to continue conversations about abortion provision and to train staff in abortion care. Potential topics include:

- Updates in contraception, unintended pregnancy, miscarriage management, and abortion regarding 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. RHAP can also help facilitate presentations on these topics.

- Information on Early Abortion, including medication abortion and MVA. It is important to avoid the assumption that everyone has the facts straight about abortion. This initial overview can help de-mystify the process, support staff in realizing the benefits of abortion access for women, and help to embrace the possibility of abortion integrated into one's 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.

- 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.

- 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
- Counseling and consent
- Ultrasound training
- Emergency preparedness
- 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.

Some points to consider when talking to staff about abortion:

- Discuss abortion service delivery in the context of reproductive choice, family planning, and the concept of helping every mother to have her children when she feels like she can best care for

them, and your health center's commitment to primary care. Ask staff members: "What do your patients do when faced with an unwanted pregnancy? How do we counseling them, and where do we refer them? How might this process change if we offered abortion here?"
- Educate staff to the reality of the abortion provider shortage, and the potential impact on women. Provide them with a history of abortion. Younger staff members may be unfamiliar with women's experiences prior to abortion legalization.
- 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.

And, help staff to stay focused on the needs of patients!

IV. Patient Education

Once a health center decides to implement medication abortion, administrators might remain averse to promoting abortion services. There are many ways short of advertising that primary care providers can indicate to patients that they offer medication abortion, as well as ways to create a clinical environment where patients feel comfortable discussing abortion with their providers.

While office visits are short, patients often sit in the exam room for 10 or 15 minutes waiting for the clinician. Consider putting up posters that promote acceptance of patients' decision-making along with all the other health information posters and patient-friendly artwork on the walls of your exam room. You can also place stickers and buttons on your bulletin boards with slogans such as, "You are not alone, one in four women has had an abortion" or "Abortion is Healthcare." For additional ideas or materials, see RHAP's compendium of Pro-Choice Posters from various reputable organizations.

Additionally, reproductive health care providers likely ask about contraceptive practices when taking a new patient's sexual history or during an annual exam. In the process of implementing medication abortion, it is important to see if and when providers at a clinic ask patients about birth control. It is quite natural to say something along the lines of, "As you know, contraception fails sometimes. If you ever have an unwanted pregnancy, I want you to know that this health center provides medication abortion."

Involving patients throughout the process of integrating medication abortion care can also be an important tool for bringing along clinic staff. Research has demonstrated patients want increased access to abortion in primary care settings and/or the privacy of their own homes, making medication abortion an increasingly important component of full-spectrum, patient-centered care.

While patients might want options, those who find themselves considering medication abortion will likely have varying levels of familiarity and comfort with the procedure. The following are the key points of a medication abortion counseling model that accounts for these myriad experiences while providing patients with the same basic information:

- Discuss pregnancy options and ensure the decision to have an abortion is informed, voluntary, and uncoerced.
- Compare the advantages and disadvantages of medication vs. aspiration abortion. Explain the differences, timing of visits, known side effects of medications, and what to expect during the process and at home for both options.
- Ask what the patient already knows about medication abortion.
- Ask about any previous abortion experience(s) and fears or anxieties.
- Discuss time off from other responsibilities (work, childcare, etc.).
- Explain the basic clinical aspects of medication abortion.
- Discuss the potential teratogenicity of misoprostol and emphasize that once the drugs have been administered, the abortion should be completed either medically or via aspiration.
- Clarify the time commitment and the preference for two office visits.
- Discuss issues of confidentiality and social and physical support.
- Discuss the cramping and bleeding associated with the medication abortion process, including heavy bleeding with clots and passage of products of conception.
- Instruct the patient on the use of all medications, including the options of vaginal or buccal administration of misoprostol and use of pain medication.
- Advise the patient regarding substances to avoid (e.g. aspirin and alcohol).
- Discuss sexual abstinence until abortion completion is confirmed.
- Be very sensitive to patients who learn they are not eligible for a medication abortion.
- Offer contraceptive counseling.
- Review aftercare instructions, including emergency contact information and what symptoms warrant a call to the on-call provider.
- Provide written take home instructions that reinforce all of the above.

RHAP has several additional resources to help clinicians address the many questions and concerns patients might have about medication abortion, including a model for counseling patients about pregnancy options, fact sheet on early abortion options, and explanation of the differences between medication abortion and emergency contraception.

V. Administrative Logistics

For medical settings that are not currently offering abortion services, 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 (including values clarification), review of professional liability insurance coverage, back-up for aspiration procedures, after hours on-call coverage, and compliance with legal and regulatory issues.

There are particular administrative and billing issues for healthcare organizations that receive Title X 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 for facilities that receive these funds. RHAP and Provide (formerly the Abortion Access Project) compiled this Administrative Billing Guide to support health centers in addressing these administrative challenges. See this guide for in-depth assistance on administrative challenges, including billing, Medicaid funding for abortion care, and 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.

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 FDA regimen, evidence-based regimen using misoprostol vaginally, and evidence-based regimen using misoprostol buccally; as well as guidance on providing medication abortion without ultrasound.
- Protocol for Medication Abortion Using Methotrexate and Misoprostol (by Ibis Reproductive Health)
- Protocol for Medication Abortion Using Misoprostol Alone (by Gynuity Health Projects, Ibis Reproductive Health, and the World Health Organization)
- Medication Abortion Protocol Comparison
- Medication Abortion Policy & Procedure
- Limited Ultrasound Protocol for Medication Abortion (by RHEDI and the National Abortion Federation)

Make sure to develop a policy for pre-abortion early dating ultrasound referrals (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 when providing a medication abortion.

It's important to set up a system to order the medications for medication abortions so they are always available when patients may need it. RHAP created this step-by-step guide on How to Order Mifepristone in the US. Danco is currently the only distributor of mifepristone (Mifeprex®) in the US and

can be ordered through their website. The first time a provider places an order for Mifeprex®, they must read and sign Danco's Prescriber's Agreement/Account Setup Form.

This document requires prescribers to review the Danco Patient Agreement Form with the patient, sign and obtain the patient's signature on the Patient Agreement Form, provide the patient with a copy of the Patient Agreement Form and the Danco Medication Guide, keep the signed Patient Agreement Form in the patient's medical record, record the serial number from each package of Mifeprex® in each patient's record, and report deaths to Danco Laboratories. These requirements are described in the Prescriber's Agreement. After the account is set up, future orders can be made over the phone by calling Danco directly at 1-877-432-7596.

Additionally, RHAP offers a number of other administrative resources to support all levels of clinic staff in implementing and managing medication abortion services, including but not limited to consent forms and guides to ordering medication. Several of these resources are included below and are available on RHAP's website:

- Delineation of Abortion Privileges
- Electronic Health Record Template for Medication Abortion
- Consent Forms: Medication Abortion, Mifepristone Patient Agreement, Rh Testing
- Ultrasound Chart Form
- Frequently Asked Questions on Integrating Abortion into Community Health Centers

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 much less than that of obstetric services, insurance companies often "bundle" abortion with general Ob-Gyn coverage (Dehlendorf 2008). There is currently no uniform code 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 Legal and Reporting 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 services. However, "add-on" or "wrap around" policies are available and health centers have sometimes already purchased a wrap around policy for other areas of care that the Federal malpractice insurance does not cover, such as hospital medicine or obstetrics.

In the rare case of an incomplete or failed medication abortion, aspiration abortion might be required as a backup. As such, implementing medication abortion necessitates educating clinic staff about manual vacuum aspiration (MVA), which can include everything from how to handle and use a manual aspirator, to what distinguishes MVA from an electric vacuum abortion procedure. For more information about aspiration abortion, visit RHAP's MVA Resources page.

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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.

Costs to provide medication abortion in a CHC are minimal. The mifepristone pill costs $90 each. Beyond that, the other medications needed for medication abortion (misoprostol, ibuprofen, and codeine or hydrocodone) are inexpensive. The CHC likely already has a sliding fee scale that can be applied to medication abortion office visits, plus the $90 to cover the cost of the medication. The Administrative Billing Guide mentioned in the "Administrative Logistics" section of this toolkit contains further information on billing for early abortion services.

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.

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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, Ob-Gyns and family physicians are able to provide medication abortion. In some states, trained advanced practice clinicians (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 trainings, technical assistance, and hosting an array of resources online. RHAP has compiled a litany of clinical training materials and guidance that can serve as a standing resource for providers as they begin to offer medication abortion.

- Medication Abortion FAQs – This resource provides answers to the most common phone calls from medication abortion patients.
- Protocol for Medication Abortion: Mifepristone + Misoprostol, Misoprostol alone, or Methotrexate + Misoprostol
- Medication Abortion Aftercare Instructions: Vaginal or Buccal
- Algorithm for Phone Triage of Bleeding – This algorithm outlines counseling and treatment options when managing a call for medication abortion patients
- Algorithm for Clinical Management When Ultrasound Shows No IUP
- Options for Clinical Management of Ongoing Pregnancy or Retained Gestational Sac After Medication Abortion

Many invaluable resources exist for providers who want to learn about medication abortion.

The Association of Reproductive Health Professionals hosts CORE (Curricula Organizer for Reproductive Health Education), which contains a database of peer-reviewed, evidence-based teaching materials that cover medication abortion. It includes presentations, slides, videos, images, activities, and handouts that be used to train all staff. We also recommend joining the Access List for guidance on providing the latest evidence-based reproductive health care. Contact info@reproductiveaccess.org if you are interested in joining the Access List.

Additionally, TEACH offers an 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. And, 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.

Once providers have learned to administer medication abortion, there are a number of clinical resources to aid in providing medication abortion in a primary care setting:

- Mifepristone Log
  Medication Abortion Charting Form
- Medication Abortion Chart Review Form
- Mifepristone Medication Guide
- Medication Abortion Precepting Checklist
- Ultrasound Chart Form (for providers with ultrasound capacity)

TEACH also provides an exhaustive list of Office Practice Tools designed to aid primary care clinicians to integrate reproductive health services into their own practice.

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.

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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
Fact Sheets on the Safety of Abortion (abortionissafe.com)
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