# MEMORANDUM

Date: May 13, 2026

To: Jon Pennell, DVM, Chair
State Board of Health

From: Andrea Rivers, Secretary
State Board of Health

Re: Petition for Approval of the National Abortion Federation (NAF) as an Accreditor for Outpatient Facilities

## PURPOSE

Pursuant to NAC 449.999424, the Division of Purchasing and Compliance ("Division") hereby submits this petition requesting the Nevada State Board of Health to review, adopt, and approve the National Abortion Federation (NAF) as a qualified accrediting organization for outpatient facilities providing abortion services in Nevada.

## BACKGROUND AND JUSTIFICATION

Nevada law, particularly NRS 442.250, protects the right to abortion in Nevada. To ensure that these services are provided in a safe and high-quality environment, facilities must comply with rigorous standards. Currently, the state faces a need for specialized, recognized accreditation for outpatient facilities to ensure compliance with standards of care, specifically for reproductive health services. The National Abortion Federation (NAF) sets comprehensive, clinically validated guidelines for abortion care, including facility management, infection control, and emergency care. NAF's accreditation standards are equivalent to, or exceed, current state requirements for outpatient surgical centers.

## ALIGNMENT WITH QUALITY CARE AND ACCESS

By approving NAF as an accreditor, the Board will:

- Ensure that Nevada outpatient facilities adhere to the highest specialized clinical guidelines, such as those detailed in the 2026 Clinical Policy Guidelines for Abortion Care.
- Provide facilities with a specialized accreditation pathway that focuses on the unique requirements of abortion care, ensuring both safety and patient access.
- Provide facilities with a specialized accreditation pathway, reducing administrative burdens on state surveyors.
- Support compliance for facilities servicing Nevada's growing demand for reproductive services.

POSSIBLE OUTCOMES IF THE PETITION NOT APPROVED

If the Board chooses not to recognize the National Abortion Federation (NAF) as an accredited body, several key impacts should be anticipated. First, outpatient facilities may face an accreditation bottleneck, relying on slower or less-specialized accreditation pathways that could delay licensing and constrain our statewide clinical capacity. Second, facilities may experience increased regulatory uncertainty as they work to interpret and comply with evolving abortion-care requirements, potentially resulting in more NVHA deficiencies.

There are also financial implications: without specialized accreditation, providers may face higher compliance costs, which could decrease service availability in already underserved communities. The absence of NAF's specialized oversight may also raise the risk of quality gaps in procedural and medication abortion care. Finally, a denial could elevate litigation exposure from organizations that may argue the decision restricts patient access by narrowing accreditation options.

STAFF RECOMMENDATION

The Division recommends that the Board of Health accept this petition and move forward with authorizing NAF as an approved accrediting body for outpatient facilities.

PRESENTER

Scott Haddrill, RN
Health Facilities Inspector III - RN

Attachments:
Application for Approval of An Accreditation Program
2026 Clinical Policy Guidelines for Abortion Care

NATIONAL ABORTION FEDERATION

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www.prochoice.org

National Abortion Federation, Inc.
P.O. Box 100
Annapolis Junction, MD 20701

Dear Ms. Walton, Hesterlee, and Sims,

I am writing to request that the Nevada State Board of Health recognize and approve the National Abortion Federation, Inc. (NAF) as an approved accreditor for outpatient facilities providing abortion care with sedation/anesthesia. NAF is currently approved as an accrediting agency in both Washington and Oregon, and we look forward to providing the same high standard of quality assurance for Nevada outpatient facilities, should we be approved.

The National Abortion Federation is the professional association of abortion providers. Since 1977, NAF has ensured the safety and high quality of abortion practice with standards of care, protocols, and medical education. NAF members include individuals, private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, telehealth facilities, and hospitals. NAF unites, represents, and supports abortion providers in delivering patient-centered, evidence-based care. NAF currently implements a Quality Assurance and Improvement (QAI) Program covering all types of abortion providers to help ensure the provision of safe, high-quality abortion care for patients.

NAF member facilities, including our Nevada members, adhere to our evidence-based *Clinical Policy Guidelines for Abortion Care* (CPGs), which set the standards for quality abortion care in North America (attached). First published in 1996, we revise and reissue our CPGs every two years in order to help ensure the provision of high-quality care at member clinics. The CPGs reflect NAF's expertise in developing evidence-based clinical standards for medical providers.

In order to become a NAF member, a clinic must successfully complete a quality assurance site visit from one of our trained Quality Assurance and Improvement Clinicians. The site visit is a critical component of the application process for applying members, and current members must comply with regular quality assurance site visits. NAF conducts regular QAI site visits at all member facilities at intervals based on the number of deficiencies identified at their site visits. As part of the site visit, NAF staff observe all aspects of direct patient care (with patient consent); review patient charts; evaluate facility policies, logs, and procedures; provide limited technical assistance; conduct training and emergency drills; and share recommendations for improvement so that member facilities can remain compliant with our CPGs. NAF's QAI site visit includes mandatory training on managing abortion emergencies. The site visit concludes with an exit summary with

*board chair:* Melissa Grant *board members:* Leah Coplon CNM, MPH ▪ Kersha Deibel, MPH, MSW ▪ Justin T. Diedrich, MD, MSCI ▪ Tiffany Hailstorks, MD, MPH
Curtiss P.S. Hannum, MSN, APN, CRNP ▪ Erin King, MD ▪ Tammi Kromenaker ▪ John C. Markley, MD, PhD ▪ Sarah McNeil, MD, FAAFP
Tram Nguyen, MHA, MBA ▪ Alisha Nord-Stewart, RN, BScN ▪ Catherine Obando MSN, NP-C ▪ TaRhonda Slydell, BSN, MBA-HCA
Maria Mercedes Vivas, MD, MPH ▪ Lin-Fan Wang, MD ▪ Ying Zhang, MD, MPH

facility staff to debrief and discuss the initial findings. Following the visit, facilities receive a detailed report identifying any CPG deficiencies observed during the site visit. They have 90 days to submit a plan of corrective action. Our clinical staff review all corrective action plans and ensure they adequately address the identified deficiencies. We are also able to provide targeted onsite training and ongoing assistance in any areas where a facility has challenges or needs additional support. NAF conducts comprehensive follow-up to ensure that clinics are implementing recommendations for improvement and to ensure the quality of abortion care is enhanced.

In addition to site visits, we require members to self-certify that they have read the current CPGs and agree to implement any changes, if needed, every year. We also collect Abortion Quality Indicators (AQI) from our members to track quality trends. We provide Quarterly Medical Updates to keep members up to date on the latest abortion research and clinical matters. To supplement our quality assurance work, we provide ongoing technical assistance, CME opportunities at our Annual Meetings and Regional Workshops, and online clinical educational webinars and trainings for our members.

Through this process, NAF is able to certify that all of our members are in compliance with the evidence-based standards contained in the CPGs, which help ensure that they are providing the highest quality care. I have attached: our CPGs; a table identifying, for each of the relevant Nevada State Regulations, the language of NAF's comparable accreditation requirements; NAF's QAI policies and procedures, which address several of the items referenced in the "Process and Requirements for an Application for Approval of an Accreditation Program"; and a list of key personnel and resumes for staff critical to management and oversight of NAF's QAI program.

We look forward to working with you to approve NAF as an accrediting agency for outpatient facilities providing abortion care with sedation/anesthesia. If you need any further information, please feel free to contact me.

Sincerely,

Reesa Roberts, PA-C, MSPA
Senior Director of Clinical Services
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# 2024 CLINICAL POLICY GUIDELINES FOR ABORTION CARE

naf NATIONAL ABORTION FEDERATION


# 2024
# Clinical Policy Guidelines for Abortion Care

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The National Abortion Federation is the professional association of abortion providers. Our mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care.

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## Introduction

The National Abortion Federation's (NAF) mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care. An important part of this work is to develop and maintain evidence-based guidelines and standards as well as to educate providers in the latest technologies and techniques.(1) NAF's programs make it possible for people to obtain the highest quality abortion care.

Like its precursors, the 2024 edition of NAF's *Clinical Policy Guidelines for Abortion Care* (CPGs) serve to provide guidance for facilities to use in establishing their clinical policies. The CPGs are developed by consensus, based on rigorous review of the relevant medical literature and patient outcomes.(2-6) These guidelines are intended to provide parameters to ensure access to the highest quality abortion care.

NAF's *Clinical Policy Guidelines* were first published in 1996 and have been revised annually since then. Since inception, they have been based on the methodology described by David Eddy, MD, in *A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach*.(7) Clinical policy guidelines are defined as a systematically developed series of statements, which assist practitioners and patients in making decisions about appropriate health care. They represent an attempt to distill a large body of medical knowledge into a convenient and readily usable format. Since 2018, we have incorporated the Institute of Medicine's recommendations.(8)

When the outcomes of an intervention are known, practitioner choices are limited. But when the outcomes of an intervention are uncertain or variable, and/or when patients' preferences for those outcomes are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. This is addressed by having three types of policies according to their intended flexibility: standards, recommendations, and options:

1) **STANDARDS** are intended to be applied in virtually all cases. Deviations will be rare and difficult to justify.

2) **RECOMMENDATIONS** are steering in nature. They do not have the force of standards, but when not adhered to, there should be documented, rational clinical justification. They allow some latitude in clinical management.

3) **OPTIONS** are neutral with respect to a treatment choice. They merely note that different interventions are available, and that different people make different choices. They may contribute to the educational process, and they require no justification.

NAF's CPGs include a list of references for each section and include discussion material for clarification when appropriate. These guidelines are meant to be living documents, subject to revision as new medical evidence becomes available.

Medline was searched monthly on Pubmed. An automated search using the following terms was created and checked monthly:

((((abortion induced [MeSH Major Topic]) OR mifepristone) OR medical abortion) OR (dilation and evacuation)) OR uterine aspiration.

The search was limited to clinical trials, case reports, comparative studies, reviews, meta-analysis, and systematic reviews in humans from January 1, 2022. The search run on December 31, 2023, yielded 667 results. In addition, abstracts from major conferences, references in articles, and related non-abortion searches (for example, in analgesia and sedation) were run.

Studies were included that addressed CPG topics and either changed, updated, or substantially added support to a current recommendation. Studies were excluded that were not relevant, had poor methodology or inconclusive results, or did not substantially add to a current recommendation.

Thirty-three new papers were included in the 2024 CPGs because they changed one or more statements, supported a new recommendation, or substantially improved the level of evidence supporting a current statement. Changes to each policy statement were drafted by NAF's Interim Medical Advisor, Alice Mark, MD, MSc, and Senior Director of Clinical Services, Reesa Roberts, PA-C, MSPA, based on the included papers. These papers were reviewed by the NAF Clinical Policy Committee and changes to each policy statement were edited and approved by the entire committee. A synthesis of how the new study altered the existing policy statement will be available in an online module.

NAF 2022-2023 Clinical Policy Committee members:

Sarah Prager, MD, MAS; Chair
Justin T. Diedrich, MD, MSCI
Angel M. Foster, DPhil, MD, AM
Tiffany Hailstorks, MD, MPH
John C. Markley, MD, PhD
Tram Nguyen, MHA/MBA
Alisha Nord-Stewart, RN, BScN
Lisa Perriera, MD, MPH
Rolanda Ryan, RN, MHSA
TaRhonda Slydell, BSN, MBA-HCA
Maria Mercedes Vivas, MD, MPH
Lin Fan Wang, MD
Beverly Winikoff, MD, MPH
Ying Zhang, MD, MPH

Note: The *Clinical Policy Guidelines for Abortion Care* are not intended to educate members regarding legal and regulatory issues, which may affect abortion practice. It is expected that administrators, staff, and clinicians will be aware of pertinent local, state/provincial/territorial, and national laws as well as the requirements and limitations of their individual duties and scope of professional practice. NAF provider members should ensure that all employees have access to appropriate resources for information and support.

Commitment to diversity, inclusion, equity, and anti-racism: Abortion is affected by structural, institutional, interpersonal, and individual-level racism that affects safety and quality of care, and degrades the abortion experience for many of those who seek it.(9,10) NAF holds itself accountable to anti-racist principles and endorses evidence-based clinical guidelines that are not a source of harm but promote health for people with historically marginalized identities, including but not limited to Black, Indigenous, and People of Color, lesbian, gay, bisexual, transgender, gender expansive, intersex, asexual and two spirit people, immigrants, refugees, people with limited financial resources, people with limited exposure to formal education, people who don't speak the dominant language, young people, people of all body sizes, and people with disabilities, chronic illness, or other conditions.

A note about language: NAF and our members understand and respect that not every person with the capacity for pregnancy identifies as a woman. We embrace and respect each individual's gender identity, expression, and experience, and desire to be inclusive and helpful to all who need information about abortion or support as providers. While we do make an effort to use gender-inclusive language (person/people/they/them/patient) in this document and our other materials, we do also use woman/women in some cases. We do so in order to acknowledge the long history of gender discrimination targeting women, the specialized health care that many of our members provide, and the need to be clear to various audiences.

**References:**

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## Notes on Formatting

As presented here, standards, recommendations, and options are hierarchical in nature. It is therefore expected that clinical practices will favor the highest level of guidance available on a given point. To clarify the relationships of Recommendations and/or Options that are subordinate to higher level Standards and/or Recommendations, NAF's guidelines are numbered and formatted according to the following scheme:

Within each section, **Standards** are numbered consecutively starting with the section number with the standard to the right of a decimal. For example, the first standard in Section 1 will be Standard 1.1.

*Recommendations* are also numbered consecutively within each main subject heading, with numbers that are placed to the right of a second decimal point. Where a recommendation follows a standard, it is included below the standard and the number of that standard will be found to the left of the decimal point (e.g., Recommendation 1.1.1). Where the recommendation stands alone and is not related to a specific standard, there will be a zero in the position to the left of the decimal point (e.g., Recommendation 1.0.1).

The consecutive numbers denoting *Options* within each main subject heading are placed to the right of the third decimal point. Where an option follows a preceding standard or recommendation, it is indented below that standard or recommendation and the numbers identifying that option will be found to the right of a third decimal point added to the end of the standard or recommendation (e.g., Option 1.1.0.1 or Option 1.1.1.1). Where the option stands alone and is not related to a specific standard or recommendation, zeros will be placed in the position for the standard and recommendation (e.g., Option 1.0.0.1).

# 1. Who Can Provide Abortions

**Policy Statement:** Abortion should be decriminalized. Abortion is a safe procedure when provided by qualified individuals.(1) The vast majority of abortions, including uterine aspiration, dilation and evacuation, and medication abortion after the first trimester, can be safely provided in medical offices or freestanding clinics.(2) Telemedicine can be safely used to provide abortion care, including medication abortion provision, informed consent, and follow-up.(3, 4) People may manage all or part of an abortion on their own.(5, 6)

**Standard 1.1**
Abortion will be provided by trained providers. This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, other health professionals and community-based providers.(7)

*Recommendation 1.1.1*
Documentation specifying privileges in accordance with each practitioner's scope of practice should be maintained.

*Recommendation 1.1.2*
Complex Family Planning accreditation or sub-specialty status are not necessary or required for the provision of safe abortion care.

*Recommendation 1.1.3*
Neither hospital admitting privileges nor transfer agreements are needed to provide safe abortion care.(2)

*Recommendation 1.1.4*
Community-based providers with appropriate training may safely provide care.(6, 8, 9)

**Standard 1.2**
People may manage all or part of an abortion on their own. People using self-managed abortion need access to evidence-based information, effective medications, and supportive services before, during, and after the abortion.

*Recommendation 1.2.1*
Don't engage in any behavior that criminalizes abortion or those who use it.

**Standard 1.3**
All individuals providing abortions must have received training to competency in abortion care, including the prevention, recognition, and management of complications.

*Recommendation 1.3.1*
When making changes to clinical practice, consider values clarification for providers and staff to optimize patient-centered care.

***Standard 1.4***
All individuals providing ancillary services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other services.

**Standard 1.5**
Appropriate referrals must be available for patients who cannot be cared for by an individual or facility.

**Discussion:** Values clarification is an essential part of hiring, training, and retaining abortion staff. Values clarification should be done routinely but particularly needs to be revisited if a clinic expands its services, increases gestational limits, if staff changes roles at clinic, or when new staff are hired. Resources for values clarification can be found on NAF's members-only website at https://members.prochoice.org in the Learning Lab.

**References:**


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## 2. Patient Education, Informed Consent, and Counseling

**Policy Statement:** A person must give voluntary, informed consent prior to an abortion and express understanding. The goal of abortion education is to give people the knowledge they need to make an informed decision about whether to have an abortion and which type of procedure to choose.

### Informed Consent

**Standard 2.1**
The practitioner must ensure that accurate information is provided about the abortion process and its alternatives, and the potential risks and benefits. The patient must have the opportunity to have any questions answered to their satisfaction prior to intervention.

> *Option 2.1.0.1*
> Information may be provided either on an individual basis, in group sessions, or with appropriate patient information materials, and can be done in person or remotely.(1)

**Standard 2.2**
Documentation must show that the patient affirms their decision to have an abortion, that their decision is voluntary, and that they are aware of the potential risks and benefits of the abortion procedure. Although other risks may be addressed, at a minimum, the following risks must be included (2-6):

1) Hemorrhage
2) Infection
3) Continuing pregnancy
4) Death.

*Recommendation 2.2.1*
For abortion procedures (uterine aspiration or dilation and evacuation), the additional risks must be included:

5) Perforation
6) Damage to organs including hysterectomy.

### Patient Education and Counseling

**Standard 2.3**
Each person must have a private opportunity to ask questions about the abortion.(7-9)

**Standard 2.4**
A person must undergo the abortion as expeditiously as possible in accordance with good medical practice.

*Recommendation 2.4.1*
Information about aftercare and contraception must be available. The importance of contacting the provider for any concerns should be emphasized.

*Recommendation 2.4.2*
Evidence-based guidelines for contraceptive counseling should be followed.(10)

**Standard 2.5**
All reasonable precautions must be taken to ensure confidentiality.

*Recommendation 2.5.1*
The person should be informed of the communication of information to any third party.

*Recommendation 2.5.2*
People need to know which individuals or agencies may receive communications regarding services. This information should include confidentiality implications of using insurance or governmental health care coverage.

**Discussion:** Informed consent and abortion counseling are two different processes. The goal of informed consent is to assure that the person's decision is voluntary and informed, and that they understand the risks and benefits of the abortion procedure. Education and counseling includes a discussion of the feelings and concerns expressed by the patient, which may include help with decision-making and contraceptive choices, values clarification, or referral to other professionals. Although the large majority of people who present for abortion are sure of their decision,(8) a referral to community services should be available if that becomes necessary or the needs of the patient are outside the scope of training of clinic staff.

Where abortion is safe and legal, the risk of death overall is less than 1 per 100,000 abortions.(5, 6, 11) Pregnancy-related deaths are significantly higher.(12)

Risks of pregnancy-related death by country, 2020 WHO data (12)

| Country | Maternal mortality ratio* |
|---|---|
| **Canada** | 11 |
| **United States** | 21 |
| **Mexico** | 59 |
| **Colombia** | 75 |

*deaths per 100,000 live births

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## 3. Infection Prevention and Control

**Policy Statement:** Patients and health care personnel are at risk for exposure to blood borne pathogens, aerosol transmissible disease, and other potentially infectious material. Infectious material may be transmitted to patients when proper engineering* and work-practice controls,† which reduce exposure, are not followed. Proper handling of chemicals and other materials needed for proper disinfection is important to prevent harm to staff. Prevention and treatment of infection will reduce post-abortion morbidity.

**Standard 3.1**
Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material.(1)

**Standard 3.2**
Hands must be washed or disinfected before and after patient contact.(2-4)

**Standard 3.3**
Personal protective equipment must be provided to all staff.(1, 5-8)

*Recommendation 3.3.1*
New staff with potential exposure should have an initial training as part of orientation.

*Recommendation 3.3.2*
Periodic facility-level training should occur at least every three years.

*Recommendation 3.3.3*
Hepatitis B vaccine should be provided at no cost to the staff.

**Standard 3.4**
Exposure control plans must be established and followed.(5, 7, 9)

*Recommendation 3.4.1*
Post-exposure evaluation, prophylaxis, and follow-up should be available to exposed patients or staff for any potentially infectious agent, regardless of source.

**Standard 3.5**
All instruments coming into contact with patients must be properly cleaned and disinfected between patients.(10)

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*Engineering control—available technology and devices that isolate or remove hazards from the workplace, such as puncture-resistant sharps disposal containers, needleless systems for withdrawing medications, and safer sharps devices.

†Work-practice control—an alteration in the way a task is performed that reduces the likelihood that an employee will be exposed to blood or other potentially infectious materials, for example, prohibiting needle recapping.

**Standard 3.6**
All instruments entering the uterus must be sterile.

*Option 3.6.0.1*
The cervix and vagina may be cleansed with a bactericidal agent though randomized trials have failed to show a benefit to this practice.(11)

**Standard 3.7**
Tubing and manual uterine aspirators must be high-level disinfected or sterilized.(10)

**Standard 3.8**
All tissue removed in the facility must be considered biohazardous and be handled, stored, and disposed of in a manner that minimizes the risk of exposure. A protocol for tissue handling, storage, and disposal must be in place.

**Standard 3.9**
Sharps containers must be readily available. Sharps containers must be made of rigid, puncture-resistant material, have a tight-fitting lid, and be labeled as hazardous material.

**Standard 3.10**
Routine antibiotic prophylaxis must be used for uterine aspiration and dilation and evacuation.(12, 13)

*Recommendation 3.10.1*
All patients having uterine aspiration or dilation and evacuation should receive antibiotics pre-procedure.(11, 14, 15)

*Recommendation 3.10.2*
Prophylactic antibiotics should not be continued after the day of the procedure.(11, 14, 15)

*Option 3.10.2.1*
Antibiotics may be initiated at the time of insertion of osmotic dilators.

*Option 3.10.2.2*
Antibiotics are not required for patients choosing medication abortion.(16) Insufficient evidence exists to support routine antibiotic prophylaxis for medication abortion.

*Recommendation 3.10.3*
Additional antibiotics are not recommended for endocarditis prophylaxis in patients with heart murmurs or other cardiac conditions.(13, 17, 18)

*Recommendation 3.10.4*
Patients should be offered or referred for testing for chlamydia and gonorrhea according to local guidelines.(19) Testing should not delay the procedure.

> *Option 3.10.4.1*
> Empiric treatment of chlamydia may be considered for patients with history, signs, or symptoms of current infection.

**Standard 3.11**
Diagnosed infection must be appropriately treated.

*Recommendation 3.11.1*
For documented infections of the reproductive tract, evidence-based regimens should be followed.(19, 20)

**Discussion:** Regulatory agency policies (see references) may be helpful in developing exposure plans that protect personnel and patients from potentially infectious material, including aerosol transmissible diseases. A sample exposure control plan can be found in the online learning resources on NAF's members-only site at https://members.prochoice.org. Techniques for collection, labeling, and disposal of biohazardous material and for the processing of instruments are integral to any complete plan.

Expedited partner treatment may be considered for patients with a known diagnosis of a sexually transmitted infection.(21, 22)

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## 4. Laboratory Practice

**Policy Statement:** Rh alloimmunization may jeopardize the health of a subsequent pregnancy.(1) There is no evidence that providing anti-D immunoglobulin in early pregnancy prevents alloimmunization and poor outcome in a subsequent pregnancy, however, it is recommended later in pregnancy.(2-7)

**Standard 4.1**
Rh status testing must be offered to all people with unknown Rh status over 12 weeks from the last menstrual period (LMP) and anti-D immune globulin must be offered to patients over 12 weeks who are Rh negative.

*Recommendation 4.1.1*
Below 12 weeks from the last menstrual period, patients and providers may forego Rh testing and anti-D immune globulin for patients who are Rh negative.(2-7) This recommendation applies to both medication abortion and aspiration procedures.

*Recommendation 4.1.2*
If anti-D immune globulin is not administered in the facility, other arrangements for administration must be documented.

*Recommendation 4.1.3*
A person who is over 12 weeks LMP and declines Rh testing or anti-D immune globulin should sign an informed waiver.

*Recommendation 4.1.4*
Documentation of Rh status may be obtained by on-site testing, outside source, or self-report.

*Recommendation 4.1.5*
Additional testing for either sensitization or other antibodies is not required in patients undergoing pregnancy termination, including testing for Du (“weak D”).

**Standard 4.2**
Anemia and the risk of bleeding must be evaluated.(8)

*Recommendation 4.2.1*
Hemoglobin or hematocrit testing should be readily available.

*Recommendation 4.2.2*
Prior to uterine aspiration and medication abortion in the first trimester, hemoglobin/ hematocrit and other laboratory evaluation should be done as indicated by medical history and patient symptoms. Routine hemoglobin or hematocrit has not been shown to improve outcomes.

*Recommendation 4.2.3*
Hemoglobin or hematocrit should be checked before all abortions after the first trimester.

**Discussion:** Epidemiologic and clinical evidence indicates that the risk of maternal-fetal hemorrhage caused by early abortion is negligible and Rh testing and provision of Rh immune globulin is not necessary.(2-7) There is no evidence to show that Rh testing and anti-D immune globulin is beneficial in the setting of early abortion, and added testing and treatment is a burden for many patients and providers. Therefore, it is reasonable to forego Rh testing and anti-D immunoglobulin for people having any type of abortion before 12 weeks LMP.

The use of approved slide/tube/spot methods is acceptable for on-site Rh testing.

Moderate or asymptomatic anemia is rarely a reason to delay abortion care.

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## 5. Limited Sonography in Abortion Care

**Policy Statement:** The use of ultrasound is not a requirement for the provision of first-trimester abortion care. Proper use of ultrasound may inform clinical decision-making in abortion care.

**Standard 5.1**
Staff members who perform ultrasound exams and clinicians who interpret those exams must either show documentation of proficiency or complete a program of training. Training must include a period of supervision. Documentation of this training must be maintained.

**Standard 5.2**
A system of proficiency review must be in place for staff members who perform ultrasound exams and clinicians who interpret those exams.

**Standard 5.3**
Patients must be informed of the purpose and limitations of the ultrasound exam in the abortion care setting.

**Standard 5.4**
Patients must be informed of the sonographic diagnosis, including early pregnancy loss.(1, 2)

**Standard 5.5**
The findings of all ultrasound exams and the interpretation of those findings must be documented in the medical record. This documentation must also include the name(s) of staff who performed and interpreted the exam.(3)

*Recommendation 5.5.1*
Ultrasound images should be included as part of the documentation, particularly for the purposes of proficiency review.

*Recommendation 5.5.2*
A standard form for documenting findings and interpretation should be used.

**Standard 5.6**
A limited ultrasound exam must include the following:

1) a full scan of the uterus in both the transverse and longitudinal planes to confirm an intrauterine pregnancy;
2) evaluation of embryo/fetal number;
3) measurements to document gestational age;(4, 5)
4) evaluation of pregnancy landmarks, such as yolk sac or the presence or absence of fetal/embryonic cardiac activity; and
5) placental location in second trimester.

*Recommendation 5.6.1*
When clinically indicated, evaluation of other pelvic structures (i.e., adnexal structures and the cul de sac) should be performed and documented or an appropriate referral should be made for further evaluation.

**Standard 5.7**
When a patient with a prior uterine scar is found to have placenta previa or a low anterior placenta after 14 weeks, or when other placental abnormality is suspected, additional sonographic imaging should be performed on-site or an appropriate referral made.(6-8)

**Standard 5.8**
Ultrasound equipment must be properly maintained.

**Standard 5.9**
All ultrasound transducers must be disinfected between patients.

**Discussion:** Resources for ultrasound training can be found in the Learning Lab on NAF's members-only website at https://members.prochoice.org.

According to the American Institute of Ultrasound in Medicine (AIUM), in collaboration with the American College of Obstetrics and Gynecology and the American College of Radiology, a "limited ultrasound examination" is performed when a specific question requires investigation.(3, 9, 10)

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## 6. Early Medication Abortion

**Policy Statement:** Medication abortion is a safe and effective method for early abortion.(1, 2) Adequate counseling and follow-up care will enhance its safety and acceptability. Providing medication abortion by telemedicine is a safe option.(3, 4) For most patients, testing before a medication abortion, including ultrasound, is not required.(5, 6) People can safely manage early medication abortion on their own.

**Standard 6.1**
Initial evaluation must include pertinent medical history.

**Standard 6.2**
The patient must be informed about the efficacy, side effects, and risks, including excessive bleeding, infection, and teratogenicity of the medications used.(7)

*Recommendation 6.2.1*
Breastfeeding is not a contraindication to medication abortion with mifepristone and misoprostol. Patients should be informed that breastfeeding can continue uninterrupted without concern for side effects in infants.(8, 9)

> *Option 6.2.1.1*
> As appropriate, patients may be informed that no evidence-based way to reverse mifepristone exists.(10)
>
> *Option 6.2.1.2*
> Not taking an evidence-based regimen of misoprostol after mifepristone may be associated with unusual bleeding, particularly after 49 days.(11)

**Standard 6.3**
The patient must be informed that a uterine aspiration may be necessary.

**Standard 6.4**
Patient instructions must include information about use of medications at home, expected symptoms and side effects, and symptoms of abortion complications.

*Recommendation 6.4.1*
Providers should discuss what patients may see depending on gestational duration.

*Recommendation 6.4.2*
For patients who travel for abortion or are using medications prescribed through telehealth, providers should discuss how to safely seek emergency care.

**Standard 6.5**
The provider must provide an emergency contact service on a 24-hour basis to assist with further care as needed.

**Standard 6.6**
Confirmation of pregnancy must be documented with a positive pregnancy test and/or ultrasound. Pregnancy dating must be verified to be within the limits of the facility medication abortion protocol.

*Recommendation 6.6.1*
If an ultrasound has been performed and an intrauterine gestation has not been confirmed, the medication abortion regimen should be offered concurrently with evaluation for pregnancy of unknown location, as outlined in CPG Section 9 Management of Pregnancy of Uncertain Location.

**Standard 6.7**
IUDs must be removed prior to proceeding with medication abortion.

*Recommendation 6.7.1*
If an IUD cannot be removed without delaying the medication abortion, the patient should be offered a uterine aspiration.

**Standard 6.8**
An evidence-based medication abortion regimen must be used.

*Recommendation 6.8.1*
Where legally available and accessible, mifepristone and misoprostol should be used.(12-14)

*Recommendation 6.8.2*
A dose of 200mg of mifepristone is recommended for combined mifepristone-misoprostol regimens.(2)

*Option 6.8.2.1*
Mifepristone may be taken outside the clinic setting.(15)

*Recommendation 6.8.3*
For medication abortion, oral mifepristone followed by vaginal, buccal, or sublingual misoprostol 800mcg is recommended.(16-21)

*Recommendation 6.8.4*
An additional dose of misoprostol 800mcg is recommended for patients over 63 days gestational duration.(22,23)

*Recommendation 6.8.5*
More than two doses of misoprostol may be provided for patients as gestational duration increases or if a patient is remote from care (see Table 1 in the discussion).(24,25)

*Recommendation 6.8.6*
Where mifepristone is either not legally available or inaccessible, misoprostol-alone regimens or other evidence-based regimens may be offered.(24-27) See discussion for more information.

**Standard 6.9**
People can safely manage early medication abortion on their own.

*Recommendation 6.9.1*
People who self-manage abortion may need support from providers at different stages in the abortion process, including determining eligibility, understanding the regimen, accessing effective medications, and managing follow-up or complications.

*Recommendation 6.9.2*
People who self-manage abortion, along with those who support them through the process, should not be criminalized for their actions.

**Standard 6.10**
Misoprostol with or without mifepristone can be used for management of pregnancy loss.

*Recommendation 6.10.1*
Mifepristone and misoprostol are more effective than misoprostol alone for patients with an anembryonic gestation or who have embryonic or fetal demise.(28, 29)

**Standard 6.11**
Analgesia or other comfort measures must be discussed and offered as needed.

*Recommendation 6.11.1*
Non-steroidal anti-inflammatories such as ibuprofen are more effective than acetaminophen for pain control.(30)

*Recommendation 6.11.2*
The risk of routine narcotic analgesics for pain management may outweigh the benefits.(31-33)

**Standard 6.12**
Patients must be offered a follow-up assessment to confirm absence of ongoing pregnancy. Confirmation can be established by ultrasonography, hCG testing, physical exam, or self-assessment.(34, 35)

*Recommendation 6.12.1*
For people who do not want further contact with the health care provider, self-assessment of abortion outcomes may be used.

*Recommendation 6.12.2*
High-sensitivity urine hCG testing should not be checked within four weeks of medication abortion.(36)

*Option 6.12.2.1*
Multi-level or low-sensitivity urine pregnancy tests may be used.(37-39)

*Recommendation 6.12.3*
Endometrial thickness should not be used to guide management after medication abortion.(41, 42)

*Recommendation 6.12.4*
Prolonged courses of misoprostol should not be given routinely to improve success.(43)

*Option 6.12.4.1*
Additional doses of misoprostol with or without mifepristone may be given for persistent gestational sac or continuing pregnancy.(29, 44)

**Standard 6.13**
Medications dispensed and prescribed must be documented.

**Discussion:** Medication abortion regimens and follow-up have evolved rapidly over the past decade and are likely to continue to improve.

**The NAF recommended protocol for medication abortion up to 70 days gestation is 200mg mifepristone followed in 24 to 48 hours by 800mcg misoprostol buccally, vaginally, or sublingually.** For those who wish to use misoprostol less than 24 hours after mifepristone, the vaginal route is recommended. Repeat dosing of misoprostol should be considered over 63 days and is recommended over 70 days. (See Table 1) In the later first trimester, repeat doses of misoprostol are recommended. For patients with a previous uterine scar, the dose of misoprostol does not need to be adjusted. More information on medication abortion regimens and follow-up may be found in NAF's Learning Lab on the members-only site at https://members.prochoice.org.

**Table 1: Efficacy of mifepristone 200mg orally and misoprostol regimens by weeks in selected publications**

| | **Overall efficacy** | **Ongoing pregnancy** |
|---|---|---|
| **57-63 days gestation** (18) | | |
| ○ Misoprostol 800mcg buccal x 1 dose | 93.5% | 3.1% |
| **64-70 days gestation** | | |
| ○ Misoprostol 800mcg buccal x 1 dose (18) | 92.8% | 3.0% |

| | | |
|---|---|---|
| ○ Misoprostol 800mcg buccal q 4 hours x 2 doses (23) | 99.6% | 0.4% |
| **71-77 days gestation** | | |
| ○ Misoprostol 800mcg buccal x 1 dose (22) | 86.7% | 8.7% |
| ○ Misoprostol 800mcg buccal q 4 hours x 2 doses (23) | 97.7% | 1.4% |
| **78-84 days gestation** (24) | | |
| ○ Misoprostol 600 sublingually or 800mcg vaginally q 3 hours up to five doses (mean 2.32 doses) | 95% | 2% |
| **85-90 days gestation** (24) | | |
| ○ Misoprostol 600mcg sublingually or 800mcg vaginally q 3 hours up to five doses (mean 2.73 doses) | 92% | 5.1% |

Mifepristone alone is not as effective as a combined regimen and has a higher risk of ongoing pregnancy. There is no high-quality evidence that progesterone given directly after mifepristone ingestion increases the rate of ongoing pregnancy compared to no intervention.(10) A recent small randomized controlled trial of progesterone vs. placebo after mifepristone was stopped early due to bleeding requiring intervention, especially in patients over 49 days gestation.(11) Laws that require abortion providers to discuss unproven methods to interrupt the abortion process with their patients are a violation of medical ethics in that they require providers to discuss an experimental treatment with no proven benefit.

There is no evidence that mifepristone exposure has a teratogenic effect on an ongoing pregnancy.(46) Misoprostol exposure early in pregnancy doubles the risk of causing major fetal malformations in a continuing pregnancy, from approximately 2% in cases with no exposure to 4% in cases of misoprostol exposure.(47) High-dose methotrexate exposure increases the risk of malformations or pregnancy loss.(48)

If mifepristone is not available, misoprostol-only or other evidence-based regimens may be used. These regimens are all more effective when multiple doses of misoprostol are used. Prolonged follow-up may be required to reach the maximum efficacy without intervention. The efficacy of these regimens for very early pregnancy (that is, pregnancy of unknown location) and pregnancies in the later first trimester are not well studied. People who use these regimens need to understand their efficacy, side effects, and the potential exposure to known teratogens if the pregnancy continues.

Where mifepristone is not available, NAF recommends misoprostol, 800mcg sublingually every three hours for 3-4 doses for people ≤77 days LMP. An extra dose may be provided in case the patient has no bleeding or ongoing symptoms. Patient information, instructions, and a detailed sample protocol may be found on NAF's members-only site at https://members.prochoice.org.

When methotrexate and misoprostol are used, an evidence-based regimen of methotrexate 50mg oral or intramuscular followed in three to five days with misoprostol 800mcg vaginally may be used.(26, 49) Adding repeat doses of misoprostol is likely to improve the efficacy of this regimen.

When letrozole and misoprostol are used, the World Health Organization (WHO) regimen of letrozole 10mg daily by mouth x three days followed by misoprostol 800mcg sublingually on day four is recommended. Adding repeat doses of misoprostol is likely to improve the efficacy of this regimen.(50)

High-sensitivity pregnancy tests, such as those found in the pharmacy, typically detect hCG levels under 25-50mIU/mL. People should not take a high-sensitivity pregnancy test less than four weeks after medication abortion. At four weeks, approximately 20% of people with a successful medication abortion will still have a positive pregnancy test.(36) Providers should be aware that delayed assessment of completion could result in the discovery of an ongoing pregnancy in the second trimester.

If pregnancy loss is diagnosed for a patient presenting for abortion, this must be disclosed to the patient. Patients with pregnancy loss who choose medication management should be offered mifepristone pretreatment prior to misoprostol unless there is evidence the expulsion is actively underway, in which case mifepristone is unlikely to provide additional benefit. Providers can use the same medication regimen for early pregnancy loss as they would with abortion at a similar gestational age. There is limited data that misoprostol may be optimally effective 7-20 hours post mifepristone pre-treatment for early pregnancy loss, and waiting 24 hours may not have added benefit.(51)

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## 7. Providing Abortion Medications Without a Positive Pregnancy Test

**Policy Statement:** Providers can prescribe and dispense abortion medications for patients who are at risk for pregnancy for future use (advance provision) or for use in the setting of suspected, but not confirmed, pregnancy (menstrual regulation or "missed period pills"). Once the patient either confirms or suspects they are pregnant and uses medication abortion, the guidelines in CPG 6 for Early Medication Abortion apply.

**Standard 7.1**
Prior to prescribing and dispensing medication, the patient must be evaluated, either in-person or remotely, and eligibility for medication abortion must be confirmed.

**Standard 7.2**
The patient needs to be informed about the appropriate time to take medications in relationship to their pregnancy dating, the efficacy, side effects, and risks of medication abortion. They must be instructed on how to use the medications and symptoms of abortion complications.

*Recommendation 7.2.1*
The patient can contact the provider once they decide to use medications to review dating, eligibility, the medication abortion process, and follow-up.

*Recommendation 7.2.2*
The provider must offer a follow-up assessment for those who decide to take the medications and want further assessment.

**Discussion**: Advance provision or "missed period pills" may be acceptable to people who want medication abortion on hand, but there is, as yet, little evidence to show how frequently pills dispensed in this manner are used, and the efficacy and safety of this mode of abortion provision.(1-4)

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## 8. Procedural Abortion by Aspiration Alone

**Policy Statement:** Procedural abortion by aspiration is one of the safest procedures in medicine. The following guidelines are intended to outline steps that maximize this safety.

**Standard 8.1**
Pertinent medical history must be obtained.

**Standard 8.2**
Pregnancy must be confirmed, and gestational age must be assessed.

*Recommendation 8.2.1*
When gestational age cannot be reasonably determined by other means, ultrasonography should be used.

**Standard 8.3**
Appropriate initial evaluation must be performed. Baseline blood pressure and pulse must be obtained for all patients.

*Recommendation 8.3.1*
Physical exam should be done as indicated by medical history and patient symptoms.

*Recommendation 8.3.2*
Weight and/or BMI alone are not contraindications to procedural abortion.

**Standard 8.4**
The cervix should be appropriately dilated for the gestational age.

*Recommendation 8.4.1*
Cervical dilation may be achieved through the use of rigid cervical dilators. Tapered dilators such as Pratt or Denniston dilators are recommended over non-tapered dilators such as Hegar dilators.(1)

*Recommendation 8.4.2*
When cervical preparation with misoprostol is used, an evidence-based regimen should be followed.(2-5)

> *Option 8.4.2.1*
> The routine use of misoprostol before procedures may reduce rare complications but must be balanced against increased pain and other side effects for all patients.(5)
>
> *Option 8.4.2.2*
> Osmotic dilators may be considered when cervical dilation is expected to be difficult.(6)

**Standard 8.5**
First-trimester abortion procedures must be performed by aspiration of the uterus, not by sharp curettage.(7-9)

*Recommendation 8.5.1*
Uterine aspiration is effective throughout the first trimester including prior to confirmation of a definitive intrauterine pregnancy on ultrasound.(10)

*Recommendation 8.5.2*
Sharp curettage should not be routinely used after uterine aspiration.

*Recommendation 8.5.3*
Uterotonics should not be used routinely after first-trimester uterine aspiration.(11)

**Discussion:** No evidence supports the routine use of sharp curettage or any uterotonic after first-trimester uterine aspiration.

Cervical preparation has limited effectiveness and is not needed before a routine first-trimester abortion. Its use must be balanced against the prolonged time in the facility, side effects, and patient satisfaction. If misoprostol is used for cervical preparation, an evidence-based regimen is misoprostol 400mcg buccally, vaginally, or sublingually, one to three hours prior to the abortion procedure.(4, 5)

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## 9. Management of Pregnancy of Uncertain Location

**Policy Statement:** Many patients seek care very early in pregnancy before an intrauterine pregnancy can be visualized on ultrasound.(1, 2) When a patient has a positive pregnancy test and pregnancy of uncertain location, the most common diagnosis is an intrauterine pregnancy, but the possibility of ectopic pregnancy must be considered. For these patients, abortion care should be offered, and the patient must be followed to ensure that the pregnancy has ended. If abortion care is delayed allowing for visualization of pregnancy on ultrasound, the patient must be evaluated by a clinician, ectopic precautions must be given, and a plan for follow-up must be made.

**Standard 9.1**
The patient must be evaluated by a clinician to assess for the risk of ectopic pregnancy in pregnancy of uncertain location.(3-5)

*Recommendation 9.1.1*
Evaluation should involve assessment of the history in combination with one or more of the following: physical exam, sonography, serial quantitative hCG, and/or uterine aspiration.(6)

*Recommendation 9.1.2*
Abortion care should be offered even if pregnancy location is uncertain.(7-9)

**Standard 9.2**
Each facility must have a written protocol to evaluate pregnancy of uncertain location. All relevant staff at the site must be familiar with the protocol.

*Recommendation 9.2.1*
This protocol may include referrals as appropriate.

**Standard 9.3**
All patients with a pregnancy of uncertain location must be informed of the options for evaluation and management. The symptoms and dangers associated with ectopic pregnancy, and a plan for when and how to seek emergency medical attention must be reviewed and documented.

*Recommendation 9.3.1*
Each facility should have a patient education handout describing ectopic warning signs and the medical record should reflect that the patient has received this handout.

**Standard 9.4**
When a medication or aspiration abortion is initiated for a patient with a pregnancy of uncertain location, resolution of the pregnancy must be verified and documented. This may be demonstrated by either the examination of aspirated tissue or by following serial serum beta-hCG levels according to evidence-based regimens.

*Recommendation 9.4.1*
Where it is not possible to follow serial serum beta-hCG levels, urine pregnancy testing may be used.(10)

**Standard 9.5**
When an intrauterine pregnancy cannot be definitively seen on ultrasound, a clinician must review the patient's history, ultrasound images, and signs and symptoms of ectopic pregnancy. A clinician must discuss the risks and warning factors for ectopic pregnancy with the patient.

> *Option 9.5.0.1*
> Serum beta-hCG levels may be used to determine whether a patient is at elevated risk of ectopic pregnancy and needs immediate evaluation if abortion care is deferred.

**Standard 9.6**
Patient follow-up must continue until one of the following:
1. the diagnosis of ectopic pregnancy has been excluded;
2. clinical resolution of a pregnancy of uncertain location has been ensured; or
3. transfer of care to an appropriate provider has been made and documented.

**Standard 9.7**
Patients experiencing symptoms suspicious for ectopic pregnancy must be evaluated emergently.

**Discussion:** Treatment of pregnancy of uncertain location is not the same as "no-test" abortion. Pregnancy of uncertain location describes a situation in which an ultrasound is performed, and an intrauterine pregnancy is not visualized. "No-test abortion" describes a situation in which a patient has a certain or estimated last menstrual period, is otherwise eligible for abortion care, and ultrasound is not used prior to abortion.(11, 12)

Although the majority of patients who present with a low-risk pregnancy of uncertain location (that is, known early LMP, no history of ectopic pregnancy or significant risk factors, no signs and symptoms of ectopic pregnancy) will have an intrauterine pregnancy, ectopic pregnancy is more common in patients with a pregnancy of uncertain location compared to the general population of abortion seekers and needs to be assessed as the abortion proceeds. Providing abortion care to patients with pregnancy of uncertain location will decrease the time to definitive diagnosis of ectopic while at the same time providing most patients with a successful abortion.(1, 2) Abortion care, along with a combination of clinical assessment, pelvic ultrasound, serum quantitative hCG, urine hCG, and/or examination of uterine aspirate can be used to distinguish between an intrauterine and an ectopic pregnancy.(3)

Following medication abortion, hCG can be used to rule out ectopic pregnancy while simultaneously evaluating success of the medication abortion.(1, 2) When medication

abortion is initiated and no pregnancy is visible on ultrasound, patients should understand that the risk of ectopic pregnancy may be higher than the general population of abortion seekers, and the risk of medication abortion failure is higher. As such, follow-up is essential.

For more information and protocols for management of pregnancy of uncertain location, as well as information on diagnosis of early pregnancy on ultrasound, please visit NAF's members-only website at https://members.prochoice.org and access the Learning Lab.

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## 10. Procedural Abortion by Dilation and Evacuation

**Policy Statement:** Abortion by dilation and evacuation (D&E) is a safe outpatient procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.(1-6)

**Standard 10.1**
Pertinent medical history must be obtained, and relevant physical examination must be performed.

*Recommendation 10.1.1*
Weight and/or BMI alone are not contraindications to D&E.(7-9)

**Standard 10.2**
Gestational age must be verified by ultrasonography, using a consistent and published table of fetal measurements, prior to the termination of a pregnancy clinically estimated to be more than 14 weeks from LMP.

**Standard 10.3**
The patient must be appropriately evaluated and prepared for the procedure.

*Recommendation 10.3.1*
Intravenous access should be established prior to evacuation.

*Recommendation 10.3.2*
When induced fetal demise is used, it should be provided through an evidence-based protocol.(10-16)

*Recommendation 10.3.3*
In a patient with a prior uterine scar, after appropriate evaluation to exclude placenta accreta spectrum, the patient may have a procedure in the outpatient setting.(17)

*Recommendation 10.3.4*
Patients should be given anticipatory guidance on breast symptoms after later abortion or pregnancy loss.

> *Option 10.3.4.1*
> Cabergoline, 1mg orally x one dose may be used immediately after the procedure to reduce breast symptoms and lactation for those who want it.(18)

**Standard 10.4**
When cervical preparation agents are used overnight or outside the facility, a plan for emergency care must be in place and communicated to the patient.

**Standard 10.5**
Appropriate dilation of the cervix must be obtained gently and gradually.(19, 20)

*Recommendation 10.5.1*
Osmotic dilators, misoprostol, mifepristone, transcervical catheter, and/or other cervical preparation agents should be used to facilitate adequate dilation.(21-25)

*Recommendation 10.5.2*
Local anesthesia should be used for pain management with osmotic dilator placement.(26, 27)

*Recommendation 10.5.3*
An evidence-based regimen should be used for dosage, timing, and route of misoprostol.(22-24, 28-32)

*Option 10.5.0.1*
Synthetic osmotic dilators or a foley/Cook catheter and/or misoprostol may be used for same-day cervical dilation.(25, 28, 30, 33)

**Standard 10.6**
All instruments entering the uterine cavity must be sterile.

**Standard 10.7**
Evidence-based practices must be used to lower the risk of complications.

*Recommendation 10.7.1*
Intra-procedure ultrasonography should be used to aid in visualizing instruments, locating fetal parts, verifying an empty uterus, reducing the risk of uterine perforation, and shortening the procedure.(34-36)

*Recommendation 10.7.2*
Inhaled anesthesia should be avoided if possible due to the increased risk of hemorrhage.(37, 38)

**Standard 10.8**
Uterotonics must be available to aid in control of uterine bleeding.(17)

*Option 10.8.0.1*
An intra- or paracervical prophylactic vasoconstrictor can be used to reduce blood loss.(39)

**Discussion:** Cervical preparation before dilation and evacuation can be achieved with multiple agents either alone or in combination. Misoprostol is commonly used, with a dose of 400mcg supported by most studies.(40)

Induced fetal demise should be provided using an evidence-based regimen. A sample protocol for digoxin injection is available on the NAF members-only site at https://members.prochoice.org. Intraamniotic or intrafetal digoxin may be used.(41, 42) Intracardiac potassium chloride or lidocaine may also be used.(11, 16, 43) Injections may be done either transabdominally or transvaginally.(44, 45) Cord transection may also be used.(46)

Prophylactic use of methergine for prevention of postabortion hemorrhage is not recommended.(47) Prophylactic pitocin for procedures between 18-24 weeks gestation may be considered.(49)

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## 11. Medication Abortion After the First Trimester

**Policy Statement:** Medication abortion is a safe and effective method for termination of pregnancies beyond the first trimester when performed by trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals. Induced fetal demise may be particularly important at later gestational ages.

**Standard 11.1**
Pertinent medical history must be obtained, and relevant physical examination must be performed.

**Standard 11.2**
Gestational age must be verified by ultrasonography, using a consistent and published table of fetal measurements, prior to the termination of a pregnancy clinically estimated to be more than 14 weeks from LMP.

**Standard 11.3**
The patient must be appropriately evaluated and prepared.

*Recommendation 11.3.1*
Intravenous access should be established.

*Recommendation 11.3.2*
Patients should be given anticipatory guidance on breast symptoms after later abortion or pregnancy loss.

> *Option 11.3.2.1*
> Cabergoline, 1mg orally x one dose may be used immediately after the abortion to reduce breast symptoms and lactation for those who want it.(1)

**Standard 11.4**
Facilities must have a policy that addresses whether and when to induce fetal demise.

*Recommendation 11.4.1*
When induced fetal demise is used, it should be provided through a standard protocol.(2-9)

**Standard 11.5**
Evidence-based regimens of medication abortion must be used.

*Recommendation 11.5.1*
Mifepristone 200mg followed in 24 to 48 hours by repeat doses of misoprostol should be used, when available and feasible.(10-13)

*Option 11.5.1.1*
Simultaneous or short interval administration of mifepristone and repeat doses of misoprostol may also be used.(14)

*Option 11.5.1.2*
Repeat dosing of misoprostol may also be used alone.(15)

*Option 11.5.1.3*
Oxytocin may be used according to a protocol.

*Option 11.5.1.4*
Osmotic dilators may be useful at later gestations.(16-18)

*Recommendation 11.5.2*
Intraamniotic injection or instillation methods should be avoided as they are less effective and result in more complications than mifepristone-misoprostol or misoprostol-alone regimens.(19)

**Standard 11.6**
Once regular contractions have been confirmed, patients must be observed by health care staff trained to monitor contractions and expulsion, and who can recognize emergent situations.

**Standard 11.7**
A trained clinician must be available from initiation of induction until post-abortion discharge.

**Standard 11.8**
Access to surgical management or appropriate referral must be available if surgical intervention is required.

**Standard 11.9**
The facility and/or clinician should continue care of the patient until completion of the abortion or transfer of care to an appropriate provider is made.

**Discussion:** Evidence-based regimens for later medication abortion are difficult to compare. Mifepristone increases the efficacy and decreases the total time and doses needed for misoprostol to cause pregnancy expulsion. Misoprostol dosing can be repeated until expulsion with no limit on the number of doses**. For abortion over 12 weeks LMP, the WHO recommends a regimen of mifepristone 200mg orally followed in one to two days by misoprostol, 400mcg buccally, vaginally, or sublingually every four hours until pregnancy expulsion**.(20) The dosage of misoprostol may be adjusted as the pregnancy progresses or with previous cesarean section; however, when those adjustments need to be made is not well established. The risk of uterine rupture during later medication abortion with misoprostol may be

significantly increased for patients with two or more previous cesarean sections, however, the absolute risk remains low.(21) The risks should be balanced with alternative procedures for later abortion.

Caution should be used with osmotic dilators in the second trimester as they may prolong the induction time.(16-18)

Induced fetal demise should be provided using an evidence-based regimen. A sample protocol for digoxin injection is available on NAF's members-only site at https://members.prochoice.org. Intraamniotic or intrafetal digoxin may be used.(22) Intracardiac potassium chloride or lidocaine may also be used.(7-9) Injections may be done either transabdominally or transvaginally.(23)

Uterine curettage or aspiration should not routinely be performed.

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## 12. Analgesia and Sedation

**Policy Statement:** Anxiolysis, analgesia, or anesthesia should be provided during abortion procedures for any patient for whom the benefits outweigh the risks, with the aim of providing the appropriate level of analgesia and sedation required for each patient's needs. Patients should be involved in a shared decision-making process about pain control and sedation during the procedure.

Implicit and explicit bias causes providers to undertreat pain for specific populations, including Black, Indigenous, and people of color, and people with substance use disorders.(1-3) All people seeking abortion care are entitled to adequate pain management.

ON THE USE OF SEDATION IN GENERAL - All medications used in procedural sedation have the potential for serious risk. This risk may be reduced to a minimum by adherence to established practice guidelines. Guidelines developed by other organizations concern themselves with anesthesia and sedation delivered primarily in hospital settings and to patients varying widely in age and general health. Regardless of the drug or route of administration, the degree of central nervous system (CNS) depression is the basis for the NAF guidelines.

These guidelines do not address the use of deep sedation or general anesthesia except to identify basic monitoring practices and appropriate providers of such care, who are expected to follow their professional standards in the delivery of anesthesia services. It is expected that those individuals providing deep sedation or general anesthesia will have appropriate emergency medication and equipment in place to ensure the safe care of a patient in the event of an anesthesia complication.

The promulgation of guidelines for the delivery and monitoring of anesthesia care issued by organizations such as the American Society of Anesthesiologists (ASA), the Canadian Anesthesiologists' Society (CSA), the American Dental Society of Anesthesiologists (ADSA), American Society for Gastrointestinal Endoscopy (ASGE), and others have clarified many of the issues related to anesthesia care.

Patient comfort and reduced anxiety are significantly affected by patient counseling and by the presence of family, friends, and supportive staff, and are not solely dependent on pharmacologic measures. Alternative modalities (such as relaxation techniques, acupuncture, hypnosis) may be helpful for some patients. The focus of NAF guidelines for analgesia and sedation, however, is on the safe provision of pharmacologic methods generally used in outpatient abortion facilities.

**Definitions**(4)

1. Local Anesthesia - Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, local anesthesia almost always involves a paracervical block.

2. Minimal Sedation (Anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, ventilatory, and cardiovascular functions are unaffected.

3. Moderate Sedation/Analgesia - A drug-induced depression of consciousness during which patients respond purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained but may be impaired. This level of sedation was previously referred to as "Conscious Sedation." However, this term is no longer recommended.

4. Deep Sedation/Analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained but may be impaired.

5. General Anesthesia - A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce any level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. *Rescue* corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation.

**Standard 12.1**
Pain control options must be discussed with the patient.

*Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

**Standard 12.2**
When minimal, moderate, deep sedation, or general anesthesia is to be given, patients must be given information about the risks, benefits, and side effects of the medications to be used.

*Recommendation 12.2.1*
Documentation should include precautions relevant to transient mental impairment.

*Option 12.2.0.1*
An informed consent form specific for analgesia and sedation may be used.

**Standard 12.3**
Levels of sedation depend on the patient response, not the route of drug administration. Oral anxiolytics and analgesics given in combination can cause moderate sedation for some patients.

**Standard 12.4**
The amount of anesthesia given depends on the desired level of sedation and the individual patient response. Patient characteristics such as age, race, parity, body size, weight, or current or past substance use disorder, and use of medication for opioid use disorder should not be used to limit appropriate anesthesia and analgesia.

**Standard 12.5**
Prior to moderate sedation, a pre-sedation evaluation of the patient must take place.

*Recommendation 12.5.1*
Evaluation should include a relevant history and review of systems; medication review; targeted exam of the heart, lung, and airway as indicated by the patient's history and review of systems; and baseline vital signs.

*Recommendation 12.5.2*
For patients receiving moderate sedation who are not at increased risk of aspiration, time from last meal should not limit access to abortion care.(5-7)

*Recommendation 12.5.3*
A reduced level of sedation, an alternate abortion procedure, or provision of care by an anesthesia professional should be considered for patients with an atypical airway assessment or ASA Physical Status Classification 3 or greater.(8, 9)

**Standard 12.6**
No additional evaluation is needed prior to paracervical block and/or NSAID administration.

**Standard 12.7**
The supervising practitioner must be immediately available when sedation is administered.

**Standard 12.8**
When local anesthesia or sedation is provided, the practitioner responsible for the treatment of the patient and/or the administration of drugs must be appropriately trained, with approval by the medical director or their designee.(9, 10)

**Standard 12.9**
To administer moderate sedation, a provider must have the following: licensure as appropriate, basic airway skills, the ability to monitor and effectively rescue patients in an emergency, and the ability to screen patients appropriately for sedation.

**Standard 12.10**
The potential need for intravenous access must be considered prior to administering any level of sedation.

*Recommendation 12.10.1*
When more than minimal sedation is intended, intravenous access should be maintained at least until discharge criteria are met.

**Standard 12.11**
Pulse oximetry, with appropriate alarms, must be employed when moderate or deeper levels of sedation are used.

**Standard 12.12**
When sedation is provided, monitoring must be adequate to detect the respiratory, cardiovascular, and neurological effects of the drugs being administered, and this monitoring must be documented.

*Recommendation 12.12.1*
The patient should be checked frequently for verbal responsiveness.

**Standard 12.13**
When moderate sedation or deeper is provided, a person other than the clinician performing the procedure, and who is trained to monitor appropriate physiological parameters, must be present. This person must not be performing duties other than monitoring the patient.(9)

## Moderate Sedation

**Standard 12.14**
When moderate sedation is intended, sedation medication must be started at a reasonable low dose and titrated as needed, based on individual circumstances, such as weight and drug tolerance.(11-13)

*Recommendation 12.14.1*
The following table should be used for guidance for these commonly used drugs when used for moderate sedation. Similar ranges of other opioids and benzodiazepines may be used.

*Option 12.14.1.1*
A regimen that includes ketamine may be used as an alternative or in conjunction with opioids for moderate sedation. Please see discussion for more information.(14)

| Drug | Usual initial dose | Max initial dose | Usual incremental Dose | Max incremental Dose |
|---|---|---|---|---|
| Fentanyl | 50-100mcg | 200mcg | 50-100mcg | 100mcg |
| Midazolam | 1-3mg | 4mg | 1-2mg | 2mg |
| Ketamine (when used with fentanyl) | 10mg | 20mg | 10mg | 20mg |
| Ketamine (when used without fentanyl) | 20mg | 20mg | 10mg | 20mg |

**Standard 12.15**
When moderate sedation is administered, at least one individual with documented airway skills must be present in the procedure room.

## Deep Sedation or General Anesthesia

**Standard 12.16**
Supplemental oxygen must be used with deep sedation and general anesthesia.

**Standard 12.17**
The practitioner administering deep sedation or general anesthesia must not be the practitioner performing the abortion.

*Recommendation 12.17.1*
For deep sedation and general anesthesia, the following should be monitored: continuous pulse oximetry, intermittent blood pressure, and respiration, either by measuring end-tidal $CO_2$ or clinical observation.

*Recommendation 12.17.2*
The capability to monitor temperature should be available.

**Standard 12.18**
Any individual responsible for administering, supervising, or monitoring a patient receiving any level of sedation must have current, health care provider level basic life support (BLS) certification.

**Standard 12.19**
The practitioner administering deep sedation or general anesthesia must adhere to established professional standards of care.(15)

## Nitrous Oxide

**Standard 12.20**
$N_2O$ must be self-administered by the patient or by a qualified anesthesia provider.

*Recommendation 12.20.1*
$N_2O$ may be an alternative to local or oral sedation but is less effective for pain management than moderate intravenous sedation.(16, 17)

**Standard 12.21**
If not self-administered, the provision of $N_2O$ must follow guidelines for patient monitoring for moderate sedation.

**Standard 12.22**
Equipment for the delivery of $N_2O/O_2$ must:
1) provide a concentration of $N_2O$ of no more than 70% inspired;
2) provide a minimum of 30% $O_2$; and
3) be checked and calibrated regularly.

*Recommendation 12.22.1*
The concentration of nitrous oxide should not routinely exceed 50% in the absence of qualified anesthesia personnel.

*Recommendation 12.22.2*
Equipment for the delivery of $N_2O/O_2$ should include an oxygen analyzer.

*Recommendation 12.22.3*
Due to the potential for occupational exposure, room or personnel monitoring for levels of $N_2O$ should be conducted.

## Emergency Equipment

**Standard 12.23**
Functioning equipment and current medications must be available on-site to handle medical emergencies and must include: an oxygen delivery system, oral airways, epinephrine, and antihistamines.

**Standard 12.24**
In settings where benzodiazepines and opioids are used, appropriate antagonists, bronchodilators, and bag-valve masks capable of delivering supplemental oxygen must be available.

*Recommendation 12.24.1*
Facilities should have a specified area for emergency equipment, which includes oxygen, medications, and supplies. A protocol and time schedule for checking equipment and removing expired medications must be in place.

**Standard 12.25**
In settings where deep sedation and general anesthesia are used, it is expected that providers maintain the appropriate medication and equipment required for an anesthesia emergency.

*Recommendation 12.25.1*
A defibrillator should be available.

**Discussion:** The time of last food intake does not increase the risk of moderate sedation.(4-7)

ON THE USE OF $N_2O/O_2$ - Nitrous oxide has a long history of use for analgesia and sedation, as well as an excellent safety record in the hands of both anesthesiologists and non-anesthesiologists. Occupational exposure to $N_2O$ has been associated with increased risks of neurologic impairment, spontaneous abortion, subfertility, and hepatic and renal disease. Recommendations for safe use of nitrous oxide can be found in the reference section. In addition to employing adequate ventilation and scavenger systems, it is also recommended to deliver 100% oxygen to the patient for five minutes before removing the mask. This will purge the system, and the patient, of any residual nitrous oxide. Occupational exposure can be monitored by asking staff members to wear personal dosimetry badges or by placing an infrared spectrophotometer in the room. Although there is no OSHA standard for $N_2O$, NIOSH recommends that airborne levels of $N_2O$ be kept below 25 ppm through well-designed scavenger systems and other engineering controls, equipment maintenance, exposure monitoring, and safe work practices.

Ketamine offers an alternative or addition to opioid containing regimens for intravenous moderate sedation. Ketamine is effective in patients with opioid use disorder, allows

clinicians to use a lower dose of opioids in combined regimens, and has a reduced risk of respiratory depression.(14, 18) Ketamine, whether used alone or with an opioid, needs to be combined with a benzodiazepine to prevent adverse side effects, particularly dysphoria and hallucinations. When ketamine is used without an opioid, a higher or repeated dose of benzodiazepine may be required to prevent hallucinations.

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## 13. Post-Procedure Care

**Policy Statement:** Appropriate and accessible post-procedure and follow-up care is essential to patients' wellbeing.

**Standard 13.1**
Patients who want contraception must receive their chosen method immediately following an abortion or appropriate referral should be made.

*Recommendation 13.1.1*
When desired by the patient, intrauterine contraception or contraceptive implants should be initiated immediately after first-trimester uterine evacuation or second-trimester D&E.(1-3)

*Recommendation 13.1.2*
When desired by the patient after medication abortion, intrauterine contraception should be initiated as soon as expulsion of the pregnancy is confirmed.(4-6)

*Recommendation 13.1.3*
When desired by the patient, contraceptive implants should be initiated on the day of mifepristone administration for medication abortion.(7-10)

> *Option 13.1.3.1*
> Depot Medroxyprogesterone acetate (Depo-Provera®) may be given at the time of mifepristone with appropriate counseling.(10-12)

*Recommendation 13.1.4*
Emergency contraception should be discussed and either dispensed or prescribed to patients who want it.

**Standard 13.2**
All patients receiving more than minimal sedation or in the second trimester must be continuously observed during the recovery period by a health care worker trained in post-procedure care.

**Standard 13.3**
Patients who received moderate or deeper sedation must be monitored until determined to be no longer at risk for hemodynamic instability or respiratory depression.

*Recommendation 13.3.1*
A pulse oximeter with alarms should be used until the patient is alert and ambulatory.

**Standard 13.4**
A clinician must remain in the facility until all patients are medically stable.

**Standard 13.5**
The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

**Standard 13.6**
The patient must be given oral and written instructions outlining what to expect post-procedure, self-care, and signs and symptoms of complications.

*Recommendation 13.6.1*
Patients who receive sedation should have access to this information prior to the administration of medication.

**Standard 13.7**
The facility must provide an emergency contact service on a 24-hour basis, where calls are triaged in accordance with written policies. A recorded message alone is unacceptable.

**Standard 13.8**
Any non-clinician involved with first-call triage must be trained to take a post-abortion health history and follow clear written guidelines indicating when immediate consultation with a clinician is indicated.

**Standard 13.9**
Any patient who gives a history suggestive of a post-procedure complication must have access to a clinician. The facility must establish a pathway for physician referral if indicated.

*Recommendation 13.9.1*
Uterotonic agents should be given as indicated and not on a routine basis. When used, an evidence-based regimen should be followed.

> *Option 13.9.1.1*
> Routine post-procedure follow-up is not required. Clinicians may offer a visit for patients who would like one.(13, 14)

**Discussion:** A recent study shows that Depot Medroxyprogesterone acetate (DMPA) (Depo-Provera®) given on the day of mifepristone may increase the risk of continuing pregnancy but does not increase the risk of needing aspiration to complete the abortion compared to when it is given at a follow-up visit.(12) Patient satisfaction is higher with immediate DMPA, but six-month use rates and pregnancy rates are the same due to high rates of discontinuation. If a patient understands the potential risk of ongoing pregnancy, DMPA may be offered and given at the time of mifepristone. DMPA given in the 24-48 hours after mifepristone, on the day of misoprostol, does not affect the rate of continuing pregnancy.(15)

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## 14. Evaluation of Evacuated Uterine Contents

**Policy Statement:** Identification of appropriate products of conception (POC) following evacuation abortion procedures confirms termination of an intrauterine pregnancy.

**Standard 14.1**
Termination of pregnancy must be confirmed prior to the patient leaving the facility or further evaluation must be initiated.

*Recommendation 14.1.1*
Evacuated uterine contents should be examined before the patient leaves the facility.

*Recommendation 14.1.2*
In first-trimester terminations, flotation of tissue should be used to identify products of conception, including gestational sac.

> *Option 14.1.2.1*
> Backlighting of tissue may be useful.
>
> *Option 14.1.2.2*
> Sending the evacuated uterine contents for additional pathological examination is not required.(1, 2)

**Standard 14.2**
In the first trimester, when insufficient tissue or incomplete products of conception are obtained, the patient must be reevaluated.

*Recommendation 14.2.1*
Re-aspiration, serial quantitative hCG, and/or ultrasonographic examination should be considered.(3-5)

*Recommendation 14.2.2*
Ectopic pregnancy should be considered.

**Standard 14.3**
After the first trimester, examination of the uterine contents must be performed to identify the placenta and all major fetal parts.

*Recommendation 14.3.1*
If the above are not identified, ultrasonographic evaluation and uterine exploration under ultrasound guidance should be considered.

*Recommendation 14.3.2*
The facility and/or clinician should continue care of the patient until completion of the abortion or transfer of care to an appropriate provider is made.

**Discussion:** One option for additional evaluation if sufficient POC are not identified is the use of serum quantitative hCG tests. A baseline hCG can be drawn and a second hCG can be done in 24-48 hours. If there is a decrease of 50% or more, no further ectopic follow-up is necessary. Otherwise, further evaluation should be initiated including consideration of ectopic pregnancy. In this situation, Section 9 (Management of Pregnancy of Uncertain Location) may be useful.

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## 15. Emergency Procedures

**Policy Statement:** Appropriate management of abortion emergencies reduces morbidity and mortality. Hemorrhage can be one of the most serious immediate complications of an abortion procedure. Early recognition of the source of bleeding can reduce morbidity and mortality. Uterine perforation is a complication of abortion that can lead to significant morbidity. Morbidity is related to site of perforation, instrumentation, and gestational age.

**Standard 15.1**
Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance (e.g., an ambulance).

*Recommendation 15.1.1*
Protocols for the following topics should be in place: bleeding, perforation, respiratory arrest/depression, anaphylaxis, and emergency transfer.

*Recommendation 15.1.2*
Staff should review protocols annually.

> *Option 15.1.2.1*
> Annual drills of the emergency protocols are encouraged.

*Recommendation 15.1.3*
Clinics should consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care.

**Standard 15.2**
All staff must know their appropriate roles in the management of medical emergencies.

**Standard 15.3**
Emergency supplies must be in known, appropriate locations and regularly updated.

**Standard 15.4**
When abortion procedures are being performed, at least one medical staff member with health care provider level basic life support (BLS) training must be present.

*Recommendation 15.4.1*
All medical staff providing direct patient care should have current health care provider level BLS certification.

**Standard 15.5**
All facilities must have a protocol for the management of acute hemorrhage.(1) This protocol must address the following items:

1) establishment of intravenous access;
2) administration of uterotonics;
3) evaluation of the cause and/or source of bleeding; and
4) criteria for hospital transfer.

**Standard 15.6**
The facility must have at least two uterotonics and/or mechanical methods of controlling bleeding.

**Standard 15.7**
If a perforation occurs or is suspected, even if the patient is asymptomatic, a protocol must address the following items:

1) establishment of intravenous access;
2) additional observation;
3) plan for follow-up including plans for completing the abortion if needed; and
4) criteria for transfer to a hospital such as the following:
    a. intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination;
    b. fetal parts are detected in the abdominal cavity;
    c. expanding intra-abdominal or retroperitoneal hematoma is detected; or
    d. hemodynamic instability is present.

*Recommendation 15.7.1*
If the procedure is completed after a suspected perforation, uterine evacuation should be performed under direct ultrasound guidance or laparoscopic visualization.(2, 3)

**Discussion:** Excessive bleeding during the procedure and in the post-procedure period is almost always due to uterine atony, often caused by incomplete emptying of the uterus. Therefore, the most important initial efforts should be directed at assuring complete evacuation of the uterus and at increasing uterine tone through uterotonics or uterine massage. Problems arise when bleeding is ignored, or its severity underestimated. Clinicians must always remember to do the simple things when confronted with a developing bleeding problem: continue assessment of the blood loss, measure and record vital signs frequently, and assure intravenous access.

The following measures may be used for treatment of post-abortion hemorrhage:

1) uterine massage;
2) methylergonovine (Methergine);
3) oxytocin (Pitocin);
4) vasopressin (Vasostrict);
5) misoprostol (Cytotec);
6) carboprost tromethamine (Hemabate);

7) Tranexamic acid;(4)
8) intrauterine pressure using a Foley or Bakri balloon or vaginal pack; or
9) uterine re-aspiration.

When bleeding continues after assurance of complete uterine emptying and when there are no visible cervical or vaginal lacerations, the clinician must consider other complications such as perforation, coagulopathy, or placenta accreta. The patient may need immediate transfer to manage these conditions.

Perforations are often occult and may be difficult to identify.(5-7) If a perforation is suspected, it is safest to proceed as if there has been a perforation.

*In the first trimester,* perforations are often asymptomatic and self-healing.(8, 9) Most perforations are midline and/or fundal in location.(10) If they occur before suction, these usually can be managed with observation and close follow-up.(9) A lateral perforation may involve uterine blood vessels and, if so, will be more significant.

*In the second trimester,* even an asymptomatic perforation may warrant transfer to a hospital for evaluation depending on the instrumentation involved.(11, 12) There may be more significant morbidity due to increased uterine blood flow and the use of larger grasping instruments.

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NATIONAL
ABORTION
FEDERATION

| NAC/TAG | Nevada Regulation Text | NAF CPG Text |
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| **NAC 449.99942**<br><br>O0010 | **Permitting**<br><br>**Application; general requirements; proof of national accreditation; fee; period for validity; application required for each location.** (NRS 449.442, 449.443, 449.448)<br>1. Before offering to a patient a service of general anesthesia, conscious sedation or deep sedation, an outpatient facility shall submit to the Division of Public and Behavioral Health an application for a permit to offer those services at the outpatient facility on a form prescribed by the Division of Public and Behavioral Health. | N/A |
| O0011 | 2. An application for a permit must:<br>(a) Be complete and notarized. | N/A |
| O0011 | (b) Be accompanied by the appropriate application fee as prescribed in subsection 3. | N/A |
| O0011 | (c) Include:<br>(1) The name of the applicant and, if a natural person, evidence that the applicant has attained the age of 21 years. | N/A |
| O0011 | (2) The location of the outpatient facility. | N/A |
| O0011 | (3) In specific terms, the nature of services and type of care to be offered. | N/A |
| O0011 | (4) The name of the person in charge of the outpatient facility. | N/A |
| O0011 | (5) Such other information as may be required by the Division of Public and Behavioral Health for the proper administration and enforcement of NRS 449.435 to 449.448, inclusive, and NAC 449.9994 to 449.999489, inclusive. | N/A |
| O0011 | (6) Evidence satisfactory to the Division of Public and Behavioral Health that the applicant is of reputable and responsible character. If the applicant is a firm, association, organization, partnership, business trust, corporation or company, similar evidence must be submitted as to the members thereof, and the person in charge of the outpatient facility for which application is made. If the applicant is a | N/A |

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| | political subdivision of the State or other governmental agency, similar evidence must be submitted as to the person in charge of the outpatient facility for which application is made. | |
| O0011 | (7) Evidence satisfactory to the Division of Public and Behavioral Health of the ability of the applicant to comply with the standards and regulations adopted by the Board. | N/A |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0011 | (8) Evidence satisfactory to the Division of Public and Behavioral Health that the outpatient facility (I) Conforms to the zoning regulations of the local government within which the outpatient facility will be operated; or | N/A |
| O0011 | (II) Has applied for an appropriate reclassification, variance, permit for special use or other exception for the outpatient facility. | N/A |
| O0011 | (d) Be accompanied by: (1) Except as otherwise provided in subparagraph (2), proof of accreditation by a nationally recognized organization approved by the Board pursuant to NAC 449.999424; or | N/A |
| O0011 | (2) If the application is for an initial permit, evidence that the outpatient facility has applied for accreditation by a nationally recognized organization approved by the Board pursuant to NAC 449.999424. | N/A |
| O0012 | 3. An applicant for a permit must pay to the Division of Public and Behavioral Health a nonrefundable fee of $3,570. | N/A |
| O0013 | 4. An application for a permit is valid for 1 year after the date on which the application is submitted. If an applicant does not meet the requirements for a permit within 1 year after the date on which the application was submitted, the applicant must submit a new application and pay the required fee to be considered for a permit. | N/A |
| O0014 | 5. An application for a permit must be submitted for each location of the outpatient facility where a service of general anesthesia, conscious sedation or deep sedation will be offered. | N/A |

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| **NAC 449.999421**<br><br>O0020 | **Inspection by Division of Public and Behavioral Health of applicant and outpatient facility; prerequisite of satisfactory fire inspection.** (NRS 449.443, 449.446, 449.448)<br>1. Upon receipt of a properly completed and notarized application for a permit and the appropriate fee, the Division of Public and Behavioral Health shall conduct an investigation of the applicant and the outpatient facility pursuant to the provisions of NRS 449.446. During the investigation, the Division of Public and Behavioral Health shall determine whether the outpatient facility is in compliance with the provisions of NRS 449.435 to 449.448, inclusive, and NAC 449.9994 to 449.999489, inclusive. | N/A |
| O0021 | 2. Before issuing a permit, the Division of Public and Behavioral Health must receive a satisfactory report of inspection of the outpatient facility from the State Fire Marshal or the local fire department. | N/A |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| **NAC 449.999422**<br><br>O0025 | **Term of permit; circumstances under which permit deemed invalid.** (NRS 449.442, 449.444, 449.448)<br>1. Except as otherwise provided in subsection 2, a permit is valid for 1 year after the date of issuance, and the holder of the permit may apply for renewal of the permit pursuant to NAC 449.999423. | N/A |
| O0026 | 2. A permit is invalid on the date on which the holder of the permit fails to:<br>Obtain accreditation as required by NRS 449.442 and NAC 449.999424 within 6 months after the date of issuance of the permit; | N/A |
| O0026 | (b) Maintain current accreditation; or | N/A |
| O0026 | (c) Provide a report from a nationally recognized organization for accreditation as required by NAC 449.999424. | N/A |
| **NAC 449.999423**<br><br>O0030 | **Renewal of permit: Application; additional inspection by Division of Public and Behavioral Health authorized; fees; untimely filing or failure to file application.** (NRS 449.444, 449.448)<br>1. Except as otherwise provided in subsection 3, a holder of a permit to operate an outpatient facility who wishes to renew the permit must submit a completed application for renewal to the Health Division, on a form prescribed by the Health Division, not later than 45 days before the date on which the permit expires. In addition to the annual inspection required by NRS 449.446, the | N/A |

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| | Division of Public and Behavioral Health may require an inspection of the outpatient facility to ensure that it meets the requirements of NRS 449.435 to 449.448, inclusive, and NAC 449.9994 to 449.999489, inclusive, before deciding whether to renew a permit. | |
| O0031 | 2. An applicant for the renewal of a permit to operate an outpatient facility must pay to the Division of Public and Behavioral Health a nonrefundable fee of $1,785. | N/A |
| O0032 | 3. A holder of a permit who, without good cause, files an application for the renewal of a permit after the date set forth in subsection 1 but before the expiration of the permit must pay, in addition to the renewal fee for the permit prescribed in subsection 2, a fee equal to one-half the amount of the fee required for the renewal of the permit pursuant to that subsection. | N/A |
| O0033 | 4. A holder of a permit who fails to file an application for the renewal of the permit before the permit expires is not eligible to renew the permit and, if he or she wishes to be permitted, must submit an application for a new permit pursuant to NAC 449.99942. | N/A |
| **NAC 449.999424**<br><br>O0040 | **Outpatient facility required to provide proof of national accreditation; submission of reports to Health Division; application by accrediting organization for recognition by State Board of Health; maintenance of list by Division of Public and Behavioral Health of approved accrediting organizations.** (NRS 449.442, 449.448)<br>1. An outpatient facility shall:<br>(a) Not later than 6 months after obtaining a permit, submit proof to the Division of Public<br>and Behavioral Health of accreditation by a nationally recognized organization approved<br>by the Board pursuant to subsection 3; and | N/A |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0040 | (b) Maintain current accreditation during the term of the permit. | N/A |
| O0041 | 2. An outpatient facility shall provide to the Division of Public and Behavioral Health each report provided by the accrediting organization, including, without limitation, the initial report, each report issued upon renewal of an accreditation and any other report issued by the accrediting organization. | N/A |
| O0042 | 3. An organization that accredits outpatient facilities and which wishes to be recognized by the Board as an accrediting organization for the purposes of this section must submit to the Division of Public and Behavioral Health an application on a form prescribed by the Health Division. The Division of Public and Behavioral Health shall review each application received pursuant | N/A (NAF is following this procedure, but this section is not relevant to NAF's internal quality assurance process/requirements) |

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| | to this subsection and shall forward to the Board each application and the recommendation of the Division of Public and Behavioral Health that the Board approve or not approve the organization as an accrediting organization for purposes of this section. The recommendation of the Division of Public and Behavioral Health must be based upon whether the applicant requires an outpatient facility to meet the minimum requirements necessary to ensure a high level of quality. The Board may approve or deny an application for recognition as an accrediting organization submitted pursuant to this subsection. | |
| O0043 | 4. The Division of Public and Behavioral Health shall maintain on its Internet website a list of all accrediting organizations approved by the Board pursuant to this section. | N/A |
| **NAC 449.999425**<br><br>O0050 | **Display of permit; maintenance of outpatient facility in compliance with law; notification of transfer of real property; notification of change of ownership, location or services provided.** (NRS 449.448)<br>1. Upon receipt of a permit, the holder shall display the permit at a conspicuous location within the outpatient facility. | N/A |
| O0051 | 2. During the term of the permit, the outpatient facility shall continuously maintain the facility in conformance with the provisions of NRS 449.435 to 449.448, inclusive, and NAC 449.9994 to 449.999489, inclusive. | N/A |
| O0052 | 3. If there is a transfer of the real property on which the outpatient facility is located, but no change in the operator of the outpatient facility, the holder of a permit shall, within 10 days after the transfer, notify the Division of Public and Behavioral Health of the transfer in writing and provide the Division of Public and Behavioral Health with a copy of any lease agreement relating to the transfer. | N/A |
| O0053 | 4. The holder of a permit shall notify the Division of Public and Behavioral Health immediately of any change in the ownership of, location of or services provided by the outpatient facility. | N/A |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| **NAC 449.999426**<br><br>O0060 | **Additional grounds for denial, suspension or revocation of permit.** (NRS 449.447, 449.448) In addition to the grounds set forth in NRS 449.447 and NAC 449.999459, the Division of Public and Behavioral Health may deny an application for a permit or may suspend or revoke a permit upon any of the following grounds:<br>1 Misappropriation of the property of a patient of the outpatient facility. | N/A |

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| O0061 | 2. Abuse, neglect or exploitation of a person who is infirm, a person with mental retardation, a person with a disability or a person who is 60 years of age or older. | N/A |
| **NAC 449.999441**<br><br>O0070 | **Adoption of guidelines by holder of permit for establishment of program.** (NRS 441A.120, 449.448)<br>1. The holder of a permit issued pursuant to NAC 449.99942 shall adopt guidelines which must be used by the outpatient facility in establishing the program for the prevention and control of infections and communicable diseases required by NAC 449.999442. | All members shall [...] – if they provide abortion care – provide quality abortion care in compliance with National Abortion Federation (NAF) Clinical Policy Guidelines, all pertinent NAF standards, and NAF rules and regulations. (NAF Bylaws, Art. II Sec. 2.01)<br><br>**Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0071 | 2 The guidelines adopted pursuant to subsection 1 may include, without limitation, guidelines, statements or recommendations issued or published by other agencies or organizations, and must:<br>(a) Be based on evidence, theoretical rationale or scientific data; and | Like its precursors, the 2024 edition of NAF's Clinical Policy Guidelines for Abortion Care (CPGs) serve to provide guidance for facilities to use in establishing their clinical policies. The CPGs are developed by consensus, based on rigorous review of the relevant medical literature and patient outcomes. (NAF 2024 CPGs, pg. i) |
| O0071 | (b) Include well-designed experimental, clinical or epidemiological studies which document the processes used in the development of the studies and which grade the strength of the evidence relied on in the studies. | Medline was searched monthly on Pubmed. An automated search using the following terms was created and checked monthly:<br>((((abortion induced [MeSH Major Topic]) OR mifepristone) OR medical abortion) OR (dilation and evacuation)) OR uterine aspiration.<br>The search was limited to clinical trials, case reports, comparative studies, reviews, meta-analysis, and systematic reviews in humans from January 1, 2022. The search run on December 31, 2023, yielded 667 results. In addition, abstracts from major |

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| | | conferences, references in articles, and related non-abortion searches (for example, in analgesia and sedation) were run. Studies were included that addressed CPG topics and either changed, updated, or substantially added support to a current recommendation. Studies were excluded that were not relevant, had poor methodology or inconclusive results, or did not substantially add to a current recommendation. Thirty-three new papers were included in the 2024 CPGs because they changed one or more statements, supported a new recommendation, or substantially improved the level of evidence supporting a current statement. (NAF 2024 CPGs, pg. i-ii) |
| O0073 | 3. The holder of the permit shall ensure that a copy of the guidelines adopted pursuant to subsection 1 is available at the outpatient facility and accessible to the staff of the outpatient facility and the public. | N/A |
| **NAC 449.999442**<br><br>O0080 | **General requirements of program.** (NRS 441A.120, 449.448)<br>1. Each outpatient facility shall establish and maintain a program for the prevention and control of infections and communicable diseases. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7)<br><br>*Recommendation 3.10.4*<br>Patients should be offered or referred for testing for chlamydia and gonorrhea according to local guidelines. Testing should not delay the procedure. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.11**<br>Diagnosed infection must be appropriately treated. (NAF 2024 CPGs, pg. 8) |
| O0081 | 2. In addition to complying with the provisions of NAC 449.999441 to 449.999447, inclusive, a program for the | **Standard 3.4** |

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| | prevention and control of infections and communicable diseases must be:<br>(a) Appropriate for the services provided at the outpatient facility; | Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0081 | (b) Based on the guidelines adopted by the holder of the permit pursuant to<br>NAC 449.999441; and | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0081 | (c) Developed in a manner that takes into consideration:<br>(1) All surgical and other medical services provided at the outpatient facility; | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0081 | (2) The types of patients typically treated at the outpatient facility, including, without<br>limitation, those whose age or medical condition makes them vulnerable to<br>infections and communicable diseases; | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0081 | (3) The types of injuries or illnesses typically treated at the outpatient facility; | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0081 | (4) The number of patients typically treated at the outpatient facility; | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0081 | (5) The level of education and training of the staff of the outpatient facility; | **Standard 1.3**<br>All individuals providing abortions must have received training to competency in abortion care, including the prevention, recognition, and management of complications. (NAF 2024 CPGs, pg. 1)<br><br>**Standard 1.4**<br>All individuals providing ancillary services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other services. (NAF 2024 CPGs, pg. 2) |
| O0081 | (6) The number of nurses available at the outpatient facility, the qualifications of such | See above |

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| | nurses and the amount of support required of the nurses by the physicians at the outpatient facility, if applicable; | |
| O0081 | (7) The types of invasive procedures performed at the outpatient facility; | **Standard 3.10**<br>Routine antibiotic prophylaxis must be used for uterine aspiration and dilation and evacuation. (NAF 2024 CPGs, pg. 8)<br><br>*Recommendation 3.10.1*<br>All patients having uterine aspiration or dilation and evacuation should receive antibiotics pre-procedure. (NAF 2024 CPGs, pg. 8) |
| O0081 | (8) The locations within the outpatient facility where invasive procedures are performed; | See above |
| O0081 | (9) The specific medical instruments and equipment used at the outpatient facility; | **Standard 3.5**<br>All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, pg. 7)<br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, pg. 7)<br>**Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, pg. 8) |
| O0081 | (10) The physical design of the outpatient facility; and | |
| O0081 | (11) The causes, risks and patterns of infections and transmission of communicable diseases that arise in the setting of each medical procedure performed at the outpatient facility. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| **NAC 449.999443**<br><br>O0090 | **Program required to include policies and procedures for prevention of exposure to blood-borne and other potentially infectious pathogens.** (NRS 441A.120, 449.448) Each program for the prevention and control of infections and communicable diseases must include policies and procedures to prevent exposure to blood-borne and other potentially infectious pathogens, including, without limitation, policies and procedures relating to: | **Standard 3.2**<br>Hands must be washed or disinfected before and after patient contact. (NAF 2024 CPGs, p. 7)<br>**Standard 3.4** |

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| | 1. Hand hygiene, including provisions regarding the time and procedure for hand washing with soap and water or the use of an alcohol-based hand rub. | Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0091 | 2. The proper use of medical gloves, including, without limitation, a requirement that each person who works at the outpatient facility must wear medical gloves when the person:<br>(a) Anticipates coming in contact with blood or bodily fluids; | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, p. 7)<br>**Standard 3.3**<br>Personal protective equipment must be provided to all staff. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, p. 7) |
| O0091 | (b) Handles contaminated instruments, items and equipment; | See above |
| O0091 | (c) Handles biological waste or biologically contaminated waste that may cause harm to<br>humans, animals or plants; | **Standard 3.8**<br>All tissue must be considered biohazardous and be handled, stored, and disposed of in a manner that minimizes the risk of exposure. A protocol for tissue handling, storage, and disposal must be in place. (NAF 2024 CPGs, p. 8) |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0091 | (d) Handles linens potentially contaminated with biological waste or biologically<br>contaminated waste that may cause harm to humans, animals or plants; and | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, p. 7)<br>**Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0091 | (e) Performs housekeeping activities or cleans contaminated surfaces. | See above |

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| O0092 | 3. Safe injection practices to prevent the contamination of equipment used for injections and medication, including, without limitation, a requirement that a new sterile needle and new sterile syringe be used for each patient and not used for more than one patient. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7)<br>**Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0093 | 4. The proper handling of sharp instruments and the disposal of sharp instruments, which must be consistent with the standards developed by the Occupational Safety and Health Administration of the United States Department of Labor for the handling and disposal of such instruments. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.9**<br>Sharps containers must be readily available. Sharps containers must be made of rigid, puncture-resistant material, have a tight-fitting lid, and be labeled as hazardous material. (NAF 2024 CPGs, p. 8) |
| O0094 | 5 Techniques for accessing a vial of medication, which must comply with the requirements set forth in NAC 449.999444. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7) |
| O0095 | 6. The infusion of intravenous medications, which must provide, without limitation, that intravenous tubing and fluid bags or bottles are not to be used for more than one patient. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from |

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| | | being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.5**<br>All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8) |
| O0096 | 7. The proper sterilization and disinfection of all medical equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to:<br><br>(a) Sterilize or ascertain the sterility of items that enter sterile tissue or the vascular system,<br>including, without limitation, surgical instruments, endoscopes, endoscopic accessories,<br>catheters, needles and probes used for ultrasounds; | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.5**<br>All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8)<br><br>**Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| O0096 | (b) Perform high-level disinfection of reusable items that come in contact with nonintact<br>skin or mucous membranes, including, without limitation, respiratory therapy | **Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |

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| | equipment, anesthesia equipment, bronchoscopes and gastrointestinal endoscopes; and | |
| O0096 | (c) Perform low-level disinfection of reusable items that come in contact with only intact skin, including, without limitation, tourniquets, blood pressure cuffs, linens, stands that are used to hold medical instruments and other furnishings. | **Standard 3.1** Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.5** All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7) |
| O0097 | 8. The proper handling of equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to:<br>(a) Sterilize and disinfect reusable items as described in subsection 7; | **Standard 3.5** All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6** All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8)<br><br>**Standard 3.7** Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| O0097 | (b) Properly dispose of single-use equipment, instruments and devices after use, if the outpatient facility has decided not to have the equipment, instruments or devices reprocessed; and | **Standard 3.7** Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0097 | (c) Ensure that:<br>(1) All equipment, instruments and devices that may be reprocessed are reprocessed only | **Standard 3.5** |

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| | by a third-party processor approved by the United States Food and Drug<br>Administration; and | All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8)<br><br>**Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| O0097 | (2) No equipment, instruments or devices that may be reprocessed are reprocessed at the<br>outpatient facility. | **Standard 3.5**<br>All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8)<br><br>**Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| O0098 | 9. The proper handling and disposal of medical waste and specimens. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7)<br>**Standard 3.8**<br>All tissue must be considered biohazardous and be handled, stored, and disposed of in a manner that minimizes the risk of exposure. A protocol for tissue handling, storage, and disposal must be in place. (NAF 2024 CPGs, p. 8) |

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| O0099 | 10. The proper cleaning and disinfection of all areas in which patient care is provided. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0100 | 11. The proper maintenance of a clean and sanitary environment. | See above |
| O0101 | 12. The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must:<br>(a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility; | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0101 | (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and | See above |
| O0101 | (c) Identify and address trends in such developments and transmissions of infections and communicable diseases. | See above |
| O0102 | 13. The care of patients with a communicable disease, including, without limitation, patients who are known to have a communicable disease at the time of arrival at the outpatient facility and patients who are found to have a communicable disease during the course of treatment at the outpatient facility. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7)<br><br>**Standard 3.10**<br>Routine antibiotic prophylaxis must be used for uterine aspiration and dilation and evacuation. (NAF 2024 CPGs, pg. 8)<br>**Standard 3.11** |

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| | | Diagnosed infection must be appropriately treated. (NAF 2024 CPGs, pg. 9) |
| O0103 | 14. The screening for communicable diseases as described in NAC 441A.375 of all employees and of all persons under contract with the outpatient facility who work at the outpatient facility and have exposure to patients at the outpatient facility. | **Standard 3.4** Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| **NAC 449.999444**<br><br>O0110 | **Program required to include policies and procedures for single-dose vials and multidose vials.** (NRS 441A.120, 449.448) 1. Each program for the prevention and control of infections and communicable diseases must include policies and procedures for single-dose vials which provide that a single-dose vial may be accessed only by using an aseptic technique. The policies and procedures must provide that:<br>(a) Each injection of a medication from a single-dose vial must be prepared in a clean,<br>designated area where contamination by blood or bodily fluid is unlikely to occur; | **Standard 3.1** Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7) |
| O0110 | The medication in a single-dose vial must not be used for more than one patient; | See above |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0110 | (c) A single-dose vial, including any remaining medication in the vial after its use, must be discarded; and | See above |
| O0110 | (d) Any remaining medication in a single-dose vial after its use must not be combined with any other medication or otherwise used for any other patients. | See above |
| O0111 | 2. Each program for the prevention and control of infections and communicable diseases must include policies and procedures for multidose vials which provide that a multidose vial may be accessed only by using an aseptic technique. The policies and procedures must provide that:<br>(a) The cap of a multidose vial must be cleaned with an alcohol-based wipe before the vial is accessed; | See above |
| O0111 | (b) A new sterile needle and new sterile syringe must be used each time to access a multidose vial; | See above |

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| O0111 | (c) Upon first access of a multidose vial, the person who accessed the vial shall date and initial the vial; | See above |
| O0111 | (d) Each injection of a medication from a multidose vial must be prepared in a clean, designated area where contamination by blood or bodily fluid is unlikely to occur; | See above |
| O0111 | (e) A needle must not be left inserted in the cap of a multidose vial after its use; and | See above |
| O0111 | (f) A multidose vial must be discarded when the medication in the vial has expired or 28 days after the vial was initially accessed. | See above |
| **NAC 449.999445**<br><br>O0115 | **Sterilization and disinfection of surgical instruments, items and equipment; training required for employees and contractors responsible for sterilization or disinfection.** (NRS 441A.120, 449.448)<br>1. All surgical instruments, items or equipment used in the care of patients at an outpatient facility must be sterilized or disinfected according to the program for the prevention and control of infections and communicable diseases adopted by the outpatient facility pursuant to NAC 449.999442. | **Standard 3.5**<br>All instruments coming into contact with patients must be properly cleaned and disinfected between patients. (NAF 2024 CPGs, p. 7)<br><br>**Standard 3.6**<br>All instruments entering the uterus must be sterile. (NAF 2024 CPGs, p. 8)<br><br>**Standard 3.7**<br>Tubing and manual uterine aspirators must be high-level disinfected or sterilized. (NAF 2024 CPGs, p. 8) |
| O0116 | 2. If such instruments, items and equipment are sterilized or disinfected by equipment or cleaning agents at the outpatient facility: | |
| O0116 | (a) Before an employee or independent contractor may be assigned the responsibility for sterilizing or disinfecting any instrument, item or equipment, the employee or independent contractor must receive training concerning the instructions of the manufacturer of the device or sterilizer for:<br>(1) Sterilizing and disinfecting the instrument, item or equipment; | **Standard 1.4**<br>All individuals providing ancillary services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other services. (NAF 2024 CPGs, pg. 2) |

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| | | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7) |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0116 | (2) The use and maintenance of the sterilizer or disinfecting equipment; and | See above |
| O0116 | (3) The agents used to sterilize and disinfect the instrument, item or equipment. | See above |
| O0116 | (b) An employee or independent contractor assigned the responsibility for sterilizing or disinfecting the instrument, item or equipment shall:<br>(1) Receive annual training concerning the manufacturer's instructions described in paragraph (a); and | **Standard 1.4**<br>All individuals providing ancillary services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other services. (NAF 2024 CPGs, pg. 2) |
| O0116 | (2) Receive training on any new equipment or procedures if there is any change in the equipment or procedures used to sterilize or disinfect an instrument, item or equipment. | See above |
| O0116 | (c) The outpatient facility shall ensure that documentation of all training completed pursuant to this subsection is kept in the file of the employee or independent contractor. | *Recommendation 1.1.1*<br>Documentation specifying privileges in accordance with each practitioner's scope of practice should be maintained. (NAF 2024 CPGs, pg. 1) |
| O0117 | 3. The manufacturer's instructions for operating any sterilizer or performing any disinfection procedure must be located or posted near the equipment used for sterilization or disinfection. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of |

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| | | patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7) |
| O0118 | 4. The outpatient facility shall ensure that each employee or independent contractor follows the manufacturer's instructions concerning:<br>(a) The instruments, items or equipment that may be sterilized or disinfected; | See above |
| O0118 | (b) The procedures for cleaning an instrument, item or equipment before the instrument,<br>item or equipment is sterilized or undergoes high-level disinfection; | See above |
| O0118 | (c) The procedures for sterilizing or disinfecting an instrument, item or equipment; | See above |
| O0118 | (d) The operation and maintenance of the sterilizer or the equipment used for high-level<br>disinfection; | See above |
| O0118 | (e) The frequency and type of biologic indicator testing of the sterilizer; | See above |
| O0118 | (f) The recommended agents for sterilizing and disinfecting the instrument, item or<br>equipment; and | See above |
| O0118 | (g) The frequency of testing of any solution for disinfecting to ensure maintenance of the<br>minimum level of effectiveness, but the solution must be tested not less often than daily. | See above |
| O0119 | 5. The effectiveness of the sterilization procedures must be checked by performing a biologic indicator test:<br>(a) At least weekly, or more frequently if recommended by the manufacturer; and | See above |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0119 | (b) While sterilizing all implantable devices. | N/A to the type of care being provided |
| O0120 | 6. Sterilization records and logs of the results of the biologic indicator test must be maintained by the outpatient facility for at least 1 year after the test is performed to ensure that the | See above |

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| | recommended testing and maintenance of the equipment is performed and the manufacturer's instructions regarding proper sterilization techniques are followed. Each outpatient facility shall establish a method to track and recall instruments, items or equipment previously sterilized or disinfected if there is a failure of the biologic indicator test. | |
| O0121 | 7. To aid in environmental control, each outpatient facility shall provide a physical barrier between the decontamination and sterilization areas of the outpatient facility. | See above |
| **NAC 449.999446**<br><br>O0130 | **Outpatient facility required to designate employee or enter into contract for overseeing and managing program; qualifications and duties of employee or contractor.** (NRS 441A.120, 449.448)<br>1. Each outpatient facility shall designate an employee or enter into a contract with a person to oversee and manage all aspects of the program for the prevention and control of infections and communicable diseases. | **Standard 3.4**<br>Exposure control plans must be established and followed. (NAF 2024 CPGs, pg. 7) |
| O0131 | 2. The person described in subsection 1:<br>(a) Must have completed specialized training in the prevention and control of the development and transmission of infections and communicable diseases; and | See above |
| O0131 | (b) Shall ensure that the program for the prevention and control of infections and communicable diseases for the outpatient facility:<br>(1) Complies with all applicable federal, state and local laws; | See above |
| O0131 | (2) Is consistent with the guidelines adopted by the holder of the permit pursuant to NAC 449.999441; and | See above |
| O0131 | (3) Is reviewed with all employees of the outpatient facility and all persons under contract with the outpatient facility who work at the facility and have exposure to patients at the facility within the first 10 days of employment and every 12 months thereafter, or more often if required pursuant to subsection 2 of NAC 449.999447. | *Recommendation 3.3.1*<br>New staff with potential exposure should have an initial training as part of orientation. (NAF 2024 CPGs, pg. 7)<br><br>*Recommendation 3.3.2*<br>Periodic facility-level training should occur at least every three years. (NAF 2024 CPGs, pg. 7) |
| **NAC 449.999447** | **Mandatory training and evaluation of employees and other persons.** (NRS 441A.120, 449.448)<br>1. Each employee of an outpatient facility and each person under contract with an outpatient facility who works at the facility and | See above |

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| O0135 | has exposure to patients at the facility shall receive training and must be evaluated by supervising staff on the employee's or contractor's knowledge and skills concerning the program for the prevention and control of infections and communicable diseases within the first 10 days of employment and at least every 12 months thereafter. | |
| **NAC/TAG** | **REGULATION TEXT** | **Remarks** |
| O0136 | 2 An employee or person under contract with the outpatient facility may be required to receive the training and evaluation described in subsection 1 more often than every 12 months if a supervisor determines that such training and evaluations are necessary to ensure that the employee or contractor understands and will follow the policies and procedures of the program for the prevention and control of infections and communicable diseases. | See above |
| **NAC 449.999448**<br><br>O0140 | **Establishment of additional policies and guidelines by holder of permit to ensure health and safety of patients; professional standards of practice; requirement of tuberculosis test for employees and persons under contract with outpatient facility.** (NRS 441A.120, 449.448) In addition to the guidelines established pursuant to NAC 449.999441, the holder of a permit to operate an outpatient facility shall establish guidelines and maintain policies for the outpatient facility which:<br>1. Ensure the health, safety and well-being of patients of the outpatient facility; | **Standard 1.1**<br>Abortion will be provided by trained providers. This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, other health professionals and community-based providers. (NAF 2024 CPGs, pg. 1) |
| O0141 | 2. Provide the professional standards of practice for services provided by the outpatient facility and ensure that all persons employed by the outpatient facility or under contract with the outpatient facility comply with such professional standards; and | **Standard 1.3**<br>All individuals providing abortions must have received training to competency in abortion care, including the prevention, recognition, and management of complications. (NAF 2024 CPGs, pg. 1)<br><br>***Standard 1.4***<br>All individuals providing ancillary services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other services. (NAF 2024 CPGs, pg. 1) |
| O0142 | 3. Require each person employed by the outpatient facility or under contract with the outpatient facility to have a skin test for tuberculosis in accordance with NAC 441A.375. | **Standard 3.1**<br>Proper engineering and work-practice controls must be in place to reduce exposure of |

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| | | patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material. (NAF 2024 CPGs, pg. 7) |

**Quality Assurance and Improvement (QAI) Policy**

**Policy Title: Site Visit Resource Allocations**

**Effective Date: July 1, 2025**

**Approved By: Reesa Roberts, PA-C, MSPA, Senior Director Clinical Services**

**Policy Number: QAI-001**

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1. **Purpose:** The Quality Assurance and Improvement (QAI) Team affirms its commitment to maintaining the necessary infrastructure, staffing, and support systems to conduct all required site visits for applicant and existing member facilities successfully. This policy outlines the established structures, systems, and practices that ensure site visits are conducted thoroughly, equitably, and per the *Clinical Policy Guidelines for Abortion Care*, current medical standards and guidelines, and organizational policies.

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**2. Scope:** This policy applies to all members of the QAI team and those involved in the coordination, planning, execution, and documentation of site visits.

**A. Staffing Infrastructure**

- The QAI team includes full-time, part-time, and consultant clinicians trained in site visit procedures, documentation standards, and clinical policy guidelines.
- Staff assignments are based on clinical experience, subject matter expertise, and geographical proximity to support scheduling flexibility.

**B. Site Visit Scheduling & Coordination**

- A centralized scheduling process is managed using a membership tracking system that includes all current applicants and existing members. For members who have previously undergone a site visit, the system records the date of their next scheduled visit. This data is used to generate the annual site visit schedule. Scheduling decisions are informed by documented visit timelines, geographic considerations, and the priority or urgency identified during the previous site visit.

- Staff use standardized tools, shared with the facility through multiple emails, including a scheduling form, introductory letters, checklists, and self-assessment documents, to ensure clarity and alignment in visit preparation.

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**3. Travel and Logistical Support**

- The organization maintains an annual budget for site visit-related travel and accommodation, including contingencies for short-notice visits triggered by urgent circumstances (e.g., complaints, ownership changes, expansion of clinical services, etc.).
- Clinical personnel are responsible for coordinating logistics, making travel arrangements, and conducting pre-travel briefings.

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**4. Data Systems and Documentation**

- NAF established a robust system of measuring clinical quality that relies on our *Clinical Practice Guidelines for Abortion Care,* the evidence-based standards for clinical care to which all NAF member clinics must adhere. We established whether CPG deviations were severe, moderate, or minor based on their impact on the safety of patients and/or staff. Careful tracking of deviations allows us to understand:
    - How a clinic's performance changes over time;
    - Whether a clinic needs an expeditious return visit to correct a serious problem;
    - The timing for the next QAI site visit; and
    - The highest performing clinics.
- Identifying high-performing facilities helps us spread and share best practices. We partner with these clinics to learn about effective clinic management and administration, and to identify resources and tools that we need to develop for other members. We have also asked these clinics to serve as partners for future clinic exchanges.
- Through our well-defined system of measurement, NAF generates a site visit report that informs members about the priority of their CPG deficiencies (serious, moderate, or minor).

- Return site visits are based on the priority of CPG deficiencies, which are tiered by year based on the number and type of findings.
- We maintain a comprehensive database of findings that informs how observations are addressed, ensuring consistent language across site visit reports.
- Site visit findings are documented in a centralized database accessible to the QAI team and other relevant stakeholders.
- Standardized templates and electronic tools are employed to ensure consistency in reporting and follow-up documentation.

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**5. Internal Quality Controls**

- Inter-rater reliability assessments are conducted regularly to ensure consistent scoring and interpretation of site visit findings across reviewers.
- All QAI clinicians participate in periodic calibration sessions to maintain alignment with clinical expectations and evaluation standards.
- For further information, see policy number QAI-002.

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**6. Professional Development**

- The QAI Team maintains an ongoing schedule of professional development and cross-training to keep staff up to date on clinical advancements, policy changes, and quality assurance best practices.

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**7. Capacity Planning**

- A quarterly capacity assessment is conducted to identify resource needs and plan for fluctuations in volume or emergent demands (e.g., unanticipated increase in membership applications, major clinic changes, policy revisions).

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**8. Equity Considerations**

- Site visit planning and resource allocation are guided by equity principles to ensure timely review of all facilities regardless of size, location, or patient volume.

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**9. Policy Review**

This initial policy will be reviewed and updated every two (2) years, or sooner, if necessary, to reflect changes in operations, staffing, or quality assurance standards.

**Quality Assurance and Improvement (QAI) Policy**

**Policy Title: Inter-Rater Reliability (IRR) in Site Visit Evaluations**

**Effective Date: July 1, 2025**

**Approved By: Reesa Roberts, PA-C, MSPA, Senior Director of Clinical Services**

**Policy Number:** QAI-002

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## 1. Purpose

To document existing practices that ensure consistency, accuracy, and fairness in the evaluation of clinical sites, assessing the degree of agreement among Quality Assurance and Improvement (QAI) site visit clinicians.

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## 2. Scope

This policy reflects the practices currently in place for all clinical site visits conducted by the QAI team, where more than one clinician assesses performance against the *Clinical Policy Guidelines for Abortion Care* (CPGs) and/or other evaluation tools.

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## 3. Definitions

- **Inter-Rater Reliability (IRR):** The degree of agreement among multiple clinicians using the same criteria and tools to assess a site visit.
- **Consensus Review:** A process in which QAI clinicians meet post-site visit to reconcile scoring and language differences.
- **Threshold for Agreement:** A benchmark of consistency, generally 85% or greater agreement across evaluation criteria.

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## 4. Existing Practices

A. **IRR Assessments**
The QAI team conducts IRR assessments as part of its standard quality assurance process. These assessments occur for at least 10% of annual site visits and in any situation involving:

- A newly onboarded QAI clinician.
- The introduction of a new or significantly revised site visit assessment tool.
- Site visits where previous findings showed marked differences in rating and language among reports.

B. **Independent Review and Documentation**
Each QAI clinician compiles a site visit report immediately after the visit and submits it to a QAI team member for review. After incorporating this feedback, the revised draft is reviewed by the Senior Director of Clinical Services before the clinician submits the finalized report to the NAF representative of the facility.

C. **Consensus Debriefs**
The QAI team regularly holds post-visit consensus debriefs to incorporate additions and changes to the comprehensive database of findings, discuss justifications for any divergent findings, and reach a consensus on the final language and scoring.

D. **Documentation and Reporting**
Consensus debrief summaries are uploaded to the clinic's QAI folder on SharePoint. These documents are reviewed annually as part of our calibration and recalibration processes.

E. **Training and Calibration**
The QAI team participates in calibration meetings to ensure alignment across clinicians. When significant issues are identified, targeted calibration and/or retraining are provided.

F. **Evaluation Tools**
The tools used for assessment are standardized and reviewed biannually to ensure they remain aligned with the current *Clinical Policy Guidelines for Abortion Care*, general medical practices, and organizational standards.

G. **Ongoing Quality Monitoring**
IRR results are used to inform updates to tools, identify areas for training, and guide quality improvement within the QAI program.

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**Policy Review:**

This initial policy will be reviewed every two (2) years and updated as necessary to reflect changes in operations, staffing, or quality assurance standards.

**Quality Assurance and Improvement (QAI) Policy**

**Policy Title: In-Person Site Visit Requirements and Procedures**

**Effective Date: August 1, 2025**

**Approved By: QAI Committee of the NAF Board of Directors**
**Reesa Roberts, PA-C, MSPA, Senior Director of Clinical Services**
**Melissa Fowler, NAF Chief Program Officer**
**Julie Gonen, NAF Chief Legal Officer**

**Policy Number: QAI-003**

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## 1. Purpose

This policy outlines the procedures and requirements for in-person site visits conducted by the Quality Assurance and Improvement (QAI) team. These visits are performed at practices applying for membership with the National Abortion Federation (NAF) and for existing members to ensure ongoing quality assurance. Site visits are a critical part of the evaluation process, ensuring that practices meet the standards outlined in the *Clinical Policy Guidelines for Abortion Care,* which serve as a benchmark for comparison during the site visit.

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## 2. Scope

This policy applies to all practices seeking NAF membership and to all current member practices that provide abortion care.

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## 3. Conditions Requiring an In-Person Site Visit

An in-person site visit will be conducted under the following circumstances:

- As part of the initial application process for new facility members.
- For existing members, scheduled at intervals of one to three years, determined by the number and severity of findings at the most recent site visit.
- In response to identified triggers (e.g., ownership change, gestational age increase, change in clinical leadership, credible complaints). *See Policy 004: Triggers for Off-Cycle Site Visits for more detailed information.*

- Following the completion of a corrective action plan or membership reinstatement from suspension.

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**4. Site Visit Preparation Requirements**

**4.1 National Provider Data Bank (NPDB)**

Once a membership application is received, NAF will request an NPDB report as part of its due diligence process for credentialing health care providers (*See Policy 005: Access to National Practitioner Data Base Reports for more detailed information).*

**4.2 Business Associate Agreement (BAA)**

Before scheduling a site visit, the facility must have a signed Business Associate Agreement (BAA) on file with NAF. This agreement protects patient health information reviewed during the visit. It only needs to be signed once unless there is a change in ownership, administration, or location.

**4.2 Minimum Operational Timeframe**

For newly opened clinics, the site must have actively provided clinical care for at least one (1) month before the site visit. This ensures sufficient patient flow and service activity to facilitate meaningful observation and evaluation.

To proceed with the membership application process, **the QAI clinician must observe the full range of services, including the latest gestational age** provided at the facility during the site visit. **If the complete scope of care is not observed, the site visit will not be considered completed, and the facility will not be approved for membership**.

- If the clinic wishes to schedule a subsequent site visit to allow for observation of all clinical services, this will be deemed an off-cycle visit, subject to a repeat site visit fee (*See Policy 004: Triggers for Off-Cycle Site Visits for more detailed information)*.

**4.3 Scheduling Process**

A scheduling form is sent to the clinic's designated NAF representative. This form captures the availability of the clinician(s) and logistical details that help the QAI team organize the site visit efficiently. The form should be completed and returned as soon as possible. Scheduling the site visit cannot move forward until the scheduling form is completed and returned.

Once the site visit dates are confirmed, a QAI team member will send an introductory email to the facility. This email includes:

- A link to the most up-to-date version of the *Clinical Policy Guidelines for Abortion Care* (CPGs).
- An **introductory letter** that details the purpose and scope of the site visit, what will be evaluated, and the expectations for the day(s) of the visit.
- A **self-assessment form** that enables the facility to outline its clinical operations, including staffing structure, services provided, patient flow, and protocols in use, so that the QAI team can tailor the visit accordingly. This form must also be completed and returned to the QAI clinician before the site visit.
- A **pre-visit checklist** that outlines the protocols, policies, and documentation that should be available for review during the visit.

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**5. Site Visit Components**

**5.1 Duration and Scope**

- A standard in-person site visit typically takes approximately **8 hours**.
- For facilities providing **multi-day abortion procedures**, the site visit may extend over multiple days to allow observation of the complete care cycle.

**5.2 Observation of Care**

The QAI team will observe the clinic staff performing all elements of patient care with the patient's consent. This includes intake, ultrasound, patient education, informed consent, lab procedures, procedural care, recovery, and discharge processes.

**5.3 Chart Review**

The QAI team will conduct a thorough chart review to assess documentation practices, clinical decision-making, and compliance with established standards.

**5.4 Policies and Procedures**

The QAI Clinician will review a range of quality management program materials, including but not limited to:

- Written policies and procedures related to abortion care.
- Documentation of staff orientation and training.
- Systems for managing, tracking, and reporting complications.
- Laboratory policies and procedures if point-of-care labs are performed on-site.
- Exposure control plans including post-exposure prophylaxis
- Protocols for instrument processing, if performed on-site
- Emergency preparedness – medical, natural disaster, and security.

The preview checklist (see 4.3 Scheduling Process) contains all relevant documents that the QAI clinician expects to review.

### 5.5 Staff Credentialing

- Current licenses for all staff
- Current emergency resuscitation certifications for all clinical staff
- Clinical privileging protocols related to ultrasound and sedation
- Documentation of periodic proficiency review
- Training and in-service

The preview checklist (see 4.3 Scheduling Process) contains all relevant documents that the QAI clinician expects to review.

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## 6. Following the Site Visit

The QAI Clinician will generate a formal report summarizing the site visit observations and clearly state the findings that were expected at the site visit. The report should be sent to the facility within 30 days. The site visit report is divided into the following areas:

1. Priority finding(s) – These represent deviations from the CPGs that could severely impact patient and staff safety. **Each finding requires a response outlining your proposed corrective action**.
2. Moderate finding(s) - These represent deviations from the CPGs that could have a significant impact on patient and staff safety. **Each finding should include a response with your proposed correction**.
3. Minor finding(s) - These findings are deviations from the CPGs that are important for quality care but have a lower impact on patient and staff safety. **While a formal response is not required, these findings should be addressed and corrected by the next visit.**
4. Best Practices - This section highlights practices not directly related to the CPGs but are reflective of standardized approaches within the reproductive health community. These best practices aim to improve patient care, patient-centeredness, satisfaction, and compliance with industry standards, state, or federal regulations. **No response is required for these observations.**

The facility is responsible for the following:

- Completing and returning a response to the QAI Site Visit report, including a corrective action plan for each area of non-compliance, within 90 days of receiving the report.

- Implementing the required changes within the same 90-day period, as outlined in the corrective action plan.

The QAI Clinicians are responsible for the following:

- Reviewing the facility's response to the site visit report and providing feedback on the corrective actions within two weeks of receipt.
- Requesting additional information if needed, with the expectation that the facility will provide the requested materials within two weeks
- Once the clinician is satisfied with the corrective action response(s) and any other additional documentation, issuing a completion letter to the facility.

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**7. Evaluation Criteria**

All site visits are conducted using the most current version of the *Clinical Policy Guidelines for Abortion Care* as the foundation for evaluation. Clinics are expected to demonstrate alignment with these guidelines in both policy and practice.

In addition to abortion-specific standards, clinics are also expected to align with **general medical practice standards**, including appropriate credentialing, chart documentation, on-the-job training documentation, and adherence to patient safety protocols. The QAI team will assess the clinic's ability to deliver safe, evidence-based care consistent with broader expectations of clinical quality and professional oversight.

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**8. Noncompliance**

1. Noncompliance with a QAI Site Visit includes:

    - Refusal to schedule a site visit despite repeated attempts by the QAI clinician, or refusal to allow the QAI clinician access to the facility for a site visit.
    - Refusal to comply with one or more components of the site visit evaluation (see Site Visit Components above).
    - Failure to adhere to established medical and professional standards of care, including the absence of patient-centered, trauma-informed care.

2. If non-compliance is observed, the following plan will be implemented:

    - **At the 90-day post-refusal mark**, a follow-up email will be sent, and a phone call will be made to the facility's NAF Representative of record. The communication will outline the requirements and explain the consequences of continuing to

refuse observation. If the refusal persists, it will be reported to the Chair of the QAI Committee of the Board.

- **After the four-month (120-day) post-refusal date**, a letter will be sent to the NAF Representative and/or facility owner/administrator by email stating that the concern will be referred to the QAI Committee of the Board, which will provide a recommendation to the NAF Board of Directors regarding suspension or expulsion from membership (See QAI 006).

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**8. Policy Review**

This policy replaces/amends the December 2016 policy and will be reviewed and updated every two (2) years, or sooner, if necessary, to reflect regulatory or organizational changes.

**Quality Assurance and Improvement (QAI) Policy**

**Policy Title: Triggers for Off-Cycle Site Visits**

**Effective Date: July 1, 2025**

**Approved By: QAI Committee of the NAF Board of Directors**
**Reesa Roberts, PA-C, Senior Director Clinical Services**
**Melissa Fowler, NAF Chief Program Officer**
**Julie Gonen, NAF Chief Legal Officer**

**Policy Number: QAI-004**

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## 1. Purpose

This policy outlines the circumstances under which a site visit may be initiated outside the regular Quality Assurance and Improvement (QAI) review schedule. Off-cycle site visits ensure that both applicants and current members of the National Abortion Federation (NAF) continue to provide safe, evidence-based, patient-centered, high-quality abortion care per the *Clinical Policy Guidelines for Abortion Care* (CPGs), standard medical practice, and relevant organizational standards.

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## 2. Scope

This policy applies to all practices seeking membership with NAF and to all current member practices that provide abortion care across the gestational spectrum.

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## 3. Policy Statement

The National Abortion Federation promotes consistent clinical and operational standards across all member practices. While regular site visits are conducted on a defined schedule, specific changes or concerns may lead to an off-cycle site visit. These visits enable timely assessment, support, and verification of compliance in response to significant operational or clinical developments.

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## 4. Triggers for Site Visits

The following circumstances may require an off-cycle site visit. Members or applicants are responsible for paying the current site visit fee and scheduling the off-cycle site visit at a time when NAF staff can observe the full range of services the practice provides.

**During the Application Process:**

- **New Membership Application:** All applicants must successfully complete the Quality Assurance and Improvement process, including a satisfactory site visit. If a member drops their membership and later reapplies, they must restart the application process as a new member. This includes completing a written application, paying a site visit and application fee, and undergoing a site visit as part of the reapplication process.
- **If Full Range of Services is not Observed:** If NAF staff are not able to observe the full range of services the practice provides, including abortion care at the practice's upper gestational limit, a repeat site visit will be required before membership can be granted. The applicant is responsible for paying the site visit fee again, working with NAF to schedule the repeat visit, and ensuring enough patients are planned so that NAF staff can observe the full range of services provided.
- **Previous Membership Application:** If a practice previously applied for membership and had a site visit but did not complete the full application process and later inquiries about membership more than one year after the initial site visit, the clinic must submit a new application, pay the site visit fee, and undergo a new site visit as part of the reapplication process.
- **Reapplication Following Unsuccessful Initial Site Visit:** If a practice does not meet membership criteria during an initial site visit and reapplies for membership, a follow-up site visit will be required to reassess compliance with the CPGs. The site visit fee must be paid in full before scheduling the repeat visit.

**For Existing Members**

To maintain membership, providers must comply with NAF's QAI process, which includes regular site visits to ensure compliance with the CPGs. Members will undergo regular site visits at intervals of one to three years, based on the number and severity of findings at their previous site visit. The following changes or updates may require a site visit outside of the regularly scheduled review cycle. Please notify NAF's Membership Department (membership@prochoice.org) if you are planning or experiencing any of the following:

- **Change in Clinic Ownership:** Any legal ownership, operational control, or corporate structure alteration that may impact service delivery or accountability. **NAF membership is not transferable**. A change in ownership requires the practice to complete a new written

application, pay an application fee, and undergo a site visit. If membership is granted, the practice will be assigned a new member number. This requirement is applicable even if the new owner or group manages other NAF-affiliated facilities, particularly when the services offered at the newly acquired site differ from those available at their existing locations.

- **Change in Medical or Clinical Director:** Appointment of a new Medical Director or lead clinician responsible for abortion care. This transition will initiate a review process that includes an inquiry to the National Practitioner Data Bank (NPDB) for the incoming Medical or Clinical Director and any new providers practicing at the site during the leadership change. The practice must pay a site visit fee and successfully complete another site visit.
- **Increase in Gestational Age (GA):** An increase of four (4) or more weeks beyond the clinic's previously observed and documented upper gestational limit. The practice must pay a site visit fee and successfully complete another site visit. During the visit, NAF must observe care at the new gestational limit. If NAF staff are not able to observe the full range of services the practice provides—including abortion care at the practice's new upper gestational limit—a repeat site visit will be required before additional membership benefits can be provided. The member is responsible for paying the site visit fee again, working with NAF to schedule the repeat visit, and ensuring enough patients are scheduled so that NAF staff can observe the full range of services provided.
- **Relocation of Clinical Site:** Moving to a new facility or physical location can necessitate an off-cycle site visit, particularly if the practice is undergoing changes or adding new services. Changes that trigger a site visit may include transitioning from a smaller facility to a larger one, or relocating the practice to a new location that becomes an ambulatory surgery center.
- **Addition of New Service Modalities:** Introduction of sedation, advanced pain management, inclusion of procedural abortion at a site that previously offered only medication abortion, or increased complexity services such as D&E.
- **Significant Changes in Staffing:** This includes major shifts in clinical leadership, staffing structures, or care delivery models (e.g., transitioning from physician-led care to APC-led teams, from a procedure-only to telemab service, or introducing new clinical roles). A site visit may also be triggered if there is a 50% or greater turnover of the clinical staff or a complete change in staff within a short period, as this may affect continuity of care, training, and adherence to clinical standards.

- **Reinstatement Following Membership Suspension:** A site visit is required after completing a corrective action plan and before any consideration of reinstatement of membership. The facility must pay the full site visit fee before the visit is scheduled or conducted.
- **Receipt of Serious Complaints or Incident Reports:** An off-cycle site visit may be triggered by the receipt of credible or sustained reports involving patient safety concerns, poor clinical outcomes, or violations of clinical standards. This includes complaints submitted by patients, staff, or third parties that highlight non-compliance with the *Clinical Policy Guidelines for Abortion Care* or other quality and safety expectations.
- **Pattern of Adverse Outcomes or Patient Death:** If a practice has a pattern of adverse outcomes or a patient death, an off-cycle site visit may be required. NAF's Clinical Staff and the Chair of the QAI Committee of the Board will evaluate the circumstances and determine if an off-cycle site visit is necessary.
- **Discrepancies in Chart Reviews or Documentation:** NAF audits charts during regular site visits and may request to review charts or documentation in some circumstances, including credible complaints or reports. An off-cycle site visit may be required if the audit shows patterns that indicate poor clinical documentation, inadequate informed consent, or deviation from standard medical protocols.
- **Request from the Board or QAI Committee:** An off-cycle site visit may be triggered by a formal request for site reassessment based on observed concerns, credible reports, or emerging risks.
- **Regulatory Action or External Investigation:** Members must notify NAF of any citation or action against licensed medical staff or the facility by a licensing or health agency. NAF's QAI staff and the QAI Committee of the Board will assess whether the action requires an additional site visit or any change in membership status.

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## 5. Site Visit Components

### 5.1 Duration and Scope

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- For facilities providing **multi-day abortion procedures**, the site visit may extend over multiple days to allow observation of the complete care cycle.

### 5.2 Observation of Care

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**7. Evaluation Criteria**

All site visits are conducted using the most current version of the *Clinical Policy Guidelines for Abortion Care* as the foundation for evaluation. Clinics are expected to demonstrate alignment with these guidelines in both policy and practice.

In addition to abortion-specific standards, clinics are also expected to align with **general medical practice standards**, including appropriate credentialing, chart documentation, on-the-job training documentation, and adherence to patient safety protocols. The QAI team will assess the clinic's

ability to deliver safe, evidence-based care consistent with broader expectations of clinical quality and professional oversight.

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    - Failure to adhere to established medical and professional standards of care, including the absence of patient-centered, trauma-informed care.

2. If non-compliance is observed, the following plan will be implemented:

    - **At the 90-day post-refusal mark**, a follow-up email will be sent, and a phone call will be made to the facility's NAF Representative of record. The communication will outline the requirements and explain the consequences of continuing to refuse observation. If the refusal persists, it will be reported to the Chair of the QAI Committee of the Board.
    - **After the four-month (120-day) post-refusal date**, a letter will be sent to the NAF Representative and/or facility owner/administrator by email stating that the concern will be referred to the QAI Committee of the Board, which will provide a recommendation to the NAF Board of Directors regarding suspension or expulsion from membership (See QAI 006).

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**9. Policy Review**

This initial policy will be reviewed and updated every two (2) years or sooner as necessary to reflect regulatory or organizational changes.

**Key Personnel and Resumes for Staff Critical to the Management and Oversight of NAF's Quality Assurance Program**

Reesa Roberts, PA-C, MSPA (resume attached)

Lindsay Borglum, MS, PA-C (resume attached)

# Reesa Roberts, PA-C, MSPA

Fort Pierce, FL ◆ Mobile: 212-690-4320 ◆ ReesaRM@aol.com ◆LinkedIn

## HEALTHCARE ADMINISTRATOR AND MEDICAL PROVIDER

Physician Associate with over a decade of expertise in healthcare/health center administration, operations, management, member relations, and over two decades of experience in Reproductive Health. Expert in crafting and executing comprehensive strategies to enhance access to reproductive services, including abortion and contraception, and healthcare quality standards through effective training programs and the adoption of clinical guidelines. Proven track record of fostering strong relationships with internal and external stakeholders to ensure collaborative success and stakeholder buy-in. Skilled in team collaboration and resource stewardship, consistently advancing the strategic planning and execution of special projects aligned with organizational priorities. Well-versed in creating and strengthening processes and systems through cross-functional leadership, silo disintegration, and coalition and partner building while promoting an equitable and inclusive environment. Works collaboratively with organizational leadership and clinical staff to ensure goals and metrics are met or exceeded. Strong knowledge of best practices in healthcare within a reproductive justice framework to promote the highest levels of evidence-based, equitable, patient-centered care.

## EMPLOYMENT HISTORY

*Reproductive Health Access Project (RHAP),* Washington, DC
**NATIONAL APC CLUSTER LEADER,** October 2022-present
Lead a collaborative effort between the Reproductive Health Access Project, Nursing Students for Choice, and the National Abortion Federation to support Advanced Practice Nurses, Physician Associates, and students of these professions to support each other in sexual reproductive health provision and advocacy nationally.

*National Abortion Federation (NAF),* Annapolis Junction, MD
**SENIOR DIRECTOR OF CLINICAL SERVICES,** March 2021-present
Manage and support multiple programs that interact with NAF's broad membership of clinics, providers, and staff working to serve abortion patients in the United States, Canada, Mexico, and Colombia:

- Quality Assurance Program - Lead the Quality Assurance team, with a staff of three clinicians, that assists NAF members with resources, training, technical assistance, and programs that support evidence-based, high-quality, data-driven abortion care at NAF member clinics. NAF's quality assurance team leads 40-60 onsite visits annually using the Clinical Policy Guidelines (CPGs) with NAF members nationwide.
- Clinical Policy Guidelines (CPGs) - Contributing editor of the Clinical Policy Guidelines, the evidence-based guidelines that set the standard for abortion care in the United States and beyond. These guidelines also govern onsite clinic evaluations of NAF member facilities.
- Diversity, Equity, Inclusion, Antiracism (DEIA) - Member of the DEIA task force. Responsible for the DEIA audit of the 2022 edition of the Clinical Policy Guidelines and the inclusion of evidence-based DEIA medical practices in the 2024 edition of the Clinical Policy Guidelines.
- Education - Collaborates with NAF's educational team to create and review ACCME-accredited learning modules and educational resources for members with a DEIA and equity-focused lens. Oversees the development of on-site training, e-learning modules, and resources for member facilities. Responsible for the review and development of over 17 e-learning modules in 2023. Member of the Annual Meeting Steering Committee responsible for evaluating and selecting content for the Annual Meeting.
- Telehealth - Supervises a two-member team supporting 16 individual members and 24 practices among NAF members with telehealth systems and educational resources.
- Clinicians in Abortion Care (CIAC) - Oversee the CIAC program, focused on Advanced Practice Clinician providers interested in abortion provision and ensuring education, training, and advocacy opportunities.
- Clinical Abortion Staffing Solutions (CASS) - Co-lead the CASS project, which provides a platform for both clinics needing staff and staff seeking abortion-related job opportunities.

**QUALITY ASSURANCE CLINICIAN,** August 2015 – February 2021

- Conducted onsite quality assurance training and technical assistance visits, developed COVID-19 guidelines, and created educational materials on various subjects in abortion care.

*Planned Parenthood of Greater New York (PPGNY)*, New York, New York
**DIRECTOR OF CLINICAL/SURGICAL SERVICES,** June 2005 – July 2015

- Oversaw clinical services, supervised clinical staff, managed center operations, and implemented systems to improve patient flow and service delivery.

**QUALITY SYSTEMS MANAGER,** April 2013 – July 2015

- Led quality assurance and improvement programs, conducted audits, and ensured compliance with health department regulations.

**PHYSICIAN ASSISTANT/ADVANCED PRACTICE CLINICIAN**, June 2005 – July 2015

- Provided direct GYN and medication abortion services to patients within scope of practice

[redacted]

*NYC Health + Hospitals - Woodhull*
**CHIEF PHYSICIAN ASSISTANT** 4.9 years
**PHYSICIAN ASSISTANT** 6.7 years

[redacted]

**Master's Degree Physician Assistant**
*Stony Brook University* – Stony Brook, NY

**Bachelor's Degree Physician Assistant**
*City University of New York* – New York, NY

[redacted]

- Advanced Graduate Certificate in Health Care Management, Stony Brook University
- Physician Assistant Licensure - Florida: Expiration 1/31/2026; New York: Expiration 9/30/2025; North Carolina: Expiration 10/6/2025; Michigan: Expiration 3/26/2025
- Basic Life Support for Healthcare Providers (BLS): Expires 1/2026

[redacted]

- *2024 Clinical Practice Guidelines Update:* (NAF Webinar, March 6, 2024)
- *Clinical Practice Updates & POCUS:* (National Abortion Federation Canada Fall Meeting. October 21-22, 2023)
- *Clinical Simulations:* (National Abortion Federation Canada Fall Meeting. October 21-22, 2023)
- *Changes in Clinical Practice*: (National Abortion Federation Canada Fall Meeting. October 22-23, 2022)
- *Compliance 101*: Creating Strong Practices to Help Maintain Abortion Access. (National Abortion Federation Annual Meeting, April 30-May 2, 2022)
- *Who Is Taking You Home Today*? Escort Policies to Help Maintain Abortion Access. December 2021.
- *Medication Abortion:* (Maryland Association of Physician Assistants Annual Conference, September 2021)
- *COVID-19 Infection Prevention 2: The* "New Normal." *(*NAF COVID-19 Webinar Series, July 2020)
- *Inspections 101:* Understanding Your Rights and Responsibilities, Building Confidence, and Decreasing Stress During the Inspection Process. (Abortion Care Network Annual Meeting, 2020)
- Medical Updates – *First Trimester Cervical Preparation.* (National Abortion Federation Annual Meeting, 2019)
- Post Graduate Seminar: *Ultrasound in Abortion Care – Introduction to Transvaginal Ultrasound*. (National Abortion Federation Annual Meeting, 2019)
- *Proactive Professional and Legal Strategies to Challenge Abortion Provider Restrictions*. (North American Forum on Family Planning, 2018)
- *Common Solutions in Quality Care*. (National Abortion Federation Annual Meeting, 2018)

- *Clinical Policy Guidelines (CPGs) and Quality Assessment Improvement (QAI) Program*. (National Abortion Federation Annual Meeting, 2017)

## PUBLICATIONS

- Mark A, Roberts R, Foster AM, Prager SW, Ryan R, Winikoff, B. Who is driving you home today? Escort policies as a barrier to abortion access. Contraception 2021. 108 (4-6). (https://doi.org/10.1016/j.contraception.2021.12.012)
- Contributing editor of the National Abortion Federation's 2024 Clinical Policy Guidelines.
- Author and editor of online learning modules, the latest including Informed Consent, Procedural Abortion by Aspiration Only, and Managing an Abortion Emergency- Respiration.
- Author and editor of clinic protocols and patient information, the latest including Early abortion options, Medication abortion consents (mifepristone/misoprostol & misoprostol-only), Ultrasound training documentation form (English & Spanish), Chart review/audit tools, Rh patient info and consent, Tissue exam protocol, and Miso-only protocol.

## PROFESSIONAL AFFILIATIONS

- American Academy of Physician Associates
- National Association for Healthcare Quality
- Society of Family Planning
- Association of Physician Associates in Obstetrics and Gynecology
- African Heritage Physician Associate Caucus
- Florida Association for Healthcare Quality
- Clinicians in Abortion Care

## VOLUNTEER EXPERIENCE

- Vice President of the board for Florida Access Network
- Floridians for Reproductive Freedom – Contraceptive Access Work Group Committee Chair

# Lindsay Borglum, M.S. RPA-C

P.O. Box 100
Annapolis Junction, MD 20701
LBorglum@prochoice.org

**Bright and knowledgeable clinician** with over a decade of clinical experience, resulting in provision of exemplary patient care with a great deal of independence.

**Critical thinker** who values lifelong learning. Continually seeks out opportunities to expand knowledge and experience, both individually and within the organization as a whole.

**Highly dedicated employee** whose passions include creative problem-solving and caring for medically underserved patient populations.

## Select Accomplishments

- First APC in PPGNY history privileged as 1st trimester surgical abortion provider in 2020
- Scored in top 5-10% of all APCs on PPFA's Press Ganey Patient Experience survey in 2019
- Co-presenter at Guthrie Clinic Medical Grand Rounds, November 2018
  - Presentation: *Welcoming LGBTQ+ Patients – Providing Thoughtful and Affirming Care*
- Guest lecturer for Syracuse University Teaching Days, January 2018
  - Presentation: *Care of Transgender & Gender Nonbinary Patients*

## Professional Experience

**National Abortion Federation** Apr 2024 to present

- Conduct Quality Assurance and Improvement (QAI) site visits for NAF's institutional members to assess compliance with NAF's *Clinical Policy Guidelines for Abortion Care*, preparing reports to provide facilities with clear, actionable follow-up recommendations and quality improvement plans
- Create and deliver technical assistance trainings on relevant clinical content to support NAF members in the provision of evidence-based, high-quality abortion care
- Collaborate with NAF's education team to create ACCME-accredited learning materials
- Contribute to follow-up analysis, measuring effectiveness of quality improvement plans
- Serve on the Learning Subcommittee of NAF's DEIA Taskforce

**Highland Women's Health** Jan 2023 to Oct 2023

- Provided comprehensive OBGYN specialist care in the outpatient setting
- Expanded clinical expertise to include management of high-risk obstetric patients
- Assisted in rollout of abortion services within the practice

**Planned Parenthood of Greater New York (formerly PPSFL)** May 2016 to Nov 2022

- Comprehensive reproductive health care provider: routine health maintenance visits, cancer screening services, GYN/GU conditions, STI screening and treatment, PrEP, all forms of contraception, management of early pregnancy conditions, abortion
- Management of gender-affirming hormone therapy for transgender/nonbinary patients
- Collaborated with Education & Outreach department to present technical assistance trainings with LGBTQ+ focus to our community partners
- Assisted in planning and implementation of new services (ex. procedural abortion, PrEP), supporting Director of Clinical Services in successful rollout by identifying and/or creating training resources for staff members
- Gained experience utilizing telehealth to provide both synchronous/asynchronous care
- Member of Sexual & Reproductive Justice and Policy Advisory Council workgroups

**Finger Lakes Health Urgent Care** (per diem) May 2013 to July 2019
- Assess and manage patients of all ages presenting to urgent care with acute conditions

**Finger Lakes Community Health** January 2014 to March 2016
- Provided comprehensive medical care to underserved rural communities
- Services offered by this FQHC include Title X family planning program and federal funding to provide medical care for seasonal migrant farm workers

**Strong Health Geriatrics Group** October 2012 to January 2014
- Responsible for providing primary health care services to medically complex elderly residents of five independent/assisted living facilities across Monroe County

## Education

**SUNY Upstate Medical University | M.S. in Physician Assistant Studies | August 2012**
- Master's thesis: Management of Depression in the Rural Primary Health Care Setting

**SUNY Geneseo | B.A. in Music | May 2010**
- Concentration: Viola Performance

## Certifications & Licensing

- NCCPA certified
  - September 2012
- Licensed in NYS
  - October 2012
- DEA certified
  - November 2012
- ACLS/BLS certified