UNM Division of Family Planning
Department of Obstetrics & Gynecology
MSC10 5580
1 University of New Mexico
Albuquerque, NM 87131
(505) 925-0687
obgyn.unm.edu

Welcome to the HO1 Family Planning Rotation!

We are very excited to have you join us for your rotation, and we hope you find your experiences here as wonderful as we have found ours. This document is intended to guide you operationally throughout your rotation. You will receive more specific instruction after you arrive and meet your attending physicians.

We continue to update and revise this document as we grow and learn, so please let us know if there are items we should include or update.

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Course Description

This is an (8) week rotation focusing on family planning care within the UNM Department of Obstetrics and Gynecology. The rotation will include clinical care within the UNM Center for Reproductive Health (CRH), the Outpatient Surgery and Imaging Services clinic (OSIS), and the Planned Parenthood Surgical Center (PP). During your rotation, you will gain knowledge and clinical experience in the following areas:

- Contraception counseling
- First- and second-trimester dating ultrasounds
- First- and second-trimester abortion care
- Management of pregancy of unknown location, miscarrage, and ectopic pregnancy
- Emergency contraception
- Sterilization: Including laparoscopic and hysteroscopic approaches
- Routine outpatient gynecologic care

Resident Responsibilities

You will train at the resident level, under the direct supervision of Ob/Gyn fellows and faculty. You are expected to participate as a full member of the family planning team. Responsibilities include:

Clinic Attendance – You will attend all assigned clinics at:

- ☐ UNM Center for Reproductive Health (CRH)
- ☐ Outpatient Surgical and Imaging Services (OSIS)
- ☐ Planned Parenthood Surgical Center

Presentation – You will be responsible for:

- ☐ Presenting a case for discussion at the Reproductive Health ECHO Clinic
- ☐ Presenting surgical case list at pre-op weekly
- ☐ Presenting cases at Family Planning M&M

Clinical Operations – You will:

- ☐ Prepare for clinic each day you are there
- ☐ Manage the clinic Beta Book
- ☐ Schedule patients for surgery
- ☐ Maintain the surgery case list
- ☐ Manage the weekly OSIS clinic
- ☐ Enter your online ACGME statistics weekly

Didactic – You will attend and participate in

- ☐ Monday morning Ryan Curriculum sessions
- ☐ Family Planning M&M: Compile case lists and present cases, *this is now often done by fellow*

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- ☐ Pre-op conference and Grand Rounds on Fridays
- ☐ Friday Resident conference
- ☐ Family Planning Journal Club (if one occurs during your rotation)

Assignments – Online Modules. You will complete:

- ☐ Ryan Program quizzes for Monday didactic: via email and also by https://ryanprogram.org/cms/wp-login.php

Values Clarification – You will:

- ☐ Complete the values clarification exercise
- ☐ Review the values clarification exercise with attending
- ☐ Sign off on values clarification, and opt-out paperwork, if applicable

Clinical Objectives

Contraception

- Effectively counsel women about and initiate all currently available methods of contraception
- Mirena and ParaGard IUD insertion
- Nexplanon implant insertion and removal
- Be able to effectively use the *U.S. Medical Eligibility Criteria* and *Selected Practice Recommendations for Contraceptive Use* and to have baseline knowledge of *Providing Quality Family Planning Services*
- Fit a diaphragm (understand and describe)

Induced Abortion

- Options counseling
- First and second trimester ultrasound
- Counsel patients about oral and IV pain management options
- Provide oral and IV pain management and understand and describe management of complications related to medication use.
- Counsel and consent patients for first trimester abortion
- Perform a surgical 1st trimester abortion with MVA and EVA
- Perform appropriate tissue exam
- Understand and describe complications of first trimester abortion
- Counsel and consent patients for second trimester abortion
- Place intracervical laminaria and dilapan
- Understand and describe complications of second trimester abortion
- Perform medical termination of pregnancy with mifepristone/misoprostol

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Spontaneous Abortion

- Perform 1st trimester ultrasound to diagnose normal and abnormal pregnancies
- Understand the approach to the diagnosis of miscarriage vs. threatened abortion vs. ectopic pregnancy
- Manage miscarriage medically with misoprostol
- Manage miscarriage surgically with manual (MVA) or electric vacuum aspiration (EVA)
- Perform appropriate tissue exam

Ectopic pregnancy

- Diagnosis of ectopic pregnancy.
- Manage ectopic pregnancy medically with methotrexate.
- Manage ectopic pregnancy surgically with salpingostomy vs. salpingectomy (understand and describe)

Sexually Transmitted Infections (STI)

- Counsel patients about risks and acquisition of common STIs
- Screen patients for common STIs based on current CDC guidelines
- Diagnose and treat common STIs

Sterilization

- Counsel and consent patients about permanent sterilization
- Perform interval laparoscopic sterilization

Assessment

Self-Evaluation: Competency/Evaluation Checklists

Please complete your self-evaluations first and then have the attending present with you complete the checklist/evaluations. We use this information to do your mid-point and final evaluations, so please be proactive about getting these done. The competency/evaluation check lists that need to be completed during the rotation are attached in this packet.

MyTipReport

Please have each Family Planning attending complete at least 1 procedure evaluation (IUD insertion, IUD removal, difficult IUD removal, implant insertion, implant removal, surgical abortion (D&C/uterine aspiration), medication abortion) with you once in the first half and once in the second half of the rotation. Your goal is to have at least one MyTipReport evaluation for each procedure in the 1st and 2nd halves of the rotation.

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We will evaluate whether you are meeting the clinical goals and objectives by:

- Directly observing your clinical, technical and communication skills
- Judging your didactic knowledge and participation in teaching sessions
- Pre- and post-tissue inspection test
- Evaluating your skills using MyTipReport

Timeline: Rotation Checklist

Before Rotation Starts

- ☐ Thoroughly review this packet. Ensure you have the tools you need to complete these assignments and to be ready to participate in discussion.
- ☐ Complete the Values Clarification Exercise at the end of this document
- ☐ Download the CDC Contraception and CDC STD Tx Guidelines apps if you do not already have them
- ☐ Meet with Dr. Krashin and off-going resident
- ☐ Plan to have a great rotation!

First Two Weeks

- ☐ Contact the SANE clinic and schedule a tour
- ☐ Review your Values Clarification with Dr. Krashin
- ☐ Read all of the Family Planning SOPs
- ☐ Review this packet again

Rotation Mid-Point

- ☐ Complete your mid-point evaluation
- ☐ Schedule appointment with Dr. Krashin
- ☐ Submit first set of evaluation forms
- ☐ SANE clinic toured

Last 2 Weeks / End of Rotation

- ☐ Complete final evaluation
- ☐ Present case at ECHO
- ☐ Schedule time to meet incoming intern to review Beta Book, OR schedule and weekly schedule.

Family Planning Faculty & Fellows at UNM

Eve Espey, MD, MPH	Chair, Ob/Gyn & Director, Fellowship in Family Planning eespey@salud.unm.edu
Lisa Hofler, MD, MPH, MBA	FP Division Director, Assoc. Medical Director, CRH lhofler@salud.unm.edu

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Jamie Krashin, MD, MSCR	Director, Ryan Family Planning Residency Program jkrashin@salud.unm.edu
Brenda Pereda, MD, MS	Dean of Diversity UNM SOM brpereda@salud.unm.edu
Gillian Burkhardt, MD	Medical Director, L&D gburkhardt@aolud.unm.edu
Regan Riley, MD, MPH	Volunteer Faculty RRiley@salud.unm.edu
Maritza Rivera-Montalvo	Family Planning Fellow (Y2) MaRiveraMontalvo@aolud.unm.edu
Anwar Jackson	Family Planning Fellow (Y1) Email pending

You may also work alongside Family Planners from UNM's Department of Family Medicine.
Family Medicine providers at CRH include:

Larry Leeman, MD, MPH	Director, Family Practice Materity & Child Health
Jennifer Phillips, MD	Assoc. Medical Director, Center for Reproductive Health
Adela Tam, MD	Faculty, Family & Community Medicine
Nicole Yonke, MD, MPH	Faculty, Family & Community Medicine
Laura Chambers-Kersh, MD	Faculty, Family & Community Medicine
Kira Paisley MD	Faculty, Family & Community Medicine
Daniel Stulberg, MD	Faculty, Family & Community Medicine

Important phone numbers and addresses

Attending Pager Numbers

Dr. Jamie Krashin	(505) 380-0435
Dr. Brenda Pereda	(505) 951-1880
Dr. Eve Espey	(505) 951-2228
Dr. Lisa Hofler	(505) 951-1970

Surgery

Scheduling:	(505) 272-2249 (Michelle Singletary)
Main Line:	(505) 272-9096
Fax:	(505) 272-2410

Pre-Op Anesthesia Clinic

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Location: 2nd Floor of old hospital (ACC)
Walk-in clinic: 8:00 AM – 4:00 PM
Patients Must Bring: Original or copy of consent
Surgical admission (blue card)

SANE Clinic – (Sexual Assault Nurse Examiners)
Location: 625 Silver Ave SW, 2nd Floor, Albuquerque, NM 87102
Phone: **(505) 450-8438** or (505) 248-3153 - Clinical Coordinator, Gail Starr – gail.starr@abqsane.org
Fax: (505) 883-8715

UNM Financial Assistance Office
Location: 1131 University NE, Suite D (*Next door to Satellite Coffee)*
Phone: (505) 272-4858
Rebecca B. Jaramillo, Patient Financial Serv. Supervisor

Family Planning Rotation Clinical Training Sites

Clinic	CRH	OSIS	Planned Parenthood
Location	2301 Yale Blvd. SE, Bldg. E Albuquerque, NM 87106	1213 University Blvd. NE Albuquerque, NM 87106	701 San Mateo Blvd. NE Albuquerque, NM 87108
Main Line	Main Line: (505) 925-4455 Dr's Pod: (505) 925-4286		Main Line: (505) 265-9511
Admin Contacts	Judy Rounsefell, Clinic Manager (505) 925-4455 jrounsefell@unmmg.org	Christopher Brock cabrock@salud.unm.edu	Adrianna Farfan Health Center Manager Adrianna.Farfan@pprm.org

Weekly Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
(0 Hour) 7:00am	Ryan Curriculum				Pre-Op Conference Grand Rounds
AM (8:00am)	Dr. Andrew's clinic	CRH until 10a PP after 10a	CRH	OSIS	Resident Conference
PM (12:30pm)	FP Admin Time	PP	CRH	CRH	CRH
(After Hours)		Journal Club once every other month, 6:15-8:15pm			

- Please arrive at CRH by 8:00 am unless otherwise instructed by your attending physician.
- Faculty will instruct you when and where to go for Planned Parenthood clinic Tuesday mornings.

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- If you begin your rotation on a Monday, please attend Ryan Curriculum session first, and then report to Dr. Andrews' clinic.

Didactic Sessions

Pre-Op and Grand Rounds

Pre-Op Conference and Grand Rounds occur every Friday morning at 7:00am and 8:00am, respectively. You will present weekly at Pre-op conference.

Ryan Curriculum Sessions

Ryan curriculum sessions occur every Monday morning at 7:00am, held in the Ob/Gyn conference room on 4ACC. Please plan to attend throughout your rotation. Your are responsible for assigning the readings to yourself and the other trainees: OB MS3, FM resident, FM MS3, any MS4. The Family Medicine Coordinator will send an email with those in attendence and the readings. Below you will find links to our wiki page with the topics, facilitator assigned to each date, and the readings.

- Link to topic/facilitator schedule
- Link to readings

Family Planning Journal Club

Journal Club occurs every other month, usually on a Tuesday, Wednesday or Thursday evening, from 6:15pm-8:15pm at Dr. Espey's house (unless otherwise notified). Below you will find a link to our wiki page with Journal Club dates, agendas (as they are finalized), and readings. Please plan to attend Journal Club if one falls during your rotation.

- Link to Journal Club dates, agendas, and readings

Online Curriculum Assignments

Residency Program: Women's Health Curriculum

To access both curriculums, click the following link: http://bit.ly/TheResidencyProgram

- The password to login to this curriculum is **education**.
- Once logged in, you will have a choice of selecting Intrauterine Contraception. Select Intrauterine contraception.

Values Clarification Exercise

An initial values clarification was conducted during Intern Orientation. Now that you will be completing your Family Planning rotation, we would like you to complete this exercise in order to allow you to focus on your attitudes and beliefs about abortion in a variety of settings. A faculty member will go over the exercise with you—please know that we respect your feelings about this sensitive subject, whatever they are. We believe there is value in exploring our attitudes about abortion to help you get the most out of

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your time with us. Please review and complete the Values Clarification Exercise attached to the end of this curriculum document.

Residents who opt out will be scheduled for family planning clinics at CRH and will cover other services during scheduled CRH abortion clinics in order to allow other residents to get further training. Please review, complete, and sign the Opt Out Policy and Process Form attached to the end of this curriculum document.

SANE (Sexual Assault Nurse Examiners) Clinic

- Contact the SANE Clinical Coordinator and make arrangements within the first two weeks of your rotation to tour the SANE facility and hear about their resources.
- During 2-4th weeks of your rotation, be on-call to go to SANE for an exam. Please call them every week to remind them you are interested and available. Give them your pager number.
- **Your faculty are committed to your learning experience.** You will be excused from clinic for your tour, and you will be excused from clinic if you get paged to perform a SANE exam.

Reporting Statistics

Enter your online ACGME statistics weekly. The four common procedures performed on this rotation that must be recorded are abortion management (elective and spontaneous, medical and surgical), transvaginal ultrasound, hysteroscopy and laparoscopy. Please discuss with Dr. Stonehocker if you have any questions.

Clinic Security

Protesters may be present outside the CRH clinic and/or Planned Parenthood Surgical Center, and we would like you to take some basic security precautions while attending clinic.

At CRH, please enter through the clinic front door. You should not be in the clinic by yourself; please finish notes before the last attending or fellow leaves. Please make sure you have all necessary paperwork for OSIS (most importantly: federal sterilization consents) before you leave on Wednesday evening.

General security tips:

- Remove anything from your person that will identify you as medical personnel before you come to the clinic. This includes: ID badges, pagers, scrubs (wear regular clothing and bring a set of scrubs to the clinic on the days you will be doing procedures), white coats.

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- Remove anything in your vehicle that might identify you as medical personnel or associate you with the clinic. These include items such as your: Parking pass, badges, mail, scrubs/clothing.
- If protesters are present, please DO NOT interact with them in any way.
- Stay alert and aware of your surroundings when entering and exiting the building as well as when you are driving.
- If you feel you are in a situation where you would prefer to have security escort you, contact the police, 242-Cops or 911 if emergency.
- If you think you are being followed: Go to a fire station, police substation or a well-lit public area.
- If you are hit from behind and you suspect it was not an "accident." Do not get out of your car. Call 911 and tell them you think you are being car jacked, that gets the police out much quicker.
- Give as little information about yourself as possible when in public. Do not share where you work unless it is necessary

Please talk to us—Drs. Pereda, Hofler, Krashin, or Espey —at any time if you have concerns about your security or concerns about the experience at the clinic. We want this to be a great clinical experience for you and understand that the rotation can bring up emotions. We are here for you!

Clinic Process at a Glance: Family Planning Clinic

Contraception (*use the U.S. Selected Practice Recommendations & U.S. Medical Eligibility Criteria for Contraceptive Use)*

- Current contraception?
- Last menstrual period?
- Last sexually active? Protected? Does she need emergency contraception?
- Negative pregnancy test
- Is screening for GC/CT needed?
- Medical contraindications?
- Back-up contraception needed?
- Counsel and sign consents (for LARC procedures)

Permanent Contraception

- Hysteroscopy (Essure) *Now rarely performed. CRH has several kits that can be used until they expire.*
    - In clinic or OSIS.
    - Certain insurances require prior authorization. Check with front office.
    - The endometrium should be prepped for at least 7 days but ideally longer. If the patient declines any contraception, then try and schedule the patient immediately after her

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menses. Depo-Provera is a good option and gives the needed protection for 3 months, or start pills.

- Laparoscopic Sterilization
    - What's her BMI?
    - Review medical history (does she need to see pre-anesthesia?)
    - Set a surgery date in the GYN OR schedule (see "Scheduling patients for Surgery" and "OSIS" section below).
    - Title X can receive Filshie clips only. They have been thoroughly counseled about reversible vs permanent contraception and do NOT need further counseling about LARC or short-acting methods by us.
- SOPs on the OBGYN Wiki:
    - Administration of DMPA
    - Extended Use of LARCs

Clinic Process at a Glance: ABO Clinic

1. History
    - Start with the one liner including LMP dating +/- prior u/s dating. Repeat in the assessment and plan.
    - POBHx – PP bleeding, previous deliveries, c-sections affect your planning.
    - PGYNHx – Regular/irregular cycles, nl vs heavy menses, dysmenorrhea, previous experience with contraception, previous history of STIs, etc affects your contraceptive counseling
    - PMH – DVTs/PEs, seizures, HTN, etc
    - PSH
    - ROS
    - Social Hx – support system, tob/etoh/drug use.

2. Ultrasound
    - All patients should have an ultrasound – Document singleton/multiple, measurements, and placenta location.
    - Take pictures and fill out the ultrasound form.
    - For early pregnancies up to 12 weeks
        - GS ± YS and no CRL
            - Measure gestational sac
            - Mean Sac Diameter (MSD) = (L+W+D)/3
            - Measure the inner margins of the sac in three dimensions, with length and depth measured in the longitudinal axis and width measured in the transverse plane.
            - Should see yolk sac when MSD 8-10 mm
            - Should see fetal pole when MSD>18 mm
            - General rule: EGA in days = MSD + 30

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- GS + YS + CRL present
  - Measure the CRL up to 12 weeks
  - Gestational age (±3 days) in days = CRL (mm) + 42
- For pregnancies > 12 weeks
  - BPD and FL
    - For patients with previous C-section(s) and anterior placenta, low-lying placenta or placenta previa may need formal scan to rule out placenta accreta/increta/percreta.
  - Require cervical preparation = extra time in clinic (consider starting cervical prep at earlier gestational ages for teens and nullips)
- Patients can be referred to Women's Ultrasound (272-8913) or to Diagnostic Imaging for a formal U/S

Table: Predicted gestational age for biparietal diameter measurements. The confidence intervals around the estimates (± 2 standard deviations) are 1.2 at 12–18 weeks and 1.7 at 18–24 weeks
(Adapted with permission from Hadlock et al)

BPD (cm)	Gestational age (wk)	BPD (cm)	Gestational age (wk)
2.6	13.9	4.3	18.9
2.7	14.2	4.4	19.2
2.8	14.5	4.5	19.5
2.9	14.7	4.6	19.9
3.0	15.0	4.7	20.2
3.1	15.3	4.8	20.5
3.2	15.6	4.9	20.8
3.3	15.9	5.0	21.2
3.4	16.2	5.1	21.5
3.5	16.5	5.2	21.8
3.6	16.8	5.3	22.2
3.7	17.1	5.4	22.5
3.8	17.4	5.5	22.8
3.9	17.7	5.6	23.2
4.0	18.0	5.7	23.5
4.1	18.3	5.8	23.9
4.2	18.6	5.9	24.2

3. Lab tests

- Pap smear if indicated
- GC/Chlamydia testing (Other STI testing prn) (Use CDC guidelines and history)

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- For first trimester abortions – check RH status. HemoCue prn (obtain for all 2nd trimester procedures).
- For second trimester abortions – Rh and Hb/Hct (preferred) or HemoCue (acceptable)

4. Contraception Counseling

- Goal is for each patient to leave with some form of contraception that she will successfully use.
- Tailor the contraception to the woman's needs. Consider previous contraceptive use, menstrual history, sexual history and insurance status.
- Use the US SPR and MEC to help decide which methods are medically appropriate and how to manage common issues.
- Don't forget to counsel then about Plan B and Ella.

5. Medical Abortion
   - Effective up to 70 days GA
   - Contraindications – Chronic renal insufficiency, long-term corticosteroid use, allergy to either Mifeprex or Misoprostol
   - Requires reliable patient for f/u.
   - Risk of fatal sepsis (Clostridium sordelli) - 1/100,000
   - Protocols (see FP SOP)
     - Mifepristone 200 mg PO in clinic
     - Misoprostol 800 mcg BUCCALLY 24-48 hours later or VAGINALLY 0-48 hours later at home
     - Office f/u in 1-2 weeks for U/S confirmation of completion vs repeat beta-hCG in 1 week.
   - Sign all appropriate paperwork including consents.
     - Fill out pink Medicaid form (or hand to attending to fill out).
     - Fill out DOH Induced Termination of Pregnancy form. This data is aggregated by the state and sent to CDC for its national surveillance.
   - Review expectations and emergency contact information
   - Check RH status.

6. Surgical Abortion
   - D&C up to 12 weeks
   - Standard D&E up to 23 6/7 weeks.
   - Beyond this gestational age we will discuss feasibility on a case by case basis.
   - Discuss pain management options – oral versus intravenous
   - Sign appropriate consent forms, including laminaria consents, D+C vs. Standard D+E/laminaria placement, IUD insertion.

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- If she is getting intravenous sedation counsel her about the risks and include it on the consent form.
- Self-pay patients need to pay additional fee for IUDs/Implant.
- If you are placing lams and/or dilapan use the reference table below. We often combine lams and dilapan. Two dilapan equals about 3 lams.
- If medically complicated patient, then she may need to be done in the OR. Depending on GA patient will be scheduled at OSIS (<14 weeks) or main OR (>14 weeks). Make sure the BLUE CARD indicates it is a therapeutic abortion since only certain OR staff will cover the case.

- SOPs on the OBGYN Wiki:
  - 2nd trimester pregnancy termination, D&E, and Induction of Labor
  - 3rd Trimester induction of labor for IUFD or fetal or maternal indications
  - CKL and intrafetal and intra-amniotic digoxin injection
  - Medical abortion
  - Medical management of EPL
  - Very early abortion
  - Local anesthesia

Table: REFERENCE RANGES FOR LAMINARIA *OR* DILAPAN FOR CERVICAL PREPARATION FOR D&E ABORTION

GESTATIONAL AGE (Weeks)	NO. OF LAMINARIA[a] *OR* DILAPAN	
	FPAMG[b]	Haskell/Easterling[c]
13.5-14.0	1-2 Laminaria	None used
14.5-15.5	2-3 Laminaria	3-6 Laminaria *or* 3-5 Dilapan
16.0-17.0	4-5 Laminaria	6-8 Laminaria *or* 4-6 Dilapan
17.5-19.5	5-8 Laminaria	8-12 Laminaria *or* 5-7 Dilapan
20.0-20.5	6-9 Laminaria *or* 4 Dilapan	8-12 Laminaria *or* 6-8 Dilapan *or* Serial
21.0-22.0	7-10 Laminaria *or* 5-6 Dilapan	Serial
22.5-23.0	Day 1: 5 Laminaria Day 2: 20 Laminaria	Serial

[a]Haskell specifies 5-mm (large) laminaria. Family Planning Associates Medical Group (FPAMG) allows clinician choice among 3-mm (small), 4-mm (mediem), and 5-mm (large) laminaria.
[b]Protocol issued by May 1996 by Family Planning Associates Medical Group. Standardized procedure for insertion of osmotic dilators by NPs/PAs. Long Beach, CA.
[c]The lower numbers listed in columns are used by Martin Haskell, MD; the higher numbers are used by Thomas Easterling, MD.

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Clinic Process at a Glance: Managing the Beta Book

You are the primary manager of the Beta Book.

Purpose of the Beta Book

- Rule out ectopic pregnancy
- Follow ectopics that have been treated with MTX
- Follow molar pregnancies
- Keep track of early pregnancy loss (miscarriage)
- Diagnose (and refer for prenatal care) early desired intrauterine pregnancies

Learning objectives for managing the beta book:

- Implement an accurate, cost-effective and sensitive approach to the workup and diagnosis of early pregnancy complications.
- Describe strategies to avoid erroneous treatment of normal desired pregnancies with methotrexate or D&C.
- Make the diagnosis and initiate treatment options for ectopic pregnancy.
- Make the diagnosis and initiate treatment options for miscarriage.
- Describe the follow-up for molar pregnancy.

General Guidelines for Managing the Beta Book

- Perhaps the best way to think of the beta book patients is as a service. These patients are on your service, so you need to keep track of them!
- You will have one family planning attending assigned to review the book with you. The attending beta book coverage changes monthly.
- It's a good idea to check the PowerChart list for any new "admits," remind L&D team to send you patients who need to be followed in the book, and to review the book daily to make sure you follow up on HCGs, urgent phone calls, etc.
- Maintain the brief history, review of labs and treatment, and plan in the cache in PowerChart.
- The initial beta-book note will be a clinical note with the auto-text below. Keep this documentation open and document all communications with the patient, including attempts to call, treatment received, and lab/US results. Have the attending sign the documentation when the patient is removed from the book.
- Although there may be 20 patients in the book, there are usually only 1 or 2 that are under real suspicion of ectopic pregnancy. Important to see these "trees" for the forest.
- If you are on vacation during the Family Planning rotation, the 4th year on will cover the service. It's important that you check out to this resident, the on-call family planning fellow, and the attending. Please email these people before leaving on vacation so that the coverage plan is clear.
- On Fridays, make a plan with the attending and on-call fellow for beta book coverage so that you have at least 24 consecutive hours not working (including not working on the beta book).

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Specific beta-book issues

- All patients who received Methotrexate for presumed ectopic pregnancy should stay in the book till the HCG is down to 0.
- Phone notes should be placed in PowerChart to document attempts to reach the patient. This should be in an ongoing document that will eventually be signed by the attending when the patient leave the book. The last entry includes how the pregnancy resolved: ongoing intrauterine pregnancy, ectopic pregnancy treated or completed abortion.
- If a patient cannot be reached after 3 attempts over 2-4 weeks, a certified letter needs to be sent and noted in the last entry of the ongoing documentation. When you write a certified letter, please note this in the final entry of the documentation and remove the patient from the beta book – this will allow you to see the trees among the forest.
- If the patient has clinic visits, the dictations from those visits explain the resolution of the pregnancy. You can refer to this note in your final entry on how the pregnancy resolved (see above).
- Please remember that contraception/plans for pregnancy should be discussed with all patients who have had a pregnancy complication.
- Not all patients need a certified letter—we'll discuss the circumstances.
- For letters that need to be in a foreign language, you may contact interpreter services for help with translation.
- SOP on OBGYN Wiki:
    - Methotrexate for ectopic pregnancy
        - Sometimes forgotten details:
            - Day of MTX administration = Day 1 (not 0)
            - Remember to counsel: no vaginal intercourse, avoid sun & folic acid

Auto-text for initial beta book clinical note (label "OBGYN Beta Book" in subject):

INITITAL BETA BOOK CLINIC NOTE

Primary provider: _.
Primary provider would like to follow up patient after resolution of reason for beta-book [_] yes [_] no
Referring provider: _

This is a _yo G_P_ who presented with _ on _. _

Initial b-hCG on _: _
Initial US on _:
Ultrasound findings: _
Uterus: _
Adnexa: _
Free Fluid: _

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Blood type: _

Plan: _
Best patient contact number: _. Okay to leave detailed messages: [_] yes [_] no

---

Clinic Process at a Glance: Scheduling Patients for Surgery

OSIS vs Main?

- Most of our patients undergoing minor procedures (laparoscopic tubals, hysteroscopy, D&C's, etc.) are performed at OSIS.
- Certain patients are not candidates for OSIS. These include:
  - Women with multiple co-morbidities
  - BMI > 40.
  - Please discuss (email/talk) with Dr. Krashin if you have a patient who you are concerned may not be a candidate for OSIS.

Your OSIS Scheduling Responsibilities are as follows:

- Schedule patients on Sharepoint (see below)
- Present patients at pre-op conference
- Perform pre-op exams and sign consents
- Create a final list of patients for OSIS by Tuesday (2 days before the actual OSIS day and email to the attending in the OR that day) in the order that the cases are to be performed (see below for more detail)
- Ensure that front office staff faxes the consents the same Tuesday (see below) or take them with you to surgery.
- If you get totally frustrated with anything OSIS-related, talk to Dr. Krashin—we'll figure it out!
- Any patient you plan to take to the operating room MUST BE added to the Sharepoint calendar.
  - https://moss.health.unm.edu/sites/som/obgyn/gyn
  - Login = HEALTH\your first initial and last name (for ex: HEALTH\sdecker)
  - Password = HSC Net ID Password
- The OSIS patients look like they are on Saturdays, but they are really on Thursdays (that is just where they are kept to keep things simple on the calendar). Ask Chief to show you how to do the first one, and it will all make sense.
- The format is this:
  - CRH (or whatever your location is);
  - Patient name;
  - Patient MRN;

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  - Planned procedure.
  - Get the date right for the patient (Thursday date not Saturday). Time doesn't matter unless you have a specific order you want, and then adjust accordingly.
  - In the notes/comments line put BCS (blue card submitted) and the date.
  - Save.
- Usually schedule 5-6 cases per Thursday.
- GIVE FRONT OFFICE 1.) a **BLUE CARD** [No card = no surgery] and 2.) the **CONSENTS** -- so they can be faxed directly to OSIS. Keep copies for yourself to hand-carry to OSIS with you.
- Set a pre-op date (at least 14-21 days prior to surgery date, if you schedule it too close the surgery date and they no-show then it leaves holes in your surgery schedule)
- For patients on medical assistance (Medicaid, Tricare, the Salud programs, and UNM SCI) the FEDERAL consent must be signed at least 30 days prior to and within 180 days of the surgery date.
- There is no waiting period for patients with private insurance.
- ***Make sure she has contraceptive coverage until her surgery.***
- For patients scheduled through CRH, RN will call them for a post-op check; you do not need to schedule post-op appointments.
- Other residents/attendings sometimes schedule PCC cases at OSIS- check with the resident to see if they wish to attend the surgery, present at pre-op conference, and have the consent/blue card submitted
- Check for latex allergies- if a patient has a latex allergy, try to put them first case. If not possible, OSIS must know to have the room latex free for all cases prior

<u>OSIS SCHEDULE:</u>

- Please email a copy of the planned schedule for Thursday OSIS to the attending in the OR by that Tuesday.
- Please do not text any OSIS numbers.
- If you need to contact OSIS:
  - **(505) 272-3719, (505) 688-0527** (Chris Brock's cell): These numbers will be answered between 0800 – 1600 for scheduling cases, or you may leave a message.
  - **(505) 925-4842** This number is the OSIS OR Front desk and should be used to communicate any clinical information or scheduling issues. You may also call this number if you don't reach anyone at the above numbers between 0800 – 1600 or outside of these hours.
  - **(505) 710-8027:** This number is the OSIS OR RN Supervisor cell phone and will be operable from 0630-1530.
  - **(505) 925-4852:** This number is OSIS PACU and can be used after 1530 but not for scheduling issues or changes to the schedule.
- Any questions please contact
  - Michelle D. Myers, Unit Director
  - Dr. Arndt, Head anesthesiologist

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Clinic Process at a Glance: Preoperative Clinic

- You may need to counsel patients about options (LARC vs Sterilization); sometimes they are scheduled in clinic without a previous counseling session.
- Preoperative packets are in the doctor's pod
- Complete History and Physical: full exam, including pelvic
- Review medical conditions again (need for pre-anesthesia?).
- Order any pertinent labs
- OR consents
    - Do NOT use any abbreviations
    - Laterality must be indication, including "bilateral"
    - Patient, provider and witness must write out their full names, sign, date and time on the form.
- Give the patient a packet with directions to OSIS/pre-op instructions.
- She will receive a call from the OSIS staff confirming her surgery time on the day prior to the surgery.
- Give a copy of the Federal Consent (if applicable) to the patient to bring with her to the surgery. Keep the original Federal Consent and the original Procedural consent form yourself to bring with you to OSIS on the day of surgery. THE FEDERAL CONSENT IS CRITICAL, CASES WILL BE CANCELLED IF THERE IS NO FEDERAL CONSENT AVAILABLE THE DAY OF SURGERY.

Clinic Process at a Glance: OSIS

You are responsible for managing OSIS each week.

- At Pre-Op Conference, you are responsible for presenting the patients scheduled at OSIS the following Thursday. Pre-op occurs at 7:00am on Friday. Contact the intern coming off of the rotation for a template of the Pre-op list
- After presenting at pre-op, discuss case order with the attending(s) and any other residents or fellows involved in the cases
- Once finalized, you will email a copy of the case order to the:
    - OSIS surgery scheduler, Chris Brock (cabrock@salud.unm.edu)
    - OSIS Nurse Coordinator, Theresa Rael (tarael@salud.unm.edu)
- On Thursday mornings, be at OSIS by at least 7am. The first case rolls at 7:30.
- The turnover at OSIS is much faster than at the main hospital OR. It is therefore recommended to have all discharge instructions and prescriptions for the day filled out and ready before the first case. Prior to each case, confirm with the patient that there have been no changes to her health and perform the H&P Update (template in PowerChart), put the procedural consent,

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federal consent (updated appropriately), discharge instructions, and discharge prescriptions in the patient's chart. This is also a good time to fill out the PACU order sheet in the patient's chart
    - PACU Orders: "Patient may be discharged when meeting PACU criteria", "Prescriptions are in the patient's chart", "The patient will be called (or has an appointment scheduled) for follow-up."
- After each case, write a brief op note in PCO, prepare the next patient (d/c instructions, scripts, H&P update) and, if you have time, dictate the Operative Report.
- Some days you will be done early. Use this time to get the next week's pre-op list ready for pre-op conference.
- If there is any question about the appropriateness of the patient for having the case done at OSIS, the patient may be sent to Nurse practitioner Bridget or the intern may directly call Dr. Chris Arndt who is the head of Anesthesia at OSIS. Dr. Arndt would prefer that he receive a call about patients with complications in order to make the final determination about appropriateness for OSIS. In general, pre-op anesthesia visits at the main are not applicable at OSIS and the patient should either see Bridget or Dr. Arndt.

Clinic Process at a Glance: Billing

- **Billing is very important!** The survival of the clinic depends on accurate billing.
- Additionally, there is a billing binder in the provider room at CRH.
- Always dictate
    - "Patient is here for options counseling" (not "for abortion"—that way you can bill an E/M code as well as the procedure code)
    - "Patient is here for contraception counseling" (not "for IUD"—again, ONLY if you counsel on the range of methods, you can bill the E/M code.)
    - that Dr. (attending) was present for (procedure).
- For meaningful use, please always complete:
    - Medication reconciliation
    - PMH & PSH form
- Don't forget there are codes for "difficult insertion" in case you have to dilate or run into a lengthier procedure. (22 modifier). Clinic Process at a Glance: Medication abortion phone triage algorithm

Clinic Process at a Glance: Bleeding with Medication Abortion

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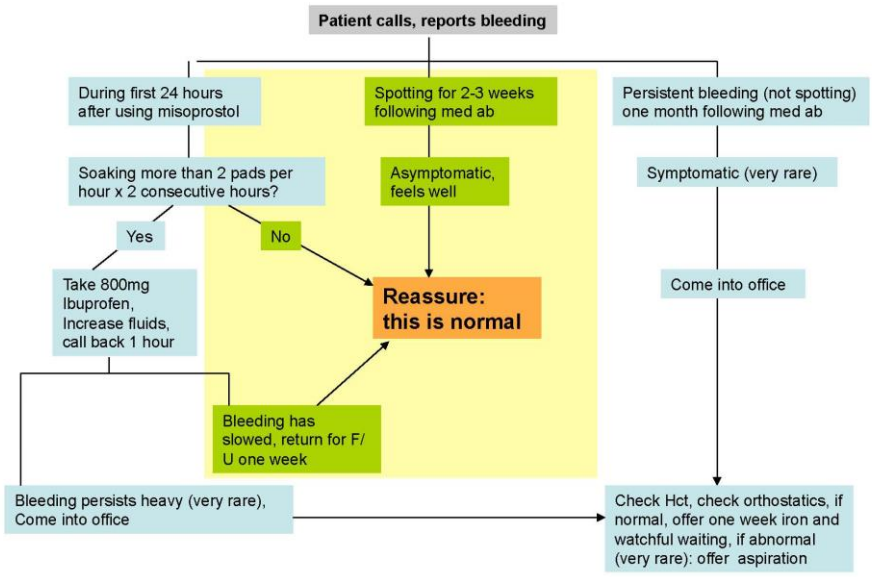
Phone Triage Call - Bleeding with Medication Abortion



Values Clarification Exercise

Adapted from Obtaining Abortion Training: a Guide for Informed Decision-Making. National Abortion Federation, 1998.

Values clarification sentence completions

Please complete the following sentences. During your values clarification session consider discussing these with your faculty member.

Abortions are:_____

_____

_____

_____

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Women who have abortions are:_____

_____

_____

_____

A woman facing an unwanted pregnancy should:_____

_____

_____

_____

With a patient who has an unwanted pregnancy, the role of an OB-GYN should be:_____

_____

_____

_____

My biggest concern about training to do abortions is:_____

_____

_____

_____

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If I provide abortions I am afraid that:_____

_____

_____

_____

In this country, abortions should be:_____

_____

_____

_____

EXERCISE 1.1: General feelings about pregnancy options

Purpose: This exercise is designed to illustrate the wide range of beliefs about the acceptability of pregnancy options and to help you clarify your personal views about your patients choosing abortion, parenthood, or adoption.

In general, how do you feel about your patients choosing abortion?

I can accept my patient's decision to choose abortion in certain circumstances including:

- ☐ If the pregnancy threatens her life
- ☐ If the pregnancy threatens her physical health
- ☐ If the pregnancy threatens her mental health
- ☐ If the pregnancy involves significant fetal abnormality
- ☐ If the pregnancy resulted from rape or incest
- ☐ If she is in an unstable relationship
- ☐ If she does not want any more children
- ☐ If she is not financially able to care for a child and requires public assistance
- ☐ If a baby would interfere with her education and career goals
- ☐ If she is very young
- ☐ If she is in prison and will be unable to provide care to her child

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- ☐ If she has AIDS
- ☐ If the pregnancy resulted from birth control failure
- ☐ I can accept my patient's decision to choose abortion in any circumstance when she has made an informed and voluntary choice

What are the reasons for your beliefs?_____

_____

_____

_____

In general, how do you feel about your patients choosing adoption?

I can accept my patient's decision to choose adoption in certain circumstances including:

- ☐ If the pregnancy threatens her life
- ☐ If the pregnancy threatens her physical health
- ☐ If the pregnancy threatens her mental health
- ☐ If the pregnancy involves significant fetal abnormality
- ☐ If the pregnancy resulted from rape or incest
- ☐ If she is in an unstable relationship
- ☐ If she does not want any more children
- ☐ If she is not financially able to care for a child and requires public assistance
- ☐ If a baby would interfere with her education and career goals
- ☐ If she is very young
- ☐ If she is in prison and will be unable to provide care to her child
- ☐ If she has AIDS
- ☐ If the pregnancy resulted from birth control failure
- ☐ I can accept my patient's decision to choose abortion in any circumstance when she has made an informed and voluntary choice

What are the reasons for your beliefs?_____

_____

_____

_____

In general, how do you feel about your patients choosing parenthood?

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I can accept my patient's decision to choose parenthood in certain circumstances including:

- ☐ If the pregnancy threatens her life
- ☐ If the pregnancy threatens her physical health
- ☐ If the pregnancy threatens her mental health
- ☐ If the pregnancy involves significant fetal abnormality
- ☐ If the pregnancy resulted from rape or incest
- ☐ If she is in an unstable relationship
- ☐ If she does not want any more children
- ☐ If she is not financially able to care for a child and requires public assistance
- ☐ If a baby would interfere with her education and career goals
- ☐ If she is very young
- ☐ If she is in prison and will be unable to provide care to her child
- ☐ If she has AIDS
- ☐ If the pregnancy resulted from birth control failure
- ☐ I can accept my patient's decision to choose abortion in any circumstance when she has made an informed and voluntary choice

What are the reasons for your beliefs?_____

_____

_____

_____

EXERCISE 1.2: Gestational age and abortion

Purpose: For some people, the acceptability of abortion is dependent upon the stage of pregnancy at which an abortion might take place. The following exercise is designed to help you clarify whether your beliefs are influenced by the gestational age of the pregnancy.

At what gestational age do you stop feeling alright about your patients choosing to have an abortion?

Check all that apply.

- ☐ At conception

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- ☐ At implantation
- ☐ At the end of the first trimester
- ☐ At quickening
- ☐ At the end of the second trimester
- ☐ At viability
- ☐ At some point in the third trimester
- ☐ It depends on the reason for the abortion
- ☐ Other (please explain):

Now consider this list again as it related to your comfort level with varying degrees of your professional involvement in abortion. At what gestational age do you stop feeling alright about

Making abortion referrals for patients:

- ☐ At conception
- ☐ At implantation
- ☐ At the end of the first trimester
- ☐ At quickening
- ☐ At the end of the second trimester
- ☐ At viability
- ☐ At some point in the third trimester
- ☐ It depends on the reason for the abortion
- ☐ Other (please explain):

Performing abortions:

- ☐ At conception
- ☐ At implantation
- ☐ At the end of the first trimester
- ☐ At quickening
- ☐ At the end of the second trimester
- ☐ At viability
- ☐ At some point in the third trimester
- ☐ It depends on the reason for the abortion
- ☐ Other (please explain):

What are the main factors that influence your feelings?_____

_____

_____

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_____

EXERCISE 1.3: Women's reasons and your choice to provide abortions

Purpose: This exercise will help you clarify your feelings about some potentially challenging situations that may arise in abortion care.

Consider the following challenging situations:

I would feel uncomfortable providing and abortion for a woman who:

- ☐ Is ambivalent about having an abortion but whose partner wants her to terminate the pregnancy.
- ☐ Wishes to obtain and abortion because she is carrying a female fetus
- ☐ Has had what I consider is too many previous abortions
- ☐ Shows little emotion about becoming pregnant and choosing abortion
- ☐ Has indicated that she does not want any birth control method to use in the future

What factors influenced your choices? How might you handle your discomfort when caring for patients under these circumstances?_____

_____

_____

_____

EXERCISE 1.4: Abortion access and your choice to provide abortion

Purpose: The negative impact on public health when abortion is illegal or otherwise inaccessible is well documented. The following exercise is designed to help you think through the consequences of limited access to legal abortion and help you determine what role you might play in addressing decreasing access. How might your decision to offer options counseling, referrals and/or provision of abortions have an influence, positive or negative, on the accessibility of abortion?

Read the following passages from the Carole Joffe's 'Doctor's of Conscience: The Struggle to Provide Abortion Before Roe v. Wade' (Beacon Press, 1996)

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A) A doctor who was a resident in a New York City Hospital during the 1960's describing what she called the "Monday morning abortion line-up":

…Women would get their paychecks on Friday, and that night they would go to their abortionist and spend their money on the abortion. Saturday they would start being sick and they would drift in on Sunday or Sunday evening, either hemorrhaging or septic, and they would be lined up outside the operating room to be cleaned out Monday morning. There was a lineup of women on stretchers outside the operating room, so you knew if you were an intern or a resident when you came in on Monday morning, that it was the first thing you were going to do….

B) While the above scenario occurred over 35 years ago before Roe v. Wade, on a smaller scale, similar situations sometimes still arise because safe, legal abortion is still not accessible to many women. A 2001 study by the Alan Guttmacher Institute found that 87% counties in the United States do not have a single abortion provider. Further legislative barriers, such as public funding restrictions, parental consent laws, mandatory biased counseling and waiting periods, make it difficult for women (particularly young, poor, and rural women) to obtain abortions. Consider the following passage from Doctors of Conscience.

On March 27, 1994, Kawana Ashley, a 19-yeaer-old single mother with a three year old son shot herself in the stomach during the 25th or 26th week of her pregnancy. She was hospitalized but ultimately survived her injuries. Doctors delivered a female infant by emergency cesarean who died 15 days later. Ms. Ashley was a Medicaid recipient, but since Florida's Medicaid program funds abortion only in cases of rape, incest, or life endangerment, she needed to find a way to pay for the surgery herself. Unfortunately, by the time she got enough money together, she was into her second trimester, and the cost was higher. When she raised the extra money she needed, she was beyond 20 weeks, the cutoff point at which the clinic stopped providing abortions. Out of desperation to end her unwanted pregnancy, Ms. Ashley endangered her own life.

MORE CASE SCENARIOS:

How do you feel about?

- Abortion in this situation in general?
- Abortion in this particular patient?
- To what extent would you feel comfortable being involved in her care?

Case 1.
24 y/o G3P2 gets pregnant from rape. You delivered her previous 2 children. She didn't report the rape to the police. She reveals it to you as her trusted physician. She is 7 weeks pregnant and would like you to do the abortion.

Case2.

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38 y/o G4P3 gets pregnant with an IUD in place. You placed it 7 years ago after she delivered her last baby. She has agonized over the decision but has decided that she cannot afford another child. She is 6 weeks pregnant and would like you to do the abortion.

Case 3.
22 y/o G1P0 has a positive first trimester screen. Amniocentesis reveals Trisomy 13. She would like to terminate the pregnancy. She would like to know what her options are for termination and if you could help her with pregnancy termination. What do you consider to be a "lethal" anomaly?

Case 4.
19 y/o G3P0 presents at 9 weeks for elective pregnancy termination. This is her third unplanned pregnancy. She has not been using birth control. She would like you to do the procedure.

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Medication Abortion Competency Checklist - Self & Mentor Assessment

Resident: _____ Attending: _____ Date:_____

Please evaluate the trainee on the following performance areas in medication abortion. 1 = Unsatisfactory 2 = Needs Improvement 3 = Satisfactory 4 = Excellent For all scores of 1 or 2, please write comments explaining the score.
If you did not observe the trainee in a particular area, write NA (not applicable) in the comments field.

Performance Area	**1**	**2**	**3**	**4**	**Comments**
Determine patient eligibility for MAB through review of history and lab results and performance					
Identifies absolute contraindications to MAB based on history and physical exam					
Sonogram interpretation					
Accurately interprets sonograms for gestational dating					
Rules out ectopic pregnancy					
Locates and outlines the uterus and endometrial cavity on ultrasound					
Identifies the presence (or absence) of an IUP on ultrasound					
Identifies the presence or absence of the yolk sac on ultrasound					
Identifies and measures the gestational sac, when present, on ultrasound Identifies and measures the crown-rump length (CRL), when present, on ultrasound					
Provides options counseling in a nonjudgmental manner					
Uses open ended questions during counseling					
Puts patients at ease					

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Explains process of medication abortion, expected side effects, possible complications, when to call, and follow-up procedures to patient in language she can understand					
Encourages patients to ask questions					
Develops post-AB contraception plan w/ patient, including discussing EC					
Obtains and properly documents informed consent for the abortion					
Prescribes and administers mifepristone/misoprostol according to protocol					
Demonstrates appropriate use of Rhogam					
Recognizes common complications of medication abortion based on patient report of symptoms during after-hours call					
Appropriately manages common MAB complications					
Performs physical exam and interprets lab results to determine completion of abortion and absence of complications, as needed					
Accurately interprets sonograms for completion of abortion					
Selects the appropriate treatment modality in the case of incomplete abortion based on clinical findings and patient preference					
Identifies unusual patient symptoms and order further testing and treatment as appropriate					
Re-examines contraception plan w/ patient at follow-up visit, including discussion of EC					
Ensures that proper procedure for missed follow-up appointments is carried out					

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Additional Comments_____

_____

_____

_____
Signature of Attending Faculty

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IUD Competency Checklist - Self & Mentor Assessment

Resident: _____ Attending: _____ Date:_____

During your family planning rotation, a faculty member will ask you to complete this form and s/he will complete a form as well. This will be used to discuss your competency in IUD insertion.

	1 (Novice)	2	3 (Competent)	4	5 (Expert)
1. Appropriate candidate selection	1	2	3	4	5
2. Appropriate history (Pap, STIs, Hcg)	1	2	3	4	5
3. Counsels appropriately: advantages and disadvantages, alternatives	1	2	3	4	5
4. Appropriate informed consent risks and benefits	1	2	3	4	5
5. Speculum placement, prepping cervix	1	2	3	4	5
6. Placement of tenaculum, sounding uterus	1	2	3	4	5
7. Placement of IUD	1	2	3	4	5
8. Appropriate collection of specimens (PAP cultures?)	1	2	3	4	5
9. Appropriate follow-up counseling	1	2	3	4	5
10. Overall communication skills	1	2	3	4	5

Overall on this task did the resident demonstrate competency to perform this procedure independently?

Yes_____ No_____

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Comments:

_____

_____

Signature of Attending Faculty _____