**©**

**Dynamic Solutions for Unplanned Pregnancy**

2012

**Optimization Tool**

**Streamlined Linear Service Model**

*A single-team, consolidated model for serving women facing unplanned pregnancy.*

Optimization Tool©

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# Optimization Tool© Summary

## 

## Optimization Tool©

### Purpose

This Optimization Tool© (OT) is intended to show exactly how existing Policies and Procedures play out in the day to day business of the ministry for greatest efficiency at reaching and serving high-risk abortion-minded women.

This manual is NOT intended to replace any formal and necessary Policy and Procedure manual that a Pregnancy Resource Center (PRC) should obtain from NIFLA or another National Affiliate.

This Tool is designed specifically to address the swamp of issues a PRC faces in an effort to stay relevant to the patient immersed in an ever changing culture.

### Primary Implementation Objectives

1. Decrease medical conversion time frames by two to six months
2. Optimize current medical operations by 20-60% by:
   1. Increasing number of abortion-minded patients
   2. Decreasing overall “no-show” rates
   3. Increasing qualified leads (“positive-test” patients)
   4. Increasing positive outcomes (women at risk of getting an abortion choosing to have their babies)

## The Requirement for Success

Why do some Pregnancy Resource Centers (PRC) who add medical services have more positive outcomes (women at risk of getting an abortion choosing to have their babies) than others? Our experience is that those who have more positive outcomes have learned to shift their thinking into a new paradigm of service.

### The “Ministry” Model is Inadequate

This is going to be hard for some in your PRC to accept at first. But the typical PRC model of functioning as a “ministry” has been one whereby a buffet of services are offered to any given “client” and these services are presented in a way that seems best to the staff member or volunteer at the time of service. In this type of model, medical services (complete with ultrasound technology) has been treated by many as yet another addition to the menu of the services a PRC may offer and is called a Global Services Model. A Global Services Model mires the PRC down in the swamp of inconsistency, unprofessionalism, and ineffectiveness.

This buffet-type paradigm (Global Services Model) typically enjoys bursts of effectiveness for a short time but only to be followed by diminishing returns. This is primarily because of the lack of systematic service implementation (not doing it the same way every time).

Also, this lack of systematic service prevents the PRC from measuring the effectiveness of any given service. Without accurate measurement of activities and results, it is extremely difficult to improve the effectiveness of existing services. In addition, without measurements, any innovation is simply guess work and not based on solid evidence to support it. Such innovation can be costly in terms of time, money, personal energy, and the PRC’s reputation.

The reality is that medical services are a powerful tool and when used outside of a holistic service approach will be less than effective and may be dangerous to the organization. However, within a comprehensive, step by step system of service that targets at risk women, medical services with ultrasound technology can be a powerful leveraging point.

### A New Paradigm is Necessary

This Optimization Tool© is NOT designed to help a PRC simply bolt on yet another service to the existing menu of services. Rather it is designed to change the entire PRC mode of operation; moving it from a Global Services Model to what we call a Linear Services Model. Again, it is NOT designed to assist in transposing medical services on top of an existing service model but to assist in overhauling the entire service model from A to Z in an effort to be focused and intentional when interfacing with women at risk for getting an abortion.

In order to reduce confusion the PRC and all of its constituents will need to begin to think and act differently. Therefore, this tool will be using a different way of speaking about the PRCs and the target patient. The terms will be more business oriented as it describes such things like target, input, outcomes, service steps, process, flow, selling, etc.

The transition to a medical model linear system of service is not easy. Streamlining a PRC service has its difficulties and pitfalls, especially if the PRC leadership wishes to build in a new laser-focused design of serving a woman from the time she calls until the time she delivers a baby. What this requires is that everything that the PRC does must be ruthlessly measured against its value to “erase the need for abortion one woman at a time.” If the service, intervention, or input does not measurably increase the number of at risk women served (pregnant women for whom abortion is a real option) or if it does not measurably increase the positive outcomes of those women, then it is either never adopted, modified, or cut altogether. We don’t have the time or resources to waste on programs or service strategies that are not measurably increasing the organization’s effectiveness at erasing the need for abortion.

### Taking Responsibility is Essential

Some may say, “That sounds awfully cold,” or “That does not seem to leave room for the Holy Spirit.” The cold hard reality is that many well intentioned people hide behind the word “ministry” as an excuse to remain sloppy and undisciplined, not wishing to take responsibility for the outcomes of a woman seeking abortion. However, if a PRC is serious about its mission to reduce and eliminate abortion in their region, they must take responsibility for the pregnancy outcomes of the women they will serve. They must do whatever they can to maximize the positive outcomes. Granted, not every woman will choose to have their baby after receiving the PRC’s services. But it still remains our responsibility to figure out why they were not positively influenced by the PRC’s services so that the PRC is better equipped to serve the next woman.

The good news is that there are simple steps and processes that can be implemented that will drastically increase the positive outcomes of the women a PRC will serve and that is what this Optimization Tool© is all about. The entire organization must be geared toward “selling a woman on the idea of having her own baby.” Therefore, it is clear that your PRC must be intentional about moving a woman through a specific process that will allow her to distill the information she is given in a way that produces a sense of security and peace in an unknown future after having had a child. Each step in the process is essential and must be followed by the proper sequence to get the desired outcome.

## Proven Results at CompassCare, Rochester NY

CompassCare Pregnancy Services of Rochester, NY has successfully adopted the new paradigm and has implemented the medical linear services model of services. Therefore, the theories behind this manual have been tested with proven results at CompassCare of Rochester NY, as well as other organizations in different parts of the country with similar results.

### 

### Summary of Results

Below are the CompassCare (Rochester NY) implementation outcomes after year 2:

1. The show rates were **as high as 81%** with a 2005 **average of 72%**.   
   Assuming a 50% national average there is a potential 31% reduction.
2. The number of abortion-minded women **increased by 53%.**  
   From 14% in 2003 to 41% in 2004 to 67% in 2005.
3. The number of “positive test” patients **increased by 25%**.   
   From 60% to 85%.
4. The positive outcomes for abortion-minded women **increased by 31%**.  
   From 50% up to 81% for the time period January 2004 to December 2005.
5. The positive outcomes for the abortion-vulnerable women were **maintained at 100%.**  
   This was 30% of patient load for 2005.

### 

### Rochester as a Test Market

The importance of a test market for developing a new program, product, or service is that it ideally contains an accurate population representation of the rest of the country. Rochester, NY, home of Kodak, Xerox, Bausch & Lomb, as well as academic research institutions for engineering, technology, and pharmaceuticals is uniquely suited as the test market for the PRC movement. Organizations such as McDonalds and Blockbuster also leverage Rochester to test new ideas primarily because it is composed of a good cross section of America’s population demographics.

### Specific CompassCare Trends

The graphs below demonstrate some of the key results and trends of CompassCare of Rochester, NY.

#### Reaching More Abortion-Minded Women

The graph below demonstrates that an increasing percentage of the patients CompassCare serves are abortion-minded women.

**Reaching More "Abortion-Minded" Women**

**2003 - 2005 Trends**

0%

20%

40%

60%

80%

100%

Jan-03

May-03

Aug-03

Dec-03

Apr-04

Aug-04

Dec-04

Apr-05

Aug-05

Dec-05

Abortion Vulnerable

(moving average)

Abortion Minded

(moving average)

Figure 1: Reaching More "Abortion-Minded" Women 2003-2005 Trends Graph

#### Reaching More Women Who are Pregnant

The graphs below demonstrate that an increasing percentage of the patients CompassCare serves are “qualified leads” (i.e. “positive-test” patients).

Figure 2: Pregnancy Tests Results in 2003

Figure 3: Pregnancy Tests Results in 2005

#### Exceeding National Averages

The graph below demonstrates two things:

1. CompassCare has consistently exceeded the national average (which is around 30%) for abortion-minded women seen by a PRC.
2. CompassCare’s transition trend was that the percentage of abortion-minded women having their babies increased each year.

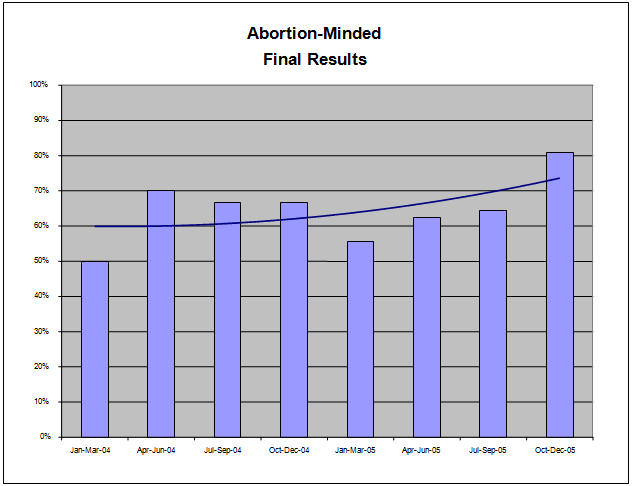


Figure 4: Abortion-Minded Final Results 2004-2005

## Pregnancy Resource Center (PRC) Optimization

### Primary Aim of PRC Optimization

PRCs are Christ-centered agencies dedicated to empowering men and women to erase the need for abortion in their regions and to serve those who have been affected by it.

### Intended Outcomes of PRC Optimization

1. Increase existing PRC medical operations efficiency by 30-60%.  
   This would be similar to the CompassCare Optimization Tool© (OT) outcomes noted in “Proven Results at CompassCare” above. For example, if current patient “no-show” rate after scheduling through the Helpline is 50%, then after Optimization implementation the “no-show” rate should drop to 20%, which is a 30% efficiency increase.
2. Reduce by two to six months the transition time from Global Services Model of PRC operation to a Medical Linear Services Model.  
   For example, if it would normally take eight months to a year to transition from the global services model to medical linear services model, it should take six months using the Optimization Tool©.

### Primary Factors for PRC Optimization

Not every PRC is ready to optimize their existing medical operations or transition from the Global Services Model to the Medical Linear Services Model. The primary factors to be considered are as follows:

1. The Board and the President have a “healthy” relationship.
2. The Board and the President are both enthusiastic and ready to work (not feeling burned out).
3. The organization either has the financial resources to sustain an excellent medical linear services model or has the immediate ability to obtain the financial resources to sustain an excellent medical linear services model.
4. The Board and Staff are willing to honestly self-evaluate on a regular basis and to innovate accordingly.
5. The organization is mission driven.
6. The organization has a name and location that is marketable to their target population or is willing to change their name and/or location to one that is marketable to their target population.

# Executive Management

## Organizational Chart

It is assumed that the primary Executive (e.g. President/CEO) is responsible to the Board of Directors. Other titles may be used, such as Executive Director instead of President/CEO or Director of Medical Services instead of VP of Medical Services.

**NOTE:** The following organizational chart needs to be reviewed and voted on by the Board of Directors. It must also be reviewed and clarified for all staff and volunteers.

Figure 5: Organizational Chart

## Organizational Strategic Plan

The Organizational Strategic Plan is sometimes referred to as the Optimization Strategic Plan. They are synonymous because the organization is to be optimized.

### Mission

To erase the need for abortion through effectively serving pregnant, at risk women by transforming their fear into confidence.

### Vision

Reaching the right women, at the right time, and serving them in the right way for the greatest possible gain on behalf of patients, babies, staff, donors, the organization, the community, and God.

### Values

1. Fighting Spirit
2. Relevance
3. Accountability

### Strategy

Develop and maintain accurate and relevant service to women at risk for abortion in an organizational environment made up of two main departments (e.g. Unified Medical Services, Advancement) lead by content expert VPs who each assemble volunteer teams for the purpose of accomplishing the mission as it relates to their respective department.

### Core Metrics

1. Appointments scheduled
2. Percentage of high risk A/M women
3. Schedule and Show rates
4. Number taking pregnancy tests
5. Percentage of positive tests
6. Ultrasounds performed
7. Abortion vulnerability breakdown
8. Demographic breakdown
9. Real outcomes (based on follow up data)

## Perspectives on Marketing

### Marketing Defined

There are two types of marketing that your PRC needs to intentionally develop.

1. General Marketing: Everything your PRC is and does communicates to your target market. This includes what color you paint the walls, your tone of voice on the phone, and how you interact with abortion-minded women when you provide them with services and every little thing in return.
2. Specific Marketing: All the specific media outlets (i.e. radio station, television station, bathroom ads, college newspaper or calendar ads, etc.) you choose to use for the purpose of acquiring patients and donors. This includes exactly what the ads say, how they say it, and what they look like.

### Recognize the Competition

Have you ever heard (or thought to yourself) “But we are a non-profit organization, we don’t have competition.” Think again. The more accurate question is “What does our competition look like?” “Competition” comes in three basic types, some more obvious than others.

1. A primary type of competition comes in the form of businesses or organizations advocating the very behavior or situation your non-profit exists to eliminate. These can be either for-profit businesses or non-profit organizations.
2. Another type of competition is the similar organizations that provide services that are being run with a differing philosophy and mission. Although they may have some similarities to your PRC, they are “competition” because they are drawing patients away from you and may be interfering with your organization’s effectiveness by inoculating that patient to your services in the future should their experience be a poor one.
3. The third type of competition is most often overlooked. It is you. Being your own worst enemy is not an unusual problem in the PRC movement and one that we all must be constantly aware. This comes in the form of focusing too much on what makes you feel good but does not necessarily put your organization in a position of authority and strength in the mind of your target population. It could also be in the form of hyper-spiritualizing the ministry and failing to focus any attention on running the business of the ministry with excellence.

Depending on your frame of reference, your organization’s competition could be spiritual in nature. As leaders of non-profits, if we understand anything, it is that there is evil in the world. Otherwise there would be no need for us.

### Know Your Enemy

Note that the maxim is not “fear” your enemy, but “know” your enemy. In order to “beware of your enemies, you must first be aware of your enemies. Know what they are doing. Understand their strategies. Research their philosophy and what drives them.

The rationale behind knowing your enemies and understanding what it is you are up against is not so that you can mimic their implementation strategy but so that you are clear on exactly how your organization and mission is different and better. This is essential. If you are unable to clearly articulate how your organization or service is superior to your competitor’s, then do not expect that anyone else will be able to see it either. Our marketing team helped us to appreciate the importance of this. They pushed us time and again as we were attempting to create better ads by asking us hard questions like the following:

1. If we put your competitor’s name on your advertising (or other marketing material), would the ad still be valid? If so, how can your target market tell the difference between you? Or more importantly, why would they bother to choose you?
2. What is so different between what you do and what your competition is doing?
3. Why would someone choose you over your competition?
4. Are those reasons clear in your marketing?
5. “If not then your ad and the way you position yourself just plain stinks.”

Again, if you cannot clearly state why your organization and services are different and better than your competition, then do NOT expect your target market to be able to figure it out for themselves, or even try to do so. This clarity requires that you know your competition.

Incidentally, if you could not answer favorably to the above marketing questions it may not be a marketing problem. It may very well be an organizational problem. You could be leading an ineffective organization and your greatest enemy is yourself. While this Optimization Tool© (OT) is designed to help you build an effective PRC operating platform, if you cannot stare the brutal reality of your organization in the face in order to determine if you are the best at accomplishing your mission, then your organization will always struggle accomplishing your mission.

You are probably thinking to yourself, “Assuming our organization does, in fact, provide a superior service to the competition’s, how can I research that competition when I have barely enough time to read this manual?” There are a few creative ways to do competitive research within your already busy schedule.

1. Create files or binders to place the information you gather on your competitors. Keep these files or binders in central (yet discrete) locations so that your staff and volunteers can add the material they gather. Keep the files current but do not throw away the out dated material. Keeping the older material will help you to track their changes in philosophy and services.
2. Set the competition’s web page as your personal computer’s browser default home page. This way, whenever you go on-line you will automatically be forced to read something about them. It may only be 30 seconds worth of reading but those bits of information really add up to a well informed leader.
3. Get on your competitors’ mailing lists. You may want to use your (or a volunteer’s) home address. Why not let them keep you informed at their own expense.
4. Make certain that your staff is well read and informed on who your target market is and how other organizations are attempting to reach them. Make it part of their responsibilities to keep their eyes and ears open to the news and other forms of information.
5. Assemble a volunteer reconnaissance team. This can take many forms. Have a college or graduate student do research papers on your competitors for a class. Ask someone interested in history to learn your competitor’s history. Have people purchase their materials. Send people to their seminars or other speaking engagements. Send people to your competitor’s training (volunteer or otherwise).

Using a combination of these suggestions and approaching this research as a “team effort” with your staff and volunteers can produce a large file or binder full of information that is beneficial to understanding the competition.

### Marketing Strategy Assumptions

Here are four basic assumptions that impact your marketing strategy:

1. Seeing abortion-minded women have their babies is an actual “sales process”! If she does not “buy” security and peace-of-mind by the time she walks out your door she will most likely have an abortion.
2. It has been determined that in any given sales presentation the sale is made or lost in the first 3 minutes. What does this mean for how you handle the reception process?
3. If every appointment with an abortion-minded woman is a sales presentation, then you must carefully consider every aspect of the appointment and its effect on the way that presentation is received by the woman (helpline, reception, advocates, nurses, sonographers, facility set up, dress code, etc.).
4. Education based marketing is more effective than rhetoric based marketing. This Linear PRC model of operation is a new paradigm. This PRC model of operation is a voice of reason to the patient through obvious and compelling education oriented medical services. It does not operate under traditional polarizing terminology (Pro-life/Pro-Choice). It recognizes that God has given humanity free will but that the choices a person ultimately makes are either positive or negative in nature with corresponding consequences. Therefore, we will not engage in the typical debates.

### Marketing Requirements

In order to produce effective marketing, it is crucial that you understand the demographic and psychographic tendencies of your target market, both potential patients and donors. Then you must understand where those types of people live and gather.

1. **Determination of Demographics:**   
   Demographics answers the question “Who are our patients or donors?” (i.e. what are the personal characteristics that make up our patients and donors?) You can obtain this information through surveys.
   1. Ask all patients to fill out the *What Can You Expect? Form* (Appendix 62)
   2. ) and the *Exit Survey* (Appendix 19)
   3. Ask supporting college and high school teachers to get their students to fill out questionnaires.
   4. Determine from your State Health Department through Vital Statistics the basic demographic information about who is getting abortions (i.e. race, gestational age, average education, payment method, etc.) and how many.
2. **Determination of Psychographics:**   
   Psychographics answers the question “Why do our patients receive our services? Or, why do our donors support our PRC? (i.e. what motivates them? Again, you can obtain this information through surveys)
   1. Ask all patients to fill out the *Exit Survey* (Appendix 19).
   2. Ask a variety of types of questions on the exit survey including preferences such as color, shapes, words, products etc. (this will be used to design the ads that target them).
3. **Determine Geographic Location of the Demographic / Psychographic Characteristics:**   
   This means to find out where your target market is located (lives, plays, works, etc.).
   1. Ascertain abortion break down by zip code from your State Department of Vital Statistics if available.
   2. Track the addresses of current patients and donors. Put them on a map to get a visual representation.

## The Use of Systems

### Types of Systems

Your PRC should integrate the following types of systems throughout your organization:

1. Equipment/Facilities Systems: These include “things” such as computers, chairs, paint color, etc.
2. Dynamic Systems: These include ideas, scripts, donor relationship development activities, service tasks, people interactions, etc.
3. Measurement Systems: These include the means of recording and analyzing information pertaining to the other two types of systems, such as trend tracking, service summary reports, exit surveys, intake sheets, follow-up forms, etc.  
     
   Tracking is a critically important aspect of Optimizing a PRC. By tracking the step by step patient flow an organization is able to measure how well it is doing for any given point in helping to transition a woman from being at risk of getting an abortion to having her baby. The point then would be to ‘tweak’ for innovation where necessary to always remain on the cutting edge of service. What would be tracked for example would be in line with the flow of the patient and goes something like this: 1) how many women who called scheduled an appointment, 2) how many were at risk and how at risk are they, 3) how many that scheduled actually showed up, 4) how many of those that did not show were followed up with 5) how many that showed up were actually pregnant, 6) how many of those received an ultrasound exam, etc. This tracking process is managed by the Unified Medical Services and used primarily by the President for the leadership team’s continual pursuit to keep the service relevant in an ever changing culture serving people who tend to think and make decisions in 8 second intervals.

### Dynamic Systems

A service system is a dynamic system which is an integrated interaction between your PRC and your patient (or donor) that follows five basic steps:

1. The clear demarcation of the specific transition points or steps in the PRC Unified Medical Services or Donor Relations process.
2. The literal scripting of the words that will transition you between each step successfully.
3. The memorization of each step’s script.
4. The development of the various materials to be used with each script.
5. The identical presentation of each script by any given volunteer or staff member.

## Introduction on PRC Executive Leadership

Effective executive leadership at the Pregnancy Resource Center (PRC) is essential to the overall stability and success of the organization accomplishing its stated mission of erasing the need for abortion one woman at a time. The swamp of issues that cause a PRC to compromise its effectiveness within a community mostly originate from within the organization itself and revolve around the Executive, the Board, or the staff and volunteers. These issues are typical and in most cases easy to resolve. However, if these issues are not addressed in a clear and decisive manner by the Executive (who will from now on be referred to as the President) they can render the organization ineffective. This section is designed to identify and address these issues categorically in order to provide freedom to move ahead relatively unencumbered.

### Reflections on Two Core Conversations

The following are two conversations intended to frame a PRC President’s outlook on the PRC’s role within the community and the President’s role within that organization. All personal references are accounts and perspectives from the author, James R. Harden, M.Div., who is the President/CEO of CompassCare Pregnancy Services.

#### Conversation A

Not too long ago I was sitting outside at a coffee shop on a beautiful sunny day in Rochester, NY reading a book. The man sitting at the table next to mine was enjoying his coffee and cigarette when, unprovoked, he turns to me and asks the question: “Do you think the world is really any better off today than it was fifty years ago?”

To him the question was rhetorical, until I gave him my counterintuitive answer, “Yes. I do believe that it is.”

A conversation ensued that was interesting to say the very least. But the point that needs to be made is that deep down in the soul of every PRC leader there is an unspoken sense that we can, and therefore we must, make the world a better place. There are estimates that over 80 million people are involved as “volunteers” in America. This volunteerism, which is driven by the non-profit world, speaks to this core optimism in most Americans.

#### Conversation B

Recently I was speaking to my good friend, Jerome Machar, author and highly effective non-profit leader turned Trappist Monk. I asked, “Jer, do you think that there is a difference between managing and leading?”

Without hesitation he said, “Oh, definitely.”

Probing deeper I asked, “Do you think it is possible for everyone who applies themselves to lead in some capacity?”

Again without hesitation he remarked, “Of course not! Some people are simply not able. They just don’t have what it takes to do the job.”

“Well, can they be taught some basics and become at least mediocre leaders?”

With certainty he replied, “A mediocre leader is no leader at all.”

### Effective Leadership

There is a difference between “managing” and “leading.” This section on the Executive Department of the Optimization Tool© (OT) attempts to focus on the latter.

It is the specific qualities of leadership that are helpful to non-profits and specifically PRCs that will be dealt with here. This is not designed to be a definitive work on leadership within PRCs but rather a handbook to be used to coach respective PRC leaders into greater effectiveness and efficiency. Inevitably there will be management concerns that are involved in leading this unique type of non-profit. But this section focuses on the fact that leading a non-profit in today’s world is significantly different than leading any other type of organization. The better part of leadership is art. Even though there are some foundational principles that can help to keep the paint on the canvas, it is important to be clear here; leadership ability is a gift, like an artist, you either are one or you are not. Leaders are born not made.

So while there certainly are those people who are in leadership positions in non-profits who have no business being there, what I have come to realize in my seventeen years of non-profit leadership experience is that the PRC world is lead, for the most part, by good people who have sacrificed their lives for the best of all causes. They are fighters and die-hard optimists who, despite the fact that the odds are stacked insurmountably against them, get up every morning daring to stare that brutal reality straight in the face. And with that knowledge they are even more certain that tomorrow will be different because of what they will do today. It is precisely because of the nature of their situation (under resourced, under paid, under staffed, over worked, etc.) that these leaders often *do not* focus on the one thing that will actually move the organization ahead. Notice I did not say “are unable to” focus. While helping that pregnant mother may be what got you involved in this fantastic organization in first place, it will not ultimately help to ensure that the organization can eliminate unplanned pregnancies or cause children to have involved parents.

The primary task that you took on when you said “Yes” to the job of President was to lead your organization to accomplish the incorporated mission of the organization. To succeed and one day stand up and say, “We have erased the need for abortion in the mind of every woman!”

Leaders must become participants in what I like to call the “Mulberry Effect.” In the ancient mid-east it was said to be illegal to plant a mulberry tree anywhere near a well. It was well known that the root systems of that type of tree were so pervasive and went so deep that it would ultimately destroy this precious source of water. Given the nature of the root system, it was also understood to be impossible to fix the problem by uprooting the tree. Jesus in the New Testament picked up on this problem by teaching his disciples this saying, “If you had faith like a mustard seed, you would say to this mulberry tree, ‘Be uprooted and be planted in the sea’; and it would obey you” (Luke 17:6 NASB).

The notion of uprooting a mulberry tree was ridiculous but to take that a step further and replant it would be insane. What Jesus said was that it would not be replanted just anywhere but in the most unlikely of places…the Sea! Can you imagine a tree, not an island, as a nautical location device? “Captain, we’re coming up on the mulberry tree, we’re only 35 miles from harbor now.”

The irony here is that the force of the conditional (if…then) statement Jesus used is that the first part is assumed to be true while the second part is presumed to by hypothetical. So the disciples he was teaching would have understood the essence of the statement as “*Since* you have the faith of a mustard seed…” The obscenely impossible hypothetical mulberry tree bit is there to prove a point about the power of one’s faith to accomplish objectives that are otherwise impossible (i.e. erasing the need for abortion). This teaching of Jesus is in the larger context of general human relationships and social responsibility. So it fits rather well in the life of a leader of a non-profit whose objective is to accomplish some seemingly impossible mission in the life of the community or world.

All that to say, if a leader has just a little faith and just a little bit of good old fashioned know-how, a little coaching will go a long way to eliminate and avoid additional or unnecessary headaches.

There are a bunch of books written for non-profits about fundraising, management, policy setting, regulatory agencies, etc. But this is not one of them. This “Tool” is designed to talk turkey when it comes to being an effective leader of a non-profit Pregnancy Resource Center.

*What I mean by “effective leader” is a person who is able to get all the constituents of the organization on the same page and moving toward accomplishing the mission of the organization.* In other words, a leader should be able to clearly articulate the goals and plan of the organization to the community and to effectively bring the staff into the fullness of their potential as leaders within the organization’s respective movement or service. Therefore each section hereafter will deal with an aspect of leadership that would have major impact on how well a leader of a non-profit can accomplish what he is really supposed to do.

### Capacity of PRC President

**The Objective** of the President as it relates to ‘erasing the need for abortion’ is to:

1. Clearly articulate the goals and plan of the organization to the community
2. Effectively lead the organizational executives into the fullness of their potential as leaders in the Medical PRC model

**The Role** of the President is to facilitate the efficient operation and development of innovation within the PRC through the management of the departments of the organization as they relate to each other (see Figure 6: Chart of Organizational Department Relationships). A document containing detailed *Executive Job Functions* and with a maturity analysis around those functions is available in Appendix 18.

**NOTE**: The Organization is led by the President/CEO who is hired by the organization’s Board of Directors. The Board of Directors is responsible for the President’s annual review via the Executive Review Committee (see the section on Executive Accountability).

### Organizational Department Relationships

The two major departments in the PRC are integrated at the operating level to varying degrees. This integration will be clarified throughout this document. However the effectiveness of each department is determined by how well and to what degree each contributes to the “Mission Intersection”, which is simply the collective accomplishment of the organization’s mission.

The role of the President is to focus all department resources on the Mission Intersection.

Mission Intersection

Figure 6: Chart of Organizational Department Relationships

### 

### Organizational Assumptions and Objectives Effecting the Mission Intersection

In order for the President to focus on the Mission Intersection, he must understand the following Organizational Assumptions and Organizational Strategic Objectives.

#### Organizational Assumptions

|  |  |
| --- | --- |
| Assumption #1 | It is not the specific medical services a PRC offers that causes a woman to have her baby but rather the manner in which those services are provided. |
| Assumption #2 | No sane woman “wants” to have an abortion. |
| Assumption #3 | Women have abortions because they feel insecure and unsupported. |
| Assumption #4 | If a woman is afforded peace of mind and security, more often than not she will choose to have her baby. |
| Assumption #5 | Medical services are essentially educational in nature and add credibility and professionalism to an organization. |
| Assumption #6 | Women feel more secure when in a controlled and professional environment. |
| Assumption #7 | Every appointment with an abortion-minded patient is a sales process. |
| Assumption #8 | The primary product a PRC provides to abortion-minded women is security (e.g. to change fear of the unknown into confidence in the future). |
| Assumption #9 | There is a constant effort to refine “what works” in order to interface effectively with the surrounding culture: Feedback loops such as Intake Sheets, Exit Surveys, and “What to Expect from Your Appointment” forms fuel ongoing organizational training and refinement. |

Table 1: Organizational Assumptions

#### Organizational Strategic Objectives

The Organizational Strategic Objectives of the OT Medical Linear Services Model are as follows:

1. To provide the highest standard of service to patients and donors, even beyond their expectations.
2. To be operated by people with varying levels of time, talent, or ability. This enables many people the blessing of participating in erasing the need for abortion.
3. To be a place of impeccable order.
4. To be a place of the highest professional standards of excellence. For example, this would include staff and volunteers observing the dress to code, using the phone system to communicate messages rather than calling out, never bringing children to work, etc.
5. To document all work done in the PRC in the Optimization Tool©.
6. To provide a uniformly predictable service to both patients and donors.
7. To utilize a consistent color, dress, and facilities code that has proven results.
8. To measure all patient innovations against two primary questions prior to implementation:
   1. Will the innovation cause more abortion-minded women to come to the PRC?
   2. Will the innovation cause those abortion-minded women to be more likely to have their baby?
9. To provide peace of mind to women facing unplanned pregnancies.

### General Executive Requirements

#### Characteristics and Abilities

The following are requisite Characteristics and Abilities the Executive (President) should have:

1. Capacity for seeing and effectively communicating the “Big Picture.”
2. Ability to delegate (not abdicate) responsibility and duties.\*
3. Capacity for imparting Vision to staff, volunteers, and donors.
4. Effective oral and written skills.
5. Effective problem solving skills.
6. Ability to relate well to all types of personalities.
7. Strong work ethic.
8. Very optimistic, not naïve but confident that there is a future without abortion.
9. Entrepreneurial tendencies or ability to foster those tendencies in primary staff members for the sake of Organizational Assumption #9 and the Core Value of Relevance.

\* The fundamental difference between delegation and abdication is authority. Delegation retains authority while allowing someone else to ‘own’ the responsibility. Abdication relinquishes authority and is the beginning of larger management difficulties.

#### Management Expectations

The following are management skills of which the Executive (President) must have an immediate and on-going knowledge. The President must be able to effectively deal with:

1. Patient Crisis (e.g. any unusual patient presentations including referrals to E.D.).
2. Any unusual incidents, including:
   1. Any media coverage or contact (no staff or volunteer is authorized to speak to the media on behalf of the organization).
   2. Any staff, volunteer, or patient injury.
   3. Any calls to fire or police departments.
   4. Any suspicions or allegations of child abuse.
   5. Any suspicions or allegations of sexual assault.
   6. Any staff grievances.
3. Weekly financial status (includes annual budgetary meetings).
4. Any staff or volunteer contact with Board Members.
5. Pastoral contacts for general information and or speaking invitations.
6. Any unusual contacts or incidents with or involving Physicians.
7. Any Unified Medical Services or Donor expansion innovation or modification.
8. Any policy or procedural addition or modification.
9. Weekly cumulative Unified Medical Services stats.

**NOTE**: The above list should be copied and explained for each staff member and posted at their work stations.

#### Weekly Meetings and Contact

The following are persons the President must meet with regularly in order to run the organization well:

1. Department Heads. These are staff meetings with only primary staff members as a group.
2. Staff Members. These are meetings with each individual Department Head one on one (these should be at least one time every other week or monthly).
3. Pastors. These are meetings with at least three different or new pastors.
4. Board Chairman. These are communications via email, phone call, or in person.

#### Suggested Reading

The following are resources for the President (and Primary Staff) to read:

##### For Scriptural Understanding of Children:

1. *The Bible* – especially Exodus 21, Leviticus 20, Lamentations 4, Psalm 127, 139, Mark 10: 13-16, and Galatians 1.15

##### For Leadership:

1. Studies in the lives of Moses, Joshua, Caleb, David, Isaiah, Nehemiah, Jesus, and Paul.
2. *The Contrarian’s Guide to Leadership* by Steven Sample
3. *The Prince* by Niccolo Machiavelli
4. *The Art of War* by Sun Tzu
5. *The Volunteer Revolution* by Bill Hybels
6. *The Four Obsessions of an Extraordinary Executive* by Patrick Lencioni
7. *Silos, Politics and Turf Wars* by Patrick Lencioni
8. *Built to Last* by Jim Collins and Jerry Perros

##### For a Solid Organization:

1. *The E Myth Revisited* by Michael Gerber
2. *Good To Great* by Jim Collins

##### For Marketing and Fundraising:

1. *Raising More Money* by Terry Axelrod
2. *The Fall of Advertising & The Rise of PR* by Al and Laura Ries

## The Role of the President

### Holding It Loosely While Pouring Out Your Soul

One of a leader’s greatest assets to the organization that they serve can also be, at the very same time, one of their greatest liabilities. I’m talking about “ambition.” This could also be described as self-sacrificing passion for the particular organization’s mission. This is one of the best assets the organization can be given. While admittedly there are those people that accept the leadership mantle to stroke their own ego, I have found that most are truly passionate and would sacrifice much of who they are to see the mission come to fruition. However, ambition, when selfishly motivated can be a significant and long-term liability. For example, those that accept the title for ego’s sake will not see long-term organizational success, even if they possess good leadership ability. They may see success during their respective “reign” but that success will not transfer to the tenure of the leader to follow. Many leaders of non-profits have become the leader simply because they have poured their soul into the organization and have proven themselves worthy to carry the burden. In fact a potential candidate for leadership should be disqualified from consideration if they have not demonstrated this kind of unselfish ambition for the organization or movement.

Jesus is in many ways the beginning of all non-profits or at least the first to clearly articulate the passion needed to be successful at running one. In the New Testament book of Matthew, Jesus is again seen teaching his disciples that sacrifice is the essence of true success in the eyes of God with respect to faith. Jesus said; “He who loves father or mother more than Me is not worthy of Me; and he who loves son or daughter more than Me is not worthy of Me. And he who does not take his cross and follow after me is not worthy of Me. He who has found his life will lose it, and he who has lost his life for My sake will find it” (Matthew 10: 37-39 NASB).

So if one is to run a successful non-profit, there must be a certain single-mindedness that is part and partial to life. Which one of us, after leading a non-profit with whose purpose we whole heartedly resonate, hasn’t had a spouse wonder if we will ever be home again? Or a mother who wonders if we will ever call again? Or a friend who wonders if we have slipped off the deep end … “and you’re getting paid how much?!”

The essential question is, ‘Has your life been swallowed up in the mission?’ Good indications that it has, for example, would be if you are on vacation and you find yourself reading this. Or, while you are watching the 11 o’clock news, something the weather man says triggers you to think of how you should change, modify, or add something to the organization. Your life is being defined by what you have *given up* rather than by what you have picked up. You are sacrificing. This ambition for the organization, not for oneself, is a clear indication that you are in a good place.

Unfortunately, many leaders do not understand how to manage this sacrificial reality. So it ends up being harmful or even destroying them. Jesus does not want us to destroy ourselves and the relationships around us. Rather, through self-sacrifice he wants us to create an environment where relationships can truly flourish and where people are empowered to give more of themselves. I don’t care who you are or where you came from; selfishness does not make for great conditions to grow solid relationships, have happy families, or develop stable organizations. Even more than that, selflessness at the expense of one’s family may be even worse that pure selfishness.

Therefore, we must “take up our cross.” What in the world is Jesus talking about? To take up one’s cross was a ridiculous statement for Jesus to make to his disciples. It was horrific. It would be tantamount to me saying to you, “Everyday, in order to be successful, you must go to work and sit in your electric chair.” Essentially, Jesus was saying we must choose to give our personal desires, passions, and preferences a back seat to the mission. And it is at that point we will be worthy to lead an effective non-profit.

The clincher here is that unless we are careful to lay down our lives every single day for the mission, it becomes very easy to take ownership and become *overly* emotionally involved and start making decisions that would adversely affect the organization . . . a significant organizational liability. It is understandable and certainly one of the greatest temptations a leader has. Once someone has invested so much of themselves into a thing, a certain attitude of ownership begins to creep in. If this attitude is nurtured just a little bit in the mind of the leader, it can grow into an insatiable monster intent on protecting the organization and artificially preserving one’s own place within it. The temptation becomes to simply devour anyone who has a differing opinion or even refuse to acknowledge when one’s tenure of effectiveness in the organization is over (this could also apply to Board Members). More often than not this temptation manifests itself while the organizational ship is sinking. Unfortunately, due to the unique tax exempt financial status of non-profits, dead organizations are permitted to limp along for years before anyone has the guts to just put the thing out of its misery.

### Two Examples

The following examples are intended to illustrate the importance of the proper placement of leadership ambition.

#### Example A

One of my first positions within a non-profit was the Youth and Education Director of a Presbyterian Church. Being relatively young, naïve, and, in many respects, ignorant of how non-profits were supposed to function, I thought I could learn a great deal from the Senior Pastor of this Church. However, it turned out that this church had a bona fide dud for a Senior Pastor. I mean the man was milking that poor church for everything it was worth. He had somehow gotten the church to pay for his PhD, which is not bad in and of itself. But what I came to realize, and what many members of the church suspected, was that he was fully intending to leave immediately after he graduated. He had no intention of staying and pouring his soul into the community. Not many months into my tenure there, the Senior Pastor resigned, leaving the church demoralized and financially broke. I was the only staff member left in an ever shrinking congregation. So I was the logical interim until they could fill the vacated position. Thankfully, I had a wise grandfather who said I should not even entertain the notion and perhaps should even step down myself.

The situation in the church, along with my grandfather’s advice, brought me to a counter-intuitive decision. In an effort to be a part of helping the church heal and grow, my wife and I had to be a part of them. We had to be with them. However, since they were now expecting paid staff to act in a mercenary or selfish fashion, if we were truly concerned with the forward motion of the church, we had to stay but not as a paid staff member.

Once I came to this conclusion, I realized that the impending conversation I would have with the elder board would be difficult at best. The time came for me to break the news that the church was to lose their last paid staff member. They expected our family to leave but, when we did not, we were accepted by the church as family and were able to reach a new level of leadership that we had not been able to accomplish before. During that time, and for the first time in decades, the church was able to take a good hard look at who they were and where they wanted to go.

A certain catharsis took place for that little church. It was a healing in their collective soul. But to lead we had to sacrifice a great deal. To earn the privilege of non-profit success one must put the mission first in the face of great adversity.

#### Example B

Not long ago some Board members from a local non-profit came to me and asked if I would consult with them. They wanted my “honest feedback.” I agreed and drove out to their facility. Upon arriving, I noticed that their location was pitiful for reaching their target market. As I walked in the front door and entered the waiting area, I was struck by the sheer and obvious confusion. Not simply by the lack of personnel but by the inhospitable clutter and utter disregard for the sensibilities of a potential client. There was no sense of excellence in the place at all. The walls were paper thin and compromised confidentiality. The religious pictures on the wall were faded. The carpet was dirty. The place was a mess.

After getting my full five cents worth out of the nickel tour, they excitedly asked, “Well what do you think? What will it take for us to reach our goal?”

Since they asked for honesty and clearly did not have much need for subtlety, I told them that they were just kidding themselves and that the best thing that they could do for themselves and for the community they were trying (and not very hard) to serve would be to shut down. The look of horror on the chairman’s face was telling. He had no idea of the dismal state they were in and had been in for many years. It crept in over time and it seemed to them that it all happened in an instant.

Now that I had his attention I continued, “The next best thing you could do would be to totally reinvent the organization from the ground up. Change the name. Move locations. Change the philosophy of service. Acquire new staff and volunteers. Start over.”

This position could have been avoided if a competent leader just had enough guts to do some honest self-assessment and stare the cold reality straight in the face. Then the leader would have recognized his options as 1) stepping down himself, 2) shut down the organization totally, or 3) re-birth the organization. That organization decided to implement my third suggestion. And, as a result, they are now poised for growth in about four more years (according to George Barna, and backed by my own personal experience, it takes about four years to re-birth an organization to the point of positive growth and stability).

This is where the idea of “holding it loosely” finds its way into the discussion. In an effort to counteract the temptation for a leader to “own” the organization he is building, that leader must constantly recognize that God can choose to do with his organization as he sees fit. And so God will provide us with little reminders every so often, if not daily, of this fact. Leaders, much to their chagrin, do not have control over every single factor in the life of the organization. They cannot control when a major donor decides to stop giving. They cannot influence national or cataclysmic events that steal the attention of the donors, causing them to pull in their financial oars from the organization, such as when the president decides to go to war or when some idiot decides to fly a plane into the side of a building. They have no control over when the computers decide to crash or when a major staff member’s spouse is relocated to another city or when the hot water heater decides it’s time to give up the ghost and create a vast basement sea two inches deep. Some (most) things we will never have total control over, nor should we. This also provides us with the motivation to steer clear of a micromanaging style, especially if that is one’s tendency.

It is possible to be one’s own worst enemy. This can happen when we as the leader of a non-profit begin to take our position too seriously. The respected leadership author John Maxwell recognized this and made a courageous decision to counteract it. While the Senior Pastor of a large church in California, Maxwell had the Elder Board ask him one question during his annual review, “Is there someone who could do this job better than you?” The day he could answer “yes” to that question is the day he needed to leave. The question forced him to self-reflect on a central leadership issue; “Am I still the right man for the job?” It is not about the leader but rather it is about the mission of the organization. If the mission is being overshadowed by the leader, it may be time for the leader to move on. It is a leader’s job to empower other people to utilize their maximum potential to accomplish their passion around the mission. On the other hand, if the organization is clearly being held back from moving forward due to the leader’s emotional inability to take measured risks, then this is also an indication that it is time for the leader to go. Unfortunately, most often the Board of Directors will need to determine when that time has come because many leaders have not made a habit out of self-reflection.

Jim Collins, in his book *Good to Great,* noted this type of quality in outstanding for-profit business leaders. Collin’s team called these types of leaders “Level 5 Leaders.” These are folks that are content being in the background yet intensely passionate about being the best in the world in whatever industry they are a part. So it is with the world of non-profit organizations. Leaders who are intensely passionate but rather than being focused on themselves are focused on a noble cause.

### Leader as Mascot

#### Champion the cause…but not at home

One of the primary responsibilities of a leader is to be the face of the organization to the community in order to clearly articulate the goals and plan of the organization in accomplishing its mission. It is the leader’s face that is on all the mailings and television interviews. It is the leader’s voice everyone hears. Again this speaks to the paradox of pouring one’s soul into an organization while holding it loosely. At the end of the day every leader must force himself to turn off the lights, lock the door, and go home. It is the path of least resistance to be always consumed by the organization. There will always be better solutions to pursue, always more problems to solve, and always never enough time to get everything done. This is the life we as leaders have chosen. If we fail to recognize this reality and fail to build in a break, *we* will ultimately break. We will burn out. It has been said, “The work of a PRC can never be finished, just managed.”

In one of the Grisham movies Robert Duvall was cast as a seasoned lawyer who had been working for the firm for many years. While the new attorney at the firm was getting acclimated to his position by working through lunch, the veteran, with his feet up on a library desk by a window, radio tuned into the ball game, eating his sandwich, lived out a piece of wisdom. Namely, intentionally take a break every day or you will be eaten alive. You and I are no good to the mission if we are emotionally starved and physically tired. When you leave the office, leave everything in it. That is not to say organizational business will not follow you by coming up in conversation at home or someone won’t recognize you while you are at the zoo with your children. But, for the most part, boundaries that demarcate “work” and “not work” are healthy.

For example, a friend of mine in Florida takes fifteen minutes every day after arriving at the large non-profit he leads to just sit in his car to think and pray. I use the half hour it takes me to drive to work to phase into the game mentally and the drive home to phase out. No system is perfect but at least we are making an effort and recognizing that unless we rejuvenate there will be nothing left for tomorrow when that staff member needs encouragement or that disgruntled donor wants to “chat.”

## Perspectives on the Relationship between the President and the Board

### Who Is Really In Charge?

**NOTE**: This section should be copied and distributed to the Board of Directors.

The only thing with two heads is a monster.

The day Barb approached me for advice was the day the idea for writing this section was born. Leading a significant non-profit in Western New York, this intelligent well meaning lady asked me how to handle her Board of Directors. Several years and many mistakes later, I have somehow become a resource for people in the non-profit sector. You see, like many non-profits, Barb’s organization was having difficulties with Board relations.

“They recently hired me for the position and some of my staff are going to the Board behind my back. The Board member then directs that staff member on how to proceed. What do you think I should do?”

“What did the Board hire you to do?” I questioned.

“Well, they hired me to lead this organization.”

“Is this situation hindering you from doing your job and properly leading the organization, Barb?”

Cocking her head and furrowing her brow she laughingly blurted out, “Of course it is!”

Getting the response I was hoping for I replied, “Then at your next staff meeting announce the policy stating that any and all communications by staff with a Board member must be approved by the President prior to that communication. Anyone who does not follow the policy will be terminated immediately for insubordination. Make sure the Board is informed of the action and ask the Board to back you up by not entertaining any staff discussions unless otherwise cleared through you. The best way to solve this problem is to establish yourself as the leader. The first person to cross the line will be removed from their position. It should take about two weeks but it will never happen again.”

Her jaw dropped and her eyes got mysteriously bigger as she said, “I can do that?”

Yes, Barb could do it. But she simply needed someone to tell her how or in some sense give her permission. It may sound a bit Machiavellian but trust me, it is the most compassionate thing you can do for the organization. It is a sort of purging of poor behavior, which, by the way, our friend Niccolo understood. Everyone will be happier.

It is of utmost importance for both the President and the Board to understand their respective positions and how their relationships should be handled. The President is the Board’s one and only employee. The Board’s single most important and primary responsibility then is to determine who that leader should be and determine when that leader should leave. In order to assess when a leader’s time is up, the Board must proactively evaluate the leader’s performance based on clearly defined standards for accomplishing the mission of the organization. This process is facilitated by the Executive Review Committee (ERC) using the [*Executive Review Form*](#_ERC_Resolution) (Appendix 17).

The Board members focus on interacting directly with the President and not around or over the President to other parts of the organization. Therefore, a Board member must be able to distinguish between his or her duties as a Board member and as a member of the organization. In addition, they must also act appropriately according to those respective duties. For example, when the Board is officially in session, members can actively (only collectively) make policy decisions. However, when the Board is not officially in session, and a Board member is involved in organizational activities, that member needs to understand that he or she is acting as a “volunteer” with No official Board authority.

Usually, when staff or disgruntled volunteers see a Board member at Church or at the store they see “power.” What they are really seeing is “influence.” Power and influence are two very different animals. What all staff, volunteers, and even Board members must understand is that the President is the one with the “power,” power given by the Board to accomplish the mission of the agency according to set policy on a daily basis.

Board members at large, when not convened, have influence within the organization by virtue of their relationship with its leader but possess *no decision making power*. The only person with that kind of daily power is the Board elected leader—you the President.

The other primary “hat” the Board must wear is to ensure and maintain the general integrity of the organization ethically and legally. In order to do this, they must review all policies and procedures prior to approval and implementation, making certain that these policies and procedures are both compliant with the State and Federal Government regulations and also in line with the overall incorporation purpose and mission. To do this effectively, Board members must be present at the meetings and pay attention to the policies, procedures, recommendations, and assessments floated out to them by the President. To do otherwise opens the door for the corporate veil to be pierced and the exposure of their personal assets should the liability winds blow foul.

### Two Things That Help to Eliminate 90% of Most Board Problems

In Robert Townsend’s book *Up the Organization* he notes a healthy word of caution regarding for-profit boards that has some merit in the non-profit world. Namely, “….alert [board] directors spend their time in silent worry about their personal obligations and liabilities in a business they can’t know enough about to understand. The danger is that their consciences, or fears, may inspire them now and then to dabble, all in the name of responsibility.” Every now and again the Board, or a Board member, will cross the line and take a stab at creating a policy due to some personal concern or fear, whether founded or unfounded. The enlightened leader will stave off this touch of insanity by clearly articulating the unnecessary nature of the request and by lovingly reassuring the person or group of the leader’s capability to execute their duties with excellence.

The two of the most valuable tools for a leader with respect to maintaining proper Board relations are 1) keeping lines of communication open on a weekly or bi-weekly basis with the Board chair and 2) establishing an Executive Review Committee that meets regularly to assess the Board’s performance, to assess the leader’s performance, and to make decisions *with the leader* on behalf of the Board in emergent situations.

#### Communication with the Board Chair

Many problems can be solved if the leader makes a concerted effort to foster and maintain a close relationship with the Board Chair. If at all possible, a leader should attempt to connect with the Board Chair over lunch at least once a month and via email or phone at least bi-weekly. These conversations may not necessarily revolve around the goings on of the corporation but will serve to allow the chairman to better understand how the leader works within his or her personality, and vice versa. This will facilitate the Board Chair and the leader’s ability to approach the Board meetings more as a team.

#### Executive Review Committee (ERC)

**NOTE**: To implement see *ERC Resolution* in the Appendix 17

The Executive Review Committee should be made up of the organization’s leader, the Board Chair, and one other person of the leader’s choosing from among the Board members. It should be commissioned by the Board as an official committee complete with power to execute. The ERC is fundamentally different from any for-profit Executive Committee, which can be used in a variety of capacities from handling customer complaints to getting the old crotchety CEO respectfully out of the way. The non-profit ERC, on the other hand, can provide a forum to hold candid discussions on a regular basis regarding issues that could possibly be embarrassing or inflammatory when presented to a group of ill-informed people. Also, if done well, the ERC can be used effectively as a warming buffer between the cold realities of a Board that may misinterpret suggestions or plans, misunderstand a leader’s sacrificial investment, and not appreciate the leader’s almost innate understanding of the organization and its ability to be more effective.

A leader will eliminate 90% of most Board problems if he does these two things and does them well.

### Board Membership

In an effort to develop a Board that works well together and naturally understands their role within the organization, the following three observations have been made:

First, the type of Board member who fits well into the mix of a healthy Board group dynamic is someone who does NOT provide a direct service as a career. That is, a person who provides a direct service such as a physician, a lawyer hired by a firm, teachers, and general blue collar workers, etc. The reason for this is because they tend not to be able to distinguish between the daily technical business tasks versus their role as a facilitator on the governing Board of Directors. This is not to say some of these kinds of people are unable to be good Board members or that they are not well meaning, intelligent people who have proven themselves time and again as loyal to the cause and organization.

For example, not too long ago I was having a very candid conversation with a good friend of mine who is a prominent and practicing OB/GYN. I’ll call him Sean. I told Sean of my reticence of bringing a physician onto the Board given my father’s chronic poor experience with physicians as a Hospital Administrator. Being the chief OB/GYN at a well-respected facility and a seasoned physician, Sean has a lot experience with hospital administrations. His response to my hesitancy was telling, “Jim, the reason why docs make such terrible Board members, by in large, is because they are scientists trained to micromanage. In fact, if they did not micromanage their respective patient’s healthcare needs they would not be doing their job and so would be exposing themselves to liability claims. It is not that a doc is unable to be a good Board member, it is simply that most have a difficult time making the mental shift from managing to leading.” Physicians are notoriously bad businessmen for this reason as well. Medical schools, for good reason, do not train doctors in how to run a business. They hopefully train them on how to heal people’s physical ailments.

This is the same reason why this type of material would be so valuable to a seminary graduate since in the same way seminaries do not regularly train future ministers (non-profit leaders) on how to effectively lead this unique sector. Seminaries and theology professors would prefer to focus their time and attention on theological matters. To their credit.

Second, although finding the right Board mix is a Board team effort, the primary burden falls on the shoulders of the leader. The leader needs to get to know the potential Board candidate, especially the person’s personality. An *Application for Appointment to the Board* (Appendix 4) is a useful but very limited tool. The leader should observe how the candidate publicly and privately carries himself or herself in situations of tension. The leader should also ascertain whether or not the person is truly committed to the organization or simply wants to add another Board membership to their resume in their quest to make a name for him/herself. It is also necessary to determine if they are committed financially and, if not, see what they do when presented with that opportunity (“Where your treasure is there your heart is also.”). Get them to visit one or two Board meetings to see how they and the Board members interact. After the meetings, get the current Board members’ feedback. This feedback may enable you to learn something that could have been otherwise hidden.

Third, do not acquire a Board member simply for the money. It can be devastating to a leader’s ability to make objective organizational decisions. If a person becomes a Board member primarily because he or she is a major donor, problems are more likely to develop. That is not to say major donors do not sometimes make good Board members, because they often do. However, if a donor gives so much money that the organization cannot survive without that person’s annual contribution, then that Board member could begin to have influence that is uninformed, misguided, and potentially harmful to the organization’s ability to objectively and efficiently attain its mission and navigate challenges. Don’t be taken in. The most stable organization is one in which the donations are diversified. A good leader will not have to rely on one or two major donors (government funding included). If a primary donor is on the Board of your organization, it may be a good time to test the strength and commitment of the particular Board member by holding the leadership line in the face of the Board member’s opposing “feelings” or “thoughts.” If the Board member stays and continues giving, fine. If they begin withholding their money, then one is simply pruning the giving tree making way for more diversified income growth.

## President Accountability

The PRC President reports directly to the Board and answers to the Board for all aspects of the management and leadership of the organization. The rule of thumb is that the Board has one employee (the President) and that President is responsible for all other staff, whether that staff reports directly to the President or indirectly via other staff members.

The Board reviews the President’s annual performance at a specified time via the ERC. This ERC is made up of the Board Chairman, the President, and one or two persons from the Board of the President’s choosing. This review is done as a group inclusive of the President (Appendix 2). The ERC then submits the completed review form, with any benefits modifications, for approval at the next Board meeting. At this meeting, the President should excuse himself from participation to avoid a conflict of interest.

This ERC should meet on a monthly or quarterly basis for consistent updates and unofficial organizational evaluation and is commissioned by the Board to have authority to make decisions when the Board is not in session, in line with predetermined organizational direction.

The *Governing Board Requirements and Agenda* (Appendix 21) is a helpful template for organizing Board activities.

## Perspectives on Staff and Volunteers

### Never Underestimate the Power of Firing Someone

I remember when I was a new non-profit leader. I was a Core Staff member of the organization reporting directly to the Executive Director and I had twelve staff members answering to me. One thing that this Executive Director understood about leading was never to undercut your direct report’s authority. On the flip side, if I had an issue with a direct report of mine, then I had to deal with it myself. So she always referred disgruntled staff members back to me. Since I was responsible for hiring, training, teaching, nurturing, and assessing the performance of these employees (Appendix 16 for *Employee Performance Evaluation*), it is only reasonable that I assume the responsibility for firing these employees when it is necessary to do so. Firing an employee after investing so much into them is no easy task. However, I learned two important lessons from that Executive Director.

First, if you are going to fire someone, do it well. To fire someone “well” involves a couple of things. You need to take on the responsibility yourself rather than passing it off to someone else. You should do it face to face and not in a letter or some other non-personal way. Firing someone should be a learning process for the person being let go. This is because one of the primary tasks of any self-respecting leader is teaching. Therefore, when a person is fired, it is important for that person to know exactly why they were let go and how they can address the issue to prepare for their next position. This teaching process should be a continuation of what the leader regularly does with the staff. The leader should write goals, focus on utilizing the person’s strengths, create a *Professional Development Plan* (Appendix 46), and meet regularly with staff to discuss the issues to keep the person talking and the relationship cordial. This type of process should not be the exception and utilized only for those who do not perform well but should be the rule for how the organization is run. It is a coaching process that assumes that the leader knows what he is doing and allows the leader to proactively create and foster a culture of excellence.

If this teaching process is in place, no one is surprised when the time comes for the person to be cut loose. An ancillary benefit to all this is that you insulate the organization against any unemployment liability claims because you now have a paper trail showing failures and deficiencies were acknowledged and a concerted effort was made to retain this person. While it may never be pleasant, if a staff member leaves without having exposed the deficiencies that precipitated his leaving, then we have not been good stewards of our human resources. To put it positively, every staff member, whatever the circumstances of their exit, should leave as a better person than when they arrived. The leader needs to ask, “How have I contributed to their betterment?” and not just, “How are they contributing to the betterment of the organization?”

Please don’t misunderstand. A good leader always puts the organization first with respect to the decisions that have to be made. But there is a precarious balance when you are talking about people. Leaders don’t lead organizations, they lead other human beings. It has been said, “If a leader has no followers then he is just taking a walk.” Keep the balance in mind.

The second lesson I learned from the Executive Director I was working for, was that firing someone is a great morale booster for the remaining staff members. In this particular position, the staff positions that reported to me were trained to handle highly volatile situations. So if they were not paying attention other people could be severely injured. Therefore, it was imperative that they be awake during their shift. One particular staff person I trained had fantastic instincts and was highly intelligent. I was looking forward to seeing her blossom into one of the better staff members over time. So, when I put her into a solo position in a fairly calm environment and later found her asleep on the job, I was a little alarmed and confused. I told her so after I woke her up, saying that if she ever did that again I would have to let her go. Then, one day I teamed her with another staff member to manage the most difficult environment. Much to my surprise, when I walked in to see if they needed anything, I found her asleep again! This time I was not so polite in waking her up. I had to let her go and she understood why of course. But it was difficult for me because she had so much up-side potential at that organization. Her team mate saw this take place and word quickly spread that lazy, ineffective work was unacceptable.

The result was that those that were slacking off tightened up the ropes and those that had been working with excellence all along felt vindicated. Momentum grew and they began feeling a sense of pride in their team and excellence began to be a cultural reality, not just a word. It was a fantastic phenomenon.

### Grow the Staff’s Leadership Ability to Grow the Organization

Virtually every non-profit organization has staff assigned to handle a division or some major component of the organization (or at the very least intends to one day). What this means is that the leader of the organization is looking for people who are also leaders with expertise in a particular aspect of the organization’s operations. If a staff member is to be hired to fill a primary responsibility that reports directly to you as the leader, then it is imperative that this person be a leader him/herself. As the head honcho of an organization that is staffed mostly by volunteers, you are going to need a team of leaders surrounding you who can effectively lead their teams to success within the mission.

Warning: If you are not careful, this is where your ego can hurt the organization in the long term. If the leadership ability of your direct reports is threatening to your ego, it will tend to drive the hiring of a less qualified leader. Less qualified leadership translates into the slowing of the organization’s movement along the path to success. Trust me, if you swallow your pride and hire someone who is much better than you in their area of expertise, it will not only benefit the organization but will benefit you as well. If you empower them, they will free you up to dream big, cast vision, and communicate that vision to the community. Just make sure that the candidate demonstrates loyalty and you will avoid that dreaded coup.

#### Be Proactive, Not Reactive

Experience has taught me that non-profits usually go about establishing leadership teams reactively rather than proactively. That is, once the existing staff and volunteers are so overworked and close to burnout the leader takes a financial “leap of faith” and hires someone to come in and help them keep the ship afloat. This “tyranny of the urgent” style of growth is the path of least resistance but is also the path of ineffectiveness and organizational decline.

#### Know What You Want to Achieve and Act That Way

There is a process that is helpful to follow when developing the leadership team within the organization. In leading an organization in the for-profit world, businesses with sustained greatness will often begin by asking themselves what they want to achieve. For example, they may target $1 million in sales in 5 years, with 10 regional offices, and an annual growth rate of 10%. This is determined by their understanding of what they can do better than anyone else in the world within their particular industry. Once they determine this, they begin to develop an internal structure that can sustain those goals. Once that is accomplished they begin assigning those duties, whether they have staff to fill the positions or not. Sooner or later they will get the necessary staff. And that it is the point. They have defined what they want and how they must act in order to get there (see *Good to Great* by Jim Collins and *The E-Myth Revisited* by Michael E. Gerber).

Process Summary for developing a focused leadership team for a non-profit:

1. Determine how the organization should look 5 or 10 years from now in order to attain your mission.
2. Define the tasks that must be accomplished in order to get there.
3. Assign those tasks to someone (yourself, a volunteer, your dog).
4. Start acting like who you want to be.
5. Keep your eyes open to new and gifted leaders who have expertise in the areas you need to fill.
6. Proactively fill the positions to do the tasks that you have previously identified (if necessary, bring them on as volunteers working two hours a week, then part-time 10 hours a week, then full-time with benefits).

#### You Get What You Pay For

By the way, non-profits tend to scrimp on the staff benefits. A worker is worthy of his wages. Just because you’re a non-profit does not mean that you, and everyone who works for you, should do their time as a poor man. Being under provided for in this way is disrespectful and demoralizing. There is a funny pithy statement that goes something like this, “If you pay peanuts you’ll always hire monkeys.”

#### Take Advantage of Recent Trends

There is a trend happening in America today. It is a transference of sorts. What I mean is that many people from the for-profit business sector are moving into the non-profit sector. This is good news for us non-profit leaders because it means our human resource pool is flooded with great leaders who are experts in their field (i.e. marketing, communications, database management, education, medicine, law, accounting, etc.).

These types of people have great instincts and tremendous capacity to lead. Hire them. Pay them. And set them loose on the world. If we are going to accomplish our respective missions, we are going to need “junk yard dogs” on our teams. We need the focused go-getters who are not afraid to stick their necks out. Some of the greatest assets to our current leadership team are the folks that have made the switch from the for-profit business or medical world.

Yes, there are risks in hiring go-getters. This means failure sometimes. But willingness to fail is often the path to success. This issue is not about whether you will fail but how fast you can get past it.

What this means though, is that you and I are going to have to train them. Make sure that your staff is challenged and growing, not only in their field but personally as well, especially with respect to their leadership ability. This can be done in a variety of ways.

1. Read books together and have them take turns on reporting on a chapter to the rest of the staff.
2. Send them to conferences and ask them to report back to the rest of the staff on what they learned.
3. Ask them to acquire a mentor in their field and keep them accountable to developing that relationship.
4. Have them create plans for professional development and make that part of their annual review.

If your leadership team does not feel like they are growing professionally and personally, they will leave for the higher paying job shortly.

#### Delegation, Not Abdication

Knowing the difference between delegation and abdication is essential to accurately assess issues and grow your team’s leadership ability. Often, when a leader hires a new staff member there is a sigh of relief, much to the tune of, “Ah, thank God I don’t have to do that anymore!” We are tempted, as overworked non-profit leaders, to never want to hear from that department again. This is a bad omen and the sign of the beginning of the abdication of authority and that you are succumbing to the Tyranny of the Urgent. What needs to happen is delegation of authority. The new staff member needs to understand that they represent you, the leader, not themselves in terms of championing the cause in exactly the way you see fit. The leader of the organization is where the buck stops and is ultimately responsible for every single department. The leader will be the only person the Board will look to for answers. Don’t abdicate that responsibility to anyone. It is yours, for better or worse. Steele yourself to that reality.

I scraped my nose on this issue one too many times. I learned my lesson when I abdicated authority to the leader of an organization with which we were partnering to provide a needed service to our patient load. Unfortunately, the leader of this other organization decided that these services needed to be run counter to the way we believed we were headed as an organization. He began to assert his power over us by tightening the authority noose around my neck. By doing this, he forced my hand and I had to sever all ties between the two organizations. You see, he thought he had control over a crucial service we intended to provide our patients. He was right. In making the decision to sever all ties, I had to be willing to shut down that aspect of our service because we had come to depend heavily on that one person and I did not have an immediate replacement. Thankfully, we did not have to suspend services, even for one day. But wrenching authority away from someone to whom it was abdicated is no bed of roses. However, that would never have been the case if I had made it clear at the beginning that I was simply delegating my authority to him. So he would need to answer to me for outcomes on a weekly or bi-weekly basis. You can save yourself a lot of trouble if you don’t make these kinds of mistakes. Define your relationships clearly, especially the authority you are delegating.

### Leadership is a Negative Job

As I mentioned above, while it is true that as a leader you must think first of the organization and accomplishing its mission, you must think second of your personal relationships and dynamics. However, there will be a tension that you must maintain between looking out for the best interests of the organization and making decisions based on relationships with the people that you like. This is no easy task. Although this is true in any organization, it is especially true in non-profits where the corporate environment by nature tends to be more social. I have experienced that women leaders tend to struggle in this area more than men. It seems that women have the ability to be more socially astute, sympathetic, compassionate, understanding, etc. These abilities in men are not so prominent. While this may be an overgeneralization, it does put men in an enviable position when there has to be a corporate restructuring and Lucy, your 17 year veteran, is not in the equation any more.

#### Two Stories

The following stories illustrate how the two different relational tendencies play out in leadership.

Story 1: Phil, a good friend of mine, is the senior pastor of a church of over 500 families. The much beloved 27 year veteran church secretary was having difficulty with change. In an effort to soften the blow, Phil, during a staff meeting let everyone know that due to the some prevailing circumstances, in the coming months there was going to be some reallocation of resources and restructuring of staff positions. He told me about how he dreaded the day but he would have to meet with the secretary and break the news that her position was to be eliminated. He was also worried how others in the church might respond. She took it well, as did the church. Now they are both free to face the future unhindered. The point is, while he appreciated the staff person, the relationship was not permitted to mitigate his judgment on how to best utilize the resources of the organization to accomplish the mission.

Story 2: Pam is a leader of a faith based non-profit as well. She relayed a story to me about how one of her department heads took her aside publicly and gave her a “stern talking to” about how she did not appreciate nor approve of how Pam handled a particular aspect of her department. Pam told me that this woman gave her an ultimatum saying that if Pam was going to act in that way again, this direct report would tender her resignation. “Isn’t that funny?” Pam said to me with a smile. “So did you accept her resignation?” I asked. Pam said she didn’t. Her reason for not doing so was based on the relationship she thought she had with this woman. She did not want to rock the boat. I understood that this staff member was already rocking the boat enough. It would have been very good for that organization if this particular staff member had been eliminated. As far as I know she still works there. The real issues here are who is in charge and what kind of message is being sent to the other staff members and volunteers?

### Solving Problems

The negativity that comes with leadership does not always revolve around things that could obviously advance the cause, such as a corporate restructuring or purging the primary staff of bad blood. When I say that leadership is a “negative job” I don’t mean that it is bad or people get hives when thinking about it. What I mean is that the buck has to stop somewhere and a good leader is unafraid of that reality. Problems need solutions and part of becoming a leader is being able to solve problems. Naturally, people will look to the leader for solutions to problems. Much of this type of thing is necessary management issues. But the dilemma you will have as a leader is determining which problems are really yours and which ones are not. To solve problems that are not yours will only serve to undermine the delegated authority that you desire your staff members to exercise, creating a culture of dependence on the leader. This culture of dependence creates an “Oh what would we do without you, boss?” ideology. Although this may serve the leader’s ego, it does not serve to grow healthy organizations. This culture of dependence also makes the inevitable transition between leaders more difficult. As far as I know, no mortal leader can stay leader of any organization indefinitely, some think no more than six years (see *Up the Organization* by Robert Townsend). Your goal should be that the organization is able to effectively function for at least one year without you. This then becomes the goal of every department head.

Jennifer was a staff member of mine several years ago when I was a young leader of a large non-profit in Chicago. I thought that to be a respected leader I needed to be willing and able to solve any and every problem I encountered. Well, when I jumped in to solve Jennifer’s problem, I was really usurping and unwittingly undermining Jennifer’s delegated authority. She respectfully told me that by solving her problem I was not helping her at all, but was in fact hurting her ability to solve problems in the future. This taught me an important lesson. Staff need to know that they are there for a reason. If you are planning on solving all the problems on your own, why have staff at all? Thank God for perceptive and honest staff who are not afraid of their leaders.

Often what I do now when a staff member comes to me with a problem they want me to solve, is to simply ask them one question, “What do you recommend we do?” I ask this because people will always follow the path of least resistance by seeking others to solve their problems. If you are that path then you will not be able to concentrate on the task of leading. Once your staff members and chief volunteers recognize that you are counting on them to do their job for the mission, they really go to work. Now it is very rare that a staff member would ever come to me with a problem for which he or she does not already have a solution. They simply want my added perspective or affirmation.

Once you have addressed the issue of who solves what problems, you’ll need to begin training your staff on what issues they really must consult directly with you. Since your confidence in their problem solving capacity will inspire their independence, which is exactly what you want, you will need to be clear on any limitations they have. It is better to have to rein someone in than always having to kick them in the pants to get them moving.

### Staff and Volunteer Strategy

All staff and volunteers who work for the PRC are expected to do their work with excellence (“Whatever you do, work at it with all your heart, as working for the Lord, not for men…” Col. 3.23).

The primary goal of staff and volunteer development is that the PRC movement becomes the expert at women’s reproductive health and the best in the world at reaching and serving women at risk of an abortion. This means that the staff and volunteers will work toward becoming the best in the world at their specific function in order to truly “erase the need for abortion.”

### PRC Departmental Leaders

There are two primary department leaders:

1. Medical Services Manager
2. Director of Advancement

These department leaders each have unique responsibilities and directly impact the effectiveness of their departments. Therefore it is crucial to get the right persons in these positions. Below are descriptions of required characteristics and abilities for each department leader.

#### Medical Services Manager

##### Required Characteristics:

1. Discerning
2. Optimistic
3. Highly Relational
4. Team oriented
5. Hunger to Learn

##### Required Abilities:

1. Able to create and maintain Medical Policies and Procedures
2. Able to orient and teach all levels of medical professionals to their PRC specific medical tasks
3. Willing and able to learn and apply new methods and approaches

#### Director of Advancement

##### Required Characteristics:

1. Strategic thinker
2. Effective Project Manager
3. Optimistic
4. Relationship Driven

##### Required Abilities:

1. Able to think creatively
2. Able to Network effectively
3. Able to recruit, lead, and train volunteers in a myriad of positions
4. Committed and able to grow local Church involvement

### Hiring Process for Staff and Volunteers

Obviously bringing on qualified staff and volunteers is an important part of having a successful PRC. Below is a recommended process for hiring both staff and volunteers. Your process may vary, but it is essential that you have a well-defined and consistent process to follow.

#### Rule of Thumb #1

Rule of Thumb #1 for hiring good staff and volunteers: Try to hire people who are currently employed, are happy doing their work, and are excellent at what they are doing. Encourage these kinds of people to use their skills for God at the PRC by working to “erase the need for abortion.”

#### Rule of Thumb #2

Rule of Thumb #2 for hiring good staff and volunteers: Try to avoid staff and volunteers who want to work for your organization simply because it makes them feel good about themselves rather than because they believe in where the organization is going. I like to call this “hedonistic volunteerism.” While you will always have people who volunteer to make themselves feel better or, worse yet, to fend off some nagging guilt that is haunting them due to past decisions, you can never develop a sustainable and effective non-profit relying them. The turnover is just too high to maintain any level of consistency. In addition, these types of folks tend to bring with them certain malcontent tendencies, even to the point of dissension and turmoil relating to matters insignificant to the mission of the organization.

#### President – Orientation

1. Give a standard presentation to all staff and volunteer applicants. This presentation should include the PRC’s creation history, mission, and its success at implementing the medical linear services model to at risk or abortion-minded women. This is typically done at a formal organizational tour.
2. Have the applicants fill out the job or volunteer application (Appendix 53).

#### Supervisor – Interviews

1. Present a short description of the characteristics and abilities required of a successful applicant for the position(s) being filled.
2. Review the job or volunteer application.
3. Interview each applicant individually.
   1. Discuss feelings about the mission of the PRC It is important that the person feel that the mission is attainable.
   2. Discuss applicant’s background and experiences. Special attention will need to be given to applicants who are post-abortive, including recovery progress and options.
   3. See Appendix 8.

#### Supervisor – Notifications

1. Notify the successful applicant(s) by the standard staff or volunteer phone and letter notification (Appendix 3).
2. Notify the unsuccessful applicants by the standard phone notification, being sure to thank each for his or her interest (Appendix 3).
3. Notify the unsuccessful applicants by the standard letter, signed by the interviewer (Appendix 3).

#### First Experience Day – Orientation

This orientation is supervised by the department head. Use the *General Orientation Checklist* (Appendix 20) as a guide.

Orient the new staff and volunteers before they begin their tasks.

1. Review PRC Mission, Model, and Core Values (see the strategic plan).
2. Summarize the entire PRC Medical Operation Model by how effectively the PRC erases the need for abortion.
3. Take person(s) on tour of the facility, highlighting people at work, systems at work, and demonstrating their interdependence.
4. Have a Question and Answer session.
5. Issue Optimization Tool© Manual (be sure to point out the dress code and job function checklists).
6. Review their specific section in the Optimization Manual including the Strategic Objectives, Organizational Strategy, etc.
7. Determine if there is any required information still outstanding for hiring process completion.

### Staff and Volunteer Management

This section contains some basic guidelines for the management of staff and volunteers. The NIFLA PRC Policies and Procedures may contain more detailed information.

#### Evaluations

All staff and volunteers should be held to the standard within the Optimization Tool© and corresponding Policy and Procedures. To do this well, two basic types of evaluations must be a consistent part of the management process. These are the on-going and annual evaluations.

##### On-going Evaluations (Regular Feedback)

Every staff member who is responsible for other staff or volunteers must take seriously the duty of providing consistent feedback on the staff or volunteer’s performance as it relates to their specific function in the organizational department. The feedback and evaluation should be so regular and consistent that the outcome of any annual performance evaluation should not be a surprise to the person being evaluated (Appendix 16).

The President should perform evaluations on the three primary department heads and provide consistent feedback on their performance on a weekly basis, both as a team in the staff meetings and as individuals in the weekly or twice monthly 1:1 meetings.

##### Annual Evaluations

In addition to regular feedback, there needs to be a formal Annual Evaluation. It is best if these evaluations are performed the same time every year. For example, every January is recommended. (Appendix 16).

#### The Role of Support Staff

Support staff includes positions such as Office Manager, Administrative Assist, and Secretary. If the President has support staff, that person should focus on tasks that facilitate the President’s role. The support staff is to assist the President as the President assists the primary department heads in accomplishing the mission of the organization. However, the support staff must never be used by the President as a go-between to provide directives to staff. Nor should the support staff be used as a buffer when a primary department head needs to speak with the President. My primary staff know that I am always available to them 24/7 including vacation. This privilege has never been abused.

#### Staff Vacation and Time Off

Because of the intense nature of the service a PRC provides, it can be very taxing on the staff who work there. In addition, PRCs have historically not had the financial resources to provide competitive pay scales to its staff. Therefore, time off for staff is essential to their emotional well-being. With this in mind, it is suggested that as much time off as organizationally prudent be made available to employees.

However, care must be taken to ensure that staff absences do not hinder the operations of the PRC. For example, it is not recommended that more than two primary department heads be away at the same time.

Use a standard process, including a *Request for Time* Off *Form* (Appendix 47). A request for time off should be submitted at least two weeks in advance of desired dates. Of course there needs to be some flexibility for “emergencies” such as sickness and funerals.

# 

# Streamlined Medical Services Department

## Departmental Organization Chart

Figure 7: Departmental Organization Chart

## Medical Services Team

### Purpose

This section will serve to train anyone to erase the need for abortion by understanding patient flow and interface at the direct service level.

### Department Objective

To erase the need for abortion one woman at a time by creating and sustaining an environment of predictable excellence empowering the Medical Services Team to succeed at reaching abortion minded women.

### Systems

Your PRC should integrate the following types of systems throughout your Medical Services Department:

#### I. Equipment and Facilities Systems

In the Medical Services Department these include:

1. Reception Area
2. Patient Exam Room
3. Nurses Office

#### II. Dynamic Systems:

In the Medical Services Department these include:

1. Recruiting and Training
2. Personnel Descriptions
3. Patient Flow Process

#### III. Measurement Systems:

In the Medical Services Department these include:

1. Forms
2. Checklists
3. Patient Records
4. Database and Tracking Statistics

The rest of this section is organized based on these systems.

## Equipment and Facilities Systems

Equipment and Facilities Systems are the material framework in which Dynamic Systems occur.

The Medical Services environment must convey confidentiality and professionalism to the patient. These reduce stress in order for the patient to be able to better process the information she is given.

The following areas are included in the Equipment and Facilities Systems for Medical Services:

1. Reception Area
2. Professional Environment
3. Recommended Exam Room Layout
4. Guidelines with Room Use

### Reception Area

1. Neutral Décor that is comforting and friendly. Avoid pictures of babies, mothers, etc.
2. Up to 10 chairs in “L” shaped against two walls so they are out of view of the front door.
3. Box of toys for toddlers.
4. End table in the corner of the “L” of chairs with magazines, plants.
5. Solid door between reception area and patient care area.

### Professional Environment

The medical environment must convey confidentiality and professionalism. This can be accomplished through the commonly accepted usage of lighting and décor.

This type of medical environment should include the following:

1. Neutral décor that is comforting and friendly. Avoid pictures of babies, mothers, etc.
2. Use of dimmed lights or soft lighting.
3. An exam table with stirrups for her feet and a leg rest when she lays flat.
4. Either an incline in the top of the table or a small pillow for patient’s comfort.
5. TV screen for better patient and visitor viewing. The TV screen must be 36” or greater for optimal patient viewing. If multiple rooms are being used for ultrasound, each room must have a TV in it.
6. Ultrasound machine capable of clear pictures at 5 weeks and 1 day gestation.
7. Bottle warmer to keep gel warm.
8. Maintain Clinical Laboratory Improvement Amendments (CLIA) waiver (Appendix 10).
9. All needed medical forms available in a file for easy access during the appointment.

### Exam Room Layout

Exam room should be arranged similar to diagram below.



Figure 8: Exam Room Layout

This layout allows the patient (and her visitor) to have some privacy and exclusiveness from everything else in the room. The door should open in for optimum patient privacy.

## Dynamic Systems

Dynamic Systems are the basic interaction between staff / volunteers and the patient.

The Dynamic Systems are designed to be a framework supporting the ability for staff and volunteers to accurately and consistently provide excellent services to the patient.

The following areas are included in the Dynamic Systems for Unified Medical Services:

1. Recruiting and Training
2. Personnel Descriptions
3. Tasks for Medical Team Shift
4. Patient Flow Process

### Four Phases of Medical Team Development

Staff recruitment and training must be facilitated by the Medical Services Manager and includes a team of professionals for each step. The training of staff must provide proficiency in each area of service. Each phase as described below must be managed by the Pregnancy Resource Center (PRC).

1. Phase I: Recruitment
2. Phase II: Relationship Development
3. Phase III: Training
   1. Part A. Orientation to General Patient Services
   2. Part B. Basic Ultrasound Skills Acquisition:
   3. Part C. Skills Development and Proficiency
4. Phase IV: Independently Perform Medical Steps of Optimization Tool© (OT)

#### Phase I: Recruitment

Use the following steps to recruit Medical Team Members.

1. Develop a list of opportunities available.
2. Post the opportunities, making them visible in your office for existing staff and volunteers.
3. Present known medical professionals with the opportunity to serve with you on your team by personally inviting them.
4. Advertise specific volunteer opportunities in places such as churches, colleges (nursing schools), and on tours of your facility. Involving church liaisons, student groups on campus to adopt places on campus for hanging posters, and of course making them visible in your office for visitors to see (see Appendix 51 for *Sample Volunteer Ad*).

#### Phase II: Relationship Development

When people show interest, be proactive in recruiting them.

1. Get their contact information on their first contact with you and schedule to meet with them within one week.
2. Call them to confirm your meeting.
3. At your meeting, give history and vision of the PRC and *Interview Questions for Volunteer or Staff Positions* with interested volunteer (Appendix 27).
4. Ask them what they “do” and what they would “like to do” within the organization. If they aren’t sure, talk with them about their strengths and weaknesses. You may fit them into an existing position based on their skills and interests. For example, if a nurse loves the teaching, then teaching the Reproductive Health Seminar is where they might fit in best. If they are good at putting people at ease and making them feel comfortable, then the exam room with the patient may be the best place for them.
5. Be open to new positions within the organization to use them. They could be used in areas you may not discovered you needed it.
6. Give *Staff and Volunteer Job Application* to volunteer (Appendix 53) after interview.

**NOTE**: It is important to get at least a one year commitment from each volunteer related to the time and cost spent on training.

1. Call them in a week to see if they have any questions or problems with the application and to schedule a second meeting with them in the office to turn in their application and to discuss any questions they may have. Be sure to follow-up when you receive the complete application from each volunteer. Keep all pieces in their personnel file before training/orientation begins.
2. Send them cards with words of encouragement and thank-you notes, even if they are only in the application process. This continual contact will motivate them.
3. Once the completed application and reference follow-up have been made, schedule to begin the next phase of training.

#### Phase III: Training

Training is guided by a simple checklist for each role in the Medical Services Department. The Parts detailed here are the primary training elements required for completion. The Trainer should use the *Trainer’s Checklist* (Appendix 55) as a guide to prepare for and complete the training process.

1. *General Orientation Checklist* (Appendix 20) – for all new staff (paid and un-paid).
2. *Clinical Coordinator Training Checklist* (Appendix 12)
3. *Data Entry Training Checklist* (Appendix 14) – data entry tasks typically performed by a nurse or clinical coordinator.
4. *Helpline Training Checklist* (Appendix 23)
5. *Medical Services Director Training Checklist* (Appendix 31)
6. *Nurse/Sonographer Training Checklist* (Appendix 36)

##### Part A. Orientation to General Patient Services

Because of the busy schedules of medical professionals, it is recommended that training for new staff take place on a single basis. Use self-learning modules for the training of the nurse. The following topics need to be included in a self-learning module:

1. Organizational Culture and Systems
2. Societal Costs of Abortion, History of Abortion, and Biblical view of the Preborn
3. Medical Services Personnel and Patient Flow Process
4. Communicating and Connecting with an Abortion Minded Patient

This portion of the training is provided completely to the PRC using *Equipped to Serve (ETS)*. Those PRC’s not using ETS will need to work with Patient Resources Director in their organization to provide a condensed version of communicating and connecting techniques.

1. Pregnancy and STD Testing
2. Health Questionnaire
3. Ultrasound Exam

##### Part B. Basic Ultrasound Skills Acquisition

Ultrasound services will be a skill that new nurses will acquire. It is vital that nurses, regardless of their professional experience, be exposed to and comfortable with the service platform that the PRC is currently running. It is also important for the nurse to be proficient in basic services provided.

There are two ways basic skills acquisition can be provided for your medical team:

* 1. Outsourced
  2. In-house
     1. The required team members and responsibilities for In-house training include:
        1. Radiologist/MD: Teach the ultrasound physics and instrumentation
        2. Sonographer: Technical Skills of Limited Ultrasound Exam
        3. Director Medical Services: Patient Education and Nursing Accountability in ultrasound.
     2. While we understand that most PRC’s are unable to provide this training in-house, it is optimal to provide your training in-house for two reasons:
        1. Cost: The cost of an outside training source can be prohibitive to developing a sound medical team long term.
        2. Departmental stability: Promotes immediate training availability, thereby eliminating gaps in medical coverage.

**NOTE:** The above are tied together. You do not want to make a significant front end investment only to have that commitment fall through. If the required people are not available at your organization, these positions must be added to your Volunteer Opportunities for Medical Services. Begin praying for these positions to be filled.

Until the required positions for in-house training of a radiologist/MD and sonographer are filled, the initial ultrasound skills acquisition will need to be outsourced with a continuation of training as described in Part C of this training phase.

##### Part C. Skills Development and Proficiency

Check with the Medical Director before allowing a new RN to scan independently in Phase IV of service with the Medical Team.

For Nurses– The following are guidelines for continuing ultrasound skill development after outsourced ultrasound initial skill acquisition has taken place:

1. Pair up nurses with staff RNs who are willing to help with the training. Require the nurse to train weekly until proficiency has been reached. Weekly scanning will help the trainee not forget skills reviewed in the previous week and will allow for them to become familiar with the routine by moving through each step quicker.
2. Schedule “Models” (pregnant women used in training) to come opposite the time you would be working with a patient. This helps double the amount of ultrasounds done in one training time and helps the volunteers become trained sooner.
3. Utilize “off day”, such as Saturdays (as sonographer is available) during the ultrasound training where the trainees can get up to 10 scans. This is so they can practice the skills they learned up to this point in the training and also to complete their required scans sooner.

##### Tracking Ultrasound Training

To be approved by the Medical Director to perform Limited Ultrasound at the PRC, each nurse needs to perform at least 50 scans. These come through the combined initial skills acquisition training and continued training. The above training program should lend itself to getting the 50 scans completed within 6-8 weeks. Each nurse should have a record of ultrasounds done during training and indicate whether they observed or performed the ultrasound. Each medical team member’s ultrasound proficiency must be reviewed and approved by the Medical Director before allowing her to scan independently in Phase IV of service with the medical team. The *Ultrasound Training Record* (Appendix 60) is important to have on file for each of your team members performing ultrasound.

##### Recruiting “Models” for Ultrasound Training:

Women who are pregnant (models) are needed in order to provide ultrasound training to medical personnel. These models need to be recruited and scheduled for the training times. Local churches and mother’s groups are good places find a source of willing pregnant women (or women who know other women who are pregnant).

Below are some guidelines for the recruiting of these models.

1. Contact specific liaisons from churches or mother’s groups that you have a relationship with. Talking to your liaisons will get you “in” where you will be most successful in recruiting models.

**NOTE**: Be aware of other events going on within your organization that are pulling the attention and support from the churches. You do not want to overwhelm them.

1. Seek the liaison’s help either via a phone call or when they are in the PRC office. Seek their input as to the best way to contact the pregnant women they know of. This will make it personal for them and give them some ownership.
2. Follow the guidance of the liaison. If an announcement is used, give them the *Sample Pregnant Model Announcement* (Appendix 50) or get it to the contacts recommended by your liaison.
3. Follow up with a call or note of gratitude to those who helped you in recruiting models. Be sure to include specific information on how they helped. For example, “I had 10 women come from your church.” This will keep them dedicated to serving with your organization
4. When women call to schedule their ultrasounds as part of the training, you will need to gather some information from them and let them know a few things.
   1. How far along is she?
   2. How did she hear about the training?
   3. Is she familiar with the organization?
   4. Explain training nature of ultrasound (that a doctor will not be reviewing it)
   5. Ask availability for schedule
   6. Schedule them (weekly) as often as they’d like up until 14 weeks
5. When models come for their scheduled time:
   1. Review the *Ultrasound Consent* form (Appendix 56) with the model.
   2. Explain to them the “concentration” for the day, what we will be looking at
   3. Give them pictures of their baby and [*Ultrasound Poem*](#_The_Ultrasound_–) (Appendix 59)
   4. Give them a gift for coming, if you have any (for example, left over fund raising incentives or branded material such as mugs, pens, etc.).

#### Phase IV: Independently Perform Medical Steps of OT

This is the final phase of staff development and continues through their tenure at the PRC. In this phase, the Medical Services Manager is to facilitate ongoing development through following areas:

1. Hosting monthly Team Meetings:
   1. Communicate process updates as they pertain to the staff performing each step.
   2. Communicate organizational developments as they impact the Medical Team and overall process.
2. Coaching individuals as areas for growth are identified:
   1. Review checklists on a regular basis.
   2. Debrief with each team member on an ongoing basis (formally and informally) for the purpose of skill refinement.
   3. Hold staff accountable to core values of the organization.
   4. Communicate with staff areas of improvement/innovation for potential implementation.
3. Mentoring in Professional Development
   1. Providing articles for each staff member to read pertaining to the services provided (this can be done weekly).

**NOTE:** Delegation, not abdication is the key, during this phase, for ongoing success.

### Personnel Descriptions

Below are descriptions of the Medical Team Personnel. For complete job descriptions for each of the medical team members, please refer to the specific Policies and Procedures from NIFLA.

#### Medical Director

The Medical Director will work to ensure that proper standards of medical care are implemented in the office. The Medical Director must be directly and immediately available during all patient service hours for communication during emergencies. Weekly meetings will need to be scheduled for complete review of each patient’s chart. The Medical Director must approve the medical services provided and this must be reflected in the Policies and Procedures regarding such services. A contractual *Medical Services Agreement* (Appendix 30) should be established between the Medical Director and the pregnancy center.

#### Medical Services Manager

The Medical Services Manager is responsible for supervising, organizing, planning, assessing, and monitoring the medical services provided by the PRC. The Medical Services Manager also works in conjunction with physicians, nurses, helpliners, and clinical coordinators to ensure that patients receive the best medical, nursing, psychosocial, and spiritual care possible.

#### Nurse Team Leader

The Nurse Team Leader provides support and care to the patients and maintains professional standards of care, following the American Nurses Association (ANA) Code of Ethics. Under the general direction and supervision of the Medical Services Manager and the Medical Director, the Nurse Team Leader is responsible for a wide variety of functions, including planning and performing direct and indirect nursing interventions. In order to ensure quality and continuity in the documentation process, the Nurse Team Leader will perform a quarterly Chart Audit, reviewing ten recently closed charts and completing the *Chart Audit Form* (Appendix 8) for each chart. If, after all ten forms are completed, there are more than two “No” responses for any item listed on the *Chart Audit Form*, that area needs to be addressed with all staff completing that section of the patient chart.

#### Nurse (RN)

The nurse provides services in conjunction with physicians and other nurses, ensuring that patients receive the best medical, nursing, psychosocial, and spiritual care possible. The nurse must only operate within her scope of practice and keep her license current.

##### Flow of Authority

Nurse reports to the Nurse Team Leader, who reports to the Medical Services Manager.

##### Appearance

The Medical Team will wear navy blue scrub pants with a white top. They may also choose to wear a white lab coat.

#### Helpliner

##### Role Objective

Provide peace of mind to women facing the possibility of an unplanned pregnancy, by scheduling patients for an appointment to receive life-saving information from the PRC in-office staff. The target is to have an 80% show rate or better.

##### Flow of Authority

Helpliner reports to the Helpline Team Leader, who reports to the Medical Services Manager.

##### Demeanor

The warm, comforting and confident demeanor of the Helpliner will assure the Patient that the PRC is a safe place to come for support and peace of mind.

The goal of the Helpline is to schedule appointments for abortion-vulnerable and abortion-minded women.

**NOTE:** No counseling should be done on a Helpline call for any reason.

##### Shift Schedule

###### Preparation for Each Shift

As a Helpliner you are literally on the “frontlines.” As the first point of contact, it is critical to be prepared both spiritually and logistically to effectively minister to each caller. To that end, it is recommend that each Helpliner establish a “prayer covering” during their shift. They should ask three close friends to be praying for them before the phones are forwarded to them and during their shift.

###### Shift Times

1. Shifts and staffing of the Helpline will be determined by the Helpline Team Leader.

###### End of Each Shift

The Helpliner is responsible for using the call-forward instructions to connect the next Helpliner, if calls are answered off-site. Once the call forwarding is verified, the Helpliner will

1. Verbally report any schedule changes.
2. Pray with the next Helpliner on duty.

##### Logistics

The Helpliner should have the following accessible near the telephone so as to be prepared to schedule appointments or provide the referral information:

1. The Helpline Manual (OT pages related to Helpline protocols, scripts, etc.)
2. The most current appointment availability
3. Blank *Helpline Intake Form* (Appendix 22)
4. A working pen or pencil

##### Basic Protocol

The Helpliner should assume all callers are abortion-vulnerable or abortion-minded women. These women have one or many of the following characteristics:

1. Single
2. Age 17-26
3. Being pressured to have an abortion (boyfriend, parents or friends)
4. Seeking information about abortions: i.e. cost, where, referral or actually has one scheduled
5. Still in school
6. Has a history of abortion
7. Experiencing financial pressure

##### Helpliner Checklist

The Helpliner is to complete a *Helpliner Checklist* (Appendix 24) following each shift to confirm that she did her job well. For more information about checklists, see Measurement Systems later in this section.

#### Clinical Coordinator

##### Role Objective

The Clinical Coordinator is the first face-to-face contact the patient receives at the PRC. She facilitates office operations and computer data entry for all patient appointments. She greets and presents the patient with the Welcome Packet.

##### Flow of Authority

Clinical Coordinator reports to the Nurse Team Leader, who reports to the Medical Services Manager.

##### Demeanor and Appearance

The Clinical Coordinator is the first face the patient will see when she arrives for her appointment.

*Demeanor:* A kind and welcoming demeanor is vital to the role she will play in order to assure that patient that the PRC is a safe place to come for support and peace of mind.

*Appearance:* The Clinical Coordinator should come to the office in professional attire, wearing formal blue. “Blue symbolizes trust, loyalty and wisdom. It is also said to have a calming effect, slowing human metabolism and elicits feelings of tranquility, thus allowing the patient to feel more welcomed and serene.”[[1]](#footnote-2)

##### Clinical Coordinator Job Function Checklist

The Clinical Coordinator is to complete a *Clinical Coordinator Job Function Checklist* (Appendix 11) following each shift to confirm that she did her job well. For more information about checklists, see Measurement Systems later in this section.

#### Data Entry Specialist

The functions of the Data Entry Specialist are typically performed by the Clinical Coordinator, but nurses can also be cross-trained to perform data entry. Data entry functions can also be assigned to a specific volunteer who exclusively fills this role.

##### Role Objective

Enter all patient information in the patient database in a timely and accurate manner. This involves adding new patients to the database when necessary, entering demographics for each patient, as well as each interaction and corresponding information.

##### Basic Protocol

Data Entry Specialist should follow these steps in completing tasks:

1. In each patient chart, refer to the *Patient Interaction Tracking Form* (Appendix 42). This lists all interactions completed or pending, with the corresponding date.
2. Each Interaction listed on the tracking form as completed or pending should be entered in the database. Then the date of data entry should be written on the *Patient Interaction Tracking Form* to indicate that it has been completed.
3. Review the patient chart, verifying that all interactions are entered in the database.
4. Communicate with supervisor regarding any questions or problems.

### 

### Tasks for Medical Team Shift

Members of the Medical Team should have regular tasks to perform on every shift. They should not simply passively wait around for something to happen. Below are typical tasks for a shift.

1. Check in with Nursing Team Leader for your shift. The Team Leader will report the scheduled appointments and review information known about each patient.
2. Pray together as a team for current appointments, past patients, each other, and whatever else you feel you should pray for.
3. Check your files from previous patients to determine if they need follow-up and to know what communication has taken place with them. Once the patient’s pregnancy has been confirmed (with the patient), the Nurse will do the follow-up. Please keep informed of your patient’s progress and if there are any concerns you could address with them.
4. If there are no appointments scheduled, please be available in the office for walk-in patients. This may increase in frequency as you advertise or if you are situated near other doctors’ offices.
5. Review any articles or other material to be sure that you are up to date on current information and issues. Articles and other types of educational material should be kept in a centralized location to be used for continuing education. This material must be kept current with new material added on a weekly basis. This should be the responsibility of a specific person, such as the department head or even the President.
6. Review the Optimization Tool© and the Policy and Procedures Manual on a regular basis. Each of these will help you serve patients with excellence.
7. Complete 15 Step process as outlined for Medical Services.
8. When you notice we are down on any stock items, please note them on the Inventory (*Sample Inventory* Appendix 49). This enables the organization personnel to perform their duties with efficiency.
9. Sign [*Nurse Job Function Checklist*](#_Medical_Services_Job) (Appendix 35).

## Patient Flow Process

The following 15 steps are the exact steps that are necessary for the patient to receive the complete service of the PRC. It is important that these steps be done sequentially (in order) and completely. The details of each step are described in this section.

**NOTE:** Although the action of most of these steps is taken by the PRC staff, the focus is on the patient and on moving the patient seamlessly through the process so as to provide her with quality care.

**CAUTION** – All patient information is by definition confidential and therefore must be protected from intentional or accidental disclosure. For example, electronic documents or devices such as PDAs, mobile phones, etc., containing patient information or related schedule must be [password protected](#_Password_Protecting_Documents). Additionally, paper copies containing documents related to patient data must be put in their proper place and locked.

### The 15 Step Patient Flow Process

1. Helpline receives call from patient.
2. Helpliner schedules an appointment for the patient.
3. Helpliner calls patient to confirm appointment.
4. Clinical Coordinator greets the patient and provides Welcome Packet.
5. Nurse performs situational assessment.
6. Nurse performs support system review and presents options.
7. Nurse obtains urine sample for pregnancy testing.
8. Nurse performs pregnancy test.
9. Nurse presents pregnancy test results.
10. Nurse obtains health history and reviews consent forms with patient.
11. Nurse performs ultrasound exam.
12. Nurse provides Patient Resource List.
13. Nurse gives Gospel presentation.
14. Nurse and Clinical Coordinator initiate exit process with patient.
15. Nurse performs follow up.

### Patient Flow Process – Functional Workflow Diagram

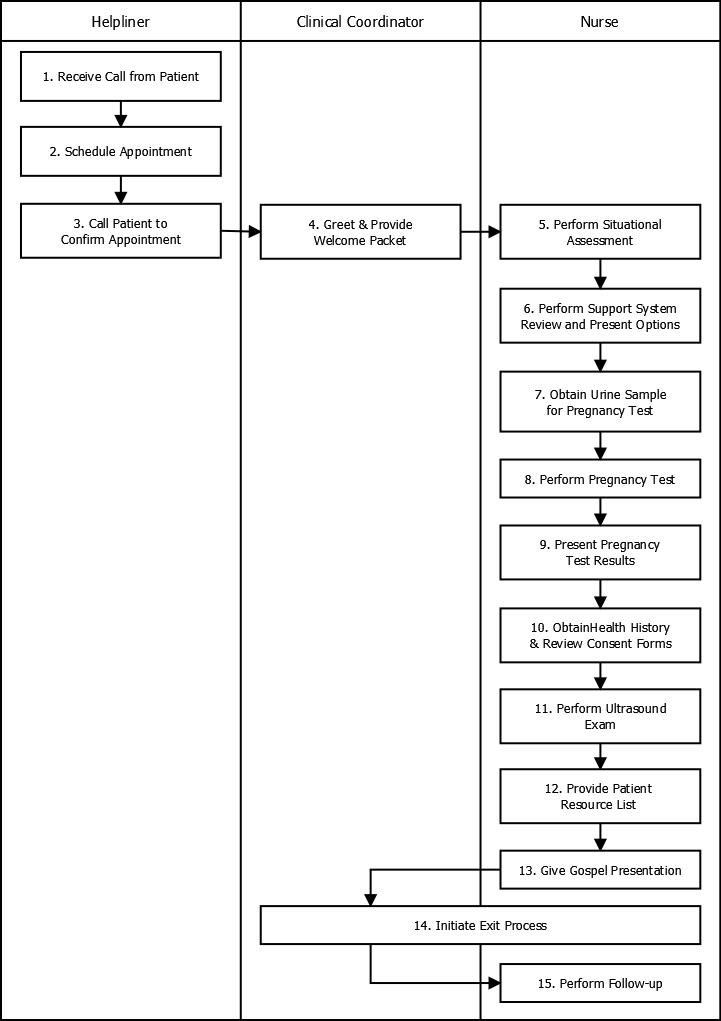


Figure 9: Patient Flow Process – Functional Workflow Diagram

### Scheduling and Logistics of Patient Appointments

**NOTE:** It is vital that each of the 15 Step Patient Flow Process be accounted for during EVERY patient appointment, regardless of the type of appointment (i.e. new initial appointment, return u/s appointment with STD results, return appointment for negative retest). However, some of those steps will be modified or shortened if the patient has already completed her initial appointment.

See Appendix 5, *Appointment Schedules*, for examples of timetables of each type of return appointment.

### Step 1 – Helpline Receives Call from Patient

This patient flow process is initiated by the prospective patient calling the PRC. This step assumes that the patient is aware of the PRC either by the PRC’s marketing or by word of mouth.

Medical Staff does NOT answer or respond directly to Helpline calls in the role of a nurse. As the medical staff, you are not the patient’s (i.e. caller’s) medical provider (doctor) and you don’t know anything about her and her health history.

**NOTE:** This is why a primary goal of the PRC’s marketing is to focus on getting the patient to call.

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 1: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Clinical Coordinator will schedule Return Appointment while patient is in office for Initial Appointment. | | | |

Table 2: Step 1 - Return Appointment Modifications

### Step 2 – Helpline Schedules an Appointment with the Patient.

#### Overview

The Helpliner is to use the following steps for each call.

1. Receive Call
2. Take the patient through ALL of the three statements when scheduling an appointment (see Scripts below).
3. Schedule an appointment by filling out the *Helpline Intake Form* (Appendix 22).
4. Report to office if the patient is scheduled for the same day she called or at end of the shift if scheduled for the following day.

#### Receiving a Call

Assume all callers are abortion-vulnerable or abortion-minded women. Greet the caller, saying:

“Hello, this is (name of PRC), your unplanned pregnancy solutions provider. May I help you?”

**NOTE:** Do not always give your personal name first so that you can ask her what her first name is later in the conversation in a natural manner (e.g. “By the way, my name is Jane. What’s yours?”), then use it frequently which engenders trust.

#### Helpline Script

Take the caller through each medical issue, giving her the opportunity to schedule an appointment. *Even if she chooses to schedule an appointment, you will address each of the three medical issues in order to communicate the value of all of the services she will receive.* Once she agrees to schedule, you may ask any remaining questions by saying this:

1. “Great. Let me just ask you a few more questions about your pregnancy.”
2. Gather the information that is on the Intake Form. This includes: patient’s name, LMP, her contact information, the purpose of her call, her intention to carry, etc. (Appendix 22).
3. This information will be documented on the Helpline Intake Form, placing an “X” to the right of the appropriate response under “Intention to Carry.” This is a very important question, as it provides our initial metric of Intention, which is measured several times throughout our relationship with her and is a direct indication of our effectiveness.

Continue talking through the script, in order to communicate the value of the services she will receive at her appointment. This should help to reduce No-Show rates, particularly for those patients who call, ready to schedule an appointment, without ever requesting answers to these questions.

If caller asks to make an appointment and does not indicate what type of appointment he/she is looking for, ask: “Are you looking for Pregnancy testing or STD testing?” They will most likely give you a clear answer that will indicate pregnancy (or possibly abortion/term), STD testing, or a service we don’t provide. If patient is not clear about intention ask “Are you considering termination with this pregnancy?” at an early, yet appropriate time in the call.

If patient is clearly abortion minded (i.e. opens with a question about abortion, cost, how to schedule an abortion, how late do you do abortions), go through **all 3 statements**:

“A lot of our patients feel a sense of urgency to take care of this quickly, and a little overwhelmed, but you have some time. There are three medical issues that every woman needs to know before determining the outcome of her pregnancy. So first things first…

##### 1.) “We need to find out if you’re really pregnant.”

“31% of pregnancies end on their own. Since a positive pregnancy test cannot medically confirm that you are pregnant we need to do **an ultrasound to confirm that you’re really pregnant**. Let’s schedule you for an appointment.”

##### 2.) “Next, once your pregnancy is confirmed we need to find out exactly how far along you are.”

“Knowing exactly how far along you are determines what type of termination procedure you could get **and how much it will cost you**. This is done using an ultrasound scan. Let’s schedule you for an appointment to meet with a nurse and have an ultra sound to confirm your pregnancy and see how far along you are. Our next available time is .”

##### 3.) “Finally, before you schedule a termination procedure, you need to have STD testing.”

If patient is Abortion Minded and has not scheduled:

“Before I let you go you may want to consider **a pre-termination evaluation that** includes STD testing and treatment so that we can help you **protect your health for a future pregnancy**. It is important that you have STD testing to make sure you don’t have Chlamydia or Gonorrhea. If you have a termination procedure with an untreated STD, it can increase your risk of contracting Pelvic Inflammatory Disease by 25%. My next available appointment is . Would that time work for you?”

If patient is not clearly abortion minded, but still has not scheduled, we should replace the words “pre-termination evaluation” with “appointment”

If patient (who has not already received all of our services somewhere else) does not schedule because they are looking for a place that does the termination procedure say:

“We do not do termination procedures or refer for them because we are a non-profit organization specializing in objective information and service delivery that does not make any money from your decision. But, we provide the pre-termination evaluation so that we can help you **protect your health for a future pregnancy**. Are you sure you don’t want to come in on for that appointment?"

##### Typical questions:

###### How much will my appointment cost?

“Our services would cost you $350.00, but we are a non-profit organization whose generous donors have paid that fee on your behalf. Will you please call us if you cannot make it to your appointment?" (Pause and wait for response) Thank you, that enables us to offer that appointment to someone else who is waiting."

###### “So you don’t actually do abortions/terminations?”

“We do not do termination procedures or refer for them because we are a non-profit organization that does not make any money from your decision, but we provide the pre-termination evaluation so that we can help you **protect your health for a future pregnancy,** during and after that procedure.”

If patient asks medical questions during call (i.e. questions regarding Plan B, Morning After pill, date of conception, chance of viable pregnancy based on Last Menstrual Period, LMP, etc.):

"I'm sorry, I am not a medical professional so it is unlawful for me to answer those questions, but our nurses are very capable and you may ask them any medical questions you have when you meet with them during your appointment. Our next available appointment is would that work for you?"

##### Conclusion:

“At your appointment, you’ll meet **your nurse** who will do a pregnancy test, and if that’s positive, an ultrasound, as well as STD testing. She will answer any medical questions you may have, including questions about abortion procedures, in addition to reviewing all of your pregnancy options and resources. Do you have any questions? **If something changes with your schedule or your pregnancy, Will you please call us if you cannot make it to your appointment? (Pause and wait for response) Thank you, that enables us to offer it to someone else who is waiting.”**

##### The following phrase may be used at any time during the call to direct patient back to the 3 Statements, if a patient indicates feeling rushed, anxious to make a decision, etc.:

“A lot of our patients feel a sense of urgency to take care of this quickly, and a little overwhelmed, but you have some time. There are three medical issues that every woman needs to know before determining the outcome of her pregnancy. So first things first…”

**NOTE**: A patient may choose to refuse permission to be contacted prior to her appointment. This must be clearly documented on the Helpline Intake Form.

**CAUTION** – When saving Helpline Intake Form, Helpliner MUST protect the document by applying a password. This password may be the same for each Intake form created, but should be unique enough that a non-staff member would not easily guess it. This will ensure that confidentiality of patient information is maintained even when document is emailed or transferred from one computer to another. Please refer to Appendix 37 for instructions on minimal password protection process regarding documents.

#### Filling Out Forms and Checklist

1. Fill out the *Helpline Intake Form* (Appendix 22).
2. Enter patient information into the Database before the end of each business day. See *Patient Interaction Tracking Form* (Appendix 42).
3. Fill out the *Helpliner Checklist* (Appendix 24) and return it to the Helpline Team Leader.

#### Helpline Notes

1. If the caller requests information or referrals for services outside of the scope of the PRC, the Helpliner should first follow all three script questions. If patient still does not schedule an appointment, and it is clear that she does not believe she is pregnant or at risk for abortion, Helpliner may refer to the topical list provided of local agencies providing social services. Try not to refer callers to one specific agency or individual, but rather offer at least two agencies.
2. If the caller has her own physician, always encourage her to call her own physician because the physician will already have the patient’s health history.
3. Never refer a caller for birth control. The PRC Nurse is prepared to discuss some of the risks of birth control if the patient would like to schedule an in-office medical consultation. However, we do not offer or refer for that service.
4. The Helpliner should not handle calls from physicians, agencies, teachers, students, reporters, television stations, advertising agencies, the phone company, etc. They should always offer the PRC Administration phone number. Alternatively, Helpliner may take the name, phone number and the nature of the call and tell the caller that you will have the appropriate person return their call as soon as possible.
5. Never encourage a minor to leave her parents. If she is being abused, then a report must be filed with Child Protective Services or the appropriate agency, at which point the Helpliner is to report the call to her PRC supervisor and follow the procedure outlined in the PRC Policy and Procedure Manual. Encourage a minor to make an appointment to come to the office to discuss her concerns.

#### Voicemail Message

The following voicemail announcement should be heard if the Helpliner is unable to answer the Helpline:

1. “Thank you for calling (name of the PRC). You have reached the Appointment Scheduling Helpline. If you are calling outside of our regular business hours, (M-F, 9a-6p.) please leave a message and we will return your call at the start of our next business day. If you are calling during our regular business hours, please leave a message and we will return your call immediately. If you are calling regarding an appointment which you have already scheduled, please call our Nurseline (555.5555) and leave a message. You may also call our Nurseline if you are a current patient and have a question or concern you would like to discuss with a nurse. Please remember that your call and all of our services are confidential. Thank you.”

#### Specialized Counseling Services for the Deaf

For PRCs that are able to provide specialized counseling services for deaf patients, appointments can be made doing the following:

1. Requests will come through a “relay service.” They provide on-line interpretation for people calling in from a TTY or TDD machine.
2. Helpliner should follow the script as if speaking directly with the patient. However, it will be necessary for her to speak much more slowly and pause frequently to allow the relay service to provide interpretation to the patient.

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| --- | --- | --- | --- |
| **Step 2: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Clinical Coordinator will schedule Return Appointment while patient is in office for Initial Appointment. | | | |

Table 3: Step 2 - Return Appointment Modifications

#### Medical Services Helpline Process

##### 

Figure 10: Helpline Process Flow Chart

### Step 3 – Helpline Confirms Patient’s Appointment

On the business day prior to the patient’s appointment, Helpliner will call patient to confirm next day’s appointment. Schedule and patient contact information will be communicated to Clinical Coordinator via Compass Care Google Calendar.

When confirming a new patient appointment, Helpliner must first check “Permission to Confirm” field. If patient agreed to be contacted prior to her appointment, Helpliner may call phone number given by patient and leave a message if patient does not answer or is unavailable.

The following script should be used for any confirmation call, regardless of whether patient is new or returning:

“This is (your name) calling from (name of PRC). I’m calling to confirm your appointment for (day, date and time of appointment). If you are unable to make this appointment, please call our Scheduling Helpline at (Helpline phone number) to reschedule. Thank you.”

**NOTE:** Never leave any information about the nature of the patient’s appointment on a message (i.e. “ultrasound appointment,” “pregnancy test appointment,” “STD test results,” etc.). This means that you may need to use caution when leaving the name of your PRC in a message, leaving out words like “pregnancy”

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| **Step 3: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No Modifications | | | |

Table 4: Step 3 - Return Appointment Modifications

### Step 4 – Clinical Coordinator Greets Patient and Provides Welcome Packet to Patient

When the patient arrives for the appointment, the Clinical Coordinator is the first face-to-face contact with the Patient and must use the following scripts.

The Clinical Coordinator stands and offers a warm smile and greeting saying:

“Welcome to (name of PRC)! Please review and fill out the information on these forms.”

#### Present Patient with Welcome Packet

The Clinical Coordinator should then present the patient with the Welcome Packet, which includes the *What Can You Expect? Form* (Appendix 62), *Patient Information* (Appendix 40), *Limitations of Service* (Appendix 28), and [*Patient Bill of Rights*](#_Bill_of_Rights) (Appendix 7).

“I will tell your Nurse, {name}, that you are here. While you are waiting, please read through this form. It will describe what you can expect during your visit today. We would also like to learn a little more about you, so please answer these questions while you wait. And this form, the Limitations of Service, tells you more about Compass Care. Also, please read the Patient Bill of Rights and sign it on the bottom. If you have questions about this form, your nurse will be happy to answer those for you when you give the form to her. Again, all our services are completely confidential. So, feel free to relax knowing you will leave with a resource list.”

#### Addressing Persons with Patient

If a boyfriend, friend, or parent come with patient, explain to them what is going to happen, saying,

“Thank you for coming with (use the patient’s name) today. Please make yourself comfortable. The Nurse will be taking (use the patient’s name) back for her appointment. Due to patient confidentiality, you will be asked to remain here in the reception area.”

**NOTE:** The Clinical Coordinator may have a conversation with the visitors on neutral topics such as the weather, where they are from, etc. The Clinical Coordinator must NOT speak with them about the specific materials that will be presented to the patient or about topics that are “controversial” or “emotionally charged”, such as about church, Bible, politics, religion, or even the specific stances of the PRC. The Clinical Coordinator is not to upset, annoy, or aggravate any person accompanying the patient because this person may become a barrier to the patient receiving necessary services from the PRC.

The Clinical Coordinator may do initial data entry into the STD lab software using the Patient Info form, at this time. If the STD testing platform is appropriate for the particular patient, additional steps will be necessary as well.

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| **Step 4: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Clinical Coordinator does not present the Welcome Packet | | | |

Table 5: Step 4 - Return Appointment Modifications

### Step 5 – Nurse Performs Situational Assessment

Nurse calls patient from waiting area, either by name or patient number, and greets them, saying,

“Hello, my name is , and I’ll be your nurse today. Please go into exam room # and have a seat in the chair.”

After she is comfortably seated,

“So, tell me, what brings you to today?”

The Nurse performs the Situational Assessment, using the *Patient Intake Form* to direct conversation.

Gather the information in the *Patient Intake Form* (Appendix 41).

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| **Step 5: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Nurse will use the first part of the Return Visit Health Questionnaire (Appendix 48) to review situational assessment and options presentation. Modified Steps 5 & 6 should take approximately 5 minutes total. | | | |

Table 6: Step 5 - Return Appointment Modifications

### Step 6 – Nurse Performs Support System Review and Presents Options

Perform support system review: ask questions on form, related to the father of the baby and her present support systems.

“O.k., let’s talk about your options.”

#### Present Abortion: Procedures, Risks and Side-effects Brochure

Nurse should present the “Abortion: Procedures, Risks and Side-effects” Brochure saying:

"We've learned that most women who have had an abortion feel they did not receive adequate information before making their decision. That's why we want to take some time to go over this brochure with you and give you an opportunity to ask questions."

Open the brochure to the place that explains the procedure for the week’s gestation from her last menstrual period (i.e. first day of her last menstrual period) as shown on the Birth Date wheel.

Allow the Patient to read it quietly to herself.

Ask the patient,

“Do you understand what you read?”

and,

“Is any of this information new or surprising to you?”

Tell the patient,

“If you have any specific medical questions related to what you read, I am happy to discuss them with you.”

"A vast majority of women who have had abortions regret not knowing more about fetal development, so I'd like to share that with you as well.”

Direct the patient’s attention to the information about the fetal development of her pregnancy, based on her LMP.

#### Present Adoption: Ten Questions Expectant Mothers Ask About Adoption Brochure

##### Overview of Adoption

Nurse should give a basic overview of the legal and social aspects of adoption as they relate to the state law where the patient lives, using the following script:

"If you chose to make an adoption plan, you would see a wide range of options for involvement with the adoptive family before and after birth. There are open adoption plans, which allow you a lot of contact with the family and your child later on. If you'd like more privacy, you can make a closed adoption plan with no contact. There are also some options in between those two. If you have any questions about adoption, even if you'd like to ask questions before you make a decision, I will provide you with some local Adoption Agency contacts that you can call. They will not pressure you to make a decision, but will be able to answer all of your questions. I'll also give you this brochure that answers a lot of questions that our patients have about adoption” (10 Questions Expectant Mothers Ask About Adoption).

More in-depth questions should be referred to a known adoption agency, listed on the PRL.

#### Present Parenting:

##### Parenting Resources

Nurse should briefly discuss resources that the patient would need in order to parent, but not spend time on specific names, phone numbers, etc., of those referrals at this time.

1. These details will be communicated to the patient in Step 12: Patient Resource List.
2. She is likely not ready to process all of the referral information, as she is still waiting for pregnancy test results and has not yet had an ultrasound. It is important not to give her too many pieces of information at one time.

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| **Step 6: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Nurse will use the first part of the Return Visit Health Questionnaire (Appendix 48) to review situational assessment and options presentation. Modified Steps 5 & 6 should take approximately 5 minutes total. | | | |

Table 7: Step 6 - Return Appointment Modifications

### Step 7 – Nurse Obtains Urine Sample for Testing

A pregnancy test may only be administered when a nurse is present. Direct the patient to leave sample in restroom for testing.

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| **Step 7: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Do not obtain urine sample. Skip to Step 10. | | Nurse directs patient to leave urine sample before performing Steps 5 & 6 | |

Table 8: Step 7 - Return Appointment Modifications

### Step 8 – Nurse Performs Pregnancy Test

The following are the steps for pregnancy testing:

1. Perform the pregnancy test per manufacturer’s directions.
   1. Draw up urine in dropper provided
   2. Drop 5 drops of urine on sample (tear drop) of test
   3. Wait 4 minutes for results
      1. A line must appear under the C (control) portion of test for results to be accurate
      2. A second line of any shade under the T (test) portion of the test indicates a positive result
      3. The absence of a second line under the T (test) portion of the test indicates a negative result
2. Document the test in the *Pregnancy Test Log* (Appendix 45)
3. Collect the sample for STD testing.
   1. Place the provided lid on container.
   2. Peel yellow sticker back revealing the needle in top of lid.
   3. Push urine collection tube, provided by CDD, onto needle and allow tube to fill to completion.
   4. Label and send urine sample as directed by CDD
   5. Complete *STD Test Log* (Appendix 54)

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| **Step 8: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No pregnancy test. Skip to Step 10. | | No modifications. | |

Table 9: Step 8 - Return Appointment Modifications

### Step 9 – Nurse Presents Pregnancy Test Results to Patient

After testing, the nurse should meet with the patient and explain the pregnancy test results.

#### If Negative Test

Report the results by saying:

“Your test was negative today, meaning that there is not enough HCG, the pregnancy hormone, in your urine to turn it positive.”

Offer a home pregnancy test to the patient, saying:

“This is a pregnancy test that you can take at home. If you think you may be pregnant later, or you don't get your period within two weeks, follow the instructions on the package. If you have a positive test at home, it does not necessarily mean you have a live pregnancy. You will need to confirm your pregnancy by calling our Scheduling Number to make another appointment.”

#### If Positive Test

Report the results by saying;

“Your test was positive today. This means that there IS enough HCG, the pregnancy hormone, in your urine to turn it positive.”

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| **Step 10: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No pregnancy test. Continue with Step 10. | | No modifications. | |

Table 10: Step 10 - Return Appointment Modifications

### Step 10 – Nurse Obtains Health History and Reviews Consent forms with Patient

**NOTE**: Paperwork must be reviewed with the patient alone to protect her privacy and allow for her to share honestly and openly.

#### Review Health Questionnaire with Patient

When using the *Initial Visit Health Questionnaire* (Appendix 25), please follow the steps below:

1. Be sure that all spaces are complete. If they do not apply, add “N/A” and cross out that area.
2. Ask the patient if she has any questions.
3. Always document the patient’s OB/GYN, or if they need a referral.
4. Always refer them to an OB/GYN doctor following their appointment.

**NOTE**: If the patient asks any question that has not yet been addressed by your Medical Director, say, “I will check with our Medical Services Manager/doctor and let you know.” Do not answer questions from your own experiences. Always check with the Medical Services Manager before answering questions. Always reassure her that if she has concerns, they are best brought up with her doctor (OB). We are, however, selling peace of mind while she’s here so we need to give her some glimpse that her perception is not as bad as it seems.

Also, it would be helpful for you to keep a notebook of Frequently Asked Questions (FAQ) as a reference.

##### Positive Pregnancy Test:

1. Review the *Initial Visit Health Questionnaire* (Appendix 25) with the patient, addressing any symptoms or issues as they come up.
2. Provide educational material as directed in the [*Health Questionnaire Breakdown*](#_Addendum_to_Step)(See Addendum to Step 10 at end of this section)
3. A patient with positive pregnancy test results may receive *a Verification of Positive Pregnancy Test Letter* (Appendix 61) to obtain insurance or medical care.
4. The patient must also complete an *Authorization for Release of Medical Information* (Appendix 6) form to receive the letter as above or to release any of her other medical information to her OB or referral OB.
5. Skip to Review Ultrasound consent later in this step

##### Positive Test – Frequently Asked Questions

The following are some questions that patients frequently ask during the health questionnaire review.

Figure 11: Positive Test - Frequently Asked Questions

##### Negative Pregnancy Test:

1. Review the *Initial Visit Health Questionnaire* (Appendix 25) with the patient, addressing any symptoms or issues as they come up. Pay special attention to the portion of the Health Questionnaire as you begin talking about their sexual history.
2. Provide educational material as directed in the [*Health Questionnaire Breakdown*](#_Addendum_to_Step) (See Addendum to Step 10 at end of this section)
3. Reschedule for repeat pregnancy test in two weeks if she has not gotten her period by then.
4. If STD testing is desired; reschedule a repeat pregnancy test for one week, during the STD results appointment.

#### Inform Patient of STD Testing

During their appointment, it is important to inform the patient of the risks associated with Sexual Transmitted Disease (STD) and pregnancy/abortion.

The nurse should inform the patient about STD testing, after your center has completed *Instructions for Establishing Contract for STD Testing (*Appendix 26).

1. Introduce the idea of testing on the STD Testing history section of the Health Questionnaire.
2. Inform the patient of STD testing and why it is important, saying, “We also offer STD testing. The STDs we test for are Gonorrhea and Chlamydia. These are two highly treatable bacterial STDs. Unfortunately 75-80% of people who have Gonorrhea or Chlamydia do not know they have it. Especially women, because they routinely do not have symptoms. It is also necessary to know whether you have Chlamydia before you make a decision to have an abortion because” (hand patient STD brochure, and point out the statistic) “of patients who have a Chlamydia Infection at the time of their abortion, 23% will develop pelvic inflammatory disease (PID) within 4 weeks.”
3. Know the statistics for the STD’s that you test for, so that you can discuss the prevalence in your community to the patient.
4. Explain what PID is by saying; “PID is an inflammation in the female reproductive system that can increase risk for ectopic pregnancy or cause infertility related to scarring.”
5. Explain how the STD test is done saying; “The test is done through the same urine sample you leave for your pregnancy test. It would require you to make a follow-up appointment next week for the results.
6. Ask the patient directly if they want to be tested for STD saying; “Would you like to have a STD test today?”

#### Review and Signing of the STD Consent

If the patient desires to be tested for STDs, the nurse should review the [*STD Consent Form*](#_Sexually_Transmitted_Disease_1) with the patient (Appendix 52).

1. Highlight the areas in the consent that are vital to your mission, stating them plainly.
2. Ask the patient to sign on the appropriate line.
3. Schedule the patient for STD results appointment within one week of initial visit. Remind patient that results will not be given over the phone.
4. Recommend a follow up with their physician at least once a year, if not every 6 months. If they do not have a doctor, give them referrals.
5. Send the STD test sample as directed in the Policies & Procedures.

#### Reporting STD Results:

When the patient comes in for an appointment to get the results of their STD testing, you need to be ready to discuss both negative and positive test results.

##### If the Results are Negative

1. Report her negative STD results
2. Reinforce education given last week and ask if they have any questions regarding the brochures, etc.
3. Refer them to follow up with their doctor on a routine, at least annual basis, for pap smears and STD testing.
4. Talk with them about STD prevention and contraceptives, including information on abstinence.

##### If the Results are Positive

1. Report Positive STD results to the patient and ask them if they have a doctor they will be able to follow-up with for treatment and routine testing.
   1. If PRC has MD standing orders for treatment, proceed with treatment.

OR

* 1. If she does have a doctor, refer her to her physician for treatment.
  2. If she does not have a doctor, but has insurance, refer her to an OB/GYN on referral list where she can get treatment.
  3. If she does not have a doctor and does not have insurance, refer her to the County Health Department, or other identified free treatment center in your area, for treatment.

1. Document her treatment plan in the medical chart. Report positive STD results and treatment plan to the County Health Department.
   1. Notify County Health Department as directed by the director of the County STD testing program.

**NOTE**: The desire of communication type and timing may vary per County Health Departments. Please follow instructions as directed by your County Health Department for reporting positive STD results.

* 1. Reinforce education given last week and ask if she has any questions regarding the brochures, etc.

#### If Positive Pregnancy Test – Review Ultrasound Consent

Review the consent with the patient whether she is too early for an ultrasound today or not, then follow the script as listed in the category of her estimated gestational age that follows:

Explain the use of ultrasound using the following scripts**:**

“We will need to do an ultrasound to confirm viability of your pregnancy. The ultrasound we do is a Limited Ultrasound--limited to confirming the viability of pregnancy. To confirm viability, we need to visualize your baby’s heartbeat within the uterus. 31% of all pregnancies are not viable. Meaning, it could be miscarriage, ectopic pregnancy, or multiple other reasons why the pregnancy hormone would be in the urine and not have a viable pregnancy. We will also be confirming how far along you are related to your last menstrual period.”

“As a nurse, I cannot diagnose that you are pregnant, but I will tell you if I see what I would expect to see. I will also let you know if I do not see what I would expect to see. Either way, we will make a plan accordingly.”

1. Answer any question there may be if her last menstrual period was abnormal or if she has irregular periods, etc.
2. Review the *Ultrasound Consent Form* with patient paying special attention to the highlighted areas. (Appendix 56)

##### If the Patient is 5 Weeks or Less by LMP

Although pregnancy cannot be confirmed before a fetal heart beat is detectable at 5 weeks and 1 day, an Ultrasound should always be performed. It is stand of medical care that when a patient presents with a positive pregnancy test to perform an Ultrasound to diagnose pregnancy and determine gestational age. A patient may be further along than she indicates, and only an ultrasound can medically confirm gestational age.

If the patient suspects that she is 5 weeks or less by LMP, explain that you’re not sure what you can see today because she is early, and that she may need to come back depending on what is seen in the ultrasound. Performing an early ultrasound which cannot detect fetal heart tones eliminates the risk of a patient not returning for a second appointment. Experience has shown that women often do not return for an ultrasound if one was not performed at her initial appointment. They do, however, return nearly 100% of the time if an ultrasound was done but not able to confirm viability at her initial appointment.

##### Introduce the Ultrasound Procedure

1. Remind the patient that the gestational age could be ±2 weeks from the date of her last menstrual period. If you are doing an ultrasound on someone who dates 6 weeks from her last menstrual period, expect anything from 4-8 weeks.
2. Explain the stepped ultrasound process, saying, “The ultrasound will first be performed through the abdomen. If we do not see clearly, we may have to do an internal ultrasound exam.”
3. Continue with ultrasound exam in step 11.

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| **Step 10: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| **Health Questionnaire:**  Nurse Completes *Return Visit HQ* (Appendix 48) | | **Health Questionnaire:**  Nurse completes *Return Visit HQ* (Appendix 48) only with positive pregnancy test results. | |
| **STD Results:**  Not given | **STD Results:**  No modifications | **STD Results:**  Not given | **STD Results:**  No modifications |
| ***U/S Consent Form*:**  No modifications | | ***U/S Consent Form*:**  Patient signs only with positive pregnancy test results. | |

Table 11: Step 10 - Return Appointment Modifications

#### Addendum to Step 10 – Health Questionnaire Breakdown

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##### History of Previous Pregnancies

It is important to know how many times she has been pregnant before and what the outcome of each pregnancy was. This will give us an idea of how she might decide in this pregnancy, as well as clue us into any side effects she may be experiencing from a previous abortion.

Do not shy away from using the word abortion. This is a professional setting and medically we need to know what her history is if we are going to be able to help her today.

It is important to get any information surrounding any previous miscarriages, ectopic pregnancies, and abortions that might be helpful, such as how long ago, how far along was she, what happened, where, who did it, what procedure did she have. *CompassCare can use this information for tracking purposes.*

##### Normal Menstrual Cycle and Pregnancy

The textbook menstrual cycle is 28 days in length, with ovulation occurring on or about day 14. The first day of a woman’s period is marked as day 1. A woman is fertile about 3-5 days before ovulation and up to 24 hours after the egg has been released. Please refer to the diagram below and the following explanation of pregnancy and how it occurs:

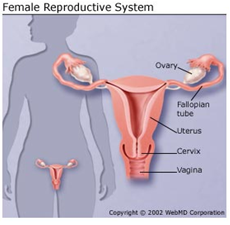


Figure 12: Female Reproductive System

There is mucus that lines the vagina, cervix, and uterus. At the non-fertile times during a woman’s cycle, this mucus is very thick and acts as a brick wall for the sperm. At the fertile time during the month, this mucus is very stringy and stretchy. This fertile mucus is necessary for the sperm to survive. When the sperm hits this fertile mucus, the mucus acts as a highway, carrying the sperm through the uterus and fallopian tube where it waits at the end of the fallopian tube for the egg to be released (ovulation). The sperm can last 3-5 days in this fertile mucus, at the end of the fallopian tube. Once ovulation occurs, the fimbriae at the end of the fallopian tube pull the egg in the fallopian tube and fertilization occurs with the meeting of the egg and sperm. This fertilized egg then travels down the fallopian tube to the uterus where it randomly implants into the uterine lining (implantation). It usually takes about 6-10 days from fertilization for the fertilized egg to travel down and implant.

Once implantation occurs, the hormones begin to change the lining of the uterus to thicken and feed the baby. The hormone hCG is present early during pregnancy and sustains the pregnancy until the development of the placenta where the placenta then maintains the pregnancy through the end. The baby begins to grow rapidly in the first trimester.

###### Exceptions to the Normal Cycle Rule

Not all women have 28 day cycles or ovulate on day 14, which is an important reason for the ultrasound, to confirm how far along she is according to her last menstrual period (LMP). Her LMP is an estimate, ±2 weeks of her estimated date of confinement/due date (EDC). The ultrasound is plus or minus a few days from her EDC. Therefore, the ultrasound is more accurate in determining how far along she is, vital information for a woman faced with an abortion decision. Knowing how far along she is answers the questions: what procedure will I have and how much it will cost, not to mention the actual fetal development that she sees for that gestation.

Also, for women who have irregular periods, you have to consider the time that her symptoms started and when she thinks conception could have taken place for a more realistic estimate of how far along she is. If a woman has irregular periods, then she is ovulating irregularly as well.

##### Missed/Belated Period

A patient’s menstrual cycle can be interrupted and therefore miss her period or have a belated period for reasons as described below:

1. With any unusual stress or activity, the menstrual cycle can interrupted due to changes in the hormone levels as a direct cause of stress or increase in activity, causing a missed or late period.
2. If she has missed any of her contraceptives or just started something, her body could be getting used to the exposure and she could miss her period or get it late due to the fluctuation in hormone levels. This usually takes a month or two to get on a “normal” schedule which may not be her previous cycle.
3. Some women are so afraid or think they might be pregnant which can induce the hormonal changes causing pregnancy symptoms without a positive pregnancy test.
   1. *A 16 year old in a doctor’s office who wanted to be pregnant and thought she was 6 months pregnant related to her LMP. Her pregnancy test was positive, she appeared to have an increase in size of her uterus on palpation, and she was excreting milk form her tender breasts, but when the ultrasound was done, there was no baby in her uterus. The diagnosis was psychological, because she thought she was pregnant and had induced pregnancy symptoms for six months.*
4. She could also have a metabolic/OB/GYN issue going on that needs medical evaluation:
   1. Ovarian cyst
   2. Uterine cyst

No matter what the cause, we can tell the patient it is not uncommon to miss a period from time to time, but she should definitely get checked by her OB/GYN doctor. Refer her either to her own physician or give her a referral if she does not have one.

The patient should also be rescheduled for a repeat pregnancy test in 2 weeks if she has not gotten her period. It is possible that she ovulated late in her cycle and that she could be very early on her pregnancy. It is possible that the patient would not have the levels of hCG in her urine that would turn a pregnancy test positive today, but would in 2 weeks, indicating a very early pregnancy.

##### Contraceptives

###### Statistics from the Alan Guttmacher Institute[[2]](#footnote-3)

1. 49% of pregnancies are unintended.
2. 43% of unintended pregnancies are ended by an abortion.
3. 54% of women having abortions used a contraceptive during the month they became pregnant.

Hormonal Contraceptives: This category includes birth control pills, the patch, shots and the ring. The morning after pill/Plan B works this way as well.

How they work:

Hormonal Contraceptives work in several different ways to prevent pregnancy:

1. Thicken the mucus at the cervix, acting as a brick wall instead of a highway- this does two things, it does not allow the sperm to travel as fast up to the end of the fallopian tube & it does not allow a fertilized egg to travel as fast as it needs to implant into the uterus before menstruation (the sloughing off of the outer most layer of the uterine lining).
2. Prevent or delay ovulation.
3. Change the lining in the uterus so that a fertilized egg would not be able to implant.

Hormonal Contraceptives do not protect against STDs. They actually increase the risk of STDs for multiple reasons:

1. Hormonal methods make your reproductive tract more vulnerable to infection.[[3]](#footnote-4)
2. Young women using hormonal contraceptives are thinking about preventing pregnancy and don’t realize they are not helping against STDs.
3. They might think that they are protected and have sex more often, therefore increasing their exposure and risk for STD.

How effective they are:

There is perfect use and there is typical use, when talking about effectiveness, as noted below. The perfect use is following the directions exactly as written and not ever being late or missing a pill. Younger people tend to have even worse results than the typical numbers reported.

Hormonal contraceptives are 99% effective with perfect use and about 95% effective with typical use. Young woman can fall into a smaller effectiveness rate (less than 95%) because they are not quite established in their menstrual cycle and their hormone levels are easily disrupted with stress and physical activity, and because they are more likely to forget or miss a pill.

The birth control pills also have different effectiveness for the kind that they are taking. A progesterone only pill is less effective in preventing pregnancy whereas, a combination pill with estrogen is most effective in preventing pregnancy. There are also different types of hormonal contraceptives, the pills are the largest category, but other hormonal contraceptive methods include:

1. Patch: use once a week, change it at the beginning of the week. Not as effective as the pill, but you don’t have to remember it every day.
2. Nuva-ring: like a little rubber ring, place it in the vagina and leave it in for three weeks. This method has questionable effectiveness related to other methods.
3. Depo shot: Given in the doctor’s office every 13 weeks, can lead to irregular periods, but is most effective in preventing pregnancy in this category.

Barrier Methods: This category includes condoms (both male and female), diaphragm, and cervical caps

How they work:

Barrier methods work exactly how their name says; they create a barrier of some sort to prevent the sperm from passing through.

How effective they are:

The statistics students are hearing today are for perfect use, but are still fabricated to make condoms look safe and effective. Students are being told that if they use condoms, they are 98-99% effective. The effectiveness of condoms with typical use averages 20% for pregnancy. The only problem is that the teens and young adults we see are actually averaging higher failure rates, than even the typical use as above. These numbers represent failure, which means a woman became pregnant while using condoms. A woman can only get pregnant, is only fertile, one week each month (as discussed in the section previous) So how much more are they not working and we don’t realize it because she’s not fertile during the rest of the month. Also to keep in mind that STDs are caused by bacteria and viruses much smaller than sperm and can get through every day.

The FDA reports a failure rate of only 11%, but is only reported in conjunction with PlanB use.

Abstinence is the only 100% effective way to prevent pregnancy and STDs. There are no games that need to be played to prove it! Using these facts allows patients to make informed decisions about their reproductive health.

Below is a chart that demonstrates the difference between the perfect use and typical use of the two most common contraceptives we see our patients use.[[4]](#footnote-5)

Figure 13: Pregnancy in One Year of Contraceptive Use

##### Normal Pregnancy Symptoms

“The Top Ten”

1. Abdominal Pain or cramping: this will typically come in the form of menstrual cramping. Some women do not get menstrual cramps; others will report the cramping/pain they are having as unusual. It is important to note if the pain is constant or intermittent and what it feels like. Is it sharp shooting pain? Where is the pain? You want to be concerned if your patient is complaining of pain centered on one side of the abdomen or if they are having constant pain/cramping that does not go away, or is it accompanied by a fever. These could indicate either ectopic pregnancy or miscarriage and should be addressed by their doctor or the ED immediately. They also do not qualify for the ultrasound that you do. The ultrasound is to confirm the viability of the pregnancy. If you do not suspect a viable pregnancy (i.e. ectopic or miscarriage) you will not do an ultrasound.
2. Some light spotting around the time that they would have gotten their period. This usually indicates some implantation bleeding and is not abnormal. Be sure to qualify how much bleeding she had, when she had it, and what color it was. Bright red blood of any amount can be cause for concern. Brown discharge/blood can indicate an old bleed that has finally worked itself out. Be sure to indicate to the patient that if she has any bleeding or spotting, even a pink spot on the toilet paper, she needs to call her doctor or report to the emergency room right away, it could indicate a serious complication and needs to be evaluated.
3. Increase in normal vaginal discharge related to the hormonal changes. Be sure to screen for any discoloration and/or odor as this could indicate an infection and would be a good time to talk about STD testing if either of these are present.
4. Increase in frequency of urination, related to anatomic position of uterus and bladder. As the uterus grows, it decreases the capacity of the bladder causing an increase in urination. They need to be encouraged to continue to maintain their fluid intake and this goes away as the uterus moves up out of the pelvis into the abdomen, usually towards the end of the first trimester. The frequency will return at the end of the third trimester due to the baby settling down into the pelvic area to get ready for delivery. Be sure to screen her for any pain or burning on urination that could indicate a urinary tract infection (UTI). UTI’s are very common during pregnancy and since increase in frequency is usually a first sign of a UTI and also a normal finding during pregnancy, we need to be on the lookout for further signs and symptoms.
5. Nausea and/or vomiting related to the increase in the hormone levels. This can be happening anytime during the day, *not just in the morning*. The important thing to pass onto patients is that this does not last forever, usually for about 6 weeks from the onset of symptoms. It is also important, as it can be a deciding factor for their situation, that you indicate there are medications that her OB/GYN can prescribe that would help with this problem. Be sure to screen for any hyperemesis where she is not able to keep anything down, this needs medical attention and probable intervention. You could recommend that she eat small meals throughout the day, with crackers in the morning and crackers at bedtime. Also, fresh fruits and fresh vegetables can sometimes curb nausea. The theory behind this is to keep something in the stomach at all times, recognizing that sometimes no matter the intervention, she is still going to have nausea and vomiting. Prenatal vitamins can also induce some nausea as well. Education here could include alternating the time she takes them, maybe at night or with food.
6. Breast tenderness related to an increase in the hormones causing stimulation for breast cell to multiply, with the breasts getting larger during pregnancy. This comes in waves throughout the pregnancy and will be more noticeable for some than others. This is a great introduction for the link between abortion and breast cancer (see the information included).
7. Fatigue is common during early pregnancy. You can encourage her that she will “wake up” into the second trimester.
8. Increased sensitivity to odors. This could be related to the rapid increase in the hormones throughout the body.
9. Food aversions. This may come and go or last throughout the pregnancy.
10. Substance aversions. Some women complain that they can’t even smoke a whole cigarette for fear they will get sick, or drink alcohol. Call it God’s way of telling her it’s not healthy or safe, but it is definitely one way to shake the habits during pregnancy.

##### Breast Cancer Link to Abortion

The explanation for the link is twofold and multi-dimensional. Recognizing that it is controversial, you need to present the facts and allow them to make a decision based on the facts.

1. Non-controversial link between abortion and breast cancer: It is well known and uncontested that a full term pregnancy alone can decrease a woman’s risk of breast cancer. If for no other reason than this, that abortion prevents the protectiveness of a full term pregnancy towards decreasing her risk of breast cancer, a patient who has an abortion is at a higher risk.
2. Controversial link: This is widely known and disputed between the different sides on the abortion issue. It is necessary to present the link stating that it is controversial, but we want them to know, especially if the patient has a history of breast cancer in her family.

The patients need to be told of the link when they are in the office. Brochures are available at abortionbreastcancer.com.

Visiting this website and researching the Abortion Breast Cancer (ABC) Link is on your implementation checklist for this training session.

###### Script for Breast Cancer Link to Abortion in Patient Appointment

After asking if she has any family history of breast cancer, proceed with the following:

***If she has a family history***:

“Having a family history of breast cancer, you have an increased risk of breast cancer. Having an abortion could increase that risk further because…” (proceed to below).

***If she does not have a family history***:

“Having an abortion can increase your risk of breast cancer. Before your first full term pregnancy, your breast cells are what we call Type 1 and Type 2 lobules, or immature breast cells. Early during the pregnancy, these Type 1 and 2 lobules begin to multiply as related to the increase in hormones” (as manifested by her tender breasts and maybe increase in breast size. Drawing a graph may be helpful here). “After 32 weeks of pregnancy, those lobules mature to Type 3 and 4 breast cells. This is important because pre-cancerous cells most often occur in the Type 1 and Type 2 lobules. Having an abortion, ending a pregnancy before 32 weeks, increases the number of breast cells vulnerable to cancer, therefore increasing your risk. It is important for me to note that not every woman who has an abortion will get breast cancer, and not every woman who has breast cancer has had an abortion.”

“Do you have any questions related to that information? Does it make sense to you?”

Please have brochures on hand from the above website that gives more information if she seems interested.

##### Substance Use/Abuse during Pregnancy

* + - 1. Medications: Ask if she has taken any prescribed or over-the-counter (OTC) medications. Document which ones, how often and for what. If they are prescription, ask if the prescribing doctor knows that she is pregnant. Encourage her to check with her doctor for the safety of the medications she is taking and a safe plan for stopping if they are not safe during pregnancy. You also want to document why she is taking medications; OTC ones to be sure she doesn’t need medical attention for a specific problem, and Prescription drugs just to know what her health history is and see if any of the conditions she has may be of concern for her as related to her pregnancy.

Remember that you are not her medical provider and it is very important that she seek his/her input for her medications as the benefits to her taking them may outweigh the risks to her pregnancy. You also don’t want to concern her or give her any additional reason to think she should not carry her pregnancy to term by giving information regarding risks of medications specific to her. Only say, “I do not know if the medications you are taking are recommended during pregnancy. You should check with your doctor to be sure.” You can tell her OTC drugs like Ibuprofen are not recommended and she should only take Tylenol or acetaminophen for headaches, etc.

1. Drugs: Ask if she is taking any street drugs and educate her that they are not recommended during pregnancy. Marijuana is related to babies small for gestational age and preterm delivery. Some drugs can cause withdrawal for the baby and lead to other complications. Be sure whatever you say to her is approved by your Medical Director.
2. Smoking: You want to know how much she smoked before she found out she is pregnant. Most of the time she will automatically decrease smoking even though she may not be intending on keeping her pregnancy, this is something you can use to encourage her—that she is doing a great job and that it sounds like she cares about what happens during her pregnancy. Smoking can also lead to a baby small for gestational age and preterm delivery. You should educate her that it is not recommended that she smoke during her pregnancy, praise the positive steps she is taking towards quitting, and encourage her to seek her OB/GYN’s help in quitting if she has any problems.
3. Alcohol: Ask if she has drank, how often, what and how much. Document all of these in the space provided and encourage her that drinking is not recommended during pregnancy. This may be an area where she is very concerned about her baby, and any damage that may have been done. You can say that it sounds like she is concerned about her baby and reassure her that stopping now definitely decreases any risk to her baby. Also encourage her that if she is still early, she may not have had much if any exposure, we’ll have to wait and see what the ultrasound shows.

**NOTE:** At any time when talking to her about the above issues, do not be judgmental. Do not condemn her for the decisions she has made, but encourage her for the concern she has and keep this interaction professional and positive.

##### Documentation of OB History and Current Care

As liability is a huge issue for the Pregnancy Resource Center, this is one area we cannot leave blank. It is necessary to identify who she will be seeking care from. If she does not have anybody, she will need to be referred. Through medical follow-up, this issue must be addressed until you have a name of her MD documented.

It is important to note, as you will in the Ultrasound consent, that follow-up care is not provided. If she has any questions or concerns related to her pregnancy care or symptoms, she should always be directed back to her own doctor. If she has any general questions, she should have access to ask you, but know that they should be referred to her doctor.

##### Sexual History

Ask how many sexual partners she has had and inform her of her relative risk of contracting an STD (see Table 2: STD Risk Odds Ratios)[[5]](#footnote-6). Point out where she is now in terms of the number of sexual partners she has had. Where does she want to be when she gets married? Where does she want her husband to be? Does she want to get married? What does that mean for her? What does she value in a relationship? What is important to her (communication, friendship…)? Where does sex fit in? Challenge her to make decisions based on her own values that you have just discussed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Odds Ratios for STDs among Females age 14-19* | | Number of partners | | |
| **1** | **2** | **≥3** |
| Duration of Sexual Activity | **0-1** | 1 | 2.5 | 4.7 |
| **≥2** | 2.8 | 7 | 13.16 |

Table 12: STD Risk Odds Ratios

Ask the patient how she plans on preventing pregnancy in the future.

Ask the patient if she thought about not having sex until she got married. Would that be possible for her? Talk about how that would change their relationship. What would that look like? How could she continue her present relationship? What would she say/do with her boyfriend that would promote that decision? Is she willing to lose her boyfriend if he doesn’t agree with her new decision? Give her “What If You Could Start Over?” brochure so she can read that and get creative in her decision making.

Empower her to stand up for her beliefs and values. Capitalize on her strengths, enabling her to make these decisions outside of your office.

##### STD History

This is a great place to do some minor education on STDs, and to present and offer of the STD testing at your center.

Rochester is #1 and #2 in the nation for Gonorrhea and Chlamydia. They are bacterial STDs that are treatable and curable if you know you have it. Up to 80% of people who have them do not have symptoms, the majority of them being women.

###### STDs and Pregnancy

It is a great place to note that if she does have Chlamydia or Gonorrhea at this time, her pregnancy is protecting her from it spreading. She has a mucus plug in her cervix which is at the end of her vagina, opening into the uterus. This plug will not allow that bacteria to pass through,it is trapped in the vaginal canal. Some STDs are able to get into the blood stream and cause problems with the pregnancy and fetal development. The other good news is that it is easily treatable during pregnancy and is curable. Another great thing about these two infections, specifically, is that they do not get into the blood stream and can cause little if any harm to the pregnancy. The viral STDs are the ones that pass through and the two most concerning are Herpes and HIV. A woman will be tested for STDs at her prenatal physical and will be followed up appropriately by her OB/GYN.

###### STDs and Abortion

Of patients who have a Chlamydia infection at the time of their abortion, 23% will develop PID within 4 weeks.

During an abortion, the bacteria can be introduced and forced into the uterus where the lining has just been irritated form the procedure. This is an environment where the bacteria can grow and the STD can spread through the entire reproductive system, causing life-long damage.

PID: Pelvic Inflammatory Disease is the advanced stages of Gonorrhea and Chlamydia

PID can cause infertility and an increased risk of ectopic pregnancy.

Infertility- the inability to have children

Ectopic Pregnancy- a life-threatening pregnancy in the tubes

Women should be tested for STDs whether they have been with the same person for years. Education on routine visits to OB/GYN for Pap tests and STD testing for her reproductive health should also take place at this time.

**NOTE:** This is not the time to preach about abstinence. This is a time to ease her most pressing fears and begin a relationship that will facilitate the making of good decisions and feed into the importance of every decision she makes as she is followed up with throughout her pregnancy.

##### Any Other Medical Conditions/Treatments

This is a great question to ask and essential to not be skipped for any reason. This is the opportunity she has to express any other concerns she has in carrying her pregnancy to term from a medical stand point. The most often responses you will hear are chronic conditions (i.e. back pain, cysts on ovaries or uterus, bleeding disorders, etc.) or that the patient will specifically say that she was told she should never have children because of…. This is where you will either give her peace by directly responding to the issue or let her know that you will find out, by asking your medical director, and get back to her when you confirm her pregnancy. You want to be careful not to discredit any provider she has had in the past, therefore losing any report you may have with her. You also don’t want to guess at a response—you are not her medical provider and even though you have just completed the Health History with her, you still do not know everything about her.

### Step 11 – Nurse Performs Ultrasound Exam

Questions the Nurse may ask during the ultrasound:

1. “Are you surprised by what you are seeing on your ultrasound?”
2. “How do you feel about seeing your baby’s heartbeat on ultrasound?”
3. “How do you think the father of your baby will react when he sees these pictures?”

#### Exclusion of Family and Friends during the Exam

**NOTE:** If the patient asks if her friends/family can come in for the ultrasound, simply explain that they are welcome once the routine is completed. Sometimes the woman will be more open with you when she is alone and not feel the freedom to say much (what she truly is feeling) in front of her visitor. She may also be uncomfortable to have her visitor present for a vaginal ultrasound, but may be too embarrassed to ask them to step out once they are already there in the room. Explain to the patient that her family/friends will be able to join her after the initial portion of the ultrasound.

#### Nurse

1. Have the patient sit on the table.
2. Explain to her that if she is early “We may have to do a vaginal ultrasound, but let’s take a look first and see what we see through your abdomen.”
3. Prepare the patient for the ultrasound at this time.
   1. Have her lie down on her back on the table and pull out the leg support.
   2. Have her slide her pants and underwear down to just below her hips. During the first trimester, her pregnancy is low in the pelvic region. You need access to that area on her abdomen. You can use the beginning of her pubic hairline as a reference.
   3. Tuck in a paper towel to protect her clothes and give her some sense of privacy. Say, “I’m going to tuck this paper towel in here to prevent the gel from getting on your clothes and to give you privacy.” The more she is covered, the more privacy she has, and the more comfortable she will feel.
4. Apply the gel to her lower abdominal/pelvic area. Warn her that it will be cold (or you can purchase a Gel warmer).
5. Place the probe on her and begin scanning.
6. Let her know right away if you can see as clearly as you’d like to perform the exam. “It looks like we’ll have a clear picture.”

***If you cannot see the boundaries clearly, go to the “***[***Vaginal Ultrasound***](#_Vaginal_Ultrasound)***” section below.***

***If you can see the boundaries clearly, go to the “***[***Ultrasound Routine***](#_Ultrasound_Routine)***” section below.***

#### Vaginal Ultrasound

1. If you *or the patient* cannot see the image clearly, you will need to perform a vaginal ultrasound. This procedure should be presented as the next logical step in a standard of care. The national standard of care for first trimester sonography uses the vaginal ultrasound.
2. Inform the patient that you need to do a vaginal ultrasound by saying, “I will need to do a vaginal ultrasound today to get a clear picture because I am not able to see clearly through your abdomen to confirm viability.”
3. Have her go to the bathroom before proceeding. A full bladder with a vaginal ultrasound can be uncomfortable.
4. Instruct her on how the vaginal ultrasound exam is performed (i.e. that you will insert the vaginal probe just a short way into her vagina. That the probe will be covered and use lubricant to make it more comfortable for her).
5. Protect her privacy by giving the patient a drape sheet.
6. Step out of the room to have her slide her pants and underwear off.
7. Have her lie down and for her comfort, have her place her feet in stirrups. Explain to her that this position will help get the best picture and that the stirrups will be helpful to her because she will not have to hold her legs up in an uncomfortable position for an extended period of time.
8. Place some ultrasound gel on the tip of the probe and place the cover on the probe.
9. Put some K-Y Jelly on the outside of the probe cover to make it more comfortable for the patient, and verbalize this to her. She needs to hear that we are looking out for her comfort.
10. Protect her privacy, asking her to insert the probe.
11. Give her a paper towel beforehand to wipe her hand off from the gel that is on the probe.
12. Tell her that you will hold the handle and she will insert the tip of the probe into her vagina for her privacy.

Proceed with [Ultrasound Routine](#_Ultrasound_Routine) (below) from here.

#### Ultrasound Routine

During the ultrasound routine, you will need to provide the patient with tangible information as soon as possible. She makes her mind up within the first 3-4 minutes of being in the PRC office. The ultrasound is performed about 30 minutes after that. Therefore, you need to monopolize on the first 3-4 minutes she is in the ultrasound room. You have to “sell her” on her baby immediately.

1. Start by trying to get a clear picture of the uterus and give her the “glamour shot” as best as you can. The sooner we give her something to “grasp” in the ultrasound, the better. Try starting with the long and transverse views of the midline.
2. Do the measurements of Gestational sac, crown-rump length, and Heart rate before moving on to the adnexa (ovaries).
3. Look around in both views to get the best shot and take that image first. If you get a clear profile, start with that picture.
4. Point out the most obvious examples of fetal development and mention the heartbeat. Discuss fetal development at her gestational age, regardless of visibility.
5. Explain while taking pictures of the adnexa that you want to make sure you can see the ovaries and measure them. You want to make sure there isn’t anything to be concerned about.

**NOTE**: Do not overload her with information.

1. Respond to the emotion she may be expressing or help her by saying, “How do you feel after being able to see your baby’s heartbeat on the screen?” “What’s your first impression after seeing the ultrasound today?” (this is where communication skills and patient sensitivity training are important).
2. Print out the report for the chart after completing your routine.
3. Ask the patient if they would like their visitor(s) to join them, saying; “Would you like your visitor to join us now, for the ultrasound?”
4. Before you let a visitor into the exam room, make sure that you ask the patient “Is there anything that you do not want me to share in the ultrasound room or say when your guest joins us?”

**NOTE:** Sometimes the due date could be surprising information (i.e. not matching with her period, indicating that she is further along or not as far along). This information could lead to the person with her realizing that they are not the father of the baby. Obviously, this could be “harmful” information.

1. You can put her name on the screen and print out some pictures for her to take with her, all the while, showing her visitor the best images. They will be able to see the heartbeat together. Don’t be afraid to be silent. Sometimes the patient will explain to her guest what she has seen, prior to their arrival in the room. Be careful not to repeat anything the patient may have said previously during the exam. Maintaining confidentiality is extremely important.
2. Provide the patient with any appropriate pictures.

**NOTE:** The only pictures she can have to take home are heartbeat measurements and unlabeled pictures of her baby. **DO NOT GIVE HER PICTURES WITH A DUE DATE OR ANY DATING INFORMATION ON THEM**. She can use such pictures to facilitate an abortion and that is not the purpose of the ultrasound. You can verbalize the date you have seen from the measurements and you can tell her the baby’s size. But you can NOT give it in writing.

1. Reiterate that a physician must still confirm what you have seen in the ultrasound.
2. After printing the pictures ask, “Is there anything else you would like to see?”
3. Give the patient her pictures in a frame. Point out what you see in the pictures to solidify what she saw and also so she can remember, as she takes the pictures home.
4. Answer any questions she may have at this point.
5. Remind her that you will be in touch to confirm her ultrasound with her once the doctor has reviewed the report. Give her a general idea of when you will talk to her and see her next.
6. Show the fetal/uterine models at the end so she can see her baby’s actual size.

#### Criteria for Scheduling a Repeat Ultrasound Exam

Ultrasound can be repeated at STD results appointment if she meets one if the following criteria:

1. Too early to confirm viability, unable to see heartbeat within uterus (to look for incremental one week’s growth and confirm viability).
2. Early pregnancy with heartbeat visualized, expectedly slow (to repeat FHR measurement and confirm incremental one week’s growth).
3. If she remains AV/AM.

##### With Permission

The following script will be used to schedule a return visit for the patient:

“We need to schedule a return visit for you, so that we can provide you with your STD results. We will also perform a second ultrasound to provide you more dating information relative to the outcome of your pregnancy. Your Nurse will talk with you about when you’re available and will schedule that 30-minute appointment for you.”

#### Review Brochures

Review brochures with patient as appropriate. Below are some suggested brochures according to what you did or did not see in the ultrasound exam. Please refer to *Ultrasound Guide* (Appendix 57).

**NOTE:** Be sure to follow the Policies & Procedures for your organization.

##### You See What You Expect to See in the Ultrasound

If you see in the ultrasound what you would expect to see and were able to measure the heartbeat, you may share the following brochure.

*So, You’re Pregnant* brochure

1. Complete the ultrasound report and assemble the Medical chart. Please refer to the *Medical Exam Report* (Appendix 29).
2. Record ultrasound in Ultrasound Log book. Please refer to the *Ultrasound Log* (Appendix 58).

Also, be sure to give her pictures of heart beat and the “glamour shot” with her name on them in a framed card.

##### You see what you would expect to see, but cannot confirm the viability of her pregnancy

If you did not see a heartbeat in the ultrasound exam, you must review and give the following brochure.

*We Were Unable to Confirm the Viability of Your Pregnancy Today* brochure

1. You should say “I cannot confirm the viability of your pregnancy today. This could be because you are too early to see what I need to see, it could be my limited skills, you could be having a miscarriage, or have an ectopic pregnancy.”
2. Review the symptoms of each and restate the need for her to see her doctor sooner, if she has any of the stated symptoms.
3. Schedule a return appointment for her if the gestational sac and/or heart beat are not visible, and or refer her to a doctor that can see her within the next two weeks.
4. Communicate the need for a repeat ultrasound to the Clinical Coordinator for scheduling a patient appointment and documenting on the PRL.
5. Complete the ultrasound report and assemble the Medical chart. Please refer to the *Medical Exam Report* (Appendix 29).
6. Record ultrasound in Ultrasound Log book. Please refer to the *Ultrasound Log* (Appendix 58).

##### You do not see what you would expect to see

1. She would not be having an ultrasound if she was experiencing any immediate symptoms, but an urgent referral to her OB/GYN, or emergency room (if she doesn’t have an OB/GYN) should be made for the next few days before she leaves the office.
2. Clear documentation of the plan must be included in her chart.
3. Always notify Medical Services Manager and/or Medical Director if you are not able to see what you would expect to see.
4. Complete the ultrasound report and assemble the Medical chart. Please refer to the Medical Exam Report (Appendix 29).
5. Record ultrasound in Ultrasound Log book. Please refer to the Ultrasound Log (Appendix 58).

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 11: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No modifications | | Only done with positive pregnancy test results. | |

Table 13: Step 11 - Return Appointment Modifications

### Step 12 – Nurse Provides Patient Resource List

After the ultrasound exam is complete and the nurse has reviewed pertinent information with the patient:

1. Ask the patient, “How are you feeling about what you saw today?” Wait for an answer and then say, “Now I would like to go over your (name of PRC) Patient Resource List with you. There is contact information on this Plan that will assist you.”
2. Present the *Patient Resource List (PRL;* Appendix 43).

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 12: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| Nurse does not give another *PRL* unless new referral needs are identified during Return Appointment. | | | |

Table 14: Step 12 - Return Appointment Modifications

### Step 13 – Nurse Gives the Gospel Presentation

Following presentation of the Church Referral section of the *PRL, Nurse* will introduce Gospel presentation using the following:

1. Ask her if she is currently involved in a church, saying “I ask because it is important to get an understanding of your support system and a church or a pastor can be a source of support.”
2. Following the review of the PRL (Step 12) –
   1. “We do all we can to provide you with resources to help you, but we also recognize that part of your need is simply to feel a sense of peace inside. We believe that peace comes from knowing that you have a real relationship with the real God, your Creator. I have a little booklet that helps explain how that sort of relationship is obtainable; can I share it with you?
   2. (“Yes” – proceed with following script. “No” – “Ok, that’s fine. Would it be alright if I pray for you before you leave?”) Refer to the booklet, Steps to Peace with God:
      * 1. Step 1 - We want to take a look at why we lack peace in the first place.
        2. Step 2 – (The Problem) When God created man, He created him in His image and out of His love. His desire was and has always been to be in relationship with us. He let us decide to either follow Him, or follow our own way. We made a choice for ourselves – to live for ourselves, making selfish and sinful decisions, and that separated from God. Because He’s altogether perfect and Holy, and we are not, there has to be a separation.
        3. Step 3 - But what still lies in our hearts, is a deep desire to be reunited with God and out of that deep, sometimes hidden desire, we often try to DO things to reconnect with God. The problem is, our only resource is our selfishness and sinfulness. All of our attempts will never be able to bridge that gap. Our only hope is if the perfect side of this relationship, that is: God Himself, if HE were to bridge this awful gap. Because of His great love, and because He’s ALWAYS wanted relationship with you and with me, He did exactly that.
        4. Step 4 - He bridged the gap by sending His perfect and Holy Son, Jesus to come to live among us, to minister love and to die for us and for our sin. When He gave His life up, He made a way for us to be reconciled with our Creator. When we make a decision by faith, to turn away from our selfish and sinful ways, and put our faith in Jesus, we find peace with God and peace inside our hearts. We discover hope and help when in the past, we felt like we were doing it all on our own.
        5. Step 5 - The thing is, God did ALL He can do to make the way open for us, and provide an invitation, but the sad part is, most people choose not to accept His way back home through Jesus. This invitation is offered to everyone, and anyone who wants it. All they have to do is to turn from an old selfish life, believe in Jesus and let the relationship with God begin. When that happens, God is able to fill us with His Spirit, and give us the peace we so desperately need.
      1. Have you ever heard this before? (More than half the time, they say no. If they say ‘yes’, then ask about their current relationship with the Lord.) What do you think about it? Is this an invitation you’d like to accept right now?
         1. **“Yes”** – “Great, why don’t we take a minute and pray and accept this gift. I can pray with you, leading out with some words and if you’re willing, you can just repeat after me. The specific words you say are not as important as the heart you pray them with.”
         2. **Prayer** – *“Jesus – I choose to believe in you, to trust in Your sacrifice and to follow You beginning today. God, please forgive me of my sin and selfishness and fill me with Your peace right now. Thank you. In Jesus’ name, Amen”* (there is also a ‘sample’ prayer on the last page of the booklet). You may choose to continue praying a prayer of blessing upon the patient, sealing the work of the Holy Spirit in that moment.

***OR***

* + - 1. “**No, I’m not ready** – maybe later.” “Ok, that’s fine. There is no pressure here. I’m wondering if I could just ask you to take this booklet with you and consider the things we’ve talked about later. Would you be willing to do that? May I pray for you? “

1. Regardless of outcome of gospel presentation, Nurse should document presentation and outcome with notes on the Patient Intake Form. This is very important information that is entered into the database, for the purpose of tracking metrics.

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 13: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No modifications | | | |

Table 15: Step 13 - Return Appointment Modifications

### Step 14 – Nurse/Clinical Coordinator Initiate Exit Process

The Nurse should ask the following two questions to complete the patient’s appointment at the PRC:

1. “Is there any other information you feel you need to make an informed decision?” Wait for her answer.
2. “Having received your Patient Resource List and all the other information from (name of PRC) today, what do you think the outcome of your pregnancy will be?”

If the patient is undecided or abortion minded, follow with this statement;

“No matter what you decide, we’re here for you. Feel free to call us about anything.”

Nurse will mention scheduling a follow-up appointment, reminding her

“You have time to make this decision. You can take a week to step back, breathe, and then come back for another ultrasound.”

Following these questions, Nurse should escort patient back to reception area, saying:

“Would you be willing to complete a short survey to let us know how we are doing?”

If patient agrees to complete *Exit Survey* (Appendix 19), direct her to complete it in the reception area and return to the Clinical Coordinator when she is finished. Clinical Coordinator will then return it to the Medical Team Leader. Be sure to give the patient a copy of the [Patient Bill of Rights](#_Bill_of_Rights) form and then put a signed copy in her file.

When appointment time and date are selected, Clinical Coordinator will hand patient an appointment reminder card. Then she will ask,

“Will you please call us if you need to reschedule?” and wait for the patient to reply.

Clinical Coordinator will perform final review of documentation and file patient chart in Active Chart drawer once all documentation is completed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 14: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| **Closing Questions:**  No modifications | | **Closing Questions:**  Nurse asks closing questions only with positive pregnancy test results | |
| **Exit Survey:**  No *Exit Survey* given | | | |

Table 16: Step 14 - Return Appointment Modifications

### Step 15 – Nurse Performs Follow-up

#### Procedure Guidelines

All patient follow-up is to be coordinated by the Nurses.

#### Medical Follow-Up: Negative Pregnancy Test

After the appointment, the nurse completes documentation and the Clinical Coordinator assembles chart. She then files the chart in the Medical Services Follow-Up (MD Signature) file drawer.

If patient has scheduled a return visit (for STD results and/or a repeat pregnancy test/ultrasound), no follow-up is necessary prior to the next scheduled visit.

If patient does not return for scheduled return visit, or if no return visit was scheduled, medical services will make one follow-up call to the patient within 1-2 weeks of initial visit and review the *Negative Pregnancy Test Follow-Up Form* (Appendix 33).

#### Medical Follow-Up: Confirmation of Pregnancy

1. After the appointment, the nurse completes documentation and assembles chart.
2. The RN then brings the patient’s medical chart to the Medical Director to confirm that the patient is pregnant. The RN is to review all medical charts with Medical Director on a bi-weekly basis.
3. Once the ultrasound is confirmed by the MD, and that is communicated to the patient, the chart must be filed in the Medical Services Follow-Up file drawer.
4. Perform follow-up as scheduled.
5. Call the Patient to provide Confirmation of Pregnancy, once MD has signed ultrasound.

**NOTE**: The Medical Team only has permission to confirm the patient’s pregnancy.

1. Confirm her pregnancy per the Medical Director using the *Pregnancy Confirmation Contact Form* (Appendix 44)
   1. Talked with patient:
      1. Document contact on the *Patient Contact Form* (Appendix 38).
      2. Document contact on the Ultrasound Report Page.
      3. Enter interaction into computer Database.
      4. File the chart in the Medical Services Follow-Up (MD Signature) file drawer for final Medical Director’s signature.
   2. Unable to talk with patient:
      1. Leave a message per patient permission
      2. Document each attempt on the Ultrasound Report Page and a brief note on the *Patient Contact Form* (Appendix 38).

##### Leaving Messages

**NOTE**: No message should ever mention her appointment, pregnancy, ultrasound, or any other confidential information that we have on file.

**With Permission**

If the patient has given full permission, the message would be as follows:

“Hi, this message is for (name of patient), this is (name) calling form (name of your organization), please give me a call when you get this message at (phone number). Thank you.”

That is all you should ever say!

**With Limited Permission**

If she says you cannot identify yourself:

Leave the same message as above but do NOT include your name.

If she says you can’t identify your PRC:

Leave the same message as above but do NOT say “from (name of your organization)” and leave a number other than the main line. Be sure that the name of your organization won’t be identified.

If the patient returns your call, please follow the instructions in 6a above.

If the patient does not return your call, call the patient for up to three attempts.

1. If after three attempts, the patient has not returned your call, file patient’s chart in Medical Services Follow-up (certified letter) folder for letter to be sent.
   1. Sending a Certified letter (Appendix 1, Appendix 34)
      1. Must be on company letterhead
      2. Should not contain the confirmation of pregnancy, only to have them call the office
      3. Should be signed by the Nurse
      4. A copy must be filed in the chart
      5. Sent with return receipt only. Restricted delivery is not necessary and increases the cost; it also decreases the probability of the letter being delivered.
2. If there is contact with the patient, follow the above instructions in 6a above.
3. If there is no contact with the patient after one week of returned receipt, or the letter is returned, the chart can be filed for final MD signature.
   1. Everything returned (receipt or letter) should be filed in the patients chart, stapled to the Medical Services Phone Contact form.
4. Once the final MD signature has been made, file the chart in To Be Closed folder

#### Return Appointment

##### Procedure Guidelines

A return appointment is scheduled routinely for STD results and/or if the viability of the pregnancy was unconfirmed in the initial appointment. STD results are communicated to the patient and a repeat ultrasound is performed at this time. This appointment is usually scheduled about 1 week following the initial appointment, or later, based on the patient’s LMP.

Using the Return Appointment Health Questionnaire, the nurse reviews the patient’s current health situation. Please see [*Return Visit Health Questionnaire*](#_Return_Visit_Health) (Appendix 48)

It is important to determine if the patient is experiencing any abdominal pain/cramping and/or vaginal bleeding/spotting, as they are contraindications for the 2nd ultrasound exam.

At this visit, the patient is again asked her intentions to carry, especially if she was undecided or abortion-minded at her initial appointment.

A new *Ultrasound Consent Form* needs to be signed by the patient at the return appointment, and each and every time an ultrasound is performed (Appendix 56).

Following the return appointment, the nurse completes a [*Return Visit Health Questionnaire*](#_Return_Visit_Health), and a new *Medical Exam Report*. These forms, along with the new *Ultrasound Consent* are filed in the patient’s chart on top of her subsequent records.

#### After Abortion Dos and Don’ts[[6]](#footnote-7)

When talking with a patient who has had an abortion, please remember the following:

1. DO listen patiently to everything they have to say. Expect and allow them to repeat themselves and to bring the subject up again later. They are trying to sort out their feelings. Verbalizing their feelings with someone who will listen often helps.
2. DON'T shut them off by changing the subject.
3. DO reassure them that it's OK to make mistakes. On a spiritual level, all religions teach that our mistakes/sins can be forgiven. God wants to forgive us. All we have to do is to admit that we need and desire forgiveness.
4. DON'T condemn them for making a bad or immoral choice.
5. DO reassure them that their feelings are normal. Others have experienced the same thing and found healing. Build up a sense of hope that they can be healed and reconciled with God and their child in heaven.
6. DON'T deny that they lost a child.
7. DO allow them to vent their anger toward others, but look for the right time to encourage forgiveness and "letting go" of one's anger. Encourage them to see that the other people they blame were also confused, scared, or just looking for the best way out of a hard situation.
8. DON'T encourage them to blame others for the abortion. But don't *push* them to forgive others, especially when they are in the initial stages of venting their anger and rage.
9. DO allow them to regret their choice. Allow them to reframe the experience as a tragic mistake. But remind them that we all can become better people when we learn from our mistakes. Women and men who have found healing after an abortion often become more humble, compassionate, and sensitive. Even a negative experience can be used to help others.
10. DON'T insist that they did the "right thing" or the "best thing" at the time.
11. DO encourage them to entrust their child to the care of God. Reassure them that on a spiritual level, their loss is only temporary. Someday they can be with their child in Heaven and they will be able to ask for, and receive, their child's forgiveness.
12. DON'T suggest that having another child "someday" can make up for the one that was lost. Future children are a blessing and comfort, but they can't replace the child who was lost. The expectation that they can may cause parenting problems in the future.
13. DO give them an 800 number to a post-abortion hotline or some other referral information. If you don't have it on hand, promise to get it to them within the week. Keep your promise.
14. DON'T leave them without encouraging them, over and over again, to find and accept the help of post-abortion counselors or peer support groups.
15. DO show that you care by continuing to be a sounding board for them.
16. DON'T be afraid to ask them how they are doing with it in the future.

#### Follow Up Procedure

1. Following initial appointment:
   1. Nurse will file chart in MD Signature/pregnancy patient folder
2. Within 2 weeks of initial appointment, if possible:
   1. Nurses will confirm ultrasound with patient.
   2. **NOTE for Negative Test Patients:** Nurses will complete a single Negative Test Follow-Up call, using the *Negative Pregnancy Test Follow-Up Form* (Appendix 52). No further follow-up attempts are necessary unless conversation indicates need to return to office for repeat testing or referral to a health care provider.
3. Follow-up:
   1. Done 4, 8, and 16 weeks from initial appointment as well as after due date, and following a negative test.
   2. All nursing staff will follow procedure outlined above for each routine follow-up event, documenting all contact on *Patient Contact Form* (Appendix 38) and completing *Patient Follow-Up Form* (Appendix 39).
4. Chart Closing procedure:
   1. Charts must be reviewed and signed by a nurse before being closed.
   2. Charts for a Negative Test patient should be kept open for 6 weeks following her appointment, in case she continues to experience pregnancy symptoms and desires another urine pregnancy test. After 6 weeks, staff will complete appropriate section of *Chart Closing Summary Form* (Appendix 9)
   3. If outcome of pregnancy (i.e. Abortion Performed, Child Born, Miscarriage) is learned during follow-up, staff will complete appropriate section of *Chart Closing Summary Form* (Appendix 9).
   4. If follow-up has been attempted three times, and no contact has been made, chart may be scheduled for closing after the patient’s due date (for a confirmed pregnancy).

**NOTE:** No confirmed pregnancy chart may be closed for reason of “Unable to Contact” or “Patient Requests No Further Contact” until due date has passed. It may be filed in a separate folder labeled “To Be Closed,” and may be officially closed after due date has passed and no further contact has been made by patient. Staff will document all attempted contact on *Patient Contact Form*, complete appropriate sections of *Chart Closing Summary Form* and file chart in file drawer.

#### Follow-Up Scheduling from initial appointment:

1. 2 weeks, for Confirmation of Pregnancy, if Ultrasound has been signed off by Dr. and pregnancy has been confirmed.
2. 4 weeks
3. 8 weeks
4. 16 weeks
5. After due date
6. Within two weeks of a negative test

#### Special Instructions

1. Mailing information to a patient:
   1. If a patient asks for information/literature to be mailed to her, confirm mailing permission on *Patient Information* form.
   2. Document on *Patient Contact Form* what items are being sent.
   3. If a note is included, always write it on letterhead or logo stationary and make a copy of note prior to sending. Include copy of note in patient chart, and indicate on *Patient Contact Form* that a personal note was sent.
   4. Scheduling Baby Visits: When calling patients after due date and a baby has been born, ask patient if she is willing to bring the baby into the office to meet the staff. Inform her that we love taking pictures of our patients and their babies, and will wish to do so if she comes in.

**NOTE**: Before any photos may be taken of the patient or child, a *Model/Photo Release* must be signed and filed in the patient’s chart (Appendix 32).

* 1. After checking the patient schedule, give the patient a variety of times that she can come in to visit with staff. Record her intended visit time and date on the *Chart Closing Summary Form*.

|  |  |  |  |
| --- | --- | --- | --- |
| **Step 15: Return Appointment Modifications** | | | |
| **Return U/S** | **Return U/S with STD Results** | **Negative Retest** | **Negative Retest with STD Results** |
| No modifications | | | |

Table 17: Step 15 - Return Appointment Modifications

#### Medical Services Follow-Up Process

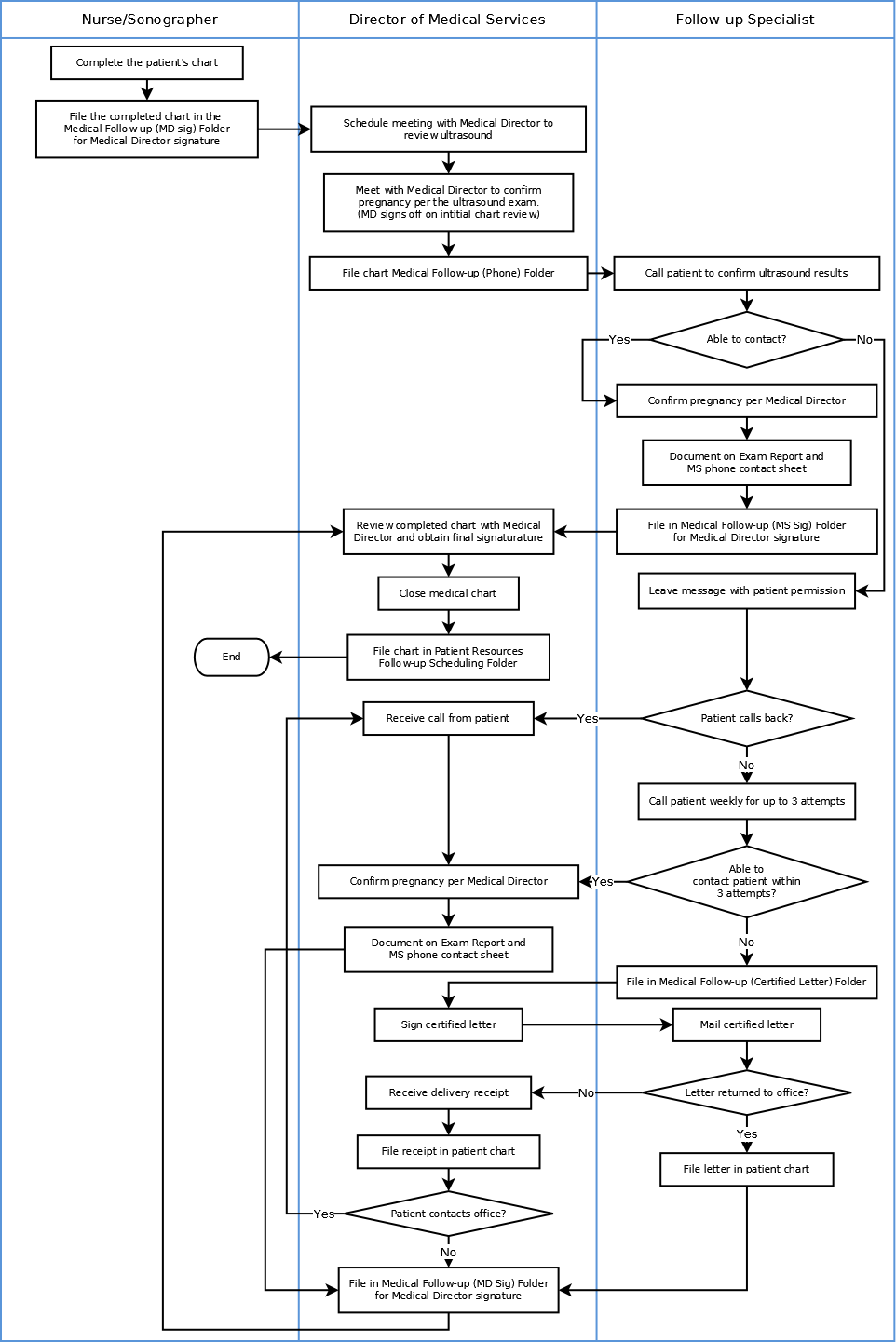


Figure 14: Medical Services Follow-Up Process

## Measurement Systems

The Measurement Systems are the means by which the PRC obtains data on how effective the Dynamic Systems are interfacing with the patient and provides information to enable the PRC to innovate and improve those systems.

The following areas are included in the Measurement Systems for Medical Services:

1. Forms
2. Checklists
3. Medical Records
4. Core Metrics Report

### Forms

Throughout this Section various forms have been referenced. Each of these forms has been included in the Appendix of this Optimization Tool©.

### Checklists

Each staff member should complete a job function checklist after each shift. Each checklist should be reviewed by the Medical Services Manager on a bi-weekly basis. Any concerns should be addressed before the staff member begins their next shift.

The following checklists are used by Medical Team staff during their shifts.

1. *Helpliner Checklist* (Appendix 24)
2. *Clinical Coordinator Job Function Checklist* (Appendix 11)
3. *Pregnancy Confirmation Contact Form* (Appendix 44)
4. *Nurse Job Function Checklist* (Appendix 35)

### Patient Records

#### Assembly of Patient Chart

Everything in the Patient chart must be in the proper order and stored as a single patient record.

##### Order of Forms in Medical Chart

The documents in the medical chart are to be completed according to [*Documentation Guidelines*](#_Documentation_Guidelines_for) (Appendix 62), fastened with the metal prongs, and placed in the following order, from front to back.

1. *What Can You Expect? Form* (Appendix 62)
2. *Limitations of Service* (Appendix 28)
3. *Bill of Rights for Women Facing Unintended Pregnancy* (Appendix 7)
4. *Verification of Positive Pregnancy Test Letter* (Appendix 61)
5. *Authorization for Release of Medical Information* (Appendix 6)
6. *Fidelis Care Request for Information*
7. *Fidelis Care Fax Cover Sheet* (from printer)
8. *Patient Resource List (PRL;* Appendix 43)
9. *Patient Intake Form* (Appendix 41)
10. *Initial Visit Health Questionnaire* (Appendix 25)
11. [*STD Consent Form*](#_Sexually_Transmitted_Disease_1)(Appendix 52)
12. *Ultrasound Consent* form (Appendix 56)
13. *Medical Exam Report* (Appendix 29), with the Physician Signature flagged to be signed
14. *Ultrasound Pictures*
15. *Return Visit Health Questionnaire* (Appendix 48)
16. *STD Lab Results*
17. *Patient Follow-Up Form* (Appendix 39)
18. *Patient Information* (Appendix 40)
19. *Patient Contact Form* (Appendix 38)
20. *Chart Audit Form* (Appendix 8)
21. *Chart Closing Summary Form* (Appendix 9)
22. Across the page (for database entry): *Patient Interaction Tracking Form* (Appendix 42).

What Can You Expect?

Limitations of Service

Bill of Rights for Women Facing Unintended Pregnancy

Verification of Positive Pregnancy Test Letter

Authorization for Release of Medical Information

Fidelis Care Request for Information

Fidelis Care Fax Cover Sheet

Patient Resource List (PRL)

Patient Intake Form

Initial Visit Health Questionnaire

STD Consent Form

Ultrasound Consent Form

Medical Exam Report with the Phyisician Signature flagged to be signed

Ultrasound Pictures

Return Visit Health Questionnaire

STD Lab Results

Patient Follow Up Form

Patient Information Form

Patient Contact Form

Chart Audit Form

Chart Closing Summary Form

Figure 15: Order of Forms in Patient Chart

### Patient Records Transfer

A patient or her prenatal care provider may request a transfer of her medical records via secure fax. Always confirm that the request comes from a legitimate medical provider or the patient herself. Ensure that they are able to confirm the patient’s name and birth date. Verify online that the fax number provided is actually that of the physician’s office.

If anyone other than the patient or her physician’s office calls requesting records be faxed, do not agree to it. Explain that the request must either come from the patient herself, or from the physician’s office. When in doubt, look up the physician’s office phone number and call to verify that the request is legitimate.

##### Check the patient’s chart to confirm that she has completed and signed the *Authorization for Release of Medical Information* (Appendix 6). Without a completed form, DO NOT transfer any identifying patient information. Communicate that the patient’s medical provider must fax a signed medical information release form, or the patient must come in to sign one, before we can send any records.

The following forms should be faxed, in this order:

1. Confidential Fax Cover Sheet
2. *Medical Exam Report(s)* (Appendix 29)
3. STD Lab Results
4. *Initial Visit Health Questionnaire* (Appendix 25)
5. [*Return Visit Health Questionnaire*](#_Return_Visit_Health) (Appendix 48)
6. Signed *Authorization for Release of Medical Information* (Appendix 6)

Return all documents to Patients chart and add fax confirmation sheet to chart. Document the transfer request and completion in the *Patient Interaction Tracking Form* (Appendix 42).

### Database and Tracking Statistics

Tracking is a critically important aspect of Optimizing a PRC. By tracking the step by step patient flow, an organization is able to measure how well it is doing for any given point in helping to transition a woman from being at risk of getting an abortion to having her baby. The point then would be to ‘tweak’ or innovate where necessary, to always remain on the cutting edge of service. What would be tracked for example would be in line with the flow of the patient services and goes something like this:

1. how many women who called scheduled an appointment
2. how many were at risk and how at risk are they
3. how many that scheduled actually showed up
4. how many of those that did not show were followed up with
5. how many that showed up were actually pregnant
6. how many of those received an ultrasound exam
7. etc.

This tracking process is managed by the Database Team and used primarily by the Medical Services Manager for the leadership team’s continual pursuit to keep the service relevant in an ever changing culture serving people who tend to think and make decisions in 8 second intervals.

#### Weekly Report

A summary of Medical Services activity should be submitted to the Medical Services Manager each week.

#### Patient Database

The Patient Database tool is used to track these Patient Resource metrics. A patient metrics report should be run at least on a quarterly basis, but it’s recommended that you run this report and review its accuracy more often, such as weekly or monthly. The value of the patient metrics is only reliable if the data entry is accurate. It is not sufficient to simply run reports. Once reports are completed, it is essential to go through the steps of verifying the data, locating any errors, and correcting them.

When entering data in the patient database, make use of the *Patient Interaction Tracking Form* (Appendix 42). This tool allows you to see at any time the progress of the data entry and status for each patient interaction by noting the date the interaction is completed, then the date the interaction is recorded in the database. This form should be updated any time there is a completed interaction or data entry for an interaction, and should be kept loosely in the patient chart.

## Addendum: Medical Services Self-Learning Module

#### Comprehensive Training System: Medical Team

#### Nurse/Sonographer Training Program

##### Self-Learning Module System

Objective: To train medical professionals in serving the abortion-minded patient, using effective listening techniques while offering her complete information about all of her pregnancy concerns.

###### Resources Needed:

1. “Equipped to Serve” Training Manual (By Cynthia Philkill, M.S. and Suzanne Walsh, M.S. Ed., 2001)
2. CompassCare Pregnancy Services Optimization Tool©
3. CompassCare Pregnancy Services Medical Policy and Procedure Manual

###### Proposed New Staff Training Process (for Paid or Volunteer Staff):

1. Prospective staff contacts PRC.
2. Interview time is established with the Director of Medical Services. A *Staff and Volunteer Job Application* (Appendix 53) is delivered to prospective staff (via email or mail), to be completed before scheduled interview. Staff must have a completed an application, including two references and signed Positional Statements and Statement of Faith, reviewed and on file with the Director of Medical Services before any patient contact may occur. Training cannot begin until entire application is completed.
3. Prospective staff attends Vision Tour to fully understand the mission and purpose of the PRC. This should be done as soon as possible after contact, but training may begin before tour is completed.
4. Following completion of interview, staff will be given a description of Self-Learning Modules including required reading and a test to be completed. A schedule of weekly meetings between the staff and her training mentor, as well as work required for each meeting, will be given at that time, according to the availability of the staff and the patient schedule.
5. At each weekly meeting, the staff will hand in the section review tests for the self-learning modules completed that week. Typically, a prospective staff will complete two modules each week and hand in two tests. The staff will also observe at least one real nursing/ultrasound appointment per week. She will then have the opportunity to ask questions and review patient flow. The training mentor will report to the Director of Medical Services following each meeting to update the staff’s progress and status.
6. After four weeks, the staff should have completed all of the self-learning modules, and observed at least four real patient appointments. She will then facilitate two patient appointments, with her training mentor observing. They will review each of those appointments, and her training mentor will report her final progress to the VP of Medical Services.
7. Following her observed appointments, she will have a final interview with the Director of Medical Services to determine her preparedness to serve independently. She will also evaluate her training mentor and the training program at that time. If training is determined to be complete, new staff will be added to the patient schedule for weekly shifts, as determined by the Director of Medical Services.

#### Medical Team Self-Learning Module #1: CompassCare Culture and Systems

##### Included in this Module:

1. PRC [Creation Story](#_Creation_Story)
2. PRC Fact Sheet
3. PRC Wish List
4. PRC Volunteer Opportunities
5. Optimization Tool© p.21:
   1. Organizational Assumptions

##### Mission

CompassCare is a Christ-centered organization dedicated to erasing the need for abortion by transforming women’s fear into confidence.

##### History

On July 1st, 1970 New York became the first state to legalize abortion. On July 2nd, the very next day, the Rochester/Syracuse region became home to the first free standing abortion clinic in the nation.

CompassCare, first named ‘Citizens for Public Morality’ was founded in 1980 out of the hearts of several people in a Bible Study who were concerned for society at the moral level. The first office was opened by volunteers in Rochester’s 19th ward. Several years later the organization began to focus more on the abortion issue and the name was changed to ‘Crisis Pregnancy Center.’ As the organization grew and offered more services it changed the name again to Crisis Pregnancy Services of Greater Rochester. By the mid 90’s, CompassCare had employed several staff and volunteers at several locations and enjoyed significant impact on the community; utilizing lay counselors, material assistance and post-abortion counseling—approximately 60% of abortion-vulnerable women chose to have their babies.

As the culture changed to more of a Post-Modern one, where women no longer made decisions based on facts but rather experiences and relationship; CompassCare recognized it had to adapt in order to remain relevant and effective. In 2002, CompassCare did what most said could not be done in New York State…implemented the current medical model of service. At that point the name was changed again to ‘CompassCare Pregnancy Services’ in order to reflect this new model of operation. Since the launch of medical services the number of abortion-vulnerable and abortion-minded women has increased exponentially and the number of those women choosing to carry their babies to term rocketed to 75-80% on a consistent monthly basis.

##### Effectiveness

96% of all CompassCare pregnancy patients are at-risk for an abortion. 70-80% of those patients choose to carry to term after receiving the services CompassCare provides. 20% pray to receive Christ as their Savior.

##### Services

1. Confidential STD Testing & Treatment
2. Community Resources & Referrals
3. Pregnancy Testing and Options Consultation
4. Ultrasound Exams
5. 12-month Follow-up
6. Reproductive Health Fairs at Local Colleges

##### National Mission

CompassCare’s national mission is to reverse the American abortion trend by increasing the effectiveness of Pregnancy Resource Centers across the US.

CompassCare’s effectiveness is among the very best in the nation. CompassCare has trained 14 other centers to operate using the CompassCare model. The model has proven to be reproducible and transferable in that the network of centers has experienced a dramatic turnaround in their effectiveness, with an overall nine-fold increase in the number of women who choose to carry their babies to term. Across the network in 2011, 2,310 women seriously considering abortion changed their minds and decided to have their babies.

##### Fact Sheet

1. Defining the Issue
   1. Definition of Abortion: Separation of the child from the mother for the purpose of fetal demise.
   2. Who has Abortions? Half of all abortions in Monroe County are received by 18-24 year old Caucasians with an average education of 2 years college and the expendable resources to pay for it out of pocket.
   3. What women want [[7]](#footnote-8)
      1. 90% said, knowing what they know now, would not have had an abortion
      2. 95% said they wanted more info on fetal development
2. The Risks and Side-Effects of Abortion
   1. Future Pre-Term Deliveries: “At least 49 studies have demonstrated a statistically significant increase in premature births or low birth weight risk in women with prior induced abortions.”[[8]](#footnote-9)
   2. Breast Cancer: Of women who have been pregnant, those who have a history of induced abortion are 1.4 times more likely to get breast cancer than those who have never had an abortion.[[9]](#footnote-10)
   3. STDs and Pelvic Inflammatory Disease: Of patients who have a Chlamydia infection at the time of abortion, 23% will develop PID within 4 weeks.[[10]](#footnote-11) “PID can lead to serious consequences including infertility, ectopic pregnancy (a pregnancy in the fallopian tube or elsewhere outside the womb), abscess formation, and chronic pelvic pain.”[[11]](#footnote-12)
   4. Mental Health: “Women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion.”[[12]](#footnote-13)
3. The Gap
   1. CompassCare’s goal is to reach and serve 20% of women seriously considering abortion per year
   2. CompassCare is currently seeing 1.5% of those women
   3. It costs CompassCare $43 for each patient call and $350 to offer transformational services to 1 woman from initial appointment through a 12 month follow-up

##### Wish List

###### Patient Resources Wish List

1. Media Allowance for Demographic Tracking
2. Underwriter for Staff to Attend Professional Development Conference

###### Medical Services Wish List

1. Laser Pen
2. Portable Digital Projector
3. Pregnancy Tests (Mainline hCg)
4. Prenatal Vitamins
5. 36x24 Plasma TV for Ultrasound Display to Patients

###### Administration Wish List

1. Phone and Voicemail System Upgrade
2. Laptop Computer for Running Presentations
3. Desktop Computer Replacements (2)
4. Printer/Copier Lease Buyout

###### Office Expansion Wish List

1. Underwriter for Opening Geneseo Office
2. Underwriter for Opening Syracuse Office
3. Underwriter for Opening Buffalo Office
4. Underwriter for Opening Corning Office

##### Volunteer Opportunities

###### Advancement Division

1. Donor Relations Specialists
2. Database Applications Developer
3. Database Managers
4. Mailing Team Assistants
5. Church Relations Specialists
6. Story Writer
7. Office Receptionists

###### Unified Medical Division

1. Nurses (RN’s and LPN’s)
2. RDMS
3. Medical Supplies and Equipment Acquisition
4. Clinical Coordinators
5. Helpliners

###### Executive Division

1. Public Relations Specialist
2. Marketing Team
   1. Graphic Design Specialist
   2. Focus Group Developer
   3. Demographic Researcher

##### Self-Learning Module #1:

###### CompassCare Culture and Systems

1. What is the mission of CompassCare? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What happened on July 1, 1970? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What happened on July 2, 1970? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What services does CompassCare provide to patients? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Compass care was the first pregnancy resource center in New York State to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. What is the cost to a woman to be served at CompassCare?
   1. What is the cost to CompassCare to serve one woman?
7. List 3 Organizational Assumptions that you may not have considered before beginning this training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #1:

###### CompassCare Culture and Systems

Notes:

Questions:

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#### Medical Team Module #2: Societal Costs of Abortion, the History of Abortion and Biblical Views on Abortion

##### Included in this Module:

1. Article: “Societal Costs of Abortion”
2. *Equipped to Serve* p. 10-17

##### Societal Costs of Abortion

**By James R. Harden, M.Div., Reginald Finger, MD, MPH   
and the CompassCare analysis team, Rochester, NY**

On the surface, some might think abortion saves money. Initially, this assumption seems especially sensible to those of us who have served in health departments and social service agencies. We see a young, single, pregnant girl in the clinic and we think about what it will cost for her to parent the child rather than abort. In keeping the baby, she will face medical bills, housing and basic living costs, delay in educational plans, and the list goes on.

We then show the young woman an ultrasound picture of her developing baby and make our case for life mostly by emphasizing that the life inside her is a BABY, and that abortion destroys a baby, and that having an abortion will also harm the mother both physically and emotionally, in the long and the short term. Then we take a deep breath and we say to her, "Oh boy, we know it’s going to cost a whole lot to do this, but we will stand with you and give you all the help we can."

We would be wrong to ignore the financial burden. However, as we shall see, we need not concede the financial side of the argument to the pro-abortion forces. A liveborn infant is a new person – one who will eventually work, contribute to society and pay taxes. As we have discussed in another report,[[13]](#footnote-14) abortion has contributed to a serious shortage of people to do all the producing, inventing, buying and caring that needs to be done. In this article, we show that, from the viewpoint of the society at large, a typical person’s eventual economic output dwarfs the costs paid to bear and raise him. This fact is true both for total costs and for costs paid by public funding sources.

In Table 18: Cost to Birth VS Abort a Child in the US (p. 122) we compare the societal costs resulting from aborting an unborn child to those that result from giving birth. The unit of analysis here is one person; the impact of women’s collective decisions at the county, state or national level would be these numbers multiplied thousands of times. Four categories of cost and one category of benefit – that of one person’s eventual economic productivity – are calculated and compared. Chart 1 tabulates all the costs, regardless of who pays them. Chart 2 shows those that are paid by (or saved by) the “public purse.” The public costs divided by the total are called the “public cost fraction.”

The first cost category is that of abortion itself. According to the National Abortion Federation (www.prochoice.org) and the Alan Guttmacher Institute (www.agi-usa.org), the average cost of an abortion up to 10 weeks pregnancy is $527. At 16 weeks it increases to $738, and beyond 20 weeks it rises to $1,370. Taking a weighted average of these costs by the national frequency of abortion by gestational age, the mean cost of an abortion is $583. In chart 2, 14 percent of this figure is entered as the public cost of abortion, based on an AGI estimate that 14 percent of abortions are paid for by Medicaid funds.[[14]](#footnote-15)

The second category in this analysis is breast cancer (based on research findings showing an increased risk of breast cancer in those women undergoing abortion, compared to those carrying the pregnancy to full term). Because this study concerns women already pregnant, there is no need to address the more controversial question of whether abortion is an independent risk factor for breast cancer. *The relative risk* of 1.38 is derived from Brind’s 1996 meta-analysis[[15]](#footnote-16) and the lifetime risk of breast cancer for women not experiencing abortion is .107 – calculated from a figure of one in eight lifetime for all women[[16]](#footnote-17) and from the *relative risk*. The $46,750 average treatment cost of breast cancer is from Polsky et al.,[[17]](#footnote-18) and 43 percent[[18]](#footnote-19) is estimated as the public cost fraction based on the approximate percentage of breast cancer patients who are eligible for Medicare.

***Relative risk*** *is the probability of an outcome (in this case, breast cancer) in people with a risk factor (in this case, abortion) divided by the probability of that same outcome in people without the risk factor.*

The third category is subsequent premature births. Women undergoing abortion remain at increased risk both for extreme prematurity (delivery at 32 weeks or less) and for delivery between 33 and 36 weeks[[19]](#footnote-20) for the remainder of their reproductive lifetimes. Costs associated with these outcomes are multiplied by their probabilities,[[20]](#footnote-21) and also multiplied by two to take into account the fact that the average woman in America today gives birth to two children during her lifetime. Births at less than 32 weeks have a small but measurably increased risk of cerebral palsy, a very expensive outcome.[[21]](#footnote-22) To be conservative with the cost estimates, other specific adverse outcomes were not tabulated separately. Lifetime medical costs for a premature infant as well as delivery / initial hospital stay costs are listed. Because approximately one-third of these infants are covered by Medicaid[[22]](#footnote-23) 0.333 is listed as the public cost fraction for all the prematurity outcomes.

The last two cost categories dwarf the others. To be fair, we have estimated generously for the opportunity cost of raising a child, since this cost of “choosing life” partially offsets the lifetime societal benefit provided by that person over her lifespan. Phillip Longman has estimated the opportunity costs from birth to age 17 and divided them into four categories.[[23]](#footnote-24) For the largest category – foregone wages – Longman assumes for the purpose of modeling that the birth of a child results in one parent quitting work for five years and then returning part-time for the subsequent 12 years. For the public cost fraction for foregone wages, we calculated from the 2004 federal tax table the income and social security tax that would have been paid on those wages. For housing, we included the cost that one extra bedroom adds to a standard U.S. military housing allowance. For food and other costs, we based the figure on what one additional child adds to the maximal benefit amounts for TANF and food stamps in the Colorado public assistance system.

We based our conservative estimates of the lifetime productivity of one person on the median per capita income from the U.S. Census Bureau, incremented for inflation at 3 percent per year from 2004.[[24]](#footnote-25) The fraction tabulated as a benefit to the public treasury is the income and social security tax that person would pay based on the 2004 federal tax table. We assumed that the individual enters the work force at 18, marries at 22 and has two children, five and eight years following marriage. This model assumes an individual who does not pursue a college education. To alter the model for a college-educated individual, one might increase the opportunity costs by about $200,000 to cover college expenses and lost earnings during the college years, but increase the ultimate lifetime earning potential by perhaps $500,000 to account for the benefits of the college degree.

The bottom line for the society, per person, comes out to roughly a $1.4 million benefit for a child allowed to be born, contrasted with a cost of just under $100,000 for an aborted child. To the public treasury, the estimated benefit of the birth is just over $200,000, compared to an abortion cost of $32,000. The figures in the second chart are perhaps the more relevant for public policy, because they are clearly borne by the public instead of by the individual or family.

Returning to our clinic setting, in many cases it will still be a hardship for a young woman to choose life for her infant. But at least we can assure her that when she does, she will not, as some might suggest to her, be creating a net financial liability to society.



Table 18: Cost to Birth VS Abort a Child in the US

##### Self-Learning Module #2

###### Societal Costs of Abortion, the History of Abortion, and Biblical Views of Abortion

1. How has abortion changed the financial outlook of America since 1970? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What did you learn from the article “Societal Costs of Abortion”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is the financial bottom line for society in terms of societal cost of abortion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What was the ruling in the 1973 Roe v. Wade case? How did it affect a woman’s decision to have an abortion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #2:

###### Societal Costs of Abortion, the History of Abortion, and Biblical Views of Abortion

Notes:

Questions:

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#### Medical Team Module #3: CompassCare Optimization Tool©: Patient Resources Personnel 15-Step Patient Flow Process

##### Included in this Module:

1. Optimization Tool© p. 60-102

##### Self-Learning Module #3 Review:

###### CompassCare Optimization Tool© 15-Step Patient Flow Process

1. What is the mission of the Volunteer Medical Team and what two positions/people help fulfill it?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. State the specific functions of the each of the positions on the medical team:  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is the importance of the steps of the medical team?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What steps are you most interested in performing and why?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #3:

###### Medical Services Personnel

###### 15-Step Patient Flow Process

Notes:

Questions:

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#### Medical Team Self-Learning Module #4: Communicating and Connecting

##### Included in this Module:

1. *Equipped to Serve* p. 75-117
2. NOTE: If you do not use *ETS*, the following information must be covered.
   1. Basic Elements to Communication
   2. Communicating with Patient in a crises situation
   3. Crisis Cycle, including where patients are in the crisis cycle when they come into the office
   4. Communication skills to climb the steps of Crisis Intervention
   5. Barriers to connecting with patient

##### Self-Learning Module #4:

###### Communicating and Connecting

1. Do you think you are a good communicator? Why or why not?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What agendas may get in the way of a Nurse connecting with the patient? What agendas might you have?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. A Nurse must understand that “people are hurting and what to be:  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List four obstacles a patient may encounter before connecting with a Nurse, and at least two things a Nurse can do to overcome each of those obstacles.

**Obstacle**

**Solution**

##### Self-Learning Module #4:

###### Communicating and Connecting

Notes:

Questions:

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#### Medical Team Self-Learning Module #5: OT Step 8: Pregnancy Testing

##### Included in this Module:

1. Optimization Tool©
   1. [Medical Services, Step 8](#_Step_8_–)
2. Pregnancy Test Log
3. Policies and Procedures
   1. PT1: Staff Performing Urine Pregnancy Tests
   2. PT2: Standing Order for Pregnancy Test
   3. PT3: Protocol for Pregnancy Testing
   4. PT4: Verification of Positive Test
   5. PT5: Standing Order for Verification Pregnancy

##### Self-Learning Module #5 Review:

###### Pregnancy Testing

* + - 1. Under what circumstances is the pregnancy test not performed by the nurse? What should happen when a nurse is not available?  
         \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In what situations would the Letter for positive Pregnancy Test automatically be given to the patient?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What other form must be completed to give the patient the Verification of Positive Pregnancy test letter?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #5:

###### Pregnancy Testing

Notes:

Questions:

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#### Medical Team Self-Learning Module #6: OT Step 10: STD Testing

##### Included in this Module:

1. Optimization Tool©
   1. [Medical Services, Step 10](#_Inform_Patient_of)
2. STD Testing White Paper
   1. Why does the Optimization Tool© advocate providing limited STD testing using a urine sample and not provide direct onsite STD treatment?
3. STD Testing Log
4. Policies and Procedures
   1. STD1: Criteria for STD Testing Appointment
   2. STD2: Standing Order for STD Testing

##### Self-Learning Module #6:

###### STD Testing

* + - 1. How long before they give us a urine sample for STD testing, should they not have urinated?
  1. 30 minutes
  2. One hour
  3. It does not matter

1. Who do we offer STD testing to?
   1. Positive Test patients
   2. Negative Test patients
   3. Males
   4. Both a and b
   5. All of the above
   6. None of the above
2. What are the benefits to the PRC for offering STD testing?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What are three reasons why we offer STD testing to patients?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #6:

###### STD Testing

Notes:

Questions:

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#### Medical Team Self-Learning Module #7: OT Step 10: Health Questionnaire

##### Included in this Module:

1. Optimization Tool©
   1. [Medical Services, Step 10](#_Step_11_–)
2. Positive Test Health Questionnaire Breakdown
3. Negative Test Health Questionnaire Breakdown
4. Highlighted STD Consent Form
5. Highlighted Ultrasound Consent Form
6. [Documentation Guidelines](#_Documentation_Guidelines_for)

##### Self-Learning Module #7 Review:

###### Health Questionnaire

1. What forms need to be reviewed with a patient who has a positive pregnancy test and wants an ultrasound and STD testing?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the importance of knowing a patient’s LMP for both a positive and negative pregnancy test?
   1. (Positive)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. (Negative)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Who on the medical team is responsible for reviewing the Health Questionnaire and consents with the patient?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What forms are given to/signed by the patient who does not have insurance?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #7:

###### Health Questionnaire

Notes:

Questions:

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#### Medical Team Self-Learning Module #8: The Ultrasound

##### Included in this Module:

1. Glossary of Ultrasound Terminology
2. Ultrasound White Paper
   1. LMP and Ultrasound Exams
3. OT Ultrasound PowerPoint
4. Ultrasound Guide
5. Quicker User Guide *(to the ultrasound machine that you use)*
6. Ultrasound Training Record
7. Ultrasound Log
8. Policies and Procedures
   1. US1: Ultrasound
   2. US2: Standing Order Protocol for Ultrasounds
   3. US3: Limited Ultrasound Training
   4. US7: Unusual Ultrasounds

##### Glossary of Ultrasound Terminology:

###### Orientation

***Longitudinal/Sagittal (LNG):*** Probe light pointing towards patient’s head. Creates a slice down the long axis of the patient’s body. Cuts patient’s body into right and left halves.

***Transverse (TRV):*** Probe light pointing towards patient’s right/ you. Creates a slice from right to left. Cuts body in half at the waist.

***AP diameter (Anterior-Posterior):*** Measurement used with ovoid structures (ovary, cysts, corpus luteum, and gestational sac). Measures the distance from front to back (depth). AP diameter is measured in the TRV view.

***Anterior:***Towards the front (Surface)

***Posterior:*** Towards the back (Back)

***Superior:***Above/ towards head

***Inferior:*** Towards lower end

***Right and left measurements:*** always refers to the patient’s right or left.

***TA:*** Trans abdominal ultrasound, an ultrasound using the abdominal probe.

***TV:*** Trans-vaginal ultrasound, an ultrasound using the vaginal probe.

###### Modes:

***B mode:*** “brightness mode,” showing the ultrasound image

***M mode:*** “motion mode,” shows the motion of what is pictured in B mode,

***B/M mode:*** shows ultrasound image and motion side by side, used for heart rate measurement, measure two full cycles for heart rate measurement (see the User Guides for each machine in this

***B/B mode:*** allows two images to be viewed side by side, one image will be frozen and the other could be live or frozen. Used for showing adnexa, and for GS measurement (allows the LNG and TRV views to be shown side by side).

###### GYN Anatomy

***Uterus:***To the left of the bladder

***Endometrium:*** Area of the uterus where the embryo will implant. Appears as a brighter white stripe in the middle of the uterus.

***Adnexa:*** Area outside of the uterus. Usually check the right and left adnexa to locate the ovaries. \*Common site of ectopic pregnancy.

***Ovaries:*** Seen just lateral to the uterus. Corpus luteum appears as a black circular structure on one ovary.

***Cervix:*** Lowest area of uterus. Located between the uterus and the vagina.

***Vagina:***Located below bladder and uterus. Bright white line is the vaginal canal.

***Bladder*:** Appears as a large black area above the vagina. Triangular in shape (long view), square in shape (transverse view).

###### 1st Trimester Ultrasound

***IntraUterine Pregnancy (IUP):*** This is the purpose of the ultrasound, to confirm that the pregnancy is within the uterus. It is very important to see yolk sac within the uterus, to exclude ectopic pregnancy.

***Gestational sac:*** Known as the double sac sign. Take 3 measurements (Longitudinal, AP, Transverse). Measure from inside borders. Use B/B mode for measuring gestational sac

***Yolk Sac:*** 1st structure to develop within gestational sac. Aides distinguishing viability of pregnancy. May be seen as early as 4-5 weeks. The baby is always visualized near the yolk sac.

***Crown-Rump Length (CRL):*** Distance from the top of the head to the bottom. This length can accurately determine age of the gestation. It is accurate to within 4 days of actual age (1st trimester measurements are most accurate).

***Heart:*** Heart motion can be seen as early as 5weeks1day (TV) and should be seen by 7 weeks (TA). Usually in very early pregnancy (6 weeks), when the heart begins beating, the heart rate can be slower (<120). This is simply because the heart just started beating. The heart beats slightly slower, then it will increase and beat faster as the pregnancy progresses, and as baby becomes more active. Normal range is anywhere from 120’s-190.

***Corpus Luteum Cyst:***Normal cyst that appears with pregnancy. May be visualized on one of the ovaries, as a black circular structure. Measure (LNG, TRV, AP).

***LMP*:** The first day of the woman’s last menstrual period. Used for determining the gestational age and due date (EDC/EDD). Pregnancy goes from the LMP as opposed to conception.  
EDC/EDD=LMP + 7days - 3months

###### 1st Trimester Fetal Development

The pregnancy is dated from the first day of the LMP. Fetal development starts at fertilization which is two weeks from LMP.

Look out to the side of the uterus, if you see the ovary, it will be similar in shape in both views. Sometimes they are up close to the uterus and sometimes they are further away.

##### Self-Learning Module #8:

###### The Ultrasound Exam

1. Why do we start the ultrasound exam with the glamour shot?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When do you do a vaginal ultrasound?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. When does the heart start beating?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Why do an ultrasound at 5 weeks and 1 day?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What is said **during** the ultrasound exam and who is present in the exam room?  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Self-Learning Module #8:

###### The Ultrasound Exam

Notes:

Questions:

# Appendix

**NOTE:** These documents are for reference only and should be customized as needed with your organization’s name, logo or letterhead. Many documents reference CompassCare Pregnancy Services. These references must be changed prior to use.

#### Appendix 1

### Abnormal Certified Letter

[Medical Director], MD

[Date]

[Patient Full Name]

[Street Address]

[City], [State] [Zip Code]

Dear [Patient’s First Name],

I have been thinking of you and hope you are doing well. Following [Medical Director]’s review of your ultrasound from [Ultrasound Date], I have tried to contact you. Your ultrasound could not be confirmed and we need to see you in the office for a repeat ultrasound. Please give me a call at [contact number] to schedule an appointment, or to confirm your physician’s care, as soon as possible.

Respectfully,

[Nursing Team Leader]

Nursing Team Leader

#### Appendix 2

### Annual Review

President and CEO

CompassCare Pregnancy Services of Rochester

Submitted by the **Executive Review Committee**

**(Names of committee members including president)**

Unanimously approved by the **CompassCare Board of Directors**

on (Date)

**(Members of Board named)**

(Name) became the President and CEO of this ministry on (DATE) and as such he/she is completing his (#) full year of leadership and service.

##### Accomplishments Concerning Previous Year’s Opportunities for Improvement

List Accomplishments pertaining to previous year’s goals

##### Additional Accomplishments

List other accomplishments not related to previous year’s goals.

##### Opportunities for Improvement

1. List coming year’s opportunities/goals for improvement
2. Goal chart for Major Donor development



1. Development and maintenance of church relationships for coming year
   1. First time visits (President meets directly with Sr. Pastor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Repeat visits (various staff & board members): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Board Member Development goals for coming year

##### Compensation

President/CEO’s compensation package consists of the following wages & benefits recommendations:

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Year-1 Actual | Year-2 Actual |
| Dates: | | date to date | date to date |
| Salary: | |  |  |
| Benefits: | |  |  |
|  | ***Medical Health Insurance*** | Comprehensive Medical (without Dental or Prescription) Cost per month = | Comprehensive Medical (with Dental and Prescription Riders) Cost per month = |
|  | ***Long Term Disability Insurance*** | Included | Included |
|  | ***Life Insurance*** |  |  |
|  | ***Vacation*** | 10-days | 15-days |
|  | ***Holidays*** | 10-Days as detailed:   1. New Year’s Day 2. Martin Luther King, Jr. Day 3. Good Friday 4. Memorial Day 5. Independence Day 6. Labor Day 7. Columbus Day 8. Veterans Day 9. Thanksgiving Day 10. Christmas Day | 12-days as detailed:   1. New Year’s Day 2. Martin Luther King, Jr. Day 3. Good Friday 4. Memorial Day 5. Independence Day 6. Labor Day 7. Columbus Day 8. Thanksgiving Day 9. Friday after Thanksgiving Day 10. Christmas Eve Day 11. Christmas Day 12. New Year’s Eve Day |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Year-3 Actual | Year-Current Proposed |
| Dates: | | date to date | date to date |
| Salary: | |  |  |
| Benefits: | |  |  |
|  | ***Medical Health Insurance*** | Comprehensive Medical (with Dental and Prescription Riders) Cost per month = | Comprehensive Medical (with B/C Dental and Prescription Riders) Cost per month = |
|  | ***Long Term Disability Insurance*** | Included | Included |
|  | ***Life Insurance*** |  |  |
|  | ***Vacation*** | 17-days | 25-days |
|  | ***Holidays*** | 12-days as detailed:   1. New Year’s Day 2. Martin Luther King, Jr. Day 3. Good Friday 4. Memorial Day 5. Independence Day 6. Labor Day 7. Columbus Day 8. Thanksgiving Day 9. Friday after Thanksgiving Day 10. Christmas Eve Day 11. Christmas Day 12. New Year’s Eve Day | 12-days as detailed:   1. New Year’s Day 2. Martin Luther King, Jr. Day 3. Good Friday 4. Memorial Day 5. Independence Day 6. Labor Day 7. Columbus Day 8. Thanksgiving Day 9. Friday after Thanksgiving Day 10. Christmas Eve Day 11. Christmas Day 12. New Year’s Eve Day |

#### Appendix 3

### Applicants Standard Notifications

#### Successful Applicants Standard Notification

##### Phone Conversation

Hello, [*Applicant’s name*]! This is [*your first and last name*] calling from [*PRC*] regarding the position of \_\_\_\_\_\_\_\_ for which you applied. Thank you so much for applying. There were so many gifted and qualified candidates but after much prayer and consideration we feel that you are the most qualified for erasing the need for abortion in the position of \_\_\_\_\_\_\_\_\_\_\_. We would love to see you begin at your earliest convenience to start your orientation process!

#### Unsuccessful Applicants Standard Notification

##### Phone Conversation

Hello, [*Applicant’s name*]! This is [*your first and last name*] calling from [*PRC*] regarding the position of \_\_\_\_\_\_\_\_ for which you applied. Thank you so much for your time and application to serve at CompassCare in attaining our mission of ‘erasing the need for abortion. Because there were so many talented and qualified individuals it was a difficult yet prayerful decision. So I regret to inform you that another candidate was chosen. But would you permit us to keep your resume on file should another position come available? We will send you a letter to this affect directly. God bless and have a great day.

#### Standard Notification Letter to follow:

Dear [*first name*],

It was an honor and privilege getting to know you and how by His grace God has brought you to where you are today. Thank you for your time, input, and interest in furthering the cause of ‘erasing the need for abortion’ by your willingness to work at CompassCare.

Regrettably the position for which you have applied has been filled.

Erasing the Need for Abortion Together,

*Signature*

*[Name of Interviewer]*

#### Appendix 4

### Application for Appointment to the Board

Directions: Please complete all of the following questions to be considered for board service with this organization. References should be provided on a separate sheet, or verbal references can be secured by the President, CEO.

Name: Home phone:

Address:

Occupation: Business phone:

Church: Pastor:

Please check the education or skills you could contribute to our board:

 accounting  management  public relations  legal

 investment  marketing  knowledge of services

 fundraising  education  public speaking

 community relations  planning  lobbying

 other (please specify)

On what other boards have you served?

What charitable or community activities have you been part of?

Can you regularly attend board meetings?  Yes  No Conflicts?

How many hours per month, in addition to meetings, could you serve this organization? \_\_\_\_

Would you attend a training session for new board members?  Yes  No

What is your interest in this organization?

Please write a brief statement of your understanding of this organization’s mission.

#### Board Member’s Statement of Agreement

As a Board member of (your organization name), I understand that my duties and responsibilities include the following.

1. **I am fiscally responsible**, with the other Board members, for this organization. It is my duty to know what our budget is, and to be active in planning that budget and planning the fundraising to meet that budget.
2. **I am legally responsible**, along with the other Board members, for this organization. I am responsible to know and approve all policies and programs, and oversee their implementation. Even though (your organization name). has considerable liability insurance for each Board member, and New York State law further protects not-for-profit Board members, I know that if I fail in my tasks, and if the organization becomes the subject of a suit from a private person, or from the federal or state government, I may be held personally liable for the debts incurred.
3. **I am morally responsible** for the health and well-being of this organization. As a member of the Board, I have pledged myself to advance the purposes of Crisis Pregnancy Centers, Inc.
4. **I will give** what is for me a substantial donation. I may give this as a one-time donation each year, or I may pledge to give a certain amount several times during the year.
5. **I will actively engage in fundraising** for this organization in whatever ways are best suited to me. These may include individual solicitation, doing special events, writing mail appeals and the like…I am making a good faith agreement to do my best to bring in as much money as I can.
6. **I will make every effort to attend** the organization’s Board meetings every year, as well as the meetings of each Board committee on which I agree to sit, and be generally available for telephone consultation. I understand that commitment to the Board may involve a good deal of time, probably not less than two hours each month.
7. **I understand that no quotas have been set**, that no rigid standards of measurement and achievement have been formed. Every Board member is making a statement of faith. We are trusting each other to carry out the above agreements to the best of our ability, each in our own way, with knowledge, approval, and support of all. I know that if I fail in good faith, I should resign, or someone from the Board may ask me to resign.

In its turn, (YOUR ORGANIZATION NAME) is responsible to me in the following ways:

1. **I can call on** the Chairman and the President to discuss overall programs and policies—and, similarly, I can also call upon the management staff—to answer questions or concerns I might have with regard to my committee responsibilities.
2. **Board members and staff** will respond in a straight-forward and thorough fashion to any questions I have which I feel are necessary to carry out my fiscal, legal, or moral responsibilities.

Signed Date

#### Positional Statements

##### Abortion

1. It is our position that every abortion claims an innocent life.
2. We are painfully aware of the trauma surrounding pregnancies related to rape, incest, deformities of the developing child, and/or health risks to the mother. We exist, in part, to provide helpful intervention in such cases, but we do not find abortion to be either effective or morally acceptable as a method of reducing such trauma.
3. In those extremely rare cases where continued pregnancy is reasonably expected to precipitate the mother’s immediate and literal death, we have been able to discover no clear biblical principle absolutely prescribing or recommending the act of abortion. In such cases, we encourage the parties involved to prayerfully consider the gravity of their decision and the merit of available alternatives. Furthermore, we commit ourselves to respect the decision of the parents and to provide whatever support is possible.

##### Birth Control

1. For far too long, “sex education” in our schools has concentrated on birth control instead of self-control. We believe that, so long as people engage in sexual relationships outside of marriage, there will continue to be great numbers of crisis pregnancies, sexually transmitted diseases and broken lives.
2. Much of the difficulty encountered in confronting the problems of adolescent promiscuity and pregnancy stems from a paradox engendered by the birth control establishment. Though young people are taught that sex outside of marriage is “no big deal,” they sense its profound significance and so feel both permission and desire to become sexually active. This has produced ever higher rates of adolescent sexuality, pregnancy, abortion and disease – the very problems that expensive, tax-funded programs promised to prevent.
3. (YOUR ORGANIZATION NAME) is working to reach young adults with the less appealing but more truthful message that sex can only be safe and loving within the context of a permanent, marital relationship.
4. Our staff does not refer or provide clients with birth control.

##### Statement of Faith

1. We believe the Bible to be the inspired, the only infallible, authoritative Word of God.
2. We believe that there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.
3. We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.
4. We believe that for the salvation of lost and sinful people, regeneration by the Holy Spirit is absolutely essential, and that this salvation is received through faith in Jesus Christ as Savior and Lord.
5. We believe in the present ministry of the Holy Spirit by whose indwelling the Christian is enabled to live a godly life.
6. We believe in the resurrection of both the saved and the lost; they that are saved unto the resurrection of life and they that are lost unto the resurrection of damnation.
7. We believe in the spiritual unity of believers in our Lord Jesus Christ.

The above Statement of Faith is consistent with that of the National Association of Evangelicals.

##### Statement of Principle

1. (YOUR ORGANIZATION NAME) is an outreach ministry of Jesus Christ through His church. Therefore, the (YOUR ORGANIZATION NAME) is committed to presenting the gospel of our Lord to women in crisis pregnancies – both in word and in deed. In keeping with this purpose, those who serve the agency as board members, staff, and volunteers are expected to know Christ as their Savior and Lord.
2. (YOUR ORGANIZATION NAME) is committed to the highest degree of integrity in dealing with its clients, earning their trust, providing promised information and services, and avoiding any form of deception in its corporate advertising or individual conversations.
3. (YOUR ORGANIZATION NAME) offers assistance free of charge and does not discriminate on the basis of age, gender, marital status, race, or religious preference.
4. (YOUR ORGANIZATION NAME) provides accurate and complete information concerning prenatal development, abortion procedures and risks, and alternatives to abortion. Recognizing that abortion compounds human need rather than resolving it, this agency does not recommend, provide, or refer for abortions or abortifacients.
5. (YOUR ORGANIZATION NAME) is committed to meeting a woman’s need at the point of decision regarding an unplanned or unwanted pregnancy. Through emotional support and practical assistance, women may face the future with hope, and plan constructively for themselves and their babies.
6. (YOUR ORGANIZATION NAME) supports adoption as an excellent alternative to abortion for women experiencing unplanned and unwanted pregnancies. A list of referrals to adoption agencies and attorneys is available for those who find parenting to be impossible at this stage of their lives. However, this organization does not initiate or facilitate adoption for our clients, nor do we receive payment of any kind from these agencies.
7. (YOUR ORGANIZATION NAME) provides accurate and complete information on birth control, distinguishing between methods that prevent conception and abortifacients, but does not provide or refer unmarried clients for birth control.
8. (YOUR ORGANIZATION NAME) is committed to encouraging sexual abstinence among those who are single, and fidelity within a marriage relationship.

Having read the above, I, the undersigned, agree to uphold each of the positional statements in full (please check all that apply):

1. Abortion Statement of Faith
2. Birth Control Statement of Principle

In the space provided below, clearly state any variance in your beliefs to the positional statements as stated above.

Print Name

Signature Date

#### Appendix 5

### Appointment Schedules

The sample schedules below are created for maximum service efficiency based on complete Advocacy teams following the recommended Patient Flow.

##### Single and Double Booking Patient Appointments

|  |  |  |
| --- | --- | --- |
| Time | Patient 1 | Patient 2 |
| 10:00 | Welcome by Clinical Coordinator |  |
| 10:05 | Nurse performs situational assessment and options presentation. |
| 10:10 |
| 10:15 |
| 10:20 | Urine Sample Collection/Support System Review | Welcome by Clinical Coordinator |
| 10:25 | Nurse obtains health history | Nurse performs situational assessment and options presentation. |
| 10:30 |
| 10:35 |
| 10:40 | Urine Sample Collection/Support System Review |
| 10:45 | Ultrasound with Nurse | Nurse obtains health history |
| 10:50 |
| 10:55 |
| 11:00 | PRL/Gospel/Exit process with Nurse |
| 11:05 |  | Ultrasound with Nurse |
| 11:10 |
| 11:15 |
| 11:20 | PRL/Gospel/Exit process with Nurse |

##### Follow Up Ultrasound Appointment with STD Results

|  |  |
| --- | --- |
| Time | Steps |
| 1:00 | Welcome by Clinical Coordinator (Modified) |
| 1:05 | Nurse reviews the Situational Assessment and the PRL (Modified) |
| 1:10 | Nurse reviews the Follow Up Health Questionnaire and the STD results |
| 1:15 | Nurse performs the Ultrasound Exam |
| 1:30 | Modified Exit Process with Nurse/Clinical Coordinator |

##### Retest Appointment for a Negative Test

|  |  |  |
| --- | --- | --- |
| Time | Steps | |
| 1:00 | Welcome by Clinical Coordinator (Modified) | |
| 1:05 | Nurse directs the patient to leave a urine sample. | |
| 1:10 | Nurse reviews the Situational Assessment and the PRL (Modified). | |
| 1:20 | Nurse delivers the pregnancy test results, the STD results, and reviews the Follow Up Health Questionnaire | |
| *If the test is:* | *Negative* | *Positive* |
| 1:30 | Patient exits | Nurse performs the Ultrasound Exam |
| 1:45 |  | Exit process with Nurse |

#### Appendix 6

### Authorization for Release of Medical Information







#### Appendix 7

### Bill of Rights for Women Facing Unintended Pregnancy

##### A Woman Facing Unintended Pregnancy Has The Right To:

1. Receive services in a non-judgmental, caring environment committed to maintaining confidentiality of patient records except where required by law.
2. Receive professional medical services from organizations committed to integrity, free from manipulation or coercion.
3. Receive services in a confidential environment that supports her right to make her own decisions regarding her pregnancy.
4. Be respected enough to make a decision that is right for her by receiving a non-biased presentation of all her pregnancy-related options.
5. Receive comprehensive information about her current medical status, including information about the nature and physiology of her current pregnancy.
6. Access objective information about all of her legal options related to pregnancy and pregnancy termination.
7. Receive services from an organization that has written documentation of all services and information provided, to insure that every patient receives the same objective information delivered with the same standard of excellence.
8. Receive services from an organization that uses a written verification process that services have been provided according to written protocol on a per-patient basis.
9. Fully understand how an organization stands to financially profit from any particular pregnancy decision a woman may choose to make at that organization.
10. Receive standardized medical services by organizations held accountable to follow protocols designed to insure that all services and information are delivered ethically and objectively.
11. Assurance of high quality medical follow-up care provided by or arranged by the physician responsible for the initial delivery of service.
12. Access to ongoing, long-term community support should she choose to carry the pregnancy to full-term.

##### Patient Responsibilities

1. Patient is responsible for providing all pertinent and accurate health history information to provider.
2. Patient is responsible to participate in determining her treatment plan.
3. Patient is responsible to follow prescribed treatment agreed upon with provider.
4. Patient is responsible to understand his/her rights.
5. Patient is responsible to communicate suggestions, complaints, and grievances using an exit survey process, completed at the end of each appointment.

I, , understand my rights and responsibilities.

(Print Name)

Signature: Date:

#### Appendix 8

Pt Initials

|  |  |  |  |
| --- | --- | --- | --- |
| Chart Audit Form | | | |
| **Yes** | **No** | **N/A** |  |
|  |  |  | Limitation of Service (*Patient Intake Form*) signed by patient. |
|  |  |  | *Patient Bill of Rights* signed by patient. |
|  |  |  | *STD Consent Form* signed by patient. |
|  |  |  | *Ultrasound Consent Form* signed by patient. |
|  |  |  | *Authorization to Release Medical Information* signed by patient. |
|  |  |  | *Medical Exam Report* completed and signed by MD in two places. |
|  |  |  | Ultrasound pictures filed for each scan performed. |
|  |  |  | STD Test Results filed in chart and documented on *Patient Contact Form*. |
|  |  |  | Pregnancy confirmed with patient and documented on *Medical Exam Report*. |
|  |  |  | Follow-up performed and documented on *Follow-Up Form*. |
|  |  |  | Chart closed and closing documented on *Chart* *Closing Summary Form*. |
|  |  |  | **Totals** |

Notes:

#### Appendix 9

### Chart Closing Summary Form

Patient Name:

Date First Seen: Date of Closing Call:

##### □ Negative Test

Notes:

##### □ Miscarriage

Date of miscarriage:

Notes:

##### □ Abortion Performed

Type of abortion: □ Medical □ Surgical

Date of abortion:

Location of abortion:

How is patient feeling?

How are patient’s family/boyfriend relationships?

Referrals requested:

Post-Abortion Syndrome indicated by patient? □ Yes □ No

Interested in Abortion Recovery counseling? □ Yes □ No

Notes:

##### □ Child Born

Date of Birth: Gender: □ Male □ Female

Baby’s Name:

Weight: Length:

Date of baby visit: □ Office Visit □ Home Visit

##### □ Unable to Contact

##### □ Patient Requested No Further Contact

##### □ Other

Closing Notes:

RN Signature: Date:

#### Appendix 10

### CLIA Waiver Instructions

A CLIA waiver must be obtained from your state Health Department. If you have multiple locations, be sure to obtain a waiver that covers each of the locations at which you will be performing pregnancy/STD tests. A CLIA waiver must be obtained before nurse-administered testing can be implemented.

1. Research your state requirements for medical professionals performing CLIA waived pregnancy tests by contacting your state Health Department.
2. Begin CLIA application process if required. Applications will most likely be filed through your local County Health Department, though may go directly to the State.
3. Review standards required to maintain waiver status, as directed by Health Department.

#### Appendix 11

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clinical Coordinator Job Function Checklist | | | | | | |
| **Date:** | |  | | **Name:** |  | |
| *Yes* | *No* | *N/A* | *Tasks to be completed each day* | | | *Notes/Comments* |
|  |  |  | **Office Opening** | | |  |
|  |  |  | Gather Medical Services Team for prayer before first patient arrives | | |  |
|  |  |  | Unlock active chart drawer | | |  |
|  |  |  | Pull return or old patient charts for day | | |  |
|  |  |  | Check toys in Waiting Room, clean toys if necessary | | |  |
|  |  |  | Turn sound system on | | |  |
|  |  |  | Check Nurseline phone for messages and deliver to nurses | | |  |
|  |  |  | Answer Nurseline phone throughout the day, including patient calls outside of Helpline Hours | | |  |
|  |  |  | Check office voicemail for messages and deliver to nurses | | |  |
|  |  |  | Open AFTIS program | | |  |
|  |  |  | Open Donation Tracking spreadsheet | | |  |
|  |  |  | Open Calendar | | |  |
|  |  |  | Print blank forms as necessary and assemble blank charts for shift. | | |  |
|  |  |  | Turn on Exam Room equipment (u/s, screen, lights) | | |  |
|  |  |  | **Office Closing** | | |  |
|  |  |  | Complete Clinical Coordinator section of each patient JFC. | | |  |
|  |  |  | Ensure that Medical Metrics are updated by Nurses. | | |  |
|  |  |  | Ensure that drug cabinet is locked. | | |  |
|  |  |  | Put each completed chart in order, ensuring that all documentation is completed. | | |  |
|  |  |  | File all charts | | |  |
|  |  |  | Return Nurseline phone to charger | | |  |
|  |  |  | Lock chart filing cabinet | | |  |
|  |  |  | Turn sound system off | | |  |
|  |  |  | Package UPS shipment and place at Front Desk for pick-up | | |  |
|  |  |  | Perform AFTIS End of Day, then close Front Desk software programs. | | |  |
|  |  |  | Take garbage out of patient areas, to dumpster on side of building. | | |  |
|  |  |  | **Other Activities** | | |  |
|  |  |  |  | | |  |
|  |  |  |  | | |  |
|  |  |  |  | | |  |

**Additional Comments:**

I embraced the three core values of CompassCare today:  
 □ Fighting Spirit □ Relevance □ Accountability

Signature: Date:

#### Appendix 12

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Clinical Coordinator Training Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *General Orientation* | |  |  |  |
| * + Use the General Orientation Checklist | |  |  |  |
| * *Self-Learning Modules (Read, Return Questions to Training Coach and Review Answers)* | |  |  |  |
| * + Module 1: PRC Culture and Systems | |  |  |  |
| * + Module 2: Societal Costs of Abortion, History of Abortion, Biblical View of the Pre-born | |  |  |  |
| * + Module 3: Optimization Tool©: Patient Resources Personnel, 15-Step Patient Flow Process | |  |  |  |
| * + Module 4: Communicating and Connecting | |  |  |  |
| * + Module 5: The Seven Fundamentals | |  |  |  |
| * *Patient Platform Training* | |  |  |  |
| * + Read entire OT manual Patient Resources Section and Whitepapers | |  |  |  |
| * + Listen to PPT recorded sessions   + PPT 1 Introduction   + PPT 4 Greeting   + PPT 10 Exit Process | |  |  |  |
| * + Watch Patient Process DVD | |  |  |  |
| * + Review all relevant Forms | |  |  |  |
| * *Clinical Coordinator Task Training* | |  |  |  |
| * + Role Objective: Refer to OT manual | |  |  |  |
| * + Preparing for the Patient | |  |  |  |
| * + Greeting the patient | |  |  |  |
| * + Welcome Packet | |  |  |  |
| * + Return Appointment Scheduling | |  |  |  |
| * + CDD Software Training | |  |  |  |
| * + Inventory and Ordering | |  |  |  |
| * + Other tasks (see Clinical Coordinator Job Function Checklist) | |  |  |  |
| * *Database Training (if applicable)* | |  |  |  |
| * + Use Data Entry Training Checklist | |  |  |  |
| **Notes:** | | | | |
| **Trainer Signature:** | | **Date:** |  | |

#### Appendix 13

### Creation Story

Show video if you have it and utilize PowerPoint if possible when sharing Creation Story.

##### Mission

CompassCare is a Christ-centered organization dedicated to erasing the need for abortion by transforming women’s fear into confidence.

##### History

On July 1st, 1970 New York became the first state to legalize abortion. On July 2nd, the very next day, the Rochester/Syracuse region became home to the first free standing abortion clinic in the nation.

CompassCare, first named ‘Citizens for Public Morality’ was founded in 1980 out of the hearts of several people in a Bible Study who were concerned for society at the moral level. The first office was opened by volunteers in Rochester’s 19th ward. Several years later the organization began to focus more on the abortion issue and the name was changed to ‘Crisis Pregnancy Center.’ As the organization grew and offered more services it changed the name again to Crisis Pregnancy Services of Greater Rochester. By the mid 90’s, CompassCare had employed several staff and volunteers at several locations and enjoyed significant impact on the community; utilizing lay counselors, material assistance and post-abortion counseling—approximately 60% of abortion-vulnerable women chose to have their babies.

As the culture changed to more of a Post-Modern one, where women no longer made decisions based on facts but rather experiences and relationship; CompassCare recognized it had to adapt in order to remain relevant and effective. In 2002, CompassCare did what most said could not be done in New York State…implemented the current medical model of service. At that point the name was changed again to ‘CompassCare Pregnancy Services’ in order to reflect this new model of operation. Since the launch of medical services the number of abortion-vulnerable and abortion-minded women has increased exponentially and the number of those women choosing to carry their babies to term rocketed to 75-80% on a consistent monthly basis.

##### Effectiveness

96% of all CompassCare pregnancy patients are at-risk for an abortion. 70-80% of those patients choose to carry to term after receiving the services CompassCare provides. 20% pray to receive Christ as their Savior.

##### Services

1. Confidential STD Testing & Treatment
2. Community Resources & Referrals
3. Pregnancy Testing and Options Consultation
4. Ultrasound Exams
5. 12-month Follow-up
6. Reproductive Health Fairs at Local Colleges

#### Appendix 14

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Data Entry Training Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *General Orientation* | |  |  |  |
| * + Use the General Orientation Checklist | |  |  |  |
| * *Self-Learning Modules (Read, Return Questions to Training Coach and Review Answers)* | |  |  |  |
| * + Module 1: PRC Culture and Systems | |  |  |  |
| * + Module 2: Societal Costs of Abortion, History of Abortion, Biblical View of the Pre-born | |  |  |  |
| * + Module 3: Optimization Tool©: Patient Resources Personnel, 15-Step Patient Flow Process | |  |  |  |
| * + Module 4: Communicating and Connecting | |  |  |  |
| * + Module 5: The Seven Fundamentals | |  |  |  |
| * *Patient Platform Training* | |  |  |  |
| * + Introduce OT Manual, so trainee is familiar with it and where it’s located for reference. | |  |  |  |
| * + Listen to PPT recorded sessions   + PPT 1 Introduction   + PPT 4 Greeting   + PPT 5, 6 Situational Assessment and Options Presentation   + PPT 10 PSA, Gospel, Exit   + PPT 11 Follow-up | |  |  |  |
| * + Watch Patient Process DVD | |  |  |  |
| * + Review all relevant Forms | |  |  |  |
| * *Data Entry Task Training* | |  |  |  |
| * + Accessing the Database/Changing default password | |  |  |  |
| * + Confidentiality/Importance of Accurate Data | |  |  |  |
| * + Patient Chart Filing System | |  |  |  |
| * + Patient Chart Contents (source of data) | |  |  |  |
| * + Adding New Patient (or locating previous patient) | |  |  |  |
| * + Patient Demographics | |  |  |  |
| * + Adding Interaction Groups | |  |  |  |
| * + Entering Interactions | |  |  |  |
| * + AVR vs. ITC – Differences and when to change | |  |  |  |
| * + Entering Pregnancy Test | |  |  |  |
| * + Entering Pregnancy | |  |  |  |
| * + Closing Summary | |  |  |  |
| * + Job Function Checklist | |  |  |  |
| * *Database Reports* (This many not be the responsibility of Data Entry Staff) | |  |  |  |
| * + Process for Running Reports | |  |  |  |
| * + Process for Verifying Accuracy of Data | |  |  |  |
| **Notes:** | | | | |
| **Trainer Signature:** | | **Date:** |  | |

#### Appendix 15

### Documentation Guidelines for Patient Charts

1. Always use black or blue ink.
2. Date and time all entries in the patient’s chart.
   1. Use full date with month/day/year
   2. Timing all entries helps with multiple entries from the same day and when messages are being left/returned.
3. Always sign with your complete name and title. This will help with identification if ever needed.  
   For example:
   1. Samantha Jackson, RN
4. Be sure you are following all necessary Policies and Procedures for follow-up.
   1. Did they give you permission?
   2. When do they want you to call?
   3. What are you allowed to say if leaving a message?
5. Ensure that all forms are completely filled out.
   1. Remember, “If it’s not documented, it wasn’t done.”
   2. If you don’t use a particular space on your documentation, put a line through it and write N/A. If you leave a space blank, it just looks like it was not addressed. The exception is when choosing from a list.
   3. Document what you said and what the patient said in response. Don’t leave out any details. Be as complete as you can from your encounter because your memory is not as good as having it all down on paper. If you were ever to have to testify regarding your documentation, chances are, your documentation is all you would have to remember the patient.
6. Keep your documentation objective.
   1. Stick to what the patient says or does.
   2. Do not interpret or rephrase the patient’s actions/words.
   3. Document in complete sentences and use quotations. For example, Pt Stated “I am mad.” As opposed to “The patient seemed mad.”
   4. Do not use “I” in accordance with yourself in your documentation (this is subjective) – this incriminates you and does not focus on the patient, it also eliminates your agenda and any opinion.
   5. Be descriptive. For example, Pt sat with arms crossed and was yelling. She was crying when she started talking about her previous abortion and stated, “I feel really bad for what I did.”
7. Cross out a mistake properly.
   1. Put one single line through it.
   2. Write ERROR over the line & Sign your initials.
   3. Never scribble over something in your documentation.
   4. Do not use correction fluids (such as “White Out”) to cover over mistakes.

#### Appendix 16

### Employee Performance Evaluation

##### Employee Information

Name Title

Supervisor Title

Date of this Evaluation Date of Previous Evaluation

##### Evaluation Purposes

The evaluation process is designed to be one of awareness raising and teaching. It is to assist in the praise of personal strengths and encourage in areas where performance needs improvement for the mutual benefit of the employee and this organization. Therefore, this process will aid in the formulation of a practical improvement program for both parties involved.

##### Prepared By

Name Title

Signature Date

##### Reviewed By

Name Title

Signature Date

Date Discussed with Employee

Part I. Appraisal of Objectives: Supervisor to list and evaluate all objectives for which the employee was held accountable during this reporting period.

|  |  |
| --- | --- |
|  | Objectives |
|  | Exceed Met Not Met |

##### Part II. General Appraisal of Employee Performance

Appraise the employee’s performance as compared to Expectations.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Exceeds Expect | Meets Expect | Below  Expect | Not Acpt |
| **1. Philosophy:** Understands and demonstrate support in the  Mission and purpose of the organization. Is supportive toward and recognizes the interdependence of all organizational systems and people. |  |  |  |  |
| **2. Attendance:** Is dependable—follows procedures for absence and requesting time off—absence is minimal. |  |  |  |  |
| **3. Punctuality:** Is punctual in reporting to work—is physically and emotionally ready to begin work at scheduled times. Follows procedure for reporting tardiness. |  |  |  |  |
| **4. Attitude:** Demonstrates a positive attitude toward the organization Adaptable and Flexible to changing circumstances—is responsive to overtime needs. |  |  |  |  |
| **5. Appearance:** Is well groomed, dressed appropriately for current position. |  |  |  |  |
| **6. Initiative:** Self-motivated, seeks increased responsibility; seeks improved methods and techniques; always tries to do better. How does the process work? |  |  |  |  |
| **7. Planning:** Sets realistic objectives; anticipates; resourceful in preparing for future requirements; establishes logical priorities; uses time wisely. |  |  |  |  |
| **8. Productivity:** Accomplishes required work on or ahead of schedule; Able to work constructively under pressure or adverse circumstances; Meets deadlines. |  |  |  |  |
| **9. Quality:** Takes pride in work-correctness, completeness, accuracy and economy of work—overall quality. |  |  |  |  |
| **10. Follow-Up:** Maintains control of workloads; insures that assignments are completed accurately and timely; amount of direction required. |  |  |  |  |
| **11. Human Relations (Co-Workers):** Gets along well with others; conflicts are minimal; is able to resolve conflicts independently; promotes harmony and enthusiasm; good team work. |  |  |  |  |
| **12. Human Relations (Supervisors):** Follows directions; demonstrates respect for authority; provides timely, accurate and adequate info, accepts responsibility for own actions. |  |  |  |  |
| **13. Communication:** Makes sure all information is distributed to proper people quickly. |  |  |  |  |
| **14. Judgment:** Able to analyze situations in a manner which leads to appropriate action. |  |  |  |  |

Part III. Remarks by Supervisor:Document on ratings in Part 1 and 2. Comment on the Employee’s outstanding achievements, strengths, etc.

Part IV. Employee Objectives for the Next Reporting Period: To be established by the supervisor with input from the employee. Objectives should be ranked in priority of order and be as measurable as possible. Personal development objectives may be included.

Part V. Employee Comments: Employee may comment on all or any part of the review. If the employee does not concur with the evaluation he/she should check the box in part VI. Use this section to explain the disagreement.

##### Part VI. Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Signature |  | Date |  |
| Supervisor Signature |  | Date |  |
| Program Director Signature (If applicable) |  | Date |  |
| Executive Director Signature (If applicable) |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Present Salary |  | | |
| Number of commendations during the report period | | | |  |
| Number of work warning during the report period | | | |  |
| Increase Recommended | | * Yes | * No | Proposed Increase | |  |

#### Appendix 17

### ERC Resolution

{Organization Letterhead}

Board Resolution for the Addition of Executive Review Committee (ERC)

The Board of Directors of {Organization’s Name} hereby adopts and employs the use of an ERC to be an official extension of the Board in accordance with Center Policy to perform the following two tasks:

1. Evaluate Primary Executive annual performance using the Executive Performance Evaluation in the NIFLA/CompassCare Optimization Tool© and proposing salary and benefits package changes accordingly.
2. Facilitate determinative organizational growth by Pre-confirming any Board decision outside the discretion of the primary Executive which would normally necessitate board approval in line with Center policy in non-emergent situations to be affirmed when next the board is in session.

The ERC is to be comprised of the following people with equal authoritative weight:

1. Chairman
2. President/CEO (Executive Director)
3. One or two other Board Directors at large one of which of is of the primary Executive’s choosing.

The ERC is to meet no less than quarterly.

The resolution becomes effective with the signature of both the current Board Chairman of {Organization’s Name} and the existing primary Executive.

This resolution will remain valid over and above organizational leadership tenure as a standing committee representing a standard of best practice.

Center Primary Executive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board Chairman \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Appendix 18

### Executive Job Functions

1. Lead Core Staff into the fullness of their potential as leaders so that they can in turn do the same for their departmental staffing (Ideal vision of meeting this objective such as 1:1s, weekly core staff, PDPs, etc)
2. Set organizational tone and direction (reinforce culture of excellence and core values)
3. Assure Quality Control in Patient Services across the network
4. Determine Resource Acquisition Process (Brand, Volunteers, Money)
   1. Increase Organizational Brand Equity by reinforcing organizational integrity through tangible mission accomplishment
      1. Communicating with media
      2. Donors
      3. Churches
      4. Etc
   2. Determine and participate in volunteer acquisition (Vision Tours), training and retention process by department
   3. Acquire and Maintain relationships for Money
      1. with major donors
      2. with Corporations and Foundations
5. Acquire and Maintain relationships for Mission Advancement
   1. with National affiliates
   2. with Board Directors
   3. with other LCs
6. Manage Local and National Operational Development
   1. R & D
   2. Ask hard questions to stay on mission
   3. Ensure proper policy and procedures so that the health of operational system is maintained
   4. Ensure budget is created and balanced for the purpose of
      1. Determining what things get funded
      2. What things do not get funded
      3. For the purpose of focusing resources of all three divisions on mission

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **1. Lead Core Staff into the fullness of their potential as leaders so that they can in turn do the same for their departmental staffing** | | |
| Level 1 Maturity | | * Sporadic and loose staff meetings revolving around solving immediate crisis | |
| Level 3 Maturity | | * Actively pursue own PDP capitalizing on your strengths rather than weaknesses * Conduct Weekly Core Staff Meetings * Conduct Annual Core Staff Performance Evals | |
| Level 5 Maturity | | * Actively pursue own Professional Development Plan (PDP) capitalizing on your strengths rather than weaknesses * Conduct Weekly Core Staff meetings * Conduct Bi-weekly 1:1 Core Staff Meetings * Facilitate Core Staff PDPs and review at each 1:1 meeting * Conduct Annual Core Staff Performance Evaluations | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **2. Set organizational tone and direction (reinforce mission core values)** | | |
| Level 1 Maturity | | * Decisions are made largely by intuition with little to no hard data | |
| Level 3 Maturity | | * Actively communicate Mission and Core Values using several modalities and creative redundancy to staff, volunteers, and donors * Targeted innovation is emphasized with Core Staff leveraging the 2 primary mission focus questions | |
| Level 5 Maturity | | * Actively communicate Mission and Core Values using several modalities and creative redundancy to staff, volunteers, and donors * Hold staff accountable to do the same * Targeted innovation is emphasized with Core Staff leveraging the 2 primary mission focus questions | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **3. Assure Quality Control in Patient Services across the network (reinforce culture of excellence)** | | |
| Level 1 Maturity | | * No clear service strategy is consistently, repeatedly used across the organization | |
| Level 3 Maturity | | * Identification and employment of linear service platform * Delineation of specific job functions to accomplish services | |
| Level 5 Maturity | | * Identification and employment of linear service platform * Delineation of specific job functions to accomplish services * Receive and review weekly and quarterly performance metrics regarding mission related services * Identification of cost per basic unit of service (i.e. life saved, woman served, day of organizational service) | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **4a. Increase Organizational Brand Equity by reinforcing organizational integrity through tangible mission accomplishment** | | |
| Level 1 Maturity | | * No consistent message or strategy is leveraged or sustained over the course of time around a highly defined and measurable mission | |
| Level 3 Maturity | | * Take responsibility for communicating * Write and ensure management of communication materials and messaging to all donors | |
| Level 5 Maturity | | * Maintain sole communication with media both reactively and proactively * Write and manage communication materials and messaging to all donors * Manage personal relationships with major donors * Determine Church communication strategy and ensure it is consistently maintained | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **4b. Determine and participate in volunteer acquisition (i.e. Vision Tours), training and retention process by department** | | |
| Level 1 Maturity | | * Volunteer acquisition process largely non-existent * Volunteer job function is loose and undefined | |
| Level 3 Maturity | | * Intentional Volunteer acquisition process * Execution of volunteer appreciation and retention strategy | |
| Level 5 Maturity | | * Identification of formal volunteer acquisition process * Determination and employment of volunteer training process by department and job function * Execution of volunteer appreciation and retention strategy | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **4c. Acquire and Maintain relationships for Money** | | |
| Level 1 Maturity | | * Loose to no intentional major donor, corporate, or foundation relationship development * Board is relied upon to raise funds | |
| Level 3 Maturity | | * Intentionally develop personal relationship with major donors * Identify Corporations and Foundations for relationship development and management | |
| Level 5 Maturity | | * Identify the definition of a major donor for the organization * Create list of existing and potential major donors * Intentionally develop personal relationship with those major donors * Identify Corporations and Foundations for relationship development and management | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **5. Acquire and Maintain relationships for Mission Advancement** | | |
| Level 1 Maturity | | * Unfocused board meetings with board development strategy centering around micro management | |
| Level 3 Maturity | | * With Board Directors via weekly communication with Board Chairman, Monthly communication with Executive Review Committee, and with Quarterly Board meetings | |
| Level 5 Maturity | | * With National affiliates and other training organizations * With Board Directors via weekly communication with Board Chairman, Monthly communication with Executive Review Committee, and with Quarterly panel meetings * With other high performance PRCs for idea sharing and encouragement | |
| Executive Maturity Level | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Executive Function** | **6. Manage Local Operational Development** | | |
| Level 1 Maturity | | * Hard questions are avoided for the sake of preserving ‘harmony’ * Board is relied upon to create and maintain budget | |
| Level 3 Maturity | | * **Ask hard questions to avoid mission drift** * Ensure proper policy and procedures so that the health of operational system is maintained * Oversee budget creation and management | |
| Level 5 Maturity | | * **Ask hard questions to avoid mission drift** * **Get right knowledge** by asking what needs to be done? And what is right for the PRC? * **Translate right knowledge into action by** creating an action plan, taking responsibility for decisions, taking responsibility for communicating and focusing on opportunities rather than problems * **Ensure organizational responsibility and accountability by** running productive meetings and by thinking ‘we’ instead of ‘I.’ * Ensure proper policy and procedures so that the health of operational system is maintained * Ensure budget is created and balanced for the purpose of; a) Determining what things get funded, b) what things do not get funded and c) for the purpose of focusing resources of all three divisions on mission | |
| Executive Maturity Level | |  |

**Executive Maturity Level Summary**

|  |  |
| --- | --- |
| Executive Function | Maturity Level |
| 1. Lead Core Staff into the fullness of their potential as leaders so that they can in turn do the same for their departmental staffing | 0 |
| 2. Set organizational tone and direction (reinforce mission core values) | 0 |
| 3. Assure Quality Control in Patient Services across the network (reinforce culture of excellence) | 0 |
| 4a. Increase Organizational Brand Equity by reinforcing organizational integrity through tangible mission accomplishment | 0 |
| 4b. Determine and participate in volunteer acquisition (i.e. Vision Tours), training and retention process by department | 0 |
| 4c. Acquire and Maintain relationships for Money | 0 |
| 5. Acquire and Maintain relationships for Mission Advancement | 0 |
| 6. Manage Local Operational Development | 0 |
| Total | 0 |
| Overall Maturity Level (Total ÷ 8) | 0 |

**Comments**

#### Appendix 19

### Exit Survey

**1) Which of the following times would be most convenient for you to come to CompassCare?***(Check all that apply.)*Weekdays Saturdays  
□ Morning (9am-12pm) □ Morning (9am-12pm)  
□ Afternoon (12pm-4pm) □ Afternoon (12pm-4pm)  
□ Evening (4pm-8pm) □ Evening (4pm-8pm)

**2) Which of the following advertisements have you seen or heard for CompassCare?***(Check all that apply.)*  
□ Yellow Pages Ad □ Radio Ad   
□ Website (Which Station? )  
□ College Campus Ad □ Friend Referral   
 (Where? ) (Who? )  
□ Professional Referral (Physician, School Nurse, etc.)  
 (Who? ) □ Other:

**3) Are there additional services CompassCare could offer that would be helpful to you or a friend?**

**4) Are there any factors that would stop you or a friend from seeking services from a service provider like CompassCare? If yes, what?**

**5) Would you recommend CompassCare to a friend?** □ Yes □ No  
Why or Why not?

**6) Please rate your overall CompassCare experience on a scale of 1 to 10:**  *(1=poor and 10=excellent)*

Your Name Nurse Date

#### Appendix 20

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| General Orientation Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *Pre-Orientation Tasks* | |  |  |  |
| * + Set up e-mail account for new employee | |  |  |  |
| * + Set up user access to the patient database (if necessary) | |  |  |  |
| * + Order name tag | |  |  |  |
| * + Send e-mail to staff introducing new member | |  |  |  |
| * *General Orientation* | |  |  |  |
| * + Introductions | |  |  |  |
| * + Discussion of Organizational structure (team structure, specific team objective, introduce team members, organizational culture) | |  |  |  |
| * + Discuss Mission Statement and our dedication to it.   + “To erase the need for abortion by transforming a woman’s fear into confidence.” | |  |  |  |
| * + Discuss Core Values:     - Fighting Spirit     - Relevance     - Accountability | |  |  |  |
| * + Office and Clinical Space Tour | |  |  |  |
| * + Provide keys, security codes, training on building access | |  |  |  |
| * + Train on accessing email, calendars, timesheet | |  |  |  |
| * + Review relevant policies and procedures; “List of Things Executive Absolutely Has to Know” | |  |  |  |
| * + Set up training schedule | |  |  |  |
| **Notes:** | | | | |
| **Trainer Signature:** | | **Date:** |  | |

#### Appendix 21

### Governing Board Requirements and Agenda

##### Typical Board of Directors Meeting Agenda

Name of Organization

Board of Directors Meeting

Day Month Day, Year; Time

Place of Meeting

Timeframe: No more than 90 Minutes

1. Opening Prayer
2. Call to Order
3. Establishment of a Quorum (note excused absences)
4. Review and Accept Previous Meeting Minutes
5. Review and Approve New/modified policies if any
6. Patient Resources Report
7. Medical Services Update
8. Financial

-Current situation review

1. Special Announcements

-Suggested Next Board Meeting

-Events, etc.

IX. Adjourn with Prayer

##### Required Annual (One Time) Board of Directors Actions

1. Provide regular governance through policy and procedure review
2. Budget Review and Approval
3. 990 Review prior to submission to IRS
4. Election of Officers
5. Review/Approve New Board Members
6. Executive Review and compensation approval (via Executive Review Committee tbd at officer election)
7. Appointment of Independent Auditor
8. Appoint Audit Review Committee to

-Review audit before finalized

-Meet with auditors to receive and review annual audit (and management letter if there is one) after finalized

##### General Categories of On-Going Required Board Duties

* Finances
* Executive Accountability
* Policy Setting
* Direction Setting
* Patient Care/Mission status review

#### Appendix 22

### Helpline Intake Form

Date Time Initials

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Demographic Information | | | Other Than Patient | | | | |
| Patient Name |  | | Caller Name | |  | | |
| LMP |  | |
| Appointment Day |  | | Caller Number | |  | | |
| Appointment Date |  | | Relationship | |  | | |
| Appointment Time |  | |
|  | | |  | | | | |
| **Preferred Appointment Confirmation**  *(Include “NO” for any or all methods that patient refuses for confirmation)* | | | **Confirmation Information** | | | | |
| Home/Mobile Phone | |  | Date Contacted |  | | Initials |  |
| Email Address | |  | Outcome: | □ No Answer | | □ Left Message | |
| Text Message (Mobile Phone #) | |  |  | □ Confirmed | | □ Cancel or R/S | |

|  |  |  |  |
| --- | --- | --- | --- |
| Purpose of Call | | Referral Source | |
| Patient Seeking Abortion Appointment |  | Phone Book |  |
| Pregnancy Test |  | Website |  |
| Ultrasound |  | Friend |  |
| STD Testing |  | Agency/Church (Name) |  |
| Counseling |  | Previous Visit (Date) |  |
| Reschedule |  | Walk-In |  |
| Other |  | Other |  |

**Helpliner Notes**

**Intention to Carry:** □ Abort □ Adopt □ Parent □ Undecided

**Abortion Vulnerability:** □ A/M □ A/V □ CTT □ N/A

|  |
| --- |
| Follow-Up Contact |
| No-Show Patient Was Called  Initials Date Time  Result  Rescheduled (Date) Cancelled  Notes |

#### Appendix 23

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Helpline Training Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *General Orientation* | |  |  |  |
| * + Use the General Orientation Checklist | |  |  |  |
| * *Self-Learning Modules (Read, Return Questions to Training Coach and Review Answers)* | |  |  |  |
| * + Module 1: PRC Culture and Systems | |  |  |  |
| * + Module 2: Societal Costs of Abortion, History of Abortion, Biblical View of the Pre-born | |  |  |  |
| * + Module 3: Optimization Tool©: Medical Services Personnel, 15-Step Patient Flow Process | |  |  |  |
| * + Module 4: Communicating and Connecting | |  |  |  |
| * + Module 5: The Seven Fundamentals | |  |  |  |
| * *Helpline Call Training* | |  |  |  |
| * + Role Objective: Refer to OT manual | |  |  |  |
| * + Listen to recorded Helpline Training Sessions (PPT #3a-b) | |  |  |  |
| * + Our goal with every call:   + Connect with the individual calling, helping them to feel comfortable   + Affirm her and that her situation is difficult.   + Communicate value and expectation- why she should come to PRC and what services she will receive at her appointment.   + Closing- “seal the deal,” schedule the appointment   + Maintain a high level of professionalism – minimal noise in background, tone of voice etc. | |  |  |  |
| * + Train Helpliner on pregnancy patient script and STD patient script (if applicable). | |  |  |  |
| * *Metrics Training* | |  |  |  |
| * + Review of Metrics   + Numbers of patients who schedule. Goal: 75-95%   + Numbers of patients who show for their appointment. Goal: 70-90% | |  |  |  |
| * + Interpretation of poor metrics:   + Data entry problem   + The process is not being executed properly: scripts, goals for each call, etc.   + The process itself is no longer working. | |  |  |  |
| * *Role Play Training* | |  |  |  |
| * + Abortion minded patient | |  |  |  |
| * + Abortion vulnerable patient | |  |  |  |
| * + STD patient (if applicable) | |  |  |  |
| * + New patient unspecified | |  |  |  |
| * + Confirmation Call | |  |  |  |

(continued…)

|  |  |  |  |
| --- | --- | --- | --- |
| * *Information Technology Training* |  |  |  |
| * + Give account number and password |  |  |  |
| * + Calendar training: Input Patient Name, LMP, intention to carry, referral source, permission to confirm, phone number, details pt. gives in conversation.   + Note: if using an online calendar enter only de-identified patient information such as first name or initials. |  |  |  |
| * + Canceled patient: Type CXL before patient’s name, but leave information on the calendar and write details in the “description box” |  |  |  |
| * + When confirming, enter outcome in the “description” box with your initials on the calendar. |  |  |  |
| * + Database training (if Helpliners will enter data directly into database) |  |  |  |
| * + Enter information for each patient: Refer to HL checklist |  |  |  |
| * + All information needs to be entered by the end of that business day |  |  |  |
| * *Smart Phone Training (if applicable)* |  |  |  |
| * + Contacts |  |  |  |
| * + Home screen use during a call |  |  |  |
| * + Texting (specifically the Nurseline) |  |  |  |
| * + Scheduling from the phone |  |  |  |
| * + Rolling the phone (Refer to phone list for numbers) |  |  |  |
| **Notes:** | | | |
| **Trainer Signature:** | **Date:** |  | |

#### Appendix 24

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Helpliner Checklist | | | | | | | | | |
| **Yes** | **No** | | **N/A** | **Job Function** | | | | | |
|  |  | |  | I called each patient scheduled for the next business day and confirmed appointment, documenting call and outcome on the appointment event. | | | | | |
|  |  | |  | For each caller, I went through all 3 of these statements: | | | | | |
|  |  | |  |  | We need to find out if you’re pregnant. | | | | |
|  |  | |  |  | Once your pregnancy is confirmed, we need to find out exactly how far along you are. | | | | |
|  |  | |  |  | You need to have STD testing. | | | | |
|  |  | |  | I used the PRC Helpline script to schedule patients. | | | | | |
|  |  | |  | I confirmed appointment location and directions for each patient. | | | | | |
|  |  | |  | I filled out the *Helpline Intake Form* for each call, even if no appointment was made, and attached to the appointment event if applicable. | | | | | |
|  |  | |  | I accurately and completely updated the *Helpline Intake Form* for any rescheduled calls, and attached updated form to rescheduled appointment event. | | | | | |
|  |  | |  | I directed all non-patient related calls to the administrative line. | | | | | |
|  |  | |  | I forwarded the phones to the next Helpliner after my shift was over. | | | | | |
|  |  | |  | I prayed with the next Helpliner on the shift. | | | | | |
|  |  | |  | I embraced the three core values of the organization:   1. Fighting Spirit 2. Relevance 3. Accountability | | | | | |
|  | | | | Number of Helpline Calls answered today (not including Admin and wrong numbers) | | | | | |
| **Comments/Questions:** | | | |  | | | | | |
| **Helpliner Signature:** | | | |  | | | | **Date:** |  |
| **Time In:** | |  | | | | **Time Out:** |  | **Total:** |  |

#### Appendix 25

Today’s Date:

### Initial Visit Health Questionnaire

Name: DOB:

Gender: □ Male □ Female □ STD Pt □ Pregnancy Pt

Chief Complaint:

##### **STD Patients Only:**

**# of Sexual Partners** in the past 90 days:

**# of Times You’ve Had Sex** in the past 90 days:

###### Have you ever:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Given | | Received | |
| Anal Sex? |  | M |  | M/F |
| Vaginal Sex? |  | M |  | F |
| Oral Sex? |  | M/F |  | M/F |

###### Do you have any of the following?

Sore throat □ Yes □ No Frequent urination □ Yes □ No

Genital pain □ Yes □ No Pain/Burning with urination □ Yes □ No

Abnormal discharge/odor □ Yes □ No Blood in urine □ Yes □ No

##### **All Patients:**

When was your last STD test? □ Never □ Date:

Have you had any sexual exposure to a person with a known STD? □ Yes □ No

If yes, when and to what? Date: STD:

Have you ever had an STD? □ Yes □ No

If yes, when? Date:

Which STD? □ HIV □ Hepatitis (A / B / C) □ Chlamydia □ Gonorrhea

□ Syphilis □ Genital Warts □ Herpes

□ Other:

Do you use any of the following? If Yes, please specify:

Over the Counter or Prescription Medications □ Yes, □ No

Other Drugs □ Yes □ No

Cigarettes □ Yes □ No

Alcohol □ Yes □ No

Are you allergic to latex? □ Yes □ No

Are you allergic to any foods or medications? □ Yes □ No

If yes, please list medication and reaction.

Any other health conditions/symptoms/concerns?

##### **Pregnancy and Female STD Patients Only:**

###### OB/GYN History

How many times have you:

Been pregnant?

Delivered how many children? Delivered premature before 37 wks?

Miscarried? Ectopic pregnancy?

Had an abortion? \_\_\_\_\_\_\_\_ If > 0: □ Medical □ Surgical Date: \_\_\_\_\_\_\_\_\_ How far along? \_\_\_\_\_\_\_\_

Have you ever had:

Cesarean section? □ Yes □ No

Infertility? □ Yes □ No

Other problems with pregnancy? □ Yes □ No

An abnormal PAP smear? □ Yes □ No

Date of last PAP:

Name of OB/GYN Physician:

###### Current Health History

When was the first day of your last period?

Was it normal or different than usual? □ Normal □ Abnormal

Are your periods regular? □ Yes □ No How often do you have a period? Every days.

What kind of birth control have you been using, if any?

When did you last use any hormonal birth control?

###### Do you or have you had any of the following?

Abdominal pain/cramps: □ Yes □ No

If yes, is it greater than your period? □ Yes □ No

Is the pain □ Consistent or □ Intermittent?

Vaginal bleeding/spotting: □ Yes □ No

Vaginal discharge: □ Yes □ No

If yes, does it have an odor? □ Yes □ No

Does it have color? □ Yes □ No

If yes, what color is it?

Nausea: □ Yes □ No

Vomiting: □ Yes □ No

Breast tenderness: □ Yes □ No

Family History of Breast Cancer: □ Yes □ No

##### **FOR COMPASSCARE OFFICE USE ONLY**

###### Pregnancy Test Results: □ **Positive** □ **Negative**

*I have reviewed the above information with the patient.*

Nurse Signature:

Title: Date:

#### Appendix 26

### Instructions for Establishing Contract for STD Testing

1. Meet with Medical Director to review & implement nurse administered pregnancy and STD testing.
2. Contact CDD to initiate contract for Gonorrhea and Chlamydia testing   
    *CDD- Mike Kossman, 3370 Nacogdoches, Suite 100, San Antonio, Texas 78217  
    (P) 888-858-8663 x214,* [Mike@cddmedical.com](mailto:Mike@cddmedical.com)*,* [www.cddmedical.com](http://www.cddmedical.com/)
3. Follow instructions given by CDD for on-going processing of samples and results retrieval.

#### Appendix 27

### Interview Questions for Volunteer or Staff Positions

1. Tell me about yourself.
2. What do you know about our organization?
3. Why do you want to work for us?
4. Do you believe it is possible to accomplish the mission of erasing the need for abortion?
5. Why should we hire you? What do you bring to the table?
   1. Strengths
   2. Weaknesses
6. What do you look for in a job?
7. Describe a time when you had to make a difficult decision. What were the results?
8. Where do you see yourself in five years? What are your long-term plans?
9. What didn’t you like about your last supervisor?
10. How would you see us working together/accomplishing the goals of the organization?
11. Have you ever led anyone to the Lord?
12. How would you describe:
    1. your temperament?
    2. personality?
    3. background?
    4. experiences?
    5. skills?
    6. passion?
13. What would it mean to you to be moving into a ministry environment?
14. Tell me your Testimony.
15. Describe your last position and organization (scarcity defined by what is lacked).
16. What has been the greatest era of challenge for you?
17. Do you prefer innovating or doing something that has been done before?
18. Do you like to read? If so what?
19. Learning Style:
    1. Best day of work in the last 3 mo.?
    2. Worst day? Why?
    3. Best manager relationship? Why
    4. When did you learn the most? Why?

#### Appendix 28

### Limitations of Service

Last Name: First Name: Date:

1. [Name of PRC] is a non-profit organization. All of our services are free, including a urine pregnancy test, ultrasound if that test is positive, and Sexually Transmitted Disease (STD) testing, as well as a situational assessment and personalized pregnancy options consultation provided by a Nurse.
2. The medical services are all referrals and are not performed or provided by [Name of PRC] but rather by licensed medical professionals. A physician must confirm your pregnancy test with an ultrasound to determine viability.
3. Whether the pregnancy or STD test is positive or negative, you should consult with a licensed physician. If you do not have a physician, your Nurse will offer referrals including that for our medical director, [Medical Director].
4. Our Nurses are all trained in crisis counseling though not necessarily licensed or degreed personnel. The counseling obtained here is not intended as a substitute for professional counseling.
5. All information is kept confidential except if child abuse or other mandated reporting laws apply or if we believe or hear that you are in danger of hurting yourself or others.
6. [Name of PRC] does not perform or refer for abortion, which includes not providing confirmation of pregnancy for abortion retention purposes.
7. [Name of PRC] does not profit from your decision.

*I have read and understood the above and hereby authorize the staff of this office to render whatever services are necessary for my care.*

**Patient Signature:** Date:

Staff Signature: Date:

#### Appendix 29

### Medical Exam Report

Name: Date: Ultrasound #:

**Orders:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Urine Pregnancy Testing | Results: + / - | | | Nurse Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Gonorrhea and Chlamydia Testing | | | | |
| □ Prenatal Vitamin Sample: PrimaCare ONE/PrimaCare | Lot Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Please do limited OB ultrasound indication | | To confirm pregnancy and determine gestational age. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | MD | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Problem list and plans:** see health questionnaire

pt was given Verification of Positive Pregnancy Test for insurance purposes

pt signed Release of Medical Information Form

pt to follow up with a physician of her choosing, referred to own

pt was referred to Hospital emergency room via ambulance

Signature of nurse completing exam: \_\_\_\_ RN/LPN/RDMS \_\_\_\_ /\_\_\_\_ /\_\_\_\_

**Ultrasound not performed:** □ Negative Test □ Patient Refused □ Bleeding/Increased Pain   
 □ Too early; GA by LMP: Weeks, Days

**Ultrasound Exam Report:**

Date of U/S: Abdominal: Transvaginal:

FHR: Fetal Number:

GS: \_\_\_\_\_\_cm x \_\_\_\_\_\_cm x \_\_\_\_\_\_cm CRL: \_\_\_\_\_\_\_cm BPD: \_\_\_\_\_\_\_cm

LMP: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gestational Age by LMP: \_\_\_\_\_\_\_ weeks \_\_\_\_\_\_\_ days EDC by LMP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gestational Age by U/S: \_\_\_\_\_\_\_ weeks \_\_\_\_\_\_\_ days EDC by U/S \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Ultrasound Notes:**

pt was given “So, You’re Pregnant” brochure

pt was given “Unable To Confirm Viability of Pregnancy” brochure

pt to follow up for repeat ultrasound/STD results \_\_\_\_ /\_\_\_\_ /\_\_\_\_ @ \_\_\_\_\_ AM / PM

Signature of person completing exam: \_\_\_\_ RN/LPN/RDMS Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_

Physician signature for review of the chart: \_\_\_\_\_\_\_\_\_ \_\_ Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_

**STD Testing:**

□ Positive Results reported to pt \_\_\_\_ /\_\_\_\_ /\_\_\_\_ by

□ Negative Results

**Medical Follow Up Report:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| \_\_\_\_ /\_\_\_\_ /\_\_\_\_ | 1st phone attempt | □ | \_\_\_\_ /\_\_\_\_ /\_\_\_\_ | Contact made with patient and plan discussed | **□** |
| **\_\_\_\_ /\_\_\_\_ /\_\_\_\_** | 2nd phone attempt | □ | \_\_\_\_ /\_\_\_\_ /\_\_\_\_ | Registered letter with return receipt sent | □ |
| **\_\_\_\_ /\_\_\_\_ /\_\_\_\_** | 3rd phone attempt | □ | \_\_\_\_ /\_\_\_\_ /\_\_\_\_ | Receipt/letter returned (filed in chart) | □ |

Medical Director Signature for final review of the chart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Appendix 30

### Medical Services Agreement

For Medical Director related to Pregnancy Services

This Medical Services Agreement is made between (PRC), and , MD (Physician).

Whereas, Physician is a Medical Doctor licensed to practice medicine in the State of and is interested in providing professional medical services to assist men and women facing unplanned pregnancy and sexually transmitted disease, and is desirous of providing limited prenatal medical services to patients free of charge;

Whereas, PRC is a tax-exempt non-profit corporation organized under the laws of New York which assists licensed medical providers in the administration of their practices;

Therefore it is agreed that PRC shall perform Medical Practice Administration Services on behalf of the Physician and his/her patients under the terms and conditions set forth herein:

1. The Duties of PRC.
   1. Governance and Organizational Dynamics
      1. PRC shall provide executive leadership and strategic planning for the management of the Physician’s professional medical services.
      2. The executive leadership will be accountable to a local board of directors and to the Physician.
   2. Public Relations. PRC shall manage all public relations related to the medical services provided by the Physician at PRC, including but not limited to media contacts, crisis communications, social media engagement, and government relations.
   3. Confidentiality
      1. PRC shall be responsible for the confidentiality of all programmatic elements of patient services, and the information technology tools which manage schedules, patient data, and all other private information.
      2. PRC shall manage the security of medical records for patients of the Physician served at PRC.
   4. Finance. PRC shall manage all accounting associated with the Physician’s delivery of medical services at PRC, including payroll and bookkeeping.
   5. Human Resources
      1. PRC shall provide other medical personnel to assist the Physician as directed by the Physician to meet the medical needs of patients.
      2. PRC shall pay for and manage all issues related to the employment of medical personnel hired to assist the Physician.
   6. Planning and Marketing. PRC shall manage all planning and marketing services for the Physician, including the use of the CompassCare brand and logo on all media.
   7. Risk Management
      1. PRC shall provide the Physician with professional liability insurance coverage for the medical services he/she provides to patients on the PRC premises.
      2. PRC shall provide for professional liability insurance coverage for all medical professionals assisting the Physician at PRC, or shall confirm that each medical professional has provided his/her own professional liability insurance coverage.
      3. PRC shall provide general liability coverage for the premises.
   8. Operations
      1. PRC shall provide space to be used by the Physician on the premises of PRC located at [Address] which shall be known as “exam rooms.” The Physician shall have use of the exam rooms for purposes of providing medical examinations to patients.
      2. PRC shall provide equipment in the exam rooms, including but not limited to exam tables, ultrasound machine and other equipment and supplies to be utilized by the Physician and the medical professionals he/she is supervising. PRC shall be responsible for all maintenance and repairs to the equipment.
      3. PRC shall manage all patient service delivery processes in concert with the Physician.
2. The Duties of the Physician.
   1. Medical Services
      1. The Physician shall exercise direct supervision and control over the medical treatment of his/her patients at PRC.
      2. The physician shall provide professional medical services on an as-needed basis including, but not limited to, pregnancy confirmation, limited Sexually Transmitted Disease (STD) screening, diagnosis, treatment and follow-up in addition to ultrasound exams.
   2. Training and Supervision. The Physician shall provide appropriate training, supervision and review of services rendered by other medical professionals involved in the medical care of patients at PRC.
   3. Continuity of Care
      1. The Physician shall review and maintain appropriate medical charts.
      2. The Physician shall make appropriate referrals as necessary for each patient.
   4. Collaborative Physician. The Physician shall act as a backup physician to other Medical Directors whose services are managed by PRC.
3. Policies and Procedures. PRC and the Physician shall develop policies and procedures related to STD medical services in order to facilitate the highest standard of ethical medical care for the Physician’s patients at PRC.
4. Term. The initial term of this Agreement shall commence on Date and shall continue for one (1) year or until such time as the agreement can be adequately reevaluated by the parties. Either party may terminate this Agreement upon thirty (30) days written notice to the other party.
5. Modifications. This Agreement may be amended or modified only by written documentation signed by both parties hereto.

In Witness hereof, the parties execute this Agreement:

Physician

Dated:

*(Physical Name)*

PRC

Dated:

*(PRC Exec)*

#### Appendix 31

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medical Services Director Training Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *General Orientation* | |  |  |  |
| * + Add the new MS Director to the database and give user access to the database and reporting website. | |  |  |  |
| * + Use the General Orientation Checklist for new staff | |  |  |  |
| * *Training Preparation* | |  |  |  |
| * + Establish weekly or bi-weekly 1:1 meeting time with your PR Coach and add to your calendar as a recurring event | |  |  |  |
| * + Complete RN Training Checklist and make sure you have completed all areas of training listed there. Use this checklist to train new nurses. | |  |  |  |
| * + Familiarize yourself with the MS Director Job Functions | |  |  |  |
| * + Complete MS Director Job Function Worksheet to assess current maturity level, and review with Executive. Identify areas of focus for improvement. | |  |  |  |
| * *Self-Learning Modules (Read, Return Questions to Training Coach and Review Answers)* | |  |  |  |
| * + Module 1: PRC Culture and Systems | |  |  |  |
| * + Module 2: Societal Costs of Abortion, History of Abortion, Biblical View of the Pre-born | |  |  |  |
| * + Module 3: Optimization Tool©: Patient Resources Personnel, 15-Step Patient Flow Process | |  |  |  |
| * + Module 4: Communicating and Connecting | |  |  |  |
| * + Module 5: The Seven Fundamentals | |  |  |  |
| * + Module 6: STD Testing | |  |  |  |
| * + Module 7: Health Questionnaire | |  |  |  |
| * + Module 8: The Ultrasound Exam | |  |  |  |
| * *MS Director Training* | |  |  |  |
| * + Read entire OT Manual Medical Services Section and Whitepapers. Make notes of questions to be discussed with your Training Coach. | |  |  |  |
| * + Review database training for your database application. | |  |  |  |
| * + Listen to all PPT recorded sessions, making notes of questions to be discussed with your Training Coach. | |  |  |  |
| * + Watch Patient Process DVD | |  |  |  |
| * + Review all relevant Forms | |  |  |  |
| * + Read Volunteer Revolution by Bill Hybels. Other suggested reading:   + Good to Great and the Social Sectors by Jim Collins   + The E-Myth Revisited by Michael Gerber,   + The Five Dysfunctions of a Team by Patrick Lencioni.   + The One-Minute Manager by Kenneth Blanchard   + Silos, Politics and Turfwars by Patrick Lencioni | |  |  |  |
| * + Complete free online Excel Training at [www.alison.com](http://www.alison.com) | |  |  |  |
| * + Complete CDD software Training | |  |  |  |
| * *MS Director Training Follow-up* | |  |  |  |
| * + Repeat completion of MS Director Job Function Worksheet to reevaluate maturity and review with Executive | |  |  |  |
| **Trainer Signature:** | | **Date:** |  | |

#### Appendix 32

### Model/Photo Release

In exchange for consideration received, I hereby give permission to CompassCare Pregnancy Services to use my name and photographic likeness in all forms and media for advertising, trade, and any other lawful purposes.

In addition, I give permission to CompassCare Pregnancy Services to use my child(ren)’s name and photographic likeness in all forms and media for advertising, trade, and any other lawful purposes.

Name of Child(ren):

By signing this release, I am acknowledging that I am the parent/legal guardian of the above-named child(ren), and that I have read this release and approve of its terms.

Print Name:

Signature: Date:

#### Appendix 33

### Negative Pregnancy Test Follow-Up Form

Patient Name:

Date First Seen: Today’s Date:

1. Did you get your period? If yes, when? Was it normal?
2. Have you had any other medical issues since you were first in our office?
3. If you did not get your period, may I reschedule you for a repeat pregnancy test appointment?  
   Appointment Date:   
   Appointment Time:
4. Is there anything else we can help you with?

Nurse Signature: Date:

#### Appendix 34

### Normal Certified Letter

[Medical Director], MD

[Date]

[Patient Full Name]

[Street Address]

[City], [State] [Zip Code]

Dear [Patient’s First Name],

I hope you are doing well. Following [Medical Director]’s review of your ultrasound from [Ultrasound Date], I have tried to contact you. Please give me a call at [contact number] upon receipt of this letter to schedule an appointment, or to confirm your physician’s care.

Respectfully,

[Nursing Team Leader]

Nursing Team Leader

#### Appendix 35

### Nurse Job Function Checklist

Nurses should check the following items at the completion of each patient appointment, and initial items completed.

Type of appointment performed:   
 □ Initial Visit  
 □ Return Visit

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Initial Appointment* | | | | |
| **Yes** | **No** | **N/A** | **Task to be Completed per Appointment** | **Notes/Comments** |
|  |  |  | Uniform is worn during scheduled shift (Blue scrubs; white shirt or lab coat) |  |
|  |  |  | Followed Scripting for all of the following steps:   * Review Limitation of Services * Situation Assessment (using intake) * Options Presentation * Support System Review (using PRL) * Report pregnancy test results * Review HQ * Present STD testing * Present and perform ultrasound |  |
|  |  |  | Pt given brochure for STD testing |  |
|  |  |  | STD Consent signed |  |
|  |  |  | Rescheduled patient for STD results appointment |  |
|  |  | ------ | **Negative Pregnancy Test:** | If yes, complete the following. |
|  |  |  | Initial Visit HQ completed using only information from the HQ breakdown |  |
|  |  |  | Brochures given per OT: *Healthy Choices; Sex, Been There, Done That, Now What?* |  |
|  |  |  | Patient referred to her/a physician |  |
|  |  | ------ | **Positive Pregnancy Test:** | If yes, complete the following. |
|  |  |  | Initial Visit HQ completed using only information from the HQ breakdown |  |
|  |  |  | Ultrasound Consent signed |  |
|  |  |  | Followed ultrasound routine |  |
|  |  |  | Gave appropriate brochure based on results of ultrasound exam: |  |
|  |  |  | * “So You’re Pregnant” (if able to confirm pregnancy) |  |
|  |  |  | * “Unable to Confirm…” |  |
|  |  |  | Gave Doctor referral |  |
|  |  |  | Rescheduled pt. per P&P for repeat U/S |  |
|  |  |  | Completed PT, STD and U/S logs as applicable |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Return Appointment* | | | | |
| **Yes** | **No** | **N/A** | **Task to be Completed per Appointment** | **Notes/Comments** |
|  |  |  | Pregnancy test was repeated | If positive, complete the Positive Pregnancy Test section above. |
|  |  |  | Followed scripting for reporting pregnancy test results |  |
|  |  |  | Return Visit HQ completed |  |
|  |  |  | If negative PT, reviewed material given at previous appointment and answered any questions patient had. |  |
|  |  |  | Reported STD results to patient |  |
|  |  |  | Referred patient per OT for treatment of positive results |  |
|  |  |  | Used scripts for presenting ultrasound exam |  |
|  |  |  | Ultrasound Consent signed |  |
|  |  |  | Followed ultrasound routine |  |
|  |  |  | Followed ultrasound scripting during the exam |  |
|  |  |  | Gave appropriate brochures following exam |  |
|  |  |  | * “So You’re Pregnant” (if able to confirm pregnancy) |  |
|  |  |  | * “Unable to Confirm…” |  |
|  |  |  | Completed PT, STD and U/S logs as applicable |  |

**Did anything not work well with this patient?**

**Did anything work in an outstanding way with this patient?**

**Additional Comments:**

I embraced the three core values of CompassCare today:

* Fighting Spirit
* Relevance
* Accountability

Signature: Date: / /

#### Appendix 36

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Nurse/Sonographer Training Checklist | | | | |
| **Trainee’s Name:** | **Training Start Date:** | **Scheduled Date** | **Completed Date** | **Trainer Initials** |
| * *General Orientation* | |  |  |  |
| * + Use the General Orientation Checklist | |  |  |  |
| * *Self-Learning Modules (Read, Return Questions to Training Coach and Review Answers)* | |  |  |  |
| * + Module 1: PRC Culture and Systems | |  |  |  |
| * + Module 2: Societal Costs of Abortion, History of Abortion, Biblical View of the Pre-born | |  |  |  |
| * + Module 3: Optimization Tool©: Patient Resources Personnel, 15-Step Patient Flow Process | |  |  |  |
| * + Module 4: Communicating and Connecting | |  |  |  |
| * + Module 5: The Seven Fundamentals | |  |  |  |
| * + Module 6: STD Testing | |  |  |  |
| * + Module 7: Health Questionnaire | |  |  |  |
| * + Module 8: The Ultrasound Exam | |  |  |  |
| * *Patient Platform Training* | |  |  |  |
| * + Read entire OT manual Medical Services Section and Whitepapers | |  |  |  |
| * + Listen to PPT recorded sessions   + PPT 1 Introduction   + PPT 8 Health Questionnaire   + PPT 9a Ultrasound   + PPT 9b Return Ultrasound | |  |  |  |
| * + Watch Patient Process DVD | |  |  |  |
| * + Review all relevant Forms | |  |  |  |
| * *RN Task Training* | |  |  |  |
| * + Pregnancy Test and Results Presentation | |  |  |  |
| * + Health Questionnaire | |  |  |  |
| * + Consent Forms | |  |  |  |
| * + Use of Brochures | |  |  |  |
| * + Follow-up: Pregnancy Confirmation | |  |  |  |
| * + Scheduling Return Appointments | |  |  |  |
| * + Return Appointment Process and Health Questionnaire | |  |  |  |
| * + For pregnancy test | |  |  |  |
| * + For second ultrasound | |  |  |  |
| * + For STD results | |  |  |  |
| * + Inventory/Ordering Training | |  |  |  |
| * + Review process for documenting inventory of current supplies | |  |  |  |
| * + Training on ordering process | |  |  |  |
| * *Ultrasound Training* | |  |  |  |
| * + Initial technique training with content expert (8-10 hours) | |  |  |  |
| * + Skills acquisition, ongoing model/patient scanning with approved nurse or sonographer (Keep copies of pictures of all scans observed or performed, record on U/S Training log) | |  |  |  |
| * + Medical Director approval of proficiency (approve RN to scan alone) | |  |  |  |
| * *CPR/AED Adult Training (or current certification)* | |  |  |  |
| **Trainer Signature:** | | **Date:** |  | |

#### Appendix 37

### Password Protecting Documents

##### This document contains instructions on:

1. How to Create Strong and Memorable Passwords
2. How to Password Protect Microsoft Excel 2003 Workbooks
3. How to Password Protect Microsoft Word 2003 Documents

**Note**: If you are using a different version of Excel or Word, the instructions might be slightly different. If you need to, consult the Help function of your version for assistance by typing “password protect” into the help search bar.

##### 1. How to Create Strong and Memorable Passwords

Strong passwords need to be complex enough so that they are not easily guessed by others. At the same time, if it is so complex that you can’t remember it, it does you no good. Coming up with a strong password that is easy to remember is a key to using your passwords successfully.

###### Strong Passwords

Strong passwords must be a minimum of 6 characters long (although 7 or 8 would be better) and must incorporate at least 2 of the following characteristics (although 3 would be better):

1. Any lower case letter (a – z)
2. Any upper case letter (A – Z)
3. Any number (0 – 9)
4. Any symbol (punctuation or non-alphanumeric characters) found on a standard ASCII keyboard   
   (! @ # $ % ^ & \* () \_ - + = ? > < ~ )

###### Memorable Passwords

Try this technique in creating a strong and memorable password.

To make the password:

1. Pick a phrase that you know well or make up one that is easy for you to remember.
2. Use the first letter of each word in the phrase to make the password.
3. Replace some of the letters with numbers or symbols to add complexity.

For example,

1. “I pledge allegiance to the flag…” could become the password – iPa2tF
2. If you are a dog lover, “I bought my dog on May 11th” could become – IbMd5/11 or IbmD5-11
3. If you are not a pet lover, “I hate cats” could become the password – iH8Tk@tz

When it is time to enter your password, say your phrase *to yourself* and enter the password.

###### Weak Passwords to Avoid

Do not create passwords that use the following conventions:

1. Common default passwords such as “password”, etc.
2. Sequences or repeated characters. "12345678," "222222," "abcdefg," or adjacent letters on your keyboard
3. Your name or variations of your name
4. Your organization’s name or variations of that name
5. The name of pets, children, favorite sports teams, etc.
6. Your birthday or other significant date
7. Phone numbers

##### 2. How to Password Protect **Microsoft Excel** Workbooks

1. Open the Excel spreadsheet to be password protected.
2. From the **Tools** menu, select **Options**.
   1. The Options window will appear.
3. Select the **Security** tab.

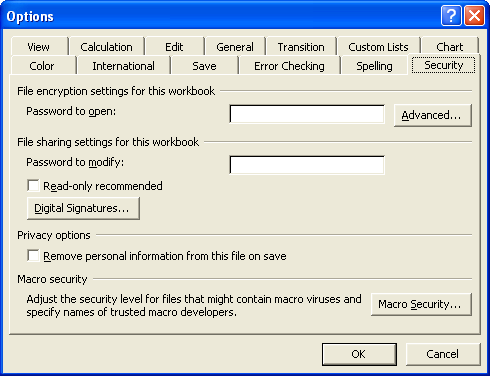


Figure 16: Microsoft Excel 2003 Options Window

1. In the **Password to open** box, enter your password.
   1. See “How to make a good password” section in these instructions.
2. Select the **OK** button.
   1. The **Confirm Password** window will appear.

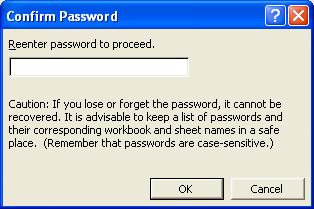


Figure 17: Microsoft Excel 2003 Confirm Password Window

1. Reenter your password.
2. Select the **OK** button.
   1. The **Confirm Password** and **Options** windows will close.

When anyone opens this document, the **Password** window will appear and they will be required to enter the correct password and then select OK to open the document.



Figure 18: Microsoft Excel 2003 Password Window

##### 3. How to Password Protect **Microsoft Word** Documents

1. Open the Word document to be password protected.
2. From the **Tools** menu, select **Options**.
   1. The Options window will appear.
3. Select the **Security** tab.

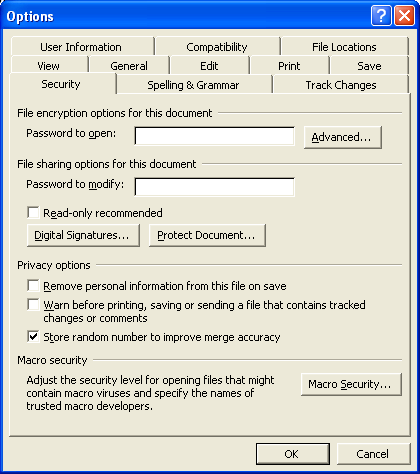


Figure 19: Microsoft Word 2003 Options Window

1. In the **Password to open** box, enter your password.   
   See “How to make a good password” section in these instructions.
2. Select the **OK** button.
   1. The **Confirm Password** window will appear.



Figure 20: Microsoft Word 2003 Confirm Password Window

1. Reenter your password.
2. Select the **OK** button.
   1. The **Confirm Password** and **Options** windows will close.

When anyone opens this document, the **Password** window will appear and they will be required to enter the correct password and then select OK to open the document.

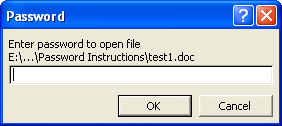


Figure 21: Microsoft Word 2003 Password Window

#### Appendix 38

### Patient Contact Form

Patient’s Name:

Date First Seen:

Please date and sign each entry.

Page of

#### Appendix 39

### Patient Follow-Up Form

##### 4 8 16 Weeks (circle one)

Patient Name:

Date First Seen: Today’s Date:

1. How are you feeling?  
   □ Physically:   
   □ Emotionally:
2. Describe your relationships with Family/Boyfriend and your support system:
3. Have you followed up with the referrals provided on your Patient Resource List (PRL)?  
   □ Physician Name:

□ Physician Phone:   
□ Other Referral Notes:

1. Do you need any additional resources or referrals?
2. Have you decided what the outcome of your pregnancy will be?  
   *(Only ask if outcome is not known from previous follow-up.)*□ Parent □ Abort □ Adopt □ Undecided
3. Is there anything else we can help you with?

Notes:

RN Signature: Date:

#### Appendix 40

### Patient Information

Patient ID: (for Office Use Only)

Name:

Address:

City: State: Zip Code:

Age: \_\_\_\_\_ Birth Date: Previous Visit? □ Yes □ No Date:

How may we contact you? □ Phone □ Email □ Mail  
 *(Please check all that apply)* □ Leave message?   
 □ Say [Name of PRC]?

Primary Phone: Alternate Phone:   
 □ Home □ Work □ Cell □ Home □ Work □ Cell

Best Time to Call: Email Address:

##### Education

School Year Completed (Circle One):

Occupation: Business/School Name:

##### Marital Status

□ Single □ Married □ Separated □ Divorced □ Widowed □ Unknown

##### Ethnicity

□ Caucasian □ African-American □ Asian □ Hispanic □ Native American □ Other:

##### Referral Source

□ Phonebook □ Website □ Radio □ Friend □ School □ Other

##### Emergency Contact Information

Name:

Relationship to Patient:

Primary Phone: Alternate Phone:

##### Insurance Information

***STD Patients Only:***Do you have health insurance? (If yes, please give card to receptionist) □ Yes □ No

#### Appendix 41

### Patient Intake Form

##### Situational Assessment

###### Reason for Today’s Visit

###### Pregnancy Test Information

1st Day of Last Period (LMP) Date PT Taken

Weeks of Gestation from LMP □ Home □ Positive

Expected Due Date from LMP □ Dr’s Office □ Negative

###### Intention to Carry

How do you feel about potentially being pregnant?

**If your test is positive, what are your intentions?**

□ **Parent □ Abort □ Adopt □ Undecided**

##### Support System Review

What is the father of the baby’s First Name?

Does the father of the baby know you are here today? □ Yes □ No

Did the father of the baby come here with you today? □ Yes □ No

What decision would the father of the baby like you to make regarding the outcome of your pregnancy?

Who will support you if you choose to continue your pregnancy?

Who will support you if you decide not to continue your pregnancy?

##### Options Presentation

|  |  |  |
| --- | --- | --- |
| Complete Presentation | Option | Patient’s Response |
| □ | Abortion |  |
| □ | Adoption |  |
| □ | Parenting |  |

* Support System Review Using PRL
* Ultrasound Exam/Medical Exam Report
* Delivery of Patient Resource List

##### Abortion Vulnerability

|  |  |  |  |
| --- | --- | --- | --- |
|  | Risk Factors | | Explain Patient Details (Complete applicable lines) |
| □ | Still in school (H.S./college/grad) | |  |
| □ | Between 17 and 26 years old | |  |
| □ | Father of baby in favor of abortion | |  |
| □ | Parents in favor of abortion | |  |
| □ | History of abortion | |  |
| □ | Financial pressure | |  |
| □ | Single | |  |
| □ | Patient states intention to abort (AM, regardless of other risk factors) | |  |
|  | **=** |  |  |
| Total | Abortion Vulnerability | Key: 0 = CTT, 1-3 = AV, 4-7 = AM |

##### Church Background

Religious Affiliation:

Are you currently active in a church? □ Yes □ No

Name of Church:

##### Evangelism Summary

* Patient claims to already be a Christian
* I gave a complete/thorough presentation of the Gospel  
  *Patient’s response to Gospel presentation:*   
  *If the patient did not respond positively what is preventing her from receiving Christ?*
* Patient accepted Christ
* We had a Christ-centered religious discussion, but I did not present the Gospel  
  *I did not give a complete presentation because:*

##### Closing Summary

1. “Is there any other information you feel you need to make an informed decision?”
2. “Having received your Patient Resource List and all the other information from CompassCare today, what do you think the outcome of your pregnancy will be?”

□ Parent □ Abort □ Adopt □ Undecided

##### Other Notes

#### Appendix 42

|  |  |  |
| --- | --- | --- |
| Patient Interaction Tracking Form | | |
| *Patient Name:* | | |
| **Patient Interaction** | **Staff Completed** | **Data Entry Completed** |
| Helpline Call (Initial Contact) |  |  |
| Initial Appointment Confirmation Call |  |  |
| Initial Appointment |  |  |
| Return Appointment Confirmation Call |  |  |
| Return Appointment |  |  |
| Appointment No-Show Follow-Up Call |  |  |
| Pregnancy Confirmation Call (2 Wk MS Follow-Up) |  |  |
| 4 Week PR Follow-Up Call |  |  |
| 8 Week PR Follow-Up Call |  |  |
| 16 Week PR Follow-Up Call |  |  |
| After Due Date PR Follow-Up Call |  |  |
| Closing Summary |  |  |
| Negative Test PR Follow-Up Call |  |  |
| Registered Letter Sent |  |  |
| Chart Audit |  |  |
| Immediate Follow-Up |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |
| Other: |  |  |

#### Appendix 43

Scheduling Helpline: *(enter phone #)*

Nurse Line: *(enter phone #)*

### Patient Resource List

Patients Name

Nurse’s Name

##### Insurance/Financial Assistance

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

##### Doctors

□ *(enter doctor’s name, address, and phone)*

□ *(enter doctor’s name, address, and phone)*

□ *(enter doctor’s name, address, and phone)*

##### General Health

□ *(enter applicable information)*

□ *(enter applicable information)*

##### Education & Financial Aid

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

##### Financial Counseling

□ *(enter name and contact info)*

##### Pediatricians

□ *(enter doctor’s name and contact info)*

□ *(enter doctor’s name and contact info)*

##### Material Assistance

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

##### Adoption

□ *(enter organization name and contact info)*

□ *(enter organization name and contact info)*

##### Church Referral

Return Appointment Date:

Return Appointment Time:

#### Appendix 44

### Pregnancy Confirmation Contact Form

Patient’s Name: Today’s Date:

Date First Seen:

□ Refer to the Patient Resource List, as well as the complete initial appointment in the chart before calling the patient.

□ Check the Patient Information form for instructions per patient for phone contact.

1. How are you feeling?
2. Describe your relations with Family/Boyfriend and your support system.
3. Have you followed up with the referrals provided on your PRL?  
    □ Physician Name:   
    □ Physician Phone:   
    □ Other Referral Notes:
4. Confirm ultrasound and due date with patient. Ask if they have any questions. Remind them of how far along they are now and what the fetal development is at this age (or what they were able to see on the ultrasound if memorable or maybe something the patient said or did that you noted or remember).
5. Have you decided what the outcome of your pregnancy will be?   
   *(Only ask if outcome is not known from previous follow-up.)*  
    □ Parent □ Abort □ Adopt □ Undecided
   1. *If the patient has had an abortion:*
      1. How are you feeling since your abortion?
      2. Ask if you may send them *Healing After An Abortion* □ Yes □ No  
         Confirm Address:
      3. How long ago was your abortion?
      4. Would you mind telling me where it was performed?
6. Is there anything else we can help you with?

Notes:

RN Signature: Date:

#### Appendix 45

### Pregnancy Test Log

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Pt ID | Lot # | Exp. Date | RN Initials | Result | Control | STD Testing |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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#### Appendix 46

### Professional Development Plan

Leader Name Date

Staff Position

Goal: To be the best in the world at that which God has called you to do for this Optimized PRC.

Rule of Thumb: If you spend one hour per day on developing understanding of a specific topic, issue, or skill, in three years you will be one of the world’s leading experts.

1. Skills Development/sharpening (i.e. U/S scanning technique, Volunteer recruitment, training, and retention, Donor acquisition, etc.):
2. Desired Content/Skill to be Developed:
3. Content Expert Mentor
   1. Name:
   2. Type of Content (i.e. OB ultrasound tech, etc.):
   3. Permission granted by mentor to contact date:
4. Development Activities (Leaders are Readers):
   1. Daily (i.e. journal articles, websites, etc.)
   2. Weekly (i.e. content specific conference tapes, books, etc.)
   3. Monthly (i.e. books on leadership, content specific classes/conferences, etc.)
   4. Annual conferences (i.e. Willow Creek Leadership Summit, etc.)
5. Department Specific Volunteer Development/Leadership Identification:
   1. Potential Department Volunteer Leader Identification:
      1. Who?
      2. How can you give them more responsibility?
      3. What can you do to groom them in their development as a leader?
   2. Volunteer Development Plan

#### Appendix 47

### Request for Time Off

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name: |  | Today’s Date: |  |

##### Time Period Requested

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From Date: |  | | | To Date: |  |
| Total Number of Requested Days Off: | |  | |  | |
| Total Number of allotted Vacation Remaining: | | |  |  | |

##### Nature of Request

* Vacation With Pay
* Vacation Without Pay
* Funeral
* Military Leave
* Jury Duty
* Maternity Leave
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Approved**
* **Denied**

Reason:

Supervisor Signature Date

#### Appendix 48

### Return Visit Health Questionnaire

Name: Today’s Date: Date First Seen:

**Repeat Pregnancy Test**

□ Not Applicable □ Positive □ Negative

**Has any of your contact information changed? If so, what’s changed?**

**How are you feeling?**

**Has anything changed with your situation since your last visit? Need additional referrals?**

##### Health Follow-Up

Are you allergic to latex? □ Yes □ No

Do you have an allergy to any medications? □ Yes □ No

If yes, please list medication and reaction:

###### Since your last visit, have you used any:

###### (If yes, please explain)

Medications □ Yes, □ No

Drugs □ Yes □ No

Cigarettes □ Yes □ No

Alcohol □ Yes □ No

*Do you or have you had any of the following   
since your last visit here?*

Abdominal pain/cramps: □ Yes □ No

*If yes, greater than your period?* □ Yes □ No

□ Consistent Pain □ Intermittent Pain

Vaginal bleeding/spotting: □ Yes □ No

Vaginal discharge: □ Yes □ No

*If yes, does it have an odor?* □ Yes □ No

*Does it have color?* □ Yes □ No

Having to urinate frequently: □ Yes □ No

Nausea: □ Yes □ No

Vomiting: □ Yes □ No

Breast tenderness: □ Yes □ No

Do you have any other health problems that you are concerned may make it difficult for you to carry this pregnancy safely or deliver a healthy baby?

**□ New Ultrasound Consent signed and in chart? (Box needs to be checked)**

*Intentions to Carry (following Return Appointment)*

□ Parent □ Abort □ Adopt □ Undecided

*I have reviewed the above information with the patient.*

RN Signature Title Date

#### Appendix 49

### Sample Inventory



#### Appendix 50

### Sample Pregnant Model Announcement

“Watch your baby grow! Are you pregnant in your first trimester? *{Name of your organization}* wants to offer you a sneak peak at your baby as we train nurses and sonographers in ultrasound. Please call *{name}* at *{name of your organization}*, *{phone number}*, to set up your FREE training ultrasound today!”

#### Appendix 51

### Sample Volunteer Ad

CompassCare Pregnancy Services needs one nurse and two sonographers to join   
Volunteer Medical Team.

Specialized training provided to serve pregnant, at risk women.

For details or to apply, please call Michelle at 414-6343.

#### Appendix 52

### Sexually Transmitted Disease (STD) Testing Consent and Release Form

I understand that:

□ [Name of PRC] provides free reproductive health medical services for men and women, including STD testing, diagnosis and treatment, pregnancy testing, and ultrasound exams for confirmation of pregnancy. **[Name of PRC] does not provide general medical care or emergency services. If you have pelvic pain, abnormal bleeding or a fever, you should go to the emergency room immediately.**

**□** I have requested the services of a volunteer physician through [Name of PRC] for the purpose of STD testing, diagnosis and, if necessary, treatment of some STDs. Those STDs not diagnosed and treated today will be addressed during my follow-up results appointment.

**□ Any recent exposure I may have had to an STD may not be evident in my test today, but I may still be able to pass it on to a partner. Any exposure following this appointment also puts me at risk for acquiring an STD.**

□ [Name of PRC] does not prescribe birth control, nor does [Name of PRC] give out information for the purpose of obtaining birth control.

□ A referral list with the names of local doctors, including gynecologists, is available for my use. I acknowledge that it is my responsibility to obtain follow up for my ongoing health care.

□ **New York State Law requires that certain positive STD test results be reported to my County Health Department, including HIV, Hepatitis, Syphilis, Gonorrhea and Chlamydia.**

□ **I am responsible for receiving the results of my tests, in person. Results will never be given to me over the phone.** I must return for a follow-up appointment with the nurse, within approximately two weeks. If I do not return within 2 weeks, I agree to be contacted at my phone number, for the purpose of scheduling a results appointment. I also give my permission for [Name of PRC] to send a certified letter to my home address if I can not be reached at the phone number provided.

□ In order to effectively provide for my medical care, staff of [Name of PRC] will have access to my confidential records. My records will not be released to any agency or individual without my written permission except as required by law.

□ **The reproductive health screening that I receive today does not include, among other things, testing for Human Papilloma Virus (HPV) or a PAP test. I must obtain those tests through my own physician.**

□ **By signing below, I am giving permission for [Name of PRC] to perform, as necessary, a urine pregnancy test, blood draw and a physical exam including obtaining swabs for purpose of STD testing.**

□ **A chaperone is available to me during the physical exam if I wish to have a third person present, and I may initial below to request that chaperone.** If I do not initial the line below, I am giving my consent to have that physical exam done with only the Registered Nurse performing my exam present.

Patient Requests Chaperone:

I hereby give full consent to these medical services and I waive and release any and all claims whatsoever kind and nature that I, my legal representatives or heirs and relatives might have or hereafter have against [Name of PRC], its physicians, medical personnel, directors, officers, employees and volunteers. I expressly agree that this waiver, release and indemnity agreement, is intended to be as broad and inclusive as permitted by the laws of this state, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

I have read and understand the above information,

Print Name:

Patient Signature:

Date:

#### Appendix 53

### Staff and Volunteer Job Application

*This application and the information provided in it will be reviewed by qualified CompassCare staff only and will remain confidential.*

##### Directions for all Volunteer and Staff Positions

1. Fill out Sections A through K of this application as completely as possible.
2. Provide the Pastoral and Personal Reference Forms to the persons completing them for you (see Section F). Ensure that your name and the position you are applying for, if known, is on the form. Return the forms to CompassCare as soon as possible.
3. Sign the application at the Signature of Agreement and Commitment section (see Section K).
4. Sign and keep the Staff and Volunteer Service Commitments document.
5. Return the completed application to CompassCare.

**Note**: If you need additional room for your answers to any of the questions, please write on the back of the page.

*Your involvement in CompassCare, including training, can begin only after the complete Application, Resume, and Reference Letters are returned to CompassCare and reviewed by appropriate staff.*

##### Additional Directions for Patient Resources and Medical Services Positions

1. Provide proof of necessary licenses or certifications, when applicable for the positions (for example, nurse).
2. Provide a Resume. Please include at least two professional references if applying for a paid staff position.

**Note**: If you need additional room for your answers to any of the questions, please write on the back of the page.

*Your involvement in CompassCare, including training, can begin only after a complete application is returned to CompassCare and reviewed by appropriate staff.*

##### A) Demographic Information

Name

Address

City State Zip

Home Phone Business Phone

Email Address Cell Phone

Where do you attend church?

##### B) Interest in CompassCare

How did you hear about Compass Care?

Why would you like to be involved with Compass Care?

Are you interested in working directly with patients? □ Yes □ No  
If Yes, please describe your expectations.

Are you interested in a staff position or a volunteer position? □ Staff □ Volunteer □ Either

##### C) Abortion & Adoption Experiences

*(For Patient Resources and Medical Services Positions Only)*

Have you had any personal experiences with abortion or adoption? □ Yes □ No

If Yes, please describe.

##### D) Mission, Values, and Strategy

Please carefully read the Mission, Values, and Strategy statements below. To be involved with CompassCare, you are expected to know and adopt the following, as well as perform your role accordingly.

###### Mission

To erase the need for abortion through effectively serving pregnant, at risk women by transforming her fear into confidence.

###### Values

1. Fighting Spirit
2. Relevance
3. Accountability

###### Strategy

1. Serve the right women (at risk)
2. Reach those women at the right time (pregnant)
3. Help those women in the right way (see them have their babies as the first step in the process of transformation)

##### E) Positional Statements

Please carefully read each of the four positional statements below. To be involved with CompassCare, you are required to sign an agreement to uphold each of the Positional Statements as stated. If you cannot agree to any part of the statements, stop the application process at this point and speak with a CompassCare representative.

**Note**: If you are not sure about your agreement or have a question about a statement, write this in the space at the end of this section and continue with the application.

###### Abortion

1. It is our position that every abortion claims an innocent life.
2. We are painfully aware of the trauma surrounding pregnancies related to rape, incest, deformities of the developing child, and/or health risks to the mother. We exist, in part, to provide helpful intervention in such cases, but we do not find abortion to be either effective or morally acceptable as a method of reducing such trauma.
3. In those extremely rare cases where continued pregnancy is reasonably expected to precipitate the mother’s immediate and literal death, we have been able to discover no clear biblical principle absolutely prescribing or recommending the act of abortion. In such cases, we encourage the parties involved to prayerfully consider the gravity of their decision and the merit of available alternatives. Furthermore, we commit ourselves to respect the decision of the parents and to provide whatever support is possible.

###### Birth Control

1. For far too long, “sex education” in our schools has concentrated on birth control instead of self-control. We believe that, so long as people engage in sexual relationships outside of marriage, there will continue to be great numbers of unplanned pregnancies, sexually transmitted diseases and broken lives.
2. Much of the difficulty encountered in confronting the problems of young adult promiscuity and pregnancy stems from a paradox engendered by the birth control establishment. Though young people are taught that sex outside of marriage is “no big deal,” they sense its profound significance and so feel both permission and desire to become sexually active. This has produced ever-higher rates of young adult sexuality, pregnancy, abortion and disease – the very problems that expensive, tax-funded programs promised to prevent.
3. CompassCare Pregnancy Services is working to reach young adults with the less appealing but more truthful message that sex can only be safe and loving within the context of a permanent, marital relationship.
4. Our staff does not refer or provide patients with birth control.

###### Statement of Faith\*

1. We believe the Bible to be the inspired, the only infallible, authoritative Word of God.
2. We believe that there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.
3. We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.
4. We believe that for the salvation of lost and sinful people, regeneration by the Holy Spirit is absolutely essential, and that this salvation is received through faith in Jesus Christ as Savior and Lord.
5. We believe in the present ministry of the Holy Spirit by whose indwelling the Christian is enabled to live a godly life.
6. We believe in the resurrection of both the saved and the lost; they that are saved unto the resurrection of life and they that are lost unto the resurrection of damnation.
7. We believe in the spiritual unity of believers in our Lord Jesus Christ.

\*The above Statement of Faith is consistent with that of the National Association of Evangelicals.

###### Statement of Principle

1. CompassCare Pregnancy Services is an outreach ministry of Jesus Christ through His church. Therefore, CompassCare is committed to presenting the gospel of our Lord to women in crisis pregnancies – both in word and in deed. In keeping with this purpose, those who serve the agency as board members, staff, and volunteers are expected to know Christ as their Savior and Lord.
2. CompassCare Pregnancy Services is committed to the highest degree of integrity in dealing with its patients, earning their trust, providing promised information and services, and avoiding any form of deception in its corporate advertising or individual conversations.
3. CompassCare Pregnancy Services offers assistance free of charge and does not discriminate on the basis of age, gender, marital status, race, or religious preference.
4. CompassCare Pregnancy Services provides accurate and complete information concerning prenatal development, abortion procedures and risks, and alternatives to abortion. Recognizing that abortion compounds human need rather than resolving it, this agency does not recommend, provide, or refer for abortions or abortifacients.
5. CompassCare Pregnancy Services is committed to meeting a woman’s need at the point of decision regarding an unplanned or unwanted pregnancy. Through emotional support and practical assistance, women may face the future with hope, and plan constructively for themselves and their babies.
6. CompassCare Pregnancy Services supports adoption as an excellent alternative to abortion for women experiencing unplanned and unwanted pregnancies. A list of referrals to adoption agencies and attorneys is available for those who find parenting to be impossible at this stage of their lives. However, this organization does not initiate or facilitate adoption for our patients, nor do we receive payment of any kind from these agencies.
7. CompassCare Pregnancy Services provides accurate and complete information on birth control, distinguishing between methods that prevent conception and abortifacients, but does not provide or refer unmarried patients for birth control. Married couples seeking contraceptive information are encouraged to seek counsel from their pastor and physician.
8. CompassCare Pregnancy Services is committed to encouraging sexual abstinence among those who are single, and fidelity within a marriage relationship.

|  |
| --- |
| If you have any variance with any part of the four Positional Statements above or any questions about them, please state them below. |
|  |
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##### F) References

Involvement with CompassCare requires two references, one from your current Pastor and one from a person who knows you well and for longer than a year. The personal reference cannot be an immediate family member.

You are responsible for getting the Reference Forms located at the end of this Application to the people who will complete the forms on your behalf.

Where do you attend church?

Please list the two people who will be completing the Reference Forms for you.

Pastor Phone

Personal Phone

Relationship to you

##### G) Relevant Experience & Skills

Please describe any experience you think may be relevant to working at CompassCare. This can be employment, volunteer experiences, occupational training, public speaking, etc.

|  |  |  |
| --- | --- | --- |
| Organization / Company | Job Title | Responsibilities |
|  | | |
|  | | |
|  | | |
|  | | |

Please provide us with information about skills you may have. These can be office skills, computer skills, medical skills, counseling skills, etc.

|  |
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##### H) Availability & Frequency

Please check the appropriate days and times you expect to be available.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Days of Week | | | | | | | | |
|  | | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Time | Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |

Please check the box under the frequency you will be able to work.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Frequency: | Multiple times per week □ | Once a week □ | Every other week □ | Once per month □ | Occasionally  (as my schedule allows)  □ | On Call  (as you need me)  □ |
| Other: |  |  |  |  |  |  |

**Note**: Volunteer positions are expected to be for a period of at least one year following training (this can vary with internship positions). Although schedules during this time may change, CompassCare is asking for a minimum commitment of one year. If you are unable to make this commitment, please indicate reasons in the space below.

|  |
| --- |
|  |
|  |

##### I) Area of Interest

Please check the box below the roles you are interested in.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medical Services | Event Logistics | Marketing | Information Technology | Finance |
| Clinical Coordinator □ | Walk for Life □ | Market Research □ | System Admin. □ | Payable Processing □ |
| Helpliner □ | VISION Tours □ | Creative □ | In-facing Systems Team □ | Receivables Processing □ |
| Mission Connection □ | Celebration Event  □ | Production □ | Out-facing Systems Team □ | Center Optimization □ |
| Church Relations □ | Commitment Event  □ | Publishing □ |  |  |
|  |  | Video Production □ |  |  |
| **Other:** |  | | | |

##### J) Commitment to Standards and Non-Disclosure

CompassCare is committed to serving our patients and donors with the highest standard of professionalism. To do this, we require that all staff and volunteers agree to and commit to the standards listed below. Please read each of the standards carefully. We require that you adhere to these standards at all times during your involvement with CompassCare.

**Note**: If you have a question about a standard or feel that you may be unable to adhere to a standard, please indicate this in the space at the end of this section.

1. I will know and responsibly work towards fulfilling CompassCare’s Mission and Strategy.
2. I will apply the values of Fighting Spirit, Relevance, and Accountability to my role and activities at CompassCare.
3. I will serve women and men in unplanned pregnancies and post-abortion counseling with care and compassion, speaking the truth in love through ministry and not manipulation (for those in positions with patient contact).
4. I will keep all patients’ identities and life situations in strict confidence at all times.
5. I will keep all donors’ identities and donations in strict confidence at all times.
6. I will keep all business operations, processes, methods, and documentation of CompassCare in strict confidence at all times.
7. I will comply with the Policies and Procedures established by CompassCare.
8. I will commit to serve in my position with CompassCare for at least one year, following training.
9. I will never refer or advise any woman to have an abortion.
10. I will uphold CompassCare’s policy on birth control, which is abstinence only for unmarried patients.
11. I will maintain my scheduled hours and to seek a qualified substitute when necessary.
12. I will be prepared for my scheduled duties and will remain responsibly engaged while performing my duties.
13. I will pray for CompassCare staff, volunteers, and patients.
14. I will commit to a monogamous marriage relationship during my time at a CompassCare (if married).
15. I will remain sexually abstinent during my time at CompassCare (if unmarried).
16. I will maintain any professional licenses and certifications required to perform services at CompassCare.

Questions or comments concerning the above Commitment to Standards and Non-Disclosure:

|  |
| --- |
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|  |

##### K) Signature of Agreement and Commitment

Having carefully read and completed this Application, I, the undersigned, agree that:

1. I have provided information that is accurate,
2. I will uphold the Mission, Values, and Strategy of CompassCare,
3. I will uphold the Positional Statements as stated,
4. I will uphold the Commitment to Standards and Non-Disclosure as stated, and
5. I have included any questions, concerns, or differences as I presently have them.

Print Name

Signature

Date

*Below this point is for CompassCare management only.*

#### Application Review

Check each item below when they are complete.

* Content of this Application has been reviewed and found to be complete and satisfactory.
* A Resume has been provided (with professional references if applying for a paid staff position).
* Questions, concerns, or differences the applicant has included in this Application have been discussed with the applicant.
* Both Reference Letters have been received and reviewed (not applicable for Advancement and Office Support positions).
* Pastoral reference has been contacted for reference follow up (not applicable for Advancement and Office Support positions).
* Proof of necessary licenses or certifications has been provided, when applicable for the positions (for example, nurse).
* The Signature of Agreement and Commitment has been signed by the applicant.
* The Staff and Volunteer Service Commitments document has been signed and given to the applicant.
* The applicant has been appropriately interviewed for the position requested or assigned.

#### Applicant Approval or Denial

Check the appropriate decision below after the Application Review is complete.

* The applicant is approved.
* The applicant is asked to resolve some issues (described in the space below) and then apply again.
* The applicant is denied (indicate reasons in space below).

|  |
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#### Management Signature

Print Name

Title

Signature

Date

#### Pastoral Reference Form

Applicant’s Name: Position:

The above named individual has applied for a staff or volunteer position with CompassCare Pregnancy Services. CompassCare would appreciate a confidential statement from you concerning the applicant's conformity to the qualities listed below and their expected ability to carry out their duties for CompassCare. Please include how long and in what capacity you have known the applicant.

**Please Note**: As part of our application process, after receiving this reference form from you, a CompassCare staff person will be contacting you to discuss the applicant’s involvement with CompassCare.

Desired Qualities – As part of CompassCare, the applicant will work for or with women who may be facing the decisions of an unplanned pregnancy. Some of the qualities desired in staff and volunteer are:

1. A genuine commitment to Jesus Christ as Savior and Lord of their life.
2. A willingness to give of themselves with compassion to the women they will serve.
3. Dependability and responsibility to perform their role and corresponding activities with excellence.
4. An ability to uphold their commitments to the Mission, Values, and Policies of CompassCare.

##### Your comments concerning the applicant's conformity to the qualities listed above:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

##### Please check the best rating for the areas listed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Below Average | Average | Above Average |
| Dependability | □ | □ | □ |
| Spiritual Maturity | □ | □ | □ |
| Communication Skills | □ | □ | □ |
| Initiative | □ | □ | □ |

Your Name Church

Address

Phone (day) (evening)

Signature Date

**Please mail or fax this form to: CompassCare Pregnancy Services**

**300 White Spruce Blvd., Rochester, New York 14623 Attn: Application Process**

**PHONE: (XXX) XXX-XXXX FAX: (XXX) XXX-XXXX**

#### Personal Reference Form

Applicant’s Name: Position:

The above named individual has applied for a staff or volunteer position with CompassCare Pregnancy Services. CompassCare would appreciate a confidential statement from you concerning the applicant's conformity to the qualities listed below and their expected ability to carry out their duties for CompassCare. Please include how long and in what capacity you have known the applicant.

Desired Qualities – As part of CompassCare, the applicant will work for or with women who may be facing the decisions of an unplanned pregnancy. Some of the qualities desired in staff and volunteer are:

1. A genuine commitment to Jesus Christ as Savior and Lord of their life.
2. A willingness to give of themselves with compassion to the women they will serve.
3. Dependability and responsibility to perform their role and corresponding activities with excellence.
4. An ability to uphold their commitments to the Mission, Values, and Policies of CompassCare.

##### Your comments concerning the applicant's conformity to the qualities listed above:

|  |
| --- |
|  |
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|  |

##### Please check the best rating for the areas listed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Below Average | Average | Above Average |
| Dependability | □ | □ | □ |
| Spiritual Maturity | □ | □ | □ |
| Communication Skills | □ | □ | □ |
| Initiative | □ | □ | □ |

Your Name Church

Address

Phone (day) (evening)

Signature Date

**Please mail or fax this form to: CompassCare Pregnancy Services**

**300 White Spruce Blvd., Rochester, New York 14623 Attn: Application Process**

**PHONE: (XXX) XXX-XXXX FAX: (XXX) XXX-XXXX**

#### Appendix 54

### STD Test Log



#### Appendix 55

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Trainer’s Checklist | | | | |
| **Trainee’s Name:** | | **Job Function:** | | **Date Completed** |
| **Trainer’s Name:** | | **Training Start Date:** | |  |
| * *Prepare for Training* | | | |  |
| * + - Complete General Orientation Checklist | | | |  |
| * + - Locate Appropriate Training Checklist(s) for Trainee Job Function (Role) | | | |  |
| * + - Determine Training Schedule and Enter Dates on Training Checklist | | | |  |
|  | | | |  |
| * *Assemble Training Materials (as required for particular job function)* | | | |  |
| * + - Self-Learning Modules | | | |  |
| * + - PPT Recorded Sessions | | | |  |
| * + - OT Manual | | | |  |
| * + - Whitepapers | | | |  |
| * + - Patient Process DVD | | | |  |
| * + - Other | | | |  |
| * *Communicate to Trainee* | | | |  |
| * + - Provide Trainee with copy of Training Checklist with Scheduled Training Dates. Trainer keeps original. | | | |  |
| * + - Provide Training Materials (or information on how to access them) with any applicable instructions | | | |  |
| * + - Review Training Expectations | | | |  |
| * *Task Training* | | | |  |
| * + - Using Training Checklist(s), complete training for each line item listed | | | |  |
| * + - Record Completed Date for each line item, and initial | | | |  |
| * + - Once Training is complete, sign and place Training Checklist in trainee’s file | | | |  |
| * *Follow-up* | | | |  |
| * + - Communicate to trainee the process for asking additional questions as they arise. | | | |  |
| * + - Verify that trainee is completing Job Function Checklist for each shift worked | | | |  |
| * + - Follow-up with trainee periodically to see if there are additional questions. | | | |  |
| * + - Perform periodic assessment to verify that job is being completed/performed satisfactorily. | | | |  |
| **Notes:** |  | | | |
| **Trainer Signature:** |  | | **Date:** |  |

#### Appendix 56

### Ultrasound Consent

I understand that:

**□** I request an appointment with a volunteer physician at [Name of PRC] of Rochester for the purposes of confirming my pregnancy. **I understand that my ultrasound exam will be limited to pregnancy confirmation and that a referral will be made to another medical provider for follow-up medical care.**

**□** The purpose of this ultrasound exam is limited to confirming the viability of my pregnancy through **detecting my baby’s heart beat** **and determining how far along I am** according to my last menstrual period (LMP).

**□ I understand that this ultrasound exam is not for the purposes of diagnosing or detecting any medical problem or condition for my pregnancy.** I will not hold [Name of PRC] responsible for diagnosing or failing to diagnose any abnormalities or conditions relating to my pregnancy or my baby and hereby release [Name of PRC] and its collaborating physicians from any and all liability in this regard.

**□** Ultrasound utilizes high frequency sound waves, and there are no known harmful effects in the twenty-five years of clinical use. The possibility always exists that effects may be identified in the future.

**□ I understand that no follow-up medical care will be provided at [Name of PRC]** and its physicians and staff are not responsible for my follow-up prenatal care, and are not responsible for emergency care that I may need. **I acknowledge that I have the duty and responsibility to use the referrals given to me or some other source to secure my follow-up care.**

**□** I have been informed that physicians and other staff who provide services at the [Name of PRC] of Rochester may do so on a voluntary basis without compensation. I understand that a referral list with the names of local doctors and prenatal health care providers is available for my use.

**□ I am not presently experiencing any immediate medical problem (e.g., pain, spotting, cramping), and I understand that this exam is not a substitute for immediate medical care**. **Should any medical problems arise before my scheduled appointment(s) at [Name of PRC], I acknowledge that it is my responsibility to seek emergency care.**

**□** In order to effectively provide for my medical care, I understand that the staff of [Name of PRC] will have access to my confidential records at [Name of PRC]. **My records will not be released to any agency or individual without my permission except as required by law.**

**□** I agree to be contacted at my phone number for the purpose of confirming my pregnancy. **If I cannot be reached at the number provided after three attempts, [Name of PRC] has my permission to send a certified letter to the address I provided.**

**□** I hereby give full consent to these medical services and I waive and release any and all claims whatsoever kind and nature that I, my baby, my legal representatives or heirs and relatives might have or hereafter have against [Name of PRC], its physicians, medical personnel, directors, officers, and employees. I expressly agree that this waiver, release and indemnity agreement, is intended to be as broad and inclusive as permitted by the laws of this state, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

I have read, understand, and agree with this statement.

Print Name: Date:

Patient Signature:

#### Appendix 57

### Ultrasound Guide

Ensure that all of the following tasks are completed before, during, and after the ultrasound exam.

##### Criteria for the Ultrasound Exam

1. Positive Pregnancy Test
2. Patient has no signs of miscarriage or ectopic pregnancy. Signs include the following:
   1. Bleeding or spotting greater than typical menstrual period
   2. Cramping/pain worse than menstrual cramps that is consistent and severe
   3. Gush of warm liquid from vagina
   4. Severe pain centered on one side of the abdomen or pelvis
   5. Lightheadedness, dizziness, or blackouts
   6. Abnormally low blood pressure

##### Before the Ultrasound Exam

1. Routine explained
2. Consent signed for ultrasound exam

##### Ultrasound Routine

1. Glamour shot
2. Gestational age measurement (CRL and/or GS)
3. Heart Beat measurement using Doppler
4. ML: TRV and LNG
5. RT ADN: LNG and TRV
6. LT ADN: LNG and TRV
   1. *If you see the ovaries/corpus luteum cyst measure them (twice in the LNG/SAG view, once in TRV)*

##### After the Ultrasound Exam

Based on what you see during the exam, give the appropriate brochure and other information to the patient.

1. You see what you expect to see:
   1. “So, You’re Pregnant Brochure”
   2. Pictures (2-3) in the card with a frame
2. You did not see what you expect to see:
   1. “We Were Unable to Confirm Viability of Your Pregnancy Today” Brochure
   2. Nurse Manager notified

#### Appendix 58

### Ultrasound Log

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| Date | Pt ID | LMP | GA per U/S | EDC per U/S | Initials | Comments |
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#### Appendix 59

### Ultrasound Poem

*The Ultrasound*Author unknown

My precious little baby,  
I have loved you from the start.  
You are a tiny miracle,  
Lying closely to my heart.

Each day I feel your presence.  
Each day you quickly grow.  
Each day your heart beats softly,  
As only I could know.

So I’ll keep this in a special place,  
And remember each year through,  
Of this special time in life;  
The months I carried you!

#### Appendix 60

### Ultrasound Training Record

**



#### Appendix 61

### Verification of Positive Pregnancy Test Letter

**300 White Spruce Boulevard  
Rochester, NY 14623  
(XXX) XXX-XXXX**

[Medical Director], MD  
Medical Director

Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Re: Verification of Positive Pregnancy Test

To Whom It May Concern:

This is to verify that was given a pregnancy test at CompassCare Pregnancy Services on \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_.

The test results were positive.

Per LMP of \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_, patient’s EDD is \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_.

If you have any questions, please feel free to contact us.

Sincerely,

RN Signature

#### Appendix 62

### What Can You Expect?

##### Initial Appointment

* 1. You will meet with a Nurse, who will:
     1. Review the Reproductive Health Screening that you will be receiving today, including STD and pregnancy testing
     2. Perform a pregnancy test. If positive,
        1. Review all of your pregnancy options, including “Abortion: Procedures, Risks and Side Effects”
        2. Perform an ultrasound exam to confirm pregnancy and determine how far along you are
     3. Collect a urine sample for STD Testing, and provide information about STDs
     4. Review your health history
     5. Answer your medical questions
     6. Review your *Patient Resource List* and provide any necessary medical referrals
     7. Schedule another appointment for you to receive your test results in one week

##### Return Appointment

* 1. You will meet with a Nurse, who will:
     1. Review your health history since your last visit
     2. Provide STD test results and treatment information
     3. Repeat a pregnancy test, if necessary. If positive,
        1. Review all of your pregnancy options, including “Abortion: Procedures, Risks and Side Effects”
        2. Perform an ultrasound exam to confirm pregnancy and determine how far along you are
     4. Answer your medical questions
     5. Provide any additional referrals you may need

|  |
| --- |
| **PRIVACY POLICY**  *CompassCare encourages the support of friends and family during your appointment. Please note that, in an effort to provide the highest quality of care, your clinical visit must be performed without any guests. However, patients having an ultrasound exam may choose to invite guests to join them for that portion of their visit. CompassCare staff is unable to provide services to patients who choose not to abide by this policy.* |

*I have read and understand the policy described above.*

**Patient Signature:**  **Date:**

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# 

#### Nurse/Sonographer Self-Learning Module #5 – Selected Policies and Procedures

##### PT1: Staff Performing Urine Pregnancy Tests

Only qualified medical professionals may perform the urine pregnancy test on patients and provide patients with the results.

###### Procedure:

1. Only qualified medical professionals shall perform the pregnancy tests and provide patients with the results. Qualified medical professionals include a licensed practical nurse, registered nurse, nurse practitioner, physician’s assistant or physician.
2. The Director of Medical Services shall verify with the appropriate state licensing boards that the pregnancy testing is within that medical professional’s scope of services.
3. A pregnancy test will only be available if a medical professional is in the office, therefore, all patient appointments must be scheduled accordingly.

##### PT2: Standing Order for Pregnancy Test

All registered nurses and other trained and approved personnel are authorized to perform urine pregnancy tests on all patients presenting at the office for such testing. These personnel are hereby authorized to inform the patients of their test results. The patient’s results shall be documented accordingly by using the appropriate Health Questionnaire.

Dated:

Medical Director

##### PT3: Protocol for Pregnancy Testing

A CLIA waiver must be in place for nurses to perform pregnancy tests per state requirements. If a CLIA Waiver is not yet obtained, Self-administered testing may be used during the processing of such.

###### Procedure:

1. Obtain a urine sample from patient for testing pursuant to OT.
2. Perform the pregnancy test per manufacturer’s instructions.
3. Document results in Pregnancy Test Log.
4. Collect and send the sample for STD testing pursuant to OT.
5. Inform patient of results pursuant to the pregnancy test standing order.
6. Provide appropriate education and referrals.

##### PT4: Verification of Positive Test

Verifications of Positive Pregnancy Tests simply verify that the pregnancy test read positive. Nurses may verify positive pregnancy tests. This is different from a Confirmation of Pregnancy that can only be diagnosed by a physician or nurse practitioner after an exam, such as ultrasound.

The PRC shall provide pregnancy documentation to any patient who requests one for the purposes of obtaining prenatal care. The LC shall not provide pregnancy documentation to patients intending to use the documentation to obtain an abortion or funding for an abortion. This policy shall be addressed in the initial intake sheet so that the patient is aware of the office’s policy in this regard.

###### Procedure:

Verification of Positive Pregnancy Tests:

1. Verification of Positive Pregnancy Tests may only be provided after a pregnancy test has been performed by a nurse or other trained personnel.
2. If the patient has a positive pregnancy test and wants verification, one shall be provided on the “Verification of Positive Pregnancy Test” form. A nurse shall fill out the form, which shall be signed pursuant to the Standing Order.
3. Confirmation of Pregnancy shall only be provided by physicians or nurse practitioners after the exam.
4. A copy must be placed in the patient’s medical record.

##### PT5: Standing Order for Verification Pregnancy

All nurses at CompassCare are authorized to complete the Verification of Positive Pregnancy Test Letter for patients requesting same, on the condition that a nurse or other trained personnel supervised a pregnancy test on the patient and the result was positive. Only physicians or nurse practitioners may provide confirmations of pregnancy.

Dated:

Medical Director

#### Nurse/Sonographer Self-Learning Module #6 – Selected Policies and Procedures

##### STD Testing White Paper

###### Why does the Optimization Tool advocate providing limited STD testing using a urine sample and not provide direct onsite STD treatment?

Every organization must decide on what services it will provide to patients and what services it will not provide to those same patients. No medical clinic or physician’s office can offer everything. In determining what services it will provide, a PRC must take into account the fact that every organization must utilize its resources strictly for the purpose of what directly relates to its mission ‘to erase the need for abortion by focusing on the two following questions:

1. Will this service cause more abortion-minded women to take advantage of the PRC?
2. Will this service cause those abortion-minded women to be more likely to carry to term?

The PRC must be able to say “Yes” to both of these questions when considering whether or not to provide a service. If not, then the service should not be provided directly by the PRC. This is not to say that at some point in the future, additional services will not be added as the culture shifts with regard to abortion-minded women.

There are reasons from both a clinical perspective and a patient perspective that provide rational as to why a PRC providing limited STD testing using a urine sample without providing direct onsite STD treatment does answer “Yes” to the above two questions.

Clinical Perspective

Providing selective STD testing refers to doing STD testing on a small number of STDs and not a broader range of STDs. Selective STD testing should be focused on STDs that have an effect on a woman’s reproductive health, for example, Chlamydia and Gonorrhea. At the present time, doing selective STD testing for Chlamydia and Gonorrhea is preferable for PRCs for a number of reasons.

First, according to the Center for Disease Control (CDC), “Chlamydia and Gonorrhea are the first and second most commonly reported notifiable diseases in the United States.”[[25]](#footnote-26) Both diseases are bacterial forms of STD that are treatable and curable, if identified.

Second, Chlamydia compounds the effects of an abortion on a woman’s reproductive health, including Pelvic Inflammatory Disease (PID). Studies indicate that, “PID is a potentially life threatening disease which can lead to an increased risk of ectopic pregnancy and reduced fertility. Of patients who have a Chlamydia infection at the time of the abortion, 23% will develop PID within 4 weeks. Studies have found that 20 to 27% of patients seeking abortion have a Chlamydia infection.”[[26]](#footnote-27) This information is an important aspect of an abortion-minded woman’s journey to making an informed decision. Gonorrhea also leads to PID.[[27]](#footnote-28)

Third, offering selective STD screening is no different than offering limited ultrasound exams because neither is intended to be an all-inclusive exam. Rather, the purpose of each type of exam is to provide the abortion-minded woman with enough clinical information to enable her to make an informed decision.

Fourth, women who come to the PRC for STD testing only are also given a pregnancy test as part of the patient care process, even if it was not originally requested. If she is concerned about having an STD, she obviously has been sexually active and therefore may be pregnant and yet not know it.

Fifth, offering testing for a large number of STDs is not necessary for assisting an abortion-minded woman in the path to an informed decision. Although knowing about other forms of STD is important for a woman’s health, these STDs have not been shown to directly and consistently impact the decision of having an abortion as do Chlamydia and Gonorrhea (as discussed above). Chlamydia is the major STD when considering services to an abortion-minded woman. “Because many people with Gonorrhea also have Chlamydia”[[28]](#footnote-29) it is a good idea to test for both at the same time. Because testing for these two is typically bundled it does not add any additional cost when testing for both STDs since the same urine sample is used.

Sixth, the urine STD testing provides the optimal type of testing when weighing accuracy, requirements, and cost as it relates to the PRC organization. According to the CDC, the sensitivity of nucleic acid amplification test (NAAT) when using urine to detect Chlamydia in women is similar, or only slightly inferior, to their sensitivity when using endocervical swabs (DNA probe).[[29]](#footnote-30) DNA probe requires advanced medical personnel to collect a sample, which most PRCs do not have and cannot afford. The Urine test collection is simple and does not require an in-house lab or advanced medical personnel for sample collection.

Seventh, it is not necessary to provide treatment along with the STD testing. PRCs are part of a larger medical community. It is helpful to remember that a PRC is only the beginning of an abortion-minded woman’s care, not the entirety. Protocols necessitate that at every step a patient is referred back to her physician or a community practicing OB/GYN. A PRC is in that sense a part of the medical community, community being the operative word. In addition, PRCs are not in a position to provide full medical care to patients, nor is it necessary for them to do so, even if they provide a part of that care. However, it is necessary for the PRC to ensure proper treatment is attained by the patient.

In an effort to avoid applying a double standard to a PRC organization it is important to follow consistent logic in identifying services that any given woman needs. To be effective, a PRC can provide pregnancy testing without providing prenatal care. This being the case, then the same logical standard needs to be applied to STD services.

Patient Perspective

From the patient’s perspective, it is also preferable to be provided selective STD testing by the PRC.

First, the PRC can be seen as a valuable resource for women concerned with STDs so that they will be more likely to return to the PRC if they think they are pregnant. Even men can be provided with STD testing because the PRC should be concerned with “influencing the influencers” in an abortion-minded women’s life.

Second, even if a woman who comes into the center is not pregnant at the time, she may still be abortion-vulnerable. Offering STD testing provides an opportunity to educate for the purpose of causing her to make good decisions around her sexuality and reproductive health.

Third, the DNA Probe is an invasive test thereby making it more uncomfortable for the patient while the urine STD testing in non-invasive. In addition the urine test is more efficient due to the fact that the urine sample for the pregnancy test can be used for the STD test as well.

Fourth, to be effective with regard to its primary mission, does a woman expect the PRC to provide STD testing, treatment, and retesting? Not necessarily. Providing the testing is enough to enable an abortion-minded woman to make informed decisions and to be directed to further comprehensive medical care for herself and her baby. By rescheduling her in one week to receive her STD results she has more time to take a step back emotionally and consider her decision regarding the outcome of her pregnancy.

##### STD1: Criteria for STD Testing Appointment

STD Testing will be offered to patients at no cost.

Patients may be referred for STD testing in these circumstances:

1. Calling Helpline for an appointment.
2. Walk-in during business hours.
3. Here for Pregnancy Test.

###### Procedure:

1. The patient will be scheduled for an appointment as above.
2. If a patient is here for a pregnancy test they will be offered STD testing in accordance with the policies and procedures below.
3. The patient shall be informed that a follow-up appointment will be scheduled within one week to report the results of the STD tests.
4. The patient shall be informed, upon making the appointment, that there are no costs involved with the STD testing.
5. The patient should be advised that they should not urinate within one hour of their scheduled appointment for STD testing.
6. The patient cannot make an appointment at the time she is having her period. She should schedule for a week or two after her period.

##### STD2: Standing Order for STD Testing

All registered nurses and other trained and approved personnel are authorized to collect a sample for urine STD testing on all patients presenting at the office for such testing. These personnel are hereby authorized to inform the patients of their test results following the receipt of them from the CDD. The patient’s results shall be recorded on Exam Report (PS 11).

Dated:

Medical Director

#### Nurse/Sonographer Self-Learning Module #8 – Selected Policies and Procedures

##### Ultrasound White Paper

###### The Difference One Week Makes The Five Week and One Day LMP Ultrasound Rationale

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Introduction

The CompassCare Optimization Tool© (OT) requires that an ultrasound exam be given to all patients who are at least as early as five weeks and one day after their last menstrual period (LMP). A follow up ultrasound exam is given to the patient if the first ultrasound was too early to confirm a pregnancy or after viability has been confirmed if she remains at risk to have an abortion. In addition, every patient interface triggers a physician referral for follow up care.

Some Pregnancy Resource Centers (PRC) have expressed concern as to whether providing an ultrasound exam at five weeks and one day is too early and as to whether there are any distinct benefits to providing ultrasounds at this stage. When considering clinical and patient perspectives, the opportunities gained to service abortion-vulnerable women, and the potential credibility of the PRC, providing ultrasound exams at five weeks and one day on a patient’s initial visit to the PRC must become the standard of medical care.

Presuppositions

Before looking at the clinical and patient perspectives of this issue, there are some presuppositions that need to be established. First, nurses and sonographers who perform medical services such as ultrasound exams within a PRC receive and maintain their “license” and permission to perform the ultrasound exams under the license of the Medical Director. The license does not come from the PRC itself or from a training organization. Any certification that nurses or sonographers receive from a third party (such as a training organization) does not provide them with the rights or permission to determine to perform or not perform any physician ordered exam, such as a limited ultrasound exam.

Second, although abortion providers are not legally required to confirm pregnancy viability prior to performing an abortion procedure, they routinely perform ultrasound exams when a woman presents with a positive pregnancy test, irrespective of her LMP and pregnancy viability. The national medical standard of care in an obstetrics (OB) setting is to perform an ultrasound exam on every patient presenting with a positive pregnancy test.

Third, if any woman comes to her PRC appointment and is symptomatic of an ectopic pregnancy or a miscarriage, she is not offered an ultrasound exam. Instead, she is either immediately referred to her physician or she is immediately referred to the Emergency Department (ED). Both of these referrals occur prior to her leaving her initial appointment.

Fourth, detection and confirmation of pregnancy can take place prior to six weeks LMP. The new pregnancy tests being used are more sensitive and can show positive test results when less than six weeks pregnant. Also, for 20% of the women pregnant between five and six weeks LMP, confirmation of viability is attainable using the limited ultrasound exam.

Clinical Perspectives

The Five Week and One Day LMP Ultrasound Process Logic

The CompassCare standard of care to do ultrasound exams at five weeks and one day is preferable for a number of clinical reasons. First, as mentioned above, confirmation of the viability of pregnancy can be obtained for 20% of women pregnant between five and six weeks LMP. This means that a fetal heart tones are detected with no anomalies. Even with a confirmation of pregnancy, if the patient is abortion-vulnerable and the outcome of the pregnancy remains uncertain, medical indication technically warrants a follow up ultrasound exam. Therefore, the patient is scheduled for a follow up exam.

Second, an ultrasound exam at five weeks and one day may not confirm the viability of pregnancy. However, there may be expected gestational development noted, such as the gestational sac and yoke sac being seen, as well as development being within normal range. In these cases, the patient is rescheduled for another ultrasound to complete the task of confirming viability. In this way, the service gap by not being able to provide confirmation is closed. The patient would be referred to a physician as well.

Third, if the ultrasound exam at five weeks and one day does not confirm the viability of pregnancy, normal gestational development is not detected, and there are no symptoms of an ectopic pregnancy or miscarriage, then the patient is provided with information regarding symptoms of miscarriage with recommended course of action should symptoms develop. She is also referred to a physician.

As stated earlier, if a patient has symptoms of ectopic pregnancy or miscarriage, she is not offered an ultrasound exam and she is referred to the ED immediately.

The Second Ultrasound Exam

The CompassCare OT requires the performance of a second (follow up) ultrasound exam whenever the patient is too early to confirm the viability or when the patient is still considering a termination of the pregnancy after the initial confirmation. This second ultrasound exam is offered either in conjunction with the patient obtaining their Sexually Transmitted Disease (STD) results or on its own.

In the OT only one additional ultrasound exam is offered after the confirmation of the viability of pregnancy. This is to maximize organizational resources. However, according to American College of Obstetricians and Gynecologists (ACOG) and American Institute of Ultrasound in Medicine (AIUM) guidelines, additional ultrasound exams may be offered at the discretion of the Medical Director, provided that such ultrasounds are medically indicated. Not providing access to a follow up ultrasound exam may be considered substandard care regarding the doctor/patient relationship that has been created by the initial medical interface. Please note that this does not replace her OB care and that in any case she is always referred to her physician.

Vaginal Ultrasound Exams

At times it is necessary to perform a vaginal ultrasound exam. The confirmation of a viability of an intrauterine pregnancy is more easily attainable through the use of a vaginal probe up to 11 weeks LMP. In addition, the vaginal ultrasound exam is indicated medically and a standard of practice in most Obstetrician (OB) settings for first trimester ultrasound. Most early term pregnancies can be imaged through the abdomen without the invasive procedure of a vaginal ultrasound. However, it is important to acquire the best image possible both for the patient and the physician. This means that all ultrasound operators must be comfortable and experienced in performing vaginal ultrasounds.

Patient Perspectives

The CompassCare standard of care to do ultrasound exams at five weeks and one day is preferable from the patient’s perspective, whether the viability of the pregnancy is confirmed or not. In addition, to wait until six weeks and one day affords the risk of the PRC losing credibility in the eyes of the patient or even the loss of the baby.

Advantages of Five Weeks and One Day

If the ultrasound exam confirms the viability of the pregnancy, the patient receives peace of mind regarding the reality of the pregnancy. In addition, she experiences reduced anxiety around feeling pressure to make a hasty or uniformed decision.

If the ultrasound exam is unable to confirm the viability of the pregnancy, the patient still experiences some reduced anxiety. If she really is too early to confirm, she is afforded the assurance that she has time to consider her options without eliminating any of them, especially if considering RU 486. In this situation, a recent patient at CompassCare confided to the nurse, “This gives me time to think and to talk to my mom and grandmother.”

If the ultrasound exam is unable to confirm viability of the pregnancy, it generates a maternal concern and the patient will return for a second ultrasound exam 70% of the time (The 30% who don’t return include both miscarriages and no shows).

Providing ultrasound exams at five weeks and one day on the patient’s initial visit offers the PRC the opportunity to build credibility with the patient. For example, if she thinks that she is five weeks along but she is really seven weeks, the ultrasound exam will confirm both the viability of the pregnancy and the gestational development. This builds credibility for the PRC in the patient’s perspective because the PRC took the initiative to provide her with clinical care and thereby brought some clarity to her situation.

Risks of Six Weeks and One Day

If the PRC waits to provide an initial ultrasound exam to an abortion-vulnerable woman until she is six weeks and one day LMP, they actually risk damaging the credibility of their organization and even losing a baby’s life. If the woman is not provided with clinical care (i.e. an ultrasound exam) on her initial visit to the PRC, she is likely not to return for the rescheduled exam. She will likely seek service elsewhere, including going to an abortion provider, where she will get an ultrasound exam on her initial visit. Standard abortion provision often includes pre-procedure viability scan irrespective of LMP.

If the patient thinks she is less than six weeks LMP and then seeks services elsewhere and finds out that she is actually further along, in her mind the credibility of the PRC is decreased because they were not the ones to help her.

Even if she does come back to the PRC for the rescheduled initial ultrasound exam, the PRC still risks damaging the credibility of their organization. This is because many women who think they are less than six weeks LMP are actually further along. For example, a patient may think she is five weeks along but she is really seven weeks. Therefore, if she is not given an ultrasound exam on her initial visit but is rescheduled for one week later, she will actually be eight weeks along at the time of her first ultrasound exam. At that point, the PRC has eliminated her option for RU 486. This type of situation reduces the PRC’s credibility and can be construed by the woman as deceptive maneuvering on the part of the PRC. Remember, although this might not be the reality of the situation, it may be her perception and what she will communicate to others.

CompassCare Statistics for 2006

It is the CompassCare standard of care to do ultrasound exams at five weeks and one day. For the first 11 months of 2006 CompassCare had the following statistics related to this topic. 20% of patients receiving ultrasound exams were women presenting less than six weeks LMP. Of these, pregnancy was confirmed during the initial visit ultrasound exam 23% of the time. Of the women who were less than six weeks LMP and were unable to confirm viability of the pregnancy, 100% were rescheduled for a follow up ultrasound exam for confirmation. Of the women who rescheduled, 12% experienced a miscarriage and 18% were no shows for their rescheduled appointment (meaning she either did not call to cancel or called reporting having had an abortion.) ***Therefore, CompassCare was able to serve 70% of the women who rescheduled.*** All of these women were patients at risk for abortion.

Potential Opportunity Loss for Refusing 6 Week LMP or earlier Ultrasound Exams

If a PRC does not provide ultrasound exams at 5 weeks and 1 day, it losses significant opportunity to serve women at risk for an abortion, and to save lives. The following estimates are based on 100 women coming to a non-optimized PRC with a 50% no show rate for rescheduled appointments. 20 pregnant and at risk women will be rescheduled for appointments 1 plus weeks later. Of these women, 10 will return for the rescheduled appointment. Of these 10, 2 will scan to be 7½ to 8 weeks along, meaning they could have been confirmed on the initial visit. Of the 10 women who did not return for their rescheduled appointment, 2 will experience a miscarriage and 8 will be no snows. Statistically, of the 8 no shows, 2 could have been confirmed to be pregnant at the initial visit. ***Therefore, the opportunity loss is 8 lives per 100 women*** (assuming a 10% margin of error on average for a non-optimized PRC).

##### US1: Ultrasound

Ultrasounds shall be prescribed according to ACOG guidelines. Indications for Limited Ultrasound include estimation of gestational age for patients with uncertain clinical dates, or verification of dates for patients who are to undergo elective termination of pregnancy. All ultrasounds performed at the medical office are limited in scope and are not provided to diagnose abnormalities that the patient or baby may have.

###### Procedure:

1. Ultrasounds will only be provided by licensed medical personnel trained in limited ultrasonography, RDMS, RN, NP, PA, or MD.
2. Patients meeting the criteria established for ultrasound services shall be provided an ultrasound pursuant to the Medical Director’s standing order.
3. Prior to the ultrasound being performed, the patient must read and sign the “Ultrasound Consent” (PS7), if she hasn’t already done so.
4. Ultrasounds are effectively performed starting from between 5 weeks 1 day from the patient’s last menstrual period, which should be considered when scheduling appointments.
5. Each chart for an ultrasound performed by ultrasonographers or trained nurses shall be reviewed by a physician.
6. The medical professional(s) performing the ultrasound shall complete the “Practitioner Examination Record” (PS11).
7. The medical professional performing the ultrasound will determine whether to perform an abdominal or vaginal ultrasound. Vaginal ultrasounds are preferred during the first trimester.
8. Second trimester ultrasounds may only be performed by physicians and ultrasonographers who are trained in second trimester sonography.
9. Photographs may be taken during the ultrasound and given to the patient. No videos will be taken unless requested by the radiologist or other trained physician for purposes of reading the chart.

##### US2: Standing Order Protocol for Ultrasounds

1. A limited ultrasound may be performed by a trained and approved registered nurse on any patient meeting the criteria heretofore established to determine gestational age and viability according to ACOG guidelines.
2. The ultrasound must be done in compliance with the relevant policies and procedures established herein.
3. All ultrasound charts shall be reviewed weekly by a physician.

Medical Director’s Signature Date

##### US3: Limited Ultrasound Training

Registered Nurses may be trained in Limited Ultrasound according to AWHONN guidelines.

###### Procedure:

1. Registered Nurses will be recruited to perform limited ultrasounds on patients.
2. Training shall consist of attending and passing a course on Limited Ultrasound, which meets AWHONN guidelines (In-house training or outsourced training).
3. Including ultrasounds performed and observed within the above mentioned training, the nurse must perform 50-75 supervised scans before the Medical Director can approve her/him to provide such services to patients.
4. The supervised scans may take place at the office upon pregnant models who sign the Ultrasound Consent (Appendix 56).
5. The Medical Director shall approve the nurses for limited ultrasound scanning and shall be responsible for continuing supervision as needed.

##### US7: Unusual Ultrasounds

Ultrasound uses high frequency sound waves to detect fetal heart tones, placental location or body parts.

###### Procedure:

1. The medical personnel performing the limited ultrasound should provide ample opportunity to answer the patient’s questions, and reassure her that the procedure is safe. Ultrasound has been used for 25 years and is considered a very safe procedure. No risks have been identified. Accurate information regarding the procedure is imperative to allay the mother’s anxiety.
2. Prepare the room.
   1. Turn the ultrasound machine and TV on.
3. Prepare the patient.
   1. The patient should have a full bladder because the bladder supports the uterus in position for the images. If this is not possible (for example, if the patient has given urine for a pregnancy test) instruct the patient to drink 1-2 glasses of water during her Gospel presentation (Do not give the patient soda, just water).
   2. Fill out the ultrasound paperwork:
      1. Ultrasound Consent Form (Appendix 56).
      2. Appropriate Health Questionnaire (Appendix 25, Appendix 48)
   3. Position the patient comfortably on the exam table.
   4. Provide the patient with the photos to take home that do not have any measurements or confirming information on them (i.e. Due date).
4. Complete the Medical Exam Report (Appendix 29).

# Glossary

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| Abortion-Hub Center | A PRC which serves a geographic area which meets both of the following criteria: (1) at least 1500 abortions are performed annually and (2) 16% or more of all pregnancies end in abortion |
| Abortion-minded (AM) | A woman with a risk factor of between 4 and 7 according to the “Abortion Vulnerability Rating Scale” on the Patient Intake Sheet. |
| Abortion-vulnerable (AV) | A woman with a risk factor of between 1 and 3 according to the “Abortion Vulnerability Rating Scale” on the Patient Intake Sheet. |
| Abortion Vulnerability Rating Scale (AVRS) | A list of seven pressures on the Patient Intake Sheet that are primary reason why women have abortions. Each pressure has a value of 1. The number of pressures a woman has determines her abortion vulnerability. |
| Advocacy Team | The group of staff (paid and/or unpaid) that provide direct patient service/care. |
| Checklist | A list of the necessary accomplishments for each volunteer member of the Advocacy Team to be used to measure the effectiveness of each team member during their shift. |
| CompassCare TM | The primary Pregnancy Resource Center responsible for the development, testing, and implementation of the Optimization Tool©. |
| Dynamic Systems | An orchestrated interaction between the Patient and the Support Services staff that utilizes scripts for each Step in order to coordinate and measure consistency and outcomes. |
| Global Services Model | The typical PRC model of functioning as a “ministry” whereby a buffet of services (including medical services/ultrasound) are offered to any given “client” and these services are presented in a way that seems best to the staff member or volunteer at the time of service. |
| Intention to Carry (ITC) | Intention of patient regarding the outcome of her pregnancy |
| Linear Services Model | A process that intentionally moves a specific kind of woman through a series of predetermined steps so as to reach clearly defined results. It is “linear” because the patient starts at “the beginning” and moves through each step in its proper order with a specific destination in mind. |
| Measurement Systems | Systems that gleans information from the Patient through both the Dynamic Systems and the Equipment/Facilities Systems helping to determine effectiveness and future innovation. |
| Non-Abortion-Hub Center | A PRC which serves a geographic area which does not meet both “Abortion Hub” criteria. See ‘Abortion-Hub Center.’ |
| Positive Outcomes | Abortion-vulnerable and abortion-minded women who decide to carry the pregnancy to term. |
| Positive Test Patients | Women who have a positive pregnancy test at the Pregnancy Resource Center. |
| President/CEO | The chosen leader of any given Pregnancy Resource Center. May also be known as the Executive Director. |
| Pregnancy Resource Centers (PRC) | The organizations designated to serve women facing unplanned pregnancies for whom abortion is a real option. |
| Qualified Leads | Abortion-vulnerable and abortion-minded women who are pregnant. |
| Script | The memorized discourse for the support service staff to follow in order to bring consistency to the patient flow, allowing a smooth transition between the Service Steps, so that patient care can be monitored for quality. |
| Show Rate | The percentage of women who make an appointment and arrive to complete that appointment. |
| Steps | An integral part in the process determined to be necessary to provide peace of mind to at-risk women by getting her to the point of having her baby. |
| Streamlined Linear Service Model | A system that combines the roles of Advocate, Nurse, and Sonographer into a single role provided by one staff member. |
| Target Population | The group of women in any given PRC’s respective region who are the primary consumers of abortion services within that region. |
| Traditional Model PRC | An organization that provides material assistance, peer intervention counseling, abortion recovery, etc without medical services. |
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# Abbreviation Guide

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| AASLM | Advocate Assisted Linear Service Model |
| AM | Abortion Minded |
| AV | Abortion Vulnerable |
| AVR | Abortion Vulnerability Rating |
| CP | Continue Pregnancy |
| CTT | Carry to Term |
| ITC | Intention to Carry |
| LSM | Linear Services Model |
| OT | Optimization Tool© |
| PRC | Pregnancy Resource Center |
| SLSM | Streamlined Linear Service Model |
| STD | Sexually Transmitted Disease |
| TP | Terminate Pregnancy |

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