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Provision of abortion and other reproductive health services among former Midwest Access Project trainees☆,☆☆

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ABSTRACT

Objective: The Midwest Access Project (MAP) offers opt-in training to students, residents and practicing clinicians in reproductive health care including abortion. We surveyed MAP alumni to identify current practice characteristics and assess predictors of reproductive health service provision.
Study design: We sent an online survey to alumni of MAP's Individual Clinical Training program, 2007–2015 (n=127). The primary outcome was current provision of any abortion service. Secondary outcomes included providing specific abortion services and other reproductive services.
Results: We received responses from 61% of eligible MAP alumni (n=77 out of 127). The majority reported a specialty of Family Medicine (68%) and current location in the Midwest (52%). Among current residents, fellows or clinicians practicing in a field whose scope includes abortion (n=56), 50% provide abortion. Most (84%) provide outpatient miscarriage management, and nearly all (≥96%) provide pregnancy options counseling and full scope contraception. Respondents who received the most advanced training in medication abortion as part of their MAP training were more likely to report providing abortion in their current practice than those who did not (63% vs. 32%, p=.027), as were those who completed more than one MAP rotation compared to those who completed one rotation (100% vs. 44%, p=.009).
Conclusions: Half of MAP's alumni provide some abortion care. Nearly all provide comprehensive counseling and contraceptive services.
Implications: Opt-in training is a promising strategy to develop providers of comprehensive reproductive health care.

1. Introduction

Between 2011 and 2014, the United States saw a 3% overall decline in the number of facilities providing abortion, while in the Midwest, these declined by 18% [1]. Barriers to abortion training have likely contributed to declining provider numbers, especially in the Midwest. Among women in the Midwest, 55% live in a county with no abortion clinic compared to 39% nationwide [1]. In a survey of obstetrics-gynecology (Ob-Gyn) residents in the Midwest, those trained in religious hospitals reported lower ability to perform common reproductive health services, including intrauterine device insertion and manual vacuum aspiration, compared to residents in nonreligious hospitals, despite equally high interest in providing these services [2]. Similarly, Family Medicine residencies in the Midwest are significantly less likely to offer abortion training than those in the Northeast or West [3].

The Midwest Access Project (MAP) works to address this problem by filling gaps in provider training. MAP's Individual Clinical Training (ICT) program is designed with the understanding that, in highly constrained settings, such as Midwestern states with restrictive laws and a high prevalence of Catholic health care systems, medical and nursing schools and residencies rarely integrate abortion and other reproductive health training into their curricula. Integrated training programs, which offer routine abortion training unless a resident opts out, have led to enhanced skill development for Ob-Gyn residents [4] and Family Medicine residents [5]. However, these programs require the residency institution to support the family planning training mission, which many do not. Thus, MAP trains highly motivated individuals willing and able to leave their home institutions for short-term learning experiences and then return to their home institution or community, with the goal of improving access in settings with otherwise very limited reproductive health care.

MAP's ICT program builds on the model of the Reproductive Health Program (RHP) at the University of Rochester, which closed in 2005

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[6]. MAP trainees opt in to the program, meaning they individually seek out and choose to attend the program. (The only exception is three Ob-Gyn residents per year from a program that since 2015 has contracted with MAP for opt-out training.) MAP welcomes trainees from all specialties and locations but primarily reaches out (e.g., via conferences) to Midwestern Family Medicine programs. MAP rotations are usually 2–4 weeks and include hands-on and/or observational experiences. Trainees who complete one rotation can return at later stages of their training or career for additional MAP rotations. Trainees include medical students, residents, practicing physicians, nursing and advance practice clinician (APC) students, and practicing APCs. MAP assesses each trainee's goals and experience using an intake questionnaire. The variability in trainees' goals, prior knowledge and experience and in trainee and trainer schedules leads to variability in the rotation experience provided by MAP. Most trainees' goals include learning about and/or providing medication and aspiration (surgical) abortion as well as the full range of contraceptive options, so most rotations include exposure to this content as part of the learning experience. Trainers include providers of abortion and other reproductive health services in Illinois and Minnesota. MAP serves as the link between trainee and trainer and provides extensive administrative support to facilitate training. For example, MAP screens and orients trainees; guarantees that they have necessary licensure, liability insurance, health screenings, and appropriate education and standing to be in reproductive health care settings; and connects them to funding opportunities to support their travel and lodging when needed. MAP maintains formal agreements with trainers and, where needed, with trainees' home programs in order to coordinate training experiences. MAP also works with trainers to optimize the quality of the learning experience, provide feedback to trainees and help trainees progress to the next stage of their training or career in reproductive health.

MAP's ICT program started in 2007 and has grown since that time. The program has always offered hands-on training for appropriate trainees. For those who are qualified to do procedures with supervision (such as residents and fellows), the number of procedures they do depends on several factors, such as their available days to train and the available trainers during their rotation. For example, a resident who does a 4-week rotation but can only spend 2 days per week with MAP because their remaining days are occupied with residency clinic and on-call duties could have the same procedure volume as a different resident doing a 2-week rotation spending 4 days per week with MAP. Overall, the number of training and hands-on learning opportunities has increased over time as MAP has contracted with more training sites.

MAP's training program aims to improve abortion access by (1) increasing trainees' motivation to provide and (2) improving their concrete skills, such that some will add abortion to their existing services or seek future opportunities in which they can provide abortion, while those who do not provide abortion will still provide more competent counseling and referrals for their patients considering abortion. We hypothesized that many MAP alumni would report posttraining that they provide abortion, contraception, options counseling and outpatient miscarriage management.

We conducted a survey of MAP's alumni to identify what reproductive health services they provide, where they work and what impact MAP training had on their intention and ability to provide the full scope of reproductive health care.

2. Methods

2.1. Participants and data collection procedures

In April 2016, MAP staff sent an email invitation to all individuals who had participated in its ICT program during the years 2007–2015 and for whom the organization had an email address (n=127). The email contained a description of the study, information about its purpose and voluntary nature, and a link to an online survey. Alumni received three reminders to complete the survey over the course of 4 weeks. No financial incentive was offered.

We excluded from analysis any respondent not currently providing patient care (n=2) or whose field excludes reproductive health services (n=1, a Pathology resident). We included all other respondent specialties (Ob-Gyn, Family Medicine, Internal Medicine and General Surgery). In analyzing the primary outcome and all outcomes related to current service provision, we excluded respondents still in school. (For example, students who completed a MAP rotation during their first year of medical school and responded to the survey during their third year of medical school would be excluded from analyses related to current service provision.) The primary analytic sample (population 1, n=56) thus included MAP alumni currently in residency, fellowship or practice in a field whose scope includes reproductive health. We also examined the subset of respondents (population 2, n=32) currently in practice rather than in training (i.e., excluding residents and fellows), and among these, we looked specifically at Family Medicine providers (n=26).

2.2. Survey instrument and outcome measures

The survey took approximately 15 min to complete, with up to 34 questions (fewer for some participants due to skip logic). The survey asked both closed-ended (check-box) and open-ended (free-text) questions. Responses were anonymous unless the respondent opted to complete a voluntary question with their name and contact information for future follow-up.

The primary outcome was report of current provision of any abortion service. Secondary outcomes were provision of specific abortion options (medication, first-trimester aspiration, second trimester) and other reproductive health services (contraception counseling, insertion and removal of contraceptive devices, outpatient miscarriage management, pregnancy options counseling). To derive these outcome measures, we asked participants how frequently they provide specific services (never, rarely, occasionally or frequently) and then dichotomized responses to never versus ever. For the primary outcome, we collapsed medication abortion, first-trimester aspiration abortion and second-trimester abortion into a composite outcome: any abortion. The survey also asked, “Are you the sole provider of any reproductive health services for your practice or community?” Respondents were also asked about their involvement in reproductive justice or advocacy, and about whether MAP impacted their intention and preparation to provide reproductive health care.

Participants were also asked about their current occupation, specialty, practice location and type of facility where they provide care, as well as the number of MAP rotations they completed, their stage of training during their MAP rotation(s) (student, resident, fellow, attending physician, advance practice clinician or other) and the level of educational exposure to different reproductive health services they received during their MAP training (no experience, didactic education only, clinical observation only with no hands-on training, or hands-on training).

2.3. Data analysis

We identified factors associated with reporting provision of any abortion (ever versus never) using the χ^2 test and Fisher's Exact Test where any cell had count ≤5, with significance set at p=.05 for all analyses. We conducted multiple logistic regression to identify the association between MAP training factors and provision of abortion controlling for potential confounders. To assess for selection bias, we compared survey respondents to nonrespondents on characteristics that MAP could ascertain based on its programming database.

The study was deemed exempt by the University of Chicago Institutional Review Board.

3. Results

3.1. Participant characteristics

Of 135 alumni, MAP had valid email addresses for 127 and received survey responses from 77, for a response rate of 61% (Table 1). Most

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