Enclosed is your copy of NAF’s 2017 Clinical Policy Guidelines for Abortion Care (CPGs), which now replace the 2016 edition. Please ensure that all clinical staff becomes familiar with the new content of the CPGs.

The 2017 CPGs have been revised from last year’s edition. A summary of the major changes is included below. Please read the new Guidelines closely for all changes.

As part of our ongoing quality assurance program, we require the medical directors of all NAF member facilities to certify that their facilities are in compliance with this year’s CPGs by completing the enclosed 2017 Compliance Agreement and returning it to us no later than April 28, 2017.

Please remember that Standards are to be followed in virtually all cases, and deviation from Standards must be appropriately justified.

Recommendations allow some latitude in clinical management. When a facility’s policies differ from CPG Recommendations, the rationale should be included under that appropriate section of the Compliance Agreement and should also be documented in your own policy and procedures manual.

Once we have received a completed 2017 Compliance Agreement and your dues for 2017, we will send you a membership display decal that will inform your patients that you are committed to meeting the highest quality standards for abortion care.

Summary of Changes

References are not shown in this summary but are available in the 2017 CPGs with hyperlinks.

1. WHO CAN PROVIDE ABORTIONS

The policy statement was expanded to add “The vast majority of abortions, including uterine aspiration, dilation and evacuation, and medical induction, can be safely provided in medical offices or freestanding clinics.”
Standard 1.3. was expanded to discuss training in ancillary services. Training for ancillary services was removed from other sections (e.g. laboratory, ultrasound):

**Standard 1.3.** All staff members must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other patient-related services.

2. **PATIENT EDUCATION, COUNSELING, AND INFORMED CONSENT**

Standard 2.2. was edited to show which risks are part of every abortion procedure and which are part of aspiration or dilation and evacuation only:

**Standard 2.2.** Documentation must show that the patient affirms that she understands the procedure and its alternatives, the potential risks and benefits, and that her decision is voluntary. Although other risks may be addressed, at a minimum, the following risks must be included:

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

For vacuum aspiration or dilation and evacuation, the additional risks must be included:

5. Perforation
6. Damage to organs including hysterectomy

Recommendation 2.5.1. was added:

**Recommendation 2.5.1.** The importance of contacting the facility for any concerns should be emphasized.

3. **INFECTION PREVENTION AND CONTROL**

No changes were made in this section.

4. **LABORATORY PRACTICE**

Standard 4.1. was changed to indicate that Rh testing must be offered to women with unknown Rh status rather than all women:

**Standard 4.1.** Rh status testing must be offered to all patients with unknown Rh status.

Discussion: A statement was added: “Moderate or asymptomatic anemia is rarely a reason to delay abortion care.”
5. LIMITED SONOGRAPHY IN ABORTION CARE

Standard 5.6. combines recommendations for first and second trimester ultrasound:

Standard 5.6. A limited ultrasound exam must include the following:
(1) a full scan of the uterus in both the transverse and longitudinal planes to confirm an intrauterine pregnancy;
(2) evaluation of embryo/fetal number;
(3) measurements to document gestational age (5, 6);
(4) evaluation of pregnancy landmarks, such as yolk sac or the presence or absence of fetal/embryonic cardiac activity; and
(5) placental location in second trimester.

6. EARLY MEDICAL ABORTION

Recommendation 6.6.1. was edited so that medical abortion may be offered even if intrauterine pregnancy is not confirmed:

Recommendation 6.6.1. If an ultrasound has been performed and an intrauterine gestation has not been confirmed, the medical abortion regimen should be offered concurrently with evaluation for pregnancy of unknown location, as outlined in CPG section 8 Management of Pregnancy of Uncertain Location.

Recommendation 6.8.7. was updated for the most recent evidence-based methotrexate and misoprostol regimen:

Recommendation 6.8.7 When methotrexate and misoprostol are used, an evidence-based regimen oral or intramuscular methotrexate followed in three to five days with vaginal misoprostol is recommended for gestations up to 63 days.

Standard 6.10. expands patient choice for medical abortion follow-up:

Standard 6.10. Patients must be offered a follow-up assessment to confirm absence of ongoing pregnancy. Confirmation can be established by ultrasonography, hCG testing, physical exam, or other evaluation in the office, by telephone, or electronic communication.
Recommendation 6.11.3. was removed. Multiple methods may be used for evaluation for women who did not have expected bleeding and are covered under other recommendations:

Recommendation 6.11.3. Ultrasonography or hCG levels should be used to evaluate completion of the abortion when expected bleeding does not occur after medications.

7. FIRST-TRIMESTER ASPIRATION ABORTION

Title and language were changed throughout from “first-trimester surgical abortion” to “first-trimester aspiration abortion”.

Discussion was added: “Sharp curettage should not be routinely used after vacuum aspiration.”

8. MANAGEMENT OF PREGNANCY OF UNCERTAIN LOCATION

No Changes

9. ABORTION BY DILATION AND EVACUATION

No changes

10. LATER MEDICAL INDUCTION ABORTION

Title and language throughout section was changed from “second-trimester medical abortion” to “later medical induction abortion.”

Standard 10.4. was added:

Standard 10.4. Facilities must have a policy that addresses whether and when to induce fetal demise.

Discussion was added: “An interval of 24-48 hours between mifepristone and misoprostol shortens the time to completion after starting misoprostol.”

11. ANALGESIA AND SEDATION

Standard 11.1. was added:

Standard 11.1. Pain control options must be discussed with the patient.
12. POST-PROCEDURE CARE

Option 12.1.3.1. was added due to new data on DMPA injection at the time of mifepristone. Because DMPA injection may increase the risk of ongoing pregnancy, it may be given at the time of mifepristone with appropriate counseling. More information is given in the discussion:

Option 12.1.3.1. Depot Medroxyprogesterone acetate (Depo-Provera®) may be given at the time of mifepristone with appropriate counseling.

13. EVALUATION OF EVACUATED UTERINE CONTENTS

No Changes

14. EMERGENCY PROCEDURES

Sections 14 (Emergency Procedures), 15 (Bleeding) and 16 (Perforation) have been combined, as they all are concerned with emergency management.

Because management of perforation is made on a case-by-case basis, generalized recommendations about management such as use of uterotonics and antibiotics have been removed.

Option 16.2.2.2. has been changed to Recommendation 14.7.1.:

Recommendation 14.7.1. If the procedure is completed after a suspected perforation, uterine evacuation should be performed under direct ultrasound guidance or laparoscopic visualization.