**Victorian Rural Clinical Network for Unintended Pregnancy and Abortion meeting, 2nd June 2020**

**Meeting notes**

**1800 My Options service update**

Approaching 10,000 calls in approximately 2 years of service delivery.

Have observed change in profile of callers during pandemic:

- Reduction in number of callers from rural Victoria. Pre pandemic 12.5 per cent of callers based in rural areas, 0.5 percent reduction during pandemic (April and May).
- Experienced a noticeable decrease in calls from Gippsland with an increase in calls from Barwon South West regions. No defined reason.
- Changes in age of callers: increase in under 18 year old age bracket, from 2.5 per cent to 4 per cent; slight increase in callers 18-25 year old.
- Gestation at time of call: increase in callers who are greater than 18 weeks gestation and 12 to 18 weeks gestation.
- Overall increase in presentations associated with anxiety and reluctance in engage in services.

The Royal Women's Abortion and Contraception Service have observed reduction in number of referrals from Gippsland & increase in presentations later in gestation.

Acknowledge the importance of 1800Myoptions role & the capacity to gather evidence of need and profile of service users.

**Case study presentation 1**

**Surgical abortion care in a rural public hospital. Simone O'Brien, Nurse Practitioner, Bendigo Health, Women's Health Clinic and Louise Holland, Community Health Nurse (CHN)/Nurse Practitioner candidate, Bendigo Community Health Service (BCHS).**

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| **Demographic profile** | 18 year old woman, "Jackie". |
| **Obstetric history** | G2 P1<br>This pregnancy, 11 +5 weeks gestation<br>1st baby 5 months, in father's care under DHHS order |
| **Psycho social presentation** | Intellectual disability. Presents as "childlike"<br>Lives with friend & former residential carer, now current carer<br>On NDIS package<br>PIP and his mother have guardianship of 5 month old daughter<br>Limited support from partner in pregnancy (PIP), had IVO due to Jackie's aggressive behaviour toward him in previous pregnancy. In this pregnancy has had support from PIP, he is the one person she insists in having in the room. |

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| **Health services involved** | Bendigo CHS, CHN Louise Holland had worked with Jackie during her first and this pregnancy. This presentation referred by Bendigo CHS GP Registrar to discuss maternal screening test.<br><br>During this consultation Jackie indicated that she wanted to end the pregnancy.<br><br>Referred to Bendigo Health for surgical abortion consultation. Simone O'Brien Nurse Practitioner, Bendigo Health provided booking consultation. |
| **Issues and challenges** | |
| **Changes to the consultation format due to pandemic, from face to face to video or telephone consultation during pandemic** | This consultation provided face to face. Video consultations not yet implemented at Bendigo Health. Anticipate challenges associated with assessment including capacity to screen for reproductive coercion. Acknowledge increased level of difficulty and challenges associated with making an assessment via video or telephone platform, such as capacity to assess nonverbal communication and who else is in the room.<br><br>During both consultations, Jackie refused to be seen on her own, insisted the PIP be present throughout the consultations. Jackie tends to revert to using threats and verbal aggression when challenged. Consequently, the consultation took some time to ensure the decision was hers. |
| **Restrictions to number of people present during care i.e. face-to-face consultation and in hospital on day of procedure** | Able to have 2 people only in the consultation room. Discussion and negotiation re who - either PIP or carer, a friend & ex residential support worker.<br><br>Jackie insists PIP be present pre and post procedure. Simone able to advocate Jackie's wishes re PIP presence in Day Surgery Unit but not able to have authority over the decision. |
| **Decision to proceed with an abortion** | Jackie initially referred to CHN Bendigo CHS for maternal screening. Presented with 18yo male partner. During consultation articulated a desire to end this pregnancy. Jackie was able to articulate that life will be the same with another baby & acknowledged fear of not seeing 5 month old baby again. These factors influenced her decision to end this pregnancy. |
| **Value of collaboration, networking and continuity of care in a community setting.** | Past experience of working with Jackie provided some knowledge and background on how to work effectively together during these presentations. Louise had seen Jackie in previous pregnancy, knew of her cognitive deficit and her responses to being challenged and coping mechanisms.<br><br>Integrated care through various hospital episodes means that Simone was able review Jackie's client file and gain knowledge of previous presentations and level of risk. Gained knowledge of multiple presentations to Bendigo Hospital, Emergency Department due to self harm and notifications to DHHS Child Protection through Birth Suite. |

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| | Working relationship between practitioners means they are able to share information so that Jackie doesn't need to retell her story, this has a potential for an emotional trigger. Working together ultimately enhances her capacity to make an informed choice. |
| **Challenging social context** | Jackie had been living with her biological mother, but removed due to Jackie's violence. Now living with carer.<br><br>Some support from PIP during this pregnancy. Present during consultations, unwilling to proceed if he is not present. Heavy reliance on him for support.<br><br>Due to COVID-19, no current access visits to 5 month daughter. Keen to reengage with supervised visits. Making plans to see daughter as soon as COVID-19 restrictions allow. |
| **Outcome** | Jackie booked to have surgical abortion this week.<br><br>Discussed contraception plan over the 2 consultations. Initially not willing to consider LARC, did acknowledge difficulty remembering to take daily OCP. Follow up at booking consultation, consent to LARC with abortion procedure. |

**Case study presentation 2.**

**Abortion care in rural general practice: a shared model of care with Loddon Mallee Women's Health (LMWH). Dr Mark Farrugia, GP Obstetrician (GPO) & Elise Kornmann, Women's Health Nurse (WHN), LMWH**

Women's Health Clinic (Choices Clinic) providing medical abortion using a shared model of care. During COVID-19 shift in emphasis to unplanned pregnancy consultations, options counselling and referral pathway to medical and surgical abortion, contraception and sexual health screening.Clinic available 3 days week, in response to COVID-19 changed model of care to consultation via telephone and video.

Profile of shared model of care:

- implemented from April 2019,
- partnership between Castlemaine GP Clinic and WHLM
- developed Memorandum of Understanding
- 60 women accessed shared care model in first 12 months (50 medical abortion, 12 surgical abortion)
- Referrals seen within 48 hours of referral via telehealth or face-to-face at Castlemaine clinic
- GPs able to provide a clinic dating scan if needed
- Referrals originate from other GPs, 1800My Options, Bendigo CHS and self-referral.
- WHLM WHN provide the work up (arrange investigations, counselling) and follow up care
- Shared care partners use a live database to summarise the referrals, process is streamlined and is no contact.

During COVID-19

- majority choose medical abortion (depending on eligibility)
- increase emphasis to screen for reproductive coercion
- increase in incidence of presentations for an abortion later in pregnancy, requires referral to Melbourne (The Women's)

- evidence of women's request for a medical abortion being denied and delay in referral for abortion, results in greater stress and trauma associated with the decision
- increase in disruption to women's choice, results in increased stress, costs and need for travel, requires surgical abortion at later gestation rather than medical,
- COVID-19 induced stress and anxiety create additional barriers to abortion. Influencing factors to the abortion decision: change of circumstances, uncertainty about the future, lack of privacy, additional caring responsibilities, restrictions to movement

**Dr Mark Farrugia, GP Obstetrician (GPO)**

Collaboration with WHN LMWH supported by an efficient referral pathway.

Requires open communication between WHN & GPO. GPO able to respond to requests same day, patient provided appointment on same day of referral and seen within 48 hours.

Efficient shared processes such as communication channels, use pre-loaded pathology requests, means the results are forwarded direct to clinic

Women report a positive experience being seen by WHN. GP allocates 30 minute appointment. By the time women attend the GP appointment the woman has sufficient information to feel informed about the procedure. Often 30 minutes not required as the work up provided by Elise is comprehensive. Much less discussion on contraception and understanding of the procedure due to Elise's input.

Key is open and efficient communication using shared excel document.

Headings

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| Completed | Date | Name | DOB | EDD | COUNSELLING | ULTRASOUND | BHCG | BG | ANTID | STI |
| | BV | CONTRACEPTION | | MTOP | CONSENT | MIFI/MISO | BHCG 1st | | 2nd BHCG | |
| | PHONE CALL | Seen | STOP | HOSPITAL CONTACTED | | DATE OF PROCEEDURE | | PATH | | |

3 out of 60 lost to follow up, less than 3 percent

Process of follow up: 2 phone calls & SMS then registered mail with pathology request.

Telehealth currently bulk billed due to COVID-19 arrangements, also efficient for women who would otherwise travel long distances

Benefits of collaboration, many and varied.

- Collaboration with LMWH streamlined and efficient.
- Extends beyond LMWH, created an opportunity to network and collaborate with RANZCOG Fellows in the region and at The Women's.
- Opportunity to communicate direct to service provider creates an efficient referral pathway.
- Efficient for the woman too, generally care provided locally, care in services most appropriate to her needs.
- Need to nurture and support relationships with others who provider care such as theatre staff. For example Kyneton, service able to be flexible and responsive to the needs of the woman concerned.

**Case study 3: Abortion care in a rural Sexual and Reproductive Health Hub. Dr Katie Snow GP Registrar Bendigo Community Health**

Relatively new to providing medical abortion service, MS2 step prescriber since Feb 2020. Quickly gained experience.

Adjusted model of care to respond to COVID-19 context. Impact not just for women and pregnant people seeking care, also for providers of care. Providers of care also need to isolate themselves and work remotely via telehealth. Became aware of the fragility of the workforce.

Need to utilise existing relationships & develop new relationships to work out new processes.

Changes implemented due to COVID-19:

- Bendigo CHS has worked closely with local Pharmacists to use their facilities to support the procedure. The consent, script, ED letter and pathology forms are emailed direct to pharmacist & provided to women. Consent emailed back to Bendigo CHS
- Have established a process for consent: first step read out consent verbatim (use the MS version), faxed to pharmacist, woman signs & pharmacists returns consent via email
- Have created an efficient referral pathway for medical abortion. First consultation with one of the S&RH/WH Nurses, acknowledge role of nurses to set up the care. Task share arrangement with the doctor
- Varied model of care either face to face or telehealth. Have flexibility to see woman in the clinic.
- Screen for reproductive coercion an important part of the consultation
- Use of interpreters as required
- STI screen provided remotely

Case study profiled challenges of working with a distressed young woman via telehealth.

14yo young woman referred by Ballarat ED. Had presented to ED with an intentional paracetamol overdose. Telephone consultation for medical abortion provided via speaker phone. Insisted that mother and grandmother be present during the consultation. Declined to be seen on her own.

Numerous barriers to care:

- not able to see young woman in person or alone
- geographic distance (70kms away)
- need to rely and trust locally based services ie mental health & GP to provide follow up support.