

**APC Testimonials for EPL Training and Integration**

Hearing from your peers can be a helpful way to gain insights on common frustrations, best practices, and strategies for success. We have spoken to two APCs who have successfully trained to provide all forms of EPL management.

**Advanced Registered Nurse Practitioner**

This ARNP took the initiative to get trained to performMUA procedures for miscarriage management. The organization she worked for needed a second licensed provider as a backup, the first being a physician. This ARNP held an administrative position, so she was regularly in clinic and had a flexible schedule, allowing her to be immediately available to observe and assist in procedures. She believes the training probably would not have worked out if she had not been there regularly for her administrative role. Since EPL is not planned or scheduled in advance, you need someone in a flexible role who can be available ad hoc. Even with this flexibility, it took a long to perform a sufficient number of MUAs, , since EPL and post-abortion is rare in her clinic. This ARNP was already proficient in performing paracervical block and dilator placements and she believes this helped usher the process forward.

When she advocated for herself to be trained, she proposed performing a certain number of procedures (20) to prove competence. At 13 procedures, the physician training her signed her off. She emphasized that a set number or procedures is not the answer, because each person has a different history and familiarity with the uterus. Someone who has been focusing on reproductive health for years post-graduate is going to pick this up MUCH quicker than someone who is just starting their clinical practice. For example, those who have been placing IUCs, removing IUCs when the strings can not be found, and performing endometrial biopsies are going to be comfortable working inside the uterus and as a result, are likely to pick up the MUA skill relatively quickly.

She worked with the leadership and updated the competencies within her clinic, removing the set number of MUA procedures required for sign-off, and made it so trainers use their discretion as to when the provider/trainee is up to competency.

She sees a big barrier for APCs to be trained is reaching and maintaining competence because this service and procedure is relatively rare, and APCs are not always first in line for training. Often residents are the first priority, as clinics receive income for training residents. No similar mechanism is set up for APCs to receive training.

**Certified Nurse Midwife, Seattle**

This CNM attended multiple TEAMM trainings through his employers, and was inspired to train to competence to provide MUAs for EPL. While one employer did train him to competence, he has struggled to maintain these skills for various reasons. He initiated his training while assisting MDs with the procedure, providing the paracervical block, and then eventually moving forward to aspirating.

The biggest barrier he initially faced was staff resistance. At his previous place of employment, APCs were only doing IV pain management during MUA procedures. The clinic’s Medical Assistants (MAs) were resistant to APCs moving to the procedure role, as they were worried that patients would not get enough relief, since they were so used to patients having IV pain management. MAs pushed back, stating that APCs should remain in this pain management role. MAs were concerned that if the APC was providing the MUA, there would be no IV pain management. Another barrier to training was money. This CNM said that having a physician train an APC on MUAs was an additional cost for the clinic. Therefore, clinic administrators needed to approve the process of APCs getting trained. Additionally he has faced institutional barriers, such as the scheduling for MUA management only being available one day a week, and barriers with the pharmacy now allowing narcotics on the same floor.

At his current health center, this CNM has run into the issue of volume. They have clinic once a week for both EPL management and terminations and see about two EPL patients per week, The current structure does not allow for APCs to provide the MUA. The MA rooms the patient and takes vitals while theCNM does everything else to prepare the patient for the procedure (u/s, exam, counseling, and medication). Then physician does the procure. They are working to be more patient centered by moving more toward on demand pregnancy loss management instead of one day a week, since EPL is not planned,

 He feels like he needs more to maintain competence for the procedure. He hopes that with the support of mentors and staff, the organization he works at will be able to move forward in training more APCs to provide this service. This CNM believes that the road to success needs to include a relatively high volume of EPL patients, mentors who are supportive of training APCs, support of clinic support staff, and continued exposure to maintain competence. Whenever discouraged, he derives determination by remembering that CNMs take care of pregnant patients and that providing comprehensive EPL services is is patient-centered care and a natural fit for their scope of practice.