

BRIEF REPORT

Facilitating Abortion Services in Primary Care Settings After the Loss of Federal Protections

Kathryn Fine, BS¹, Anna Fiastro, PhD, MPH, MEM², Ying Zhang, MD, MPH², Grace Shih, MD, MAS², Emily M Godfrey, MD, MPH², Dinah Aldrich², Ian M Bennett, MD, PhD²

¹ School of Medicine, University of Washington, ² School of Medicine, Department of Family Medicine, University of Washington

<https://doi.org/10.3122/jabfm.2025.250136R1>

Journal of the American Board of Family Medicine

Vol. 39, Issue 1, 2026

Introduction: Abortion care access became more restricted following the 2022 US Supreme Court decision, *Dobbs vs Jackson Women's Health*, that eliminated federal protection. We sought to engage healthcare clinicians in states in the Northwestern U.S. with varied abortion regulations to develop strategies for primary care involvement in access to and follow up for abortion care.

Methods: The "Won't Go Back" initiative began in July 2022, recruiting members from the five state WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) region Practice Based Research Network (WPRN), Family Medicine Residency Network (FMRN) and Washington state family planning clinics. We completed a cross-sectional needs assessment survey (winter 2022) and virtual convenings (summer 2023). We used descriptive statistics to describe participant demographics, reproductive health services offered, documented needs, and proposed solutions including abortion care education and referral networks.

Results: 193 surveys were sent to individual clinicians with 40 responses (21% response rate) from Washington, Idaho, Montana and Alaska. All participants provided reproductive health services, and 25% offered abortion care. All clinicians wished to support their patients seeking abortion care. Barriers faced by convening attendees included obtaining mifepristone, federal funding restrictions and navigating anti-abortion views. Proposed solutions from survey and convening representatives included creation of a learning collaborative and regional networks of primary care abortion clinicians.

Conclusion: Survey and convening representatives were interested in enhancing abortion access for their patients. Clinicians faced barriers due to federal and state legal restrictions. Creation of an abortion learning collaborative and referral networks addressing identified barriers can potentially support patients.

Keywords: Abortion, Access to Care, Continuity of Care, Family Medicine, Health Disparities, Needs Assessment, Patient-Centered Care, Primary Health Care, Reproductive Health, Women's Health

Introduction

Abortion restrictions rapidly increased following the United States (U.S.) Supreme Court's case, *Dobbs vs Jackson Women's Health Organization (Dobbs)*, ending the federal protection of abortion rights in the U.S.¹ Restrictions are expected to worsen pregnancy-related morbidity, mortality, and disparities, which are already U.S. public health crises.²⁻⁴

Community based primary care is well-positioned to address health disparities due to its accessibility and patient-centered approach.⁵ Prior studies have demonstrated patient preference for and satisfaction with receiving an abortion in primary care settings.⁶⁻⁹ Furthermore, primary care-based abortion services have been shown to be both

safe and effective.¹⁰ Despite the need, patient preference, and safety of abortion services in primary care, many clinicians face barriers that prevent them from incorporating these services into their practice.¹¹⁻¹³

The five state WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) region of the Northwestern U.S. is diverse in its abortion access following the *Dobbs* decision.¹⁴ Regional learning collaboratives, a method uniting peers and experts to drive practice change through focused, team-based learning, can support abortion care in primary care settings.^{10,15,16} We sought to explore the interest and potential effort of a regional learning collaborative focused on supporting abortion access and care to patients of clinicians belonging to regional networks across the WWAMI territory.

Table 1. Description of Survey Respondents' Clinic Practice Location and Setting.

	Total		FMRN		WPRN		WA Title X	
	N	%		%		%		%
Total Surveys Sent	193		45		94		54	
Total Survey Responses	40		18		6		16	
State								
WA	31	78	13	72	2	33	16	100
WY	-	-	-	-	-	-	-	-
AK	1	3	0	0	0	0	1	6
MT	4	10	3	17	1	17	0	0
ID	6	15	2	11	3	50	1	6
Other	2	5	0	0	0	0	2	13
Geographic descriptor								
Urban	21	53	10	56	3	50	8	50
Suburban	15	38	8	44	2	33	5	31
Rural	25	63	8	44	4	67	13	81
Frontier	4	10	1	6	1	17	2	13
Proportion of population that is of reproductive age								
10-25%	8	20	5	28	1	17	2	13
26-50%	13	33	10	56	3	50	0	0
>50%	18	45	3	17	2	33	13	81
Prefer not to answer	1	3	0	0	0	0	1	6

Abbreviations: FMRN: Family Medicine Residency Network; WPRN: WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) region Practice Based Research Network

Methods

The *Won't Go Back* (WGB) initiative was launched in July 2022 to: 1) support the delivery of safe and legal abortion care to patients, and 2) assist primary care clinicians in their care of patients seeking this service across the WWAMI region. A needs assessment survey and clinician convenings were carried out to explore interest and opportunities for moving forward.

The survey assessed clinician demographics, reproductive health services offered and interest in a learning collaborative supporting abortion services in primary care. Survey items were created, then pretested through cognitive interviewing with five independent staff members. An initial anonymous section was followed by a second survey for those who indicated interest in participating in the WGB learning collaborative. Study data were collected and managed using REDCap (Research Electronic Data Capture) tools hosted at the Institute of Translational Health Sciences.^{17,18} The survey was disseminated to three networks involved with primary care training, research or reproductive health services: 1) the Family Medicine Residency Network (FMRN), 2) the WWAMI Population Research Network (WPRN), and 3) Federal Title X recipient clinics in Washington State. Survey links were emailed to clinician representatives from the aforementioned clinics, with some clinics possibly having multiple representatives. Two reminder emails were sent two weeks apart. Data was col-

lected from December 2022-February 2023. No incentives were provided.

Respondents to the learning collaborative section received an invitation to attend online Zoom convenings. Agenda items focused on introductions (location and context), family planning service status, and goals. A transcript of each convening was recorded, and verbal consent was obtained for transcript collection and data analysis. Two research members compiled field notes and transcripts to assess common themes and summarize convening results. These were reviewed by the larger team to reduce analysis bias and guide the creation of a primary care abortion learning collaborative. The University of Washington (UW) Institutional Review Board reviewed this study and determined that the effort had exempt status.

Results

Survey

The overall response rate was 21% (40/193). All states across the WWAMI region were represented, except Wyoming. Most respondents were from Washington (n=31, 73%), followed by Idaho (n=6, 15%). Most clinicians (63%) worked in rural clinics, followed by urban settings (53%). Approximately 45% of respondents reported that over half of their practice consists of people with reproductive potential (Table 1).

Table 2. Reproductive Healthcare Service Availability Across Surveys Clinic Sites.

	Total N	%	FMRN	%	WPNR	%	WA Title X	%
Total Surveys Sent	193		45		94		54	
Total Survey Responses	40		18		6		16	
Contraception								
Pill, patch, ring	40	100	18	100	6	100	16	100
Implant	39	98	18	100	6	100	15	94
IUD	37	93	18	100	4	67	15	94
Tubal ligation	14	35	10	56	2	33	2	13
Vasectomy	22	55	11	61	3	50	8	50
Early pregnancy loss								
Expectant management	30	75	17	94	6	100	7	44
Medication management	25	63	15	83	4	67	6	38
Uterine aspiration	19	48	11	61	3	50	5	31
Ectopic pregnancy management								
Medication management	17	43	11	61	2	33	4	25
Surgical management	6	15	5	28	0	0	1	6
Referral	29	73	13	72	3	50	13	81
None of the above	7	18	2	11	3	50	2	13
Obstetrics								
Prenatal care	28	70	18	100	6	100	4	25
Vaginal delivery	25	63	18	100	4	67	3	19
Surgical delivery	18	45	12	67	3	50	3	19
Abortion								
Medication management	10	25	4	22	0	0	6	38
Uterine aspiration	7	18	2	11	0	0	5	31
Referral	22	55	10	56	4	67	8	50
None of the above	12	30	6	33	2	33	4	25

Abbreviations: FMRN: Family Medicine Residency Network; WPNR: WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) region Practice Based Research Network; IUD: Intrauterine Device

All respondents provide pregnancy diagnosis and contraceptive services (n=40, 100%). Three quarters (75%) offer their patients early pregnancy loss (EPL) expectant management (Table 2). Most participants referred ectopic pregnancy management (n=29, 73%). Half referred patients to other clinicians/clinics for abortion management (55%). A quarter (25%) offered medication abortion management, 18% provided uterine aspiration, while a third (30%) did not refer or offer abortion services.

Although most clinicians (Table 3; 78%) reported no change in their practice after *Dobbs*, five individuals (13%) stated that their services had changed, three were unsure (8%) and 1 respondent preferred not to say (3%). When asked about concern for people in their community accessing abortion and miscarriage care after this legal change, almost half (48%) reported concern.

All respondents expressed interest in developing abortion care at their clinics or participating in an abortion referral network. Almost half of respondents were interested in support for implementing abortion care (45%) and an abortion care learning collaborative (43%). Webinars on

abortion care and long-acting reversible contraception (LARC) were of equal interest to individuals (35%). A fifth of clinicians were not interested in these specific offerings and 13% preferred not to say.

Convenings

Eight clinicians, all from distinct sites, attended six convenings. Most participants were from Washington, with one from Idaho. Most clinicians were at the beginning stages of exploring the incorporation of abortion services into their practice. Barriers described by participants included access to mifepristone provision, coordination with pharmacies for dispensing/mauling medications, and regulatory obstacles specific to federally qualified health centers. One clinician, serving rural Washington, highlighted the lack of abortion services in her county, requiring patients to travel long distances, saying:

“it’s very hard. That’s a long way to access [abortion services] for our Central Washington patients, even though we’re in a state that is friendly [of supporting this care].”

Table 3. U.S. Supreme Court Decision on Abortion Protections: Changes in Practice and Interest in Incorporating Abortion Care Services and Referral Networks

	Total		FMRN		WPNR		WA Title X	
	N	%		%		%		%
Total Surveys Sent	193		45		94		54	
Total Survey Responses	40		18		6		16	
Has your clinical practice changed any services based on the supreme court decision overturning federal protections for abortion care access?								
Yes	5	13%	1	6%	2	33%	2	13%
No	31	78%	15	83%	4	67%	12	75%
Unsure	3	8%	2	11%	0	0%	1	6%
Prefer not to answer	1	3%	0	0%	0	0%	1	6%
Is there concern that people in your community will have increased difficulty accessing abortion and/or miscarriage care as a result of this legal change?								
Yes	19	48%	6	33%	5	83%	8	50%
No	10	25%	6	33%	0	0%	4	25%
Unsure	11	28%	6	33%	1	17%	4	25%
Interest in developing								
Abortion care	40	100%	18	100%	6	100%	16	100%
Abortion referral networks	40	100%	18	100%	6	100%	16	100%
Education:								
Webinars	14	35%	7	39%	3	50%	4	25%
Learning Collaborative	17	43%	10	56%	4	67%	3	19%
Not interested	8	20%	5	28%	0	0%	3	19%
Prefer not to answer	5	13%	0	0%	0	0%	5	31%

Abbreviations: FMRN: Family Medicine Residency Network; WPNR: WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) region Practice Based Research Network

When discussing current restrictions in Idaho, another clinician explained that in addition to the current ban on abortion services, the Attorney General made it a prosecutable offense to refer patients out of state. Per the Idaho Legislature, Title 18, Chapter 87,

“No person, agency, organization, or any other party that receives funds authorized by the state...may use those funds to perform or promote abortion, provide counseling in favor of abortion, make referral for abortion, or provide facilities for abortion or for training to provide or perform abortion.”¹⁹

There was also need for technical support on clinical questions related to care delivery. For some, there were concerns regarding community and staff support. A clinician in rural Washington noted,

“Our county is very conservative compared to the Western counties of [WA] state. So, there is a lot of resistance from our board of directors.”

Another clinician reported nontransparency from administrators regarding their clinic’s policy on abortion, stating,

“I’ve never seen the written policy. I cannot find it. [Also,] I do not have a nursing staff that would clinically support it.”

The most requested support for primary care settings included training and education addressing intra- and extra-organizational obstacles. A learning collaborative including training, support and clinician partnership was preferred as a solution that addressed the need for education and individualized assistance for implementation of services. An alternative approach included connecting patients seeking abortion care with the telemedicine services at UW.

Discussion

Our study provides novel insight into the variety and prevalence of reproductive health services offered across primary care clinics in the Northwestern U.S., clinician interest in starting/growing abortion services within their practice, barriers faced by interested clinicians and preferred support options for implementation of services. Training primary care clinicians in abortion services and creating a referral network of clinicians could potentially address identified needs.

Most clinicians (63%) offered EPL management, a highly transferable skill to early abortion care. Additionally, most clinicians expressed concern about their community's access to abortion or miscarriage care, highlighting the fears experienced by those even in states with full legal protections, such as Washington. The most requested solution to clinician barriers from the survey was implementation support and a collaborative model to help clinicians integrate abortion services and share knowledge.

Key themes from the convenings highlighted barriers to incorporating abortion care into primary care, including restricted access to mifepristone, federal funding limitations, lack of organizational support, legal challenges, and staff with anti-abortion views. The most supported solution was an abortion learning collaborative offering webinars on protocols, counseling, telemedicine, staff values clarification, and logistics.

Our findings should be interpreted within the study's limitations. The response rate (21%) is consistent with other clinician surveys but remains low, potentially reflecting response bias.^{20,21} Convenings were limited to WPRN, FMRN, and Title X clinic respondents, with most responses from Washington; therefore, the results may not be generalizable across the region. This study aimed to explore interest in regional collaboration, not provide epidemiologic evidence of specific clinics. The exact number of clinics represented is unknown, but our focus was to assess individual

views and protect anonymity. Therefore, the data reflects this goal.

As restrictions expand, increasing access to safe abortion care is a public health need. We found substantial interest in abortion care training and referral networks across our WWAMI region. This needs assessment helped to inform the development of and curriculum for a Project ECHO focused on increasing access to medication abortion in primary care, launched in September 2024. Additional research and reproductive health training programs are needed to address the abortion care access need across restricted and non-restricted states.

Funding

This work was supported by an award from the San Simeon Foundation and a grant from the Washington State Department of Health. The REDCap survey used is supported by the Institute of Translational Health Sciences, which is funded by the National Center for Advancing Translational Sciences of the National Institutes of Health under award number UL1TR002319.

Conflicts of Interest

There are no competing or conflicting interests among any authors.

Corresponding Authors

Anna Fiastro, PhD, MPH, MEM, afiastro@uw.edu; Kathryn Fine, BS, kfine@uw.edu

This article was externally peer reviewed.

Submitted: April 03, 2025 EDT. Accepted: September 02, 2025 EDT.

References

1. Guttmacher Institute. Roe v. Wade in Peril: Our Latest Resources. Guttmacher Institute. August 12, 2021. <https://www.guttmacher.org/abortion-rights-supreme-court>
2. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995-2017. *Contraception*. 2021;104(5):496-501. doi:[10.1016/j.contraception.2021.03.018](https://doi.org/10.1016/j.contraception.2021.03.018)
3. MacDorman MF, Declercq E, Thoma ME. Trends in Maternal Mortality by Sociodemographic Characteristics and Cause of Death in 27 States and the District of Columbia. *Obstetrics & Gynecology*. 2017;129(5):811-818. doi:[10.1097/aog.0000000000001968](https://doi.org/10.1097/aog.0000000000001968)
4. Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-Related Mortality in the United States, 2011–2013. *Obstetrics & Gynecology*. 2017;130(2):366-373. doi:[10.1097/aog.0000000000002114](https://doi.org/10.1097/aog.0000000000002114)
5. Prine LW, Lesnewski R. Medication Abortion and Family Physicians' Scope of Practice. *The Journal of the American Board of Family Medicine*. 2005;18(4):304-306. doi:[10.3122/jabfm.18.4.304](https://doi.org/10.3122/jabfm.18.4.304)
6. Summit AK, Casey LMJ, Bennett AH, Karasz A, Gold M. "I Don't Want to Go Anywhere Else": Patient Experiences of Abortion in Family Medicine. *Family Medicine*. 2016;48(1):30-34. PMID:26950663
7. Wu JP, Godfrey EM, Prine L, Andersen KL, MacNaughton H, Gold M. Women's satisfaction with abortion care in academic family medicine centers. *Fam Med*. 2015;47(2):98-106. PMID:25646981
8. Logsdon MB, Handler A, Godfrey EM. Women's preferences for the location of abortion services: a pilot study in two Chicago clinics. *Matern Child Health J*. 2012;16(1):212-216. doi:[10.1007/s10995-010-0722-4](https://doi.org/10.1007/s10995-010-0722-4)
9. Rubin SE, Godfrey EM, Shapiro M, Gold M. Urban female patients' perceptions of the family medicine clinic as a site for abortion care. *Contraception*. 2009;80(2):174-179. doi:[10.1016/j.contraception.2009.01.017](https://doi.org/10.1016/j.contraception.2009.01.017)
10. Bennett IM, Baylson M, Kalkstein K, Gillespie G, Bellamy SL, Fleischman J. Early Abortion in Family Medicine: Clinical Outcomes. *The Annals of Family Medicine*. 2009;7(6):527-533. doi:[10.1370/afm.1051](https://doi.org/10.1370/afm.1051)
11. Lee CM, Johns SL, Stulberg DB, Allen RH, Janiak E. Barriers to abortion provision in primary care in New England, 2019–2020: A qualitative study. *Contraception*. 2023;117:39-44. doi:[10.1016/j.contraception.2022.08.001](https://doi.org/10.1016/j.contraception.2022.08.001)
12. Razon N, Wulf S, Perez C, et al. Exploring the impact of mifepristone's risk evaluation and mitigation strategy (REMS) on the integration of medication abortion into US family medicine primary care clinics. *Contraception*. 2022;109:19-24. doi:[10.1016/j.contraception.2022.01.017](https://doi.org/10.1016/j.contraception.2022.01.017)
13. Razon N, Wulf S, Perez C, et al. Family Physicians' Barriers and Facilitators in Incorporating Medication Abortion. *J Am Board Fam Med*. 2022;35(3):579-587. doi:[10.3122/jabfm.2022.03.210266](https://doi.org/10.3122/jabfm.2022.03.210266)
14. WWAMI. UW Medicine. <https://www.uwmedicine.org/school-of-medicine/md-program/wwami>
15. Bennett IM, Johnson M, Wu JP, et al. A Family Medicine Training Collaborative in Early Abortion. *Family Medicine*. 2007;39(3):164-166.
16. Bennett I, Aguirre AC, Burg J, Finkel M, Bowman K, Fleischman J. Initiating abortion training in residency programs: issues and obstacles. *Family Medicine*. 2006;38(5):330-335.
17. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform*. 2009;42(2):377-381. doi:[10.1016/j.jbi.2008.08.010](https://doi.org/10.1016/j.jbi.2008.08.010). PMID:18929686
18. Harris PA, Taylor R, Minor BL, et al. Building an international community of software partners. *J Biomed Inform*. Published online May 9, 2019. doi:[10.1016/j.jbi.2019.103208](https://doi.org/10.1016/j.jbi.2019.103208)
19. *No Public Funds for Abortion Act.*; 2021.
20. Cunningham CT, Quan H, Hemmelgarn B, et al. Exploring physician specialist response rates to web-based surveys. *BMC Medical Research Methodology*. 2015;15(1). doi:[10.1186/s12874-015-0016-z](https://doi.org/10.1186/s12874-015-0016-z)
21. Sheehan KB. E-mail Survey Response Rates: A Review. *Journal of Computer-Mediated Communication*. 2006;6(2). doi:[10.1111/j.1083-6101.2001.tb00117.x](https://doi.org/10.1111/j.1083-6101.2001.tb00117.x)