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A Qualitative Content Analysis of Crisis Pregnancy Center Websites to Assess Medical Misrepresentation in Georgia

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ABSTRACT

A QUALITATIVE CONTENT ANALYSIS OF CRISIS PREGNANCY CENTER WEBSITES TO ASSESS MEDICAL MISREPRESENTATION IN GEORGIA

By

LAURA ELIZABETH ANDERSON

JUNE 30, 2019

INTRODUCTION: Crisis Pregnancy Centers (CPCs) are nonprofit organizations that provide free or low-cost services to women seeking reproductive health services. A trend amongst CPCs is to present themselves as licensed medical facilities on their client-facing websites (CFWs).

AIM: To identify the current state of medical representation of Crisis Pregnancy Center websites in Georgia.

METHODS: The sample was selected from a Crisis Pregnancy Center Map website. 71 CPCs were identified in Georgia. Modes of medical presentation and medical services offered on the CFWs as well as commonly used tropes to encourage clients to seek their services were systematically documented. Data were analyzed using qualitative content software.

RESULTS: Of the 71 CPC websites reviewed, 56.3% of CFWs describe their services as medical in nature. A third of centers (32.4%) directly described themselves as a “medical clinic”. Thirty-four centers describe their center volunteers as “medical professionals”, however, only 9 centers explicitly list the name and credentials of medically trained staff providing services. While 100% of CPCs offer free pregnancy testing, 73.2% offer limited obstetric ultrasound, and 25.4% offer STI/STD testing. Many centers in Georgia are affiliated with anti-abortion umbrella organizations like Care Net (61.9%), National Institute for Family and Life Advocates (54.9%), and Heartbeat International (42.2%).

DISCUSSION: At least half of all Georgia CPCs are using some method or combination of methods to represent themselves as licensed medical facilities to potential clients seeking reproductive health services. Anti-abortion umbrella organizations, who have programs to convert CPCs to “medical ministries”, have a significant presence in the state. Many of these centers are eligible for federal and state funding, and the growing conversion to “medical ministries” must be well understood if they are to continue to receive public dollars and provide services to women and families in Georgia.

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LAURA E. ANDERSON

GEORGIA STATE UNIVERSITY

A Thesis Submitted to the Graduate Faculty
of Georgia State University in Partial Fulfillment
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MASTER OF PUBLIC HEALTH

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30303

APPROVAL PAGE

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Author's Statement Page

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Laura E. Anderson

Signature of Author

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1. INTRODUCTION

1.1. BACKGROUND

An Overview of Crisis Pregnancy Centers

Crisis Pregnancy Centers (CPCs), alternatively known as Pregnancy Resource Centers, have long been a staple in the effort to reduce abortion access in the United States. The Vice President of Americans United for Life, an anti-abortion law firm, describes them as the “darlings of the Pro-Life Movement” (Belluck, 2013). Advocacy groups like The Pearson Foundation and Birthright International shaped the rise of Pro-Life activism by creating the CPC model. This of course was a response to the cultural shift on abortion in the 1960s. Today, most CPCs are affiliated with at least one of three major anti-abortion umbrella organizations: Care Net, Heartbeat International, and the National Institute of Family and Life Advocates (NIFLA) (Chen, 2013). CPCs are increasingly more prolific than abortion clinics. There are upwards of 3,500 CPCs estimated to be in business in the U.S., as opposed to only 1,800 abortion clinics (Stacey, 2017).

Most CPCs are federally tax-exempt nonprofits, otherwise known as 501(c)(3) charitable organizations. For decades, the services they offered were limited to free over-the-counter pregnancy tests and information on abortion, parenting, and adoption. Due to increased public funding and political clout, CPCs are expanding their ministrations to various medical services, such as limited obstetric ultrasounds and testing for STI/STDs.

The predominate criticism of these centers is that they use misleading or deceptive tactics to dissuade, or prevent, women from choosing abortion. The ways in which they do so have continued to evolve over the last 52 years. One well-documented method is to choose names and locations near local clinics that provide abortion, leading women to mistakenly

enter the anti-abortion organization (NARAL Pro-Choice America, 2016). Anti-abortion centers have become proficient advertisers by using Google Grants and internet search optimization to increase traffic to their sites. CPCs often appear under online directories for “Abortion”, “Abortion Alternatives”, and “Abortion Services” (NARAL Pro-Choice America, 2016).

The most recent form of deception, and potentially most disruptive, is the shift towards adopting the medical model. The Pro-life movement is entering a new frontier for engaging “abortion-minded” women through expanding their services beyond lay counseling and into the medical field. The background will cover the types of funding that CPCs receive, the growing trend of medicalization amongst these centers, the NIFLA v. Becerra Supreme Court case, and CPCs in Georgia.

Funding: Federal, State, and Private

CPCs today benefit from a multitude of federal and state funding mechanisms. George W. Bush’s administration (2001 – 2009) was a major turning point for CPCs. Prior to 2001, few CPCs could depend on public funds. During Bush’s first term, more than \$30 million in federal dollars were distributed to over 50 CPCs (Waxman, 2006), as part of President Bush’s pro-life and faith-based agenda. Much of the federal and state support CPCs receive is directed through initiatives that promote two-parent households and child-rearing within the confines of marriage (Allard, 2007). One effort to increase tax-payer funding for these centers was through welfare reform (Waxman, 2006).

Although the rise in government funding for faith-based, anti-abortion organizations occurred during the Bush Administration, it did not begin with him. Rather, he built upon a

foundation laid by the Clinton Administration. To understand welfare reform under George W. Bush, one must first look at its first reformation in 1996.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) marks the first change to welfare since its creation in 1935. PRWORA instituted Temporary Assistance for Needy Families (TANF) in place of Aid to Families with Dependent Children (AFDC). AFDC is a federal cash assistance program for low-income, single parent families, and is commonly referred to as “welfare” (Allard, 2007). TANF was created as a block grant, which gave states greater flexibility in the ways they delivered cash assistance. The 1996 law had four major goals: continue cash support for low- and no-income families, facilitate welfare recipients into the workforce, reduce pregnancies that occur outside of legal marriage, and encourage two-parent households (Allard, 2007). It is the latter two provisions that became centerfold during Bush’s execution of his faith-based agenda.

PRWORA laid the groundwork for the Bush administration to shift further away from cash assistance (i.e. welfare checks). One of the most predominate changes in welfare policy history was created by the shift from cash assistance to funding a variety of social service programs (Allard, 2007). Today, only one-third of welfare spending manifests as cash assistance, while states allocate about 60% of welfare dollars to social service programs. To put it in perspective, twenty years ago, 68 out of every 100 low-income families received cash welfare, but in 2016, only 23 out of every 100 low-income families could qualify for direct cash assistance (Marketplace, 2016).

Welfare spending became divided into two categories: Core and Non-Core. Core Welfare Reform Areas include cash assistance, child care, and work support services (i.e. career

counseling and subsidized employment opportunities). Non-Core Welfare Reform Areas include initiatives such as refundable tax credits, and “Out of Wedlock Pregnancy Prevention & Two-Parent Family Formation/Maintenance”. As recent as 2016, 24 states, including Georgia, spent most of their welfare dollars on “non-core” areas (Marketplace, 2016). Their support does not come from welfare programs alone. CPCs and the pro-life movement have received millions of dollars from a variety of federal and state programs, in addition to their funding accrued through private donations.

Another major funding source that began under the Bush Administration is the Community-Based Abstinence Education Program (CBAE). CBAE is a middle and high school health education program that discourages young people from engaging in sexual activity outside of marriage. Roughly \$24 million in CBAE funds were allocated during his first term and disbursed among 29 CPCs (Waxman, 2006). CPCs could easily qualify for this program because advocating against contraceptives and premarital sex was already a staple of their mission (Chen, 2013).

There are numerous other federal grants that allocate smaller grants to states and CPCs. Title V section 510 is a grant specifically dedicated to abstinence only education funding for states. The Waxman Report (2006) estimated that between 1999 and 2006, an additional \$6 million dollars were disbursed to CPCs. However, the report acknowledges that this estimation may be low, because information on these grants were not easily accessible (Waxman, 2006). CPCs are also eligible for federal funding through the Compassion Capital Fund, another program created under the Bush Administration. The Compassion Capital Fund distributed \$150 million directly to CPCs as “mini-grants”, or indirectly as subgrants through the Institute for

Youth Development (IYD). The IYD no longer exists but had a funding initiative specifically for CPCs transitioning to a medical model, called the “Pregnancy Resource Center Service Delivery and Medical Model” program (Chen, 2013).

Federal funding for CPCs waned under Obama, but support for anti-abortion advocates was renewed under the current administration. Under President Trump, the U.S Department of Health and Human (HHS) services has repurposed Title X, which is typically reserved for comprehensive family planning funding. In March of 2019, The Trump Administration declared that it would give over \$5 million in Title X funds to Obria Medical Clinics, an anti-abortion chain of CPCs (Vogel and Pear, 2019). In the past three years, HHS has shifted Title X in ways that make it more difficult to fund comprehensive family planning clinics, and redirected funds toward groups that oppose abortion access (Vogel and Pear, 2019).

States provide their own funding programs for CPCs, adding an additional layer of public funds for anti-abortion charitable organizations. These funds are often routed through the same mechanisms as federal grants, focusing mostly on abstinence-only education. Chen (2013) remarks that in 2007 alone, states allocated upwards of \$13 million in public funding to organizations and programs that discourage women from seeking abortion. States also fund anti-abortion organizations through the “Choose Life” campaign. “Choose Life” license plates are sold by state Departments of Motor Vehicles and the profits go to pro-life organizations who promote adoption and parenting (Chen, 2013). Today, these license plates are available for purchase in 37 states, including the District of Columbia (Choose Life America, Inc., 2019). According to Choose Life America, Inc, Georgia sold over 50,000 Choose Life plates between 2007 and 2017, raising more than \$500,000 dollars destined for “life-affirming” agencies

(Choose Life America, Inc., 2019). Georgia has since developed more funding opportunities for CPCs in Georgia, which will be discussed under *A Focus on Georgia*.

Private donations are the final source of funding for CPCs. Most, if not all CPCs are 501 (c)(3) tax-deductible organizations. CPCs often hold pro-life galas, 5k walk/runs, and other fundraising events for their centers. CPCs typically have two separate websites. The first is a website dedicated to garner donations and communicate with their donors. This site tends to report numbers, like the number of clients served, pregnancy tests administered and number of “babies saved” (i.e. how many clients continued their pregnancies after their visit). The second type of website will be referred to as the Client-Facing Website (CFW) from this point on. CFWs are designed for potential clients of the CPC, where they advertise their services and provide information on abortion, parenting, and adoption options. Mechanisms for one-time and monthly donations can appear on both websites.

The Increasing Medicalization of CPCs

Medicalization describes the phenomenon of CPCs expanding their service provision to include some medical services. This expansion can describe CPCs providing STI/STD testing and treatment, increasing the number of volunteers who are licensed medical professionals, providing abortion pill reversals and prenatal care. In the latter half of the 20th century, CPCs were resigned to providing free over-the-counter pregnancy tests, information on pregnancy options, community resources and referrals. Over the course of several decades, anti-abortion proponents realized that this model could not thrive as is and still achieve the breadth of influence they wished to impart on women seeking reproductive healthcare. Ergo, a paradigm

shift towards the adoption of the medical model began to permeate through the day-to-day operations of CPCs. **Figure 2** illustrates the medical model spectrum that CPCs fall along in terms of services.

The medicalization of CPCs begins with expanding their services to offer limited obstetric ultrasounds in house. However, the term “medicalization” used throughout this paper extends beyond just offering ultrasounds. **Figure 2** illustrates how the services offered by CPCs fall along the spectrum from “non-medical” to “medical”. “Non-medical” services are described as layman services, and consist primarily of self-administered pregnancy testing, community referrals, parenting classes, and peer counseling on pregnancy options. More CPCs are now offering “basic medical services”, and few offer “expanded medical services”. Service provision is not the only mode of medicalization for CPCs. Many CPCs are taking steps to appear as though they are licensed medical clinics on their CFWs and at their physical locations.

The legitimacy of the presentation is difficult to determine and varies widely amongst CPCs. To be sure, some CPCs are licensed with their state, and some CPCs do have licensed medical professionals providing their ultrasounds and STI/STD testing. But from the position of a potential client seeking services, it’s virtually impossible to discern between centers who are licensed and those who are not. One tactic that is in growing use by CPCs is the implementation of the Health Insurance Portability and Accountability Act (HIPAA) and Notice of Privacy Practice (NPP) documents on their websites.

HIPAA marked a significant move by congress to ensure the safeguarding of Protected Health Information (PHI) as they anticipated the growing use of electronic transmission for health insurance billing (U.S. Department of Health and Human Services, 2017). HIPAA was first

signed into law in 1996. Congress then tasked the Department of Health and Human Services to create the HIPAA Privacy Rule. The Privacy Rule required that covered entities (see **Figure 1**) must safeguard patient information. Covered entities are required to post an NPP so that patients are informed on their rights to privacy. NPPs cover the legal disclosures of PHI, and details how patients may control when their PHI is disclosed in certain cases. In the event there is a privacy breach and a covered entity acted inappropriately, patients can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights.

“Only licensed CPCs are obligated to follow confidentiality rules”, but licensed pregnancy resource centers are few and far between (Chen, 2013). It is difficult to estimate the number of licensed CPCs in the United States. According to NIFLA, they claim that 1,100 of their 1,400 members are licensed medical clinics (NIFLA, 2019). Even though CPCs are collecting PHI, they are not legally obligated to protect it. This is because they do not fall under the definition of a covered entity. In order to be considered a covered entity, CPCs would have to receive payment for medical services provided. However, virtually all CPCs offer their services at no cost. Some CPCs do charge a small fee if they provide STI/STD testing and treatment. However, because this payment is not submitted to insurance, this does not bring them under the definition of a covered entity. Thomas Glessner, the president of NIFLA, advises his members that “voluntary compliance with HIPAA is essential to good risk management for pregnancy centers” (Better By Design, INC, 2019). Major leaders in the anti-abortion movement are aware that CPCs are by and large not required to adhere to HIPAA (Chen, 2013).

Obria Medical Clinics is an example of a CPC offering “extended medical services”. The CEO of Obria Medical Clinics, Kathleen Bravo, stated that 15 years ago she “knew, that for the

pro-life movement to really survive and thrive, the pregnancy center model needed to change; it was becoming outdated and a bit obsolete” (Osberg, 2019). It is vying to become a major contender in reproductive healthcare. Kathleen Bravo is modeling Obria after Planned Parenthood and is growing thanks to the support of the Trump Administration by way of additional federal funding sources. Obria currently has 38 clinics nationwide and is on track to open another 22 centers. Obria offers STI/ST testing, treatment and cervical cancer screenings, but does not offer any form of contraceptives or abortion care. (Varney, 2018). In 2016, the growing enterprise absorbed the Pregnancy Resource Center of Gwinnett, located in Lawrenceville, Georgia, making it the first (and only) Obria Medical Clinic affiliate in the state.

Major anti-abortion umbrella organizations are working to encourage affiliate CPCs to embrace the medical model. NIFLA has created The Life Choice Project (TLC), a “comprehensive medical conversion program” (NIFLA, 2019). NIFLA remarks on the TLC webpage that ultrasound is the most valuable tool in demonstrating the personhood of a fetus. Affiliates of NIFLA can access benefits to assist them in “medical clinic conversion”. CPCs can register nurses and directors for a three-day course at NIFLA’s Institute in Limited Obstetric Ultrasound, where they receive one day of live ultrasound scanning training and can accrue continuing education credits. Centers will receive “a nurse manager mentor to help train your nurses in medical procedures”, NIFLA medical membership, and discounts for a medical malpractice insurance program (NIFLA, 2019).

Service Disclosures, Legal Challenges, and NIFLA v. Becerra

Service disclosures are currently at the center for the legal fight to regulate CPCs. After the Waxman Report was released in 2006, city and county governments acted to regulate CPCs through local ordinances. Many of these attempts had been struck down in lower courts. CPCs most often challenge these ordinances as violations of their right to free speech. Typically, these challenges for regulating CPCs under the First Amendment must determine if the “CPCs speech is ideological, commercial, or professional” (Brown, 2018).

In 2015, California passed the FACT Act and it was signed into law October of that year. The law consisted of two critical parts and was intended to target all entities providing services relating to pregnancy and childbirth, which included CPCs. The first part of the law is referred to as the “Unlicensed Disclosure”. Pregnancy counseling centers that were not licensed with the state had to provide a conspicuous sign stating that they “were not licensed as a medical facility and had no licensed medical provider” (Brown, 2018). This disclosure had to appear on all advertisements as well. The second provision of the law is referred to as the “Licensed Disclosure”. Any licensed facility that provided pregnancy related services were required to display signage that alerted women of state-funded family planning services, which included contraceptives, prenatal care, and abortion services for those who qualify under California’s Medi-Cal program (Brown, 2018).

CPCs in California challenged the law, claiming that both provisions were a violation of their right to free speech, which was struck down by California district courts and the Ninth Circuit. NIFLA petitioned the Supreme Court to review the lower court’s decision in 2017. Despite NIFLA’s TLC project which aids CPCs in their conversion to “medical clinic status” (NIFLA, 2019),

NIFLA argued that CPCs are not actually medical providers, nor do they provide medical interventions, therefore CPC speech cannot be regulated by the state because it is ideological in nature. Michael Ferris, NIFLA's attorney, told the court that even services provided by their licensed centers should not be considered medical interventions (Oral Argument, 2018).

The Supreme Court decision held that CPCs speech is ideological, not commercial or professional, because they are not medical providers (Brown, 2018). This decision has been characterized as markedly different than previous Supreme Court decisions when presented with cases on commercial speech regulation. In the past, the Supreme Court has recognized the State's interest in protecting consumers and ensuring that patients are able to determine they are visiting a licensed medical provider (Brown, 2018).

A Focus on Georgia

Recent policy change in Georgia has created an environment where CPCs will be supported by the state. Georgia's support for CPCs began in 2005 when Governor Sunny Perdue signed the Woman's Right to Know (WRTK) Act into law. Perdue framed the law into easily digestible terms, alleging that "Women have a right to learn about all of the options available to them in the event of an unwanted pregnancy" (Georgia Department of Public Health, 2016). WRTK requires that the physician performing the abortion must inform the patient about possible medical risks during the procedure, adverse mental health outcomes, and where they can obtain free ultrasounds. The Georgia Department of Health created a resource called Abortion: A Woman's Right to Know, which details information on the WRTK law and available

pregnancy resources. On page 24 the state resource, the GDPH directs women to Optionline.org, a directory that refers women to CPCs in the state.

The year 2016 was another major success for the Pro-life movement and their CPCs, not only considering Donald Trump's Presidential win, but in Georgia as well. The Positive Alternatives for Pregnancy and Parenting Grant Program was created to fund CPCs in the state. The grant program sought to disseminate upwards of \$2 million dollars to CPCs in the state to serve as alternative resources to abortion (Elroy, 2016). The bill was signed into law by Nathan Deal on April 26, 2016 (GA Code § 31-2A-32, 2016). Delegating millions of dollars in state funds was now passed on to a group called Life Resources of Georgia (LRG). In fact, it was the Georgia Department of Public Health that awarded the contract to LRG in 2017 (Life Resources of Georgia, 2019). LRG was established back in 2007, and their primary mission is to provide "high impact trainings, executive coaching, networking, and grant administration" to pro-life organizations throughout Georgia (Life Resources of Georgia, 2019). Life Resources of Georgia list the "participation requirements" for the Positive Alternatives for Pregnancy & Parenting Grant Program on their website, which can be viewed under **Figure 3**.

As of November 2017, Life Resource of Georgia (LRG) approved the application of 13 CPCs in the state and submitted them to the Georgia Department of Health. During December of that year, LRG reported completed contracts with 13 "Direct Client Service Providers" between December 1, 2017 and June 20, 2018 for a total of \$2,704,946 (Annual Report, 2017). In the second annual report for fiscal year 2018, another \$1,827,690.84 in public funds were disbursed through LRG to several CPCs (Annual Report, 2018). However, this annual report

offers much less information than the 2017 report, so the number of “Direct Client Services Providers” receiving tax-payer dollars is unknown.

During the 2019-2020 session, Democratic representatives introduced HB 188 to repeal the funding granted by the Positive Alternatives for Pregnancy and Parenting Grant Program (House Bill 188, 2019). However, this bill never made it out of the House Health and Human Services Committee, considering the Committee Chair sponsored the original bill in the house (GA Code § 31-2A-32 (2016)).

1.2. THE POSTMODERN MEDICAL PARADIGM

The postmodern medical paradigm consists of three facets: values and evidence are equally important, preoccupation of risks rather than a focus on the benefits, and the rise of the informed patient (Gray, 1999). Postmodernism marks a contemporary shift in history and is often characterized by relativism (Gray, 1999). A general feeling of mistrust toward authorities and suspicion of science permeates postmodern thinking. Specialists and experts who are leaders of their respective fields no longer hold the same weight of trustworthiness to laypeople. Due to the internet, contradictory evidence can be easily sought out, leading non-experts to suspect the major scientific authorities. Ulrich Beck argues in his book, *The Risk Society*, that the scientific and medical community has become “a branch office of politics, ethics, business, and judicial practice in the garb of numbers, and no longer deserve to be blindly trusted (Beck, 1986).

Kata (2012) applied the postmodern medical paradigm when she assessed anti-vaccination user generated content on the internet. She described how user generated content online was

spreading misinformation and creating distrust of the scientific community. Because of the pervasiveness of misinformation available online, it is easy for those who question vaccines to discover. The existence of such information further confirms for them what they believe to be true, therefore influencing future decisions. Kata's utilization of the postmodern medical paradigm is similar in its ability to apply to CPC websites. It is particularly illustrative of CPCs as they shift toward the medical model. Anti-abortion advocates present information on CPC websites that confirm their belief that abortion is dangerous, both physically and mentally, to women.

The first pillar of the paradigm is the rise of values-based healthcare (Gray, 1999). Both evidence and values must be considered when making healthcare decisions in postmodern medicine. In the context of anti-abortion CPC websites, the prevailing value is that abortion is dangerous, regardless that the weight of the evidence shows that it is a safe procedure. However, medical evidence shows that carrying a child to full term is riskier, in terms of physical and mental health, than a first-trimester abortion (Henshaw, 1998)

The second pillar is the overemphasis of potential risks, rather than benefits. CPC websites often write about the potential risks a woman could suffer in the event she has an abortion. CPCs have been the greatest proponents of Post Abortion Syndrome (PAS). Kelly (2014) describes PAS as a social diagnosis, which can be created by laypeople in a political, social, and cultural context. PAS counseling began in CPCs during the 1970s, and anti-abortion activists liken it to Post Traumatic Stress Disorder (PTSD). PAS advocates view trauma as an inevitable side effect of abortion and a type of PTSD that only child-bearing women can suffer (Kelly, 2014). Despite the insistence of anti-abortion advocates, the American Psychological

Association, American Psychiatric Association, American College of Obstetricians and Gynecologists and the American Public Health Association all deny the existence of PAS (Kelly, 2014). Another common area where the anti-abortion movement, and CPCs by extension, is the idea that abortion causes breast cancer. The American Cancer Society and the National Cancer Institute are two authorities that refute that abortion increases a woman's risk for breast cancer (Bryant et al., 2014). Despite this, one anti-abortion researcher named Angela Lanfranchi, MD, created the Breast Cancer Prevention Institute, providing a rebuttal to the weight of the evidence.

The final pillar of the postmodern medical paradigm is the rise of the well-informed patient. Postmodernism calls for an alternative approach to traditional medicine. This is marked by an increase in coordinated care and a shift towards a patient-centered treatment approach. The silo that medicine has existed in for decades has been breached by the accessibility of the internet, allowing patients to participate more in the decision-making process and therefore empowering themselves (Gray, 1999). The ability to access medical research has led to the creation of the "informed patient". CPCs use this idea of the informed patient to foster an idea that the medical community and the "abortion industry" are skewing the truth about abortion. Most centers suggest that because they are sharing information about the risks of abortion, and the options to parent or adopt are highlighted, that it is then a potential client can truly make an informed decision.

1.3. RESEARCH QUESTIONS

CPCs have a well-documented history of using duplicitous practices. Several studies have aimed to determine their impact on public health by assessing the information propagated on their websites and compared it against the consensus of scientific and medical communities. Others have worked to document the types of services offered at CPCs. The knowledge that CPCs indeed present themselves as licensed medical facilities is well known but has not been systematically measured. This research is filling a gap in the literature by strategically documenting the ways in which CPC websites are communicating to prospective clients that they are licensed facilities and staffed by medical providers. More specifically, the research questions are as follows:

1. What are the various methods CPC Websites use to present their mission and services as being licensed and meeting medical standards?
2. In what ways do CPC websites describe their medical services to encourage potential clients to seek their services?

2. REVIEW OF THE LITERATURE

2.1. MEDICAL AND NON-MEDICAL SERVICES OFFERED AT CRISIS PREGNANCY CENTERS

Sexual and Reproductive Health Services and Related Health Information on Pregnancy Resource Center Websites: A Statewide Content Analysis

Swartzendruber, Newton-Levinson, Feuchs, Phillips, Hickey, and Steiner (2017) conducted a content analysis of 64 CPC websites in Georgia. This study was conducted shortly after Georgia Governor Nathan Deal signed the Positive Alternatives for Pregnancy and Parenting Grant

Program in 2016 (See **Figure 1**). The analysis sought to describe the reproductive health services that CPCs commonly advertise, to fill a gap in the current research. Swartzendruber et al. (2017) stated that “[CPCs] are increasingly being ‘converted to medical clinics’ and offering medical services”, extending their services to include limited ultrasound examinations and STI testing. Advertised services and information was compared to current national guidelines for family planning.

CPCs in Georgia most commonly advertised peer counseling (98.4%) on topics such as pregnancy options, abortion recovery, and sexual health. They observed a trend of medicalization in Georgia CPCs, considering roughly two-thirds of centers advertised some medical services, such as ultrasound examinations (Swartzendruber et al., 2017). While pregnancy testing was offered at 98.4% of the centers sampled, ultrasound examination provision stood at 62.5%. STI testing was far less prolific, as only 21.9% of CPC websites advertised testing. The most common tests offered were for Chlamydia and Gonorrhea. Only 3 centers out of the 14 that offered testing also offered treatment. Less than 4 CPCs offered STI testing beyond Chlamydia and Gonorrhea.

2.2. QUALITY OF INFORMATION AND DISCLAIMERS ON CPC WEBSITES

Sexual and Reproductive Health Services and Related Health Information on Pregnancy Resource Center Websites: A Statewide Content Analysis

Swartzendruber et al. (2017) focused on the frequency of four falsehoods surrounding abortion; abortion causing mental health issues, miscarriage statistics, utilizing ultrasounds to predict miscarriage, and breast cancer as a consequence of abortion. Seventeen percent of CPC websites in Georgia included information that overrepresented the likelihood of miscarrying,

and 9% stated that an ultrasound is a reliable predictor of miscarriage. The study highlighted a compelling example of how these centers posit the “need” to seek an abortion against the likelihood the pregnancy will end in a miscarriage. Whispering Hope Women’s Resource and Pregnancy Center states this quote under their frequently asked questions:

“What do you mean that I “may not need an abortion”? How can you tell? Many women can avoid having to decide what to do with their unintended pregnancy, because 1 in 5 of all pregnancies end naturally. Pregnancies that end naturally are not viable and result in what are called miscarriages. Who wants to go through the pain, cost, and risk of an abortion if it’s not necessary? A good way to check if you’ll miscarry is by ultrasound technology” (Swartzendruber et al., 2017).

One limitation of the study was that they were unable to evaluate the influence or impact this information has on those seeking pregnancy information online. It is unclear how many people are viewing these websites. This study was beneficial for public policy by increasing the literature on how CPCs function, especially within the context of an increase in state funding in Georgia (Swartzendruber et al., 2017). Most importantly, it gave visibility and greater understanding of CPCs in Georgia, one of twenty states that have more than fifty CPCs.

Crisis Pregnancy Center Websites: Information, Misinformation, and Disinformation

Bryant, Narasimhan, Bryant-Comstock, and Levi (2014) explored the information provided on CPC websites and the extent to which it was misleading or false. Websites were identified through state health department directories. Twelve state directories were analyzed, including Georgia. The authors hypothesized that since these centers are being advertised on a state government resource, they may be regarded by patients as a licensed medical facility. Topics analyzed included the alleged connections between abortion and preterm birth, breast cancer,

and mental health issues. They identified 12 state directories and after reviewing a total of 601 agencies, were left with a total of 254 CPC websites for analysis.

First, the study established baseline characteristics for the websites and found that the information offered on each website varied significantly. Of these websites, 16% that were analyzed did not include any information on women's health or reproductive health care, while 57% offered information on abortion. The researchers found that 87% of the websites did not display a disclaimer that the center was not a healthcare facility. Less than a fifth (17%) of the websites in their sample advertised the presence of a doctor or a nurse.

The study examined the amount of misleading or false information offered on the 254 CPC websites, of which 80% propagated such information. The greatest sources of misinformation were from 186 websites that "asserted a link between abortion and post abortion stress" (Bryant et al., 2014). Information on post-abortion stress and "Post-Abortive" counseling services are prolific throughout CPC websites, even though it does not fall in line with the consensus of the American Psychological Society and the American Psychiatric Association. Around 20% of websites said that abortion will cause future preterm birth, despite the disagreement of major public health leaders like The World Health Organization and the Centers for Disease Control and Prevention (Bryant et al., 2014).

A prominent weakness of this study, and one that seems to permeate the research of CPC websites, was the inability to determine the number of women who utilized these websites as a resource for abortion information. It is virtually impossible to quantify without conducting studies that rigorously analyze the first-hand experience of women seeking such information (Bryant et al., 2014). However, like the Swartzendruber et al. (2017) study, it is important to

continue to shine light on the information being propagated by these websites in the context of state promotion and public funding.

Abortion Misinformation from Crisis Pregnancy Centers in North Carolina

Bryant and Levi (2012) conducted a secondary analysis of data from a “secret shopper survey”. This data was collected by a nonprofit reproductive health organization located in the state. In North Carolina, CPCs outnumbered abortion providers four-to-one, with a total of 122 CPCs (Bryant and Levi, 2012). Researchers from the original study presented themselves as women who suspected a positive pregnancy test and were seeking additional information about pregnancy related options. Details of the visit were compiled in a report, which was later deidentified and analyzed by the 2012 study to assess the content for medical inaccuracies (Bryant and Levi, 2012).

Over a period of four months, researchers physically visited 19 centers. Almost two-thirds of the centers disclosed that they did not perform or refer for abortions but 44% stated that they did provide information and counseling on “abortion and it’s risks” (Bryant and Levi, 2012). The authors found that 17 centers, half of the total number contacted via telephone, provided “at least one misleading or inaccurate piece of information”. Several centers told the researchers that there was “plenty of time” to decide on whether to have an abortion because pregnancy has a high risk of miscarriage. Overall, 86% of the websites reviewed gave false or misleading information.

Bryant and Levi acknowledged several instances of potential selection bias and threats to external validity in the sample. In the original study, many of the centers were unable to be

reached on the telephone and some did not have websites that could be reviewed. The centers called and visited were a convenience sample, which may have contributed to skewed results. The researchers calculated 95% confidence levels for each proportion to account for possible information bias (Bryant and Levi, 2012). However, the original study was a “secret shopper” design, which is particularly beneficial in studying CPCs, and is a method that should continue to be embraced for future studies.

2.3. EXPERIENCES AND IMPACTS ON WOMEN SEEKING SERVICES AT CRISIS PREGNANCY CENTERS

What Women Seek from a Pregnancy Resource Center

There is a deficiency of research surrounding CPCs. The current existing literature most often describes the information and services offered, but there is very little information about the client experience. Kimport, Dockray, and Dodson (2016) sought to understand CPCs from the patient’s perspective. Their 2016 study highlighted a significant gap in the literature surrounding CPCs; we know virtually nothing on why women and families go to these centers.

The study examined intake data from a secular pregnancy resource center in Bloomington, Indiana, and potentially “the only non-antiabortion PRC in the US” (Kimport et al., 2016). This center stood amongst 86 other anti-abortion pregnancy resource centers in the state of Indiana (NARAL Pro-Choice America, 2015). The researchers tracked the intake data for all first-time clients over a span of six months. Peer counselors at the All-Options Pregnancy Resource Center gave first time visitors a paper intake form, consent form, and then conducted a counseling session where open-ended questions were asked “about what brought them to the center and

how they are feeling” (Kimport et al., 2016). Unlike many anti-abortion CPCs, All-Options does not offer free ultrasounds, but does offer free condoms and abortion funding. Despite those differences, much of their other services fall in line with the typical service provision of anti-abortion CPCs, such as dispersing free material goods, free pregnancy tests, counseling and information.

The researchers observed that 273 clients visited All-Options Pregnancy Resource Center for the first time over the 6 months. A total of 87% of all first-time clients had come to get diapers, and 44% requested baby clothes and items. Peer counseling was a highly sought-after resource, with 270 of the 273 first time clients participating. Over half of all visitors discussed parenting resources and community referrals, “followed by money/financial resources (40%), relationship or family support (36%), parenting support or counseling (30%), and social services (30%)” (Kimport et al., 2016).

The authors concluded that first time clients, based on the services requested, were not seeking out options counseling to decide between abortion, parenting, or adoption. The study results suggested that CPCs were most commonly frequented for parenting resources, rather than pregnancy options resources (Kimport et al., 2016). Kimport et al recognized that their results are difficult to generalize; in part because they examined only one center, and that All-Options was secular and did not share the anti-abortion values that many CPCs propagate.

The Prevalence and Impacts of Crisis Pregnancy Center Visits Among a Population of Pregnant Women

Due to the lack of generalizability from the Kimport et al. (2016) study previously discussed, Kimport, Kriz, and Roberts (2018) took a mixed methods approach to understand the actual impact that CPCs have on pregnancy decisions. The purpose of this study was two-fold; the first was to establish the prevalence of pregnant women seeking services at a CPC, and the second was to characterize the impact a visit has on the decision-making process to carry a pregnancy to term (Kimport et al., 2018). The team of researchers recruited 114 women from a local abortion clinic, and 269 women from three prenatal clinics in Southern Louisiana. The researchers collected data on the participants age, race, number of pregnancies, and whether the participant visited a CPC during their current pregnancy. Amongst the women who were recruited at the abortion clinic, only 6% had visited a CPC prior to seeking an abortion. A similar percentage, 5%, of prenatal clinic recruitments had also visited a CPC during their current pregnancy.

To understand the potential impact on the decision to continue a pregnancy, the study conducted an in-depth phone interview with twelve prenatal participants (Kimport et al., 2018). Most women went for a free pregnancy test. One participant described being misled when she did an online search for local abortion clinics and was directed to a CPC. The CPC “told her that they did not provide abortions but did ‘offer the classes and the consultation that is required before you get an abortion, for free’” (Kimport et al., 2018). The patient opted to satisfy the state mandated counseling for free at the CPC, though it could not legally fulfill the requirement, and subsequently decided to continue her pregnancy. Throughout the interviews,

several women highlighted that cost of care was a factor in choosing to seek services at a CPC, which offer everything for free or at low-cost. One patient opted to determine her gestational age at a CPC, rather than risk losing \$125 for an ultrasound at the abortion clinic in the event she surpassed the legal gestational limit (Kimport et al., 2018).

The study did not find substantial evidence that pregnancy women actively seek care at CPCs. This finding was consistent with existing research, where Kimport et al. (2018) referred to her 2016 study. Throughout their interviews with women recruited from prenatal clinics, most were not considering abortion at the time of their visit. The study found insufficient evidence that CPCs are frequently changing women's minds about their reproductive health choices but did see evidence of deceptive practices. This study also struggled with generalizability, given the very small sample of women who had previously visited a CPC.

3. METHODS AND PROCEDURES

3.1. RATIONALE OF STUDY

While types of services offered, and quality of information have been studied, the methods they use to convey themselves as "medical clinics" has not. After the Supreme Court ruling of *NIFLA v. Becerra*, close examination of Georgia's CPCs and their methods of self-representation is both timely and necessary. NIFLA encourages their CPC members to adopt the medical model and offer more medical services. However, in 2018, NIFLA argued to the Supreme Court that CPCs cannot be regulated because they are not medical providers, nor do they perform medical services (Oral Argument, 2018). Despite NIFLA's assertion that they are not medical providers, CPCs are attempting to enter the reproductive healthcare arena and are receiving an increase

in public funding because of it. Due to the Supreme Court ruling, these centers currently have more legal protections than doctors who perform abortions do when it comes to compelled speech. In terms of a focus on Georgia, the state has recently delegated upwards of three million dollars to CPCs. Many of them are representing themselves as medical clinics. A greater understanding of where CPCs are in the medical model spectrum is important for public policy in Georgia to respond accordingly and protect women and families.

3.2. SAMPLE

Center Identification

CPCs were identified in Georgia by the Crisis Pregnancy Center Map website (<http://www.crisispregnancycentermap.com>). This website was created by Dr. Andrea Swartzendruber and her colleagues at the University of Georgia in 2018. CPCs were included on this website if they were currently in business, and if they were categorized as CPC. To be considered a CPC, the study had two requirements: 1) A center had to be identified by a standard online search process or through an online directory maintained by the following organizations: Care Net, Heartbeat International, NIFLA, Birthright International, or Ramah International. 2) The center advertised free pregnancy tests and counseling.

CPCs were organized into two distinct categories. They either provided free pregnancy tests and information, or they provided limited medical services in addition to free pregnancy tests and counseling. “CPCs that advertised free limited obstetric ultrasound services (excluding referrals) on a proprietary domain or confirmed the availability of free limited obstetric ultrasound services were categorized as providing limited medical services”

(Swartzendruber, 2018). The study excluded adoption agencies, maternity homes, and mobile clinics, although several CPCs have mobile clinics in addition to their primary location.

On the CPC Map Website, the locations were filtered by State which identified a total of 91 centers in Georgia. The display options were converted from “Map View” to “List View”, then the center name and address were compiled into an excel spreadsheet. The centers were organized alphabetically by city. A Master Spreadsheet was then created to collect the website URL, verify the name, and addresses. If multiple addresses were listed on the main website, the address were identified in the list of 91 centers and consolidated. After consolidating the websites of CPCs with multiple locations, the sample yielded a total of 71 independently operated CPCs. All 71 centers were then assigned a study ID. During this study, an additional center that has opened since Swartzendruber’s website went live in 2018 was identified. A total of 92 locations belong to 71 independently operating non-profit organizations. 14 centers have more than 1 location.

3.3. MIXED METHODS ANALYSIS

Data Collection

This study did not require IRB approval from Georgia State University. Between December 2018 and May 2019, each website was converted into PDF format using the Batch Conversion tool at PDFmyURL.com. A quality check was performed on the PDF to verify completeness and to minimize duplication of individual pages. Once the quality check was complete for the entire sample, all 71 PDFs were uploaded to NVIVO 12 Plus, a qualitative software, for content analysis.

An initial review of the website content was conducted before the final content analysis. Five categories of information were collected in the first phase of exploration: the presence of a PHI Privacy statement (e.g. HIPAA Notice of Privacy Practices), any form of medical licensure or accreditation (e.g. AAAHC), use of medical terminology to describe the services or staff (e.g. “clinic”, “laboratory-quality”, “medical professionals”), explicit disclosure of medical staff (e.g. lists name and medical license on website), and service disclosures (e.g. “We are not a medical facility”).

Once the initial review was conducted and themes amongst the 71 websites had been identified, the master spreadsheet was then expanded to collect newly defined data points. Forty data points were collected on each center website, most of which were captured for this study and can be reviewed under **Table 1, 2, & 3**.

A standardized tool was created to maintain consistency during data collection and attempted to streamline the ways in which certain types of information were categorized. For example, the tool helped to make determinations such as whether a photo would be considered a “medical” or “non-medical” image.

In addition to quantifying the methods of medical representation on the websites, a deeper content analysis was conducted to examine the various tropes used by CPCs to encourage women to utilize their services. Inductive codes were developed during the discovery of emerging themes. Four common tropes were observed throughout the sample and are captured under **Table 5**.

4. RESULTS

4.1. CHARACTERISTICS OF SAMPLE

Table 1 illustrates the prevalence of a variety of characteristics that imply a CPC could be a licensed medical facility. This includes the methods of presentation, services offered, and the professional demographics displayed on the CFW.

Notice of Privacy Practices & HIPAA

Almost half (43.7%) of Georgia CPCs display an NPP document on their CFW. In total, 12.9% of CPCs in Georgia use some method to indicate that they are following federal HIPAA laws. Many of these websites will display an icon that says, “HIPAA Compliant”. Despite such a small percentage of centers suggesting that they are legally responsible for patient privacy protection, an even smaller proportion of these (4.2%) NPPs explain that they are not covered entities under the HIPAA definition. Therefore, they are purely voluntarily presenting an NPP document on their website and in their centers. Twenty-eight (39.4%) of the NPPs borrow the language directly from the HIPAA Privacy Rule and provide no indication that they are not a covered entity. Only covered entities are legally accountable in the event there is a data breach or inappropriate disclosure of PHI.

Presentation

A third (39.4%) of websites displayed imagery depicting medical professionals in a doctor or hospital setting. These images included people in white lab coats with stethoscopes hanging from their necks, nurses smiling while holding a clipboard, and pictures of specimen tubes and urine samples. A quarter of centers used either “Clinic”, “Medical”, or “Healthcare” in their

center names and over half (56.3%) of all Georgia centers describe their services as “medical services”, or medical in nature. One of the most prevalent incidences of this characterization was the description of their pregnancy tests, often describing them as “lab-quality”, or “medical-grade” pregnancy tests.

Finally, 47.8% of the websites described the center’s volunteer staff as “medical professionals”, referring to center volunteers as nurses, trained medical personnel, or patient advocates. Choosing to refer to people seeking services as “patients” rather than “clients” was a recurring theme amongst centers that described their services and volunteer staff as “medical” in some way.

Medical Accreditation

Out of the 71 centers across the state, only four (5.6%) are licensed with the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). No other type of medical accreditation was displayed amongst the sample.

Services

Each one of the CPCs identified by the Crisis Pregnancy Center Map (Swartzendruber, 2018) offer free pregnancy testing. Therefore, all 71 centers as CPCs in Georgia offer this service. The majority (73.2%) of centers offer limited obstetric ultrasounds. Of the 52 centers that offer ultrasounds at their facility, 2 centers indicated that they provide transvaginal ultrasound. An additional center provided information about transvaginal ultrasounds, citing a blurb on transvaginal ultrasound procedures from the American Institute of Ultrasound in Medicine. The

rest of the sample, 19 centers, offered referrals for limited obstetric ultrasounds but did not perform them at their center.

STI testing is offered at 25.3% of Georgia centers, although the scope of the service varies widely. Most test primarily for Chlamydia and Gonorrhea by way of a urine sample. A few clinics offer both urine and blood testing, and test for additional STIs such as Syphilis, HIV, Trichomoniasis, and Hepatitis B and C. All testing services are low to no cost and are not billed through insurance. Less than a fifth of centers offer STI treatment, however the CFWs can be vague on what STIs they provide treatment for. Thirteen centers state (18.3%) offer treatment themselves, while others (7%) refer those with a positive test result to the local health department.

Volunteer staff and medical oversight

Thirty-four centers described their volunteer staff as “medical professionals”, “licensed healthcare providers”, or simply described their services as being performed by doctors and nurses. Just less than half of CFWs in the sample used these descriptions. However, only 14.1% (N=10) centers displayed the names and credentials of licensed providers who volunteer at their center on their CFW. Another 12.7% displayed this information on their donor page instead. Assuming most potential clients would view the CFW, any information provided on the donor page may not be readily available to review the licensure of their medical staff. Between the centers who provided this information, either on their CFW or their donor page, only 4 doctors and 14 nurses are listed on the staff.

In the hierarchy CPCs, Medical Doctors typically sit on the Board of Directors, and Nurses serve on the volunteer staff. Ten centers displayed their Board of Directors on their CFW, and 10 displayed it on their donor page. Out of the 71 total centers in the state, only 10 centers had a doctor on their Board of Directors, and one center had a nurse sitting on the board.

4.2. ANTI-ABORTION UMBRELLA ORGANIZATION AFFILIATES IN GEORGIA

Care Net has the greatest presence throughout the state with a total of 61.9% of Georgia CPCs holding a Care Net membership. The second most prevalent anti-abortion umbrella organization affiliate is NIFLA, with 39 of Georgia's 71 operating organizations holding membership. Heartbeat International membership sits at the smallest, yet still sizable, rate of Georgia Affiliates, with about 42.3% belonging to this group. Rates of membership vary and overlap throughout the state. As of May 2019, one-quarter of CPCs in Georgia do not affiliate with any of the three major anti-abortion umbrella organizations. Thirteen (18.3%) are affiliated with just 1 organization, 29 (40.8%) have memberships with at least 2 organizations, and 15 (21.1%) are affiliated with all 3.

4.3. SERVICE DISCLAIMERS

The most prevalent disclaimer displayed on CFWs in Georgia is the statement that a center "does not perform or refer for abortions", appearing on over half of the sample (52.1%). Out of the entire sample, only 16.9% of centers stated that they "do not provide extended OB/GYN or pre-natal care". The same percentage (16.9%) said on the CFW that they were "Not a medical center or medical facility". Only 18.3% said that they did not provide contraception/birth control prescriptions, or emergency contraceptives, such as Plan B and Ella. Virtually all CPCs

provide information on abortion, adopting, and parenting, and contraceptives, but only 14 centers asserted that “the information provided is not medical advice”.

4.4. MEDICAL ACCREDITATION

Table 4 illustrates the characteristics of those who are accredited by the AAAHC (n=4). This information was retrieved from AAAHC.org under the “Find a Health Care Organization” tab. The “Organization Information” section described the type of organization accredited, and the specialty it was accredited as. The AAAHC was the only accreditation displayed amongst the sample. Two centers were registered as a “Medical Group Practice” and specialized in service categories such as “administrative, infectious disease, OB/GYN, women health, and diagnostic imaging”. The other two centers were registered as “other”, and their specialty was singularly categorized as “OB/GYN”.

4.5. EXAMPLES OF COMMON TROPES

Table 5 highlights a particularly popular trend of hyperbolizing the efficacy of CPC pregnancy tests versus over-the-counter, or at-home pregnancy tests that can be purchased anywhere. One CPC website states under their FAQ section:

“I already bought a pregnancy test from Wal-Mart. Why do I need to come in and be tested with you? The pregnancy tests offered by our center are lab-quality, high-sensitivity urine tests with instant results. These tests are accurate as early as 7 to 10 days after conception, either before or by a missed period.”

Even centers who are not very far on the medical model spectrum use terms like “lab-rated”, “medical-quality”, “medically-certified and urine-based” to describe the pregnancy tests offered at their center.

Another common trope was describing services as “complimentary pre-abortion screenings”. One center offered two types of abortion screenings. The first type of screening included options counseling, “free, lab-certified pregnancy test results that are required before your abortion”, and a free ultrasound. The next was referred to as an “advanced abortion screening”. This service was like the previous abortion screening, but included chlamydia and gonorrhea testing, “Rh factor testing to determine if a medication is needed based on your blood type”, and “hemoglobin testing to determine if blood level risk is a concern”.

The third trope is referred to as “The Viable Pregnancy”. **Table 5** provides an example of this, where the same center that provides advanced abortion screening, suggests that they can predict the chance of a possible miscarriage through limited obstetric ultrasound. The center states that “it is medically recommended to eliminate miscarriage as a possibility before getting an abortion”. Centers who use this trope attempt to entice women to use their free ultrasound service to determine the possibility of a miscarriage so that they may avoid getting an abortion. Cumming Women’s Center, as mentioned under the literature review by Swartzendruber et al. (2018), presents this service to save money by depending on miscarriage as method of ending a pregnancy, in place of seeking safe abortion care. The website says “Who wants to go through the pain, cost, and risk of an abortion if it’s not necessary? A good way to check if you’ll miscarry is by ultrasound technology”.

5. DISCUSSION AND CONCLUSION

5.1. DISCUSSION OF RESEARCH QUESTIONS

The purpose of this study was to obtain a more concrete understanding of how CPCs are presenting themselves as licensed medical facilities. CPCs in Georgia are taking steps to

increasingly represent themselves as such. As of May 2019, there are 71 centers operating in Georgia, with a total of 92 locations across the state. Many centers are affiliated with at least one major anti-abortion umbrella organization that assists them in “medical clinic conversion”. Voluntary HIPAA Compliance is a substantial trend that is being utilized on CPCs websites, but none are covered entities because they do not bill insurance for their services. Therefore, compliance is strictly voluntary, and if there were to be an inappropriate breach of patient data, unlicensed CPCs cannot be held legally responsible under the HIPAA law. Roughly a third of Georgia centers are using some type of imagery on their CFW to suggest they are a medical facility. Over half of the sample are describing their services as medical in nature. About a third of centers describe their volunteer staff as “medical professionals” in some variation (i.e. nurses, doctors, licensed medical professionals). However, only 10 centers explicitly display who is on their volunteer medical staff, including their licensure, so that prospective patients may verify their credentials.

One trend that was observed during this study was the occurrence of medical accreditation. Only four centers sought accreditation, and all four were accredited by the Accreditation Association for Ambulatory Health Care, Inc., a body that accredits ambulatory surgical centers most often. The most common disclaimer provided on CPC CFWs was that the center “does not perform or refer for abortions”. The other observed disclosures were not nearly as prolific. Only 16.9% disclosed that they were not a medical facility, and the same percentage stated that they do not provide “extended OB/GYN” care beyond a free pregnancy test and one free limited obstetric ultrasound.

In May 2019, NIFLA held their 2019 National Legal & Medical Summit in Virginia Beach,

Virginia. During the “One-Day Medical” portion of the conference, topics such as limited obstetric ultrasound, breast cancer, the abortion pill reversal protocol, and how to limit legal liability in addition to implementing HIPAA were presented and the 2018 version of NIFLA’s Medical Policies and Procedures Manual were distributed. The following topics of CPC medicalization discussed in this thesis will be within the context of NIFLA’s ongoing efforts to promote “medical clinic conversion”. This context is particularly relevant to Georgia CPCs, given that 54.9% of centers in the state are affiliates of NIFLA. These affiliates receive membership benefits; including legal guidance, access to manuals that cover HIPAA compliance and medical clinic conversion, training with NIFLA’s Institute in Limited Obstetric Ultrasound, and Patriot Insurance, where they can obtain “medical malpractice insurance written specifically for pro-life pregnancy centers and medical clinics” (NIFLA, 2019).

HIPAA Compliance and Notice of Privacy Practices

31 centers in the state have implemented an NPP document on their CFW. Only 3 of these centers explicitly state in their NPP that they are not a covered entity under the HIPAA Privacy Rule, therefore their effort to maintain patient privacy is entirely of their own volition.

All 3 centers include this phrase on their document,

“This center is a medical care provider that does not engage in any transactions covered under the federal Health Insurance Portability and Accountability Act (HIPAA). This center abides by all applicable medical privacy and licensing laws of the state of Georgia. The privacy practices described in this notice are voluntarily undertaken and ARE NOT INTENDED TO CREATE ANY CONTRACTUAL OR LEGAL RIGHTS ON BEHALF OF CLIENTS”.

As for the other 28 centers, they all generally have the same template, taken from a HIPAA model document provided on the Health and Human Services website for healthcare

providers. NIFLA provides this template in the medical policies and procedures manual. The “Model Notice of Privacy Practices” is written to cover healthcare providers in a variety of settings (i.e. hospitals, specialties, U.S. Dept. of Veterans Affairs). Considering this, permitted uses and disclosures of PHI are often far outside the scope of services for CPCs. For example, many of the NPPs state that they may release PHI for coroners and funeral directors in the event of a death. The voluntary implementation of HIPAA could lead laymen volunteers to misconstrue the situations in which they can disclose PHI. NIFLA suggests that the least amount of information that should be captured on a client intake form includes their full address, phone number, email address, age and occupation.

Many NPPs suggest they bill insurance. Outside of language on the NPP, it was not determined that any of the centers billed insurance. Based on the CFWs, there was no indication that any of them billed Medicaid or private insurance. Several CFWs advertised that they offered services without taking insurance. For the few centers that explicitly asked for payment for services rendered, it was always concerning STI/STD testing. Only one center provided an explicitly labeled cost chart for STI/STD testing. The same center advised those seeking STI/STD testing to bring exact cash payment, as they were not able to give change.

Upon examining the centers that display a HIPAA NPP, it is not clear whatsoever that they are not covered entities. The only exception is the three centers who explicitly state on the NPP that they are not required by federal law to protect patient information. Because these centers display an NPP on the website, or in some cases, state they are HIPAA compliant on the CFW, they are providing an experience like most doctor’s offices. Lay people may not be fully familiar with HIPAA laws or recognize that a NPP indicates HIPAA compliance. However, the presence of

a HIPAA NPP document on the CPCs website is enough to suggest that they are legally responsible for patient privacy and may ultimately aid in potential clients assuming they are a licensed medical facility.

Limited Obstetric Ultrasounds and The Transition to Transvaginal Ultrasound Examinations

There is a rise in the attractiveness of transvaginal ultrasounds and its provision to fulfill the Pro-Life movements agenda. It is worth noting that most, if not all, ultrasound machines come with a transvaginal transducer wand. Even if transvaginal ultrasounds are not advertised on the CFW, there is no way of accounting for how often they are performed. At the NIFLA “One-Day Medical” summit, Audrey Stout presented a one-hour session on “Case Challenges and Tips in Limited Obstetric Ultrasound”. Stout is NIFLA’s Vice President of Medical Services and teaches courses for NIFLA’s Institute in Limited Obstetric Ultrasound.

Stout presented an example detailing her conversation with a sonographer from Texas during a NIFLA Ultrasound training. They began discussing her experience with the Pregnancy Resource Center and Stout recalled that,

“She had not worked with them for very long, but she had working at the ER for years and this pregnancy center would send women to the emergency room suspecting ectopic [pregnancies]...a lot. And I said well did you ever find ectopics and she said very rarely do we ever see them. And I said well what’s the problem? She said if they had simply done a vaginal scan, they could have ruled it out themselves” (Audrey Stout).

CPCs aim to attract low-income women seeking care at their facilities. CPCs are so fearful of the legal repercussions of missing a possible ectopic pregnancy diagnosis, that it could be assumed that the practice of turning women to the ER is a version of practicing “defensive medicine”. Unfortunately, because CPCs target low-income communities, minority populations,

and vulnerable women who are in high school and college, it is possible that they may not have health insurance coverage (Campbell, 2017). Therefore, they could be being forced to cover an emergency center bill out-of-pocket.

Stout went on to encourage the attendees to use transvaginal ultrasound considering the recent passages of a 6-week heartbeat bill in several states.

“Women are using the abortion pill more and more and more. With our states determining that the heartbeat bill, we can find information earlier. We used to never expect to find an intrauterine pregnancy before six weeks. With better skills, better scanning, vaginal scanning, and good equipment, we’re finding, we’re getting down to where we can measure crown rumps under 2 millimeters at 5 weeks 5 days. So, we can give her information she needs and evidence that her baby is alive, by the beating heart in those early stages here” (Audrey Stout).

Although it appears that NIFLA is taking calculated steps to increase the presence of licensed medical professionals performing ultrasounds in CPCs, NIFLA’s policies and procedures manual treads the line between providing medical care and shirking legal responsibility. The manual that was provided for all attendees of the 2019 summit advises CPCs to instruct the patient to insert the transvaginal transducer into her own vagina. “Before the procedure is begun, explain to the patient that she will insert the transducer herself while the medical professional holds onto the transducer” (NIFLA, 2018). It is concerning that the licensed medical professional who is to perform a transvaginal ultrasound is advised against performing part of the procedure. Furthermore, that over half of CPCs in Georgia are advised in this way.

Medical Accreditations

The only medical accreditation utilized by Georgia CPCs is from a body called the AAAHC. The front page of AAAHC.org tells patients that “whether you’re anticipating a surgical

procedure, selecting a pediatrician for your newborn, or something in-between, you expect safe, high-quality care. The AAAHC certificate of accreditation is a sign that a health care organization meets or exceeds nationally-recognized Standards” (aaahc.org). Only four centers in total sought this accreditation. It was not prevalent in the sample in the least and is difficult to consider this a “trend” of CPC medicalization. But nonetheless, it’s display on the CFW could illicit trust in the center as a “licensed medical facility”, as it suggests the center is holding itself to a medical standard.

Service Disclaimers

The importance of service disclaimers is important given the outcome of the NIFLA v. Becerra Supreme Court Case. The most common disclaimer is that a center “does not perform or refer for abortion”. Some centers may provide the disclaimer because they do not align with abortion from a moral stance, and some centers may provide it to qualify for state funding. Two stipulations of the Positive Alternatives for Pregnancy and Parenting Grant Program state that the center must “Ensure grant funds are not used to counsel toward abortion, refer for abortion or provide abortion”, and “have a primary mission of promoting healthy pregnancy and childbirth” (Life Resources of Georgia, 2019). NIFLA does not advise centers to display any kind of disclaimer per the Medical Policies and Procedures Manual. NIFLA also argued during NIFLA v. Becerra that CPCs cannot be compelled to provide service disclosures because they are not medical providers and they are not providing medical services (Oral Argument, 2019). The Supreme Court classified CPC speech as ideological, securing their speech under the first amendment (Brown, 2018).

Most disclaimers were not easily located on the CFW, and were typically at the bottom of the page, or on a single webpage somewhere on the CFW. Patently different from the pervasiveness of the “no abortions” disclaimer, less than 15 of the 71 centers provided disclaimers that let potential clients know they did not offer extended OG/GYN care, they did not offer birth control, nor should they be considered a medical facility.

5.2. STUDY STRENGTHS AND LIMITATIONS

The largest limitation of this study is that these findings are restricted to the information directly provided by these centers on their CFW. It is difficult to determine how comparable the websites are to the services and information provided in person at each center. While this is a limitation, it is also possibly the most representative of how this information will be communicated to potential and ongoing clients of CPCs. Most women seeking services will find them through online search engines and will be directed to these websites.

Second, the inter-rater reliability was not able to be assessed during the coding process, as only one reviewer was available for this effort. Therefore, the reviewer’s determination was not based on a consensus of researchers and is subject to bias. To account for this as much as possible, multiple quality checks were conducted of the data against the websites, although it cannot fully remediate this issue.

This study does have several strengths, including generalizability to other states given the large presence that anti-abortion umbrella organizations, like NIFLA, have in Georgia and across the country, and the fact that data was abstracted based on a well-established map. The Crisis Pregnancy Center Map website project had inter-rater reliability because multiple coders were

involved during the identification and confirmation of CPCs in each state. Protocol during data collection included contacting each identified CPC and confirming the services provided over the telephone, so the most accurate representation of which centers were providing limited medical services was demonstrated.

An additional strength for the state of Georgia is that this study adds to the literature about CPCs in Georgia. Multiple studies on the state have been conducted to identify the types of services offered, and the quality of information provided on their CFWs. This study provides additional insight to how CPCs in Georgia are representing themselves as licensed medical facilities at a time when Georgia has the worst rate of maternal and infant mortality in the nation. This study can further inform public policy making decisions on how to best remediate the issue of limited access to reproductive healthcare in Georgia.

5.3. IMPLICATIONS FOR PUBLIC HEALTH

An increasing amount of public funds are going to CPCs. CPCs could potentially fill a gap in care access for socioeconomically disadvantaged women. It is well documented that anti-abortion CPCs provide misleading and false information on their websites and in their facilities. Now that *NIFLA v. Becerra* has been decided, it will be more difficult for Georgia to set standards for CPCs and attempt to regulate them. Understanding the modes of medical misrepresentation might provide policy makers a better way to create some form of regulation that protects clients, while also maintaining a center's right to exercise their first amendment and protect religious conviction. Researchers must work with policy-makers to create

regulations regarding accountability for these centers who can reach so many women seeking reproductive health services.

5.4. CONCLUSIONS

While efforts to voluntarily implement HIPAA and seek medical accreditations are arguably a step in the right direction, they fall short of real accountability for patients. CPCs are increasingly seeking to take up space in the reproductive healthcare arena, and their efforts to do so must be carefully watched and consistently accounted for. Unfortunately, due to the polarizing nature of abortion as a reproductive health service, researchers are not left with many options to study this phenomenon. This can be evidenced by the weight of the research, which is typically limited to assessing CPC services by their websites, or by conducting secret shopper surveys to gain understanding of CPCs. Despite that public health's comprehension of CPCs is currently still very narrow, these centers have garnered a significant amount of support from policy makers. Since George W. Bush's administration, these anti-abortion advocacy groups have received an increase in public funding. Although this support waned during the Obama presidency, it has been resurrected and amplified by the Trump administration. Because the increasing medicalization of CPCs has significant implications on the health, privacy, and trust women have in the healthcare system, it is important to understand the methods these centers use to attract them. It is possible that funding has accelerated their move towards the medical model and providing medical services and employing volunteer medical staff will in turn allow them to secure more funding in the future.

This study has added to the literature about CPCs in Georgia, by providing additional insight to how CPCs in Georgia are representing themselves as licensed medical facilities at a time when Georgia has the worst rate of maternal and infant mortality in the nation. This study can further inform public policy making decisions on how to best remediate the issue of limited access to reproductive healthcare in Georgia. Future research should aim to study CPCs who are receiving public dollars and identify their impact on their local community. State policy makers should be wary of the subjugation of reproductive healthcare access and understand where public dollars are best spent to improve healthcare outcomes for women and infants in Georgia.

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APPENDICIES A

Table 1: Characterizations of Medicalization of Georgia Crisis Pregnancy Centers (n=71)

Characterization of CPCs	N (%)
Notice of Privacy Practices	31 (43.7)
State Center is not covered entity under HIPAA	3 (4.2)
Suggest Center is HIPAA Compliant on Website	9 (12.7)
Presentation	
Use of Medical Stock Photos	28 (39.4)
Center name includes "Clinic", "medical", or "Healthcare"	19 (26.8)
Describe services as "medical" in nature (i.e. medical-grade pregnancy tests, medical care...)	40 (56.3)
Describe Center staff as "medical professionals" (i.e. doctors, nurses, medical personnel)	34 (47.8)
State Center is a Medical Clinic (i.e. medical center, medical ministry)	23 (32.4)
Medical Accreditation	
Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)	4 (5.6)
Services	
Offers Abortion Pill Reversal Service/Referrals	3 (4.2)
Offers information on Abortion Pill Reversal Service	7 (9.9)
STD testing, no treatment	5 (7.0)
STD testing, with treatment	13 (18.3)
Limited Obstetric Ultrasounds	52 (73.2)
Transvaginal Ultrasounds	2 (2.8)
Ultrasound Referral	19 (26.8)
Staff/Medical Oversight	
Board of Directors on CFW	10 (14.1)
Board of Directors on Donor Page	10 (14.1)
Doctor on Board of Directors	10 (14.1)
Nurse on Board of Directors	1 (1.4)
Staff Displayed on CFW	10 (14.1)
Staff Displayed on Donor Page	9 (12.7)
Doctor on Staff	4 (5.6)
Nurse on Staff	14 (19.7)

Table 2: Description of Crisis Pregnancy Center Affiliates in Georgia

Affiliations	N (%)
Care Net	44 (61.9)
National Institute of Family and Life Advocates (NIFLA)	39 (54.9)
Heartbeat International	30 (42.3)
Centers with no affiliations	14 (19.7)
Centers with 1 affiliation	13 (18.3)
Centers with 2 affiliations	29 (40.8)
Centers with 3 affiliations	15 (21.1)

Table 3: Disclaimers on Crisis Pregnancy Websites

Disclaimers	N (%)
No Abortions or Referrals for Abortions	37 (52.1)
Information provided is not medical advice	14 (19.7)
Do not provide contraception/birth control	13 (18.3)
Do not provide "extended OB/GYN or pre-natal care"	12 (16.9)
Not a medical center or medical facility	12 (16.9)

Table 4: Description of AAAHC Accreditation per Program Details (n=4)

Name	Doing Business As (DBA)	Type	Specialty
Cobb Pregnancy Services	First Care Women's Clinic	Medical Group Practice	Administrative, Infectious Disease, OB/GYN, Women health
Pregnancy Resource Center of Gwinnett, Inc.	Obria Medical Clinics	Medical Group Practice	Administrative, Diagnostic imaging, Women health
A Beacon of Hope Women's Center	Women's Clinic of Atlanta	Other	OB/GYN
Caring Solutions of Central Georgia	CORE Healthcare for Women of Central Georgia	Other	OB/GYN

Table 5: Examples of common tropes used on Crisis Pregnancy Center CFW

The Viable Pregnancy	<p><i>“Is my pregnancy viable?”</i></p> <p>During our advanced abortion consultation, our medical team will determine if your pregnancy is likely to end with a natural miscarriage, including monitoring for a heartbeat. It is medically recommended to eliminate miscarriage as a possibility before getting an abortion.”</p>
The Informed Patient	<p>“They will provide you with evidence-based information regarding abortion, adoption and parenting, so you can make an informed decision. You have a right to know!”</p>
Complimentary Pre-Abortion Screening	<p><i>“Our abortion screening service includes:</i></p> <p>Easy-to-understand information about your abortion options. Free, lab-certified pregnancy test results that are required before your abortion. Ultrasounds for qualifying patients to measure fetal size and gestational age which determines what abortion procedure you’re eligible to receive. We understand that an unplanned pregnancy diagnosis can be overwhelming, but know that you aren’t facing it alone. Our licensed medical professionals and trained patient advocates support your choice and are here to serve Atlanta women from all backgrounds. We will listen to your concerns without judging your decisions. Contact us to Schedule Abortion Screening Today.”</p>
Lab-rated, medical quality pregnancy tests	<p><i>“I already bought a pregnancy test from Wal-Mart. Why do I need to come in and be tested with you?”</i></p> <p>The pregnancy tests offered by our center are lab-quality, high-sensitivity urine tests with instant results. These tests are accurate as early as 7 to 10 days after conception, either before or by a missed period.”</p>

APPENDICIES B

Figure 1: Definitions related to Crisis Pregnancy Centers

Client Facing Websites (CFW)	CPCs often have two websites; one for potential clients seeking services online, and another for potential donors.
Covered Entity	Covered entities are defined in the HIPAA rules as health plans, health care clearinghouses, and health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.
Crisis Pregnancy Centers (CPC)	Religiously affiliated, 501(c)(3) charitable organizations that offer free and low-cost services to women and families in their community. CPCs are against abortion and have been criticized for using deceptive tactics to dissuade women from exercising their right to choose an abortion.
National Institute of Family and Life Advocates (NIFLA)	NIFLA is an anti-abortion advocacy organization that provides legal counsel and ongoing education to affiliates. There are over 1,400 members in the U.S., and NIFLA considers 1,100 of them as licensed medical clinics (NIFLA, 2019).
NIFLA v. Becerra	The 2018 Supreme Court ruling which determined that California’s Reproductive FACT Act violated CPCs right to free speech
Positive Alternatives for Pregnancy and Parenting Grant Program	Added to the Georgia code in 2016, under Governor Nathan Deal. It’s purpose is to promote healthy pregnancies and childbirth through grants given to nonprofit organizations that provide pregnancy support services and do not offer or refer for abortion (<u>GA Code § 31-2A-32 (2016)</u>)
Protected Health Information (PHI)	Any information held by a covered entity which concerns health status, the provision of healthcare, or payment for healthcare that can be linked to an individual. It is protected under the HIPAA Privacy Rule (U.S. Department of Health and Human Services, 2017).

Figure 2: Medical Model Spectrum

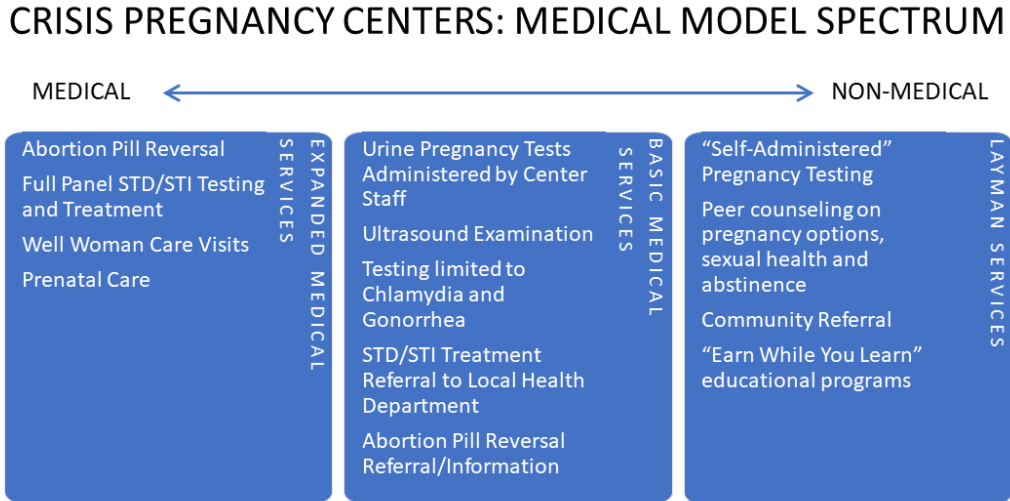


Figure 3: Participation Requirements listed on Life Resources of Georgia Website to Qualify for the Positive Alternatives for Pregnancy and Parenting Grant Program

- 1 Nonprofit organizations in Georgia with a tax-exempt status pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986 may apply for this funding
- 2 Organizations must have a primary mission of promoting healthy pregnancy and childbirth
- 3 Follow financial accounting consistent with generally accepted accounting principles, including an annual budget
- 4 Have a board who hires a director who manages the organization’s operations
- 5 Have provided pregnancy support services for a minimum of one year may apply for this funding
- 6 Currently offer pregnancy tests and counseling for women who are or may be experiencing unplanned pregnancies
- 7 Provide confidential and free pregnancy support services
- 8 Provide each pregnancy client with accurate information on fetal development and assistance available following birth, including the Women’s Right to Know booklet, provided DPH
- 9 Ensure grant funds are not used to counsel toward abortion, refer for abortion or provide abortion
- 10 Maintain confidentiality of all data, files and records of clients in compliance with state and federal laws

(Liferesourcegea.com/grant-administration)