Two Different Versions of Serving Women At-Risk for Abortion

Chapter 1 Two Models of Service: From Global to Linear

A. How the terms were developed

The honor of serving as President on both a local and consultant on a national level in the pro-life Pregnancy Resource Center (PRC) movement has been given to me by the people who volunteer, work, donate, and subscribe to our organization's medical PRC training. In my eight year tenure as President and CEO of CompassCare in Rochester, NY I have had the privilege of meeting and training some of the finest, most sincere women and men in the country. They are hard working, principled people who have sacrificed a great deal of themselves and their families to, as they would put it, have the privilege of helping women have their babies. It is for these people and those that will follow that this book has been written. The old guard has done well their bit for 'King and country' and the new guard is fast moving in to take their place in the noble yet wildly unpopular task of reversing the national abortion trend one woman at a time. After personally training and interfacing on a professional level with over 300 PRC executives it is clear from their comments that our story of the development of a new model of service is in demand. Furthermore, many of my colleagues who also train executives of PRCs at a national level and who have been doing so since the beginning of the movement itself agree that the information in this book is necessary to facilitate forward progress. It is with a spirit of humility and excitement about the future that the information and opinions within this book are offered. It is my prayer that the mission of reversing the national abortion trend is embraced. An America where no woman need fear having her child because she feels supported and secure is an American we all want. It is my hope that an America where abortion is not the first thing a woman thinks about when facing an unplanned pregnancy but the last is so compelling to a PRC that as an organization it will commit to do whatever it takes irrespective of what has been done in the past in order to reach and effectively serve women seriously considering abortion.

To tell you the story of the PRC I lead it is important to start at the beginning. As you may know abortion in modern America has its roots in Western New York. Margaret Sanger who started Planned Parenthood, the single largest abortion provider in the country, was born in Corning, NY 90 miles south of Rochester. New York State was the first State in the union to legalize abortion on demand on July 1st, 1970 three years before the land mark Roe V. Wade Supreme Court case. According to the history of Planned Parenthood of the Rochester/Syracuse Region, Syracuse was home to the first free standing abortion clinic in the U.S. opening on Monday July 2nd, 1970 one day after surgical abortion was legalized. In 1980, an organization was formed called the 'Citizens for Public Morality' which may be an oxymoron in the post-Clinton era morality being largely relegated to a personal level. That organization quickly realized that it wanted to focus on serving women facing unplanned pregnancy and seriously considering abortion. So the name was changed to Crisis Pregnancy Center and in some sense has become a

bell weather of sorts, one of the first of many thousands of such organizations to come. As it grew it adopted a local multi-office strategy offering material assistance, lay options counseling, parenting classes, post-abortion counseling, community referrals, etc and changed its name again to Crisis Pregnancy Services. Around the mid 1990's the organization began to experience a down turn in the number of women it was serving who were seriously considering abortion. In fact by the time I had arrived on the scene in October of 2001 the organization served no more than a handful every year. To put it bluntly, if the Rochester, NY PRC I took over were a for profit company that relied on paying customers as its bottom line the organization would have been bankrupt years earlier. Its people fought with each other. It had very little money. It had been adrift and confused as to its core purpose for years. What it did have was people with passion and drive to see women at risk for abortion served such that their decision making process was not driven by the fear of the unknown but rather by information and support. At the time we were a typical PRC offering no medical service and virtually no valid key decision-making help for the demographic of women seriously considering abortion. The focus was more on the baby we were trying to save than the woman who simply needed to be served.

It all started unintentionally in a staff meeting sometime around 2002 after we changed the name of the organization to CompassCare. We unwittingly embarked on a journey to create a new process for delivering services to women facing unplanned pregnancy. The staff began talking about a performance metric related to enhancing the number of clients the organization was able to serve; appointment no show rates. Simple math says that the more clients we can get to arrive for their appointments the more at risk women we may have a chance of serving. At that time the percentage of women who scheduled an appointment but failed to show had never been under 50%. We had a cadre of staff and volunteers who viewed themselves as phone counselors called "HelpLiners". Their role was to 'counsel' any given woman who called and in many cases attempt to talk her out of having an abortion, maybe attempt to proselytize her by presenting the gospel, and if possible to schedule her to take advantage of an in-house appointment. By this time in the organization's history we had already been offering limited medical services, the addition of which was supposed to aid the organization's ability to reach and serve more women seriously considering abortion. It did have a positive affect but only provided marginal increases at reaching more women at risk for abortion and serving them in such that they go on to have their babies.

After poking around the data for a while someone casually asked Val, the Director of Client Services in charge of this particular aspect of the organization, whether some HelpLiners were more effective at getting women to schedule and arrive for their appointments than others. She said, "Oh, definitely." Not the response we thought we would get. I Picked up on that and said, "Would one of those people be you?" Thankfully and in all humility she said, "Yes." We were on to something. As we pursued the conversation it became clear that not only was Val 90% more likely to schedule a client but that client was 90% more likely to arrive for her appointment than some of the poorer performing staff and volunteers. Val was then asked if she said something similar to each of the prospective clients when they called. She intimated that

in fact what she said to prospective clients on the phone was virtually identical every time. The result of this conversation was to write down exactly what Val said into a script, retrain all the HelpLiners, and have everyone begin using only that script and nothing else for the next month. The outcome was staggering. In one month the organization went from a 50% no show rate down to a 15% no show rate. We could hardly believe it. So of course the next question was, "Can we do this for everything?" Can we take the process we used in our finer moments of serving the women at highest risk for abortion, the abortion-minded, and make it standard operating protocol? The answer, of course, was a resounding, "Why not!" This was the best news we had had in years and we literally stumbled over it.

Armed with this new process CompassCare became quite effective at reversing the trends at the organization's points of pain. Namely, reaching more women at risk for abortion and serving them in a way that helps them feel comfortable enough to carry their babies to term.

We assess how at risk for abortion a woman is by adding up the number of the most common factors that drive women to get abortions she has in her life. We call this the abortion-vulnerability rating scale or AVRS in CompassCare lingo. There are seven risk factors typically assessed. If a woman has between one and three risk factors there is enough pressure in her life that would cause her to think seriously about abortion as an option. We call this woman "abortion-vulnerable". If she has between four and seven risk factors she is typically so overwhelmed that her mind immediately gravitates to fight or flight mode. We call this woman abortion-minded. The number of abortion-vulnerable and abortion-minded women CompassCare served increased exponentially from 5-10 per year to over 95% of the entire client load since we embarked on this journey and the aggregate number of those women choosing to carry their babies to term rocketed to over 80% on a consistent monthly basis. The quick, sustained, and staggering nature of the results that optimizing our services in this way did for the mission of the organization can be demonstrated in the following outcomes typically tracked in a PRC:

1. The no-show rates dropped to a consistent **low of 19%** with a 2005 **average of 28% with 198 overall at risk appointments scheduled**. Assuming a 50% no show rate as a national PRC average there is a potential 31% client load increase for a typical PRC.
2. The number of *high risk* abortion-mined women **increased by 53%.** From 14% in 2003 (24 clients) to 41% in 2004 (59 clients) to 67% in 2005 (132 clients).
3. The total number of "positive pregnancy test" clients **increased by 25 points** from 60% to 85%. The following numbers demonstrate that an increasing percentage of the clients CompassCare served were "qualified leads" (i.e. clients with pregnancy tests that were positive since a woman cannot be at risk for abortion unless she is actually pregnant).

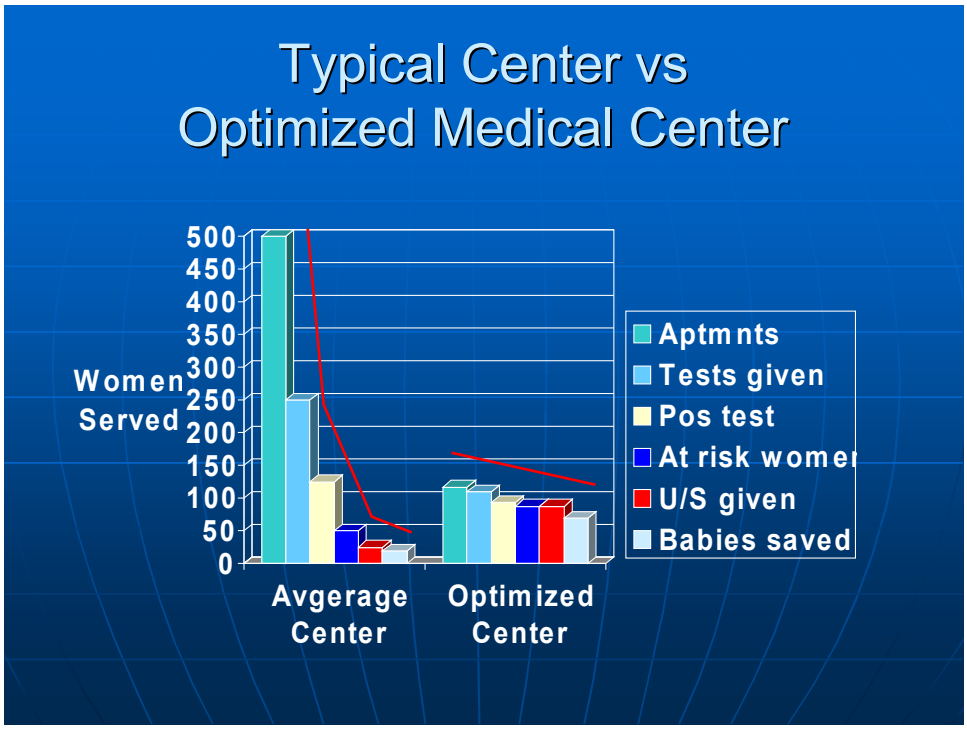
Pregnancy Tests Results– 2003	**Pregnancy Tests Results - 2005**
41% Negative	**20% Negative**
59% Positive	**80% Positive**

4. The positive outcomes (i.e. clients who went on to have their babies) for the high risk

abortion-minded women **increased by 31%** from 50% up to 81% for the time period January 2004 to December 2005.

News quickly spread across the country that there may be an organization that has solved the client load problem that most PRCs were facing. CompassCare began to entertain requests for consultation, training, and permission to use various aspects of the new service process. I was even asked to become a training consultant for the national affiliate organization specializing in medical conversions called the National Institute for Family and Life Advocates (NIFLA). Some people attributed it strictly to the fact that we added limited medical services a year earlier in the form of ultrasound pregnancy confirmation. While that did give us a bump in the number of abortion-vulnerable women we were serving it provided very little increase the abortion-minded category—the really hard cases that represent the bull's-eye of our demographic target. Some people thought it was our aggressive marketing that drew the clients but that did not account for the increased number of at risk women having their babies. Some people thought that it was the script we used to schedule clients for appointments but that was just the first step in the service platform and anyway no more than three to four minutes was spent on the phone with any one client. Others thought it was the fact that we relocated near several college campuses but the fact that at least 50% of the client load were not in college could not alone account for our increased effectiveness. The more cynical observer maintained disbelief assuming that we had manipulated the data.

At any rate, we quickly became overwhelmed with requests for information relative to the perceived organizational needs of the enquirer. So in an effort to continue to meet the needs of not only our clients but also of organizations that had similar mission foci we decided to create a training system. The idea was to give other PRCs the opportunity to experience the same effectiveness that CompassCare was enjoying. This proved to be more challenging than we had first thought. Be that as it may, in the end CompassCare created the first transferable, franchise type PRC in the history of the movement with demonstrated repeatability in nine sites from Lakeland, FL to Santa Barbara, CA from rural to urban, from college town to boom town. The model actually worked with the same if not better effectiveness in very different parts of the country serving very different types of women. Honestly, we did not know if it was going to work and so when it did we were ecstatic. The following side by side graphs represent typical before and after trend results of a medical PRC optimizing their service according to CompassCare's model. The lines in red reflect the use of the organizations resources as they are applied when serving women. In the typical center the majority percentage of the resources are applied to women who are not even pregnant with a lower bottom line of babies born. In an optimized center that red line flattens out and the bottom line goes up. Again these are averages and if you are involved in a PRC this will not be an exact reflection of your experience but the percentages will likely be within 10-20% of your reality. What a lot of PRCs find is that at every major point listed they have about a 50% step function decline in the number of women who "qualify" for the next level of service.



At this point in the story we began to get resistance from other organizations at the national PRC level mostly around a concern over the difference in philosophy of service, push back on the manner in which our services were offered. It became clear that we were more effective than the average PRC in the movement primarily because we had a fundamental difference in philosophy of service. But the almost mythical positive results could not be ignored. Sociologists have a way of studying how change happens within people groups and they call it the "diffusion model." It is noted that any time a new idea or initiative is introduced into an existing industry or population people respond in one of three ways and therefore represent typical response groups; 1) The aggressive Innovators and Early Adopters, 2) The risk averse Early and Late Majority (the wait-and-see group that watches the innovators), and 3) The Laggards who see no need to change unless it becomes the norm. The first group represents about 20 percent of the population, the second group about 60 percent and the third group the remaining 20 percent. Of that first group an even smaller percentage are innovators probably less than half or 10 percent of the overall population and the other half are early adopters representing another 10 percent of the population. If these percentages are in the ball park when applied to the PRC movement of 600 PRCs with medical services probably less than 120 organizations would be willing to adopt this new optimized service paradigm. 360 medical PRCs would be considered the majority and will need to really grasp the absolute necessity of this new paradigm in accomplishing the mission before they would attempt it. If you are reading this book you are likely an early adopter or part of the early majority of PRCs. One of the greatest challenges then in the development of an innovation that truly works is the effective communication of that innovation to the population that could benefit from it.

B. Our Responsibilities to the Client/Patient

CompassCare's results were so dramatically other than the average medical PRC experience that even the casual observer could see that the model used was very different than the typical or traditional approach. But what exactly was different? Could it be labeled? Was it philosophical or just logistical, or both? So in an effort to define the model we were using we had to define the model we left behind. The term we used for the traditional paradigm of PRC service was the "Global Model" and the term used for describing the new service paradigm was the "Linear Model." These two models differ in many ways in terms of how we provided services to women but the reason for that is that it represented a fundamental shift in philosophy of ministry. As we slowly began to see more abortion-minded women (women with an AVRS of between 4 and 7) we noticed their extreme impatience in the service process. In fact, it was not uncommon for an abortion-minded woman to just get up and leave in the middle of her appointment after 45 minutes to an hour of not getting what she felt she needed. In our commitment to providing a relevant service we began investigating what her typical questions were in an attempt to uncover the perceived gaps in information and service of the client flow process from the perspective of the woman. It was at that time we realized that a woman earnestly desired information on all her options including abortion. Once we asked ourselves why we were not providing this information we realized that it was because of our philosophy of service. We were focusing on the baby not what the mother needed to have in order to have the baby. First things first, right? It was then that we moved from baby-centered to woman-centered. The theory is that if a woman feels secure and supported she will likely have her baby. If she does not then she will likely have an abortion.

The role of the organization became clear; identify what drives a woman to get an abortion and address that. Thus the primary objective of the organization changed: Erase the need for abortion by transforming a woman's fear into confidence. All the noise and chatter of additional services clamoring for the time and money of the organization fell to shadow in the new and dazzling light of that clear and compelling purpose. Our job was no longer to assume the worst of her and influence her toward our agenda but rather to insulate her from additional external pressures driving her to get an abortion. We must be proactive about providing her information about all her options so that the decision in front of her was clear in her mind. Or if she had already made a decision to help her understand the options associated with that decision. Our perception of women facing unplanned pregnancy as people who WANTED to have abortions changed to understanding that they are people who did NOT want to have abortions. The basis of our service platform shifted from an empirical, evidence based debate where we represented one side and she represented another to one of advocacy with a heightened respect and support for the autonomy of the individual and a belief that given all the information and support most women will choose the path leading to having her baby. After all, this is exactly the Biblical account of how God treated Adam and Eve in the garden. In the first book of the Bible, Genesis chapter 3 gives an account of the trust that God placed in humanity's first representatives. Essentially there was a tree in the Garden of Eden, a tree of the knowledge of good and evil, the fruit from which they were

prohibited from eating. However, they clearly had been given the power to do so by God with respect to their own free will. They could choose of their own free will to obey or disobey. The very presence of a choice that ran counter to God's desire is at the very least a sign of the nature of humanity made in the image of God. God gave humanity free will to choose to determine his own destiny for good or for ill. And while we know that good decisions ultimately yield positive consequences and bad decisions negative ones we determined to believe in a woman's maternal instinct to make a choice that is right for both her and her baby. Facing an unplanned pregnancy does not need to be an either/or scenario for her. It can be a both/and scenario. She wants it to be. We want it to be. This occurs only after her anxiety is reduced to the degree that her decision is not driven by fear of the unknown but by confidence.

We called the difference in approach 'global' versus 'linear' and a little revolution was born.

C. The Global Model: A Client Centered Approach Equals Humanism

When a woman arrives at an average PRC she is usually asked what type of service she would like to receive and how on a clipboard menu. Offered are services like pregnancy counseling, material assistance, ultrasound scan, post-abortion counseling, abortion procedure video, etc. It is assumed that a woman would know what is meant by pregnancy counseling or even understand the value of an ultrasound scan. While many PRCs offer limited medical services in the form of pregnancy confirmation via an ultrasound scan it is usually optional and not necessarily part of the initial client experience. For our purposes here we are concerned about the initial client interface and the pregnancy counseling related to it as it is presumably at the heart of the why a PRC exists.

Most PRCs use some pre-established counseling manual by which to train their staff and volunteers who are responsible for the first face to face meeting with the client or patient. These manuals are written and published specifically for PRCs and while they all have their differences they all seem to have a common theory underlying them; humanistic psychology, in this case the Carl Rogers 'client-centered approach' to counseling developed in the 1940s and 50s. This client-centered approach, also known as Person-Centered Therapy (PCT), has its roots in 19th and 20th century existentialist philosophy which grew out of a reaction to the absurdity of reality in general and the relatively inapplicable nature of current philosophy to true human experience in particular. It asserts that a person is utterly alone in a world that has no value save for the value an individual assigns to it.[1] This client-centered approach is often employed "to help a person come to terms with a specific event or problem they are having. PCT is based on the principle of talking therapy and is a non-directive approach."[2]

[1] It may be interesting to note here the irreconcilable legal penalty a forced miscarriage of a 'wanted' child brings in terms of qualifying for manslaughter as opposed to an elective abortion of a child the same age in the case of an 'unwanted' pregnancy. The child is assigned value from the existential perspective of the woman rather than from a predetermined objective moral principle.

[2] http://en.wikipedia.org/wiki/Person-centered_psychotherapy

On the surface one may think that a client-centered approach is as it should be. A woman comes to see us because of her circumstances and needs help solving a very significant problem. While it is true that many of the women who agree to engage a PRC happen to be pregnant it is important to note that the nature of a client-centered approach is 'non-directive' meaning the counselor does not have a set plan to deliver information of specific value to the decision-making process of the client. The reality of this type of approach is ill-suited to engage a common human dilemma with three clear choices like unplanned pregnancy. In fact, a directed plan to get specific information into the hands of the person facing the problem is exactly the opposite of the definition of the client-centered approach. The counselor follows the client into whatever eddies the river of conversation take them all the while attempting to convey what Rogers called 'unconditional positive regard' toward the client. It is 'talking therapy' with the assumption that if the client is permitted to talk long enough in an environment of pure positive regard that he or she will arrive at a decision wholly their own. This simply means that nothing a person can say or do will change the counselor's acceptance of them while the counselor offers no real solutions or information to help a person with making a decision. This puts the client in the position as expert and the counselor in the position of little more than a dog wagging his tail at its master's tears or maybe at best an uninformed friend. What the counselor simply offers is a non-judgmental environment in which a person can grapple with their unique personal experiences and make a choice that the person facing the problem finds most valuable to her at the moment.

Most counselors at a PRC have no idea what they are going to say, what information they may inject into the conversation, etc even while a woman contemplating the outcome of her pregnancy sits in the chair opposite. Many PRCs have spiritualized this phenomenon, noting that the apparent freedom a counselor has 'allows room for the Holy Spirit to work.' If, it is argued, a counselor was required to provide specific information in a specific way it would quench the movement of God in the room. In reality, what the PRC movement has done by in large is not create a pure Christian environment as much as adopt secular humanism as its mode of operation. The PRC movement has adopted humanistic, Rogerian, client-centered therapy and put a Christian veneer on it.

Allow me to explain; a mantra of many PRC counseling manuals is that the counselor is to not have an agenda when counseling a woman facing an unplanned pregnancy. You and I both know that people passionate enough to devote their time to serving women specifically facing unplanned pregnancy whether pro-life or pro-choice can be described as a lot of things but 'non-agenda oriented' is not one of them. Nevertheless, counselors are trained to engage a client with empathy and unconditional positive regard without a specific or clear conversational plan or presentation of steps in a decision-making tree relative to unplanned pregnancy options. To be sure, there is a wealth of information that the 'non-agenda oriented' counselor can use to interject in the conversation including the counselor's own personal experiences. However the client-centered model in this context is used in a manner that is not in integrity with the intentions of the PRC nor the intentions for which the client-centered approach was created. If a counselor at a PRC did not use a 'client-centered', client directed model of interface then that would mean the counselor may be required to provide information that they are unwilling to give;

information that they fear might encourage a woman's decision to elect for abortion rather than adoption or parenting. What is left unsaid becomes a means of manipulating outcomes toward the agenda of the counselor. This runs counter to the objective of a pure client-centered approach.

Furthermore the GSM approach used by a PRC enters into a relationship with a client with the assumption that she wants an abortion. This model is comfortable for the traditional PRC in that it permits the counselor to interject personal experience or thoughts and empirical data about the development of the child while at the same time withholding information about the various abortion options available to the client at that moment because, it is assumed, that women actually want to have an abortion. It is assumed that clients do not know that what they are aborting is a human being at its earliest stages of life. Ironically, based on input CompassCare has compiled from focus groups, the essential reason women feel like abortion is such a hard choice is precisely because they believe that what is aborted is a child. Moreover, it is a hard choice because they feel torn. One part of them wants their life to continue as it was and the other part wants to be responsible and have the child. But complications like lack of support from the father of the baby are introduced that create a sense of overwhelming anxiety such that they cannot fathom life after having had a child. They come seeking information to determine a course of action usually around a decision they are already predisposed to making--abortion. They feel the weight of the choice and that is what drives them to call the PRC. They are desperate for data and a clear understanding of the steps involved in each of their three options. If a PRC cannot deliver then they will leave having been inoculated to ever again receiving service from a PRC. Providing certain data, accurate or not, and intentionally not providing certain other types of data or service is disingenuous at best and does not allow a client to find a solution quickly but is interpreted by her as a disrespectful waste of her time.

The following represents common elements of a typical PRC scenario and will serve to illustrate the dilemma a PRC creates when using a global service model. A woman named Jenna arrives for her appointment and is concerned that she may be pregnant. Jenna saw a yellow pages ad that this organization offered pregnancy confirmation which seemed a reasonable thing to have done before determining whether or not she should get an abortion. Her assumption is that she will be interfacing primarily with a nurse or some other medical professional. Upon Jenna's arrival she meets a very friendly lay counselor who invites her into a 'counseling room.' She patiently follows all the while in the back of her mind wondering where this is going. After sitting down she is engaged in a conversation about her life as it relates to the issue of her pregnancy (e.g. a form of 'talk therapy'). After some time Jenna is asked to leave a urine sample for a pregnancy test which takes approximately 4 minutes for a result. However, the time elapsed between when she leaves her urine sample and when the results are read is more than 30 minutes. During that time she is given no real information about her options but smiles and platitudes around the nature and development of a child in the womb and the negative side-effects of abortion (some of which may not be verifiable) none of which Jenna has the emotional wherewithal to question. After almost an hour of 'client-centered' counseling the counselor announces, "Congratulations, you're test is positive!" careful

not to make the medical diagnosis of the condition of pregnancy. To Jenna this response shows almost total disregard for the heart wrenching choice in front of her and feels intentionally unsympathetic and almost manipulative. The counselor quickly conveys the fact that her pregnancy would have to be confirmed by a physician via an ultrasound scan but that it could not be done that day. Jenna leaves the PRC an hour and a half later with a clear impression that this PRC was anti-abortion but with no more clarity on the nature of the choices in front of her or the steps involved in pursuing any of them. She was hoping for an expert organization that would provide a fair and objective analysis of the options in front of her possibly with next steps in pursuing them. Instead Jenna remains confused and now a little frustrated at the waste of time feeling tired and a bit used.

I am not discounting humanistic psychology in situations or venues relative to improving personal understanding or achievement. However, at the very least a pure client-centered approach prohibits its counselor from providing clear paths for potential resolution of an acute life problem. To the degree that the above scenario fails to provide tangible and circumspect decision-making assistance is the degree to which average PRC activity reflects a client-centered approach.

We call this take-it-as-it-comes, client-centered approach to PRC service the Global Service Model (GSM). It is our contention that there are two unacceptable things that happen when a woman is exposed to this model: 1) The GSM makes a woman who is at risk for abortion more vulnerable to external manipulation not just by what is said but by what is left unsaid by the counselor and 2) The GSM does not increase a woman's sense of empowerment and autonomy relative to making a sound decision because she is not getting any unique information that she could not figure out for herself with 30 minutes on the internet. The GSM is a default mode of operation for most PRCs and reflects a lack of intentionality in understanding the role the woman needs the organization to play in her life. This is demonstrated by the relatively low number of women truly at risk for abortion receiving services at a typical PRC and further reflects an inappropriate use of the organization's resources. The bad news is that the current humanistic model of PRC service is a failure for women and a failure for true Christian charity. The good news is that this problem can be solved by adopting a new philosophy of service and a new model of operation. It can be solved by adopting a Linear Service Model.

D. The Linear Model: A Problem Centered Approach

If a GSM engages a client in an open-ended manner providing certain information while withholding or manipulating other types of information whether it is truly non-agenda oriented or not it makes assumptions about the nature of the desires of a woman facing an unplanned pregnancy. The primary assumption about the woman via a GSM is that she wants to have an abortion and must be convinced otherwise. A Linear Service Model (LSM) on the other hand springs from a more appropriate Biblical perspective respecting the decision-making ability of the individual.[3] The primary mode of operation of an LSM is the delivery of information and services in a very specific, step by step approach the primary assumption being that a woman does not want to have an abortion. This approach moves away from the subjective client-centered approach which focuses almost

[3] Genesis Chapter 3

exclusively on the turbulent and unpredictable emotion and thoughts of the client to a problem-centered approach focusing squarely on the issue or crisis and its relevant and legal (however immoral) solutions common to all clients.

The LSM produces a focused response to a specific problem which does two things; 1) The LSM reduces the chance of client manipulation by ensuring a consistent and accurate delivery of a specific body of information and service set and 2) Increases the client's sense of autonomy with respect to managing the problem she is facing. To be sure we did not pull this idea of a LSM out thin air. We were helped along the way by many people in the education, business, and medical sectors as well as many good books not the least of which is Michael Gerber's *The E-Myth Revisited* which is required reading for any new Executive wanting to implement CompassCare's LSM. A LSM is as old as the Catholic Church and as practical as lunch at McDonald's. Simply put it is a delivery mechanism by which a need is efficiently met with predictable excellence. In the face of rapidly growing membership the Catholic Church had to democratize the representation and distribution of the sacraments. The end product was a local parish model each with a priest representing the Bishop. Each were required to follow a dress code and a liturgy through which the seven sacraments or means of grace the population so desperately needed could be dispensed with accuracy and accountability. McDonald's is another LSM giving way to the experience of expecting the exact same hamburger in Omaha as you ate in Toledo for the same price. In the process it maximizes the resources of the restaurant while at the same time meeting or exceeding the expectations of the patron.

The LSM that CompassCare developed has similar objectives of resource maximization and exceeding the expectations of the client but in an emotionally charged service environment with political implications. Our bottom line is not how much money we made yesterday or even how many parishioners were able to partake of the grace of God through the sacraments but rather how many woman at risk for abortion walked out of our doors at peace enough to think clearly about the choice they have in front of them. Our objective is the autonomous support of women at risk for abortion. This means trusting her with all the information regarding not just parenting and adoption but abortion as well. To be in integrity with the mission of the organization we cannot provide nor refer for abortions but we certainly can be the best in the world at answering the three basic questions every woman needs to have answered BEFORE she determines the outcome of her pregnancy; 1) am I really pregnant?, 2) how far along am I in the pregnancy?, and 3) is it important to know if I have a Sexually Transmitted Disease (STD) before I get an abortion? These three questions represent a focus not on the woman but on the problem the woman is facing. This actually serves to reduce her anxiety because she knows that there is relevant information that she has to acquire in chronological order before she need ever think of abortion. When an organization engages a problem-focused approach it creates a certain freedom when faced with each unique client scenario. As long as the primary driving force of the engagement between the client and the organization is the problem called "unplanned pregnancy" then applying the same approach will work very well for most women.

But how does this work for a woman in fight or flight mode, emotionally reeling from the positive pregnancy test she took in her apartment bathroom who, calling the HelpLine asks, "How much will an abortion cost?" These types of questions illustrate the fact that what we are facing is a typical problem with a binary outcome not a thousand unique problems lived out by totally different sorts of people. Simply put when a woman is facing the crisis of an unplanned pregnancy one of two things will happen; she will either have the baby and make normal parental choices including whether or not to place the child for adoption OR the pregnancy will abort whether by her choice or through a spontaneous miscarriage. A LSM will answer the woman's initial HelpLine question but using a form called the 'Socratic Method.' The Socratic Method of teaching is one whereby a complex issue is raised and the teacher responds to the issue with a question or enquiry that forces an engagement of not just the facts but an understanding of the implication of the facts for any given outcome. Often this can take the form of a student asking a teacher a question and the teacher responding not with a direct answer of fact but with a different question. The teacher is not assuming that the student's question was inappropriate just misplaced. We see Jesus doing this often in Scripture, answering a question with a question. So when attempting to solve a problem it is imperative that a student ask the right questions and in the right order. Answers to certain questions may change what types of questions will be relevant in determining an appropriate resolution. An organization that engages a GSM will have a hard time even fathoming not attempting to answer every question a woman asks in the order that she asks it. An organization that has adopted a LSM will understand the logical progression of solving the larger problem and where each question fits in the continuum.

A simple example might be the following: Let's say a girl named Annie is facing a credit card debt crisis to the tune of $10,000. She has several credit cards all of which are maxed out with between five to nine percent interest rates. She determines that she needs to consolidate those credit cards into one low percentage rate loan. She looks in the phone book under the category "Debt Consolidation" and finds a full color, full page ad for a debt consolidation company called "FISH," an acronym that stands for Freedom Insurance and Savings Health. The ad promises that those with no credit or bad credit will not be turned down up to $10,000. The ad also boasts of low introductory interest rates and no payments for the first month. Annie thought this was the answer to her dilemma giving her some breathing room with a little extra cash in her pocket. She calls FISH and asks, "Can I get a loan?" The curt, almost rude, loan officer immediately says, "Yes," without asking any questions and pre-approves her over the phone for $10,000. She will need to go to one of their local offices the next day with an employment check stub and some other documents in order to sign off on the loan terms. What Annie does not know is that the debt consolidation program at FISH is basically a legal loan sharking operation that hooks people who are financially vulnerable with low short term 'introductory' interest rates that bump up to prime plus 19% (a total of 24% interest) after six months thereby enslaving the borrower even more to their debt.

After she makes the appointment she sees another much smaller, simpler ad in the Phone book opposite FISH. This ad says, "Before making a decision about debt consolidation call us." The ad intimated that there were certain things a person needs to know about

debt consolidation before one commits to it. In her interaction with FISH they had not attempted to educate her at all with respect to the available debt consolidation options. They just assumed that she knew all she needed to know. Somewhat out of curiosity she called this other organization called "Financial Security Consulting." A friendly voice immediately answered the phone and Annie asks the same question, "Can I get a loan with you?" To her surprise the person on the other end responds with the question, "Why do you feel you need a loan?" Annie answered by saying, "Because I have too many credit card payments and I need to get them down to one payment." The polite and respectful voice responded again with a question, "If you added up all your monthly credit card payments what would it equal?" Funny, Annie had never thought to figure that out. To her surprise it totaled $459. The friendly voice then asked, "What level of monthly payment *can* you afford to make?" Annie did not know how to answer that question. The friendly voice said, "Why don't you let me schedule you for a complimentary appointment with a one of our debt consolidation specialists to go over your options to see what would work best for you?" Annie agreed that this would be a good idea and scheduled it just before her appointment at FISH. What she learned at Financial Security Consulting was that she could actually afford $401 per month in debt payments. She also realized that she could pay off the credit card with the highest interest rate with two larger payments which would bring her total monthly debt payment down to $367. She could then take the remaining $34 dollars and put it towards the next highest interest rate credit card and pay it off in 5 months which would in turn free up an additional $230 per month to put toward the last credit card payment. At that rate she would have her debt paid off in two short years.

If she had taken the low introductory debt consolidation offer at FISH she would have had a very affordable $250 monthly payment for six months and a very unaffordable $600 payment for three and a half years. It is only after the appropriate data had been collected that either Annie or the financial advisor could gain a clear enough understanding of the optimal consolidation approach for Annie. The consolidation approach that FISH was offering was certainly good for FISH but it was not in Annie's best interests.

Asking the right questions in the appropriate order play a significant role in getting a need met in the manner that is best suited for the person. This example is not far from the reality of interfacing with organizations specializing service to women facing unplanned pregnancy. One the one had there are abortion providers who expect that a woman calling for an abortion understands all the ramifications and is willing to pay the price while on the other hand PRCs should stand ready to assist in the education and consulting to help a woman understand what is best for her. Abortion providers will have a hard time being objective with respect to available options outside of abortion because they have a vested interested in her choice for an abortion, not unlike FISH had a stake in a person choosing debt consolidation with their loan program. A good example for a PRC would be when a woman calls the HelpLine and asks, "How much does an abortion cost?" Knowing the nature of the problem she is facing the first response should be, "Are you sure you are pregnant?" The reason being is that it is possible to not have a viable pregnancy and to still have a positive pregnancy test. There are really only two ways to

truly confirm a pregnancy; time or medical technology. And because time is of the essence it becomes imperative that medical technology is employed and the pregnancy is confirmed. It is to some degree a pressure reliever for her to know that a significant percentage of pregnancies will naturally end for various reasons. If it is determined that the pregnancy is not viable abortion related information becomes obsolete to her.

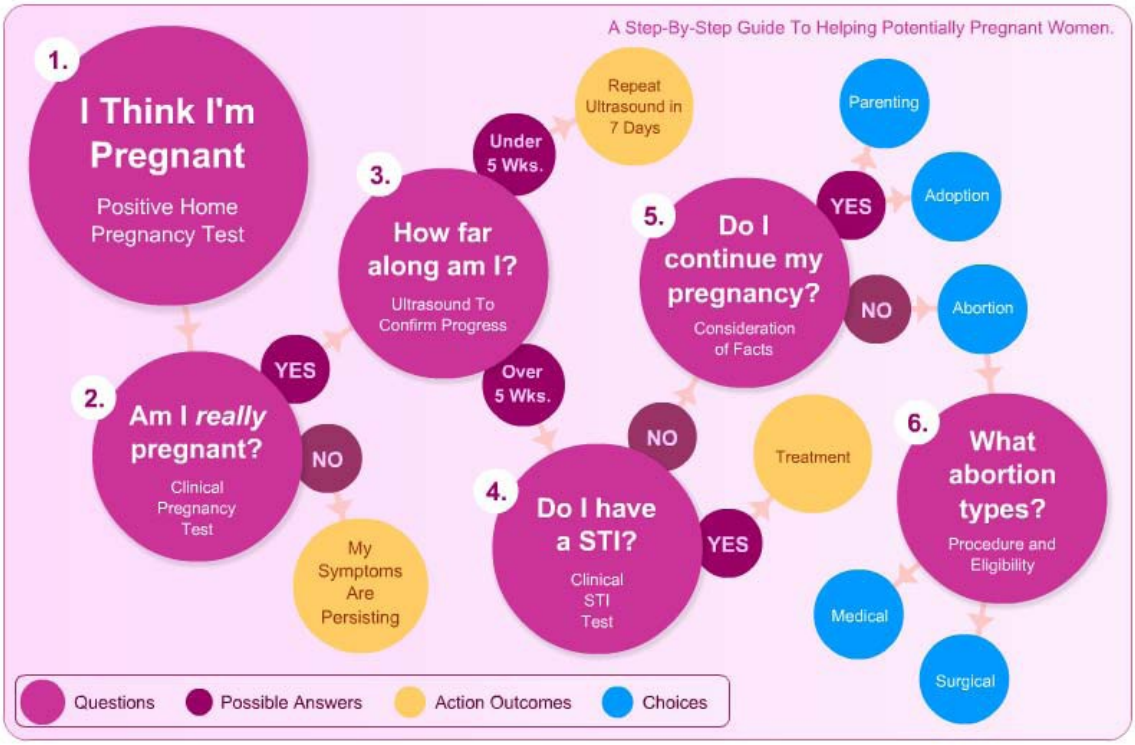
On the other hand if the pregnancy is deemed viable then what should the next question be? Determining exactly how far along in the pregnancy she is. This is called 'gestational age'. Determining gestational age is important information to have because abortion procedures depend on how far along the pregnancy is. The procedures change as the pregnancy progresses. The further along in the pregnancy the more expensive and risky the procedures become. Often the fact that there are different types of pregnancy termination procedures and the fact that they relate to her specific pregnancy diagnosis is new and important information for her. It is at that time when the question "how much does an abortion cost?" becomes relevant. If she were prior to nine weeks gestation she would have a choice of abortion procedures of medicinal (e.g. RU-486 at a cost of between $4-500) or surgical (e.g. Suction or Vacuum Aspiration a cost of between $4-600). If she was between 12-15 weeks she would be eligible for a procedure called Dilation and Curettage (D&C) at a cost of between $3-600 and if she was within 15-21 weeks she would need a Dilation and Evacuation (D&E) at a cost of between $500-2000. Each abortion options carries with it somewhat different relative risks not to mention different expectations in terms of personal experience. However women facing unplanned pregnancies are not only interested in the abortion option no matter what her AVRS rating is. She is also interested in adoption and parenting options. If she were to choose adoption she typically wants to know how that works and who she would contact. If she were to choose to parent what is the best way to approach the myriad of details, everything from medical care to child care? We do not believe any one organization is big enough to handle all aspects of unplanned pregnancy but we certainly do believe that pregnancy follows typical pathways and requires certain specific relationships which can be communicated and followed up with; relationship issues like how to tell grandparents, negotiate life with the father of the baby, identifying a medical insurance carrier, OB/GYN prenatal care provider, pediatrician, securing living arrangements, etc. Often these things can only be addressed in a specific chronological order and fits nicely with the old adage: How do you eat an elephant? One bite at a time. Having a baby is a big deal and she needs someone, anyone who will acknowledge that with her and at the same time provide her with a vision of her future after having had a child.

Once gestational age has been determined and the relevant data pertaining to all her options for both pregnancy termination and having the baby have been presented then the next question becomes, "Is it important to know if I have an STD prior to getting an abortion?" The answer is, "Yes." Most women facing unplanned pregnancy want to view themselves as mothers but not now or not in this way. What this means is that their future reproductive health is important to them. For example, of patients who test positive for Chlamydia without receiving treatment prior to an abortion, 23% could

develop Pelvic Inflammatory Disease (PID) within four weeks after the procedure.[4] PID can cause internal scarring, infertility, future ectopic pregnancies, which can cause death. And since Chlamydia is one of the most common STDs of which most people infected do not even know they have it becomes imperative for the woman to gather this information and potential treatment if not for the sake of this pregnancy for the sake of future ones (something abortion providers do not typically offer).

The LSM that CompassCare has created while driven from a philosophy of autonomous support ultimately creates service structures that not only efficiently meet the needs of the woman but also maintain the organization's integrity to its mission. This is done by providing structure to consistently engage a common problem focusing on helping a woman to understand what she can know and control versus focusing on the specific emotional responses to that common problem. This LSM transforms what at first appeared to be a threat to one's very existence into a challenge that could prove to be very fulfilling. CompassCare's LSM is a highly regulated and defined 15 step service process that uses scripts, forms, brochures, medical technology, and personalized solution plans over the course of one hour in an effort to free a woman from fear feeling like abortion is her only option. This rigorous information and service delivery structure have the benefit of moving her to a sense of confidence in her decision making process. This decision making process is fairly simple however grave the ramifications might be and it is represented below (See Road Map to Choice).

Roadmap To Choice



[4] T. Radberg, et al., "Chlamydia Trachomatis in Relation to Infections Following First Trimester Abortions," Acta Obstricia Gynoecological (Supp. 93), 54: 478 (1980).

An LSM is appropriate for crisis or problem situations because it lends itself well to clear decision pathways that lead a person, in this case a woman, to critical points of information that help to determine an outcome that is in line with her needs and ultimate desires.