EXHIBIT A-J

EXHIBIT J

MO Bureau of Ambulatory Care —Ab Facility Plan of Correction (POC) Instructions

Facility Name	Reproductive Health Services of Planned Parenthood of the St. Louis Region	Survey Exit Date	March 12, 2019
Facility Address/ City/Zip	4251 Forest Park Avenue, St. Louis, MO 63108	Statement of Deficiencies (SOD): L-tags	L-1076

1. **Include a copy of the first page of the original Statement(s) of Deficiencies** for the State (L-tags) **signed & dated by administrator** or designee, along with associated completed POC forms. If you have any questions, contact BAC at BAC@health.mo.gov or call 573-751-1588.

2. **Required elements of an acceptable Plan of Correction**. **Each** deficiency shall be addressed separately by completing the applicable information for **all** elements below for **every** citation.

   A. (TAG):
   Indicate the prefix or Tag number for each deficiency indicated on the form Statement of Deficiencies (L1128, L1136, etc).

   B. (CORRECTIVE ACTION):
   Fully describe the plan for correcting the deficiency. Address the complete deficiency: several underlying problems may be cited under a single Tag number. Address any processes that lead to the deficiency, and what systemic changes will be made to ensure that the deficiency will not recur. The description must be specific, realistic, and complete. A general statement indicating that compliance will be achieved is not acceptable. The POC should be a **standalone document**, giving sufficient detail to show compliance. Do not attach policies, meeting minutes, or training documentation unless necessary and only include the pertinent sections to answer the deficiency. These documents must be available to the survey team at the revisit. However, it is acceptable to reference a policy as needed describing only what is pertinent to the POC. The POC may provide a brief description of training documentation or meeting minutes to demonstrate compliance.

   C. (WHEN):
   For each deficiency, indicate **date correction will be made** on all components for correction put in place. Correction CANNOT be prior to the Exit Date.

   D. (WHO):
   Refer to the one person responsible for implementing the plan of correction for each deficiency by **job title** only and not proper names.

   E. (MONITORING AND/OR TRACKING PROCEDURES):
   Describe the **monitoring and/or tracking procedure** that will ensure that the POC is effective and the issue remains in compliance. Include frequency and duration of monitoring, and mechanism of data collection. These monitoring/tracking activities should begin soon after exit and may continue for an extended period of time past the correction date to ensure ongoing compliance. If the person responsible for ongoing monitoring is different than the person named in "D," above then note it here. If you choose to use percentages to describe evidence of compliance, use only 100%. It is acceptable to state "until compliance is achieved" rather than percentages."

   F. EVIDENCE/EXHIBIT ATTACHMENTS(s). If written evidence exists to document that corrections have been made, attach the numbered exhibit(s) to this POC and indicate the exhibit number(s) in this column. If documentation is not applicable, indicate "N/A"

MO Bureau of Ambulatory Care — Ab Facility Plan of Correction (POC) Form

A (TAG)	B (CORRECTIVE ACTION)	C (WHEN)	D (WHO)	E (EVIDENCE OF COMPLIANCE)	F
ID/tag number (L1128)	Plan of correction for deficiency noted and plan for addressing all related areas affected by deficient practice.	Correction Date	Title of Person Responsible for Correction. No names	Describe monitoring procedure to ensure continued compliance, to include: - Frequency/duration of monitoring - Method of data collection - Who monitors, if different than "**D**"	Evidence/ Exhibit Attachment Numbers or "N/A"
L-1076	On May 23, 2019, RHS received a letter responding to the Amended Plan of Correction it submitted on May 22, 2019, in response to the Statement of Deficiencies issued by the Department on March 25, 2019. The Department's May 23 letter seeks additional clarification or information regarding RHS's Amended Plan of Correction of one deficiency, and accepts RHS's Amended Plan of Corrections as to the deficiency identified in L-1103 regarding pelvic examinations, and in L-1131 regarding infection control standards. RHS continues to hope the Department will reconsider its position of requiring an invasive and medically unnecessary pelvic exam prior to the day of the abortion procedure, as imposing this requirement hurts patient care. In the meantime, effective today RHS is providing pelvic exams on the day of the state-mandated information visit. RHS submits this Second Amended Plan of Correction in order to provide additional clarification on the remaining deficiency the Department has identified.	5/28/2019		See column B (CORRECTIVE ACTION)	N/A

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	As the Department is aware, our license is scheduled to expire on May 31, 2019, and RHS has been endeavoring in good faith to resolve the issues raised by the Department for two months. RHS once again asks the Department to renew its license prior to the May 31 expiration date. Under section 188.027.6 RSMo., "[t]he physician who is to perform or induce the abortion shall, at least seventy-two hours prior to such procedure, inform the woman orally and in person of" the information required in the statute. In its May 20, 2019 letter, the Department expressed concern that a supervising physician who "is merely present in the building without taking any active role in performing or inducing the abortion" is not a physician who performs or induces an abortion within the meaning of section 188.027.6. And as RHS had noted in its Plan of Correction, the Department previously advised the Circuit Court of Jackson County in its legal filings that "[w]hen there are two or more physicians who are substantially involved in performing or inducing the abortion, any one of those physicians may satisfy section 188.027.6 by providing informed consent." Defendants' Suggestions in Opposition to Plaintiffs' Motion for Temporary				

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	Restraining Order at 22, Circuit Court of Jackson County, Missouri, Case No. 1716-CV24109 (Oct. 16, 2017). Additionally, as the circuit court found, under the Department's reading of the statute, "when multiple doctors are involved in the continuum of care before, during, and after a procedure that anyone of those physicians could provide the required information." Judgment/Order at 6, Circuit Court of Jackson County, Missouri, Case No. 1716-CV24109 (Oct. 23, 2017). For these reasons and the other reasons set forth in its prior submissions, RHS believes its attending physicians have always been substantially involved in patient care provided through its residents and fellows. Nevertheless in its May 22 Amended Plan of Corrections it agreed to revise its policies to require that when a fellow or resident is providing a procedure under supervision, the supervising physician will provide the state-mandated information required by section 188.027.6, RSMo., at least 72 hours prior and will be physically present in the procedure room during the abortion procedure. The Department has now rejected that Amended Plan of Corrections, stating that "mere physical presence is not enough" and also that the physician who provided the				

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	state-mandated information must play a "substantial and active role in performing or inducing the abortion" although it again does not define "substantial and active." To be clear, to the degree the Department is suggesting that an attending physician must be physically involved in providing patient care in order to meet this requirement, the Department's interpretation runs counter to accepted understanding by the larger medical education community of the relationship between attending physicians and the fellows and residents they supervise. Fellows and residents learn to practice medicine by performing hands-on procedures under the supervision of attending physicians, and it is well established that in this context the attending physician is understood to be actively involved in performing these procedures even if the fellow or resident is providing the hands-on care. Indeed, in prior litigation the Department specifically rejected the idea that it was unclear how the same-doctor requirement applied *in the scenario of "a medical resident working with a teaching physician to perform an abortion*" (emphasis added), stating that "Section 188.027.6 is not, in fact, ambiguous as applied to [this] scenario[]. When there are two or more physicians who are substantially involved in performing or inducing the abortion, any one				

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	of those physicians may satisfy section 188.027.6 by providing informed consent." Defendants' Suggestions in Opposition to Plaintiffs' Motion for Temporary Restraining Order at 22, Circuit Court of Jackson County, Missouri, Case No. 1716-CV24109 (Oct. 16, 2017). Thus the Department clearly indicated that for purposes of Section 188.027.6, an attending physician who supervises a resident (or a fellow, presumably) in providing an abortion is sufficiently involved to be able to provide the state-mandated information required by Section 188.027.6. Moreover, while the Department now asserts that the Circuit Court "explicitly rejected the interpretation on which you now rely" by saying the Department's interpretation "expands the language of subsection 6 beyond its written words," this ignores that the Court went on to recognize that "[the Department's interpretation] is a reasonable interpretation of subsection 6." Judgement/Order at 6, Circuit Court of Jackson County, Missouri, Case No. 1716-CV24109 (Oct. 23, 2017). For these reasons RHS continues to believe its attending physicians have always been appropriately involved in patient care provided through its residents and fellows. Moreover, the Department's shifting interpretations of				

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	section 188.027.6, RSMo., seem to relate in no way to the Department's mission of promoting patient health and safety as the Department has never throughout this process suggested that any of RHS's prior or proposed practices with respect to section 188.027.6, RSMo. are inconsistent with the standard of care or have compromised patient health and safety. Nevertheless, in the interest of resolving this issue promptly and ensuring patients can continue accessing abortion in Missouri, RHS will revise its policies to require as follows: If RHS continues providing care through fellows and/or residents, it will ensure that the fellow or resident provides the information required by 188.027.6 RSMo, in the presence of the attending physician, and that both the fellow or resident and the attending physician document their participation in this process. In addition, as noted in our prior plan of correction, the attending physician and the fellow and/or resident will also both be present in the procedure room. In the normal course, the fellow or resident will be the primary or sole physician providing hands-on care to the patient during the abortion procedure. However, in any instance where in the medical judgment of the attending physician the attending physician should				

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	complete the procedure, the attending physician shall do so. In the alternative, RHS will ensure that both the attending physician and the resident or fellow play a substantial and active role in performing the abortion. RHS has concerns as to whether it is possible for multiple physicians to play a substantial and active role in providing an abortion procedure without interfering with good patient care, if by "substantial and active role" the Department means physical contact with the patient. This is especially true in the context of a short and straightforward procedure such as an aspiration abortion, which typically takes 3–5 minutes to complete. RHS also has concerns as to whether requiring this type of participation by the attending is consistent with the teaching and training function of a fellowship or residency through a teaching hospital. However, if RHS concludes that there is a way to do this consistent with providing meaningful training and without violating our ethical commitment to patient-centered care, we will advise the Department of revised protocols that provide (as the Department has directed) more specific guidance as to the substantial and active role the attending physician would play.				