

Empowering Care: Best Practices for Prescribing Medication Abortion

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Faculty & Disclosures



Panna Lossy, MD

Dr. Lossy and Dr. Slater have no relevant financial relationships with ineligible companies to disclose.

CAFP's RHI Faculty Advisory Panel, Sheila Attaie, DO, Shannon Connolly, MD, FAAFP, C. Peony Khoo, MD, FAAFP, Amy Tressan, MD, and Aisha Wagner, MD, have no relevant financial relationships with ineligible companies to disclose.



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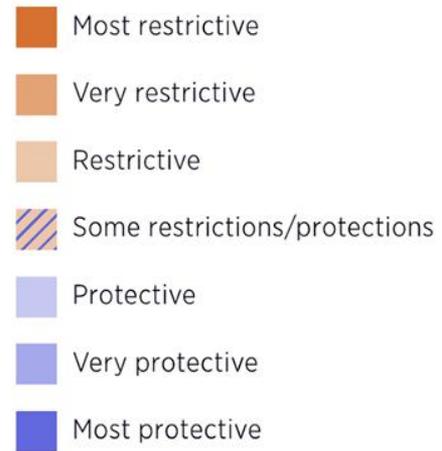
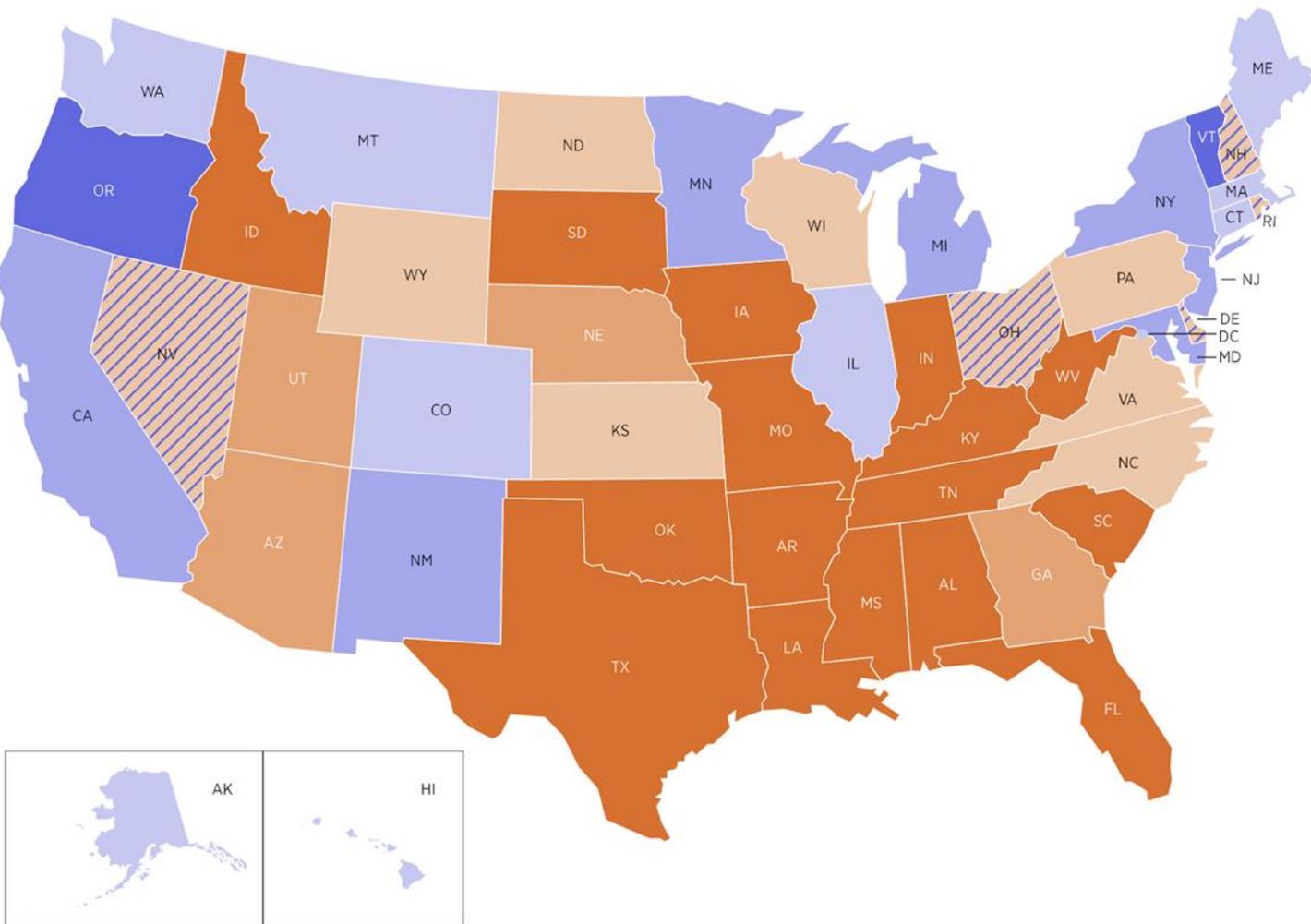


Objectives

- Explain accepted protocols and contraindications of medication abortion
- Discuss safety and efficacy profile, including complications, of medication abortion
- Identify unique aspects of providing medication abortion through telemedicine

A Historical Perspective

- Abortion isn't modern
- Ancient Egyptian papyrus (1600 BC) first documented ways to use herbs, vaginal douches and suppositories to end pregnancy
- Ancient Greeks and Romans didn't consider a person pregnant and didn't consider a fetus alive until "quickening"
 - Advice on abortion focused on "restoring menstrual irregularities"
- Enslaved Black Americans in pre-Civil War-era USA used self-managed abortion as a form of resistance against plantation owners (and often sexual abusers)
- Questions around personhood and legal challenges are more modern inventions



Why should abortion be part of primary care?

- Improves equity in access to reproductive health care
- Many areas have no abortion clinic but have primary care providers (90% of US counties do not have a known abortion provider)
- 1 in 14 people in the U.S. relies on an FQHC for health services
- Referrals are difficult for patients
- Improves continuity of care
- Helps provider morale and retention
- Decreases siloing of abortion, making it harder to protest and defund
- Stand-alone abortion clinics may be impacted with out-of-state patients

What is a reproductive justice lens?



Reproductive Justice

The right to **have**
children

The right to **not have**
children

Founded in the 1990s by black women,
indigenous women, and other women of color.

What is a reproductive justice lens?

Social Justice

Equitable rights, opportunities and power

Social, political, economic institutions

Reproductive Health

Access to services

Access to information

Reproductive Justice

The right to **have** children and raise them in safe and healthy communities

The right to **not have** children

Founded in the 1990s by black women, indigenous women, and other women of color.



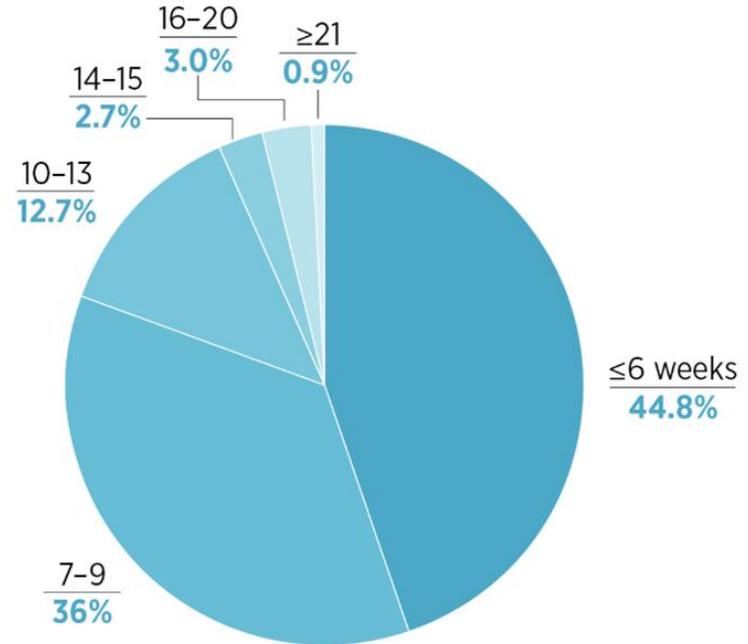
Who has abortions in the US?

- 1 in 4 people with uteruses will have an abortion in their lifetime
- 70% are poor (<200% FPL)
- 55% had at least 1 prior birth
- 10% are adolescents (but only 2% ≤ 17 years old)
- Most (60%) in their 20s
- 15% identify as non-heterosexual



Most abortions are early!

- 80% ≤ 9 weeks
- Almost 95% ≤ 13 weeks



Source: Centers for Disease Control and Prevention, 2023.



Hyde does NOT prohibit abortion in FQHCs!

- No federal funds can be spent on abortions
- FQHCs can offer an “other line of business” outside of 330 grants
- Alternate ways to cover abortion costs:
 - Use state-only funds
 - Grant funds
 - Donations



Abortion is covered in CA

- Medi-Cal and Presumptive Eligibility cover abortion
- CVS and Walgreens accept prescriptions for mifepristone and misoprostol to be dispensed at the local pharmacy
- HoneyBee pharmacy will ship mifepristone and misoprostol to the patients' home
- You can order mifepristone and misoprostol to stock at your clinic to dispense in person

MEDICATION ABORTION 101!



Medication abortions are safe

- Less than 0.4% experience a major complication ¹
- Comparison of mortality rates (2018-2021)²
 - Abortion (legal and illegal): **0.464**
 - Pregnancy-related: **32.3**
- Mortality associated with pregnancy is up to **70 times higher** than that of abortion²



1. MIFEPRISTONE

progesterone blockade

Decidual
Necrosis

Cervical
Ripening

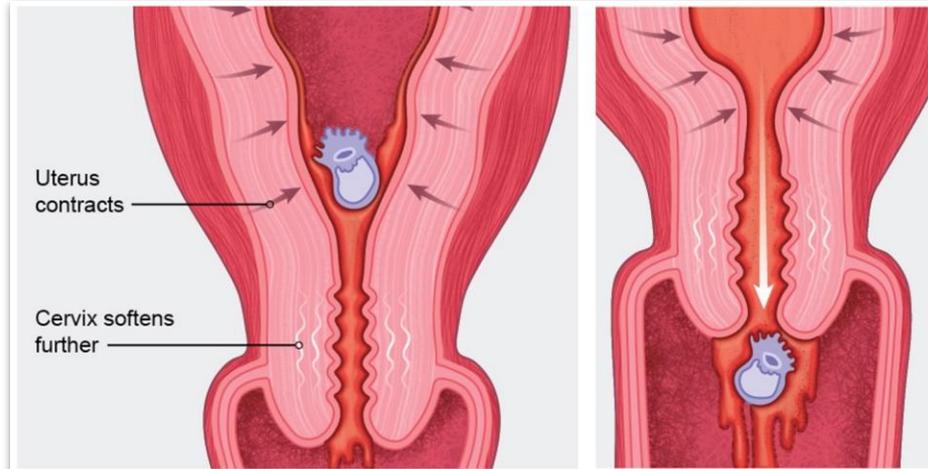
Pregnancy detachment

2. MISOPROSTOL

prostaglandin

Uterine contraction

Pregnancy expulsion



Considering Gestational Duration

- Mife is FDA approved through 10w
- More widely used through 11w in USA
- MAB up to 12 weeks is used widely in international settings, some studies working on 12-14 week protocols
- Self-managed abortion into the second tri has become more common post-Dobbs

Length of pregnancy	% who needed further medical care
0- 49 days (0-7 weeks)	<2 %
40-63 days (7-9 weeks)	2.5%
64-70 days (9-10 weeks)	2.7%
71-77 days (10-11 weeks)	3.3%
77-84 days (11-12 weeks)	5.1%
85-91 days (12-13 weeks)	8%

[Women on Web](#)



Contraindications

- Previous allergic reaction to mifepristone* or misoprostol
- Known or suspected ectopic or molar pregnancy
 - Pregnancy of unknown location is NOT a contraindication for MAB
- Inherited porphyria*
- Chronic adrenal failure*

* may still be candidates for a misoprostol-only regimen

Precautions

- IUD in place (remove before treatment)
- Severe anemia (HGB < 10)
- Other severe or unstable health conditions, including (but not limited to)
 - hemorrhagic disorders or concurrent anticoagulation therapy
 - heart disease
 - uncontrolled asthma*
 - long-term corticosteroid therapy*



Rhogam? Labs? Ultrasound?

- If < 12 weeks from LMP, can forego Rh(D) testing & Rhogam
- No H/H needed unless recent history of severe and/or symptomatic anemia
- No US needed if sure LMP <77d (+/- 1wk) and no ectopic risk factors



Summary chart of recommendations on medical management of abortion

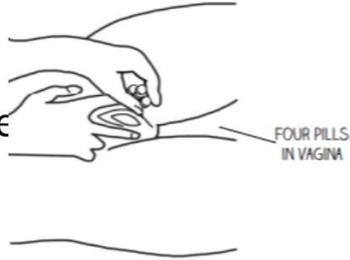
RECOMMENDATIONS	COMBINATION REGIMEN ^a		MISOPROSTOL-ONLY
	MIFEPRISTONE	» 1-2 DAYS » MISOPROSTOL	MISOPROSTOL
27a. INDUCED ABORTION < 12 WEEKS	200mg PO once	800µg PV, SL or B ^b	800µg PV, SL or B ^b
27b. INDUCED ABORTION ≥ 12 WEEKS ^c	200mg PO once	400µg PV, SL or B every 3 hours ^b	400µg PV, SL or B every 3 hours ^b
31. MISSED ABORTION < 14 WEEKS	200mg PO once	800µg B,PV or SL ^b	800µg B,PV or SL ^b
32. INTRAUTERINE FETAL DEMISE ≥ 14–28 WEEKS ^c	200mg PO once	400µg PV or SL every 4–6 hours ^b	400µg SL (preferred) or PV every 4–6 hours ^b
36a. INCOMPLETE ABORTION < 14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		600µg PO or 400µg SL ^b
36b. INCOMPLETE ABORTION ≥ 14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		400µg SL, PV or B every 3 hours ^b
	LETROZOLE	MISOPROSTOL	
27c. INDUCED ABORTION < 12 WEEKS ^d	10mg PO daily for 3 days	800µg SL on day 4	



Protocols - choice of administration

Vaginal:

92-98% effective
fewer GI
side effects



- PROS: least GI side effects, avoids flavor/feel of pills in mouth
- CONS: pill fragments may be observable on internal exam, may not absorb properly if already having VB, requires privacy

Buccal:

95% effective



- PROS: absorption is less variable than VA, private & not discoverable
- CONS: requires holding in mouth, more GI side effects than VA

Sublingual:

97-98% effective

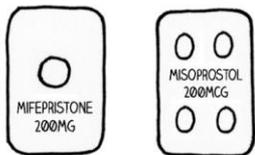


- PROS: fastest absorption and onset of action
- CONS: requires holding in mouth, produces more saliva/discomfort than buccal, stronger side effects (GI, fever, chills)



4. THE PILLS

You need two types of pills. The first is **mifepristone**. The second is **misoprostol**.



5. TIMELINE FOR TAKING PILLS

Time since last period →	8 weeks or less	9-11 weeks	11+ weeks
Day 1	Take mifepristone	Take mifepristone	Take mifepristone
Day 2 (24-48 hours after taking mifepristone)	Take pain medication ↓ Then take 4 tabs of misoprostol	Take pain medication ↓ Then take 4 tabs of misoprostol ↓ Wait 4 hours, then take 4 more tabs of misoprostol	Take pain medication ↓ Then take 4 tabs of misoprostol ↓ Wait 3 hours, then take 2 tabs of misoprostol ↓ Repeat 2 tabs every 3 hours until pregnancy passes

6. FIRST DAY: TAKE MIFEPRISTONE

Swallow one 200-mg pill.



7. SECOND DAY: TAKE PAIN MEDICATION

Up to four 200-mg ibuprofen pills, up to two 220-mg naproxen pills, or up to two 500-mg acetaminophen pills. You can take any of these pain pills before misoprostol. You can take more if needed – follow the directions on the package.



8. SECOND DAY: USE MISOPROSTOL

Choose: Put pills inside your cheeks, under your tongue, or in your vagina. Choose the method that feels best to you. Do this about 24 hours after swallowing the mifepristone.

8 weeks or less: If your period was 8 weeks or less ago, just use 4 of the 200mcg misoprostol pills. If your period was over 8 weeks, put a second dose in your mouth 4 hours later.

More than 11 weeks: If your period was more than 11 weeks ago, use 4 pills of the misoprostol at 24 hours and then 2 more pills 3 hours later, and then 2 more pills 3 hours after that and then 2 more pills every 3 hours until the pregnancy passes.

For Mouth: Put two pills inside each cheek or put four pills under your tongue. Hold them there for 30 minutes while your body absorbs the medicine. Then swallow the pills with a drink.

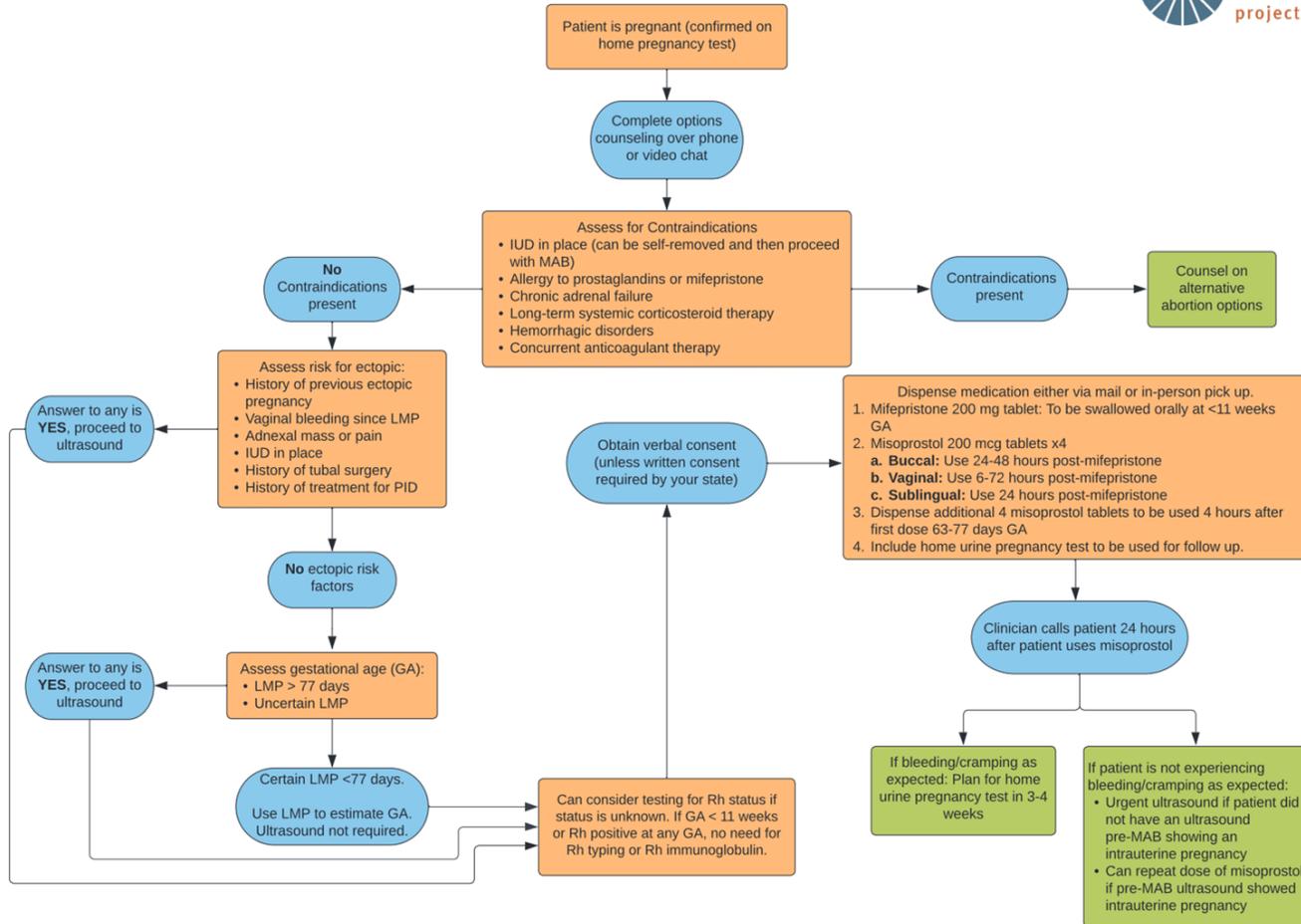
For Vagina: Put pills in your vagina. Lie down for 30 minutes as your body absorbs the medicine. If the pills fall out after 30 minutes, throw them away.



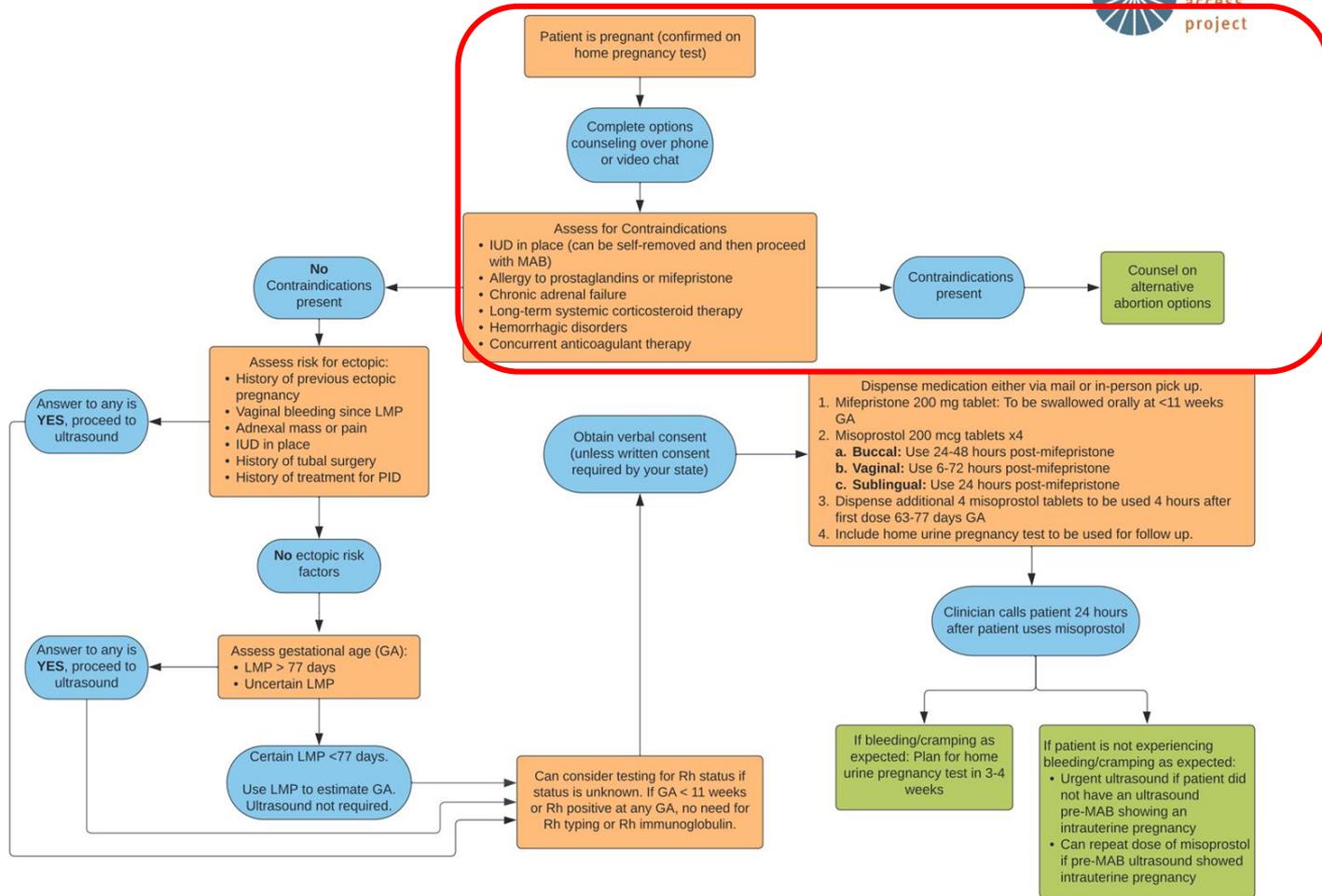
Your body absorbs the medicine from the pills within 30 minutes.



Telehealth Care for Medication Abortion Workflow



Telehealth Care for Medication Abortion Workflow





Patient is pregnant (confirmed on home pregnancy test)

Complete options counseling over phone or video chat

Assess for Contraindications

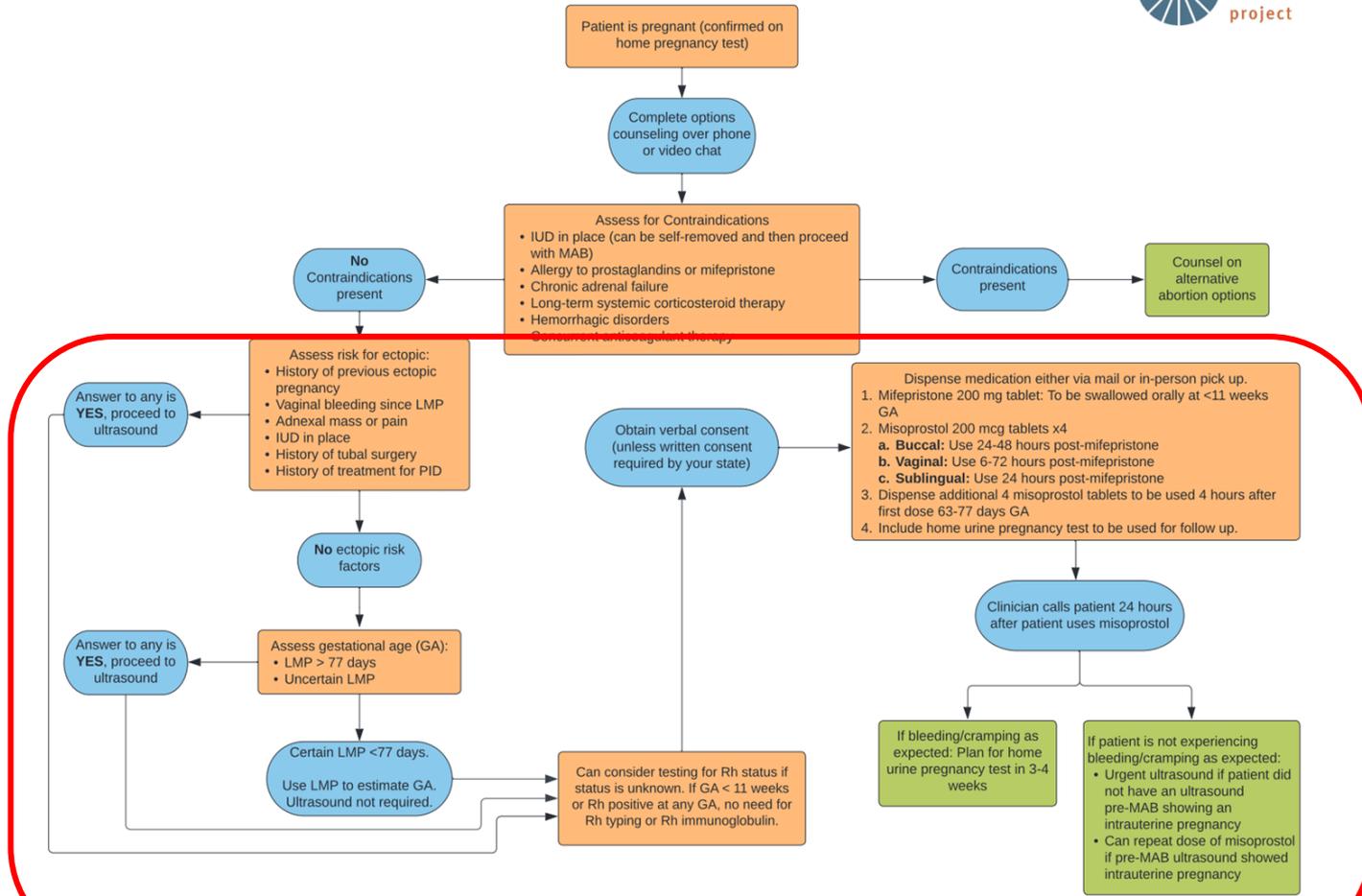
- IUD in place (can be self-removed and then proceed with MAB)
- Allergy to prostaglandins or mifepristone
- Chronic adrenal failure
- Long-term systemic corticosteroid therapy
- Hemorrhagic disorders
- Concurrent anticoagulant therapy

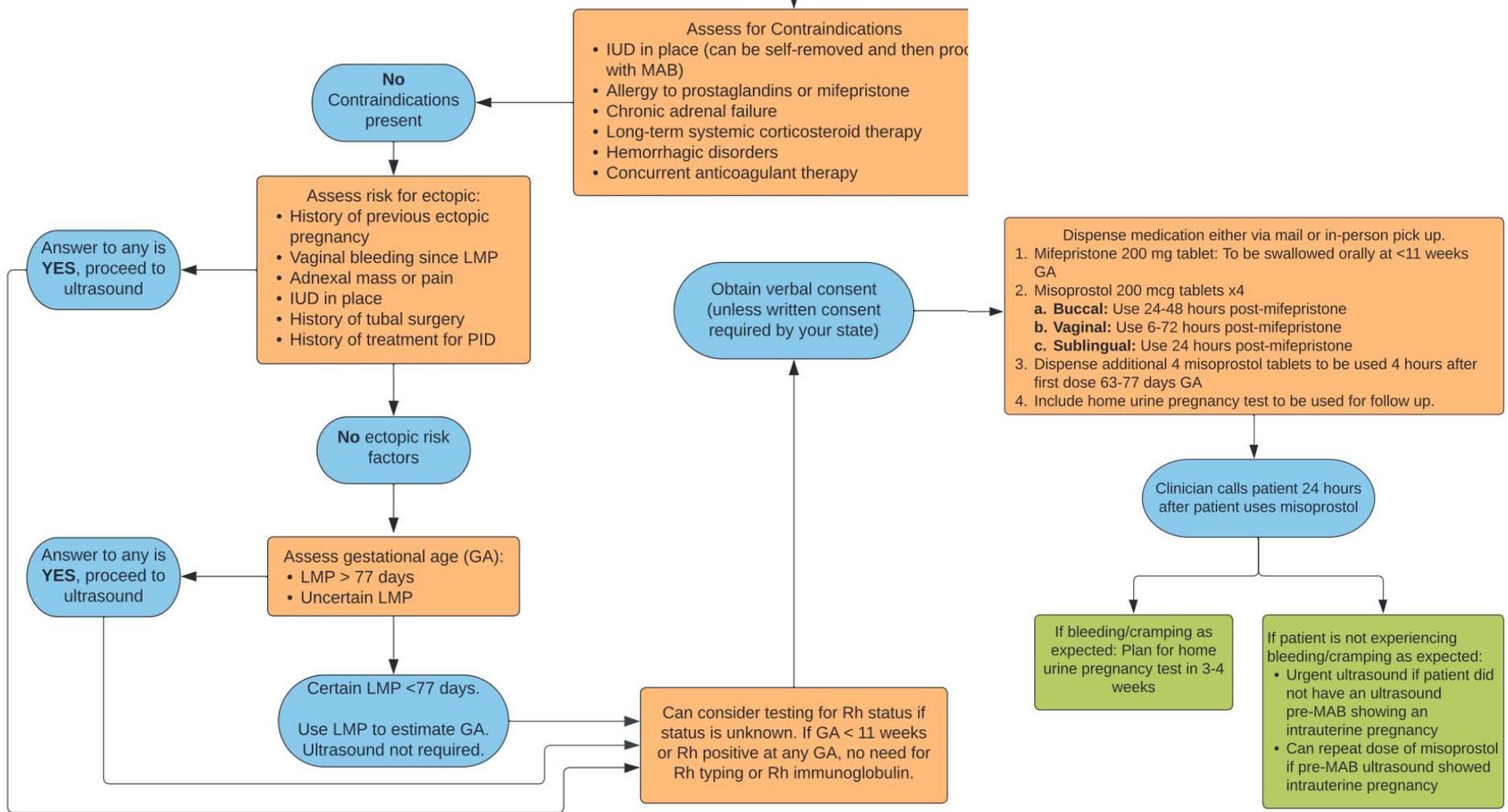
Contraindications present

Counsel on alternative abortion options



Telehealth Care for Medication Abortion Workflow





Ensuring Completion

1. History checklist at one week and negative home pregnancy test at 5 weeks

- Did you have bleeding at least as much as a period* within 24 hours of taking misoprostol?
- Do you feel like you passed the pregnancy (as if you had a spontaneous abortion)?
 - Should report passing clots/tissue
- Are your pregnancy symptoms resolving?
 - Nausea usually resolves in 1-2 days, vomiting, breast tenderness in 1-2 weeks
- Is your bleeding lighter now than the heaviest bleeding after misoprostol?
 - Bleeding should be lighter, may continue until next period

2. Serial beta HCG levels – draw quantitative beta Hcg on day of mifepristone and repeat 1 week later

- Hcg should fall by 80% to ensure completion

3. Ultrasound before and after abortion

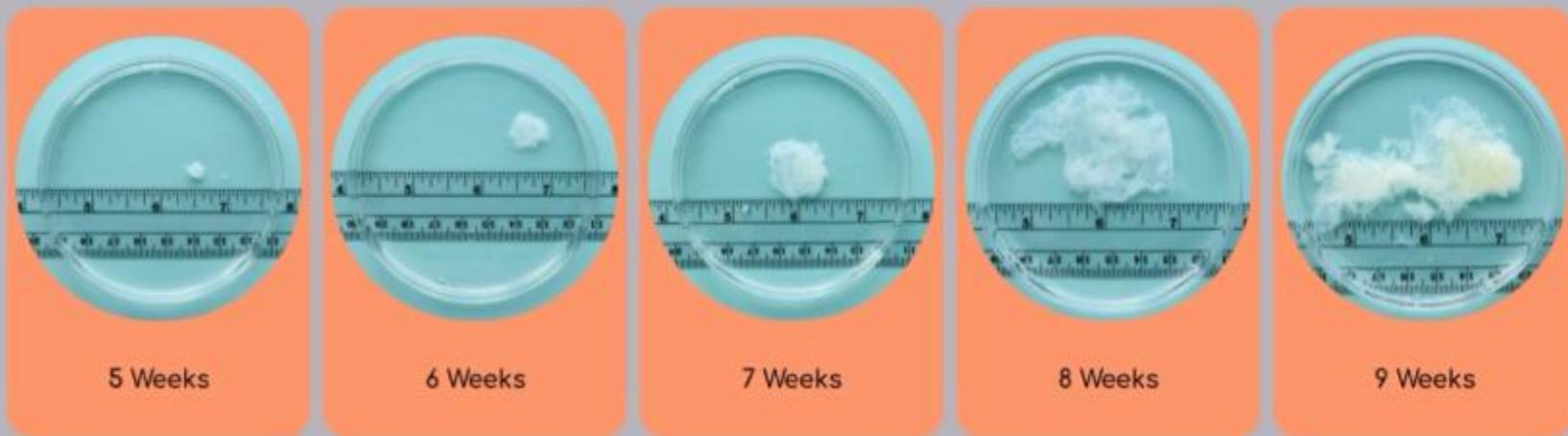
- If intrauterine pregnancy seen on pre-MAB US, and not after MAB, the abortion is complete
- No need to measure or treat thickened endometrial stripe or intrauterine material
- “Treat the patient not the ultrasound”

* very early MAB (~4-5 weeks EGA) can have less bleeding than a typical period, there is a wide range of normal



What does Pregnancy Tissue Look like?

(after washing off blood and removing uterine lining)



Warning Signs

More than 24 hours after last misoprostol dose, it is NOT normal to have:

- Fever 100.4 or higher x 4 hours
- Severe abdominal pain or pelvic pain
- Bleeding that soaks through more than 4 large/nocturnal pads in 2 hours and not slowing down

What to expect?

- Usually there are no side effects from mifepristone (OK to drive, work, etc).
 - Some patients will have bleeding or cramping; this is normal, and they should still take misoprostol as planned.
- Misoprostol causes bleeding and cramping which usually starts 2-6 hours after dissolving pills
 - More on this in next slide
- Should plan to take misoprostol:
 - After taking a painkiller like ibuprofen
 - When/where there is access to a bathroom
 - It's nice to have a support person, but at minimum not be responsible for caring for others
- Miso can cause flu-like symptoms (nausea, vomiting, diarrhea, fever, muscle aches, etc) in first 24 hrs after administration
- Bleeding usually slows down after several hours but can wax and wane until next period
- Anecdotally, the first period after MAB is often heavier than normal - a frequent source of patient concern

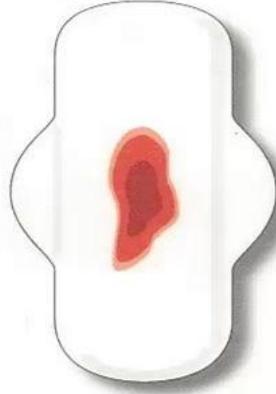


What to expect: bleeding & cramping



Scant amount

Blood only on tissue when wiped or less than one-inch stain on maxi pad within one hour.



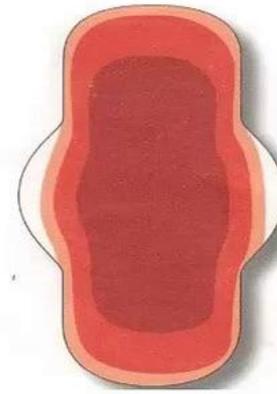
Light amount

Less than four-inch stain on maxi pad within one hour.



Moderate amount

Less than six-inch stain on maxi pad within one hour.



Heavy amount

Saturated maxi pad within one hour.

By 1 week post-MAB follow-up, patients generally:

- Feel normal
- Are back to their usual routine and activities
- Experience minimal pain and cramping
- Feel pregnancy symptoms such as N/V resolved, although breast or chest tenderness may continue for 2-4 weeks post-MAB
- Can be on contraception, if desired
 - pill/patch/ring, POPs, depo, implant can be started on day of mifepristone
 - IUD can start at/after follow up

Managing Complications

Medication abortion using mifepristone and misoprostol

Need for unplanned uterine aspiration for reason other than ongoing pregnancy	1.8% to 4.2%
Ongoing pregnancy	0.8%
Hemorrhage requiring transfusion	0.03% to 0.6%
Undiagnosed ectopic pregnancy	0.02%
Pelvic infection	0.01% to 0.5%

[Macnaughton et al. 2021](#)

Mife/miso can also be used for:

- Early pregnancy loss - recommended by ACOG because it is faster and more effective than misoprostol alone
- Advanced provision - can be prescribed and ordered before someone is pregnant
 - Great for someone who might be moving to a restrictive state and definitely would not want to continue a pregnancy
- Missed period pills - can be taken if someone wants to “bring on a period” but doesn’t want to take a pregnancy test first
- <https://www.plancpills.org> lists places that sell MAB pills and has vetted them to be sure they are legitimate



Looking forward & next steps

- For you:
 - [TEACH's free online Abortion Pill CME](#)
 - TEACH's [Abortion Training Curriculum](#), also available for CME and updated version is en route for 2025
- A few additional resources:
 - [M+A Hotline](#)
 - [MYA Network](#)
 - [Aid Access](#)
 - [National Network of Abortion Funds](#)
 - [Repro Legal Helpline](#)
 - [Exhale Pro-Voice](#)
 - [Beyond Do No Harm Principles](#)
- Integrating Abortion into Primary Care! ([RHAP Toolkit](#))



Reproductive Health Service Corps Accelerator

- Individual didactics and clinical abortion training opportunities for California providers (MD, DO, NP, PA and CNM)
- Priority: rural, underserved, providing culturally concordant care
- Apply now! <https://teachtraining.org/rhscaccelerator>



RHSC
REPRODUCTIVE
Health Service Corps





INTEGRATE

REPRODUCTIVE HEALTH

START-TO-FINISH TECHNICAL SUPPORT

FUNDING AVAILABLE FOR FQHCS, COMMUNITY HEALTH CENTERS & TRAINING PROGRAMS

Support to integrate reproductive health in existing practices

Training for the entire healthcare team in:

- Early pregnancy loss
- Abortion
- Options counseling
- Contraceptive training

Learn more and apply for funding at:



www.teachtraining.org/integrate



1-844-REPROHH / 1-844-737-7644

The Reproductive Health Hotline is launching in Spring 2025!

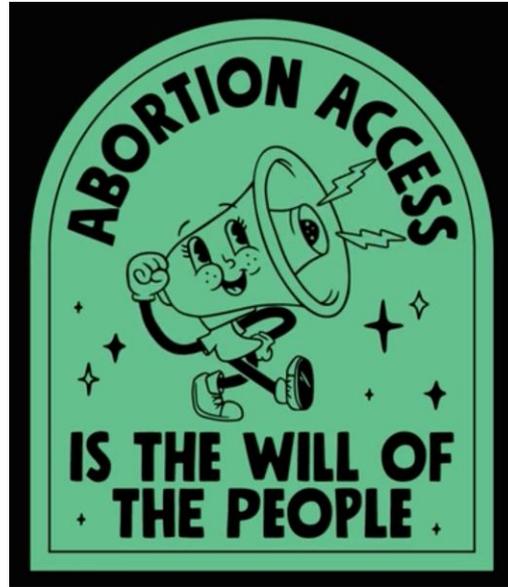
**A free, on-demand, evidence-based hotline for health
care providers staffed by clinicians with expertise in
sexual and reproductive health (SRH)**

Open M-F 6AM – 5 PM Pacific Time

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Acknowledgements

Thank you to prior TEACH fellows for adaptation and use of teaching materials



[RHAP](#)

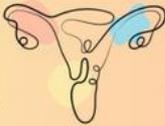
More Reproductive Health Education

Edit

Am I Helping or Harming?

UNBIASED COMMUNICATION ABOUT PREGNANCY

Case studies and self-reflection for positive change
Approved for 1.5 AAFP Prescribed Credits

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