

ExPAND Mifepristone: Medical Management of Miscarriage and Abortion in FQHCs

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THE INNOVATION

We piloted a learning collaborative, *Excellence in Providing Access to New Directions in Mifepristone Use (ExPAND Mifepristone)*, to support primary care physicians (PCPs) in initiating provision of mifepristone for early pregnancy loss (EPL) and/or abortion. Mifepristone is FDA-approved for abortion at ≤ 10 weeks and is highly effective for medical management of EPL, with greater efficacy than misoprostol alone.^{1,2}

WHO AND WHERE?

ExPAND Mifepristone is run by the University of Chicago Department of Family Medicine. Participants were 2 Chicago-area, multisite federally qualified health centers (FQHCs). Participants were asked to send a minimum of 2 representatives, 1-2 clinician champions, and 1-2 nursing or administrative leaders, to attend didactic sessions.

HOW?

Learning Collaborative Design and Purpose

Based on interviews with Illinois PCPs and research suggesting modifying medication protocols alone is insufficient to change clinical practice,^{3,4} we developed *ExPAND Mifepristone* to help clinics overcome barriers to providing mifepristone by building skills, self-efficacy, and capacity for practice change.⁴

Pilot Year: Recruitment and Programming

We recruited 3 organizations for the pilot, a combination of in-person and remote programming for Illinois PCPs in multiple clinical settings. COVID-19 pandemic adaptations for remote delivery resulted in 1 organization being unable to participate. The remaining 2 organizations were FQHCs and we tailored program content for this audience.

From May 2020 through April 2021, representatives attended hour-long, monthly group sessions on clinical protocols, billing, and the legal landscape surrounding mifepristone provision via Zoom

Conflicts of interest: authors report none.

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(**Supplemental Appendix**). *ExPAND Mifepristone* electronically provided all learning materials, which included peer-reviewed journal articles, published protocols for medication abortion and medical management of EPL, and patient consent and education documents. Trainers included: *ExPAND Mifepristone*'s co-directors, a family physician (D.B.S.) and a public health researcher (E.J.); an attorney experienced in FQHC and reproductive health policy; a family physician experienced in FQHC-based provision of mifepristone for both abortion and EPL; and an educational professional serving as technical advisor, experienced with clinic-based implementation of reproductive health innovations. Both participating FQHCs opted to provide mifepristone onsite for EPL and to refer offsite for abortion care.

Outcomes

Baseline surveys ($n = 83$) demonstrated clinicians and staff had little knowledge of mifepristone before program implementation; knowledge measures increased in follow-up surveys ($n = 38$), but gaps remain. For example, the proportion of clinicians who correctly identified mifepristone and misoprostol as superior to misoprostol alone for EPL increased from 26% to 44%. Not all clinic sites within each FQHC had participated in *ExPAND Mifepristone* when we fielded post-intervention surveys, so our estimates of organization-wide knowledge change may be limited. Both clinics have stocked and begun providing mifepristone for EPL following program completion; neither has provided mifepristone for induced abortion. Service delivery data were collected from 1 clinic, demonstrating a post-implementation increase in medical management from 7.7% to 11.3% of all miscarriages. Before the program, all patients receiving medical management were treated with misoprostol alone; post-implementation, 47.8% of medically managed miscarriage patients received the more effective regimen—mifepristone plus misoprostol.

LEARNING

With individualized technical support and shared learning sessions, clinics overcame barriers and provide mifepristone for EPL care. Although abortion can be provided at FQHCs in accordance with federal regulations, the financial procedures required and the fear of losing funding caused an abortion-specific chilling effect in this pilot program. Our program navigated these barriers by providing didactic sessions clarifying where Hyde Amendment restrictions do and do not apply. Overall, our results showcase the promise of learning collaboratives in increasing PCP provision of comprehensive reproductive care.

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Key words: pregnancy loss; miscarriage; community/public health; abortion; primary care issues

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