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Postpartum Contraception and COVID-19

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COVID-19 is affecting contraception provision

Difficult to access postpartum contraception

- Tubal ligation = “elective surgery”
- Early discharge
- Postpartum visits converted to telemedicine

Worsening the challenge of rapid repeat pregnancy

- MA unintended preg rate: **40 per 1,000 women** aged 15–44
- **47%** of all pregnancies unintended

Vulnerable populations at higher risk

Telehealth may affect ability to counsel patients

Do you currently offer IUD and implant placement for postpartum patients?

A. Yes, both devices, for all patients
B. Yes, either IUD or implant, for all patients
C. Yes, both devices, for patients with MassHealth only
D. Yes, either IUD or implant, for patients with MassHealth only
E. Yes, but only for patients with high medical need
F. Yes, some other process
G. No

Partners in Contraceptive Choice and Knowledge (PICCK)

EOHHS-funded 5-year program

Massachusetts birth hospitals

- Direct engagement
- Statewide activities (webinars, annual meeting Sept 2020)
- Resources (www.picck.org)

COVID-19-related programming

- Webinar – *Contraception in the Time of COVID-19*
- Telemedicine Best Practices
- Accessing Birth Control Without a Visit
- Upcoming webinar on reopening services

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PICCK and Immediate Postpartum LARC

Group presentation

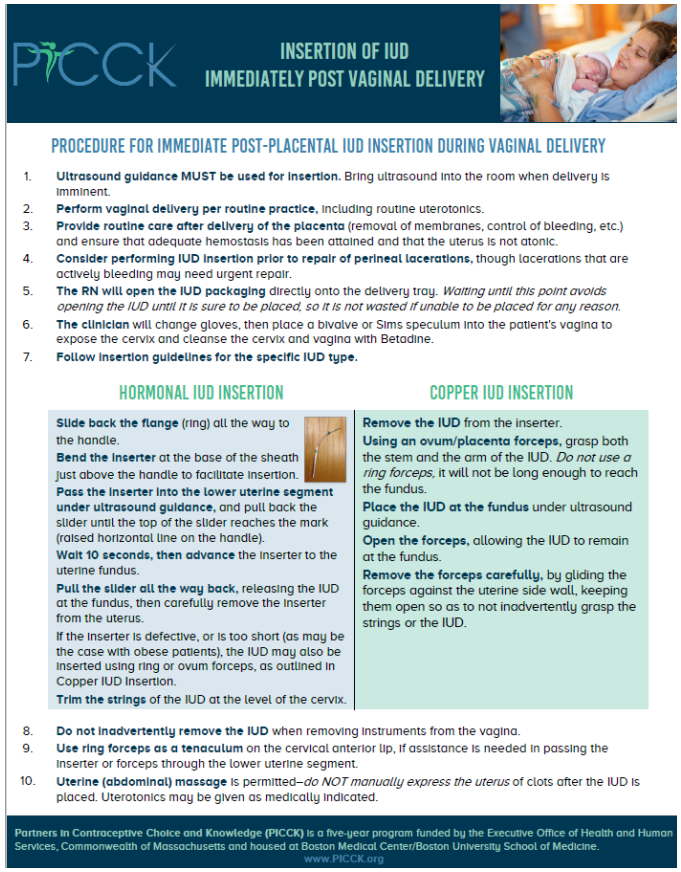
- Grand rounds
- Nursing education

Champion efforts

- Protocol adoption
- Aligning with stakeholders
- Pharmacy, billing

Resources

- Champion toolkit
- Printed resources



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INSERTION OF IUD
IMMEDIATELY POST VAGINAL DELIVERY

PROCEDURE FOR IMMEDIATE POST-PLACENTAL IUD INSERTION DURING VAGINAL DELIVERY

1. **Ultrasound guidance MUST be used for insertion.** Bring ultrasound into the room when delivery is imminent.
2. **Perform vaginal delivery per routine practice,** including routine uterotonics.
3. **Provide routine care after delivery of the placenta** (removal of membranes, control of bleeding, etc.) and ensure that adequate hemostasis has been attained and that the uterus is not atonic.
4. **Consider performing IUD insertion prior to repair of perineal lacerations,** though lacerations that are actively bleeding may need urgent repair.
5. **The RN will open the IUD packaging** directly onto the delivery tray. *Waiting until this point avoids opening the IUD until it is sure to be placed, so it is not wasted if unable to be placed for any reason.*
6. **The clinician** will change gloves, then place a bivalve or Sims speculum into the patient's vagina to expose the cervix and cleanse the cervix and vagina with Betadine.
7. **Follow insertion guidelines for the specific IUD type.**

HORMONAL IUD INSERTION

Slide back the flange (ring) all the way to the handle.

Bend the inserter at the base of the sheath just above the handle to facilitate insertion.

Pass the inserter into the lower uterine segment under ultrasound guidance, and pull back the slider until the top of the slider reaches the mark (raised horizontal line on the handle).

Wait 10 seconds, then advance the inserter to the uterine fundus.

Pull the slider all the way back, releasing the IUD at the fundus, then carefully remove the inserter from the uterus.

If the inserter is defective, or is too short (as may be the case with obese patients), the IUD may also be inserted using ring or ovum forceps, as outlined in Copper IUD Insertion.

Trim the strings of the IUD at the level of the cervix.

COPPER IUD INSERTION

Remove the IUD from the inserter.

Using an ovum/placenta forceps, grasp both the stem and the arm of the IUD. *Do not use a ring forceps,* it will not be long enough to reach the fundus.

Place the IUD at the fundus under ultrasound guidance.

Open the forceps, allowing the IUD to remain at the fundus.

Remove the forceps carefully, by gliding the forceps against the uterine side wall, keeping them open so as to not inadvertently grasp the strings or the IUD.

8. **Do not inadvertently remove the IUD** when removing instruments from the vagina.
9. **Use ring forceps as a tenaculum** on the cervical anterior lip, if assistance is needed in passing the inserter or forceps through the lower uterine segment.
10. **Uterine (abdominal) massage** is permitted–*do NOT manually express the uterus* of clots after the IUD is placed. Uterotonics may be given as medically indicated.

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www.PICCK.org

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PPLARC Implementation

Process measures

- How many trainings
- % of staff trained
- Credentialing

Outcome measures

- Protocol adopted
- Devices available
- Uptake (devices placed!)

Qualitative data

PPLARC	
Goals/Tasks	**PICCK Contribution**
Providers: ❑ Knowledge about how to: ❑ Counsel for PPLARC during prenatal care ❑ Obtain consent and transfer to L&D ❑ Place PPIUD in all 3 insertion scenarios (at VD, at c/section, during postpartum days) ❑ Comfort in their skills in immediate postpartum IUD placement	• Grand rounds • Insertion training • Webinar • Infographics (timeline of counseling and consent; three insertion scenarios) • Resident presentation
Nurses: ❑ Familiar with the equipment needed ❑ Familiar with the procedure of vaginal IUD insertion, including patient-facing tasks (pain meds, voiding)	• Nurses presentation • Infographics (implant and IUD prep and equipment lists)
Pharmacy: ❑ Decide which insurance types are eligible ❑ Decide if independent insurance verification is required ❑ Figure out how to store devices on L&D/postpartum ❑ Decide on par levels for devices ❑ Understand billing for IPP LARC	• Billing guide • Web presentation
Practice Leadership Decisions: ❑ Decide how equipment for insertion will be obtained--individual instruments vs. premade kits ❑ Decide if the same process for IUD and implant ❑ Decide appropriate credentialing process for providers ❑ Approval of protocol by appropriate committee	• Toolkit • Credentialing sheet • Sample protocols • Videos (curated)
Champion: ❑ Coordinate training for staff, particularly around: ❑ Ambulatory consent procedure ❑ Where consents will be stored ❑ Training for nurses ❑ Training for OR scrub techs ❑ Work with practice leadership to determine workflow, from both triage/L&D and on the postpartum unit ❑ Create/adapt autotext for EMR for documentation ❑ Determine how to ensure all staff members trained and providers credentialed ❑ Posting of protocol and infographics for easy access ❑ Decide on patient-facing resources to make available	• Sample autotext for EMR • Patient-facing resources
Sustainability: ❑ Training of new staff on PPLARC ❑ Training of new providers on PPLARC	• Best practices overview

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PPLARC Best Practices

Takes longer than you expected

Don't forget to align with stakeholders *early*

Balancing measures to ensure reproductive justice and guard against coercion

- *Counseling during prenatal care (30-32 weeks)*
- *Counseling metrics*
- *Going home with a method (not just LARC)*

Think about sustainability from the beginning

- *Training of new staff*

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Thank You

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