Learning Forum

June 2024

Name and Agency/Hospital in the CHAT

FOURTH TRIMESTER INITIATIVE

KPQC Virtual Fall Conference

Save the Date:

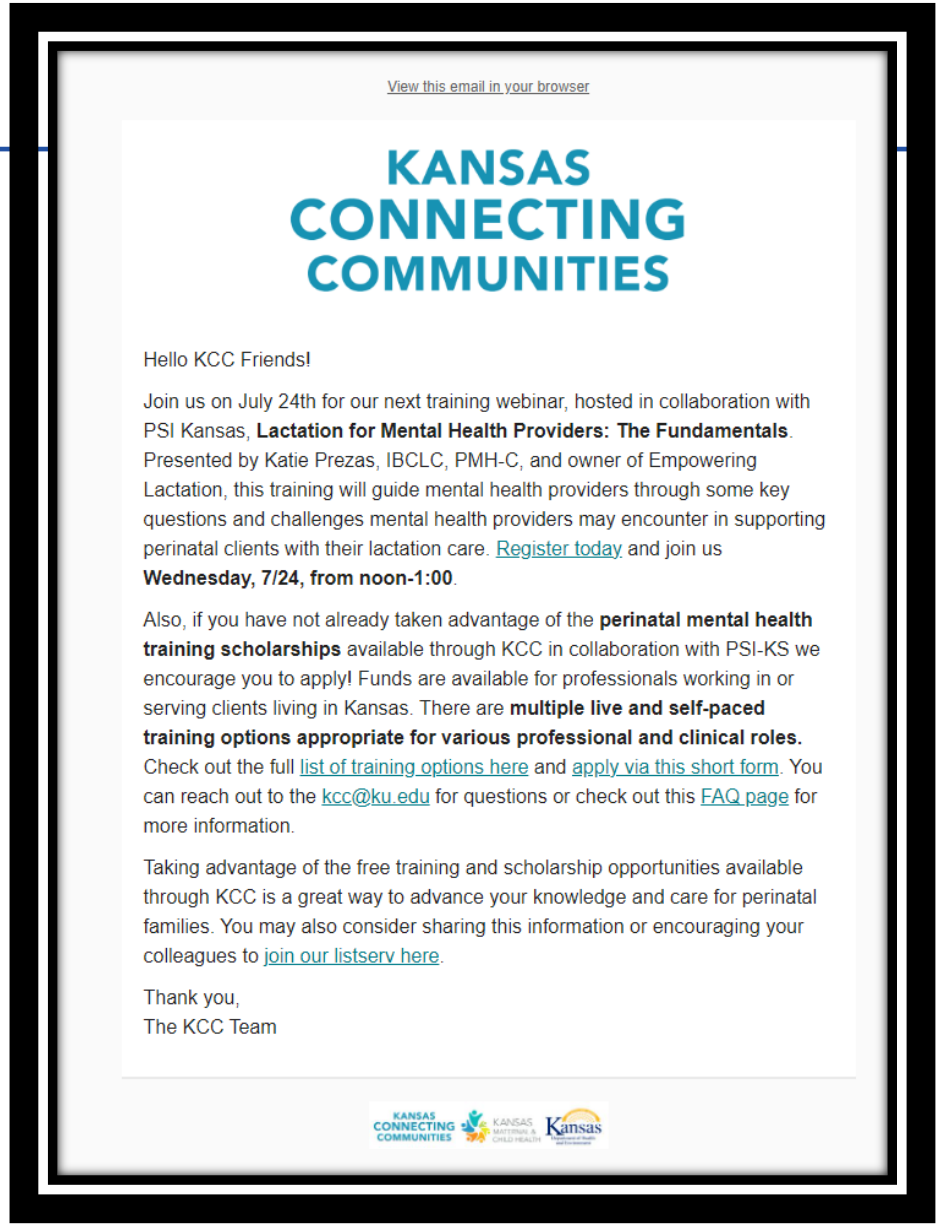
Date: October 22, 2024
Time: 9:00-12:00

MORE INFORMATION COMING SOON!

KPQC
Kansas Perinatal Quality Collaborative

Rapid Response

1. KCC Training opportunities
2. ALL hospitals (FTI Champs, Admin from non-enrolled Hospitals)-
   - Next safety bundle input: http://docs.google.com/forms/d/e/1FAIpQLSct6OuEAZp-d9pwKkd_RJddQPEW9VWeQKGO6ywnZd1fhuIurA/viewform?usp=sf_link
3. SMM Case Review template



View this email in your browser

KANSAS CONNECTING COMMUNITIES

Hello KCC Friends!

Join us on July 24th for our next training webinar, hosted in collaboration with PSI Kansas, **Lactation for Mental Health Providers: The Fundamentals**. Presented by Katie Prezas, IBCLC, PMH-C, and owner of Empowering Lactation, this training will guide mental health providers through some key questions and challenges mental health providers may encounter in supporting perinatal clients with their lactation care. Register today and join us **Wednesday, 7/24, from noon-1:00**.

Also, if you have not already taken advantage of the **perinatal mental health training scholarships** available through KCC in collaboration with PSI-KS we encourage you to apply! Funds are available for professionals working in or serving clients living in Kansas. There are **multiple live and self-paced training options appropriate for various professional and clinical roles.** Check out the full list of training options here and apply via this short form. You can reach out to the kcc@ku.edu for questions or check out this FAQ page for more information.

Taking advantage of the free training and scholarship opportunities available through KCC is a great way to advance your knowledge and care for perinatal families. You may also consider sharing this information or encouraging your colleagues to join our listserv here.

Thank you,
The KCC Team

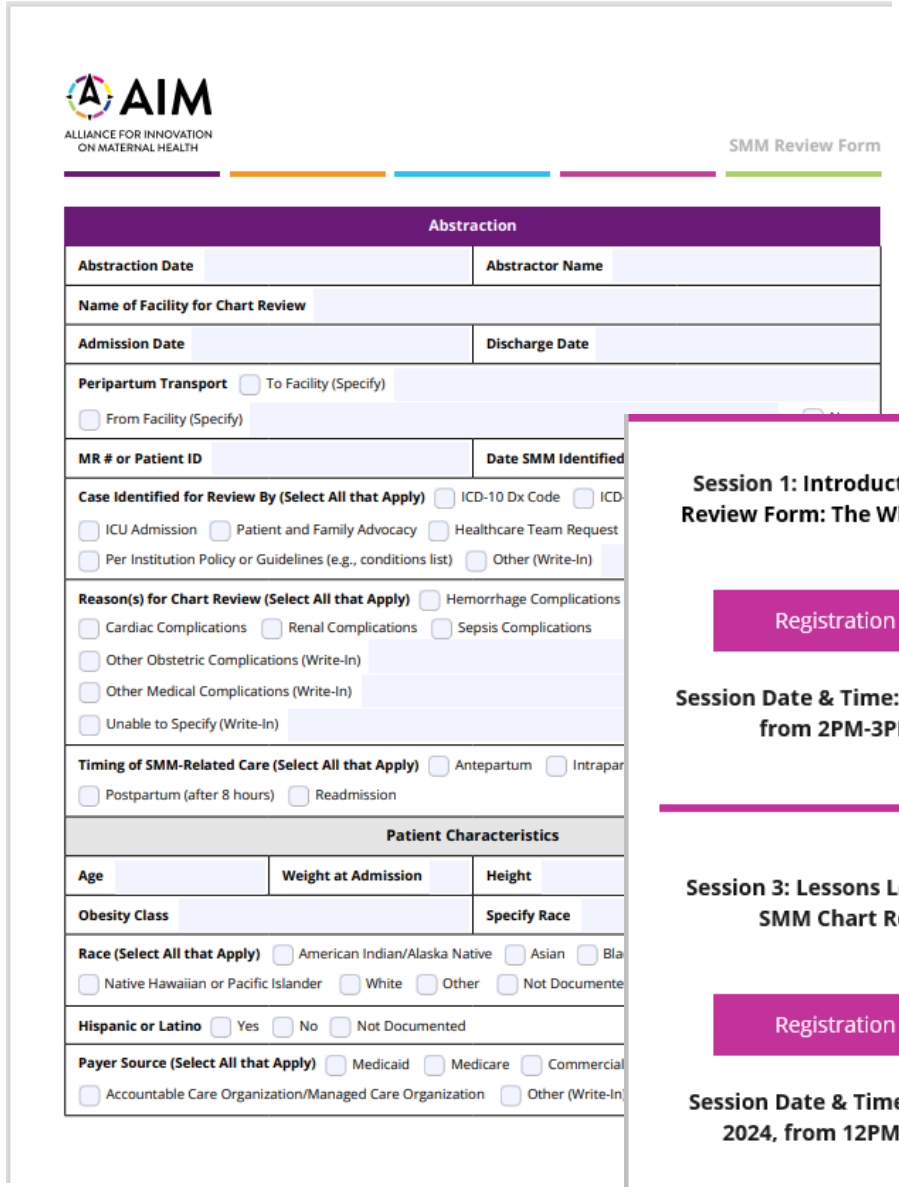
KANSAS CONNECTING COMMUNITIES KANSAS MATERNAL & CHILD HEALTH Kansas

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Severe Maternal Morbidity

AIM/ACOG Case Review templates

AIM Learning Session(s)- invite email can be sent. Notify Terrah or Kari asap!



AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

SMM Review Form

Abstraction

Abstraction Date	**Abstractor Name**
Name of Facility for Chart Review	
Admission Date	**Discharge Date**
Peripartum Transport ☐ To Facility (Specify)	
☐ From Facility (Specify)	
MR # or Patient ID	**Date SMM Identified**

Case Identified for Review By (Select All that Apply) ☐ ICD-10 Dx Code ☐ ICD-
☐ ICU Admission ☐ Patient and Family Advocacy ☐ Healthcare Team Request
☐ Per Institution Policy or Guidelines (e.g., conditions list) ☐ Other (Write-In)

Reason(s) for Chart Review (Select All that Apply) ☐ Hemorrhage Complications
☐ Cardiac Complications ☐ Renal Complications ☐ Sepsis Complications
☐ Other Obstetric Complications (Write-In)
☐ Other Medical Complications (Write-In)
☐ Unable to Specify (Write-In)

Timing of SMM-Related Care (Select All that Apply) ☐ Antepartum ☐ Intrapar
☐ Postpartum (after 8 hours) ☐ Readmission

Patient Characteristics

Age	**Weight at Admission**	**Height**
Obesity Class		**Specify Race**

Race (Select All that Apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Bla
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Not Documente

Hispanic or Latino ☐ Yes ☐ No ☐ Not Documented

Payer Source (Select All that Apply) ☐ Medicaid ☐ Medicare ☐ Commercial
☐ Accountable Care Organization/Managed Care Organization ☐ Other (Write-In)

Session 1: Introduction to SMM Review Form: The When and Why

Registration Link

Session Date & Time: July 30, 2024, from 2PM-3PM EST

Session 2: Chart Abstraction Best Practices for SMM Review: The How

Registration Link

Session Date & Time: TBD

Session 3: Lessons Learned from SMM Chart Review

Registration Link

Session Date & Time: August 22, 2024, from 12PM-1PM EST

Session 4: Integrating Equity into SMM Chart Review

Registration Link

Session Date & Time: August 29, 2024, from 12PM-1PM EST

FTI Project: Updates on Completion steps

Rapid Response

How do I submit “completion” documentation for FTI Projects

NOT Qhi!

Part VII:
Community Resource List

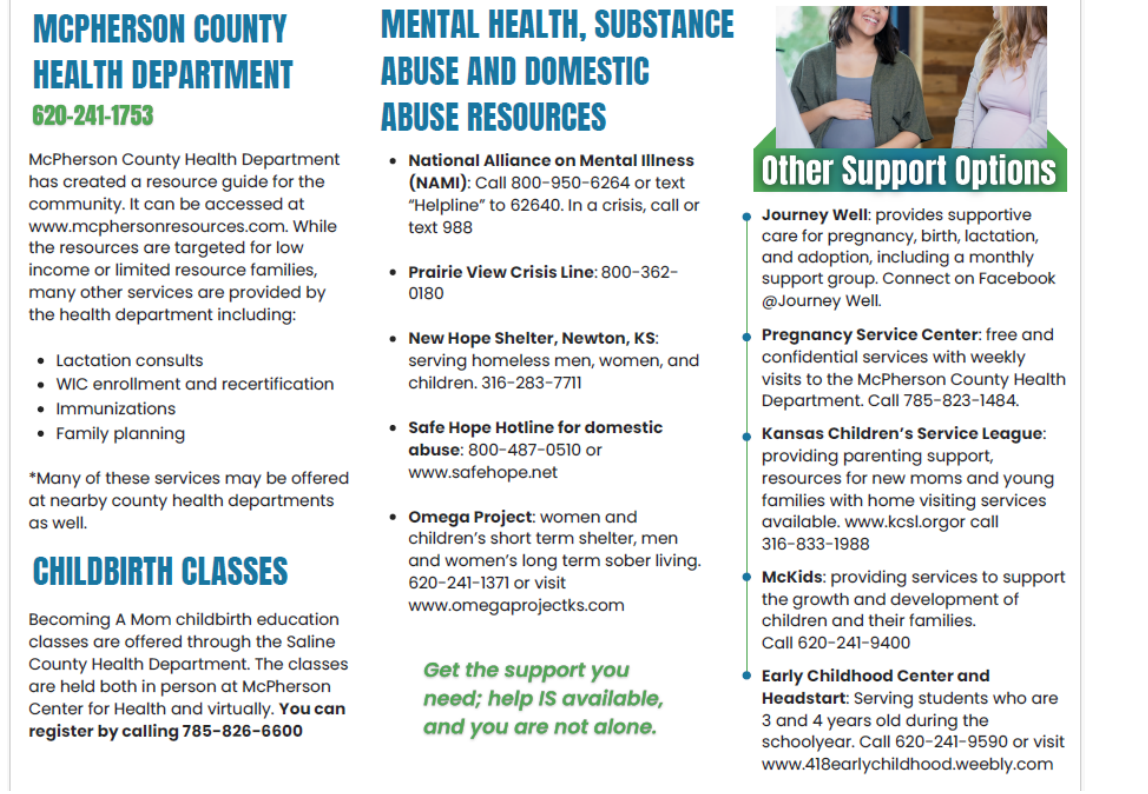
FTI Goal: Updated list and date of Implementation

FTI Goal:
Create a Community Resource List

Create and maintain the following list, which should be specific to <u>your community</u>:

- ✓ OB Practices
- ✓ Pediatric Practices
- ✓ Breastfeeding
- ✓ Care Coordinator Services (OB Navigator, CHWs, Home Visitors, etc)
  - ❑ Housing, Transportation, Insurance, Navigation Services
- ✓ WIC
- ✓ Health Department (MCH)
- ✓ Federally Qualified Health Center
- ✓ Home Visitor Programs
- ✓ Behavioral Health Agencies
- ✓ Patient Support Networks (Doulas, CHWs, Churches, etc)

McPherson: FTI Champ Jacqueline Disque



KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Part V
Comprehensive PP Visit Template

**To include the “Standardized Discharge Summary”

FTI Goal

Every FTI Site shares out with all clinics/agencies seeing Postpartum patients

Example of wording:

As part of our continued work with the state and national maternal health initiative (Fourth Trimester Initiative), we were asked to share information with all postpartum care providers in our community. Please find attached new updates to the Postpartum Standardized Discharge Summary, as well as the criteria now recommended for the Comprehensive Postpartum Visit. Please reach out with further questions, and our hospital will continue to work towards improving the communication, documentation, and referral portions of this criteria prior to discharge.

ACOG: *Standardized Discharge Summary*

Should include:

- ✓ Patient Name and age
- ✓ Support person contact information
- ✓ Gravida/para status
- ✓ Birth information:
  - ✓ Date and type of birth
  - ✓ Gestational age at birth
  - ✓ Relevant maternal conditions and complications
- ✓ Name, contact information and appointments for relevant providers, including OB/GYN specialists, mental health provider, etc.
- ✓ Positive screening for medical risk factors, mental health, and substance use
- ✓ Medications and supplements at time of discharge
- ✓ Unmet actual and potential SSDOH needs
- ✓ Suggested community services and supports
- ✓ Need for specific postpartum testing such as glucose testing or CBC

AIM PPDT "Postpartum Discharge Element Implementation Details" (2021)

KPQC
Kansas Perinatal Quality Collaborative

Comprehensive Postpartum Visit (template)

Should include:

- Screening for social and structural drivers of health and postpartum risk factors including mental health and substance use disorders
  - Provide linkage to needed referrals and services and/or provision of treatment as needed
- Assessment of physical recovery from birth and pregnancy-associated conditions
- Assessment of chronic diseases (pre-pregnancy onset or enduring from pregnancy-onset conditions)
  - Provide management or referral to primary or specialist care
- Establish care congruent with the patient's reproductive life plan
  - Provide access to highly effective methods of contraception, if desired
- Transition to ongoing well-person care including provision of or scheduling of indicated health maintenance services with transition to appropriate provider as needed

Comprehensive PP Visit (template, cont'd)

Box 1. Components of Postpartum Care

Mood and emotional well-being

- Screen for postpartum depression and anxiety with a validated instrument[1,2]
- Provide guidance regarding local resources for mentoring and support
- Screen for tobacco use; counsel regarding relapse risk in postpartum period[3]
- Screen for substance use disorder and refer as indicated[4]
- Follow-up on preexisting mental health disorders, refer for or confirm attendance at mental health-related appointments, and titrate medications as appropriate for the postpartum period

Infant care and feeding

- Assess comfort and confidence with caring for newborn, including
  - — feeding method
  - — child care strategy if returning to work or school
  - — ensuring infant has a pediatric medical home
  - — ensuring that all caregivers are immunized[5]
- Assess comfort and confidence with breastfeeding, including
  - — breastfeeding-associated pain[6]
  - — guidance on logistics of and legal rights to milk expression if returning to work or school[7,8]
  - — guidance regarding return to fertility while lactating; pregnancy is unlikely if menses have not returned, infant is less than 6 months old, and infant is fully or nearly fully breastfeeding with no interval of more than 4–6 hours between breastfeeding sessions[9]
  - — review theoretical concerns regarding hormonal contraception and breastfeeding, within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy[7]
- Assess material needs, such as stable housing, utilities, food, and diapers, with referral to resources as needed

Sexuality, contraception, and birth spacing

- Provide guidance regarding sexuality, management of dyspareunia, and resumption of intercourse
- Assess desire for future pregnancies and reproductive life plan[10]
- Explain the rationale for avoiding an interpregnancy interval of less than 6 months and discuss the risks and benefits of repeat pregnancy sooner than 18 months
- Review recommendations for prevention of recurrent pregnancy complications, such as 17α-hydroxyprogesterone caproate to reduce risk of recurrent preterm birth, or aspirin to reduce risk of preeclampsia
- Select a contraceptive method that reflects patient's stated needs and preferences, with same-day placement of LARC, if desired[11]

Box 1. Components of Postpartum Care *(continued)*

Sleep and fatigue

- Discuss coping options for fatigue and sleep disruption
- Engage family and friends in assisting with care responsibilities

Physical recovery from birth

- Assess presence of perineal or cesarean incision pain; provide guidance regarding normal versus prolonged recovery[12]
- Assess for presence of urinary and fecal continence, with referral to physical therapy or urogynecology as indicated[13,14]
- Provide actionable guidance regarding resumption of physical activity and attainment of healthy weight[15]

Chronic disease management

- Discuss pregnancy complications, if any, and their implications for future childbearing and long-term maternal health, including ASCVD
- Perform glucose screening for women with GDM: a fasting plasma glucose test or 75 g, 2-hour oral glucose tolerance test[16]
- Review medication selection and dose outside of pregnancy, including consideration of whether the patient is breastfeeding, using a reliable resource such as LactMed
- Refer for follow-up care with primary care or subspecialist health care providers, as indicated

Health maintenance

- Review vaccination history and provide indicated immunizations, including completing series initiated antepartum or postpartum[17]
- Perform well-woman screening, including Pap test and pelvic examination, as indicated[18]

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

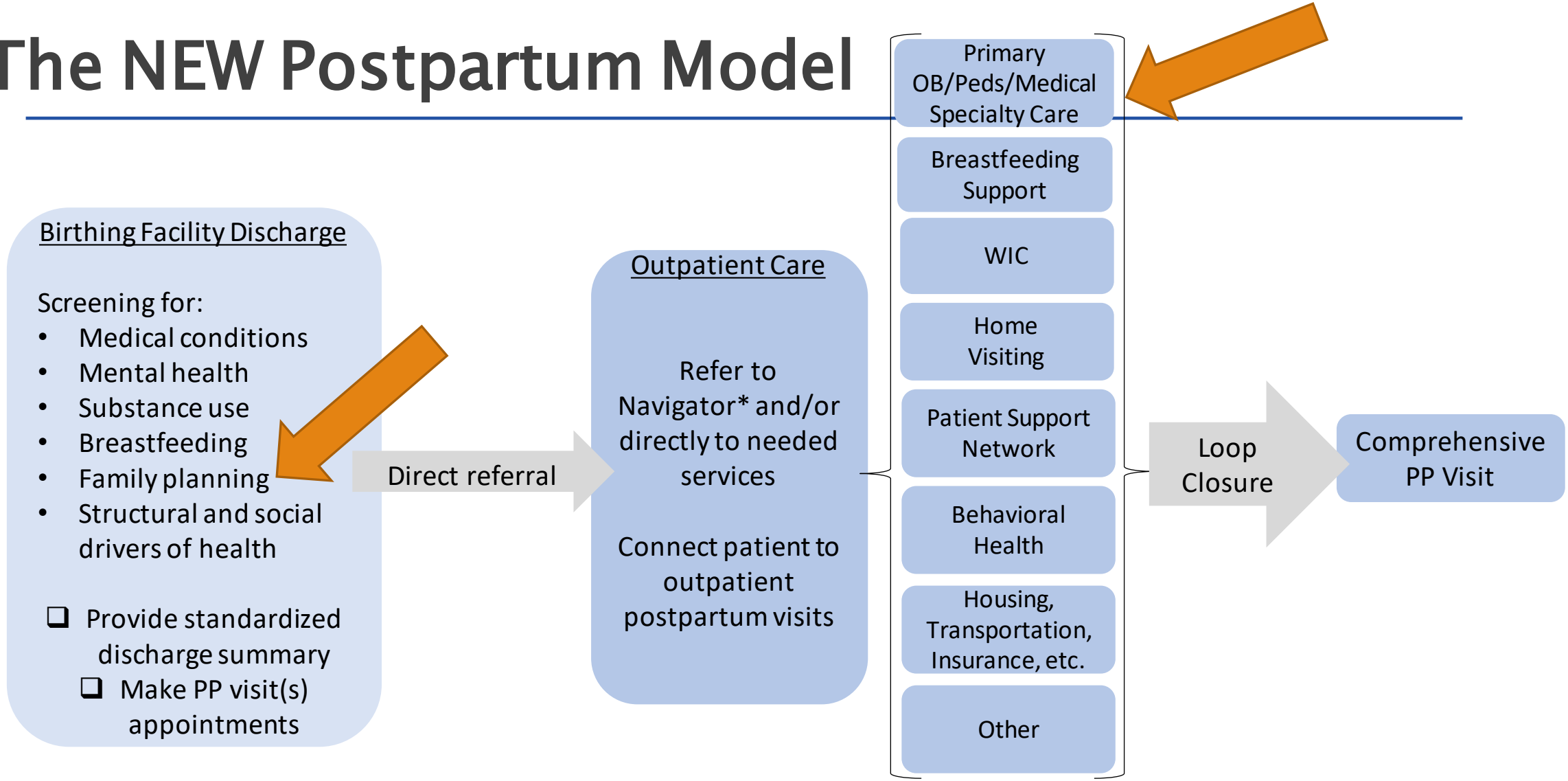
FEATURED Presentation

FTI:
Family Planning Immediately Postpartum

Recognition & Prevention — Every Patient

Recognition Element	Key Points
Reproductive Life Planning	Considerations may include: • Using shared medical decision-making • Congruence with patient's goals and values • Contraceptive options • Birth spacing and pregnancy intention • Chest or breastfeeding • Other health and parenting choices as prioritized by the postpartum patient

The NEW Postpartum Model



KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Why immediate postpartum LARC?

Up to 40 –60% of women do not return for a postpartum visit due to:

- Childcare obligations
- Unable to get off work
- Unstable housing
- Lack of transportation
- Communication or language barrier
- Lack of insurance coverage or potential expiration of Medicaid eligibility.

40–57% of women report having unprotected intercourse before the routine 6-week postpartum visit

Featured Speaker

Dr. Cara Busenhart, CNM, PhD, FACNM

Family Planning immediately after a delivery

FTI Goal:

Screening question prior to discharge for ALL Postpartum patients:

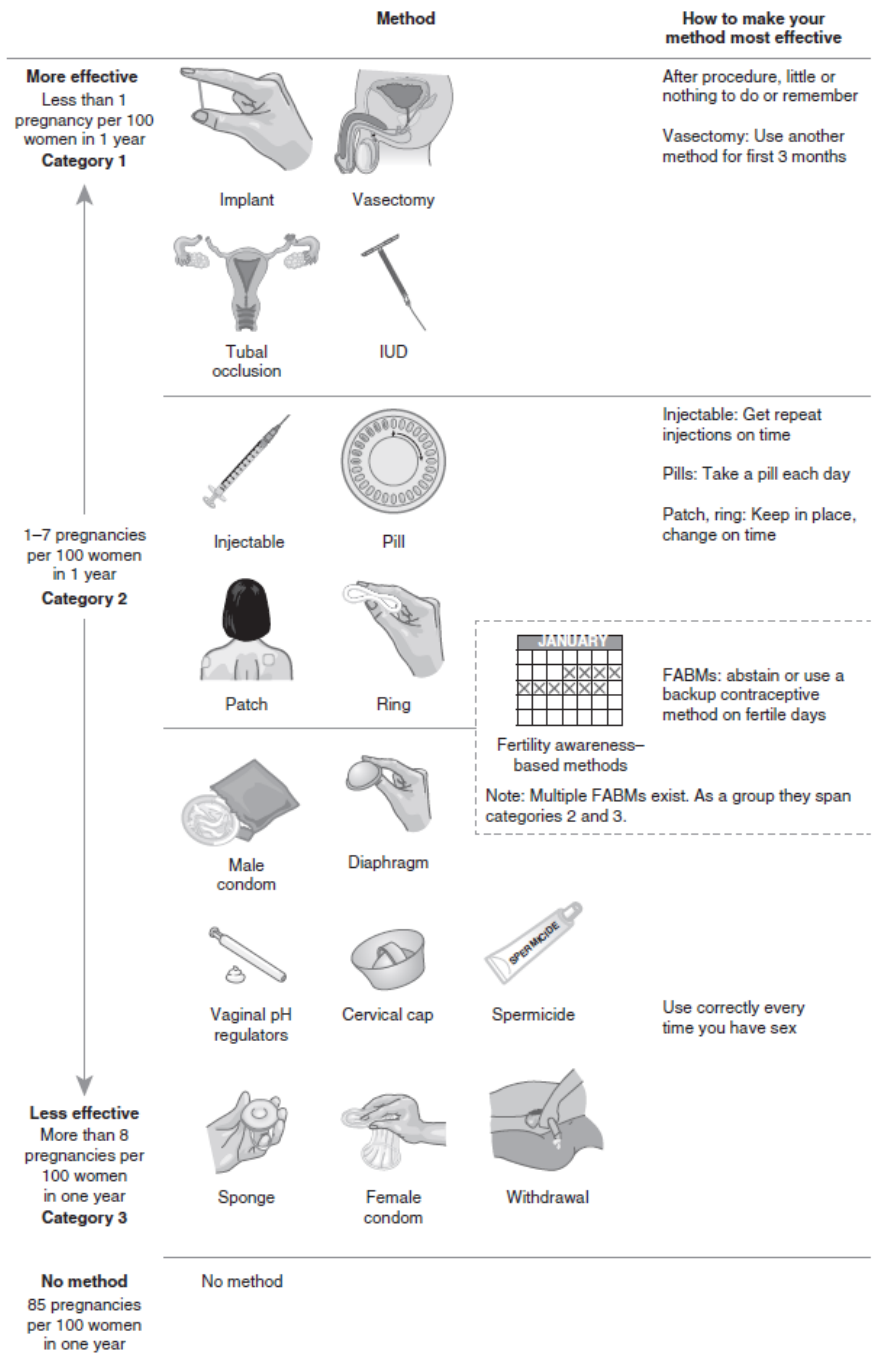
"Do you plan to become pregnant again in the next year?"

OR

"What are you plans for pregnancy or contraception?"

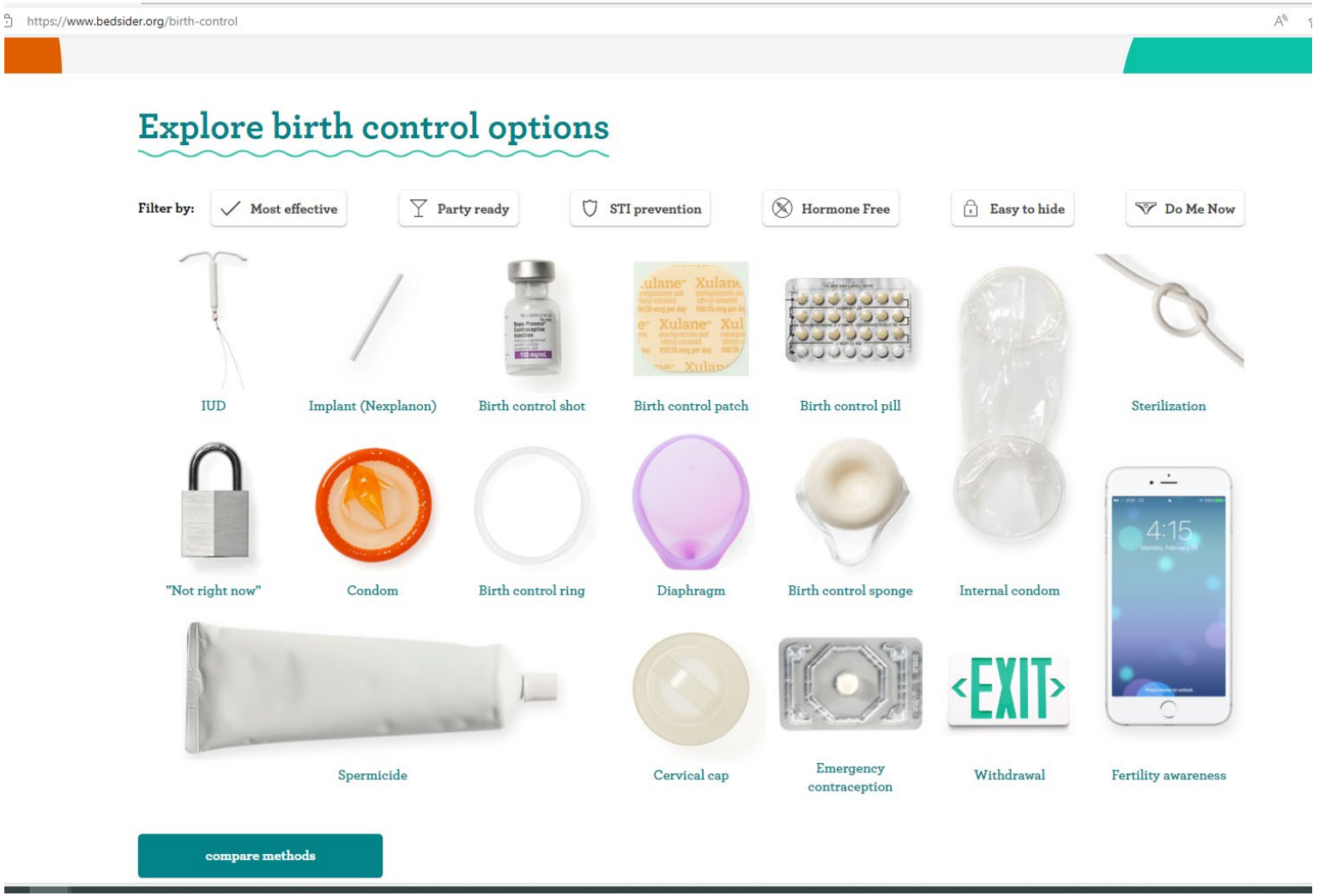
KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Handouts should also be available on your unit



Resources & websites should also be readily available and in Discharge literature

Example: Bedsider.org



Family Planning: LARC inpatient codes

KMAP GENERAL BULLETIN 22311

Long-Acting Reversible Contraceptive Billing Allowance – Post Partum

Effective with dates of service on and after January 1, 2023, long-acting reversible contraceptives (LARCs), both IUDs and implants, are no longer included in the Diagnosis Related Group (DRG) rate. A hospital will bill the Medicaid fiscal agent or the Managed Care Organization (MCO) and be reimbursed on a fee-for-service basis. The LARC must be billed separately than the inpatient claim on a UB04 Form with type of bill 131or 851 using the acute hospital National Provider Identifier (NPI). The professional provider or surgeon will bill on a CMS 1500 Form utilizing procedure code 58300 or procedure code 11981.

Currently active J-codes for LARCs are as follows:

J7296	J7297	J7298	J7300	J7301	J7307

An exception to the inpatient/outpatient claims edits for same day billing will be allowed for the LARC procedure code.

Note: The effective date of the policy is January 1, 2023. The implementation of State policy by the KanCare managed care organizations (MCOs) may vary from the date noted in the Kansas Medical Assistance Program (KMAP) bulletins. The **KanCare Open Claims Resolution Log** on the KMAP Bulletins page documents the MCO system status for policy implementation and any associated reprocessing completion dates once the policy is implemented.

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Dr. Cara Busenhart is a Clinical Associate Professor and the Program Director for Midwifery Education at the University of Kansas School of Nursing. While she has provided care to women across the lifespan in private practice, at an academic health center, and in safety net clinics, Cara has focused much of the last decade (or more) to developing the next generation of health care providers—through educational program administration, teaching, and now as a HRSA-funded project director on multiple grants to improve maternal-child health in rural and urban underserved communities. Cara is also the Past Chair of the KPQC. For fun, Cara hosts a podcast with her best friend and colleague, Dr. Missi Stec—it is The EngagED Midwife podcast and is available on most podcast apps.

FAMILY PLANNING AND REPRODUCTIVE LIFE PLANNING

Cara A. Busenhart, PhD, APRN, CNM, FACNM
Past Chair, Kansas Perinatal Quality Collaborative

AGENDA

Family Planning& Reproductive Life Plan

Patient-centered Counseling

Contraceptive Options

Resources

WHAT DOES IT MEAN TO PLAN YOUR FAMILY AND REPRODUCTIVE LIFE?

Empowerment and Engagement in care

FAMILY PLANNING

Dictionary

Definitions from Oxford Languages · Learn more

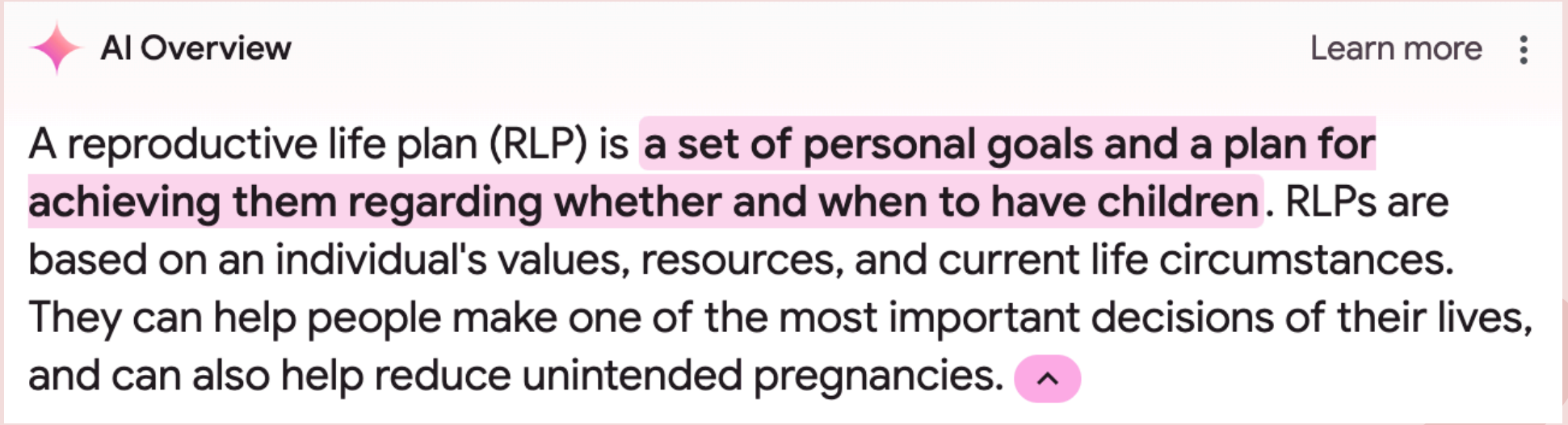
fam·i·ly plan·ning

/ˌfam(ə)lē ˈplaniNG/

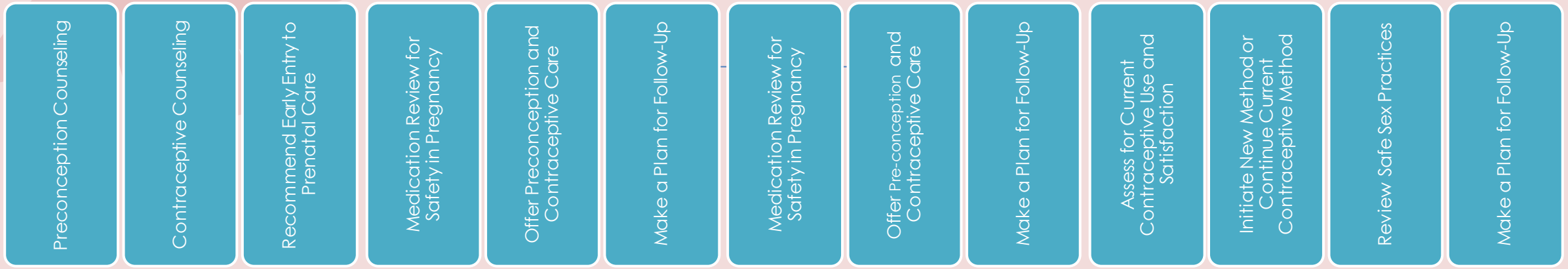
noun

the practice of controlling the number of children in a family and the intervals between their births, particularly by means of artificial contraception or voluntary sterilization.
"family-planning clinics"

REPRODUCTIVE LIFE PLAN



ONE KEY QUESTION



Yes	I'd be okay with it	I'm unsure	No

Would you like to become pregnant in the next year?

Reproductive Health & Wellness Program

Reproductive Life Plan

ONE KEY QUESTION...

Do plan to become pregnant within the next year?

PLANNING FOR A FAMILY

- Do you have children now?
  - If yes, do you want more children?
- Do you know about safe spacing (time between pregnancies)?
- Are you now using a birth control?

YOUR HEALTH HISTORY

Things that may cause a problem if you want to become pregnant:

- Do you smoke or use vapors?
- Do you drink alcohol?
- Do you use street drugs or prescription drugs for fun?
- Do you take a multivitamin with folic acid every day?
- Do you have more than one partner or many partners?
- Do you have a primary care provider?
  - Do you see them for any conditions?
- Do you eat too much or not eat enough?
- Do you take any special medications every day?

HEALTH HISTORY FOR YOU, YOUR PARTNER AND YOUR FAMILY

It is important to know your health history before you become pregnant. Sometimes what your family or partner has can affect you, your family or unborn baby.

- Are your vaccines up to date?
- Do any of the following apply to you?
  - A baby born 4 weeks early or weighing less than 5 pounds
  - Have you had a baby that died before 1st birthday?
  - High blood pressure in pregnancy
  - Diabetes in pregnancy
  - A baby with a heart defect
  - Two or more miscarriages
  - Stillborn baby

Continued on reverse side...

EMOTIONAL HEALTH

Things that can cause a problem if you want to be a parent or have a healthy relationship:

- Do you often feel sad?
- Do you often feel overwhelmed?
- Do you feel safe at home?
- Does anyone force you to have sex when you don't want to?

LIFE GOALS

What is important to you?

- Family
- Good health
- Education
- Career or job
- Healthy relationships
- Eating healthy
- Being more active
- Having good preconception health and wellness
- Making my own choices about my health
- Having health insurance coverage
- Practice safe sex (use a condom)
- Having that crucial conversation about birth control

ADDITIONAL RESOURCES

I want more information about...

- Birth control methods
- Stop smoking
- Alcohol/drug abuse
- Eating Healthy or losing weight
- Being more active or exercising
- Physical/emotional abuse
- Depression or sadness
- Sexually transmitted infections
- Health insurance coverage

QUESTIONS?
Contact the Women's Health & Family Planning Center at Columbus Public Health: 614-645-1850

COLUMBUS PUBLIC HEALTH
240 Parsons Ave, Columbus, OH 43215
www.publichealth.columbus.gov

Updated 3/2016

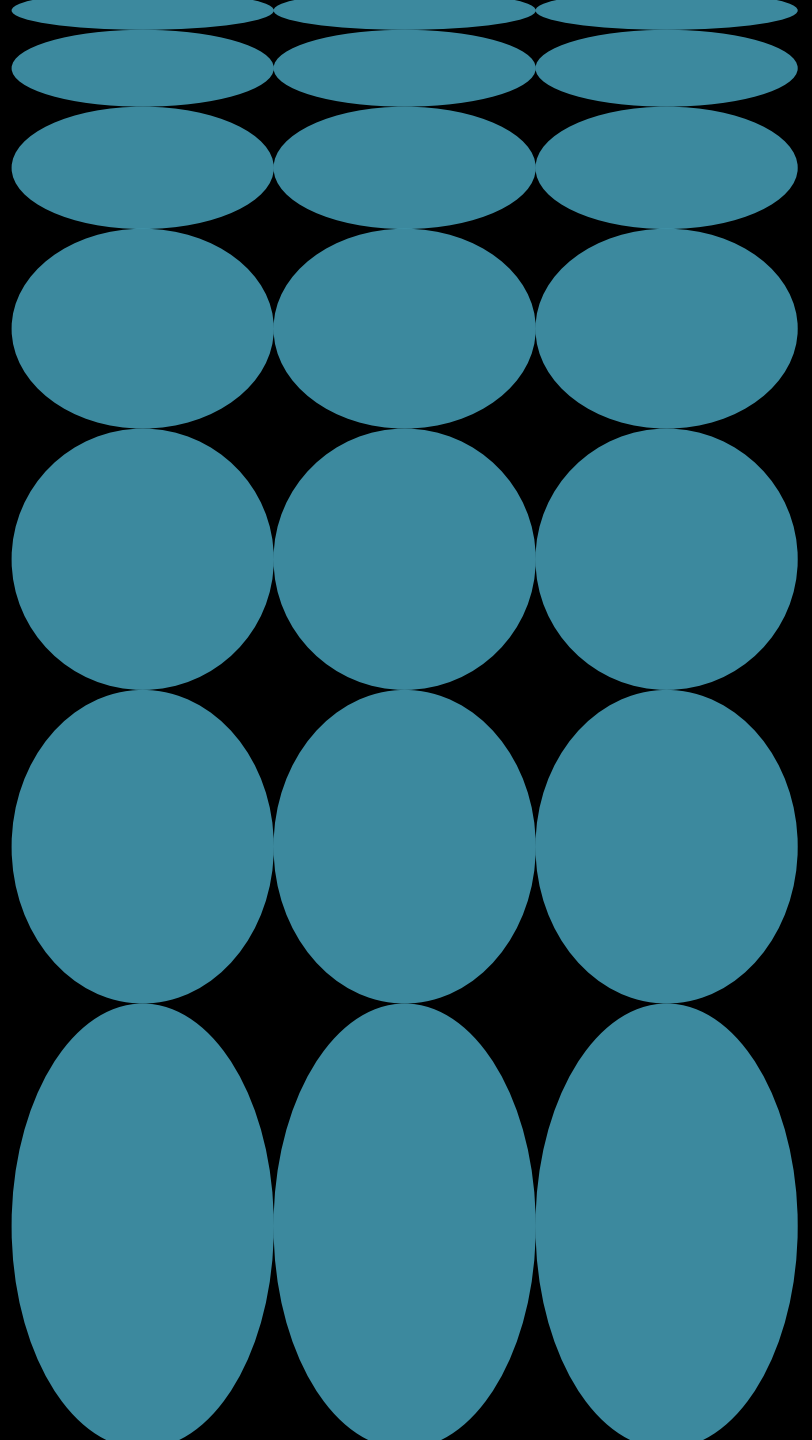
THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

WHEN SHOULD WE ADDRESS FAMILY PLANNING?

1. SEEKS CONTRACEPTIVE SERVICES
2. PRESENTS FOR STI/STD TESTING
3. PRESENTS FOR PREGNANCY TESTING
4. PRESENTS FOR WELL-PERSON CARE
5. **AFTER PREGNANCY LOSS OR TERMINATION**
6. **PRENATAL CARE: MID-PREGNANCY TO EARLY 3RD TRIMESTER**
7. **PRENATAL CARE: NEAR TERM**
8. **POSTPARTUM: PRIOR TO DISCHARGE FROM BIRTHING FACILITY**
9. **POSTPARTUM: OFFICE VISIT**

PATIENT-CENTERED COUNSELING

Offering and empowering choice

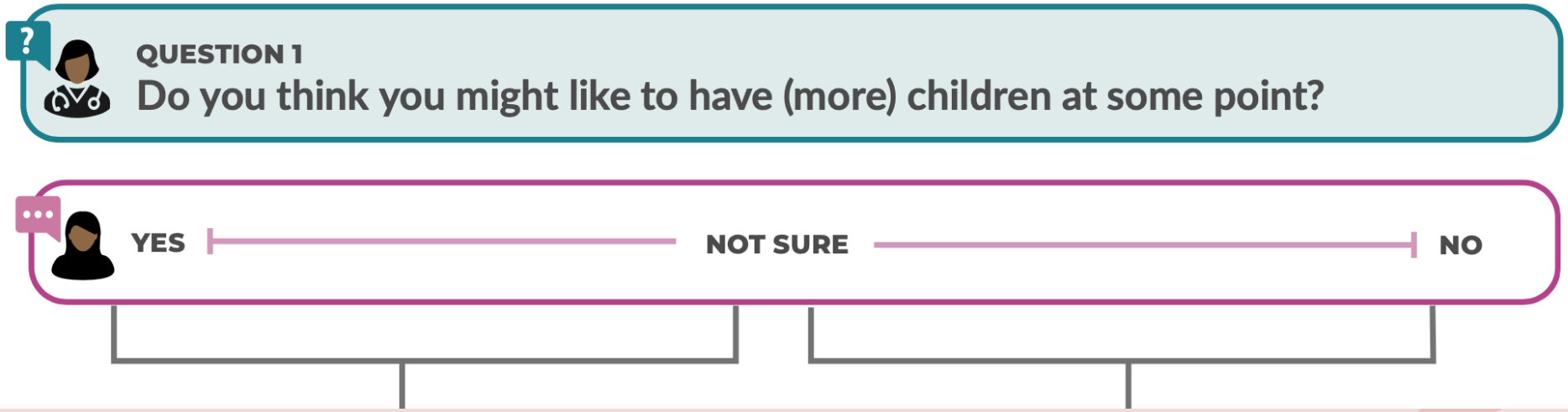


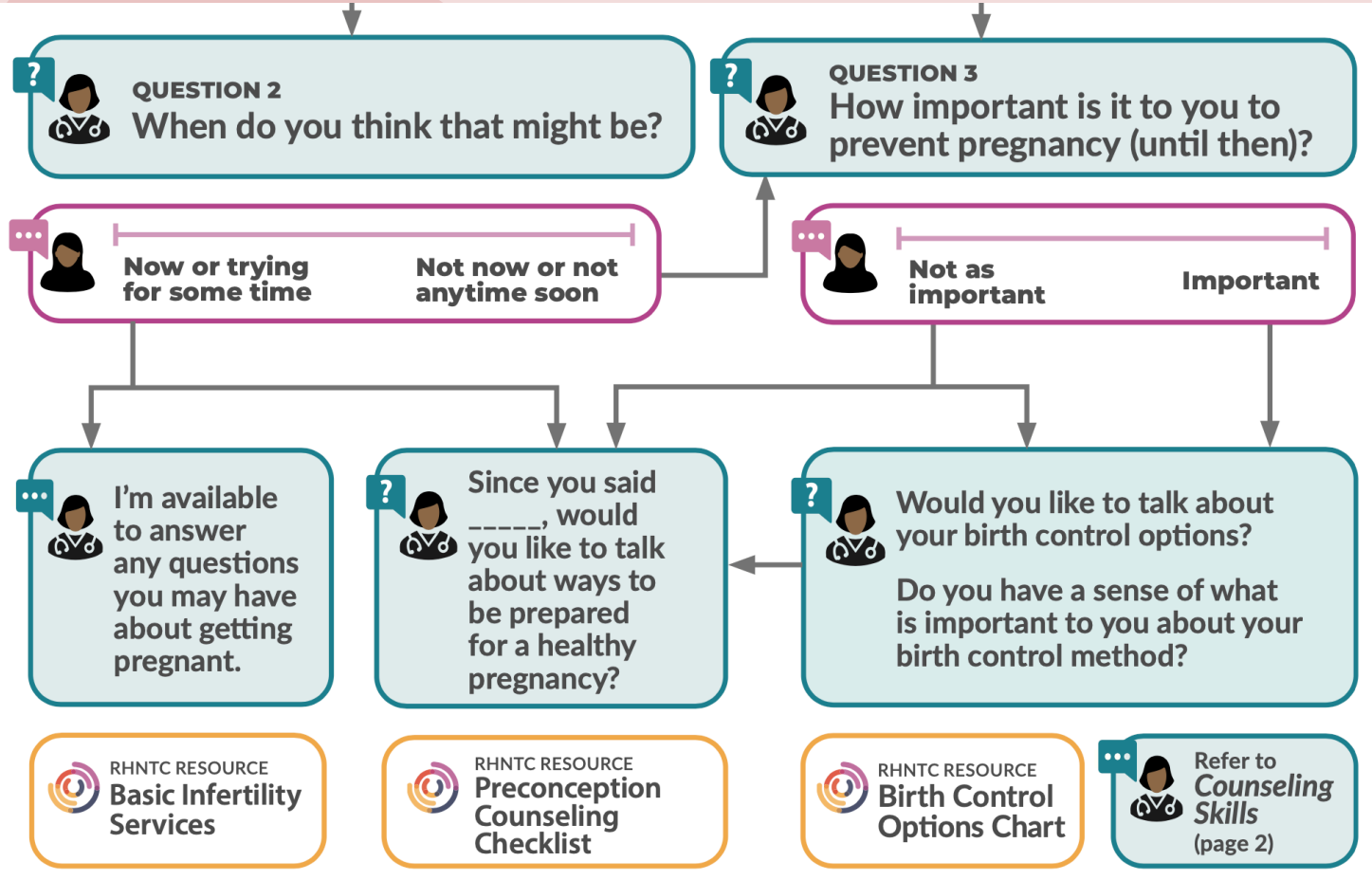
FOCUS ON THE PATIENT/CLIENT, NOT THE PROVIDER

Client-Centered Reproductive Goals & Counseling Flow Chart

RHNTC
REPRODUCTIVE HEALTH
NATIONAL TRAINING CENTER

The PATH questions are one client-centered approach to assess **P**arenthood/**P**regnancy **A**ttitude, **T**iming, and **H**ow important is pregnancy prevention. PATH can be used with clients of any gender, sexual orientation, or age. PATH is designed to facilitate listening and efficient client-centered conversations about preconception care, contraception, and fertility as appropriate.





- WOULD YOU LIKE TO TALK ABOUT YOUR BIRTH CONTROL OPTIONS?
- DO YOU HAVE A SENSE OF WHAT IS IMPORTANT TO YOU ABOUT YOUR BIRTH CONTROL METHOD?

DECISION AID

Reflect on: **What is important to you about your contraception?** *To help you select the method that is best for you right now, consider what you want and need from it. There are many attributes of the method that may matter to you. For example:*				
how easy it is to start and stop	how easy it is to use	how often you have to use it	where on your body it goes	is it safe to use postpartum
how it affects your period or cramps	how it affects acne	how it affects your weight	how well it prevents pregnancy	if your partner is involved in using it
does it treat symptoms of endometriosis	does it affect your risk of vaginal infections	privacy from partner, parent, roommate, etc.	how quickly you can get pregnant once stopped	how to store the method or supplies
does it contain hormones	does it prevent STIs	how much it costs	does it affect sexual pleasure	*many more...*

Postpartum Contraception (Birth Control) Guide

PICCK

Key — No hormones · Progestin hormone · Progestin and estrogen hormones · How often to use/take/change

Can start using right after delivery

In-person visit to start

May be able to start during delivery stay before going home

Shot

12-14 weeks

Once stopped, fertility return may be delayed.

Arm Implant

3-5 years

Plastic rod placed just beneath skin.

Hormonal IUD

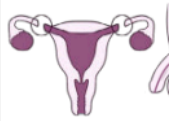
3-8 years

Can be emergency contraception.

Copper IUD

10-12 years

Can be emergency contraception.

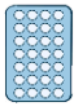
Sterilization

once

Either partner can be sterilized.

Permanent

Prescription to start

May be able to fill prescription while pregnant

Progestin-Only Pills

daily

Good bridge to estrogen-containing methods.

Phexxi® Vaginal Gel

before sex

May act as a lubricant to help with dryness.

Ella® Emergency Contraception

after sex

Works best for BMI <35.

Plan your contraception before you deliver

It is possible to get pregnant 25 days after giving birth. It is helpful to talk to your provider about your contraception options during a prenatal visit and to leave the hospital after delivery with a contraception plan.

All methods are safe to use while breast/chestfeeding in terms of parent and infant health, initiation, milk quality and quantity.

Start on your own

Plan B® Emergency Contraception

after sex

Works best for BMI <26.

Pulling Out

during sex

Requires partner control.

Condoms
External or Internal


before sex

Can prevent sexually transmitted infections.

Spermicide

before sex

May act as a lubricant to help with dryness.

Breast/Chestfeeding as Contraception

4 hours

Must follow instructions perfectly:

- Must be exclusively nursing - no pumping, formula, or other beverages or food.
- Must nurse at least every 4 hours during the day and 6 hours at night.
- Must be within 6 months of delivery.
- Must not have had your period return.

Scan for

- This guide
- Information sheets on each method
- A general contraception guide

www.PICCK.org 2023

Must wait to start using until 6 weeks after delivery

Prescription to start

Diaphragm or Cervical Cap

Must refit at 6 weeks.
Use with spermicide.

Combined Hormonal Pills

Patch

Vaginal Ring

Estrogen can increase risk of blood clots before 6 weeks postpartum.
Start after breast/chestfeeding is well established.

Start on your own

Vaginal Sponge

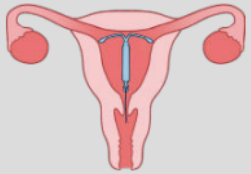
Must wait for cervix to shrink at 6 weeks.

Notes

Fertility Awareness Methods

These methods should be used with caution because your postpartum cycles may be too irregular to be able to predict fertility.

Timing IUD Insertion



Some hospitals can provide an IUD immediately after you deliver in the hospital before you go home. You can also get an IUD at a future visit, like your 6 week postpartum visit.

- Both times are equally safe and effective at preventing pregnancy.
- It may be more convenient to get an IUD during delivery so you have one less thing to think about when caring for a newborn and you may be able to avoid an additional visit to the clinic.
- It may be less painful to get an IUD inserted during the delivery stay, especially if you had an epidural. If you get an IUD later, you can ask for numbing to help with pain.
- With an IUD insertion there is a risk of expulsion, which is not harmful, but may be uncomfortable. Inserted during your delivery stay, the risk of IUD expulsion is 8-25%, depending on cesarean or vaginal delivery. Inserted in the clinic, the risk of IUD expulsion is 2-5%.

On average* out of 100 people, this many will get pregnant in a year using this method

No contraception (average fertility)	85	
Cervical cap (with spermicide)	29	
Vaginal sponge	27	
Spermicide	21	
Internal condom	21	
Pulling out	20	
Diaphragm (with spermicide)	17	
Phexxi® gel	14	
External condom	13	
Progestin-only pills	7	
Combined pills	7	
Patch	7	
Vaginal ring	7	
Shot	4	
Breast/chestfeeding	2	
Sterilization	1	
Copper IUD	0.8	
Hormonal IUD	0.2	
Arm implant	0.1	

*Some methods are harder to use than others. 'Average' or 'typical use' pregnancy rates consider the chances of user error.

US MEDICAL ELIGIBILITY CRITERIA

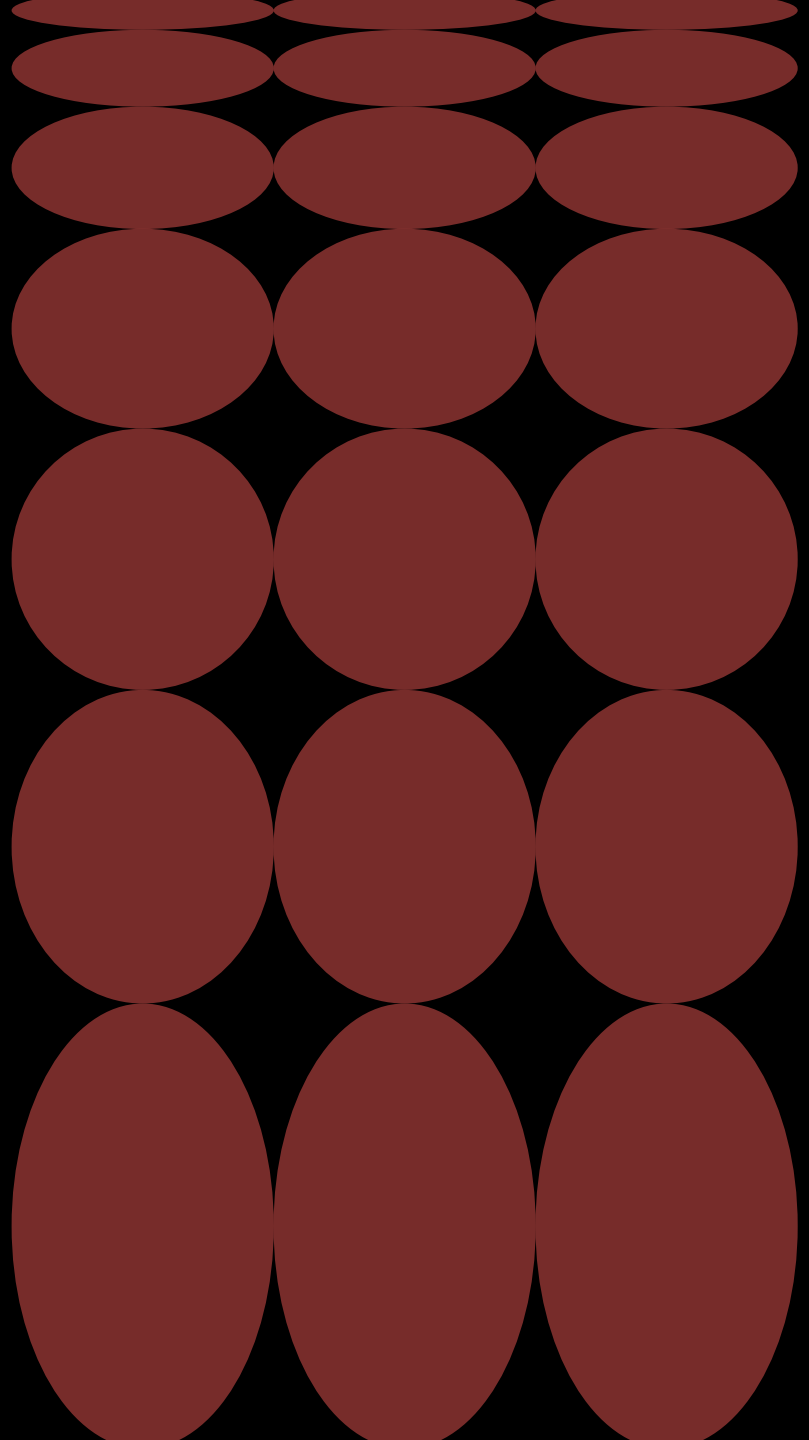
BOX K1. Categories for Classifying Hormonal Contraceptives and IUDs

1 = A condition for which there is no restriction for the use of the contraceptive method.
2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

	function						
Postabortion	a) First trimester	1*	1*	1*	1*	1*	1*
	b) Second trimester	2*	2*	1*	1*	1*	1*
	c) Immediate postseptic abortion	4	4	1*	1*	1*	1*
Postpartum *(nonbreastfeeding women)*	a) <21 days			1	1	1	4
	b) 21 days to 42 days						
	i) With other risk factors for VTE			1	1	1	3*
	ii) Without other risk factors for VTE			1	1	1	2
	c) >42 days			1	1	1	1
Postpartum *(in breastfeeding or non-breastfeeding women, including cesarean delivery)*	a) <10 minutes after delivery of the placenta						
	i) Breastfeeding	1*	2*				
	ii) Nonbreastfeeding	1*	1*				
	b) 10 minutes after delivery of the placenta to <4 weeks	2*	2*				
	c) ≥4 weeks	1*	1*				

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
Personal Characteristics And Reproductive History						
Pregnancy	4*	4*	NA*	NA*	NA*	NA*
Age	Menarche to <20 years: 2	Menarche to <20 years: 2	Menarche to <18 years: 1	Menarche to <18 years: 2	Menarche to <18 years: 1	Menarche to <40 years: 1
	≥20 years: 1	≥20 years: 1	18–45 years: 1	18–45 years: 1	18–45 years: 1	≥40 years: 2
			>45 years: 1	>45 years: 2	>45 years: 1	
Parity						
a. Nulliparous	2	2	1	1	1	1
b. Parous	1	1	1	1	1	1
Breastfeeding						
a. <21 days postpartum			2*	2*	2*	4*
b. 21 to <30 days postpartum						
i. With other risk factors for VTE (e.g., age ≥35 years, previous VTE			2*	2*	2*	3*

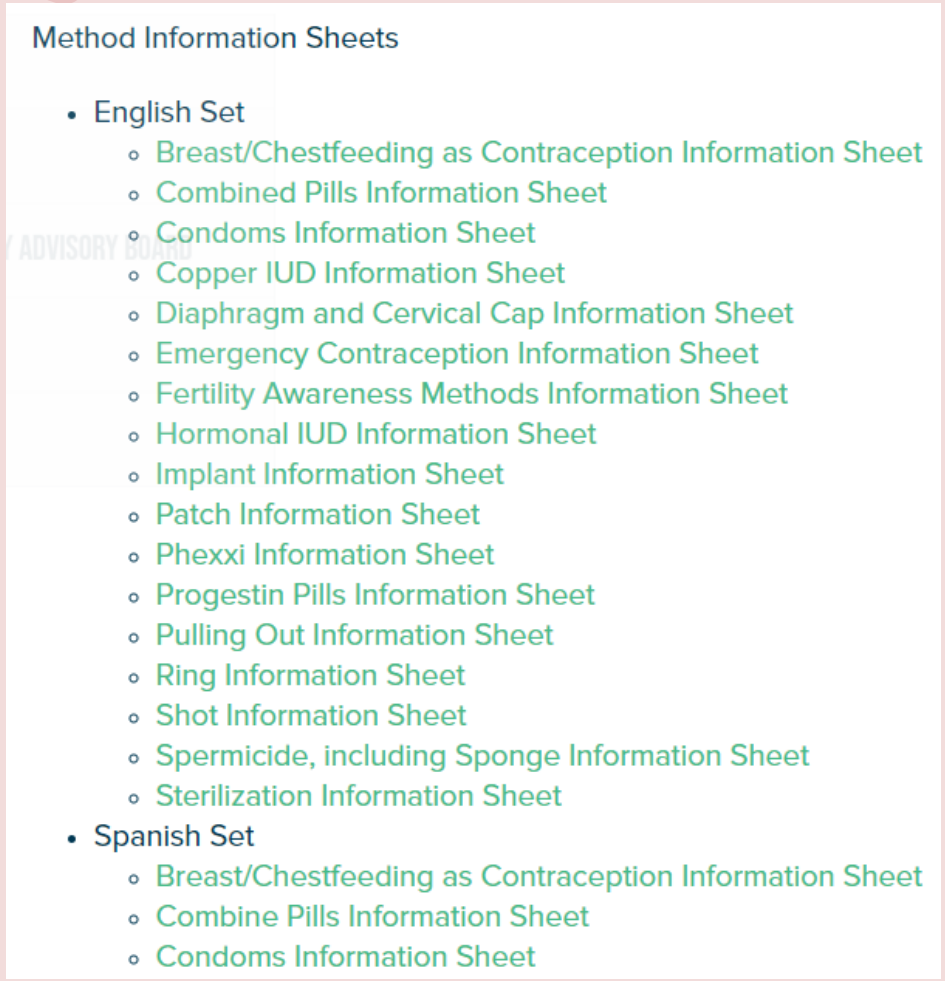
Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
d. >42 days postpartum			1*	1*	1*	2*
Postpartum (nonbreastfeeding women)						
a. <21 days postpartum			1	1	1	4
b. 21–42 days postpartum						
i. With other risk			1	1	1	3*
Postpartum (including cesarean delivery)						
a. <10 minutes after delivery of the placenta						
i. Breastfeeding	1*	2*				
ii. Nonbreastfeeding	1*	1*				
b. 10 minutes after delivery of the placenta to <4 weeks (breastfeeding or nonbreastfeeding)	2*	2*				
c. ≥4 weeks (breastfeeding or nonbreastfeeding)	1*	1*				
d. Postpartum sepsis	4	4				
Postabortion						
a. First trimester	1*	1*	1*	1*	1*	1*
b. Second trimester	2*	2*	1*	1*	1*	1*
c. Immediate postseptic abortion	4	4	1*	1*	1*	1*



OPTIONS

Permanent, Long-acting, Non-Hormonal, etc.

HTTPS://PICCK.ORG/RESOURCE/CONTRACEPTION-GUIDE-CONTRACEPTION-INFORMATION-SHEETS-AND-POSTPARTUM-CONTRACEPTION-GUIDE/



Method Information Sheets

- English Set
  - Breast/Chestfeeding as Contraception Information Sheet
  - Combined Pills Information Sheet
  - Condoms Information Sheet
  - Copper IUD Information Sheet
  - Diaphragm and Cervical Cap Information Sheet
  - Emergency Contraception Information Sheet
  - Fertility Awareness Methods Information Sheet
  - Hormonal IUD Information Sheet
  - Implant Information Sheet
  - Patch Information Sheet
  - Phexxi Information Sheet
  - Progestin Pills Information Sheet
  - Pulling Out Information Sheet
  - Ring Information Sheet
  - Shot Information Sheet
  - Spermicide, including Sponge Information Sheet
  - Sterilization Information Sheet
- Spanish Set
  - Breast/Chestfeeding as Contraception Information Sheet
  - Combine Pills Information Sheet
  - Condoms Information Sheet

- METHOD SHEETS AVAILABLE IN:
  - ENGLISH
  - SPANISH
  - CHINESE
  - PORTUGUESE
  - HAITIAN CREOLE
  - VIETNAMESE
  - ARABIC

PERMANENT METHODS

STERILIZATION

Vasectomy

Bilateral tubal ligation or salpingectomy

TUBAL PROCEDURES

NEARLY HALF OF ALL STERILIZATION PROCEDURES PERFORMED IN THE US ARE IN THE IMMEDIATE POSTPARTUM PERIOD; OTHERWISE—INTERVAL PROCEDURES ARE DONE AT ANY OTHER TIME

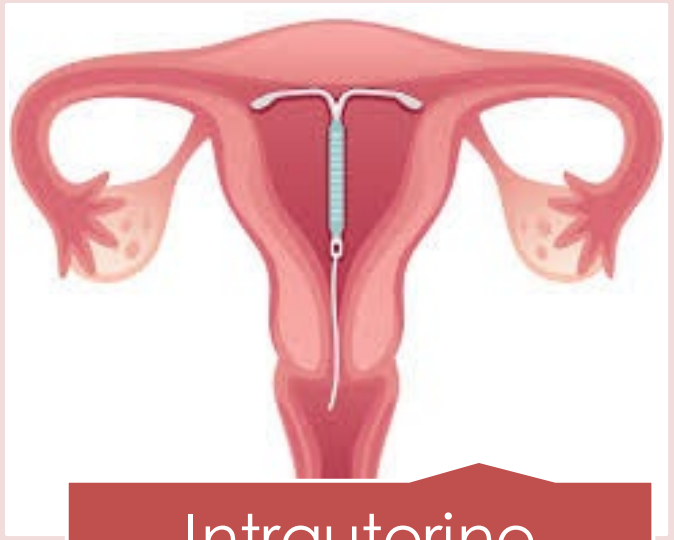
STERILIZATION IS PERFORMED LAPAROSCOPICALLY OR THROUGH A MINI-LAPAROTOMY-- OCCLUDING THE TUBES WITH CLIPS, BANDS, OR ELECTROCAUTERY

WHILE POSTPARTUM STERILIZATION WAS TYPICALLY ACCOMPLISHED VIA PARTIAL SALPINGECTOMY THROUGH A MINI-LAPAROTOMY

COMPLETE **BILATERAL SALPINGECTOMY HAS BECOME THE STERILIZATION PROCEDURE OF CHOICE** DURING INTERVAL AND POSTPARTUM PROCEDURES BECAUSE IT DECREASES THE RISK OF EPITHELIAL OVARIAN CANCER AND POST-STERILIZATION CONTRACEPTIVE FAILURE COMPARED WITH TRADITIONAL STERILIZATION TECHNIQUES WITHOUT INCREASING SURGICAL RISK

LONG-ACTING REVERSIBLE METHODS

HIGHLY EFFECTIVE AND REVERSIBLE—THE USER CAN CHANGE THEIR MIND AT ANY TIME AFTER INSERTION



Intrauterine device/system

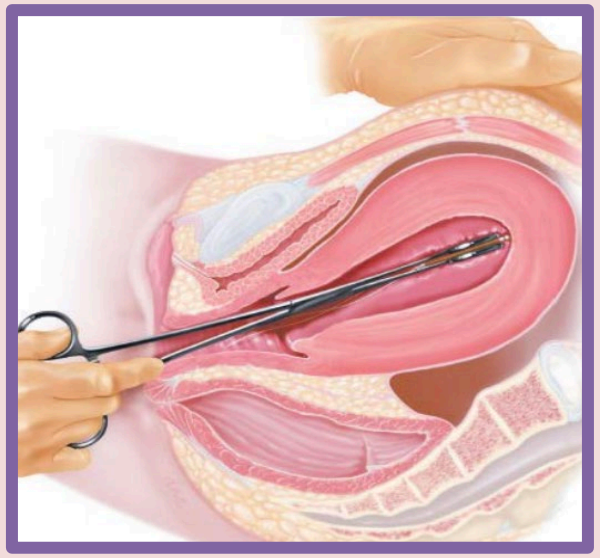
Implantable rod

Injectable hormone

INTRAUTERINE DEVICES/SYSTEMS

IUD comparison					
Brand name	Paragard	Liletta	Mirena	Kyleena	Skyla
Years effective	12	8	8	5	3
Can it be used as EC?	✓	✓	✓	X	X
Total LNG dose (mg)	--	52	52	19.5	13.5
Daily LNG dose (mcg/day)	--	20	20	17.5	14
Size (mm)	32 x 36	32 x 32	32 x 32	28 x 30	28 x 30
String color	White	Blue	Brown	Blue	Brown
Silver ring?	X	X	X	✓	✓

POSTPARTUM IUD/IUS



Post-placental: within 15 minutes

Interval: 6-12 weeks

RESOURCES: SAMPLE PROTOCOLS, DOCUMENTATION TEMPLATES

POSTPARTUM NEXPLANON™

MAY BE INSERTED AT ANY TIME, INCLUDING IMMEDIATELY POSTPARTUM

IF DONE BEFORE DISCHARGE, IS TYPICALLY DONE ON DAY 1 OR 2 POSTPARTUM

IF INSERTED WITHIN 21 DAYS OF BIRTH, NO NEED FOR BACKUP METHOD

POSTPARTUM DEPO PROVERA™

MAY BE GIVEN WITHIN 5 DAYS OF BIRTH IF NOT BREASTFEEDING

MAY BE GIVEN AT 6 WEEKS POSTPARTUM IF BREASTFEEDING (CDC AND FDA)

NON-HORMONAL METHODS

Natural family planning

- Lactational Amenorrhea
- Standard Days

Barrier methods

- Male condoms (external)
- Female condoms (internal)

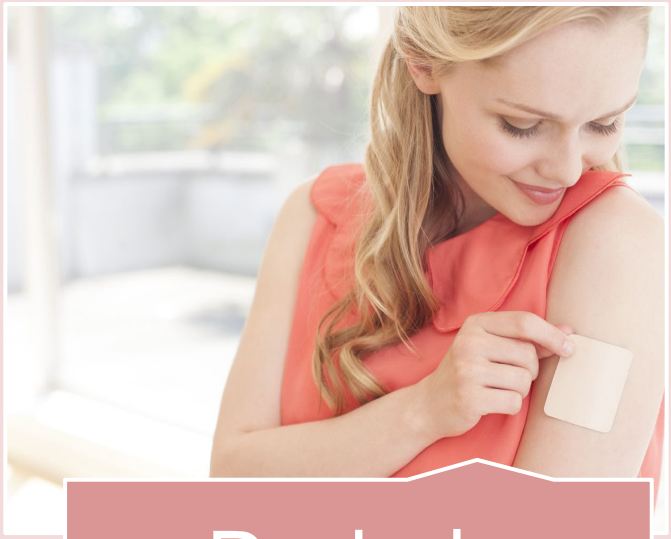
Spermicides

- Nonoxynyl-9
- Phexxi™

TRADITIONAL HORMONAL METHODS

PROGESTIN-ONLY OR COMBINATION OF ESTROGEN AND PROGESTIN

Pills



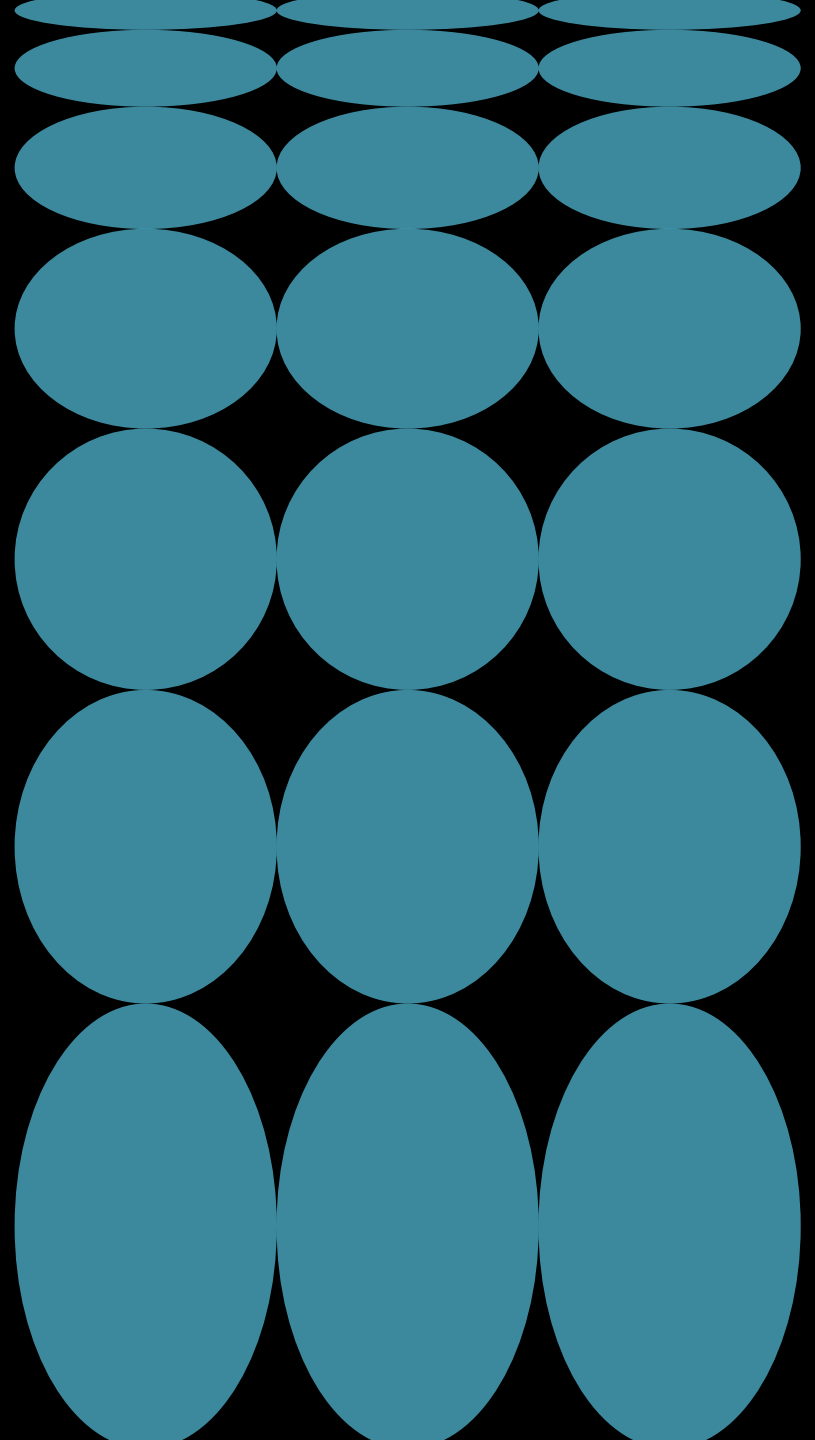
Patch

Ring

In general, okay to begin these methods at 6 weeks postpartum (breastfeeding and not breastfeeding)

**Concern for clotting (PE and/or DVT due to hormone levels during pregnancy and in the immediate postpartum)

RESOURCES



https://picck.org/ (no longer updated since 2023, but may use as appropriate)

https://www.bedsider.org/ (excellent patient resource, reminders, and comparisons)

https://pcainitiative.acog.org/resource-library/acog-resources/ (Postpartum Contraceptive Access Initiative; ACOG guidance and provider resources)

https://www.reproductiveaccess.org/contraception/ (excellent patient teaching aids)

THANK YOU

CARA BUSENHART

CBUSENHART@KUMC.EDU

NO July Learning Forum!

Learning Forum

Dr. Cara Busenhart, CNM, FACNM

Family Planning immediately after a delivery