Termination of Pregnancy in the Rural Setting

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THE UNIVERSITY OF BRITISH COLUMBIA
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LAND ACKNOWLEDGMENT

I acknowledge I live, work and play on the stolen lands of the Gitxsan Nation.

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Wrinch Memorial Hospital

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PRESENTER DISCLOSURES

Name: Hana Lang

Relationships with commercial interests:

- Nil

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LEARNING OBJECTIVES

- Identify barriers to accessing timely termination of pregnancy
- Identify relevant community specific resources to support access to TOP
- Collaborate to create site specific strategy for TOP

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CASE #1

- 17 y/o G2A1P0, previous mTOP via RMs
- Presented for TOP, 20 weeks, decided to stay pregnant
- Abruption @ 25 weeks, C/S @WMH 1A site (infant currently well)

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CASE #2

- 18 y/o G2P1, presented to care for ? pregnancy, wanting TOP, didn't attend F/U due to scheduling conflicts
- PTB @ 36 weeks at WMH

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Accessible abortion = better perinatal outcomes

Of pregnant people considering abortion, significant distance to abortion facility positively associated with still being pregnant 4 weeks later (Pleasants et al., 2022)

Redd et al (2022) found restrictive abortion environments positively associated with poor perinatal outcomes like PTB

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OVERVIEW

- ***Problem***: Many patients in Hazelton catchment area encounter barriers accessing timely TOP
  - MAIN BARRIER: timely access to a provider to initiate process
  - Patient / provider scheduling conflicts (transportation/lack of childcare often contribute to missed appointments)

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Wrinch Memorial Hospital (WMH)

- Most providers in Hazelton prescribe mTOP
- GPs under resourced (5.3FTE currently full, funded for 9.5FTE)
- 1A maternity site: no OB, periodic anesthesia coverage
- 1 GP trained in providing surgical abortion up to 13+6wks
- Hosted local HOUSE-OB course in 2022, familiarizing providers with dating techniques by POCUS

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POLL QUESTION

What is the most significant barrier in your community affecting patient access to TOP?

- 1. Wait time to access provider
- 2. Shortage of providers providing mTOP
- 3. Access to ultrasound
- 4. Provider comfortability around mTOP

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Collaborative Based Care Solution

APP contract allows RMs to provide care within scope of practice for which there is no corresponding MSP billing code

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RMs @ WMH funded via APP contract - NOT FFS.

- RMs **cannot** rx Mifegymiso, **can** order labs/US, provide pregnancy counselling and support, rx hormonal birth control
- In Hazelton - RM on call 24/7, accessible to TOP patients via pager
- RMs often have greater flexibility in terms of scheduling than GPs
  - one RM on call and one RM in clinic most weeks

Skeena Midwives

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Practice Protocol

Termination of Pregnancy

Print off pages 3-8 of this document, provide pages 4,5, 7 and 8 to the patient and retain page 3 and 6 for clinical records.

Abbreviations:

mTOP :medical termination of pregnancy

1. Purpose/Background

To provide a comprehensive guideline to providers facilitating medical termination of pregnancy at Wrinch Memorial Hospital.

2. Intake / Access

All clients looking to review pregnancy options / secure a termination of pregnancy should leave a message on the Skeena Midwives Non-Urgent Phone Line.

QUESTIONS TO ASK AT FIRST CONTACT:

- When was the first day of your last period?
- Have you taken a home pregnancy test?
- Do you want to be pregnant?

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3. Assessment

ULTRASOUND

- Some providers prefer to have a dating US. Depending on the GP/NP consultant, arrange formal / dating US PRN. Many physicians are also confident in T1 POCUS, consider requesting this in the context of uncertain LMP.
- If formal US add "considering TOP" to ensure it's done ASAP

LABS (serologies do not need to be back prior to mTOP initiation)

- CBC
- Group and Screen
- HepB, HIV, Syphilis, Rubella, quantitative bHCG, Ch/Gc, MSU

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4. Procedures

mTOP - UNDER 10 WEEKS

- Most GPs/NPs at WMH are comfortable prescribing mTOP meds
- Complete checklist / fill out lab and ultrasound info on page 3 of this document
- Provide pages 3-8 to prescribing GP/NP, request they retain pages 3&6 for patient clinical records. *Consider consulting with ER GP and instruct patient to present to ER to receive meds if patient / RM availability in conflict*

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Follow-Up

Be sure to provide QUANTITATIVE bhcg req to patient - to be done a week or so after MISOPROSTIL (see checklist). This can be printed out and given to patients directly as SCANLAB can take up to 48hrs to register new requisitions on the cloud. Copy the patient's provider on the bloodwork. Book follow up appointment for patients with GP/NP for post-abortion check in and contraception.

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5. Documentation

Document all conversations, counselling and consultations in MOIS. Retain pages 4&6 for patient clinical records. Send a message to the patient's provider through MOIS that mTOP has been conducted or that surgical abortion has been organized.

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Mifegymiso Prescribing for Providers

Selection Criteria

- ❑ Patient has made clear decision for termination
- ❑ Intrauterine pregnancy < 63 days by U/S (off-label but SOGC recommends use up to 70d in practice)
- ❑ No IUD in place
- ❑ Patient able to understand consent form and follow patient instructions
- ❑ Has access to telephone (email if necessary) and transportation
- ❑ Has access to emergency medical services for the next 14d
- ❑ Aware of need for surgical procedure if method is ineffective
- ❑ HGB > 95
- ❑ No active kidney or liver disease
- ❑ No chronic PO steroid use or adrenal disease
- ❑ No allergies to misoprostol or mifepristone
- ❑ Not breastfeeding
- ❑ No anticoagulation medications or hemorrhagic diseases
- ❑ No uncontrolled severe asthma (or porphyria)

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Mifegymiso Prescribing for Providers

Checklist

- ❏ LMP =
  - ❏ If unclear/unknown dates - dating U/S done? (either POCUS per prescriber comfort or formal U/S)
  - ❏ eGA from dates or ultrasound: ________________
- ❏ Initial BhCG quantitative level: __________
- ❏ CBC
- ❏ STI screening done (self-swabs preferable + b/w on req for CBC/HCG)
- ❏ Counselling offered, referrals done if requested
- ❏ Rx for: cramping/pain, nausea, loose stools
  - ❏ Tylenol ES/T#3, NSAIDs, Gravol, ondansetron (not covered), loperamide (not covered)
  - ❏ 2nd dose of misoprostol (if needed for later dates)
- ❏ Requisition for repeat b-hCG **quant** levels at 48hrs and/**or** 7-14 days post medication
  - ❏ (write out the word **quantitative**, as these have been missed through our lab)
  - ❏ 50% drop within 24-48hrs (after MISOPROSTOL), OR 80% drop within 7-14d, confirms complete abortion
- ❏ Choice of contraception after termination: IUD, OCP, Depo, Nexplanon, other:_______________________
- ❏ Date of follow-up appointment: _______________________

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Surgical Terminations @ WMH

- OR typically operates 9 days / month based on visiting surgical specialists
- OR team is committed to facilitating urgent surgical termination
  - GP provider travelled to Vancouver for 3 months to obtain training in sTOP (13+6 GA) at CARE center
  - Whatsapp group used to communicate / organize terminations
    - GP surgical termination provider, GP anesthesia, OR nurses

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Team Based TOP Data

Spring 2023 - Spring 2024 (12 months)

- 24 terminations total
- 4 surgical terminations
- Several IUDs under sedation

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Next Steps...

- Advocacy for RM scope expansion to include Mifegymiso prescribing
- Advocacy for RM scope expansion to include early pregnancy ultrasound dating
- Continued data collection

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Q&A

POST YOUR QUESTIONS IN THE CHATBOX

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RESOURCES & REFERENCES MENTIONED

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For a complete list of references used in the creation of these protocols and documents please contact hanarae@gmail.com

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