IPLARC Monthly Teams Webinar: IT/EMR and Engaging Outpatient Prenatal Providers

December 17, 2018
12:00 – 1:00 PM
Introductions

• Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  • Name
  • Role
  • Institution
• If you are only on the phone line, please be sure to let us know so we can note your attendance.
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- WebEx is currently unable to add the meeting to your calendar if you are accepting the meeting on a mobile device

Add to calendar by clicking either of these options

Call-in info
Call Overview

• Progress Towards GO LIVE and Review of Data
• IT/EMR and Communicating with outpatient sites
  – Jill Edwardson, MD, MPH, Johns Hopkins Medicine, Baltimore, MD
• Team Talk: Norwegian American Hospital
• Team Talk: Carle Foundation Hospital
• QI Corner
• Key Players Meetings
PROGRESS TOWARD GO LIVE AND REVIEW OF DATA
# Aims and Measures

<table>
<thead>
<tr>
<th>Overall Initiative Aim</th>
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<tr>
<td>Within 9 months of initiative start, ≥75% of participating hospitals will be providing immediate postpartum LARCs.</td>
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<th>“Go Live” date is March 2019 for Wave 1 teams!</th>
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## Structure Measures

- IT/EMR systems that allow for documentation of IPLARC placement for tracking, and documentation.
- Coding / billing strategies in place for reimbursement for IPLARC.
- IPLARC devices stocked in the inpatient pharmacy.
- IPLARC protocols in place for labor and delivery and postpartum units.
- Implemented standardized education materials and counseling protocols* for patients during delivery admission regarding contraceptive options including IPLARC.
- Communicated launch of IPLARC availability during delivery admission with affiliated prenatal care site and provided sites with provider/staff and patient education materials for contraceptive options counseling, including IPLARC.

## Process Measure

- Educated all participating providers/nurses on benefits of IPLARC, protocols, counseling & IPLARC placement.

## Outcome Measure, among participating hospitals

- Provide and document comprehensive contraceptive counseling, including IPLARC, during prenatal care and delivery admission.
- By increasing access to IPLARC, increase in utilization of IPLARC.
This month’s topic: IT/EMR and Communicating with Outpatient Sites

Aim:
- EMR/IT systems in place for IPLARC tracking
- Hospitals reimbursed for IPLARC insertion
- LARC devices available on site at the hospital for immediate postpartum insertion
- All OB/postpartum units equipped to provide IPLARC
- Patients aware of IPLARC as a contraceptive option
- Trained clinicians available to provide IPLARC

Primary Drivers:

Secondary Drivers:
- Create order set for IPLARC
- Educate providers and staff on IPLARC documentation procedures
- Develop billing mechanism in place for Medicaid and private insurance
- Add devices to formulary
- Assure devices/kits available on all OB/postpartum units in timely manner
- Revise policies/procedures to provide IPLARC
- Educate clinicians and staff on the evidence and clinical recommendations of IPLARC
- Educate clinicians and affiliated prenatal care sites on contraceptive choice counseling
- Train clinicians on IPLARC insertion

Recommended Key Practices:
1. Assure that all appropriate IT systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARC.
2. Assure billings codes are in place and that staff in all necessary departments are educated on correct billing procedures.
3. Have protocols in place for billing in/out of network, public/private insurance
4. Establish communication channel and multidisciplinary support among appropriate departments.
5. Modify L&D, OB OR, postpartum and clinic works flows to include placement of LARC.
6. Store LARC devices on L&D and/or develop process for acquiring devices in a timely manner.
7. Educate providers, nurses, lactation consultants, social workers about clinical recommendations related to IPLARC placement and breastfeeding.
8. Educate clinicians, community partners and nurses on informed consent and shared decision making.
9. Connect with providers and staff at prenatal care sites to ensure they are aware the hospital is providing IPLARC and that education materials are available.
10. Distribute patient education materials that are culturally sensitive and use shared decision making to counsel patients about IPLARC.
11. Participate in hands-on training of IPLARC insertion.
Practice Changes for IPLARC Success – Pre-implementation

1. Assure early multidisciplinary support by educating and identifying key champions in all pertinent departments for your IPLARC QI team.

2. Establish scheduled meetings for your team at least monthly, assuring that all necessary departments are represented, develop 30/60/90 day plan, establish timeline to accomplish key steps.

3. Establish and test billing codes and processes to assure adequate and timely reimbursement (see toolkit).

4. Expand pharmacy/ inpatient inventory capacity and device distribution to assure timely placement on labor and delivery and postpartum units.

5. Educate clinicians, nurses, pharmacy, and lactation consultants about benefits and clinical recommendations related to IPLARCs (see toolkit for e-modules, slide decks, materials).

6. Assure that all appropriate IT/EMR systems are modified to document acquisition, stocking, ordering, placement, counseling, consent, billing and reimbursement for IPLARCs (dot phrases to document counseling and placement, consent forms, order set, billing framework see toolkit examples).

7. Modify L&D, OB OR, postpartum, and clinic work flows (protocols/process flow/checklists) to include counseling, consent, and placement of IPLARC (see toolkit for example).
8. Establish consent processes for IPLARC that allows for transfer of consent from prenatal clinic as well as obtaining inpatient consent (see toolkit for examples).

9. Develop educational materials and shared decision making counseling practices to educate patients about the availability of IPLARC as a contraception option (outpatient prenatal care locations, L&D, postpartum) (see toolkit for examples).

10. Educate clinicians, and nurses on informed consent and shared decision making related to IPLARC as well as IPLARC placement and documentation (see toolkit for ILPQC/ACOG training, e-modules, slide decks, education materials).

11. Standardize system / protocol / process flow to assure all patients receive comprehensive contraception choice counseling including IPLARC in affiliated prenatal care sites and during delivery admission.

12. Communicate launch date of hospital’s IPLARC capability to all providers, nurses and affiliated prenatal care sites: communicate protocols, documentation and billing strategies.

13. Track and review IPLARC data, collected monthly through ILPQC REDcap data system with real-time data reports, share data with providers and nurses and review standardized counseling for prenatal sites and labor and delivery and IPLARC uptake, to evaluate program success and sustainability.
Teams on track to complete steps for their IPLARC GO LIVE goal

Wave 1 teams GO LIVE by March 2019!

7 teams are live!
7 teams have a GO LIVE date set!
Hospitals Providing IPLARC

Percent of Hospitals Providing Any IPLARC

Percent of Hospitals Providing IPLARC broken down by IUDs and Implants
IPLARC on L&D/Postpartum

Percent of Hospitals with LARC Devices on L&D or Postpartum Unit
IPLARC Protocols/Process Flow in Place

Percent of Hospitals with Immediate Postpartum Protocols in Place and Process Flows in Place for IUDS

Percent of Hospitals with Immediate Postpartum Protocols in Place and Process Flows in Place for Implants
IPLARC Billing Codes

Percent of Hospitals with Billing Codes Implemented for **IUDs**

<table>
<thead>
<tr>
<th>Date</th>
<th>In Place</th>
<th>Working On It</th>
<th>Have Not Started</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Apr 2018</td>
<td>26.67</td>
<td>33.33</td>
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Percent of Hospitals with Billing Codes Implemented for **Implants**

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<th>Working On It</th>
<th>Have Not Started</th>
<th>Goal</th>
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<td>Oct 2018</td>
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<td>20</td>
<td>9.09</td>
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IPLARC Standardized Patient Education at Prenatal Sites

Percent of Hospitals that have Provided Standardized Education Materials and Counseling Protocols to Affiliated Prenatal Care Sites

<table>
<thead>
<tr>
<th>Month</th>
<th>Yes, All</th>
<th>Yes, 1 or more</th>
<th>No</th>
<th>Goal</th>
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<tr>
<td>Apr 2018</td>
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<td>86.67</td>
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<td>Oct 2018</td>
<td></td>
<td>36.36</td>
<td>54.55</td>
<td>9.09</td>
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IPLARC Inpatient Patient Education & Counseling Protocols

Percent of Hospitals with Standardized Education Materials and Counseling Protocols during Delivery Admission

[Bar chart showing the percent of hospitals with standardized education materials and counseling protocols during delivery admission from April 2018 to October 2018.]

- April 2018: 6.67%
- May 2018: 6.67%
- June 2018: 13.33%
- July 2018: 13.33%
- August 2018: 13.33%
- September 2018: 13.33%
- October 2018: 36.36%

Developed and Implemented: Green
Developed but not yet implemented: Yellow
No: Red
Goal: Between 80% and 100%
Provider IPLARC Education

Percent of Physician/Midwife Training on IPLARC Evidence, Protocols, Counseling & Placement

- Physicians/midwives trained on IPLARC evidence, protocols, counseling
- Physicians/Midwives trained on immediate postpartum IUD placement
- Physicians/Midwives trained on immediate postpartum implant placement
Staff IPLARC Education

Percent of Nurses, Lactation Consultants, Social Workers Trained on IPLARC Evidence, Protocols, and Counseling

- Nurses Trained
- Lactation Consultants Trained
- Social Workers Trained
Don’t Forget!

• November data was due on December 15
• Make sure to update structure measures as you move to go LIVE
Important Measure to Drive your QI once set GO LIVE

- Random sample of 10 delivery records
  - # with comprehensive contraceptive counseling including option of IPLARC documented in the prenatal record
  - # with comprehensive contraceptive counseling including option of IPLARC documented in the delivery admission

Work with your outpatient sites to develop a mechanism to document prenatal comprehensive contraceptive counseling for every patient in the prenatal record

Possible approaches:
1. Share a universal dot phrase – best way to document
2. Problem list include comprehensive contraceptive counseling and postpartum contraception plan
## Outcome Measures

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
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<tbody>
<tr>
<td>30. Number of deliveries this month:</td>
<td></td>
</tr>
<tr>
<td>31. Is your hospital routinely counseling, offering, and providing</td>
<td>Yes/No</td>
</tr>
<tr>
<td>immediate postpartum LARCs either IUD or Implants (i.e., is your system</td>
<td></td>
</tr>
<tr>
<td>live)?</td>
<td></td>
</tr>
<tr>
<td>31a. If yes, please specify:</td>
<td>IUDs/Implants/Both</td>
</tr>
<tr>
<td>32. Total number of immediate postpartum IUDs placed this month:</td>
<td></td>
</tr>
<tr>
<td>33. Total number of immediate postpartum implants placed this month:</td>
<td></td>
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</tbody>
</table>

If your hospital is routinely counseling, offering, and providing immediate postpartum LARCs, either IUD, implants, or both, please review a random sample of 10 charts for this month.

Begin by systematically selecting 10 records.

First, divide the total number of live births occurring at your facility in a given month by 10 and then select every nth chart where n is the result of that division.

Example 1: If your hospital has 102 births in a month, then divide 102 by 10=10.2 and you will select every 10th birth for that month.

Example 2: If your hospital has 28 births in a month, then 28 divided by 10 is 2.8 and you will select every 2nd birth for that month.

Review this random sample of charts and record the number of charts (0-10) with the following information documented:

34. How many charts with contraceptive counseling, including IPLARC, documented/10 during prenatal care?
35. How many charts with contraceptive counseling, including IPLARC, documented/10 during delivery admission?
IT/EMR MODIFICATIONS AVAILABLE IN IPLARC TOOLKIT
Checklist for Ensuring IT/EMR is ready for GO LIVE

- Dot phrases developed and implemented
- Checklists updated/implemented
- Order sets developed and implemented
- Staff/Providers informed of new updates
Example Dot Phrases/Procedure Notes

Post-placental IUD Insertion Procedure Note

**Time of delivery of placenta:** ***

**Time of insertion of IUD:** ***

**IUD Type:** [IUD Type:26674]

**Insertion Type:** [Insertion Type:26675]

**Ring Forceps:**

After delivery of the placenta, it was confirmed that the patient did not have any contraindications to IUD placement. Specifically, she did not have a postpartum hemorrhage or chorioamnionitis. It was confirmed that the patient desired the placement of the IUD. The previously signed informed consent was verified. The perineum was cleansed with betadine. New sterile gloves were placed on the operator's hands. A ring forceps was placed on the anterior cervical lip. The IUD was grasped gently with a second ring forceps, with care not to close the ratchets on the ring forceps. The IUD was then inserted past the internal os. With one hand on the abdomen palpating the fundus, the IUD was then placed to the fundus without difficulty and the ring forceps were removed. The IUD strings were cut to the level of the external cervical os. All instruments were removed. The patient tolerated the procedure well.

**Operator's Hand:**

After delivery of the placenta, it was confirmed that the patient did not have any contraindications to IUD placement. Specifically, she did not have a postpartum hemorrhage or chorioamnionitis. It was confirmed that the patient desired the placement of the IUD. The previously signed informed consent was verified. The perineum was cleansed with betadine. New sterile gloves were placed on the operator's hands. The IUD was grasped between the 2nd and 3rd fingers of the operator's hand. With one hand on the abdomen palpating the fundus, the IUD was then placed to the fundus without difficulty and the operator's hand was then removed. The IUD strings were cut to the level of the external cervical os. All instruments were removed. The patient tolerated the procedure well.

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**Nexplanon Insertion Procedure Note, DOT Phrase**

**Procedure- Nexplanon Insertion**

The risks, benefits, and alternatives of Nexplanon insertion were reviewed with the patient. All questions were answered to her satisfaction and consents were signed.

The patient was placed in the dorsal supine position with her non-dominant [left/right:311354] arm flexed at the elbow and externally rotated. The area for insertion was marked approximately 8 cm from the medial epicondyle of the humerus over the triceps muscles. The area of planned insertion was prepped with [Betadine/Chlorhexidine:24927]. 3cc of 1% lidocaine was injected subdermally along the planned insertion tunnel. The Nexplanon applicator was grasped, the protection cap was removed from the applicator and the white Nexplanon device was visualized within the applicator. The applicator needle was inserted subdermally in the standard fashion, and the device was deployed. The implant was palpated to verify correct subdermal location by myself and the patient. The site dressed with a Band-Aid and a pressure bandage. User card was completed after insertion and given to patient.

**Assessment/Plan-**

Nexplanon Insertion in [left/right:311354] arm without complication

**Removal Date:** ***/20***

100% condom use encouraged for sexually transmitted infection prevention

Wound care instructions reviewed, call if any problems

NSAIDs and Ice packs for insertion site pain
IUD:
IUD ***, Lot # ***, Expiration ***
Risks, benefits, and alternatives were discussed with patient at length. Written consent was obtained for the procedure and scanned into patient’s medical records.
Post placement placement of the IUD was requested by the patient. Uncomplicated *** delivery of both neonate and placenta. Fundus firm, minimal bleeding noted. The *** IUD was then placed via *** method. Fundal placement was confirmed with ***palpation***ultrasound. ***If placed at time of cesarean: The hysterotomy was then closed as dictated in operative report, ensuring the IUD strings were not incorporated into closure. Vaginal exam confirmed lack of visualization of the IUD, retained fundal placement. The IUD strings were shortened to the level of the external os.

Implant:
Implant Lot # *** and Expiration ***
Risks, benefits, and alternatives were discussed with the patient at length. Written consent was obtained for the procedure and scanned into patient’s medical records.
Patient requested placement in *** arm. *** arm was examined. A 4cm linear area approximately ***cm from *** medial epicondyle was marked. This area was prepped with betadine solution. A subcutaneous injection of 2cc of 1% lidocaine was inserted for local anesthetic. The Nexplanon device was used for implant insertion. Implant visible within device prior to insertion. Insertion without difficulty. Implant was then palpated by both physician and patient. Pressure dressing was placed. The patient tolerated the procedure well. All questions answered.

Thank you Northwestern!
CONTRACEPTIVE IUD CHECKLIST

(Courtesy of Palmetto Health)

› Verify patient’s name and birth date
› Counsel patient, provide informational pamphlet
› Patient signs IUD consent
› Order IUD ’On Call’ from order set in EMR
› Call nurse to verify that IUD is on the floor, or in the Pyxis, and instruct nurse to bring in the room before delivery
› Provider verifies if they will place by hand, with the introducer, or with ring forceps
› Procedure performed at time of placental delivery, and documented in nursing note
› Procedure card signed, dated, and given to patient
› Procedure included by Provider in Delivery or Operative Note

CONTRACEPTIVE IMPLANT CHECKLIST

(Courtesy of Palmetto Health)

This checklist can be modified and posted in the procedure room or can accompany the supplies.

› Verify patient’s insurance (do not place if self-pay or enrolled in emergency Medicaid)
› If Tricare insurance, the patient will need to have preauthorization
› Provider has 3 observed placements with upper level or attending
› Counsel patient
› Order Nexplanon and Lidocaine
› Call nurses to verify that Nexplanon is on the floor and nurses are available for placement
› Patient signs Nexplanon consent
› Procedure performed in treatment room
› Compression bandage placed for 24 hours
Example Order Sets

SAMPLE ORDER SET
(Courtesy of Greenville Health System)

- Etonogestrel (Nexplanon) 68 mg Implant for Subdermal Insertion
- Etonogestrel 68 mg IMPLANT x 1 dose prior to discharge
- Lidocaine 2% 3-5 ml SBQ x 1 dose for Etonogestrel insertion
- Patient to receive Nexplanon Implant prior to discharge
- Initiate/Print Consent for Nexplanon Insertion
- Initiate/Print Bedside Timeout

SAMPLE ORDER SET

Choose one:
- **Mirena® IUD** (52 mg levonorgestrel-releasing intrauterine system)
- **Kyleena® IUD** (19.5 mg levonorgestrel-releasing intrauterine system)
- **Skyla® IUD** (13.5 mg levonorgestrel-releasing intrauterine system)
- **Paraguard® IUD** (copper-releasing intrauterine system)

Device ordered from EMR ‘On Call’ so it can be brought to the floor as soon as needed

Have ultrasound available to evaluate fundal placement as needed

On Mayo stand or delivery table:
- Sterile gloves
- Rings forceps x2
- Betadine
Communicate IT/EMR Updates

• Send email explaining how to use IT/EMR enhancements for IPLARC to your team
• Hang up reminders on or near computers in provider workroom/nurse stations
• Integrate into new hire education
• Take time during a department meeting to explain the changes
ENGAGING OUTPATIENT PROVIDERS
Checklist for Engaging Outpatient Providers

1. Communicate launch of IPLARC GO LIVE with your outpatient providers
2. Develop a plan for communicating patient contraception counseling plan between outpatient and inpatient sites
3. Share comprehensive contraceptive counseling strategies with outpatient sites
4. Circle back with outpatient providers outcome of IPLARC placement and scheduling of potential follow-up appointment
1. Communicate IPLARC Launch

- Work with **outpatient rep** to develop a communication plan
- Create an **IPLARC Go-Live Packet**
  - Additional Items to include:
    - Announcement flyer with department letter (look for example letter in newsletter this week)
    - IPLARC Fact Sheet
    - Contraceptive counseling strategies
    - Patient education materials
    - Process Flow / Protocol for IPLARC placement including billing/coding process
    - Sample dot phrases for counseling and placement
- **Attend a staff/provider meeting** and explain the value/availability of IPLARC
- **Send email** to outpatient and inpatient staff announcing the availability of IPLARC (draft announcement available)
- Host **Grand Rounds** (we have a slide deck to share!)
Attention all Delivering Providers:

We are pleased to announce that XX Hospital will be offering immediate postpartum LARC (IPLARC) devices including IUD and Nexplanon as an additional contraceptive option to our patients in the hospital post-delivery starting March 1, 2019. IPLARC is recommended as an important postpartum contraceptive option by ACOG CO 6670. Offering IPLARC will help improve access to a highly effective contraceptive option for patients. LARCs are safe, cost-effective, and a highly desired option with high levels of patient satisfaction and continuation. Even with slightly higher rates of expulsion for IUD in the immediate postpartum period, given the barriers to accessing LARC post-discharge, immediate postpartum LARC has been shown to be more effective for many women.

We know that our patients face many barriers to attending their postpartum visit. The immediate postpartum period has several potential barriers to return such as lack of transportation, employment status, home care responsibilities, hospital stay, insurance status, and increasing the risk of short-interval pregnancy. Through the Illinois Perinatal Quality Collaborative (ILPQC) and PQC UNHED program, our patients will not have to return for a postpartum LARC.

In 2015, Illinois unbundled payment for the LARC device allowing for a separate reimbursement in addition to Delivery. We have created a system that allows our nurses to provide LARCs to our patients post-delivery. We have also attached a flyer for information regarding the specific device you should choose for your patient.

We know that we cannot achieve lasting results without participating in a state wide quality initiative with the Illinois Perinatal Quality Collaborative (ILPQC) to improve access to immediate postpartum LARC. We are participating in the statewide IPLARC initiative. The data will allow us to track the percentage of women with documented counseling including the option of IPLARC. We are also tracking the percentage of patients with comprehensive counseling, including the option of IPLARC, documented during outpatient prenatal care appointments. We are working together, we can improve access to effective contraception for all patients, help reduce short interval and unwanted fetal outcomes. Should you have any questions please contact our IPLARC team.

All the best.

IMMEDIATE POSTPARTUM LARC IS NOW LIVE!

WHAT
Nexplanons
Mirenas
WHEN
Monday
March 4th, 2019
HOW
- Mirenas order through - Admission order set
- Nexplanon order through - Post-partum order set
Once ordered, devices are now available on L&D and the postpartum unit. Insertion kits with all needed supplies are available in the clean utility room on L&D and the postpartum unit. Insertion checklist, consent and patient post-procedure information are available in the EMR. Dot phrase for documentation, billing codes are also available.

AVAILABLE OPTIONS FOR PATIENTS
COUNSELING
Prenatally provide comprehensive contraceptive counseling including IPLARC as an option. See attached counseling materials for patient resources.
Document counseling and the postpartum birth control plan.
DATA COLLECTION
We will track comprehensive contraceptive counseling documentation with a random sample of delivery records to review patients received counseling with a postpartum plan documented. If the patient desires IPLARC please include in the problem list.
BILLING & REIMBURSEMENT
IUDs are now unbundled from the global delivery fee and can be billed through hospital billing/coding system similar to other services provided.
2. Communicating Patient Contraception Plan

- Share with outpatient sites / providers example dot phrases for comprehensive contraceptive counseling including IPLARC
- Develop strategy for communicating contraception plan for IPLARC, such as note in problem list or on “EMR pink sticky”
- Include question on intake to L&D re: contraception plan – potentially add to admission H&P or checklist
- Add patient plan for IPLARC to L&D grease board
- Include question regarding patient’s plan for IPLARC in delivery / cesarean checklist (similar to PPTL)
3. Share Comprehensive Contraceptive Counseling Strategies

• Host a Grand Rounds for providers
• Incorporate comprehensive contraceptive counseling including IPLARC into resident/new hire/ongoing staff education
• Distribute comprehensive counseling including IPLARC resources to outpatient sites. Provide a script!
• Include dot phrase to document comprehensive counseling including IPLARC
CONTRACEPTIVE COUNSELING MODEL
A 5-Step Client-Centered Approach

1 Identify the client's pregnancy intentions
   • Do you want to be pregnant in the next 3 months or have a baby in the next year?

2 Explore pregnancy intentions & birth control experiences and preferences
   • What would be hard about having a baby now?
   • Why is now a good time for you to have a baby?
   • What experience have you had with birth control?
   • What is important to you in a birth control method?
   • What does your mom/boyfriend/friends think about you using birth control?

3 Assist with selection of a birth control method
   • If it's ok with you, I'd like to review the birth control methods that are available to make sure you have all the information you need to make a decision that is right for you.

4 Review method use and understanding
   • How are you feeling about your decision?
   • What other questions or concerns do you have?
   • Let's develop a follow-up plan in case you experience side effects.

5 Provide birth control that same day
   • You will see the clinician next who will take a medical history and make sure the method you chose is a safe option for you.
   • Would you like CC or condoms before you leave today?

LARC Insertion: Contraceptive Counseling with Shared Decision Making Framework
from ACOG

ACCESS LARC
Increasing Access to Immediate Postpartum Long-Acting Reversible Contraception

Chapter Six: Patient Education and Counseling

SAY: We recommend moms wait at least 18 months before getting pregnant again after delivery. This is best for the healthiest mom and baby.

ASK: Have you thought about if and when you would like to have another child?

No

Unsure, don’t know, don’t care

Yes

Educate on birth spacing and having a healthy pregnancy

When? Have you considered using birth control after delivery?

No

Yes

1) Build rapport with women (and families/partners)
2) Assess women’s intentions and educate women (and families/partners) using motivational interviewing
3) Document patient’s preferences and reinforce education throughout care
4) Provide informed consent and ongoing support (may include referrals or linkages to care)
4. Coordinating Patient Follow-Up

- Ensure outpatient providers / clinic care team know that LARC was placed/not placed
  - Discharge summary
  - Procedure Note
- Coordinate follow-up appointment (can correspond to early postpartum visit or 6-week postpartum visit)
- Give patients a number to call to schedule follow-up appointment
- Share patient handout re: follow-up care/when/how to check IUD for expulsion
- Share resources for patients re: options for future removal of device if patient desires
Postpartum Care

After the IUD is placed, your postpartum care will be the same as if you had not had the IUD. Your IUD may come out during your routine postpartum care, this is ok, but remember that you now need to use another form of birth control (for example: condoms, pills, or depo-provera shot). It is our recommendation that you abstain from intercourse until your six week visit when the IUD strings have been trimmed and we can confirm the IUD is in your uterus. Without confirmation that the IUD is in the correct place, you can get pregnant. In addition, intercourse may be painful for your partner if the strings are in the vagina and this could also increase your risk of the IUD coming out. If you do have intercourse prior to your postpartum follow up visit, it is recommended that you use an alternative form of contraception. We are happy to provide this to you at discharge.

Who do I call if I have questions or problems?

If you have questions call the clinic at (303) ____________. You can also call the Denver Health NurseLine at (303) 739-1211 any time day or night.

Special instructions:

IUD Take-Home Sheet

1. Copper-T IUD (Paragard®)
   - It begins working now to prevent pregnancy.
   - It can stay inside you for 12 years.
   - Removal date _____ (12 years from today)

2. Progestin IUD (Mirena®, Liletta®, Skyla®)
   - It begins working in 7 days to prevent pregnancy.
   - You MUST use condoms for the first 7 days after your IUD was inserted. If you have sex without using a condom, you will need to take emergency contraception as soon as possible to prevent pregnancy.
   - Mirena® can stay inside you for 7 years. Skyla® or Liletta® can stay inside you for 3 years.
   - Removal date _____ (7 or 3 years from today)

Today you may go back to school or work after your visit. You must wait 24 hours after your IUD is put in before you can use tampons, take a bath, or have vaginal sex.

You may have more cramps or heavier bleeding with your periods, or spotting between your periods. This is normal. The cramping and bleeding can last for 3-6 months with the Mirena®, Liletta®, and Skyla® (hormone) IUDs. After 6 months, the cramping and bleeding should get better. Many women will stop having periods after 1 or 2 years with the Mirena®, Liletta®, and Skyla® (hormone) IUDs. If you have the Paragard® (copper) IUD, you may have more cramping and more bleeding with your periods as long as you have the IUD inside you.

Ibuprofen (also called Advil® or Motrin®) helps decrease the bleeding and cramping. You can buy ibuprofen at any drug store without a prescription. You can take as many as 4 pills (800 mg) of ibuprofen every 8 hours with food (each pill contains 200 mg). To prevent cramping, start taking Ibuprofen as soon as your period starts and keep taking it every 8 hours for the first 2-3 days of your period. You can also put a hot water bottle on your belly if you have bad cramps.
“Immediate PP LARC: IT/EMR and communicating with outpatient clinics”
Immediate PP LARC: IT/EMR and communicating with outpatient clinics

Jill Edwardson MD, MPH
Disclosures

• I have no actual or potential conflict of interest in relation to this program/presentation.
• I will be discussing “off-label” uses of IUDs and implants
Questions to address

1) How do you communicate between inpatient and outpatient that a patient desires LARC?
2) How do you communicate counseling strategies with outpatient sites?
3) How do you let the outpatient site know that the patient received the LARC device immediate postpartum?
4) How do you schedule a follow-up appointment with the outpatient site for a string check?
Communicating between outpatient and inpatient providers

1. Outpatient considerations
2. Inpatient considerations
IPLARC: Starts in the outpatient clinic

- Contraceptive counseling should follow a shared decision-making model
- Many women resume sexual activity before their postpartum checkup
- Eliminates barriers to LARC such as need for repeat visit, possible loss of insurance
- Systems should be in place for women to receive LARC at PP visit if unable to do so
Key points about IPLARC

- When inserted immediately PP (vaginal delivery or c-section), LARCs are:
  - Safe
  - Effective
  - Cost-effective
  - Convenient
- No effects on lactation/breastfeeding
- Women should be counseled about increased risks of IUD expulsion
Outpatient EMR/documentation considerations

• Appropriate patient counseling and selection

• Documenting in the outpatient chart
<table>
<thead>
<tr>
<th>Problems</th>
<th>Plans</th>
<th>Resolved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
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</table>
### Plans/Education (continued)

By Trimester. Initial and Date When Discussed.

<table>
<thead>
<tr>
<th>NA</th>
<th>Date</th>
<th>Follow-Up Needed</th>
<th>Referral</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Third Trimester

**Birth Preferences**

- **Pain Management Plans**: – –
- **Trial Of Labor After Cesarean Counseling**: – –
- **Labor Support Person(S)**
- **Immediate Postpartum Larc**: – –

**Infant Feeding Intention**: – –

**Anticipatory Guidance**

<table>
<thead>
<tr>
<th>Implant</th>
<th>LNG-IUS</th>
<th>Copper IUD</th>
<th>TOLAC</th>
<th>Elective RCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Circumcision Preference**: □ Yes □ No

**Infant Feeding Intention**: □ Exclusive □ Mixed □ Formula

**Anticipatory Guidance**

[Insert table content here]
**Plan**

- **Meds & Orders - SmartSets**
  - oxycodone-acetaminophen (PERCOCET) 10-325 MG per tablet
  - prednisone (Deltasone) 10 MG tablet

- **BestPractice**
  - **Advisories**
    - 
      - **Influenza vaccine due:** Order the immunization, document the immunization in the Immunizations activity, give a reason for not giving the immunization, or add the exclusion modifier to remove from influenza plan.
    - 
      - **HIV screening:** This patient has not had HIV screening. Click the Accept button to open the recommended SmartSet. To decline, use OVERS/DE below and choose 'DECLINED'.
    - 
      - **TDAP vaccine due:** Order the immunization, document the immunization in the Immunizations activity, give a reason for not giving the immunization, or add the exclusion modifier to remove from adult TDAP plan.
    - 
      - **Pap Smear Due:** Patient is due for a pap smear. Click the Accept button to open the recommended SmartSet or select the modifier to remove the patient from the screening plan.

**Problem List**

- **New Problem**
  - **Problem:** Normal intrauterine pregnancy, antepartum
  - **Display:** Normal intrauterine pregnancy, antepartum
  - **Diagnosis:**
    - **Resolution:** Noted: 12/15/2018
    - **Specialty:** Obstetrician/Gynecologist
    - **Nervous and Auditory**
      - Carpal tunnel syndrome
      - Musculoskeletal and integument
      - Arthritis rheumatoid
Postpartum immediate PP LARC smartphrase

- Example: “Patient desires immediate postpartum Mirena IUD insertion. Discussed advantages of immediate insertion including early postpartum pregnancy prevention and opportunity for placement with epidural in place. Discussed increased risks of expulsion (10-27%) and importance of postpartum string check.”
Inpatient considerations

• Order the device (and necessary supplies)
• Documenting the procedure
  – Implant: order the procedure and document under the order
  – IUD: document in delivery note
• Add to problem list
• Document in the discharge summary
• Document patient instructions
@AGE@ P*** at @GA@ who presented with ****. The initial exam was ****. Patient was GBS***. An epidural was placed for pain control. *** was initiated for augmentation***/induction of labor. ****amniotomy for *** fluid. She progressed spontaneously to fully dilated. She pushed well to deliver the fetal head in the *** position. *** nuchal cord was present. The rest of the body delivered easily, weighing ***g. ***The infant was immediately placed on mother's chest for skin to skin. ***Delayed cord clamping was preformed for *** seconds. The Apgars were *** at one and five minutes, respectively. The cord was clamped and cut. Cord gas and blood were obtained *** (Arterial: pH:***/BE:***). The placenta delivered intact and easily via Brandt maneuver. IV postpartum pitocin was initiated. {Blank single:19197::”Within 10 minutes of placental delivery, a *** IUD was placed under ultrasound guidance, Lot# ***, Exp ***.”} The perineum, vagina, and cervix were examined and *** lacerations were noted. ***The second degree laceration was repaired with *** Vicryl in the usual fashion. The fundus was firm on palpation. Placenta examined and noted to be intact with 3 vessel cord and *** insertion. EBL: ***. The patient was taken out of the lithotomy position and left in stable condition in the care of nursing staff.
Report Viewer

Epididymitis, repair: None
Perineal Laceration, repair: None
Perirenal Laceration, repair: none
Lateral laceration, Repair: none
Sigmoid laceration, Repair: left
Vaginal laceration, Repair: No
Cervical laceration, Repair: No
Inspection completed: Vaginal

Blood loss (ml):

Specimens: none

Complications: none

Condition: stable

Repair Comments: Left incisional tear, deep with evidence of presacral fat. Repaired in three layers with good hemostasis.

Delivery Comments: 25 y.o. G2P at 39w3d who presented for induction of labor for gestational HTN. The initial exam was 1/50-2. Patient was U/S negative. An epidural was placed for pain control. For her induction she received a Foley bulb, misoprostol, and IV pitocin. An amniotomy with clear fluid. She progressed spontaneously to fully dilated. She pushed well to deliver the fetal head in the ROA position with compound presentation of right arm. Nuchal cord was present but delivered through the rest of the body delivered easily. The infant was placed directly on mother’s chest for skin to skin. Delayed cord clamping was performed for 60 seconds. The Apgars were 9 and 9 at one and five minutes, respectively. The cord was clamped and cut. The placenta delivered intact and easily via Brandt maneuver. IV postpartum pitocin was initiated. She had uterine atony, which improved after bimanual massage. Placenta was examined and small 3x5cm area was absent but removed on subsequent manual extraction. US was performed afterwards and thin strip was visualized. Uterine fundus was subsequently firm. Amniotic fluid was placed under ultrasound guidance. LOT TUG21AE Exp 04/2021

The perineum, vagina, and cervix were examined and a left sided deep sulcus laceration was noted. It was repaired in three layers with 2-0 Vicryl with good hemostasis. EPIL: 400. The patient was taken out of the lithotomy position and left in stable condition in the care of nursing staff.

Patient Active Problem List

- Myopia bilateral

Code: H52.53
**New Problem**

- **Problem**: IUD (intrauterine device) in place
- **Display**: IUD (intrauterine device) in place
- **Priority**: Noted: 12/15/2018
- **Class**: Resolved: Chronic
- **Share with patient**: Yes

**Episodes**

<table>
<thead>
<tr>
<th>Linked</th>
<th>Name</th>
<th>Type</th>
<th>Noted</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pregnancy 2018</td>
<td>PREGNANCY</td>
<td>5/14/2018</td>
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</tr>
</tbody>
</table>

**Complication of**

- **Linked**: LABOR ANALGESIA
- **Date**: 12/12/2018
- **Provider**: Tu-C-Ar Thanh Nguyen
- **Type**: Surgery

**Overview**

Immediate PP Minna placed 12/13/18, Lot# TUX21AE Exp 04/2021.
Inclusion in the discharge summary

- Under “procedures”
- Within the body of the discharge summary
- In the “patient instructions” section
Postpartum instructions

• Standardize the information you provide to patients
  – Implant: Dressing instructions, expected bleeding patterns, infection precautions
  – IUD: Expected bleeding patterns, warning signs for expulsion, strings lengthening
Postpartum visit

• Documenting in the progress note the presence/absence of the LARC
• Making certain the patient knows where to go for removal if desired
Resources

- ACOG: Immediate Postpartum LARC Website. https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC
TEAM TALKS
TEAM TALK: IMMEDIATE POSTPARTUM LARC

NORWEGIAN AMERICAN HOSPITAL
PRESENTED BY: SARA McLACHLAN, RNC-OB
OB NURSE CHAMPION
Norwegian American Hospital

• Hospital
  – 200 bed community hospital in Humboldt Park, Chicago
  – Averaged 34 deliveries per month in 2018
  – 80-95% Medicaid
  – 7.5% walk-in

• Providers
  – In-house clinic with three OBs and two midwives
  – Family Practice residency with 12 residents
  – 3 private providers
• Initial team members:
  – Maternal Child Services (OB) Director
  – Clinical Coordinator
  – Physician champion
  – Nurse champion
  – Head of pharmacy purchasing
  – Billing codemaster

• Additional members over time:
  – IT
  – Outpatient clinic representative
  – Materials management (briefly)
<table>
<thead>
<tr>
<th>Barrier</th>
<th>Solution</th>
</tr>
</thead>
</table>
| Pharmacy concerned about reimbursement due to our 340B status as outpatient | Educated pharmacy on the benefit/need of the program  
Confimation from ILPQC and HFS separately that hospital could pay in full and be reimbursed in full according to fee schedule, even if we purchase through 340B for outpatient devices. |
| Materials management considered LARC medication | RN, pharmacy rep, mat. mgmt rep, and codemaster attended “Stocking IPLARC” webinar. Guidance seemed directed toward pharmacy stocking so we went that route. |
| Concerns of motivation or potential bias with the program | Physician, RN, and dept director provided a thorough program education                                                                                                                                  |
| Concerns about billing/reimbursement for IPLARC                       | Discussed and analyzed at length the HFS Informational Notice regarding billing and reimbursement for LARC devices                                                                                       |
• Coding/Billing became the main focus of team meetings
  – We came up with possible ways to document between our three systems that would satisfy if we had to bill with the individual practitioners’ NPIs versus the hospital NPI
  – Don’t be shy about emailing Danielle many many times
• We finally decided that some outside, expert guidance was needed, so we decided to set up a key players meeting
Prep for Key Players Meeting

- We found a few options for dates on which everyone could attend.
- All committee members were asked to attend the meeting and bring a list of questions and contingencies they wanted guidance on.
• Danielle, Autumn, and Kai met with our dept director, physician champ, RN champ, codemaster, pharmacy purchaser, pharmacy director, and clinical coordinator.

• Started with a brief overview of the importance of implementing an IPLARC program and then quickly led to tackling our specific obstacles.

• Lindsay (codemaster) discussed her question regarding the “fee for service NPI” written in the HFS Informational Notice in toolkit.
  – Kai speaks coding and billing and was able to verify within minutes which code we are to use.
  – Once Lindsay knew exactly which code to use, she knew exactly what needed to be built and in which charting systems.
• Pharmacy was able to reverify that we can purchase and be reimbursed at full price of devices according to the fee schedule
  – Pharmacy and OB Dept directors agreed on whose budget they would be purchased with and how reimbursement would happen between departments
• At this point, the team didn’t have any looming obstacles left. Together we came up with some 30/60/90 day plans for things like staff education, purchasing, policies, and order sets and settled on a Go Live date of 12/15/18.
• Dept director responsible for submitting the order set and policies (which were very borrowed from the toolkit) and creating documentation windows
• Pharmacy responsible for ordering devices separately from outpatient devices, stocking in Omnicell with RN input
• Codemaster writing billing codes
• RN responsible for staff education (minus providers) and coordinating supplies
• Physician worked with residency head to schedule resident implant training in hospital and chose educational materials for providers
• We did change our go live date by two days to accommodate the residents’ Nexplanon training, which happened this morning.

• Billing/coding did become a bit of a hurdle again because we had a change in coding staff.
  – previous codemaster agreed when she left to continue to work some registry time with us until her projects were completed
  – New coding staff did have some confusion, but Lindsay was able to steer them in the right direction when needed
  – OB director made sure the project maintained a high priority status as well
• Charting sections have been built for both prenatal education in the clinic system and for device placement as inpatient
• Policies and order sets are live
• Devices and supplies are stocked and organized
• Provider and Nursing staff have completed education
Initial presentation/general education on IPLARC program by dept. director and RN at staff meeting.

Assessed for knowledge gaps, areas of concern from staff.

RN edu ppt created from AIMMC's/ILPQC and FPQC toolkits. Included areas of focus from NAH staff questions/knowledge deficits/changes to NAH practice and documentation.

Ppt submitted to appropriate IPLARC team members for evaluation/editing, uploaded and assigned to all L&D/MB/ICN RNs, LCs, and support staff education via Healthstream.

In-depth trained several day and night shift RNs and clinical coordinator to be IPLARC program resources to fellow RNs. (Expanded on powerpoint educational slides, ensured understanding of key program details, and sought/addressed further questions about program implementation.)

Evaluated questions and feedback from in-depth training.

Created reference display board at RN station based on in-depth training evaluation, focusing on RN’s role in IPP IUD and Nexplanon insertion, documentation, and supply checklists for devices, and a hard copy of the ppt.

Ppt to be added for all new hire education and IPLARC added to preceptor/orientee checklist.
THE IPLARC INITIATIVE

MALLORIE ALLEN, RN BSN
CARLE FOUNDATION HOSPITAL—URBANA, IL
PROJECT IMPLEMENTATION: WHERE WE ARE NOW

- Identified key players: OB provider champion, nurse champion, pharmacy, billing/coding, IT, ambulatory, lactation
- Bi-weekly scheduled team meetings → now monthly
- 30-60-90 Day Plan created → ongoing work plan
- Confirmed inventory and storage: Mirena, Paragard & Nexplanon
- Coding strategies identified & created for reimbursement (Confirmed with Medicaid, pending with private insurers)
- Examined current OB care process flow in ambulatory/acute settings & explored potential changes
- Education supplies ordered for providers & patients
# IPLARC INITIATIVE WORK PLAN

## IPLARC Initiative: Work Plan

<table>
<thead>
<tr>
<th>Status</th>
<th>Activity</th>
<th>Owner</th>
<th>Term</th>
<th>Deadline</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>Explore Insurance Options, Managed plans options, payer contracting</td>
<td>Alli</td>
<td>High</td>
<td>28-Sep</td>
<td>Medicaid to reimburse</td>
</tr>
<tr>
<td>Completed</td>
<td>Soft Coding Option?</td>
<td>Alli</td>
<td>High</td>
<td>28-Sep</td>
<td>Can self-code if placed in delivery note/procedure note for c/s. Will need to do separate procedure note with physician putting in charges for Neplanon</td>
</tr>
<tr>
<td>Completed</td>
<td>Inventory/Ordering</td>
<td>Katie</td>
<td>High</td>
<td>28-Sep</td>
<td>Pharmacy carries Neplanon &amp; Minora</td>
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<tr>
<td>Completed</td>
<td>Storage</td>
<td>Katie</td>
<td>High</td>
<td>28-Sep</td>
<td>Email from Katie - room in omniscell for Neplanon and Minora</td>
</tr>
<tr>
<td>Not Started</td>
<td>Create INR Report</td>
<td>Mallorie, Jenn</td>
<td>Medium</td>
<td>12-Oct</td>
<td>To take RedCap data form and create INR report to closely resemble RedCap</td>
</tr>
<tr>
<td>In Progress</td>
<td>Add &amp; order sets for IUD placement, STD &amp; C/S</td>
<td>Mary Ingram, Mallorie, Chantele</td>
<td>Medium</td>
<td>TBD</td>
<td></td>
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<tr>
<td>In Progress</td>
<td>Order set for Neplanon insertion</td>
<td>Mary Ingram, Mallorie, Chantele</td>
<td>Medium</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>Build screening question in admit process to ask about postpartum LARC</td>
<td>Mallorie</td>
<td>High</td>
<td>Completed 11/16</td>
<td></td>
</tr>
<tr>
<td>In Progress</td>
<td>Nursing Documentation Needs</td>
<td>Mallorie, Jenn McBride</td>
<td>High</td>
<td>23-Nov</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>Building SmartTest procedure notes for Mirena immediately PP &amp; Neplanon insertion during incident setting</td>
<td>Mallorie, V.J. Jenn McBride</td>
<td>High</td>
<td>12-Oct</td>
<td></td>
</tr>
<tr>
<td>Not Started</td>
<td>Attend Postpartum shift huddles to discuss Neplanon insertion</td>
<td>Mallorie</td>
<td>Medium</td>
<td>12-Dec</td>
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<tr>
<td>Completed</td>
<td>Invite unit educations to attend meeting for staff education needs</td>
<td>Mallorie</td>
<td>Low</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>Mail燎isie to present at New staff meeting</td>
<td>Mallorie</td>
<td>Medium</td>
<td></td>
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</tbody>
</table>

## Education

- Reach out to Lisa to find out what the timeline looks like.
November 8th: ILPQC visited CFH to meet with key players

- Thoughtful, productive discussion
  - Successes
  - Challenges
  - Innovative strategies to work towards project success

- Inventory added: Paragard

- Added key players: social work, RN from lactation, Healthy Beginnings
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Education</td>
<td>Mama-U x2 ordered</td>
</tr>
<tr>
<td>Comprehensive contraceptive counseling</td>
<td>Capability for RNs to provide counseling</td>
</tr>
<tr>
<td>Lidocaine shortage (Nexplanon insertion)</td>
<td>Ropivacaine .5%</td>
</tr>
<tr>
<td>Lactation buy in</td>
<td>To invite lactation RN/Paragard added to inventory</td>
</tr>
<tr>
<td>Instrument selection: Polyp v. curved ring forceps</td>
<td>Curved ring forceps → peel packs</td>
</tr>
<tr>
<td>Confirmation of reimbursement from private insurers</td>
<td>…</td>
</tr>
</tbody>
</table>
PROJECT IMPLEMENTATION: WHAT’S TO COME

- Order set implementation
- Screening process during admission
- Education for staff on IPLARC evidence, contraceptive counseling & IPLARC placement
- Activate a standardized process flow in the ambulatory/inpatient setting that incorporates IPLARC counseling, consent, placement, and follow up care
- Creating reports to track IPLARC placement & successes
- **Anticipated Go-Live Date: January 2, 2019**
PDSA CYCLE: INITIATING IPLARC AT CARLE

- **Test Duration:** Jan 2-Jan 31
- **Objective:** Introduce IPLARC to the inpatient setting
- **Plan:**
  - Test the process created in order to successfully provide IPLARC services to 2-3 pre-identified interested individuals
  - How will we know the process is successful? → Feedback from staff, providers, patients, and following up with billing for timely reimbursement
  - This change will impact all primary key drivers of IPLARC initiative
  - Prediction: All processes in place will equip providers & staff to successfully place, document, & bill postpartum LARC.
**Immediate Postpartum LARC Checklist**

**Nexplanon Insertion**
- Provider: Discuss options, risks, and benefits with patient
- Obtain signed consent
- Remove Nexplanon & Ropivacaine from Omnicell
- Gather Nexplanon supply kit from supply room
- Time Out
- Scan Nexplanon & Ropivacaine into patient MAR
- Provider: To write procedure note, document that counseling was provided & bill in Inpatient Navigator
- RN: To document Time Out in Pre-Procedural Checklist flowsheet & Epic Implants

**IUD Insertion**
- Provider: Discuss options, risks, and benefits with patient
- Obtain signed consent
- Remove IUD from Omnicell
- Optional: Remove rapid-acting pain medication for non-epiduralized patients per provider order
- Time Out—to document in Pre-Procedural Checklist flowsheet
- Scan IUD into patient MAR
- RN Documentation: Add Device in Inpatient Navigator for C/S, & Implant section for SVD
- Provider: Include phrase in Delivery Note to automatically drop charge

**Nexplanon Insertion Supply Kit**
- Marking Pen
- Paper ruler
- Sterile gloves
- Betadine swabs
- Sterile 4x4 gauze
- 20g injection needle (3-4cm in length) & a 3ml syringe
- Steri-strips
- Self-adherent stretch gauze (Coban)
CONCLUSION

- Carle Foundation Hospital serves a large region. Within this region is a significant obstetric patient population. Much of the patient population we serve are at risk for unintended pregnancies & short interval pregnancies. By providing immediate postpartum long-acting contraception, we hope that this service will help prevent adverse outcomes for the mother.
KEY PLAYERS MEETINGS
Key Players Meeting

- Invitations for this **FREE CONSULTATION** went out on August 30
  - If you did not receive this email, please notify Danielle Young
  - Goal is to schedule all KP meetings before 2019, email Danielle to schedule

- Key Players Meeting at your hospital - we will come to you!
  - We want to **help you succeed** by:
    - **Partnering with you** to arrange your Key Players meeting.
    - **Assist you** with who to invite at each hospital for most effective meeting with representative from ILPQC
    - **Provide you with a expert clinician** from the IPLARC speakers bureau to partner with you to problem solve, overcome barriers and move implementation forward.
    - **Learn your experiences**, for problem solving solutions to share with other teams

- **Key Players Assessment Survey**
  - All teams fill out key players assessment survey
  - Goal is provide helpful information for personalized consultation and tailored Key Players meeting to help your team meet the GO LIVE March 2019 goal
  - If unable to host a Key Players meeting in person, ILPQC will schedule a **FREE CONSULTATION CALL** to review survey data, progress and problem solve.
Thanks to Teams who have Completed a Key Players Meeting!

• 7 teams have complete a Key Players Meeting!
• We’ve enjoyed meeting with teams from all across the state – Chicago, Waukegan, Urbana and Carbondale!
• We look forward to meeting with the remaining Wave 1 teams to learn from each other!
## Key Players Meetings Status

<table>
<thead>
<tr>
<th>Key Players Meeting Completed</th>
<th>Key Players Meeting Scheduled</th>
<th>Working on it...still to be scheduled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norwegian American Hospital</td>
<td>University of Chicago</td>
<td>Memorial Medical Center</td>
</tr>
<tr>
<td>Carle Foundation Hospital</td>
<td>Advocate Lutheran General</td>
<td>Rush Copley</td>
</tr>
<tr>
<td>Swedish Covenant Hospital</td>
<td></td>
<td>NorthShore University HealthSystem Evanston Hospital</td>
</tr>
<tr>
<td>Northwestern Memorial</td>
<td>Advocate Christ Medical Center</td>
<td></td>
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<tr>
<td>Advocate Illinois Masonic Medical Center</td>
<td></td>
<td>UI Health</td>
</tr>
<tr>
<td>Vista Medical Center</td>
<td></td>
<td>Stroger</td>
</tr>
<tr>
<td>Memorial Hospital of Carbondale</td>
<td></td>
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</tr>
</tbody>
</table>

Key Players Meetings aim to:
1. Support your hospital team in overcoming challenges
2. Create a space for ILPQC to learn from teams to provide needed support
NEXT STEPS
Upcoming IPLARC Teams Calls & Training Opportunities

- January 21, 2019 – Canceled due to MLK Holiday
- February 2019 – All IPLARC Wave 1 Round Robin with Go Live updates and troubleshooting remaining challenges
- March 2019
- April 2019 – Sustainability & Wave 2 Launch Call
- Stay tuned for another ACOG/ILPQC IPLARC Hands-On training opportunity in early 2019!
Next Steps

• Develop 30-60-90 Day plan for Go Live Goal (March 2019)
• Complete REDCap data submission for November (and October if you have not yet submitted)
• Confirm dates for Key Players Meetings in January with Danielle and confirm your GO LIVE date plan.
• Continue monthly team meetings and review data reports with your team!
• Contact us if you need help troubleshooting a challenge to achieving your GO LIVE date!
Contact

• Email info@ilpqc.org
• Visit us at www.ilpqc.org