Severe Maternal Hypertension OB Teams Call

May 6, 2019
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.
Overview

- Review of Sustainability One Year In
- Review of Hypertension Sustainability Data
- Team Talks – Hypertension Sustainability
  - Northwestern Medicine Central DuPage
  - Northwest Community Healthcare
- Round Robin
- Upcoming Events
REVIEW OF SUSTAINABILITY
ONE YEAR IN
Review and Update your Sustainability Plan

1. Compliance Monitoring
2. New Hire Education
3. Ongoing Staff/Provider Education

Sustainability Plan
Review and Update your Sustainability Plan

- Review your current plan
- Review your compliance data
- Discuss what’s working and where there are opportunities to improve
- Revise your plan
- Share your plan

### Compliance Monitoring of key process measures:
1. Time to treatment for severe HTN < 60 minutes
2. Magnesium provided
3. Early follow-up for BP check within 7-10 days
4. Patient discharge education
5. Demographic and basic descriptive information including BP

**How will measures be collected?**

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**Will you continue to track additional data internally?**  
- Yes  
- No

**Team member(s) in charge of reporting in REDCap:**

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**How often will your QI team meet to review hospital data reports via REDCap and develop and implement PDSA cycles if compliance on measures starts to slip?**

- Weekly  
- Monthly  
- Quarterly  
- Other

**New Hire Education** for all new hires

**What education tool(s) will you use for new hires?**

- AIM e-modules / webcast  
- ILPQC Grand Rounds Slide Set  
- ILPQC Severe Maternal HTN Toolkit Binder  
- Other: ____________________________

**How will you incorporate Severe Maternal Hypertension education and hospital identification, treatment, and discharge workflows and protocols into hospital new hire education?**

---

**Ongoing Education** for all providers and nurses

**What education tool(s) will you use for ongoing education for all nurses and providers?**

- Drills  
- Simulations  
- Laminated protocols  
- Algorithms  
- Active debrief  
- AIM e-modules / webcast  
- Other: ____________________________

**How will you incorporate Severe Maternal Hypertension education and hospital identification, treatment, and discharge workflows and protocols into ongoing education?**

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Hypertensive Emergency Checklist

Hypertensive Emergency:
- Two severe BP values (≥160/110) taken 15-60 minutes apart. Values do not need to be consecutive.
- May treat within 15 minutes if clinically indicated.

- Call for Assistance
- Designate:
  - Team leader
  - Checklist reader/recorder
  - Primary RN
- Ensure side rails up
- Ensure medications appropriate given patient history
  - Administer seizure prophylaxis (magnesium sulfate first line agent, unless contraindicated)
- Antihypertensive therapy within 1 hour for persistent severe range BP
- Place IV; Draw preeclampsia labs
- Antenatal corticosteroids (if ≤34 weeks of gestation)
- Re-address VTE prophylaxis requirement
- Place indwelling urinary catheter
- Brain imaging if unemitting headache or neurological symptoms
- Debrief patient, family, and obstetric team

Magnesium Sulfate
- Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure
- IV access:
  - Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min
  - Label magnesium sulfate; Connect to labeled infusion pump
  - Magnesium sulfate maintenance 1-2 grams/hour
- No IV access:
  - 10 grams of 50% solution IM (5 g in each buttlock)

Antihypertensive Medications
- For SBP ≥ 160 or DBP ≥ 110 (See SMi algorithms for complete management when necessary to move to another agent after 2 doses.)
  - Labetalol (initial dose: 20mg):
    - Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure; use with caution with history of asthma
- Hydralazine (5-10 mg IV* over 2 min):
- May increase risk of maternal hypotension
  - Oral Nifedipine (10 mg capsules):
    - Capsules should be administered orally, not punctured or otherwise administered sublingually
  - Maximum cumulative IV-administered doses should not exceed 220 mg labetalol or 25 mg hydralazine in 24 hours

Note: If first line agents unsuccessful, emergency consult with specialist (MFM, internal medicine, OB anesthesiology, critical care) is recommended

Anticonvulsant Medications
- For recurrent seizures or when magnesium sulfate contraindicated
  - Lorzepam (Ativan): 2-4 mg IV x 1, may repeat once after 10-15 min
  - Diazepam (Valium): 5-10 mg IV q 5-10 min to maximum dose 30 mg

Eclampsia Checklist

Magnesium Sulfate
- Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure
- IV access:
  - Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min
  - Label magnesium sulfate; Connect to labeled infusion pump
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Postpartum Preeclampsia Checklist

Magnesium Sulfate
- Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure
- IV access:
  - Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min
  - Label magnesium sulfate; Connect to labeled infusion pump
  - Magnesium sulfate maintenance 1-2 grams/hour
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EMERGENCY DEPARTMENT

Postpartum Preeclampsia Checklist

If Patient > 6 Weeks Postpartum without:
- BP ≥ 140/100
- BP ≥ 140/100 with unwell appearing baby, visual disturbances, epigastric pain
- Call for Assistance
  - Team leader
  - Checklist reader/recorder
  - Primary RN
- Ensure side rails up
- Call obstetric consult; document call
  - Place IV; Draw intrapartum labs
  - CBC
  - Chemistry panel
  - LFT
  - PT/INR
  - Fibrinogen
  - Type and screen
  - Cross medications appropriate given patient's history

Preeclampsia seizure prophylaxis:
- Administer anticonvulsant therapy
  - Contact MFM or Critical Care for refractory/bleeding pressure
  - Consider inducing labor to deliver baby

Brain imaging is not contraindicated headache or neurological symptoms

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REVISED JULY 2017
Magnesium Therapy

- Magnesium sulfate therapy for seizure prophylaxis (DOES NOT TREAT HTN) should be administered to any patients with:
  - Preeclampsia with “severe features” i.e., subjective neurological symptoms (headache or blurry vision), abdominal pain, epigastric pain, OR BP > 160/110.
    - Do not need to wait for +protein or wait 6 hours for confirmation, if new onset severe HTN start Mag
  - New onset severe HTN
    - treat BP and start Magnesium for seizure prevention
  - Eclampsia
  - Should be considered in patients with preeclampsia without severe features
DATA REVIEW – CELEBRATING STATEWIDE SUSTAINABILITY SUCCESS
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Maternal Hypertension Data: Time to Treatment

ILPQC: Maternal Hypertension Initiative
Percent of Cases with New Onset Severe Hypertension Treated in <30, 30-60, ≥60 minutes or Not Treated
All Hospitals, 2016-2019

Wow!
Between 2015-Q4 and 2017-Q4, the SMM rate among women experiencing hypertension at delivery was cut in half.
Maternal Hypertension Data: Time to Treatment

ILPQC: Maternal Hypertension Initiative
Percent of Women with New Onset Severe Hypertension Treated Within 60 Minutes and Proportion of Hospitals in Collaborative Treating Women Within 60 Minutes
All Hospitals, 2016-2019
Maternal Hypertension Data: Patient Education

ILPQC: Maternal Hypertension Initiative
Percent of Women with New Onset Severe Hypertension Who Received Discharge Education Materials and Proportion of Hospitals in Collaborative Giving Discharge Education to Women
All Hospitals, 2016-2019

- Proportion of Hospitals with 80% of women who received discharge materials
- Proportion of Hospitals with 0-79% of women who received discharge materials
- Percent overall women in collaborative who received discharge materials
Maternal Hypertension Data: Patient Follow-up

ILPQC: Maternal Hypertension Initiative
Percent of Women with New Onset Severe Hypertension Where Follow-up Appointments were Scheduled within 10 Days and Proportion of Hospitals in Collaborative Where Follow-Up Appointments were Scheduled within 10 Days All Hospitals, 2016-2019

- Green bar: Proportion of hospitals with 80-100% of women with follow up
- Orange bar: Proportion of hospitals with 0-79% of women with follow up
- Blue line: Percent overall women in collaborative with follow up
Maternal Hypertension Data: Magnesium Sulfate Administration

ILPQC: Maternal Hypertension Initiative
Percent of Cases with New Onset Severe Hypertension with Magnesium Sulfate Administered
All Hospitals, 2016-2019

Chart showing the percent of cases with new onset severe hypertension with magnesium sulfate administered across different months from July 16 to Mar 19. The data shows the proportion of cases with 0-79% of cases with Mg administered, the proportion of hospitals with 80-100% of cases with Mg administered, and the overall percentage of cases with Mg administered.
Maternal Hypertension Initiative
Northwestern Medicine Central DuPage Hospital

Presented to: MAPS PSO-ILPQC Perinatal Safety Round Table
Presented on: April 16, 2019
Presented by: Margaret Colliander MSN, RNC-OB
Overview

Northwestern Medicine Central DuPage Hospital

- Community, non-academic hospital
- Level III perinatal hospital
- Hospital: 392 beds
- Labor: 19 beds
  - 11 LDR
  - 5 Antepartum
  - 3 triage
- Mother Baby: 37 beds
  - 5 Antepartum
  - 32 Postpartum

Winfield, IL (Chicago suburb)
How Did We Get There?

Initial Successes

• Report pulled from EMR based on vital signs (SBP ≥160 and/or DBP ≥110)
• Staff education (presentations, newsletters, rounding, laminated reference sheets)
• Labetalol syringes (20mg)
  – Staff satisfier for easier and safer administration
• Multidisciplinary team
• Preeclampsia patient education standard on all pregnant/postpartum discharges
How Did We Get There?

Initial Barriers

• Low perception of risk to the patient with severe range hypertension with no other subjective symptoms
  – Explained away the severe range hypertension (i.e. anxious)
  – Staff did not notify the provider or escalate concerns
  – Providers did not order IV antihypertension
    • Did not treat
    • Treated with oral antihypertensive

• Lack of awareness of the severity of severe range hypertension
  – Staff did not recheck the severe range hypertension
Case Example – Maternal Adverse Outcome

- 39 year old, admitted for preeclampsia observation at 33 weeks gestation
- 0600 – met severe range hypertension requiring treatment
- RN contacted the OB, no order to treat per policy
- Post shift change new OB rounded and did not treat again per policy (still sustained severe range hypertension)
- MFM rounded and ordered IV antihypertension
  - Sustained severe range hypertension for 3 hours
- Patient’s condition deteriorated: back pain, headache, suspected placental abruption at this time
- Started Magnesium Sulfate and induction of labor
- Unsuccessful labor and delivery via cesarean at 1446 the same day
- Apgars 1/1/3/5/7 and required resuscitation
Event Response

Overcoming Barriers

- Reinforced education
- Developed escalation algorithm
- Case studies and practice using escalation algorithm/chain of command
- Timely follow-up for missed cases
  - RNs met with Clinical Director to review policy and expectations
  - 2nd occurrence results in coaching
  - Physicians sent to Peer Review
- Patient Family Advisor presented to staff on her previous experience with Preeclampsia
Escalation Algorithm

Severe range Hypertension (HTN) confirmed
Staff Nurse Contacts:

Primary Obstetric (OB) Physician On-Call

UNRESOLVED
MD does not follow HTN protocol
RN communicates obligation to contact Maternal-Fetal Medicine physician on-call.

RESOLVED
MD orders IV Labetalol, IV Hydralazine or oral Nifedipine IR (if no IV access) per HTN protocol

Staff Nurse Notifies Charge Nurse and Contacts:

MFM Physician On-Call
MFM decides further course of action

Charge Nurse Contacts:

Clinical Director - Update on situation

MFM Physician On-call Contacts:

Primary OB Physician On-Call – Update on situation

1. A NETS report is submitted when MFM is contacted
2. MFM will give orders for subsequent anti-hypertensive medications during this episode of severe range hypertension
3. Staff nurse will enter MFM Consult order, if not already in place

Northwestern Medicine
Continued Management

- Data report reviewed weekly
- Prompt follow-up by leadership if missed opportunity
- Quarterly meeting of the hypertension group
- Remains on quality dashboard
Lessons Learned

• Benefit of actual case examples
• Timely and complete data for prompt feedback and change
• High level support for implementing system change
• Escalation algorithms/chain of command helps to empower staff
• Bedside/nurses station resources for quick staff referral
Quick References

**Nursing Assessment**

**New Onset Hypertension**

- **Patient Status**
  - Antepartum
  - Intrapartum
  - Postpartum

- **Vital Sign Frequency**
  - Blood Pressure, Heart Rate, Respirations, O2 saturation

- **Preeclampsia Assessment**
  - Long Sounds, Level of Consciousness, Edema, Headache, Visual Disturbances, Epigastric Pain, DVTs, Clonus

- **Intake & Output**
  - Routine Care

- **Weight**
  - Routine Care

**Preeclampsia WITHOUT SEVERE Features or Chronic HTN**

- **Patient Status**
  - Antepartum
  - Intrapartum
  - Postpartum

- **Vital Sign Frequency**
  - Every 15 minutes x 1 hour. If hypertension persists, notify MD. Then monitor every 4 hours while hypertensive.

- **Preeclampsia WITHOUT SEVERE Features or Chronic HTN**
  - Every 4 hours

- **Intake & Output**
  - Every 4 hours if IV fluid and/or Foley Catheter in place

**Preeclampsia WITH SEVERE Features**

- **Patient Status**
  - Antepartum
  - Intrapartum
  - Postpartum

- **Vital Sign Frequency**
  - Every 1 hour

- **Preeclampsia WITH SEVERE Features**
  - Every 4 hours

- **Intake & Output**
  - Every 4 hours if IV fluid and/or Foley Catheter in place

- **Weight**
  - Daily

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**Severe Hypertension Bedside Checklist (for Staff Nurses)**

**Assess**

1. SBP ≥ 160 mmHg or DBP ≥ 110 mmHg*
2. Repeat BP no sooner or later than 15 minutes after the first reading (taking the BP more often is not beneficial)
3. SBP ≥ 160 mmHg or DBP ≥ 110 mmHg?
4. SBP ≥ 160 mmHg or DBP ≥ 120 mmHg for 15 minutes?

**Act**

- Assess blood pressure and pulse
- Monitor for signs and symptoms of preeclampsia
- Obtain blood pressure and heart rate every 15 minutes
- Counsel patient about the risk of severe hypertensive disorder
- Notify labor and delivery
- Notify obstetrician/gynecologist
- Notify critical care
- Notify intensive care unit
- Notify transport
- Notify pharmacy
- Instruct patient to avoid all activity
- Administer magnesium sulfate
- Administer antihypertensive medication
- Provide suction as needed
- Monitor and record vital signs
- Monitor and record intake and output
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- Monitor and record respiratory rate
- Monitor and record temperature
Questions?

Contact Information: Maggie Colliander
Margaret.Colliander@nm.org 630-933-2325
Thank You
Northwest Community Healthcare

- 489 bed hospital with main campus in Arlington Heights, Illinois. Non-profit independent facility with additional outpatient sites and immediate care centers.
- Level III Perinatal services
- 2494 births in 2018
- 325 NICU admissions in 2018
- 16 bed single room NICU with 8 designated level III beds
- 12 bed Labor and Delivery unit with 3 OR suites
- 9 bed Antepartum/Triage
- 34 bed OB postpartum/gyne
Treatment Data

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Treatment in less than 60 minutes
Incorporating the OB RRT into first line treatment for severe HTN

Brief Summary of Procedure
Northwest Community Healthcare, including all of its subsidiaries and entities (NCH), has established the following procedure for the OB Rapid Response Team (RRT) to provide urgent medical assistance and intervention for the obstetrical patient experiencing an acute obstetrical problem.

Our Mission
We exist to improve the health of the communities we serve and to meet individuals' healthcare needs.

Our Vision
Northwest Community Healthcare will be an Integrated System of Care that delivers innovative, exceptional and coordinated care while creating value for the communities and populations we serve.

Procedure
A. Purpose
1. To outline the OB RRT role and responsibility in providing urgent medical assistance and intervention for the obstetrical patient experiencing an acute obstetrical problem.

B. Expected Outcome
1. The patient will experience stabilization of her clinical status.

C. General Protocol Information
1. The OB Rapid Response Team (OB RRT) should be called in the following situations:
   a. Clinical instability (i.e., hypotension, respiratory distress, acute change in mental status).
      i. Acute change in heart rate < 40 or > 130.
   b. Acute change in systolic BP to < 90 mmHg.
   c. Severe range BP: systolic ≥ 160 and/or diastolic ≥ 110 that persists for at least 15 minutes. (see appendix A)
   d. Acute change in respiratory rate to < 8 or > 30.
   e. SI/S of NEW onset stroke.

3. First Responders:
   a. The first responders for the Mother Baby Unit (MBU) are the OB/GYN Hospitalist or attending physician if immediately available, and a Labor & Delivery (L&D) Qualified L&D nurse.
   b. The first responders for the L&D Unit are the OB/GYN Hospitalist and the anesthesiologist along with an additional qualified L&D nurse.
   c. Additional support may be provided by the NCH Rapid Response Team.
   d. The Intensivist is immediately available to the OB RRT via the NCH RRT Team.

4. The Attending Physician will be paged as soon as safely possible when the OB RRT is activated.

5. The OB RRT procedure does not replace the Code Blue procedure, as it is not intended for patients in or impending a cardiac and/or respiratory arrest.
   a. Call Code Blue in the event of cardiac or respiratory arrest and any other sudden medical emergency.
ROUND ROBIN
Discussion

• Please share your team’s biggest success or challenge that you have overcome in sustainability in one of the following areas:
  – Compliance Monitoring
  – Magnesium sulfate administration
  – New hire/ongoing provider/staff education

• Discussion questions for each area follow
Compliance Monitoring Discussion Questions

• How often are you reviewing your compliance data in the ILPQC Data and Reporting System? Has the frequency changed since the start of sustainability? If so, how has this affected your data?

• How is compliance data shared with other team members? With hospital administration? Has this changed since the start of sustainability?

• Is your team facing new challenges to data entry now that we are in sustainability year 2?

• Have you conducted any PDSA cycles during sustainability for data slipping below the goal? What did you learn?
Magnesium Sulfate Discussion Questions

• Have you reviewed your hospital’s magnesium sulfate administration data in the ILPQC Data and Reporting System?
• What provider and nurse education is needed to increase the number of patients with sustained severe hypertension receiving magnesium sulfate?
• What changes can you make to your orders sets, protocols, and policies/procedures to increase the number of patients with sustained severe hypertension receiving magnesium sulfate?
• How will you incorporate monitoring of your magnesium sulfate administration in the ILPQC Data and Reporting System into your team’s routine ILPQC data monitoring?
New Hire/Ongoing Education Discussion Questions

• Have you made any changes to new hire education since the start of the sustainability period?
• What has been successful in maintaining new hire education in sustainability?
• How have you incorporated Grand Rounds or the AIM e-modules into ongoing provider staff education?
• What steps have you taken to incorporate education on Severe Maternal HTN into ongoing nursing and physician education?
NEW ILPQC OPPORTUNITIES –
(1) IPLARC WAVE 2
(2) IMPROVING POSTPARTUM ACCESS TO CARE (IPAC)
IPLARC Wave 2:

CALLING ALL HOSPITALS!

We want YOUR HOSPITAL to join Wave 2 of ILPQC’s Immediate Postpartum LARC Initiative!

- Receive a IPLARC Wave 1 hospital mentor to provide guidance as your hospital implements IPLARC
- Access to IPLARC rapid-access DASHBOARDS, resources, support
- Learn about hot topics on monthly collaborative webinars, including billing & coding, stocking, provider education etc.
Redefining Postpartum Care

ACOG Committee Opinion #736:

- To **optimize** the health of women and infants, postpartum care should **become an ongoing process**, rather than a single encounter

- **All women** should ideally have contact with maternal care provider **within the first 3 weeks postpartum**
  - Blood pressure checks
  - Breastfeeding support
  - Mental health well-being
  - Contraception

- Initial assessment should be followed up with **ongoing care as needed**

- Conclude with a **comprehensive** postpartum visit **NO LATER than 12 after birth**
Aim: Within 11 months of initiative start, ≥80% of participating hospitals will be documenting and offering a universal two-week early postpartum visit to optimize the health of women by increasing access to early postpartum care within the first two weeks postpartum to facilitate follow-up as an ongoing process, rather than a single 6-week encounter and provide an opportunity for a maternal safety check and link women to appropriate services.

Key Goals:
- Increase % of women with a postpartum encounter scheduled with an OB provider within the first two weeks after delivery
- Increase % of women receiving postpartum education prior to discharge after delivery regarding
- Increase % of providers / staff receiving education on optimizing early postpartum care
- Achieve GO LIVE goal to provide IPAC for ≥80% participating hospitals by May 2020
• **Improving Postpartum Access to Care (IPAC).** This initiative will assist with implementing the new ACOG recommendation for universal early postpartum visits by two weeks postpartum, in addition to the standard six week postpartum visit, to improve maternal health and safety checks and link women to needed care and services earlier in the postpartum period.

• **Opportunity to work to implement this new ACOG standard of practice with support from ILPQC!**

• Learn from national and state experts and other teams on monthly teams calls on the **3rd Monday of the month, 11-12pm**

• **Billing guidance** and one-on-one QI support provided

• **Monthly data collection, brief and essential to drive quality improvement/implementation progress**

• The IPAC launch call will be held on Monday, May 20, 2019, 12:00 pm – 1pm

+1-312-535-8110 | Access code: 807 719 991 | [Access the webinar here](#)
Timeline for IPAC

- Initiative Development and Pilot with St. Anthony Hospital: April – December 2018
- Recruitment for IPAC Teams: Winter/Spring 2019
- IPAC Kick-Off Call: May 20, 2019
- Wave 2 Launch Face-to-Face Meeting: May 29, 2019
- Monthly Team Webinars / Active QI Period: 2019-2020
UPCOMING EVENTS
Happy National Nurses Day!

A heartfelt THANKS for all you do!
You’re Invited!

2019 OB & Neonatal Face-to-Face Meetings

Nurses, Providers, & Staff join us for an interactive day of collaborative learning for current ILPQC initiatives!

OB Teams: May 29, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - OB (MNO-OB)
Immediate Postpartum LARC (IPLARC)
Improving Postpartum Access to Care (IPAC)

Neonatal Teams: May 30, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - Neonatal (MNO-Neonatal)

Register now! https://ilpqc.eventbrite.com

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. (08N-001-91)

Abraham Lincoln DoubleTree Hotel, Springfield, IL

Illinois Perinatal Quality Collaborative
633 N. St. Clair, 20th Floor
Chicago, IL 60611
Immediate Postpartum LARC Training Workshop

Interested in learning next steps for providing immediate postpartum LARC at your hospital? Want to gain hands on experience with immediate postpartum IUD insertion?

Become part of the Illinois community working to increase access to highly effective contraception!

**Thursday, May 30, 2019**
(Following the OB Face-to-Face Meeting)
Abraham Lincoln DoubleTree Hotel, Springfield, IL

**Monday, July 29, 2019**
Prentice Women’s Hospital, Northwestern University, Chicago, IL

8:00am-10:00am - Provider training
10:00am-10:30am - Implementation and Resources (ILPQC IPLARC Toolkit)
10:30am-12:00pm - Nursing training

$25 registration fee | Refreshments will be provided

Upon completion of the training, participants will be able to:
- Understand the impact of unintended pregnancy in the postpartum period
- Summarize existing data on the efficacy and safety of IPLARC
- Understand and practice immediate postpartum IUD insertion techniques
- Understand the importance of shared decision-making for contraceptive counseling

This activity has been approved for AMA PRA Category 1 Credit™

**Registration now open!**
https://ilpqc.eventbrite.com

Training presented by the ACOG Postpartum Contraceptive Access Initiative

All providers and staff not yet trained are invited!
2019 ACOG/ASAM Buprenorphine Trainings
(Registration Information Coming Soon)

• Monday, June 24th, 2019
  8:00am – 12:30pm
  Lurie Children’s Hospital, Chicago, IL

• Friday, September 20th, 2019
  8:00am – 12:30pm
  HSHS St. John’s Hospital, Springfield, IL

• Friday, December 13th, 2019
  8:00am – 12:30pm
  Carle at the Fields, Champaign, IL