IPLARC Wave 2: IT/EMR and Engaging Outpatient Prenatal Providers

December 16, 2019
12:00 – 1:00 PM
Introductions

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  • Role
  • Institution
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  - Global call-in numbers:
    - Can't join the meeting?
Call Overview

• IPLARC Wave 2 Updates
• IT/EMR and Engaging Outpatient Clinics
  – Jill Edwardson, MD, MPH, Johns Hopkins Medicine
  – Overview of IT/EMR and Outpatient Provider Engagement resources from ILPQC
• Team Talk: NM Central DuPage Hospital
• Round Robin
• Upcoming events
WAVE 2 UPDATES
IPLARC Initiative Goals

- Increase access to IPLARC
- Educate Patients on contraceptive options
- Educate Providers on counseling and placement
- Simplify IPLARC Billing
- Implement IPLARC Protocol
- Stock LARC in Pharmacy
- Systems Changes to OB Care Process Flow
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:**
- Within 9 months of initiative launch, ≥75% of participating hospitals will be providing immediate postpartum LARCs.

**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 work 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.
Key Players Meeting

• **FREE CONSULTATION** with every team
  – We come to your hospital
  – Goal is to schedule all KP meetings before 2020
  – Initial email invitations went out to teams on July 30!
  – 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.
  • **Hands-on nurse/provider training**
## IPLARC Wave 2 Key Players Meetings

<table>
<thead>
<tr>
<th>Team</th>
<th>Date</th>
<th>Team</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>Abraham Lincoln</td>
<td>8/19/19</td>
<td>NM Central DuPage</td>
<td>2/13/20</td>
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<tr>
<td>Advocate Sherman</td>
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<td>Passavant</td>
<td>8/26/19</td>
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<td>Rush-Copley</td>
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<td>Barnes Jewish</td>
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<td>Rush University</td>
<td>8/29/19</td>
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<td>FHN Memorial</td>
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<td>Gibson Area Hospital</td>
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<td>Touchette Regional Hospital</td>
<td>1/15/20</td>
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<td>Mt. Sinai</td>
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<td>West Suburban</td>
<td>11/14/19</td>
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<td>Mt. Sinai</td>
<td></td>
<td>West Suburban</td>
<td>11/14/19</td>
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</tbody>
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DATA REVIEW
Don’t Forget to Submit Your Team’s Data!

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Teams Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2019</td>
<td>11</td>
</tr>
<tr>
<td>May 2019</td>
<td>11</td>
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<tr>
<td>June 2019</td>
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<td>July 2019</td>
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<td>August 2019</td>
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<td>September 2019</td>
<td>11</td>
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<tr>
<td>October 2019</td>
<td>5</td>
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<tr>
<td>November 2019</td>
<td>0</td>
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</tbody>
</table>

Don’t forget to submit October-November data!
Teams Live with IPLARC (of 11 teams reporting)

Proportion of Wave 2 Teams that are Routinely Counseling, Offering, and Providing Immediate Postpartum LARC (either IUD or Implant), April-October 2019
IPLARC on Inpatient Formulary

Percent of Wave 2 Hospitals with IUDs on Inpatient Formulary, April 2019-October 2019

- IUDs on Formulary Have not started
- IUDs on Formulary Working on it
- IUDs on Formulary In place

Percent of Wave 2 Hospitals with Implants on Inpatient Formulary, April 2019-October 2019

- Implants on Formulary Have not started
- Implants on Formulary Working on it
- Implants on Formulary In place

5 teams reporting for Oct-19
IPLARC Protocols in Place

Percent of Wave 2 Hospitals with Immediate Postpartum Protocols and Process Flows in Place for IUDs, April 2019-October 2019

- IUDs Protocol Have not started
- IUDs Protocol Working on it
- IUDs Protocol In place

Percent of Wave 2 Hospitals with Immediate Postpartum Protocols and Process Flows in Place for Implants, April 2019-October 2019

- Implants Protocol Have not started
- Implants Protocol Working on it
- Implants Protocol In place

5 teams reporting for Oct-19
IPLARC Billing Codes

Percent of Hospitals with Billing Codes for IUDs In Place, April 2019 - October 2019


Percent of Hospitals with Billing Codes for Implants In Place, April 2019 - October 2019


5 teams reporting for Oct-19
IPLARC Standardized Patient Education at Prenatal Sites

Percent of Hospitals that have Provided Standardized Education Materials and Counseling Protocols to Affiliated Prenatal Care Sites, April - October 2019

- Patient education materials No
- Patient education materials Yes, one or more
- Patient education materials Yes, all

5 teams reporting for Oct-19
IPLARC Inpatient Patient Education & Counseling Protocols

Percent of Hospitals with Standardized Education Materials and Counseling Protocols during Delivery Admission, April 2019-October 2019

- **Patient education materials No**
- **Patient education materials Developed but not yet implemented**
- **Patient education materials Developed and implemented**

5 teams reporting for Oct-19
Comprehensive Contraceptive Counseling

Percent of Wave 1 & Wave 2 Hospital Charts with Contraceptive Counseling, including IPLARC, April 2018-October 2019

Wave 2 teams start reporting
JILL EDWARDSON, MD, MPH
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 outpatient and inpatient that a patient desires IPP 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
IP LARC: Starts in the outpatient clinic

- Contraceptive counseling should follow a shared decision-making model
- Many women resume sexual activity before their postpartum checkup
- IP LARC 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 IPP-LARC

• 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
### Patient Addressograph

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Birth Date:</th>
<th>ID No.:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Allergy:</td>
<td>Latex Allergy: Yes</td>
<td>Postpartum Contraception Method:</td>
<td>Counseled About LARC?: Yes</td>
</tr>
<tr>
<td>Is Blood Transfusion Acceptable?: Yes</td>
<td>Antepartum Anesthesia Consult Planned: Yes</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Problems</th>
<th>Plans</th>
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<tbody>
<tr>
<td>1.</td>
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<td>4.</td>
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<td>5.</td>
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### 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>
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#### Third Trimester

**Birth Preferences**

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<th>Follow-Up Needed</th>
<th>Referral</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Pain Management Plans</td>
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<tr>
<td>Trial Of Labor After Cesarean Counseling</td>
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<tr>
<td>Labor Support Person(S)</td>
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<tr>
<td>Immediate Postpartum Larc</td>
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<tr>
<td>Circumcision Preference</td>
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<td>Infant Feeding Intention</td>
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<tr>
<td>Anticipatory Guidance</td>
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- Implanted: Yes  
- LNG-IUS: No  
- Copper IUD: No
Problem list documentation of planned PP contraception
Other ICD-10 codes

• Z30.9 – Counseling for birth control regarding intrauterine device (IUD) – Contraceptive management

• Z30.017 – Evaluation for contraceptive implant
Immediate PP
LARC counseling 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, as well as increased risks of expulsion (10-27%) and importance of postpartum string check.”
Inpatient considerations

- Order the device (and necessary supplies)
- Documenting the procedure
  - Implant: Document separately
  - IUD: Document in delivery note
- Add to problem list
- Document in the discharge summary
- Document patient instructions
Implant documentation at JHM

• Outpatient:
  1. Place an order for implant insertion
  2. Document under the order in the procedures tab

• Inpatient: Write a note of “procedure” type
Inpatient implant documentation
IPP IUD: Vaginal delivery summary dot phrase

...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 strings were trimmed at the level of the cervix.”} The perineum, vagina, and cervix were examined and *** lacerations were noted...
Documentation in delivery note

12/3/2016 Delivery Note McNaught, Meghan, MD

Episiotomy, repair: None
Perineal laceration, repair: None
Perineal laceration, repair: None
Anal laceration, repair: None
Bulbul laceration, repair: Left
Vaginal laceration, repair: No
Cervical laceration, repair: No
Inspection completed: Vaginal

Specimens: None
Complications: None
Condition: Stable
Repair Comments: Left sulcal tear, deep with evidence of presacral fat. Repaired in three layers with good hemostasis.

Delivery Comments: 25 y.o. P. D at 38wks who presented for induction of labor for gestational HTN. The initial exam was 1:30-2. Patient was GBS positive. An epiplord was placed for pain control. For her induction she received a Foley bulb, misoprostol, and IV placin. An amniocentesis 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 1 immediately placed on mother's chest for skin to skin. Delayed cord clamping was performed for 60 seconds. The Apgar's were 9 and 5 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

...small 3x3x3mm area was absent but removed on subsequent manual extraction. US was performed afterwards and thin stripe was visualized. Uterine fundus was subsequently firm. Mirena IUD was placed under ultrasound guidance. Lot#: TU021AE Exp: 04/2021

Sulcal laceration was noted. It was repaired in three layers with 2-0 Vicryl with good hemostasis. 400 IU L. K패 100. The patient was taken out of the lithotomy position and left in stable condition in the care of nursing staff.
Delivery summary: Procedures
Documentation on problem list

- Z97.5
  - IUD in place
  - Presence of subdermal contraceptive implant
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


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
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 palpat ing 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.

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
Example Dot Phrase/Procedure Note

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.
**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

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**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
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 #670. 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 including that 40-60% of women have follow-up barriers to the 6-week postpartum visit. In addition, women in subfertile status, do not attend their 6-week visit limiting the ability to increase the risk of short-interval pregnancy. In our hospitals, our patients will not have to return for LARC.

In 2015, Illinois unbundled payment for the LARC allowing for a separate reimbursement in addition to a delivery and delivery. We have created a system that allows for providing LARCs to our patients post-delivery. We have attached a flyer for information regarding the specific LARC for your patient.

We know that we cannot achieve lasting results by simply participating in a state wide quality initiative within the Illinois Perinatal Collaborative (ILPQC) to improve access to immediate postpartum LARC at our hospital. We are participating in the statewide IPLARC initiative. The data will allow us to track the percentage of women with documented contraceptive counseling including the option of IPLARC. We will be tracking the percentage of patients with comprehensive contraceptive counseling documented during outpatient prenatal care and during labor and delivery. Working together, we can improve access to effective contraceptive options for patients, help reduce short interval and unwanted pregnancies. The 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 EHR. Notulice for documentation, billing codes are also available.

AVAILABLE OPTION FOR PATIENTS

CONSEILING
Prenatally provide comprehensive contraceptive counseling including IPLARC as an option. See attached counseling materials for patient resources.

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
Comprehensive Counseling Resources

Florida Perinatal Quality Collaborative
Partnering to Improve Health Care Quality for Mothers and Babies

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 at 2 weeks ideally** 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 okay, 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

I. 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)

II. Progesterin 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.
TEAM TALK: NM CENTRAL DUPAGE HOSPITAL
Immediate Postpartum LARC

Lisa Sullivan MSN RNC-OB CNML CBC
Northwestern Medicine Central DuPage Hospital
December 16, 2019
Who am I?

• 1986- BSN, Northern Illinois University
• 2009- MSN, Lewis University
• 25 years of OB experience in a variety of inpatient roles (staff nurse, charge nurse, CNS, unit manager)
• Current role- Clinical Director of L&D and Prenatal Education
• RM Team Leader and Process owner for IPLARC project
Establishing Buy in for IPLARC

How do I get others interested?

- Provide education on recent statistics and advantages
  - 10-40% of women do not attend follow up postpartum visit, even higher for those on Medicaid
  - Rates of unprotested sex before postpartum visit = at least 50%
  - IPLARC placed in hospital is convenient and immediate acting; prevents unintended, short-interval pregnancy

- ACOG Committee Opinion number 670 Immediate Postpartum Long-Acting Reversible Contraception, Obstetricians should:
  - Incorporate IPLARC into practices
  - Counsel women appropriately about advantages and risks
  - Advocate for institutional and payment policy changes to support provision

- Patients are requesting this service
Who are the Key Stake Holders

Who do we need on the team?

- OB providers and MFM
- L&D and Mother Baby staff
- Pharmacy
- Coding/billing specialists
- IT support/EPIC clinical analyst
First steps
Develop a Team Charter

Project Charter: IPLARC

Overview

Problem Statement: Unplanned pregnancies and short interpregnancy intervals are associated with higher rates of poor maternal and infant outcomes, including preterm birth and low birth weight. In 2010, 52% of pregnancies in Illinois were unintended. Between 2011 and 2016 in Illinois, 29% of pregnancies were conceived before the recommended interpregnancy interval of 18 months. LARC methods (IUDs and contraceptive implants) are the most effective form of reversible contraception.

Goal/Benefit: All women should be able to leave the hospital with the contraceptive method of their choice, including LARC. LARC will be available in the immediate postpartum period by March 2020.

Scope: Immediate postpartum vaginal delivery or cesarean section patients from delivery through discharge (Labor & Delivery and Mother Baby units).

Definitions of Success

Key Deliverables:
- LARC will be available in the immediate postpartum period beginning in March 2020.

Outcome Metric(s):
By increasing access to LARC, increase in utilization of LARC methods prior to discharge.

Process Metric(s):
Educated providers/nurses on benefits of IPLARC, protocols, counseling & IPLARC placement

Key Milestones

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Date</th>
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<tbody>
<tr>
<td>Define</td>
<td>6/2019</td>
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<tr>
<td>Measure</td>
<td>8/2019</td>
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<tr>
<td>Analyze</td>
<td>7/2019-2/2020</td>
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<tr>
<td>Improve</td>
<td>3/2020</td>
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<tr>
<td>Control</td>
<td>5/2020</td>
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</tbody>
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Team

Executive Sponsor: Angie Black
Process Owner: Lisa Sullivan
Team Members: Mark Gapsinski MD, Lisa Sullivan, Evangeline Burns, Maggie Collander, Jennifer Infantino, Kimberly Olson, Christine Garcia-Palm, Tara Blum, Carol Roon, Kasia Mansfield
System Partners: Analytics, IT and Epic team

Clinical Sponsor: Dr. Mark Gapsinski
Performance Improvement Leader: Maggie Collander
Sponsor: Lisa Sullivan, Evangeline Burns
Project Charter

- Describes the Problem Statement, Project Goal and Scope
- Defines both Outcome and Process Measures
- Key Milestones with target dates using DMAIC methodology
- Lists Team members and responsible parties
- Helps keep team on task and defines the nature and scope of the project
First Steps

Develop a Project Plan so we can stay on track!
First steps

Why recreate the wheel? Let’s see what work has already been done by our system hospitals

IPLARC in place at NM Prentice campus
• SMART Phrases for providers
• Billing and coding completed
• Education for staff via PowerPoint presentations
• EPIC orders
• IPLARC policy
• Much larger volume for IPLARC based on community demographic

Pharmacy assisted with determining NM Prentice product use (i.e. what kind of IUDs do they use?)
Narrowing down the Choices

• NM Prentice has multiple types of IUDs stocked in both L&D and Mother Baby
• Concern about overstock at CDH may result in waste
• Team decided to develop an OB Provider survey regarding product and incorporate a few other questions about IUD experience, contraception counseling
Physician Survey on Long Acting Reversible Contraception

Physician: ________________________________

1. Do you place LARC? Yes No (Stop if No)

2. What devices do you place?

Paraguard  Mirena  Skyla  Liletta  Kyleena  Nexplanon

Other: ________________________________

3. Where do you place the devices?

Office  PTC  Operating Room  Other: ________________________________

4. When do you start counseling your pregnant/postpartum patients on contraception after delivery?

Prenatally  Prior to d/c on delivery admission  Postpartum off visit
Results

Providers surveyed

- Physicians who place LARC
- Physicians
Results

Device Experience

IUD Device Experience

- Mirena
- Paraguard
- Kyleena
- Nexplanon
- Skyla
- Liletta
Results

When are patients being counseled?

LARC Counseling timing

- Prenatally
- Postpartum
- Delivery Admission
Results

Where they prefer to place LARC

Device Placement Location

- Office
- Operating Room
- Physician Treatment Center
- Other
Next Steps

- Determine inventory levels in conjunction with Pharmacy
- Testing for scan function and order link to MAR
- Define locations for storage in PYXIS on both units
- Unbundling of LARC from delivery charge
  - Contract negotiation
  - Will not delay go live
- Develop/distribute educational materials for OB offices
Next Steps

• Develop education for staff and providers
  – IT support for SMART phrases for providers
  – Insertion must be documented in EMR to receive reimbursement
• Key Players meeting with ILPQC
• Nexplanon
  – Request to add to formulary
  – certification for providers to place device
  – certificate will need to be submitted to Pharmacy
Take Aways

• Establish Buy In from Key Players
• Establish a team charter and project plan to maintain forward movement and keep everyone on task
• Use the Toolkit!!! Valuable resources are right at your fingertips
• Ensure billing/coding members on team in the beginning
• Pharmacy can really assist with navigating devices and inventory levels
  – If Nexplanon is not on the formulary, will need to see how to have it added
  – At CDH, provider needs to complete a request form and present the need to the P & T Committee
Thank you!
ROUND ROBIN – TEAMS
UPDATE ON PROGRESS
TOWARDS GO LIVE GOAL
What steps do you need to take to schedule a Key Players Meeting if you haven’t already?

What are your next steps to meet your GO LIVE goal by May 2020?

How does your team engage OB providers in this initiative?

What are your biggest successes so far?

What are the biggest challenges and what is your plan to overcome the barrier/challenge?
UPCOMING EVENTS
IPLARC Calls

- THIRD MONDAY OF THE MONTH

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>January 20</td>
<td>CANCELED due to MLK Holiday</td>
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<tr>
<td>February 17</td>
<td>Round Robin with Wave 2 Teams</td>
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<tr>
<td>March 16</td>
<td>Comprehensive Contraceptive Counseling</td>
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<tr>
<td>April 20</td>
<td>Preparing to GO LIVE</td>
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<tr>
<td>May 20</td>
<td>ILPQC Face-to-Face Meeting, Springfield, IL</td>
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<tr>
<td>June 22</td>
<td>Wave 2 Sustainability (Wave 1 teams welcome)</td>
</tr>
<tr>
<td>August 17</td>
<td>Wave 2 Sustainability (Wave 1 teams welcome)</td>
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</tbody>
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Next Steps

• Develop 30-60-90 Day plan for Go Live Goal (May 2020)
• 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!
THANKS TO OUR FUNDERS

Online: www.ilpqc.org
Email: info@ilpqc.org