ILPQC: improving outcomes through the magic of collaboration

Texas Collaborative for Healthy Mothers and Babies Summit
January 29, 2019
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Disclosures and Support

• No conflicts to report
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  – Centers for Disease Control and Prevention,
  – Illinois Department of Public Health
  – Alliance for Innovation on Maternal Health (AIM)
    Maternal Child Health Bureau
Overview

• ILPQC Structure
• Launching an Initiative
• Helping Teams Succeed
• ILPQC in Action
  – MNO: launch and engagement
  – HTN: support hospitals QI success / sustainability
Improving Together

ILPQC is a collaborative of physicians, nurses, hospital teams, public health and other stakeholders implementing data-driven, evidence-based practices to improve maternal and neonatal outcomes in Illinois.
State-wide Participation

- 119 hospitals participating in ILPQC initiatives
  - 99% of IL births covered by ILPQC
  - 100% of IL NICU beds covered by ILPQC
- 110 hospitals with 101 OB hospital teams and 70 Neonatal teams participated in ILPQC Face to Face meetings in 2018
- Strong ILPQC advisory group participation
  - OB Advisory Group – 74 members have participated over time representing 30 hospitals
  - Neonatal Advisory Group – 31 members representing 19 hospitals
## ILPQC Milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestones</th>
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<tbody>
<tr>
<td>2012</td>
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</table>
  - IL Perinatal Advisory Committee Prematurity Task Force Report  
  - Start Up Funding: CHIPRA / HFS  
  - Stakeholder Meetings Begin  
| 2013 |  
  - Consultation with Perinatal Quality Leaders (OH, CA, NC, FL)  
  - Website Launch  
  - ILPQC Kick-Off, 1st Annual Conference  
| 2014 |  
  - ILPQC Data System Launched  
  - CDC Award with IDPH  
  - Launch EED and Neonatal Nutrition Initiatives  
| 2015 |  
  - Launch Golden Hour Initiative  
  - Launch Birth Certificate Initiative  
  - Started yearly spring Face to Face Meetings for OB and Neo Teams  
| 2016 |  
  - Launch Maternal Hypertension Initiative  
  - IDPH Funding  
  - Golden Hour Initiative Ongoing  
| 2017 |  
  - Maternal Hypertension and Golden Hour Initiatives Ongoing  
  - CDC Funding for MNO Initiative  
  - Pritzker Grant Award for IP LARC Initiative  
| 2018 |  
  - Launch Mothers and Newborns affected by Opioids (MNO) Initiative  
  - Launch Immediate Postpartum LARC Initiative  
  - Launch Sustainability for Maternal Hypertension and Golden Hour Initiatives  

ILPQC Central Team

Ann Borders
ILPQC Executive Director, OB Lead

Leslie Caldarelli & Justin Josephsen
Neonatal Leads

Patricia Lee King
State Project Director

Daniel Weiss & Danielle Young
Project Coordinators

Autumn Perrault
Nurse Quality Manager

info@ilpqc.org OR www.ilpqc.org
ILPQC Provides Responsive QI Services to Hospital Teams

**Webinars/ Calls**
- Monthly & quarterly collaborative learning and QI Topic Calls
- QI Support Calls with Perinatal Network Administrators
  - Key players meeting
  - RedCap data training

**Face to Face**
- Spring Face-to-Face Meeting Breakouts
- Annual Conference Breakouts
- Key Player Site Visits
- Grand Rounds speakers group

**ILPQC Resources**
- Paper/online QI toolkits
- Patient-education materials
- Monthly e-newsletters
- Previous months webinar recording

**ILPQC Data**
- Rapid Response data system
- Real-time reports for teams to compare data across time & hospitals

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**Quality Improvement Support Services**
ILPQC Data System drives QI

Data Collection

Hospital teams collect data on structure, process, and outcome measures

Input data into ILPQC Data System

Team input data monthly into ILPQC REDCap Data System for rapid response reports of real time data

Review of reports with team during monthly QI meetings

Review reports on structure dashboards, process, and outcome measures to compare data across time and across hospitals

Decide next QI steps for team

Team uses data to drive Quality Improvement at their hospital

ILPQC Data System drives QI.
Communication is Key

- Monthly hospital team webinars
- Hospital QI support calls
- Website for resources and initiative toolkits
- Monthly e-newsletters per initiative
- Face-to-Face meetings / Annual Conference
  - Teams enjoy meeting in-person, sharing, learning from each other and networking
www.ilpqc.org

Up-to-date resources, Team Webinars, and QI Toolkits

Monthly initiative communications, REDCap

MNO-OB Toolkit
1. Initiative Resources
2. Mothers and Newborns Affected by Opioid Initiative Slide Set
3. National Guidelines: Naloxone Shares
4. National Guidelines: MCCG Committee Opinions
5. Screening and assessment of pregnant women with OUD
6. Screening, Brief Intervention, Referral to Treatment (SBIRT): Protocols and Example Process Flow
7. Improve Linkages to Addiction Care
8. Example Protocols/Best Practice Recommendations/Checklists for Prenatal - Intrapartum - Postpartum Care of Women with OUD
9. Counseling/Prescribing Naloxone/Narcotic
10. Additional Resources/Optimize Care of Women with OUD
11. Patient and Provider Education
12. Clinical guidelines/MANAGEMENT TO REDUCE OPIOID PRESCRIPTIONS
13. Overview of new Illinois state law on ILMP Lookup

REDCap
Log in
Please log in with your user name and password. If you are having trouble logging in, please contact support.assistant.

Username: 
Password: 
Log in
Forgot your password?
USING ILPQC STRUCTURE TO LAUNCH AN INITIATIVE
Start with Initiative Selection:
Achieve Buy-In

Survey ILPQC hospital teams pre-conference

State PQC leaders share overviews of initiatives at conference

Discuss and vote on initiatives at conference break out sessions

Buy-in with advisory workgroup, perinatal network

Engage key stakeholder buy-in
Getting Ready to Launch:

**LEADERSHIP**
- Identify Clinical Leadership
- Review resources with leadership: clinical leads, OB Advisory Work Group, State Quality Council/Perinatal Network Administrators
- Update ILPQC Leadership Committee (state agencies, Illinois Hospital Association, national and local partners)

**COLLABORATION with other PQCs**
- Hold calls with other PQCs to learn process/resources
- Assessment of state & national resources

**RESOURCE DEVELOPMENT**
- Develop Toolkit & Data Form
- Wave 1 teams test data form and data collection process
Promoting Engagement In Work of the Collaborative
Team Building and Roster Formation

**Recruitment**
- Perinatal Network Administrators
- ILPQC Team Contact Lists
- IDPH Letter to all hospitals administration

**Formation**
- Teams submit rosters online
- QI Team responsibilities

**Engagement**
- Team lead
- Physician and nurse champions
- Initiative-specific interdisciplinary team members
Engaging Hospital Teams

**Engage**
- Collectively identify initiatives
- Support development of interdisciplinary teams
- Engage providers & nurses as leaders at the collaborative & hospital level

**Motivate**
- Develop hospital team buy-in
- Break down the work into key steps
- Demonstrate frequent examples of success

**Support**
- Collaborative learning opportunities support system & culture changes
- Rapid-response data system supports use of data to drive QI
- QI support to ensure equity across hospitals
Implementing the IHI Breakthrough Series through a Collaborative Planning:

- Create collaborative Key Drivers Diagram, SMART AIMS, and specific measures to track progress across the initiative

ILPQC Collaborative-Level QI:
- Monthly review of specific measures on collaborative learning webinars
- Offer QI topic calls on specific improvement strategies of the initiative
- Recruit national experts to share QI strategies on collaborative learning webinars

ILPQC Hospital-Level QI Support:
- Review of hospital-level monthly data to provide tailored support
- 1:1 QI Support calls to coach hospitals to implement PDSA cycles and 30-60-90 day plans to achieve hospital-level initiative goals
Timeline of Initiative Launch

Hospital teams vote for next initiative at ILPQC Annual Conference

Initiative Development
- AIMS
- Key Driver
- Toolkit
- Data form

Recruit Wave 1 teams (Dec/Jan)

Launch Wave 1 (January)

Wave 1 – teams test the data form/data collection process
Recruit Wave 2 teams (Jan-April)

Launch Wave 2 with two hour webinar kick off (April)

Face-to-Face Kick-off Meeting (May)
HELPING TEAMS SUCCEED
Quality Improvement Strategy

- Engage statewide stakeholders and OB Advisory Workgroup in development and implementation of QI initiative
- Facilitate development of multidisciplinary hospital-based QI teams
- Facilitate monthly collaborative learning webinars with national experts, toolkit resources and team sharing and twice annual opportunities for in-person collaborative learning
Quality Improvement Strategy

- Disseminate **toolkits and training e-modules** to support hospital system and culture change

- Develop **rapid-response data system** for hospitals to see data on key **process, outcome, and structure measures** over time and compared to other hospitals
Quality Improvement Strategy

QI Topic Calls
Small Group Format
- Review collaborative level data on key measures
- Identify Mentor Hospitals among teams demonstrating early improvement on key measures
- Host QI Support call with mentor hospital - call is open to all teams and focus is on discussion between teams

QI Support Calls
Individual Hospital Format
- Review hospital level data for teams that need or request improvement support on key measures
- Reach out to hospital team to schedule and conduct QI support calls
- Connect team with resources, support data review to focus PDSA cycles, develop 30-60-90 day plan
Teaching Hospital Teams
Key QI Steps for Success

• Build a multidisciplinary QI team
• Assess where starting from (baseline data)
• Plan where want to get to (30-60-90 day plan, set goals/aims)
• Try small test of change (PDSA cycle), repeat
• Collect data (structure, process and outcome measures) to track progress, challenges, success, compliance
• Review/share rapid response data reports showing change from baseline and comparison across hospitals, key for quality improvement
• Learn from other hospital teams
Encouraging Providers/Nurses Engagement in QI

- **Buy-In matters**: Sell the initiative to OB providers and nursing staff: why are we doing this work, why it matters, what they need to do, how will compliance be monitored

- **Systems change that assist clinical team doing the right thing every time**: Protocols, checklists, order sets, debriefs, EMR prompts

- **Culture change needs provider and nursing staff education**: Grand Rounds, E-modules, Simulations, Drills

- **Active monthly review and use of QI data is key**: Sharing monthly QI data progress and comparison to other participating hospitals with OB providers and nursing staff and track compliance in sustainability
Engaging Patients & Families in QI Work

Patient /Family Advisors:
• Share personal stories and provide feedback
• Review process flow and identify opportunities for improvement
• Develop, review, and test content of materials
• Discuss quality improvement findings

6 patient/family advisors serving on OB/Neonatal Advisory Groups

Resources for teams seeking patient/family advisors
Motivating Teams to Make Culture and System Changes

- QI award banners for teams meeting initiative goals
- Certificates of achievement for hospital teams submitting timely data
- Letters to hospital leadership acknowledging teams successfully meeting initiative goals
ILPQC IN ACTION:
- MNO INITIATIVE LAUNCH
- IPLARC INITIATIVE LAUNCH
- HTN INITIATIVE SUSTAINABILITY
Sustain Hypertension Success

- Sustainability Plan
- Compliance Monitoring
- New Hire Education
- Ongoing Staff/Provider Education
Launched 2 new statewide QI initiatives in 2018

MNO

Mothers and Newborns affected by Opioids Initiative

OB

Neo

IPLARC

Immediate Postpartum Long Acting Reversible Contraception Initiative

Wave I
Mothers Affected by Opioids in IL: Scope of the Problem

Pregnancy is a window of opportunity to identify women with OUD and link to treatment as well as begin to develop a plan for optimizing her baby’s care.

116% increase in recorded maternal opioid use between 2011 and 2015
Rate of Pregnancy-Associated Deaths Due to Drug Poisoning, Illinois Residents, 2008-2016

Between 2008 and 2016:

- Pregnancy-associated deaths specifically related to opioid overdose increased almost 6-fold.

Neonatal Abstinence Syndrome in IL: scope of the problem

53% increase in rate of NAS from 2011 – 2016
NAS rate increased 2.1% per quarter from 2011-2016
The Faces of OUD

IT CAN HAPPEN TO ANYONE

“Opioid use disorder (OUD) is a chronic treatable brain disease that can be managed successfully by combining mediations with comprehensive care and recovery support, which enables those with OUD to regain control of their health and their lives.”

In 2014, an estimated 1.9 million people had an OUD related to prescription pain relievers and an estimated 586,000 had an OUD related to heroin use.
ILPQC Mothers and Newborns affected by Opioids (MNO)

Initiative AIMS

• Increase pregnant women affected by opioids identified, linked to care prenatally and receiving Medication Assisted Treatment (MAT) for opioid disorder at delivery
• Optimize clinical care of pregnant women with OUD through patient and provider education & implementation of care checklists
• Increase non-pharm care and decrease pharmacologic treatment in opioid exposed newborns (OENs)
• Increase breastfeeding rates in mothers and newborns affected by opioids at infant discharge
• Increase safe and optimized discharge plans for OENs
• Optimize prevention of OUD through provider and patient education, provider compliance with PMP lookup, and implementation of clinical guidelines for strategies to reduce opioid over-prescribing after delivery

107 hospitals participating in the MNO OB & Neonatal Initiative
• 101 MNO-OB Hospital QI Teams
• 88 MNO-Neo Hospital QI Teams
• Facilitated monthly MNO-OB & Neo collaborative learning webinars with ~150 participants/call
• Paper & Online MNO-OB & Neonatal QI toolkit for teams including sample protocols, guidelines, and patient & provider education
Our Goals for MNO

1. **Increase validated screening and linkage to MAT for mothers with opioid use disorder**
   - Implementation of **universal OUD screening & documentation**
   - Ensure **standard SBIRT protocol** response for all screened positive women
   - Mapping of available local **MAT/OUD Resources Mapping Tool** and resources and **standardize process to link pregnant and postpartum women to MAT/ support services**,
Our Goals for MNO

2. **Optimizing care for mothers and newborns affected by opioids.**

   - Implement standardized provider and nurse education on OUD screening, the OUD protocol, and stigma/bias
   - Standardize patient education on OUD, MAT, Naloxone, NAS, and the importance of breastfeeding and engaging moms in the opioid exposed newborns care
   - Implementation of an **OUD clinical care check list**: such as offering Narcan/Naloxone, Hep C screening, standard consults to optimize prenatal care, delivery, and postpartum care for moms with OUD
   - Neo Teams Improve outcomes for opioid exposed newborns (OENs) through key interventions: **standardized identification and assessment of OENs**, increased maternal participation in OENs newborn care, optimize **non-pharmacologic newborn care**, standardize **pharmacologic treatment**, and develop **standard safe discharge plans**.
Our Goals for MNO

3. **Prevent opioid use disorder (OUD)**
   - Systems changes to reduce the number of opioids prescribed for routine deliveries
   - Increase documentation of IL PMP look up by providers prior to prescribing opioids
   - Provide education on OUD prevention for providers, staff and pregnant women
Getting Started with MNO

- **Jan-April 2018** Wave 1 Teams (XX) evaluated data form, trialed data collection strategies, provided feedback
- **April 2018** kick-off 2 hour webinar to introduce MNO Initiative to teams statewide
- **May 2018** Face to Face Meeting Springfield: > 300 participants, > 100 hospital teams, storyboards, toolkit launch, patient education materials, breakout sessions, leaders from other state PQC’s share strategy
- **June 2018** Monthly team webinars start: education, data review, clinical / QI leaders other states, Team Talks
- **Baseline data collection 4th quarter 2017 due 8/15/18**
- **July 2018** Teams start monthly data collection
ILPQC Mothers and Newborns affected by Opioids (MNO)-OB Initiative
Jan 2018 – Dec 2019

MNO-OB TOOLKIT
WEB VERSION AVAILABLE
WWW.ILPQC.ORG
OB Toolkit Sections

• Introduction
• Initiative Resources
• Mothers and Newborns Affected by Opioids Slide Set
• National Guidance: ACOG Committee Opinions

**Screening & Linkage to Care**

• Screening and assessment of pregnant women with OUD
• Screening, Brief Intervention, Referral to Treatment (SBIRT)
• Improve Linkage to Addiction Care

**Optimizing Clinical Care for Pregnant/Postpartum Women with OUD**

• Example Protocols/Best Practice Recommendations/Checklists for Prenatal-Intrapartum-Postpartum Care of Women with OUD
• Counseling & Prescribing Naloxone/Narcan
• Additional Resources to Optimize Care of Women with OUD
• Education Materials for Pregnant Women with OUD
OB Toolkit Sections (cont.)

Prevention of OUD

- Patient and Provider Education for OUD Prevention
  - Patient education for all pregnant women
  - Provider/nursing/staff education on OUD

- Clinical guidelines стрategies to reduce opioid over prescribing postpartum

- Overview of new Illinois state law on ILPMP lookup
Education Materials for Pregnant Women with OUD

- Pregnancy and MAT one-pager
- Are you in treatment or recovery
- NAS What you need to know one-pager
- NAS Booklet

Prescription Pain Medicine, Opioids, and Pregnancy: What All Pregnant Women Need to Know

What are opioids?
Opioids are a class of drugs that includes prescription pain relievers such as oxycodone and hydrocodone, the illegal drug heroin, and dangerous synthetic opioids such as fentanyl, carfentanil, and other analogues. Opioids work in the brain to reduce pain and can also produce feelings of relaxation and euphoria.

Prescribed opioids include:
- Hydromorphone (Dilaudid, Hydromorphone, Iohexol)
- Methadone (Dolophine, Methadone)
- Methadone (OxyContin, OxyContin, Percocet, Percocet)
- Oxycodone (Oxycodone, Oxycontin)
- Tramadol (Conips, Ryzoli, Ultram)

Your doctor may prescribe an opioid for you if you’ve had surgery, dental work, an injury, or after you deliver your baby. Prescription opioids are important pain medications that can provide relief for acute or chronic pain. Unfortunately, they can also be prescribed inappropriately and misused. Misuse or chronic use of prescription opioids increases the risk of developing opioid use disorder (OUD) and may lead to overdose. If you take opioids during pregnancy, they can also cause serious problems for your baby.

What is opioid use disorder?
Opioid use disorder can be dangerous and addictive. Symptoms of opioid use disorder include developing a need for higher doses in order to feel the same effect, using more than the amount of the drug that is prescribed, taking non-prescribed opioids such as heroin; having work, school, or family problems caused by your opioid use; feeling a strong urge or desire (“craving”) to use the drug, and experiencing painful withdrawal symptoms if you abruptly stop taking opioids. Taking higher doses of opioids or using opioids for extended periods of time increases the risk of developing OUD.

Neonatal Abstinence Syndrome (NAS): What You Need to Know

Be with your baby:
You are the treatment!
AIM Bundle and Resources

- Obstetric Care for Women with Opioid Use Disorder Bundle and Resources Listing
- OUD Clinical Pathway
MNO-OB work so far...

- Implement a standardized screening tool for OUD in affiliated outpatient prenatal care sites and labor & delivery
- Implement an SBIRT protocol to counsel and document screen positive, assess risk and link to care.
- Complete mapping tool of local SUD support services and MAT resources
- Implement a check list to optimize prenatal care, delivery admission, postpartum care for moms with OUD
- Standardize education for women with OUD: OUD and NAS, breastfeeding for OENs and maternal participation in newborn care.

Stigma, Bias, and Trauma Informed Care

Standardize a process to systematically educate providers, nurses and staff on stigma, bias and trauma informed care
MNO-OB in 2018: Making Change Happen

Key QI Strategies

- Implement universal screening and documentation (prenatal/L&D)
- Ensure standard SBIRT protocol response for all screen positive
- Complete and share Mapping Tool to identify local resources for MAT/SUD support services & standardize process for linking patients to care
- Implement OUD Clinical Care Checklist (prenatal / L&D medical record)
- Standardize patient education on OUD & NAS, and importance of participation in newborn care
- Complete Provider/Nurse Training on stigma and bias, screening, SBIRT, clinical care checklist and activating the OUD Protocol
OUD Protocol: Activate for every screen positive patient

- Screen and document positive result
- Provide SBIRT risk assessment and brief counseling re: benefits of treatment, next steps for linking patient to care
- Activate care coordination and navigation to link woman to MAT, addiction services and behavioral health support
- Insert and complete OUD clinical care checklist in electronic medical record (or paper chart) (prenatal / L&D)
- Provide patient education re: OUD and NAS, and engaging in newborn care via neonatology consult, counseling, hand-outs.
Barriers to treatment

- Prenatal provider lacks experience and process for linking to MAT providers
- Limited MAT providers near by
- Economic obstacles to entering and staying in treatment.
  - Cash only options
  - Insurance provider issues
- Accessibility to services:
  - Lack of flexible service times
  - Location to patient’s home or work
  - Transportation issues to/from clinic
- Threat of legal sanction – child custody.
- Lack of affordable child care.
- Oppositions for entering treatment from family/friends.
  - Partner substance abuse
  - Lack of support systems
  - Caretaker role for dependent family.
HELPING OUR PATIENTS NAVIGATE TO TREATMENT

- Map local resources for MAT providers and SUD support services
- Establish process flow to link all patients with OUD to care
- Expand the number of Buprenorphine providers

Maintenance MAT
MNO Teams Track Key Measures

• Monthly Data (by the 15th of the following month)
  – OB Teams
    • All women with OUD collect process outcomes and measures
    • Random sample of 10 charts from all deliveries to collect % of patients screened for OUD
  – Neo Teams
    • All opioid exposed newborns
  – All teams:
    • Structure measures to track our QI work: screening tool and SBIRT implementation, patient and provider education, protocol implementation, mapping resources, process flow, etc.
    • Red / yellow / green (haven’t started / working on / implemented)
### MNO-OB Project Aims

By December 2019, for all pregnant/postpartum women with OUD across participating hospitals:

| Goal                                                                 |  
|---------------------------------------------------------------------|---
| Increase proportion of all pregnant women screened with a universal validated screener during prenatal period / during delivery admission | ≥ 80%  
| Increase proportion of women with OUD receiving MAT prenatally or by delivery discharge | ≥ 70%  
| Increase proportion of women with OUD connected to Behavioral Health Counseling/Recovery Services prenatally or during delivery admission | ≥ 80%  
| Increase proportion of women with OUD with an OUD clinical care checklist completed prenatally or during delivery admission | ≥ 70%  
| Increase proportion of women with OUD receiving: Narcan, contraception plan, Hep C screen, behavioral health /social work consult, prenatally or during delivery admission | ≥ 70%  
| Increase proportion of women with OUD receiving pediatric / neonatal consult, on NAS and role in non-pharmacologic newborn care, prenatally or during delivery admission | ≥ 70%  
| Increase proportion of women with OUD receiving OUD/NAS education, prenatally or during delivery admission | ≥ 80%  

MNO-OB Baseline Data (Q4 2017)
Opportunities for Improvement

3%
Women with screening documented prenatally and on L&D

2.6%
Narcan counseling and prescription

53.7%
Of mothers and newborns roomed together during maternal hospitalization

40%
Women with OUD on MAT at delivery

40.7%
Hep C screened and documented

56.2%
Eligible mothers with OUD breastfeeding/providing breastmilk during maternal hospitalization

Screening & Linkage to Care

Clinical Care Checklist

Engaging Moms in Care
Screening & Linkage to Care: Standardized Screening Tool on L&D (Structure Measure)

ILPQC MNO Initiative:
Percent of hospitals that have implemented a standardized, validated self-report screening tool for screening all pregnant women for OUD on units caring for pregnant women
All Hospitals, 2018

AIM: Increase proportion of all pregnant women screened with a universal validated screener on L&D
AIM: Increase proportion of women with OUD receiving MAT and Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge
Screening & Linkage to Care: Sample of Documentation of Screening for OUD on L&D

MNO-OB Monthly Sample of Documentation of OUD Screening on L&D
All Hospitals, 2018


- Validated Self-Report Screening Tool
- Non-Validated Screening Tool
- Screening Not Documented/Missed Opportunity

BENCHMARK = ≥ 80%
Screening & Linkage to Care: Mapping Community Resources (Structure Measure)

ILPQC MNO Initiative:
Percent of hospitals that have completed ILPQC Community mapping tool to map local community resources (MAT/addiction treatment services/behavioral health services) for pregnant/postpartum women with OUD
All Hospitals, 2018

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<th>Have not started</th>
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<td>Baseline (2017)</td>
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<tr>
<td>Nov-18</td>
<td>63%</td>
<td>30%</td>
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<tr>
<td>Dec-18</td>
<td>55%</td>
<td>36%</td>
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Optimizing Care: Standardized Education for Women with OUD (Structure Measure)

ILPQC MNO Initiative:
Percent of hospitals that have standardized use of materials for educating pregnant women with OUD regarding OUD/NAS, importance of breastfeeding, and importance of mothers role is NAS newborn care
All Hospitals, 2018

AIM: Increase proportion of women with OUD receiving OUD/NAS education prenatally or during delivery admission
Optimizing Care: Cumulative Provider & Nursing Education on OUD care protocols (Structure Measure)

ILPQC MNO Initiative:
Average cumulative proportion of providers and nurses educated on OUD care protocols (including stigma & bias)
All Hospitals, 2018
MNO in 2019

Key Strategies
- Screening
- SBIRT
- Mapping
- Checklist
- Education

Covered in 2018
- Build trust / reduce stigma
- Improve patient navigation for MAT and support services
- Improve engaging providers in checklist / clinical care
- + Buprenorphine prescribing
- Standard system wide response for screen positive (OUD protocol)

Strategies to review in 2019
- Work towards goals in 2019

- Increase # of women screened & linked to care
- Increase # of women on MAT
- Increase # women with completed checklist
- Increase # women engaged in Opioid exposed newborn Care

How do we begin to make progress?
Aims: Empower women with information and improved access to effective contraception before discharge home after delivery to reduce short interval and unintended pregnancies linked with adverse MCH outcomes

Key Goals:
1) Increase % of women with prenatal comprehensive contraceptive counseling and documentation
2) Increase % of providers/nurses trained to provide IPLARC
3) Increase % of hospitals who have completed key steps needed to provide IPLARc
4) Achieve GO LIVE goal to provide IPLARC for Wave 1 hospitals by March 2019
Consequences of Unplanned Births and Short Interval Pregnancy

Of the 158,522 total births in IL in 2014:

- **42%** Unintended
- **58%** Intended

Consequences of Unplanned Pregnancies

- Poor pregnancy outcomes
- Delayed initiation of prenatal care
- Lower breastfeeding rates
- Higher risk of maternal depression and potential future child maltreatment

Consequences of Short Interpregnancy Interval

Higher risk of poor maternal and infant outcomes: Preterm birth, low birthweight, preeclampsia

50% of IL births covered by Medicaid
ILPQC IP LARC Initiative

**Goals**

- Increase access to IP LARC
- Standard education for patients on contraceptive options
- Implement IP LARC Protocol
- Educate Providers counseling and placement
- Simplify IPLARC Billing
- Systems Changes to OB Care Process Flow
- Stock LARC in Pharmacy
IPLARC Wave I work so far…

- Establish and test billing codes and test process for timely reimbursement
- Add LARC devices to formulary, stock in pharmacy, and make available on L&D/postpartum
- Implement IPLARC protocol on L&D/Mother Baby through protocols/process flow changes
- Standardize patient education (on all contraceptive options including IPLARC) and process flow for providing education and documenting education/counseling for all patients at affiliated prenatal care sites and on L&D/mother baby units

GO LIVE by March 2019
IPLARC on Formulary

Percent of Hospitals with Inpatient **IUDs** Available on Hospital Formulary

Percent of Hospitals with Inpatient **Implants** Available on Hospital Formulary
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!
- Learn about hot topics on monthly collaborative webinars, including billing & coding, stocking, etc.!
- *Opportunities to participate in IPLARC Alternative Strategies focusing on universal early postpartum follow up visits for maternal health and safety check and access to family planning*
Upcoming IPLARC Training Opportunities

• We’re working with ACOG to offer 3 IPLARC trainings in 2019:
Improving Postpartum Access to Care (IPAC)

- Pathway for hospitals that do not provide contraception to participate in increasing access to early postpartum care
- Goal universal early postpartum visit at 2 wks
- ACOG committee opinion #736 and MMRC Report
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: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% by December 2017

Approach: 4 key goals
1. Reduce time to treatment
2. Improve postpartum patient education
3. Improve postpartum patient follow up
4. Improve provider & RN debrief

• 110 hospital teams - May 2016 kick off to December 2017
• 106 Hospitals submitted data for over 17,000 women who experienced severe maternal HTN across the initiative
• Sustainability started January 2018
• 86 teams have submitted sustainability data
Critical Pathways to Poor Outcomes

- Clinical Symptoms Not Recognized
- Delayed Diagnosis
- Delayed Treatment
- Assumption Delivery Fixes Problem
- Discharge without timely Follow-up
### Project Aims

By December 2017, for all women with confirmed severe maternal HTN across participating hospitals:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Increase the proportion of women treated for severe HTN in &lt; 60 minutes</td>
<td>≥ 80%</td>
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<tr>
<td>Increase the proportion of women receiving preeclampsia education at discharge</td>
<td>≥ 80%</td>
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<td>Increase the proportion of women with follow-up appointments scheduled within 10 day of discharge</td>
<td>≥ 80%</td>
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<tr>
<td>Increase the proportion of cases with provider / nurse debriefs</td>
<td>≥ 50%</td>
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<tr>
<td>Reduce the rate of severe maternal morbidity (SMM)</td>
<td>↓ 20%</td>
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</table>
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, 2016-2018

Wow!
Maternal Hypertension Outcome
Data: Severe Maternal Morbidity

ILQPC: Women with New Onset HTN with Severe Maternal Morbidity
All Hospitals, 2016-2017

Severe Maternal Morbidity Diagnoses:
- Intracranial Hemorrhage or Ischemic event (stroke)
- Eclampsia
- Pulmonary Edema
- HELLP Syndrome
- Oliguria
- DIC
- Renal Failure
- Liver Failure
- Ventilation
- Placental Abruption
- OB Hemorrhage
- ICU Admission

15% 17% 23% 15% 13% 15% 16% 14% 12% 18% 9% 16% 10% 11% 17% 11% 13% 8% 12% 10% 9% 9% 9% 12% 10% 9% 9% 9%

13,263 patients included
Severe Maternal Morbidity Rate Deliveries with Hypertension, Hospital Discharge Data, All Illinois Hospitals

Between 2015-Q4 and 2017-Q4, the SMM rate among women experiencing hypertension at delivery was **cut in half**.
ILPQC Support Strategies
Hospital Teams Report Most Helpful

• ILPQC Hypertension Toolkit Binder
• Reviewing ILPQC Data Reports with Team
• AIM/ACOG Online E-Module Education
• May 2017 Face to Face Meeting
• Team Talks on monthly webinar

**Additional QI Training Requested**

• Teamwork for Quality Improvement/TeamSTEPPS
• IHA’s Model for Improvement

*ILPQC Team Survey, 2017*
Reducing Time To Treatment

Elements of Maternal Hypertensive Bundle Most Effective in Reducing Time to Treatment

ILPQC Team Survey, 2017
Achieving Initiative Goals with Team Recognition

ILPQC Quality Improvement Recognition Awards

**GOLD**
- Structure Measures
- **All 4** Process Measure goals met

**SILVER**
- Structure Measures
- **3 of the 4** Process Measure goals met

**BRONZE**
- Structure Measures
- **2 of the 4** Process Measure goals met

Hospital X is committed to improving the quality of care for moms and babies.
Award Criteria for IL Maternal Hypertension Hospital Teams:

Structure Measures:
- Severe Maternal HTN Policies in place in all units (Implementation Checklist question 1 A-C)
  - Standard protocols for early warning signs, updated diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia on L&D, Antepartum/Postpartum, Triage
- Provider & Nursing education: ≥80% of providers and nurses educated (AIM Quarterly Measures questions 2 A,B and 3 A,B)

Process Measures:
- Time to treatment ≤60 minutes: ≥80% of cases
- Debrief: ≥30% of cases
- Discharge education: ≥70% of cases
- Follow-up appointments scheduled within 10 days of discharge: ≥70% of cases
Hypertension Sustainability

- Sustainability Plan
- Compliance Monitoring
- New Hire Education
- Ongoing Staff/Provider Education
Compliance Monitoring in ILPQC Data System

- Time to treatment severe HTN < 60 minutes
- Magnesium provided
- Early follow up for BP check within 7-10 days
- Patient discharge education
Lauren Bloomstein: 33 year old healthy NICU nurse, wife, mom, severe HTN in labor, preeclampsia not diagnosed, severe HTN not treated, stroked and support withdrawn 20 hours after delivery.
Our Goals for 2019

Ensure MNO & IPLARC initiative success for every hospital

Support strong hospital QI teams and expand QI capacity

Expand Immediate postpartum LARC for all IL hospitals

Support QI sustainability and compliance monitoring

Expand and engage stakeholders, patient/families, hospital teams for ongoing collaboration
Conclusion

• ILPQC is a collaborative of hospital teams working together to improve care and outcomes for IL moms and babies

• The collaborative is the teams of providers / nurses/patients and stakeholders who drive the initiatives with input from all

• ILPQC provides opportunities for collaborative learning, rapid response data and QI support

• Teams provide the magic of collaboration, belief in the importance of data, commitment to evidence based practice and the drive to do better together
Questions?

Email: info@ilpqc.org
Website: www.ilpqc.org
Additional Slides
ILPQC Mothers and Newborns affected by Opioids (MNO)-OB Initiative
Jan 2018 – Dec 2019

MNO-OB TOOLKIT
WEB VERSION AVAILABLE
WWW.ILPQC.ORG
OB Toolkit Sections

• Introduction
• Initiative Resources
• Mothers and Newborns Affected by Opioids Slide Set
• National Guidance: ACOG Committee Opinions

Screening & Linkage to Care
• Screening and assessment of pregnant women with OUD
• Screening, Brief Intervention, Referral to Treatment (SBIRT)
• Improve Linkage to Addiction Care

Optimizing Clinical Care for Pregnant/Postpartum Women with OUD
• Example Protocols/Best Practice Recommendations/Checklists for Prenatal-Intrapartum-Postpartum Care of Women with OUD
• Counseling & Prescribing Naloxone/Narcan
• Additional Resources to Optimize Care of Women with OUD
• Education Materials for Pregnant Women with OUD
Prevention of OUD

- Patient and Provider Education for OUD Prevention
  - Patient education for all pregnant women
  - Provider/nursing/staff education on OUD

- Clinical guidelines/strategies to reduce opioid over prescribing postpartum

- Overview of new Illinois state law on ILPMP lookup
ILPQC MNO Slide Set

• ILPQC Mothers and Newborns affected by Opioids Initiative Slides set from ACOG District II*

• Tool to increase cumulative proportion of providers, nurses, and staff educated on OUD care protocols
National Guidance: AIM Bundle

- Obstetric Care for Women with Opioid Use Disorder Bundle and Resources Listing*
ACOG Committee Opinion

- ACOG Committee Opinion #711: Opioid Use and Opioid Use Disorder in Pregnancy*
Example Screening Tools

- NIDA Quick Screen
- 5 P’s Screening Tool & Follow-Up Questions*
- Institute for Health and Recovery Integrated Screening Tool*
SBIRT

• Helping Women Get Treatment: Screening and diagnosis of OUD Overview*
• Screening for Substance Use using SBIRT Framework*
• Example process flow map for SBIRT at Initial OB Visit*
• Example protocol for Women who Endorse or Screen Positive for OUD
• Example Algorithm/Process Flow
Mapping Local Resources

- ILPQC Mapping Tool to map local resources*
- IDPH Opioid Use Treatment Resources for Pregnant Women with Medicaid in Illinois
Prenatal-Intrapartum-Postpartum Care

- Example Best Practice Recommendations for Prenatal/Intrapartum/Postpartum Care Complicated by Substance Use Disorders*
- Example Checklist for Providers for Prenatal/Intrapartum/Postpartum Care for Pregnant women with substance use disorders*
- Example Checklist to optimize prenatal care for women with OUD, Chart template
Counseling & Prescribing Naloxone/Narcan

- AMA Opioid Task Force Prescribing Naloxone One-Pager*
- Naloxone Rescue Kit Consultation Checklist*
- Narcan Nasal Spray- Quick Start Guide
Other Resources to Optimize Care for Women with OUD

- Breastfeeding Guidelines for Women with a Substance Use Disorder*

* Breastfeeding Guidelines for Women with a Substance Use Disorder:
  - **Medical Contraindications to Breastfeeding:**
    - Maternal HIV infection
    - Maternal HTLV infection
    - Infant Galactosemia
    - Infant taking certain medications where risk of morbidity outweighs benefits of breastmilk feeding (e.g., cancer chemotherapy, radioactive isotope, antiglaucoma, antiretroviral medications)
    - Maternal Substance Use with Significant Risk to Infant in Breastfeeding and:
      - Mother expresses an intent to continue substance use, ANX/OH
      - Mother refuses substance use treatment

General Guidelines for Infant Feeding:
  - Recommend, encourage, and support breastfeeding if no medical contraindications to breastfeeding exist. Provide information regarding benefits of breastfed/infant feeding if mother indicates preference for formula feeding.
  - Encourage mothers to spend time in skin-to-skin contact to facilitate bonding, maternal-infant physiologic transitions, and infant feeding.
  - Provide education, assessment, and support based upon mother's preference for infant nutrition after discussion of breastfeeding benefits.
    - Advise mothers to
      1. Skin-to-skin
      2. When hungry
    - Ensure effective, firm latch
    - Provide lactation consultation
    - Ensure infant is fed
      - Infants 32
      - Infants stressful
      - After this date
        - Not
        - Poor
        - Full
      - If weight gain is not
        - Assess why
        - Optimize feeding
        - When additional
          - Calorie
          - Activity
          - Other...
Education Materials for Pregnant Women with OUD

• Pregnancy and MAT one-pager
• Are you in treatment or recovery
• NAS What you need to know one-pager
• NAS Booklet

Prescription Pain Medicine, Opioids, and Pregnancy:
What All Pregnant Women Need to Know

What are opioids?
Opioids are a class of drugs that includes prescription pain relievers such as oxycodone and hydrocodone, the illegal drug heroin, and dangerous synthetic opioids such as fentanyl, carfentanil, and other analogues. Opioids work in the brain to reduce pain and can also produce feelings of relaxation and euphoria.

Prescribed opioids include:
- Hydromorphone (Dilaudid, Hyromorphone, Duramorph, Sublimaze)
- Oxycodone (Oxycodone, Vicodin, Percodan, Percocet)
- Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone (Hydromorphone, Hyalgrain)
- Methadone (Dolophine, Methadone)
- Morphine (Morphine, Avinza, Durogesic, Roxanol)
- Oxydolone (Oxycodone, Percodan, Percocet)
- Oxymorphone (Oxymorphone, Oxycontin)
- Tramadol (CandiZap, Ultram)

Your doctor may prescribe an opioid for you if you’ve had surgery, dental work, an injury, or after you deliver your baby. Prescription opioids are important pain medications that can provide relief for acute or chronic pain. Unfortunately, they can also be prescribed inappropriately and misused. Misuse or chronic use of prescription opioids increases the risk of developing opioid use disorder (OUD) and may lead to overdose. If you take opioids during pregnancy, they can also cause serious problems for your baby.

What is opioid use disorder?
Opioid can be dangerous and addictive. Symptoms of opioid use disorder include developing a need for higher doses in order to feel the same effect; using more than the amount of the drug that is prescribed; taking non-prescribed opioids such as heroin; having work, school, or family problems caused by your opioid use; feeling a strong urge or desire (“craving”) to use the drug, and experiencing painful withdrawal symptoms if you abruptly stop taking opioids. Taking higher doses of opioids or using opioids for extended periods of time increases the risk of developing OUD.
Patient and Provider Education for OUD Prevention

- Pain Medication, Opioids and Pregnancy ILPQC Handout*
- Pause Before You Prescribe- ILPQC Handout*

**PAUSE BEFORE YOU PRESCRIBE**

Prescription drug dependency is harming mothers and their infants at alarming rates. You can be part of the solution.

Retail pharmacy prescriptions for opioids, such as the pain medications hydrocodone and oxycodone, have more than doubled since 1998, with nearly a quarter of a billion prescriptions written in 2012. Nationally, the number of pregnant women using opioids has increased nearly fivefold from 2010 to 2015, while the rate of NAS has increased nearly fourfold from 2000 to 2012.

Neonatal Abstinence Syndrome (NAS), also known as neonatal withdrawal, is a set of distressing physical symptoms in infants born to mothers who took opioids or other drugs during pregnancy.

The symptoms for NAS can range from mild to severe and may include:

- Feeding difficulties
- Tremors and irritability
- Vomiting and diarrhea
- Low birth weight
- Breathing problems
- Excessive crying

“Five years ago, I nearly saw babies with neonatal withdrawal. Now, I treat a baby with NAS on a near daily basis. By partnering with women of reproductive age to carefully manage pain, physicians can be part of the solution.”

- JUSTIN JOSEPHSEN, MD
  ILPQC NEONATAL CLINICAL LEAD

“A Public Health Epidemic”

- Every 33 minutes, an infant is born with NAS in the United States.
- In Illinois, infants with NAS stay 11 days longer and have total charges for hospital care nearly $3 million higher than infants born without NAS.
- There was a 116% increase in maternal opioid use and a 32% increase in the NAS rate in Illinois between 2011 and 2016.

Methadone Treatment Drop Rate per 1,000 live births in Illinois 2011–2016
Reduce Opioid Over Prescribing Postpartum

• A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery – article and PowerPoint tool*

• Example Enhanced Recovery after Surgery (ERAS) Pathway for Cesarean*

Opioid Epidemic: Procedures and Instruments

A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery

Malvika Pradhan, MD, Emily McQuaid-Hansen, MD, Stephanie Hopp, MS, Sara M. Barnes, MD, Lisa R. Laffert, MD, Ruth Lunden, MD, Julie G. Langenberger, MD, MPH, Nelson R. Choudhry, MD, MS, Jeafal Kalsi, MD, MS, and Brian T. Brennan, MD, MS

OBJECTIVE: To assess whether a shared decision-making intervention decreases the quantity of oxycodone tablets prescribed after cesarean delivery.

TECHNIQUE: A tablet computer-based decision aid informed the basis of a shared decision-making intervention. The intervention used a decision aid with algorithmic steps to help patients and providers decide on optimal duration of pain medication and expected opioid use after cesarean delivery and then chose the number of tablets. The subjects were randomized to either an intervention group or a control group.

EXPERIENCE: From April 1 to July 1, 2016, 1,034 women were recruited; 780 were eligible, and 764 were randomized. The mean age of the subjects was 31.9 years (range 18-45 years). The median body mass index was 24.9 kg/m² (range 16.6-52.7 kg/m²). The median gestational age was 39 weeks (range 28-42 weeks). The median duration of labor was 13.9 hours (range 1-72 hours). The median length of stay was 44 hours (range 1-106 hours). The median length of stay in the hospital was 2 days (range 1-10 days).

CONCLUSIONS: A shared decision-making approach to opioid prescribing after cesarean delivery is associated with significantly reduced opioid requirements in the labor and delivery setting when compared with our institutional standard prescription. This approach is a promising strategy to reduce the amount of opioid medication after treatment of acute postpartum pain.

Cesarean delivery is the most common inpatient surgical procedure in the United States, and prescription opioids are one of the mainstays of pain management after discharge. There have been several studies that have evaluated the effectiveness of postpartum pain management and opioid use after cesarean delivery. A shared decision-making intervention to guide opioid prescribing after cesarean delivery is associated with significantly reduced opioid requirements in the labor and delivery setting when compared with our institutional standard prescription. This approach is a promising strategy to reduce the amount of opioid medication after treatment of acute postpartum pain.

Appendix 1

SHARED DECISION-MAKING FOR PRESCRIPTION OPIOIDS AFTER CESAREAN DELIVERY
Offer Responsive QI Services to Hospital Teams 2018

- **HTN – 112 teams**
  - 4 sustainability webinars
  - 1 QI topic call on sustainability plans
- **IPLARC – 17 wave 1 teams**
  - 8 webinars
  - 3 QI topic calls
  - 2 state wide IPLARC provider trainings (Springfield, Chicago)
- **MNO – 100 OB teams, 88 Neo teams**
  - **OB**: 11 webinars, 2 QI topic calls (+3 scheduled)
  - **Neo**: 8 webinars, 2 QI topic calls
  - 3 Buprenorphine provider trainings (Springfield, Champagne, Chicago) with 70 OB providers trained
- **OB Advisory Workgroup – 10 webinars**
- **Neo Advisory Workgroup – 8 webinars**
Effective Steps to Implement Education Program

- We identified RN and MD champions for the whole hospital along with unit champions and have the support of nursing administration.
- We used consistent reminders after education in huddles and unit meetings and audited charts.
- We incorporated HTN education as part of nursing skills day yearly. All new staff and physicians will be educated using the comprehensive slide set.
- We have included the education into our computer modules and have made it an annual requirement. We have also included maternal hypertension simulations.

ILPQC Team Survey, 2017
Barriers to Implementing Education Program

**ILPQC Team Survey, 2017**

- Time to accomplish simulations and ongoing time for educational offerings is a barrier.
- Provider buy in has been the biggest barrier. Many providers are still not on board with the protocol despite education and policy changes.
- It’s hard to engage private practice physicians and get buy in from them to attend education.
- Our initial roll out was very successful but sometimes it’s difficult to keep up with new hires.

**Key Terms:**
- Emergency Room
- Hospital
- Barriers
- Doctors
- Getting
- Staffing
- Staff
- Challenge
- Education
- Board
- Physician
- Resistance
- Providers
- Aware
- Buy
- Follow
- Patients
- Outside
- Difficult
- HTN
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- **Our initial roll out was very successful but sometimes it’s difficult to keep up with new hires.**
Effective Steps to Implement Standard Protocols

We reiterate what the goal is at physician OB department meetings and work closely with OB chair to promote an overall culture of safety where the chain of command is used and event reporting is done to determine trends.

We have updated policies and created a protocol for management of severe HTN that is posted in all rooms with other visual aides.

We use common order set for all units. ED knows that they have the full support of the OB unit and can call at anytime for us to facilitate the treatment of possible patient.
Barriers to Implementing Standard Protocols

It's hard to develop mechanisms to trigger the memory of providers and staff for a condition they are rarely exposed to in practice.

We had a delay in making order sets available because we needed various committee approvals and the IT build.

We have lack of support/buy in from private physicians. Resistance from some who do not want to follow protocol-want to do things their own way.

We experience high turnover in the ED and face resistance to treat BPs in the ED.
Percent of Hospitals with Inpatient **IUDs** Available on Hospital Formulary

<table>
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<tr>
<th>Month</th>
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Percent of Hospitals with Inpatient **Implants** Available on Hospital Formulary

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IPLARC on L&D/Postpartum

Percent of Hospitals with LARC Devices on L&D or Postpartum Unit
IPLARC Protocols 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**

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

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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
IPLARC Inpatient Patient Education & Counseling Protocols

Percent of Hospitals with Standardized Education Materials and Counseling Protocols during Delivery Admission
IT/EMR Revisions In Place

Percent of Hospitals with IT/EMR Revisions for Tracking and Documentation of Immediate Postpartum LARC