Florida Perinatal Quality Collaborative

Partnering to Improve Health Care Quality for Mothers and Babies

Access LARC
May 2018
Mid-Project Meeting Notes

Pre-Implementation Round Robin Notes

Policy/Work Flow/EMR

- Challenges:
  - EMR will have 2 different FIN numbers -> 1 note attached to each number
  - Delayed due to pharmacy – IT cannot start their process until the device is added to the formulary
- Solutions:
  - Have procedure and J codes built into the EMR
  - Ability to test billing codes
  - Borrowing from FPQC sample policy/consents
  - Dedicated IT person for children and family section
  - Double check billing codes are correct when building them in the EMR – Do not reinvent the wheel
  - Policy for handling the pharmacy benefit
  - Policy so the patient who wants ppLARC identified at admission – initial nursing assessment
  - Create a separate note for the procedure - EMR

Pharmacy

- Challenges
  - Concerns about storage of devices on the OB floor
  - Administration still doubtful about reimbursement to cover cost
  - Formulary process is dragging
- Solutions
  - Define IUDs as device -compare to drug eluting stent –
  - Explore possibility of working with provider for outpatient IUD devices to increase order for inpatient placement (based on specific physician relationships with IUD provider)
  - Make sure there is someone on committee with clout
  - Might be able to recover some cost at end of year (write off)

Providers

- Challenges:
  - Getting everything ready so docs can place
  - Don't want to train too early on insertion
  - Concern with expulsion rate, reimbursement, having the device ready in the room
  - Do midwives/mid-level providers need additional privileges? Is this hospital specific?
  - Individual orders and adding to the EMR
  - Lack of interest by private docs
  - Care in not targeting certain patient population groups
  - Emergency Medicaid patients and ippLARC? (yes, they are covered)
- Solutions:
  - Starting with certain provider groups, then expanding
  - Starting with implant

- Some way to identify the patient who is getting an IUD to make sure it is in the room
  - Anesthesia cart
  - Symbol or ag on the table
  - Device in the Pyxis
  - Put "Family Planning" on the patient white board (outside room and/ inside the room to remind nurse). This also prompts the patient to think about this!
- Early consent and have it in the orders well in advance
- Educate private docs on unbundling and expulsion rate concerns
- Educate on the project to address concerns early

Billing/Contracting

- Challenges:
  - Corporate hospital – not all educated on the issue. Hoops to jump through to negotiate contracts. How to make it break even.
  - Can't get certain devices (Liletta)
  - Pricing different non-profit vs for profit
  - Supplier contract slow
  - Recent outpatient placements not reimbursed
  - Slow process
  - Can't test billing until devices are on pharmacy/ even if billing is set, can't test payment
  - Private patients/insurance – may not cover – how to handle?
  - Some MCOs know of the issue/project, some say "what is LARC?"
- Solutions:
  - Partnership with FQHC for devices outpatient
  - Can prescriptions be filled at other pharmacy
  - Self pay: go through ARCH foundation
  - Wait and have patience
  - Make the argument for future savings vs. immediate costs using language CFOs can understand
  - Make sure billing is at kickoff to push the issue and ask the right questions
  - MCOs should test on their side
  - Need to know which MCOs are on board and contact person per hospital

Community (Healthy Start, MCO, March of Dimes, DOH group)

- Challenges
  - Patient and providers need clear, consistent and accurate information about postpartum contraception/ ippLARC
  - All providers need a unified goal (nurses, docs, Rx, LCs, etc); Harmony -> team
  - Focus on interconception care – training on choice. When to educate and reinforce education? Conduct follow-up? Education to empower women – women talk to provider
  - Focus on patient-centered counseling: When to have the conversation – dressed? Timing? Resources? Tools?
  - Need to have a smooth transition from the clinic to hospital and back to clinic/ID liaison L/D nurse
  - How well do we know a woman is pregnant?/ TANF ID pregnant members, late initiation
  - How to educate providers about bias, coercion, reproductive justice
  - "Off-label" use concerns
  - Hospital credentialing for staff privileges > 1 degree contact person
  - Patient navigator – advocate – not for delivery
  - Moving out to community. Catholic hospitals
  - Can prescriptions be filled at other pharmacy
- Solutions

- Conduct provider visits: teaching pearls: Talk about BC ASAP. "creating culture" constant education. IT?
- Peer to peer education is critical – generally more admins than providers
- Check sheet – patient gets a copy. Choice document 2x
- HEDIS measure – 2 weeks vs. 6-8 weeks. 3 week and/or 6 week visit – reinforce and educate
- Good dialogue with MCO
- Screening: HS – prenatal screen and postpartum screen. Provide info/resources. Can help with dissemination
- Screening: 2 step: A) risk screen HS. B) HS MCO to try to engage (#s low still)
- Screening: HS risk screen and Medicaid screen – combine – do you want more info on BC? Get what you want then approach MCOs
- Cost of devices: You can get IUDs for free; providers don't know; partner with FQHC for devices outpatient; If patient is self pay: go through ARCH foundation
- Educate women through multiple platforms: prenatal class? Youtube? Online? Staywell LARC, short communications: Instagram, snapchat, twitter, Facebook, ads, App for parents – teen app
- Use resources – ACA guidelines
- Leverage grandmothers/ community resources during education (ex: MOD – who are the connectors? Divine 9 engagement)
- Make the argument for future savings vs. immediate

Implementation Planning Brainstorm

Challenges	Solutions

• Patient without prenatal care presenting to the hospital in labor
• Individual provider preferences and setting up alternative provider for insertion
• Clinician participation in educational activities
	• Family planning counseling done by nurse
	• Consent like tubals in health department clinic -> send to hospital, patient has a copy
	• "You can't over-consent/counsel"
	• Counsel/consent EVERY PATIENT that comes into the hospital, just in case they did not adequately receive it prenatally
	• Communicate the same message
	• Catch providers in different ways to educate on shared decision making, etc.
	  ○ PAMR
	  ○ ACOG newsletter
	  ○ Go to offices
	• Talking points: this is what LARC is and this is what we are doing