**TITLE X PERFORMANCE MEASURES ACTION PLAN**

**CON-2: Effective Method Mix, All Ages**

**Benchmark**: **Increase** in % of female users of Tier 4 and 5 methods (IUD, implant, sterilization) between 2010 and 2011

| CON-2 ACTION PLAN CREATION (due 8/31) | | | ACTION PLAN COMPLETION (due 12/31) | |
| --- | --- | --- | --- | --- |
| Mark an X For All Chosen Items | Action Item | | Progress Notes/Documentation | Date Completed |
| Possible Cause: Issues with CDS Data Collection | | | | |
|  | A. | We will train staff on the definition of method used for CDS data (the most effective method as of the end of the visit), as well as the location and importance of consistent entry of CDS method data in the PMS/EHR. |  |  |
|  | B. | We will train clinical staff on how to fill out the superbill/PMS/EHR so that it reflects not only the most effective method at the end of the visit but also how to correctly document any other method given (e.g. a patient who already has an IUD and is given condoms at a visit should be recorded as an IUD user on the CDS Method field, with condoms recorded as dispensed using S-code). We will train clinical staff, not billing staff, to complete the CDS Method field. |  |  |
|  | C. | We will confirm that our CDS report is configured correctly to collect and report contraceptive method, and make updates to the PMS/EHR as needed. All methods should be collected, and any mapping will be shared with and approved by CDS Team. |  |  |
|  | D. | We will ask the CDS Team to confirm that their system is configured correctly to match our data report. |  |  |
|  | E. | We will conduct a chart review to confirm that the method recorded in the patient chart matches the method that appears in CDS data (ideally by viewing the data on the CDS website). |  |  |
|  | F. | We will request additional technical assistance from the CDS Team (describe): |  |  |
|  | G. | Other (describe): |  |  |
| Possible Cause: Need for Additional Provider/Staff Knowledge/Training | | | | |
|  | H. | We will train additional providers in IUD and Implanon insertion, including how to counsel clients appropriately when discussing their options and how to make insertion less painful. |  |  |
|  | I. | We will review with all providers the newest protocols/indications/guidelines for appropriate candidates and insertion (i.e. nulliparous women, menses not required, assessing a complete sexual history so that a CT/GC can be done the same day as an insertion, deferring CT/GC when it has been done recently, abnormal Pap OK, other US MEC recommendations). |  |  |
|  | J. | We will train staff on the common side effects of LARC methods and how to manage them without removing. |  |  |
|  | K. | We will train staff on the economics of LARC methods (not all lost revenue, there are reimbursements to help cover costs, provider learning curve- takes time to increase speed of insertion). |  |  |
|  | L. | We will have providers and staff attend the LARC webinar, to be held on August 14, 2012, or we will ask providers and staff to download it for review after that date. |  |  |
|  | M. | We will request additional training from the Medical Specialist (describe): |  |  |
|  | N. | Other (describe): |  |  |
| Possible Cause: Need for System Changes to Visit Flow, PMS/EHR, etc. | | | | |
|  | O. | We will train health education staff to mention LARC methods first when introducing/educating patients on birth control methods. |  |  |
|  | P. | We will train staff to efficiently implement Quick Start IUD/Implant at any family planning visit (i.e. efficient education/consenting, availability of supplies). |  |  |
|  | Q. | In our Prenatal Clinic, we will add a LARC discussion at all 36-week prenatal visits and at the post-partum visit. We will add a reminder to the PMS/EHR for these visits. |  |  |
|  | R. | We will request additional technical assistance from the Medical Specialist (describe): |  |  |
|  | S. | Other (describe): |  |  |
| Possible Cause: Need for Patient Education/Outreach | | | | |
|  | T. | We will provide new and/or increase the number of posters, videos, pamphlets, and other written materials about the benefits of LARC methods in waiting rooms, vitaling areas, and exam rooms (specify): |  |  |
|  | U. | We will request additional technical assistance from the Medical Specialist (describe): |  |  |
|  | V. | Other (describe): |  |  |
| Other Possible Cause | | | | |
|  | W. | Other: We will research additional ways to fund the purchase of LARC supplies (describe): |  |  |
|  | X. | Other: We will incorporate this measure into our agency’s overall Quality Improvement process (describe): |  |  |
|  | Y. | Other (describe): |  |  |

**TITLE X PERFORMANCE MEASURES ACTION PLAN**

**CON-3: Effective Method Mix, Adolescents 17 and Under**

**Benchmark**: **Increase** in % of adolescent female users of IUD and implant between 2010 and 2011

| CON-3 ACTION PLAN CREATION (due 8/31) | | | ACTION PLAN COMPLETION (due 12/31) | |
| --- | --- | --- | --- | --- |
| Mark an X For All Chosen Items | Action Item | | Progress Notes/Documentation | Date Completed |
| Possible Cause: Issues with CDS Data Collection | | | | |
|  | A. | We will train staff on the definition of method used for CDS data (the most effective method as of the end of the visit), as well as the location and importance of consistent entry of CDS method data in the PMS/EHR. |  |  |
|  | B. | We will train clinical staff on how to fill out the superbill/PMS/EHR so that it reflects not only the most effective method at the end of the visit but also how to correctly document any other method given (e.g. a patient who already has an IUD and is given condoms at a visit should be recorded as an IUD user on the CDS Method field, with condoms recorded as dispensed using S-code). We will train clinical staff, not billing staff, to complete the CDS Method field. |  |  |
|  | C. | We will confirm that our CDS report is configured correctly to collect and report contraceptive method, and make updates to the PMS/EHR system as needed. All methods should be collected, and any mapping will be shared with and approved by CDS Team. |  |  |
|  | D. | We will ask the CDS Team to confirm that their system is configured correctly to match our data report. |  |  |
|  | E. | We will conduct a chart review to confirm that the method recorded in the patient chart matches the method that appears in CDS data (ideally by viewing the data on the CDS website). |  |  |
|  | F. | We will request additional technical assistance from the CDS Team (describe): |  |  |
|  | G. | Other (describe): |  |  |
| Possible Cause: Need for Additional Provider/Staff Knowledge/Training | | | | |
|  | H. | We will train additional providers in IUD and Implanon insertion, including how to counsel clients appropriately when discussing their options and how to make insertion less painful. |  |  |
|  | I. | We will review with all providers the newest protocols/indications/guidelines for appropriate candidates and insertion (i.e. nulliparous women, menses not required, assessing a complete sexual history so that a CT/GC can be done the same day as an insertion, deferring CT/GC when it has been done recently, abnormal Pap OK, other US MEC recommendations). |  |  |
|  | J. | We will train staff on the common side effects of LARC methods and how to manage them without removing. |  |  |
|  | K. | We will train staff on the economics of LARC methods (not all lost revenue, there are reimbursements to help cover costs, provider learning curve- takes time to increase speed of insertion) |  |  |
|  | L. | We will train the Teen Clinic staff/Teen Clinic Director and/or school-based/other teen outreach workers on the use and benefits of LARC methods. |  |  |
|  | M. | We will train providers (including pediatric providers) and other staff on LARC methods and other adolescent family planning issues (describe): |  |  |
|  | N. | We will have providers and staff attend the LARC webinar, to be held on August 14, 2012, or we will ask providers and staff to download it for review after that date. |  |  |
|  | O. | We will request additional training from the Medical Specialist (describe): |  |  |
|  | P. | Other (describe): |  |  |
| Possible Cause: Need for System Changes to Visit Flow, PMS/EHR, etc. | | | | |
|  | Q. | We will train health education staff to mention LARC methods first when introducing/educating patients on birth control methods. |  |  |
|  | R. | We will train staff to efficiently implement Quick Start IUD/Implant at any family planning visit (i.e. efficient education/consenting, availability of supplies). |  |  |
|  | S. | In our Prenatal Clinic, we will add a LARC discussion at all 36-week prenatal visits and at the post-partum visit. We will add a reminder to the PMS/EHR for these visits. |  |  |
|  | T. | We will request additional technical assistance from the Medical Specialist (describe): |  |  |
|  | U. | Other (describe): |  |  |
| Possible Cause: Need for Patient Education/Outreach | | | | |
|  | V. | We will provide new and/or increase the number of posters, videos, pamphlets, and other written materials about the general benefits of LARC methods in waiting rooms, vitaling areas, and exam rooms (specify): |  |  |
|  | W. | We will provide new and/or increase the number of teen-friendly posters, videos, pamphlets, and other written materials about the benefits of LARC methods in waiting rooms, vitaling areas, and exam rooms (specify): |  |  |
|  | X. | We will request additional technical assistance from the Medical Specialist (describe): |  |  |
|  | Y. | Other (describe): |  |  |
| Other Possible Cause | | | | |
|  | Z. | Other: We will research additional ways to fund the purchase of LARC supplies (describe): |  |  |
|  | AA. | Other: We will incorporate this measure into our agency’s overall Quality Improvement process (describe): |  |  |
|  | BB. | Other (describe): |  |  |