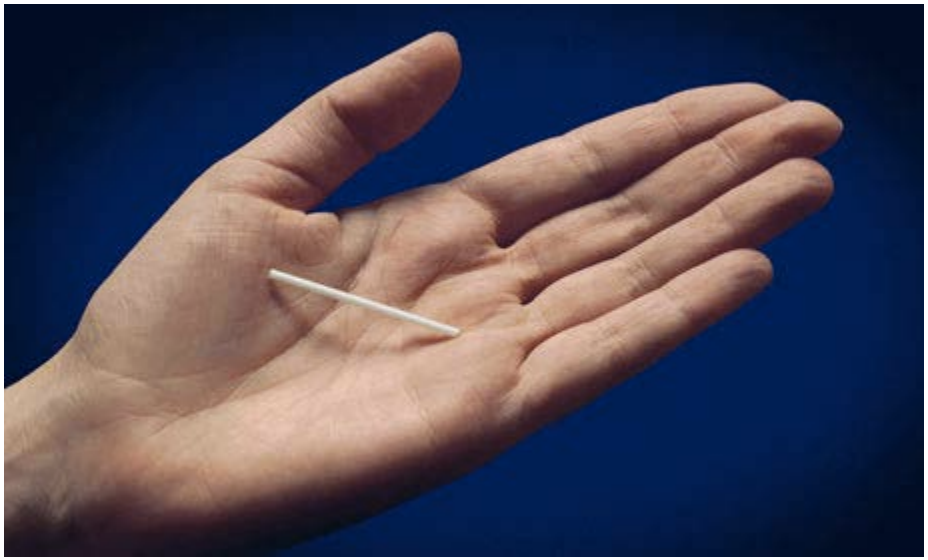
Implementing Immediate Postpartum LARC Program



Judith Burgis and Rhonda Quinones

ACCESS LARC

Florida Perinatal Quality Collaborative

November 3, 2017

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Objectives

Identify *KEY* steps in starting a program

Understand the Barriers that exist

Ensure ongoing success of the program

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Starting a Program

Why LARC and why now??

High **unintended pregnancy rates**

Low **attendance at the postpartum visit**

Contraceptive Choice Project

ACOG and AAP endorsements

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Unintended Pregnancy in the U.S.

49%

Unintended

Of 6.4 million pregnancies per year

3.2 million are unintended

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Finer LB, Zolna MR. 2011. Unintended pregnancy in the United States: incidence and disparities, 2006.

35% of pregnancies in the US are conceived within 18 months

34% of women did not Return for their routine Postpartum visit

Contraception, 92(2015)532-35

South Carolina

Post partum Visit

South Carolina Department Health and Human Services

non attendance rates as high as 55%

Reasons include

- Childcare obligations
- Unable to get off work
- Unstable housing
- No transportation
- Communication or language barrier
- Lack of insurance coverage or potential expiration of Medicaid eligibility

45% women are sexually active by 6 weeks postpartum

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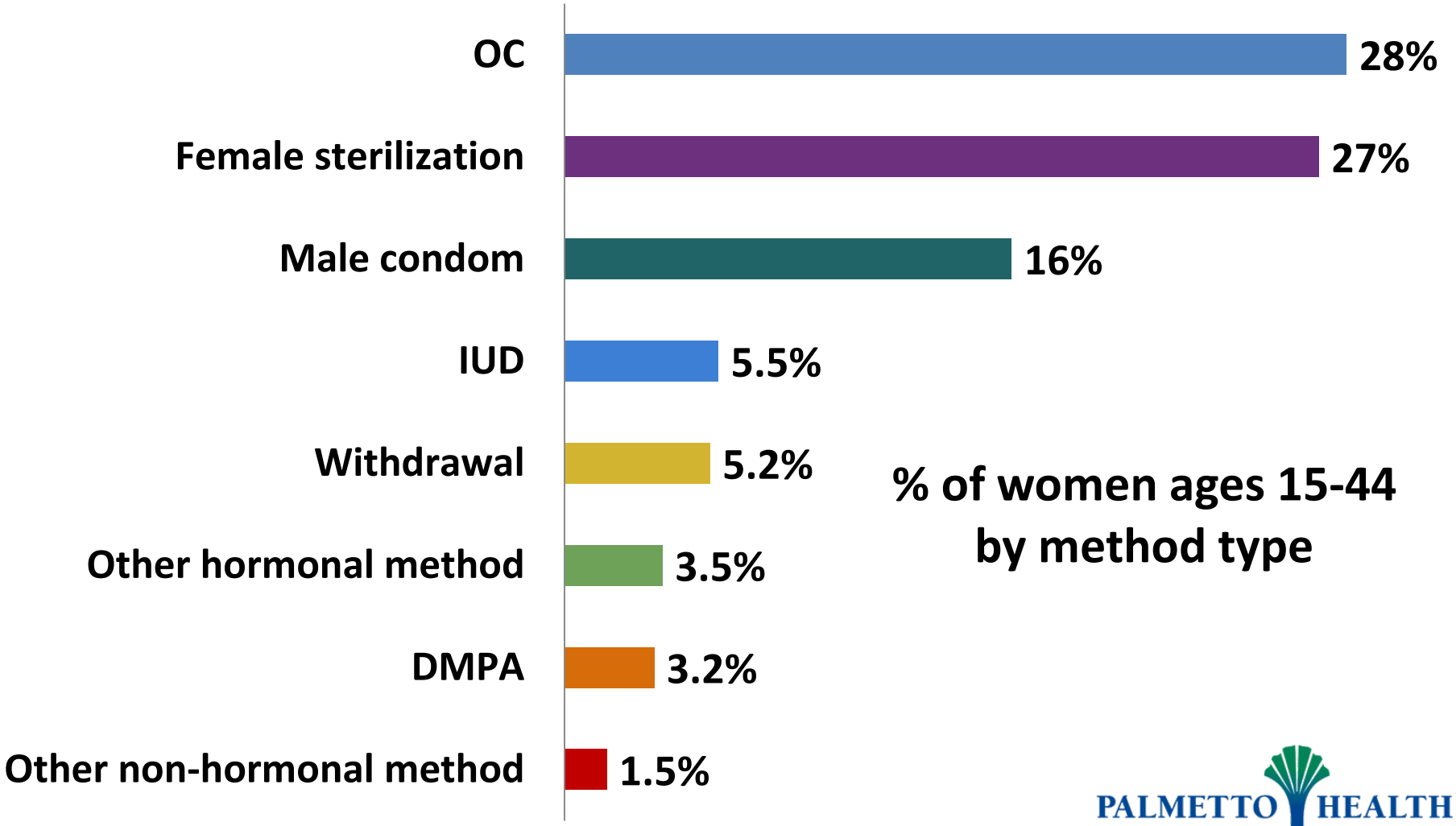
U.S. Contraceptive Use



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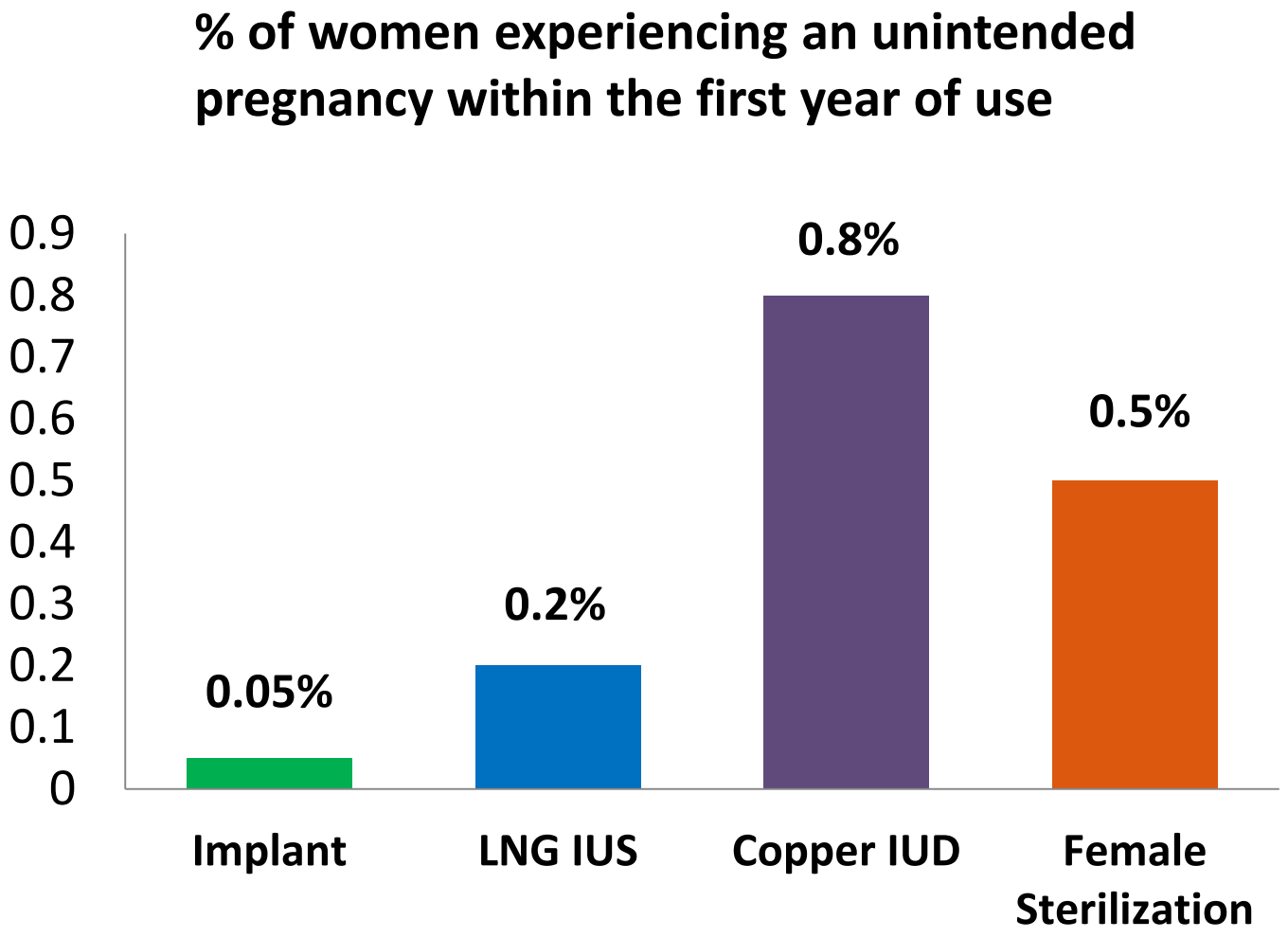
Reversible Contraception that Works as Well as Sterilization



Increased use of LARC* has the potential to lower unintended pregnancy rates

*LARC = Long-Acting Reversible Contraception

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Contraception for Adolescents

abstract

FREE

Contraception is a pillar in reducing adolescent pregnancy rates. The American Academy of Pediatrics recommends that pediatricians de-
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Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

COMMITTEE ON ADOLESCENCE

KEY WORDS

contraception, adolescent, birth control, intrauterine device, contraceptive implant, oral contraceptive pills, contraceptive

INTRODUCTION

Pediatricians play an important role in adolescent pregnancy prevention and contraception. Nearly half of US high school students report ever having had sexual intercourse.[1] Each year, approximately 750 000 adolescents become pregnant, with more than 80% of these pregnancies unplanned, indicating an unmet need for effective contraception in this population.[2,3] Although condoms are the most frequently used form of contraception (52% of females reported condom use at last sex), use of more effective hormonal methods, including combined oral contraceptives (COCs) and other hormonal methods, was lower, at 31% and 12%, respectively, in 2011.[1] Use of highly effective long-acting reversible contraceptives, such as implants or intrauterine devices (IUDs), was much lower.[1]

Adolescents consider pediatricians and other health care providers a highly trusted source of sexual health information.[4,5] Pediatricians' long-term relationships with adolescents and families allow them to

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 539 • October 2012 (Replaces Committee Opinion No. 392, December 2007 Reaffirmed 2014)

Committee on Adolescent Health Care
Long-Acting Reversible Contraception Working Group

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Adolesce... Contrace...es

Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods

ABSTRACT: ...he contraceptive implant—are safe... ...e LARC methods are top-tier contra... ...r year for perfect use and typical us... ...n of all reversible contraceptives. Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods.

Sexual Behavior and Contraceptive Use Among American Adolescents

In the United States, 42% of adolescents aged 15–19 years have had sexual intercourse (1). Although almost all sexually active adolescents report having used some method of contraception during their lifetimes, they rarely select the most effective methods. Adolescents most commonly use contraceptive methods with relatively high typical use failure rates such as condoms, withdrawal, or oral contraceptive (OC) pills (1). Nonuse, inconsistent use, and use of methods with high typical use failure rates are reflected in the high rate of unintended adolescent pregnancies in the United States. Eighty-two percent of adolescent

depot medroxyprogesterone acetate (DMPA) injections, are mainstays of adolescent contraceptive choices, but these contraceptives have lower continuation rates and higher pregnancy rates than LARC methods (5, 6). Of 1,387 females aged 15–24 years who initiated short-acting hormonal methods, only 11% using the contraceptive patch, 16% receiving DMPA injections, and approximately 30% using the vaginal ring and OCs were still using the same method after 12 months (6). In a study of 4,167 females aged 14–45 years that compared continuation rates for LARC and short-acting contraceptive methods, the continuation rate for LARC was 86% at 12 months compared with 55% for short-acting contracep-

OCTOBER 2015

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 642 • October 2015

(Replaces Committee Opinion Number 450, December 2009)

Committee on Gynecologic Practice
Long-Acting Reversible Contraception Working Group

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy

ABSTRACT: Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician–gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices. Obstetrician–gynecologists should encourage consideration of implants and intrauterine devices for all appropriate candidates, including nulliparous women and adolescents. Obstetrician–gynecologists should adopt best practices for long-acting reversible contraception insertion. Obstetrician–gynecologists are encouraged to advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 670 • August 2016

Committee on Obstetric Practice

The American College of Nurse–Midwives and the Society for Maternal–Fetal Medicine endorse this document. The American Academy of Family Physicians and the Association of Women's Health, Obstetric and Neonatal Nurses support this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Ann E. Borders, MD, MSc, MPH and Alison M. Stuebe, MD, MSc, and reviewed by the Long-Acting Reversible Contraception Work Group.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Immediate Postpartum Long-Acting Reversible Contraception

ABSTRACT: Immediate postpartum long-acting reversible contraception (LARC) has the potential to reduce unintended and short-interval pregnancy. Women should be counseled about all forms of postpartum contraception in a context that allows informed decision making. Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum intrauterine devices and implants. Obstetrician–gynecologists and other obstetric care providers should discuss LARC during the antepartum period and counsel all pregnant women about options for immediate postpartum initiation. Education and institutional protocols are needed to raise clinician awareness and to improve access to immediate postpartum LARC insertion. Obstetrician–gynecologists and other obstetric care providers should incorporate immediate postpartum LARC into their practices, counsel women appropriately about advantages and risks, and advocate for institutional and payment policy changes to support provision.

AUGUST 2016

SEPTEMBER 2016

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 672 • September 2016

Committee on Gynecologic Practice
Long-Acting Reversible Contraception Work Group

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and the Long-Acting Reversible Contraceptive Expert Work Group in collaboration with committee member David L. Eisenberg, MD, and Expert Work Group members Nichole Tyson, MD and Eve Espey, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Clinical Challenges of Long-Acting Reversible Contraceptive Methods

ABSTRACT: Long-acting reversible contraceptive methods are the most effective reversible contraceptives and have an excellent safety record. Although uncommon, possible long-acting reversible contraceptive complications should be included in the informed consent process. Obstetrician–gynecologists and other gynecologic care providers should understand the diagnosis and management of common clinical challenges. The American College of Obstetricians and Gynecologists recommends the algorithms included in this document for management of the most common clinical challenges.

South Carolina

Reimbursement was KEY !!

Medicaid and other payors had one payment for delivery

All services bundled together

***Perinatal Quality Collaborative* was instrumental**

PALMETTO HEALTH

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
August 13, 2013
MB# 13-037

MEDICAID BULLETIN

HOSP

TO: **Providers Indicated**

SUBJECT: **Clarification Bulletin: Long Acting Reversible Contraceptives provided in an Inpatient Hospital Setting**

On January 19, 2012, the South Carolina Department of Health and Human Services (SCDHHS) issued a bulletin titled "Long Acting-Reversible Contraceptives (LARCs) provided in a Hospital Setting". In that bulletin, the agency indicated that coverage for LARCs would be considered an add-on benefit to the Diagnostic Related Group (DRG) reimbursement for all dates of service on or after March 1, 2012.

Since publishing the previous bulletin, SCDHHS has worked with providers to determine the most effective approach to code and reimburse providers for LARCs provided in an inpatient hospital setting. Effective immediately, SCDHHS will reimburse providers for these LARCs through a gross level credit adjustment process for dates of service on or after March 1, 2012, according to the process described below.

In order to process the LARC payment, hospitals are required to utilize the Healthcare Common Procedure Coding System (HCPCS) Code that represents the device, along with the ICD-9 Surgical Code and the ICD-9 Diagnosis Codes that best describes the services delivered. These codes must be included on the UB-04 or Institutional Claim so that a gross level credit adjustment can be generated. Providers will receive a monthly listing of affected claims included in the gross level adjustment and the credit will appear on a future remittance advice. Providers will be able to identify this particular credit adjustment on the remittance advice in the Adjustment Section under the "Provider's Own Reference Numbers" column. Each adjustment will have a provider's own reference number that begins with "LARC". Relevant codes are listed below:

Included in the change were

Fee for Service Medicaid

Medicaid MCOs

South Carolina Blue Cross and Blue Shield

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Instructions for Medicaid Claims

Codes must be included on the UB-04 or Institutional Claim so that a gross level credit adjustment can be generated

The claim will adjudicate and the DRG portion will be paid in the weekly claims payment cycle. The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice.

HCPS:

- J7300 Intrauterine(IU) copper IUD (Paragard®)
- J7302 Levonorgestrel releasing IUD 52 mg (Mirena®)
- J7303 Etonorgestrel (contraceptive) implant system (Nexplanon®)

ICD-10 Surgical Code:

- 0UH90HZ Insertion Contraceptive Device

ICD-10 Diagnosis Code:

- Z30.018 Initiate Contraceptive NEC
- Z30.430 Insertion of IUD

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Institutional level

Identify project champions!

Physician

Nursing – administration, L&D, postpartum

Pharmacy

Billing

Lactation

Supply

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Institutional level

Create an Implementation Team

All relevant departments

Obtain financial reassurance

Ensure hospital administration awareness

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Institutional level

Meetings – communicate to all

Ensure hospital administration awareness and support!!

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Barriers

Lack of knowledge about post partum LARC

Providers

Patients

Hospital staff

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Barriers for Providers

Knowledge

Patient acceptance

Suitability for immediate postpartum

Continuation rates

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Provider Knowledge

Mechanics

How to insert immediate pp IUD

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Provider Knowledge

- **Spires post partum instruction**

video*www.youtube.com/watch?v=uMcTsuf8XxQ*

- **Aspire**

  project*https://www.engenderhealth.org/.../P*
  *P**IUD**_Trainers-Manua...*

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Provider Knowledge

IUD placed at time of Cesarean Section

10 minute training video

Randomized 112 women

-postplacental

-interval

Analyzed for use at 6 months

Expulsion

Discontinuation

String visibility

Satisfaction

Levi et al, OB/GYN vol126 july 2015

Provider Knowledge

	Immediate IUD	Interval IUD
Expulsion	8%	2%
Discontinuation	15%	4%
String visibility		
LNG-IUS	67%	80%
Copper	40%	50%
Satisfaction	92%	100%

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Barriers for Patients

LARC knowledge

LARC safety

LARC continuation and satisfaction

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Patient Knowledge

The American College of Obstetricians and Gynecologists

FAQ

FREQUENTLY ASKED QUESTIONS
FAQ184
CONTRACEPTION

Long-Acting Reversible Contraception (LARC): IUD and Implant

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Provider and Patient Knowledge

Breastfeeding

Initiation and continuation for 4 weeks

Implant vs no contraception

No differences in breast milk production

G.C. Braga et al. / Contraception xx (2015) xxx–xxx

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Provider and Patient Knowledge

Breastfeeding initiation and continuation

Immediate insertion vs insertion at 4 to 8 weeks postpartum

Lactation failure

Supplementation with formula

Milk composition

Gurtcheff et al *Early Postpartum Contraceptive Implants*

Barriers for Hospital Staff

May be different for different staff

Nursing – how will this affect my care of patients, what differences will there be?, when and where will the implant be inserted

Pharmacy – ordering, storage, and distribution demands

Lactation – how will LARC affect lactation, safety for patients who are breastfeeding

Barriers for Hospital Staff

Billing – what changes for billing? How will billing be done??

Administration – will we recover our costs?

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Barriers

Financial Concerns

May unmask:

Competing clinical and administrative priorities

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SUCCESS !!

Prioritize clear Communication

With all involved parties

- **nursing**
- **physicians**
- **pharmacy**
- **supply**
- **administration**
- **billing – both inpatient and outpatient**

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SUCCESS !!

Continuing education!!

Patients

Providers

Staff

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Current Reimbursement Rates for LARC Devices

HCPCS	Name	Before 7/1/16	7/1/16	1/1/17 (Current Rate)
J7300	ParaGard®	$745.00	$804.50	$804.50
J7301	Skyla®	$655.52	$707.96	$778.05
J7307	Nexplanon®	$777.69	$839.91	$923.06
J7297	Liletta®	$630.00	$680.40	$680.40
J7298	Mirena®	$816.99	$882.35	$934.41
J3490	Kyleena™	N/A	N/A	Manually priced

*Reimbursement for sales tax included in South Carolina

SUCCESS !!

Palmetto Health Richland

January 1, 2014 through December 31, 2016

1378 patients received LARC

PALMETTO HEALTH

SUCCESS !!

South Carolina

Subsets	Age In Years	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	Difference (FFY16 – FFY12)	Relative Change (Improvement)
Female Inpatient LARC patients:	Ages 15 - 44	102	374	874	1,228	1,491	1,117	1095.10%
	15-18	4	44	121	153	154	110	2750.00%
	19-44	98	330	753	1,075	1,338	1,008	1028.57%

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SUCCESS !!

SC Medicaid FY13-FY16

500% growth in patients benefiting from IPP services

30% of all LARC's can be attributed to immediate post partum

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Prenatal Education

Post partum contraception is part of ***each*** patient's problem list

It's discussed at ***every prenatal visit***

Plans are clearly laid out

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WHAT'S THE RISK?

Risks of Using Birth Control

IMPLANT

RISKS

Infection/ Complication at Insertion or Removal

0.1

Accidental Pregnancy

0.5

IUD

RISKS

Expulsion

50

Pelvic Inflammatory Disease

5

Perforation

0.5

Accidental Pregnancy

8

DEPO

RISKS

Reversible Bone Loss

Accidental Pregnancy

60

THE PILL

RISKS

Blood Clots

1

Stroke

0.2

Heart Attack

0.1

Accidental Pregnancy

90

If you're like most people, you probably took a shower this morning, drove to work or school, or took an aspirin.

Like many other things in life, using birth control sometimes involves risk.

But, compared to other risks we face on a daily basis, the chance of experiencing a serious health complication from using a contraceptive is low.

Risks of NOT Using Birth Control

Without birth control, 90 in 100 young women will get pregnant each year.

And during pregnancy and birth, half will have a medical problem:

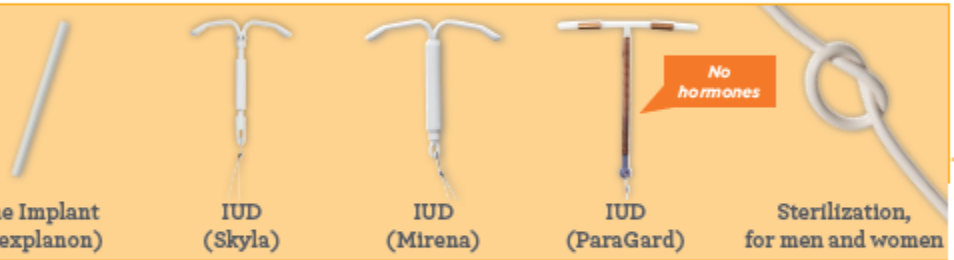
BEDSIDER
Bedsider.org

Bixby Center for Global Reproductive Health

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well



	The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
Works, hassle-free, for up to...	3 years	3 years	5 years	12 years	Forever

Less than 1 in 100 women

Okay

	The Pill	The Patch	The Ring	The Shot (Depo-Provera)
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not so well

	Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women
For each of these methods to work, you or your partner have to use it every single time you have sex.				

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

BEDSIDER
Bedsider.org

Bixby Center for Global Reproductive Health

Multidisciplinary Teamwork

PALMETTO HEALTH

Providing women with the Opportunity to choose an Immediate post partum LARC is a powerful strategy To help women meet their Contraceptive needs!!

www.co-obgyn.comvol 27,#6,12-2015