Postpartum Contraceptive Access in South Carolina

SC Birth Outcomes Initiative
March 26, 2015

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This webinar is being recorded.
OBJECTIVES

- Participants will improve their ability to prescribe LARC contraception for their patients and will understand the importance of contraceptive counseling throughout pregnancy, with a focus on informed choice related to LARC acceptance and continuation.

- Participants will identify the procedures necessary for inpatient insertion of LARC in the immediate post-partum period and will incorporate them into the system of postpartum services.

- Participants will obtain information to clarify billing for immediate post-partum LARC insertion for Medicaid-eligible (enrolled) women.
AGENDA

I. Prenatal Counseling about LARCs
   Deborah Billings, PhD

II. Hospital Strategies for Inpatient LARC Insertion
    Judith Burgis, MD
    Amy Picklesimer, MD

III. Q & A

IV. Survey
Prenatal Counseling about LARCs

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Importance of Prenatal Counseling for Postpartum Contraceptive Access

Summary Review of the Evidence Base
What we know about LARC use overall

- Overall use is low (women ages 15-44) but increasing over time: 1.5% in 2002 to 7.2% between 2011 and 2013 (*CDC NCHS Brief, 2015*)

- Women who have had at least one birth use LARCs at a higher rate compared with women who have had no previous births, and this difference has increased over time (*CDC NCHS Brief, 2015*)

**HOWEVER:**

- Low utilization of LARC may not reflect the true underlying demand for the intrauterine device (IUD) and implant. Contraceptive CHOICE Project (among other work) have shown a dramatic uptake of LARC when there is:
  1. **supportive counseling**
  2. methods are provided at no cost (*Peipert et al., 2012*)
Prenatal and Postpartum Periods: Opportune Moments for Contraceptive Care

• High interest in LARC exists among postpartum women, particularly among women with a recent unintended pregnancy and women who do not desire pregnancy for at least 2 years (Tang et al., 2013)

• Over half of unintended pregnancies among women in the US occur within 2 years following delivery despite (In Potter et al., 2014):
  • Improved access to health care and insurance coverage in the immediate postpartum period
  • Women’s increased motivation to prevent pregnancy
Prenatal Contraceptive Counseling

- Women report limited contraceptive counseling during prenatal care.
- Prevalence of counseling is higher postpartum.
- Either prenatal or postpartum: LARC and permanent methods often not discussed.
- Preference for these methods not confined to particular segments of the population.
- Hispanic women had a higher interest in and use of LARC than other ethnic/racial groups among participants who wanted to or might have an additional child (consistent with nationally representative data).

Such limited counseling likely affects access to and uptake of highly effective methods, as well as subsequent risk of unintended pregnancy.

Women’s contraceptive needs could be better met by counseling about all methods, by reducing cost barriers and by making LAPM available at more sites.

(Aiken et al. 2013; Potter et al., 2014)

- 3 Hospitals, Austin and El Paso, TX.
- Prospective cohort study.
- 800 postpartum women aged 18-44 who wanted to delay childbearing for at least 24 months.
Prenatal Contraceptive Counseling

- Lack of access to LARC (long-acting reversible contraception) postpartum
  - lack of provider training;
  - misperceptions regarding eligibility, safety, and effectiveness;

- insufficient counseling;
- structural barriers related to the postpartum provision of both LARC and female sterilization

(Aiken et al. 2013; Potter et al., 2014)
Prenatal Contraceptive Counseling

• Atlanta study: baseline characteristic found to be most significant for intent to use LARC was discussion about LARC with a provider during the prenatal period, (adjusted odds ratio, 20.1; 95% CI, 6.1–66.1).

• Women's contraceptive goals postpartum are consistent with attributes of LARC methods.

• Discussion with a provider about these methods in prenatal period may influence the decision to use LARC methods (Kotke, 2010)
Don’t wait until postpartum visit

• North Carolina study: hypothesized that women who received a “LARC script”* during their postpartum hospitalization would be more likely to report LARC use after their 6-week postpartum visit, compared to women who did not receive the script

FINDINGS:

• Administration of a LARC script to postpartum women (before leaving the hospital) did not significantly increase postpartum LARC use (at 6-week PP visit).

• However, the script significantly increased interest in using LARC

*LARC script adapted from the CHOICE Project; (Tang et al 2014)
Specific Needs of Adolescents

• Adolescents who do not initiate a LARC method postpartum have up to a 35 times increased risk of rapid repeat pregnancy (RRP) compared with their peers using LARC. Risk of RRP is decreased when LARC methods are initiated earlier after an abortion or within the postpartum period. (Baldwin and Edelman, 2013)

• Receipt of prenatal contraceptive counseling and receipt of a postpartum checkup were both associated with a decreased likelihood of having sex without contraception (although LARC use low- 11% IUD and 1% implant)

• Enhancing the scope and quality of prenatal contraceptive counseling and increasing the proportion of adolescent mothers who return for a postpartum checkup may also improve postpartum contraceptive use. (Wilson et al., 2013)
Importance of Prenatal Counseling for Postpartum Contraceptive Access

High Quality Practice: Ethics and Informed Choice
Ethics and Informed Choice

• Providers as *facilitators*, who offer information that enables women to make informed decisions about their contraceptive methods in relation to their lives

• Contributes to the empowerment and dignity of women postpartum

• Respect for women’s autonomy

• Core part of high quality care

• Frames our work clearly as meeting the needs of women
References


Hospital Strategies for Inpatient LARC Insertion

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LARC: Long Acting Reversible Contraceptives

Etonorgestrel Implant

Levonorgestrel Intrauterine System

3 and 5 year options
WHY LARC?
THE CHOICE

Our website provides the most up-to-date information about the CHOICE Project, publications, research findings and dissemination efforts. Start by watching an overview of our research results in "Pathway to CHOICE", check out local and national resources or learn more about your contraceptive options. The CHOICE is yours!
WHO ENROLLED IN THE STUDY?

A diverse group of women enrolled in CHOICE and are very similar to women who live in the St. Louis region. Each chart shows the percent of women in each category of the 9,256 enrolled.
WHAT METHOD DID WOMEN CHOOSE?

This chart shows the birth control methods 9,256 women chose when they enrolled in CHOICE. Overall 75% of women chose a long-acting reversible contraceptive method (LARC: IUD or implant). Teens also chose LARC methods.
ARE WOMEN STILL USING THEIR METHOD?

Among women who chose a LARC method, 86% were still using their method at 1 year. Only 55% of women who chose non-long-acting methods were still using their method at 1 year.

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HORMONAL IUD</td>
<td>88%</td>
</tr>
<tr>
<td>COPPER IUD</td>
<td>84%</td>
</tr>
<tr>
<td>IMPLANT</td>
<td>83%</td>
</tr>
<tr>
<td>SHOT</td>
<td>57%</td>
</tr>
<tr>
<td>PILLS</td>
<td>55%</td>
</tr>
<tr>
<td>RING</td>
<td>54%</td>
</tr>
<tr>
<td>PATCH</td>
<td>49%</td>
</tr>
<tr>
<td><strong>LONG-ACTING METHODS</strong></td>
<td><strong>86%</strong></td>
</tr>
<tr>
<td><strong>NON-LONG-ACTING METHODS</strong></td>
<td><strong>55%</strong></td>
</tr>
</tbody>
</table>
ARE WOMEN SATISFIED WITH THEIR METHOD?

Women using LARC had the highest satisfaction at 1-year follow-up. Women who stopped their method were considered not satisfied.
HAVE WOMEN HAD UNINTENDED PREGNANCIES?

Women using LARC or the shot had the lowest unintended pregnancy rates at 1, 2 & 3 years of follow-up. Pill, ring & patch users had a pregnancy rate that was 20 times higher than LARC users. LARC was very effective at preventing pregnancy regardless of age, but women <21 using the pill, ring or patch were 2 times more likely to get pregnant than women ≥21 years using the same methods.
WHY NOW?
POLICY STATEMENT

Contraception for Adolescents

abstract

Contraception is a pillar in reducing adolescent pregnancy rates. The American Academy of Pediatrics recommends that pediatricians develop a risk-benefit evaluation for each adolescent patient. Additionally, the pediatrician should have discussions about contraception with adolescents and their parents. Adolescents have low rates of reported use of contraception and the rates are even lower among obese adolescents. The American Academy of Pediatrics recommends that adolescents have discussions with their pediatricians about contraception.

Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

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.2,5 Although condoms are the most frequently used form of contraception (52% of females reported condom use at last sex), use of other 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' frequent interactions with adolescents and families allow them to

Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.

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 contraception.
MEDICAID BULLETIN

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:
Long Acting Reversible Contraceptives

- Challenge identified in BOI Care Coordination Workgroup. 50% of Medicaid beneficiaries miss their 6 week post-partum appointment which often results in unplanned/unwanted pregnancies

- March 1, 2012: Medicaid allowed for in-patient insertion of the device, but billed outside the DRG for full payment to the hospital.

- SC was the first state in the nation to enact this policy with 3 others recently adopting it.

- Coverage for LARC is included in the MCO capitation rate; the Plans adopted the insertion/inpatient policy as well.
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:
- A4264 Intratubal Occusal Device (Essure)
- J7300 Intrauterine (IU) copper IUD (Paraguard)
- J7301 Levonorgestrel-releasing IUD 13.5 mg (Skyla)
- J7302 Levonorgestrel releasing IUD 52 mg (Mirena)
- J7307 Etonorgestrel (contraceptive) implant system (Implanon/Nexplanon)

ICD-9 Surgical Code:
- 69.7 Insertion Contraceptive Device

ICD-9 Diagnosis Code:
- V25.02 Initiate Contraceptive NEC
- V25.1 Insertion of IUD
<table>
<thead>
<tr>
<th>Code</th>
<th>Previous Reimbursement Rate</th>
<th>Current Reimbursement Rate</th>
<th>Insertion Code</th>
<th>Rate</th>
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<tbody>
<tr>
<td>A4264</td>
<td>$1,164.00</td>
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<tr>
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<tr>
<td>J7307</td>
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<td>$777.69</td>
<td>11981</td>
<td>$price depends on specialty and modifier</td>
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<tr>
<td>J7302</td>
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<td>$Price depends on specialty and modifier</td>
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<tr>
<td>J7301</td>
<td>n/a</td>
<td>$702.35</td>
<td>58300</td>
<td>$Price depends on specialty and modifier</td>
</tr>
</tbody>
</table>
Immediate Postpartum Insertion of Long-Acting Reversible Contraception

Nearly 1 in 5 teen births are repeat births, about 183 a day.

Many repeat births could be prevented through postpartum use of long-acting reversible contraception (LARC) such as IUDs and implants. Counseling women during prenatal visits about postpartum contraception, and offering women LARC in the hospital after delivery makes it easier for women to avoid unintended pregnancy.

A Teen-Friendly Reproductive Health Visit

South Carolina’s Medicaid program reimburses for LARC insertion in the hospital before women who have just given birth leave the hospital.

Learn more about South Carolina’s Medicaid Health Initiatives.
Nexplanon Insertion

http://youtu.be/ug7q_1RUMio

Request in-person training by calling Merck 877-467-5266 or online at http://www.nexplanon-usa.com
Supplies

Hospital Pyxis

- Nexplanon device and local anesthetic
Supplies

Tackle Box

- Sterile gloves
- Sterile towels
- Betadine swabs
- Sterile marking pen
- 20 cc syringe
- 18 and 23 gauge needles
- Band-aid
- Dressing pads and wrap
Order picklists -- Webpage Dialog

GMH OB Triage-08OB02

Allergies: 0 (Reassess) Diagnosis: (1) MR# 970104967

- Selected Visit
- No Visit
- Do Not Discontinue Orders After End of Visit

Common Patient Based Order Sets Search Personal Favorites

Favorites

- Soarian Updates / Reminders CPOE
- Admission Set_Floor/Monitored Bed
- Admission Set_ICU Non-Ventilated
- Admission Set_ICU Ventilated
- Common IV Fluids
- Common Labs
- Common Meds
- Common Nursing Care
- Common Rad
- Common Respiratory Meds
- Food & Nutrition Services
- Sets Anesthesia
- Sets Cardiology
- Sets Cardiovascular
- Sets Medical
- Sets OB/GYN
- Sets Surgical

nexplanon

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 (M10253)
- Initiate/Print Bed Side Time Out (M10730)
What about breastfeeding?

The implant can be inserted at any time following delivery. The advantages generally outweigh real or theoretical risks if placed <1 month post-partum, and there is no restriction if placed >1 month post-partum.

CDC MMWR June 21, 2013

Observational studies of progestin-only contraceptives suggest they have no effect either on a woman’s ability to successfully initiate and continue breastfeeding, or an infant’s growth and development.

ACOG Practice Bulletin #121, July 2011
The risks of unintended pregnancy are much greater than the real or theoretic risks of progestin exposure in the post-partum period.

The advantage of Nexplanon over Depo Provera is that the implant can be removed in women who are struggling with lactation.

An additional advantage of Nexplanon over Depo Provera is that it has a lower peak serum concentration.

- After Depo Provera injection, medroxyprogesterone acetate plasma concentrations peak at 7 ng/ml 3 weeks after injection.
- After Nexplanon insertion, etonorgestrel plasma concentrations peak at 0.8 ng/ml 4 days after insertion.
Do women (and doctors) like it?
Nexplanon insertion rates as percentage of total deliveries

- January: 15.0%
- February: 16.0%
- March: 23.4%
- April: 15.2%
- May: 16.8%
- June: 10.3%
- July: 18.4%
- August: 20.8%
- September: 18.4%
- October: 15.2%
- November: 16.0%
- December: 18.4%
Palmetto Health Richland

- Implant experience similar to GHS
- Worked with Nursing, Pharmacy, Billing and Residents place the majority
- Ongoing enrollment of adolescents to evaluate satisfaction, continuation
Intrauterine Device (IUD or IUS)

- Levonorgestrel
- Copper

Insertion
- Immediate post-placental (10 minutes)
- 6 weeks post-partum

Studied with vaginal and cesarean delivery
Insertion technique

https://youtu.be/zgi3mbW2YdA?t=2m35s
CDC and ACOG state the benefits of immediate post-placental insertion generally outweigh the risks.
Complications with post-placental insertion

- **Expulsion**
  - Post-placental insertion 20-27% expulsion
  - Insertion at 6 weeks post-partum 4.4% expulsion

- **Pain – similar**

- **Infection rates – similar**

- **Breastfeeding continuation – similar**
Techniques

- “Bayer” inserter
- Ring Forceps
- Manual insertion
Post-partum IUD insertion

https://youtu.be/-xNIKUI5v_0?t=38s
Questions?
SC Birth Outcomes Initiative

Thank You!

Please visit: https://www.scdhhs.gov/boi