



Road to Access: Successes and Challenges in implementation of IPP LARC

Eve Espey, MD MPH

New Mexico Perinatal Collaborative

ILPQC 11-5-18

OR....

**If at first you don't succeed,
try try again**

Disclosures and acknowledgements

- No financial relationships or conflicts of interest
- Acknowledgements
 - Abby Reese, CNM
 - Lisa Hofler, MD MPH, MBA
 - Michelle Moniz, MD

Learning objectives

- Why care about immediate postpartum LARC?
- The agony and ecstasy of implementation
 - Implementation key steps
 - New Mexico story
- Training
- Comprehensive contraception counseling
- The big picture

Unintended pregnancy

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Declines in Unintended Pregnancy in the United States, 2008–2011

Lawrence B. Finer, Ph.D., and Mia R. Zolna, M.P.H.

ABSTRACT

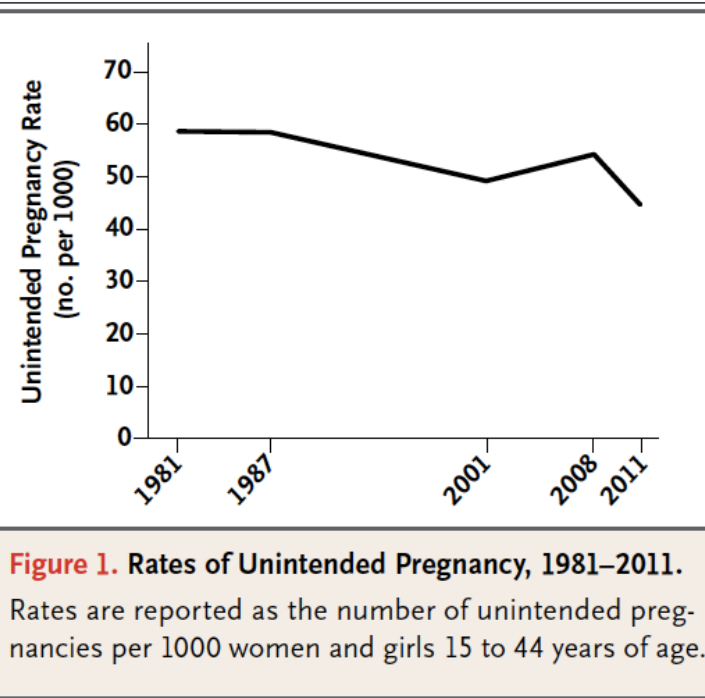
BACKGROUND

The rate of unintended pregnancy in the United States increased slightly between 2001 and 2008 and is higher than that in many other industrialized countries. National trends have not been reported since 2008.

METHODS

We calculated rates of pregnancy for the years 2008 and 2011 according to women's and girls' pregnancy intentions and the outcomes of those pregnancies. We obtained data on pregnancy intentions from the National Survey of Family Growth and a national survey of patients who had abortions, data on births from the National Center for Health Statistics, and data on induced abortions from a national census of abortion providers; the number of miscarriages was estimated using data from the National Survey of Family Growth.

RESULTS



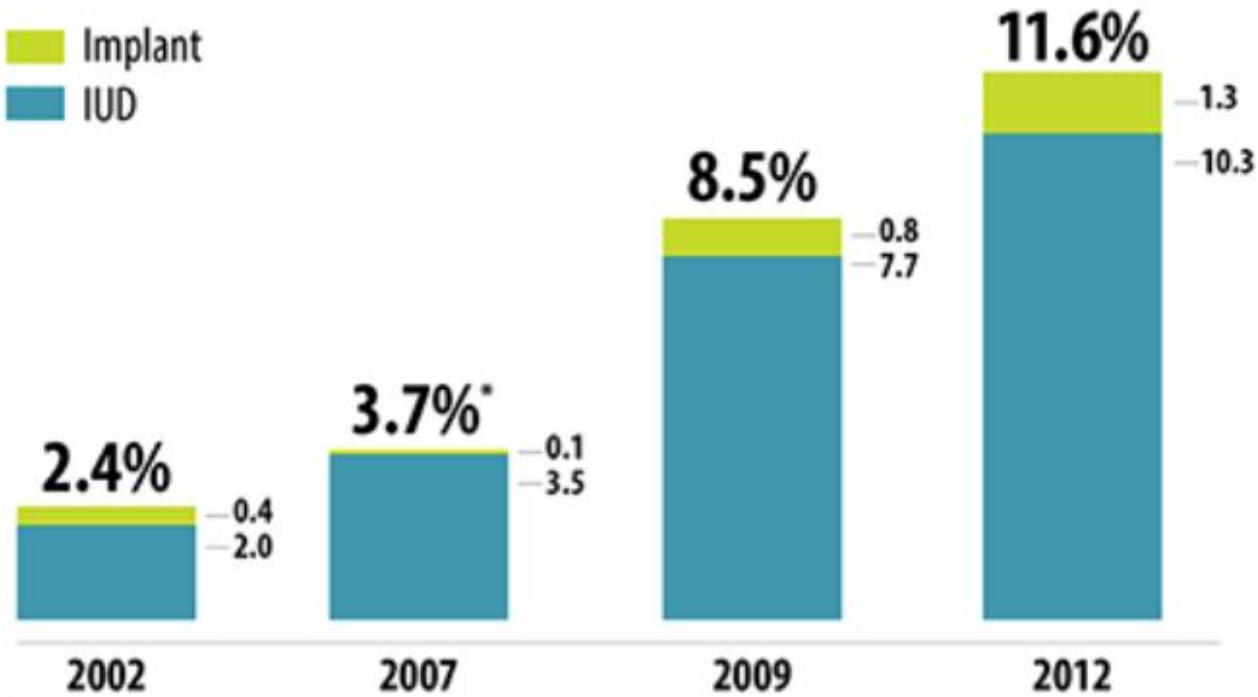
Finer NEJM, 2016

U.S. women's use of long-acting reversible contraceptive (LARC) methods, like the IUD, has increased over the past decade



Female contraceptive users aged 15–44

■ Implant
■ IUD



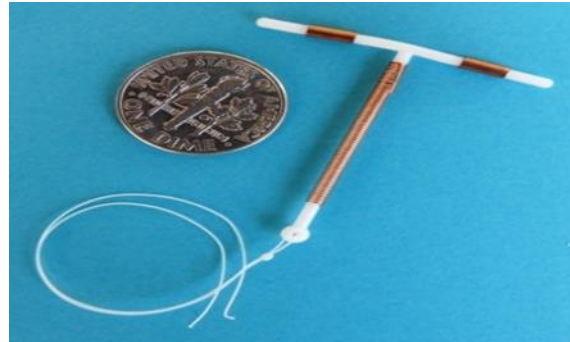
www.guttmacher.org

*Numbers do not add to total due to rounding.

What is immediate postpartum LARC?



Levonorgestrel IUDs



Copper IUD



Etonogestrel Implant

- Available prior to hospital discharge after delivery
- Access endorsed by numerous professional organizations



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 Obstetricians and Gynecologists, in collaboration with the American Academy of Family Physicians, has developed this Committee Opinion in collaboration with the American Academy of Family Physicians Long-Acting Reversible Contraception (LARC) Workgroup. This document reflects the views of the Committee on Obstetric Practice and should not be construed as an official position of the American College of Obstetricians and Gynecologists or the American Academy of Family Physicians.

Immediate Postpartum Contraception

ABSTRACT: Immediate postpartum long-acting reversible contraception (LARC) is an effective option for postpartum contraception and implants. Obstetrician–gynecologist–family physician collaboration during the antepartum period and counseling and institutional protocols are important for immediate postpartum LARC insertion. Obstetrician–gynecologist–family physician collaboration should facilitate postpartum LARC into their practice. Institutional and payment policies should be reviewed to ensure that women have access to immediate postpartum LARC.

Recommendations

The American College of Obstetricians and Gynecologists (the College) recommends the use of immediate postpartum long-acting reversible contraception (LARC):

- Optimally, women should be counseled about the option of immediate postpartum LARC. Counseling should include advantages, risks of intrauterine device (IUD) expulsion, contraindications, and the option of immediate postpartum LARC.

partum IUD insertion compared with interval IUD insertion.

- Systems should be in place to ensure that women

“The American College of Obstetricians and Gynecologists supports immediate postpartum LARC insertion as a best practice, recognizing its role in preventing rapid repeat and unintended pregnancy.”

PP LARC has many advantages

- ❖ Convenience
- ❖ Motivation
- ❖ Time limits on some postpartum insurance coverage
- ❖ Not pregnant
- ❖ High rate of satisfaction
 - ❖ 74% IPP IUD continue at a year
 - ❖ 84% IPP implant continue at a year
- ❖ Cost-effective
- ❖ Effectiveness

Cohen, 2016
Crockett, 2017
Woo, 2015

IUD Expulsion is higher with PP insertion

- 1.9% in the first year of use with “interval” insertion
- 10% within 10 minutes of placental delivery
- 29.7% from 10 minutes to 4 weeks after delivery
 - Hormone IUD > copper IUD
 - Vaginal delivery > C/S
- **Provider experience has a major influence on expulsion rates**

Expulsion rates: Bottom line

“Despite the higher expulsion rate of immediate postpartum IUD placement, evidence strongly suggests the **superiority of immediate placement in reduction of unintended pregnancy** especially for those at greatest risk of not having recommended postpartum follow-up visit.”

PP IUD contraindications

- Hemorrhage
- Severe perineal laceration
- Infection
 - Chorioamnionitis
 - Sepsis
- Not well studied
 - Prolonged rupture of membranes
 - Prolonged labor

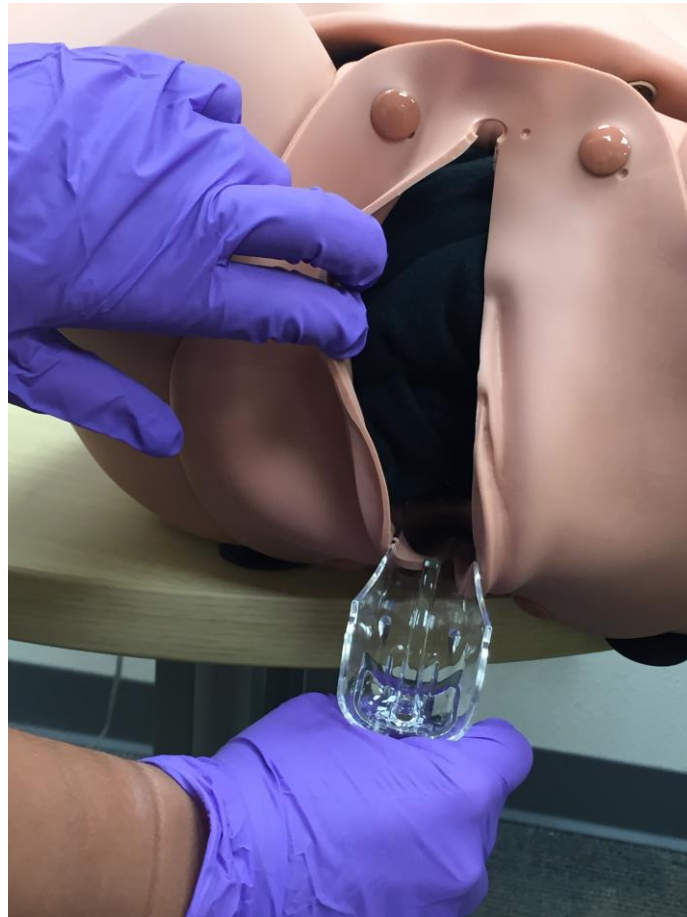
IUDs OK with Breastfeeding!

		LNG-IUD	Copper-IUD
Postpartum (in breastfeeding or non-breastfeeding including post-section)	a) < 10 minutes after delivery of the placenta	2	1

“Given available evidence, women considering IPP hormonal LARC should be counseled about the theoretical risks of reduced duration of breastfeeding, but the preponderance of evidence has not shown a negative effect on actual breastfeeding outcomes” ACOG

Technique vaginal delivery

- ❖ Identify anterior cervix with short ring forceps.



Technique

- ❖ Cut IUD strings to 10 cm. Load IUD on long ring (placental) forceps at a slight right angle.



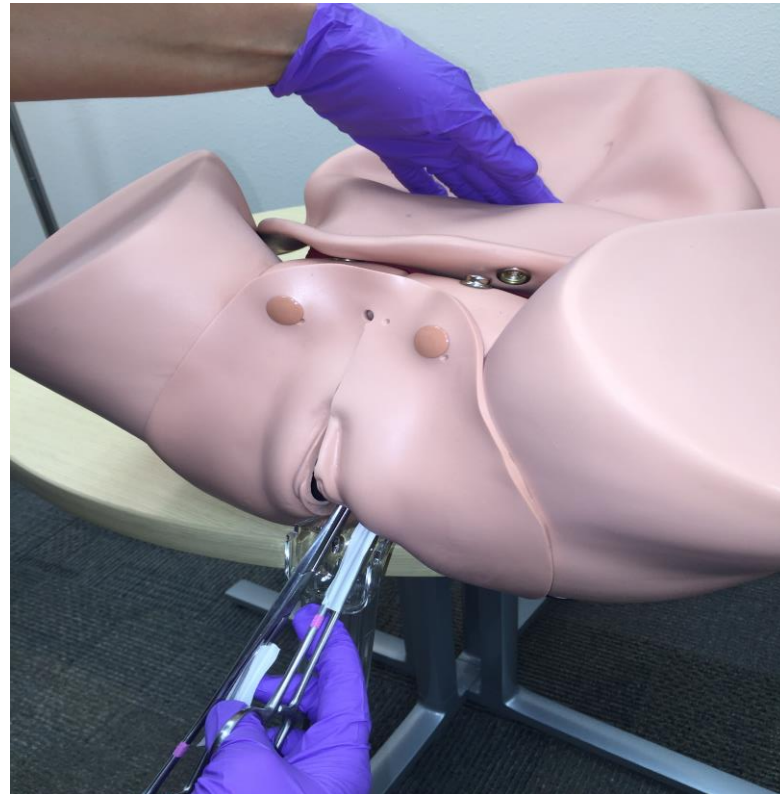
Technique

- ❖ Pass IUD through the cervix. Let go of ring forceps and place hand on abdomen to palpate uterine fundus.



Technique

- ❖ Observe IUD placement with ultrasound, if available.
- ❖ Open forceps wide to release IUD and remove forceps keeping forceps **WIDE OPEN**.

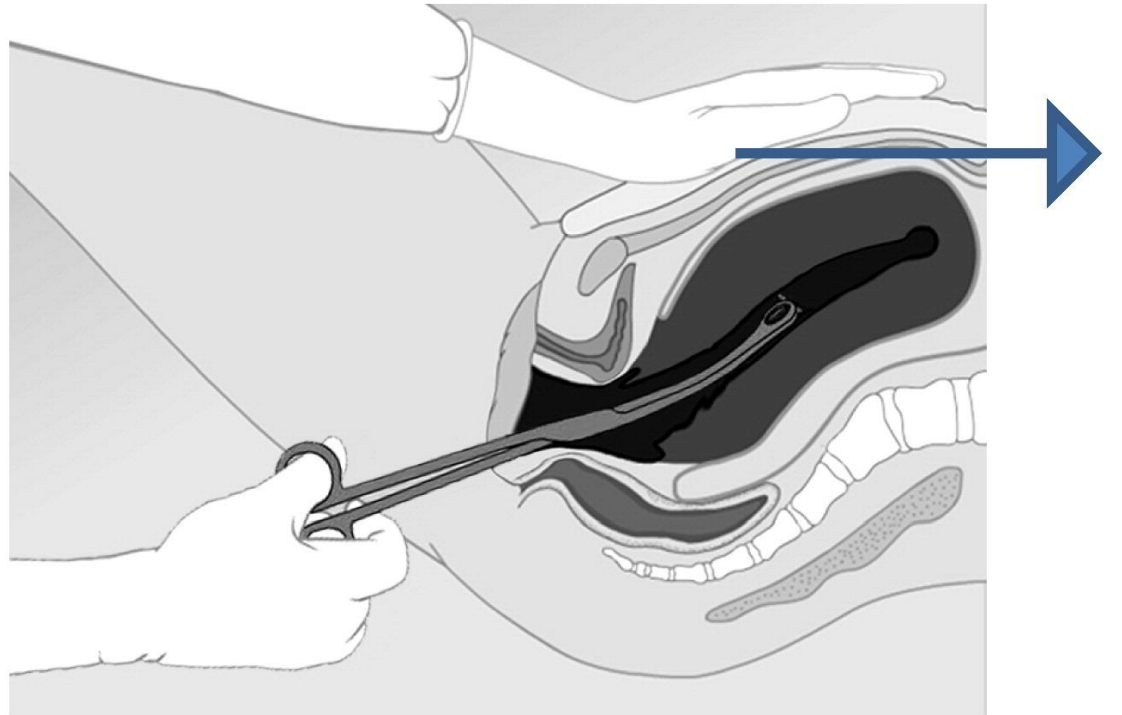
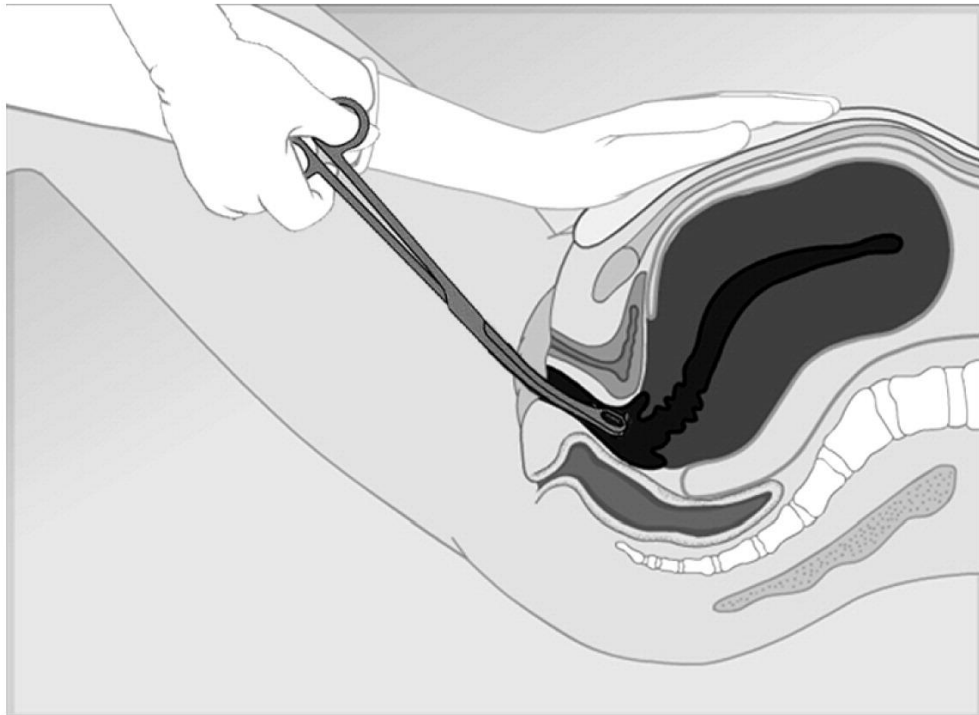


Technique

- ❖ If available, helpful to check fundal placement with ultrasound.



Importance of fundal placement



Contraceptive implant insertion is the same...



The FDA requires health care providers who perform implant insertions and removals receive training from the manufacturer of Nexplanon.[®]



Request a Nexplanon[®] training:

Website: <http://www.nexplanon-usa.com/en/hcp/services-and-support/request-training/>

Phone number: 1-877-467-5266

Goal of contraception?

Reduce unintended pregnancy
**Empower women to make the
decision that is best for them**

Reproductive coercion

- The act of forcing a woman to use a method of birth control that she did not choose

LARC Statement of Principles



- *We acknowledge the complex history of the provision of LARCs and seek to ensure that counseling is provided in a consistent and respectful manner that neither denies access nor coerces anyone into using a specific method.*
- *We commit to ensuring that people are provided comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner in order to ensure that each person is supported in identifying the method that best meets their needs.*

Counseling & Consent

- Patient-centered counseling approach: Shared decision-making
- Discussion timing
- Documenting consent
 - Practice standards
 - Communicating plan



A. Neri, 2016

B. ACOG Committee Opinion #490, Partnering With Patients to Improve Safety

Postpartum contraceptive counseling!

- Counsel about all forms of postpartum contraception in a context that allows informed decision making
- Counsel prenatally about IPP LARC if possible
 - Advantages
 - Risk of IUD expulsion
 - Potential breastfeeding risks with hormonal methods
 - Disadvantage of non-woman controlled method
 - Access to removal

Tools for contraceptive counseling

HOW WELL DOES BIRTH CONTROL WORK?

Really, really well

Works, hassle-free, for up to...

The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
3 years	3 years	5 years	12 years	Forever

No hormones

What is your chance of getting pregnant?

Less than 1 in 100 women

Okay

For it to work best, use it...

The Pill	The Patch	The Ring	The Shot (Depo-Provera)
Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not so well

For each of these methods to work, you or your partner have to use it every single time you have sex.

Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women

Needed for STI protection

Use with any other method

12-24 in 100 women, depending on method

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

U. S. Medical Eligibility Criteria Wheel For Contraceptive Use

June 2012

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Bedsider.org....

BEDSIDER

[birth control methods](#)

[where to get it](#)

[reminders](#)

[features](#)

[questions](#)



IMPLANT /



The implant (Nexplanon is the brand name; previously Implanon) is a teeny-tiny rod that's inserted under the skin of your upper arm. It's so small, in fact, most people can't see it once it's inserted—which means it can be your

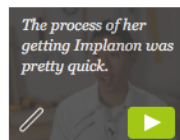
little secret, if you're so inclined. The implant releases progestin, a hormone that keeps your ovaries from releasing eggs and thickens your cervical mucus—which helps block sperm from getting to the egg in the first place. It prevents pregnancy for up to four years. Not too shabby.

[view all methods »](#)

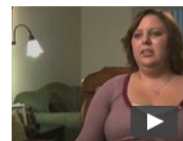
real stories /



abigail, 19



ashley, 19



ashley, 19

quick facts /

Invisible to the world but not to you. It's easy, incredibly effective, long lasting, and reversible.

★ effectiveness

The implant is among the most effective methods.

● side effects

Irregular bleeding is the most common side effect of the implant.

★ effort

Quick insertion and you're set for 4 years.

easy to get

You need to see a provider to get it inserted.

cost

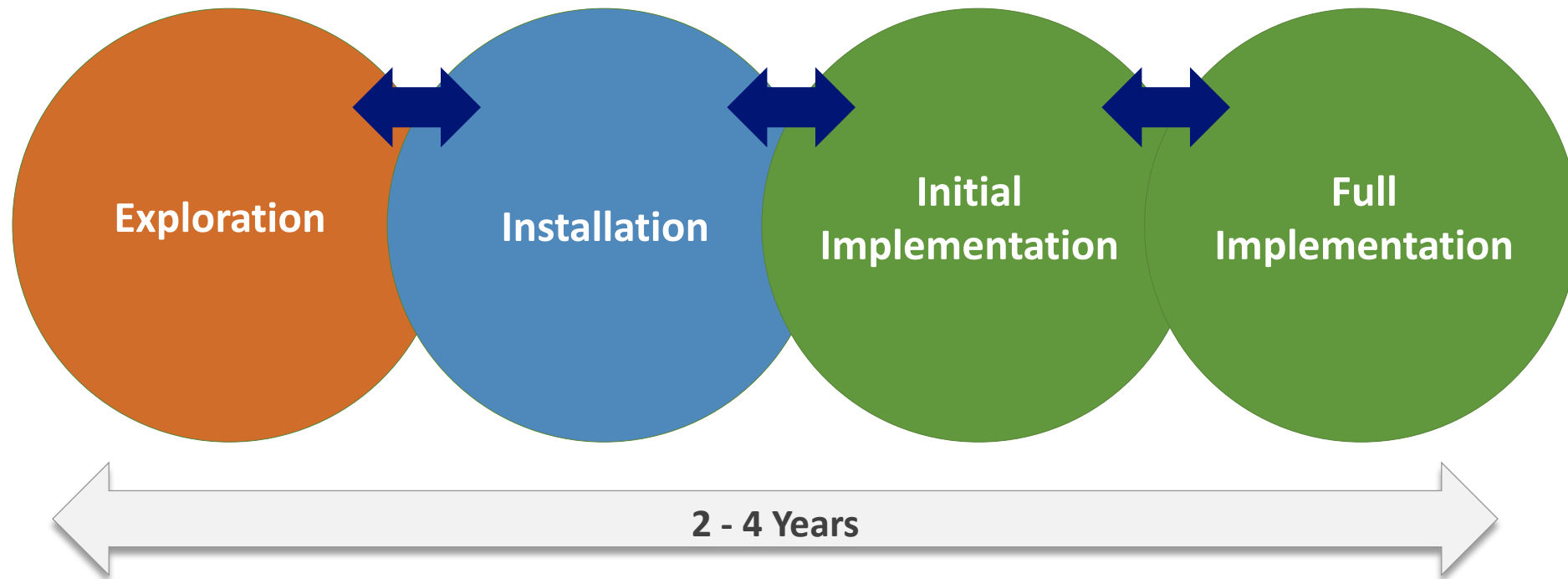
Anywhere from \$0-\$800. Big range, right? [Read more about why or contact a clinic.](#)

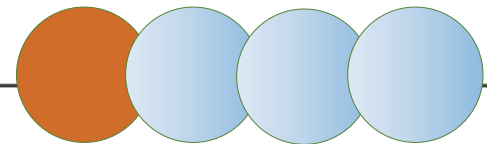
You'll look **awesome** in a

Implementation

“Obstetrician-gynecologists, other obstetric care providers, and institutions should develop the resources, processes, and infrastructure, including stocking LARC devices in the labor and delivery unit and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births.”

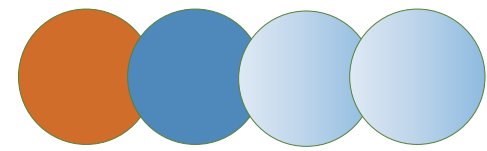
Implementation stages





Exploration

Clinician Steps	Pharmacy Steps	Finance or Billing Steps	IT & EHR Steps
Identify Project Champions			
Provide Clinical Evidence	Verify Insurance Participation		
Confirm Appropriate Administrative Awareness	Reimbursement Reassurance	Verify Payment	
Assemble Immediate Postpartum LARC Team Plan for Ongoing Communication or Meeting			

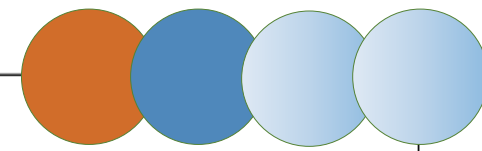


Installation stage

- Preparing to offer immediate postpartum LARC



Installation



Clinician Steps	Pharmacy Steps	Finance or Billing Steps	IT & EHR Steps
<div data-bbox="129 372 336 622"> <p>Policies Guidelines Protocols Supplies List</p> </div> <div data-bbox="129 682 336 789"> <p>Consents</p> </div> <div data-bbox="129 849 336 956"> <p>Patient Education</p> </div>	<div data-bbox="792 372 1314 479"> <p>P&T Committee Application</p> </div> <div data-bbox="1110 511 1314 682"> <p>P&T Committee Approval Device on Formulary</p> </div> <div data-bbox="1110 725 1314 1082"> <p>Pharmacy Planning: Vendor Contracts Inventory System, Estimated Use Distribution Plan</p> </div> <div data-bbox="1110 1118 1314 1296"> <p>Order from Vendor Purchase Devices</p> </div>	<div data-bbox="1493 372 1699 651"> <p>Clarify Payment Submission: Appropriate Codes Inpatient vs Outpatient</p> </div> <div data-bbox="1493 694 1699 801"> <p>Charge Documentation</p> </div>	<div data-bbox="1870 372 2076 651"> <p>Clinical Documentation: Provider Ordering Charting MAR</p> </div> <div data-bbox="1870 694 2076 801"> <p>Charge Capture</p> </div> <div data-bbox="1870 849 2076 956"> <p>Inventory Notification</p> </div> <div data-bbox="1870 1006 2076 1113"> <p>Implant / Device Log</p> </div>

Team roles

- **Nursing**

- Responsibility for determining contraceptive plan, verifying consent, insurance coverage, stability of mother-baby dyad, assistance with supplies, documentation?

- **Pharmacy**

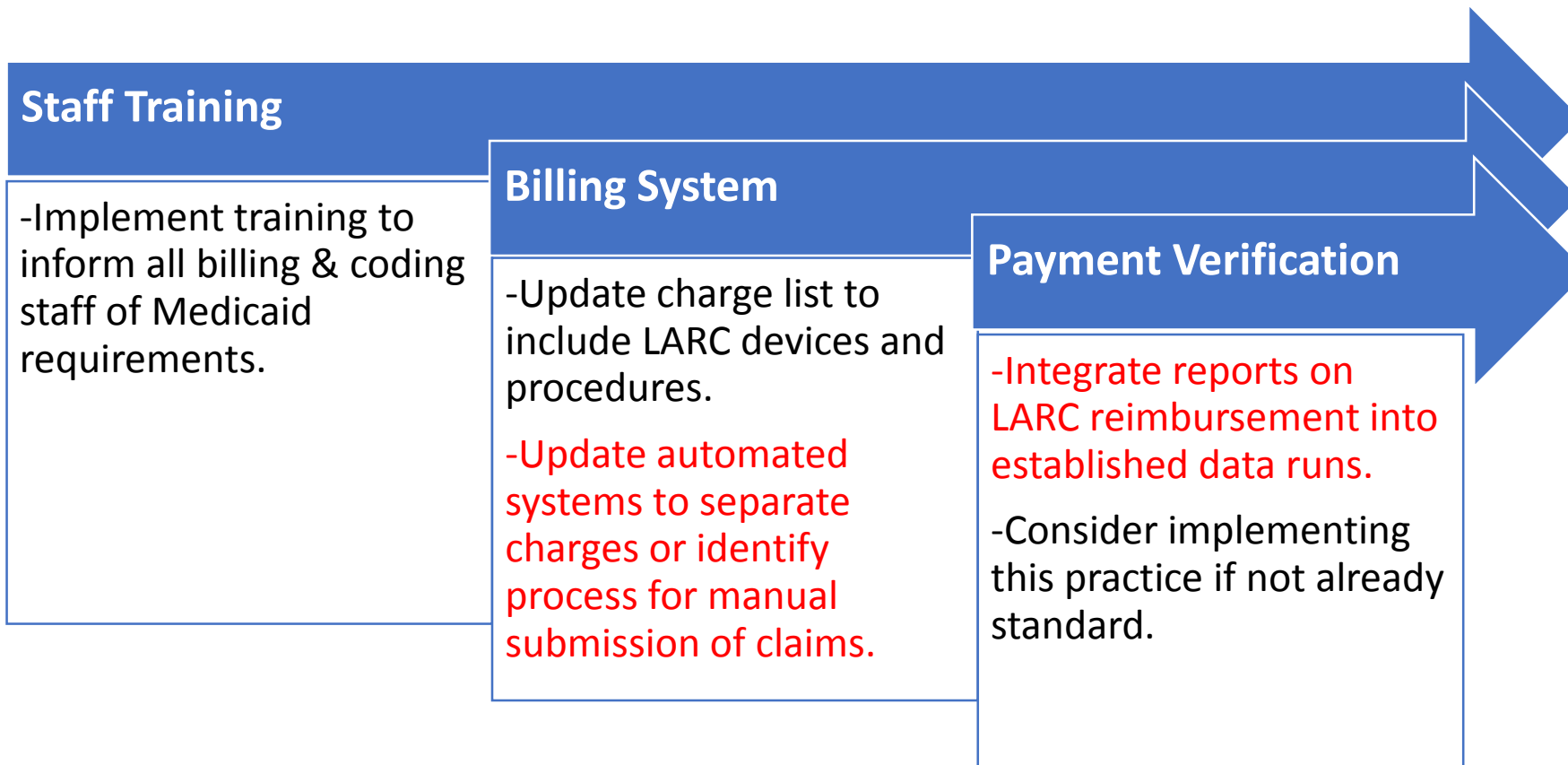
- Inpatient pharmacy and unit-based stocking recommended so that devices are readily available when needed

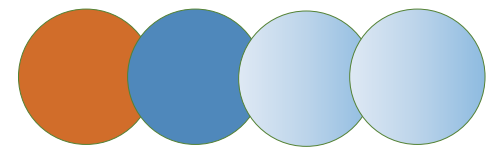
- **Patient finance**

- Training re: Medicaid coverage and identification of processes for ensuring reimbursement and tracking it after implementation

Coding & Reimbursement:

Planning & Implementation Considerations



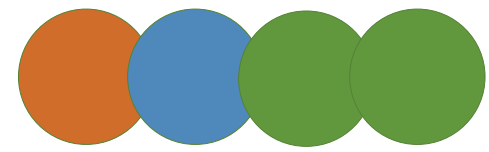


Installation stage: Key facilitators

- Technical project champions
- Clarity of roles and responsibilities
- Steps and tools supporting installation and implementation
- External training and project support

Coding & Reimbursement: Evaluation for Sustainability





Sustainability stage: Key facilitators

- Managerial buy-in
- Piloting to troubleshoot process
- Feedback or support for correct insertion, billing, documentation

People

Patients

- Shared decision making tools



Billing Staff

- Education
- Auditing and feedback



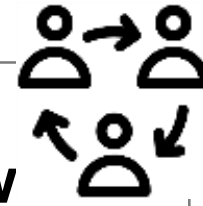
Providers

- Pharmacy
- Education
- Skills workshops
- Reminders
- Performance feedback



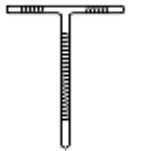
Workflow Re-design

- Clinicians for immediate postpartum LARC insertion
- Documentation templates



Supply Chain

- Algorithm for predicting LARC demand
- Automated device re-ordering



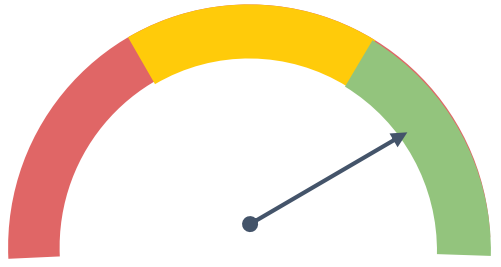
Monitoring & Evaluation

- Monthly reports on LARC insertion and payments

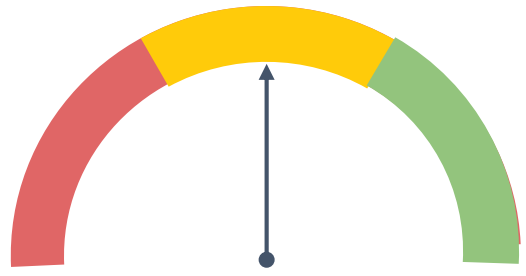


Domains of Work

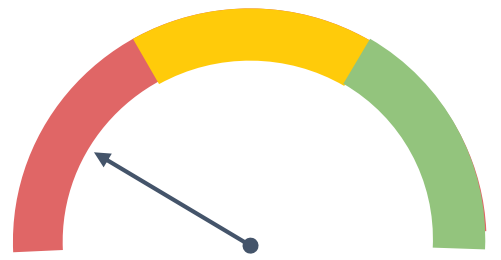
Big picture: Where are we now?



**Clinical Safety
&
Effectiveness**



**Cost
Outcomes**

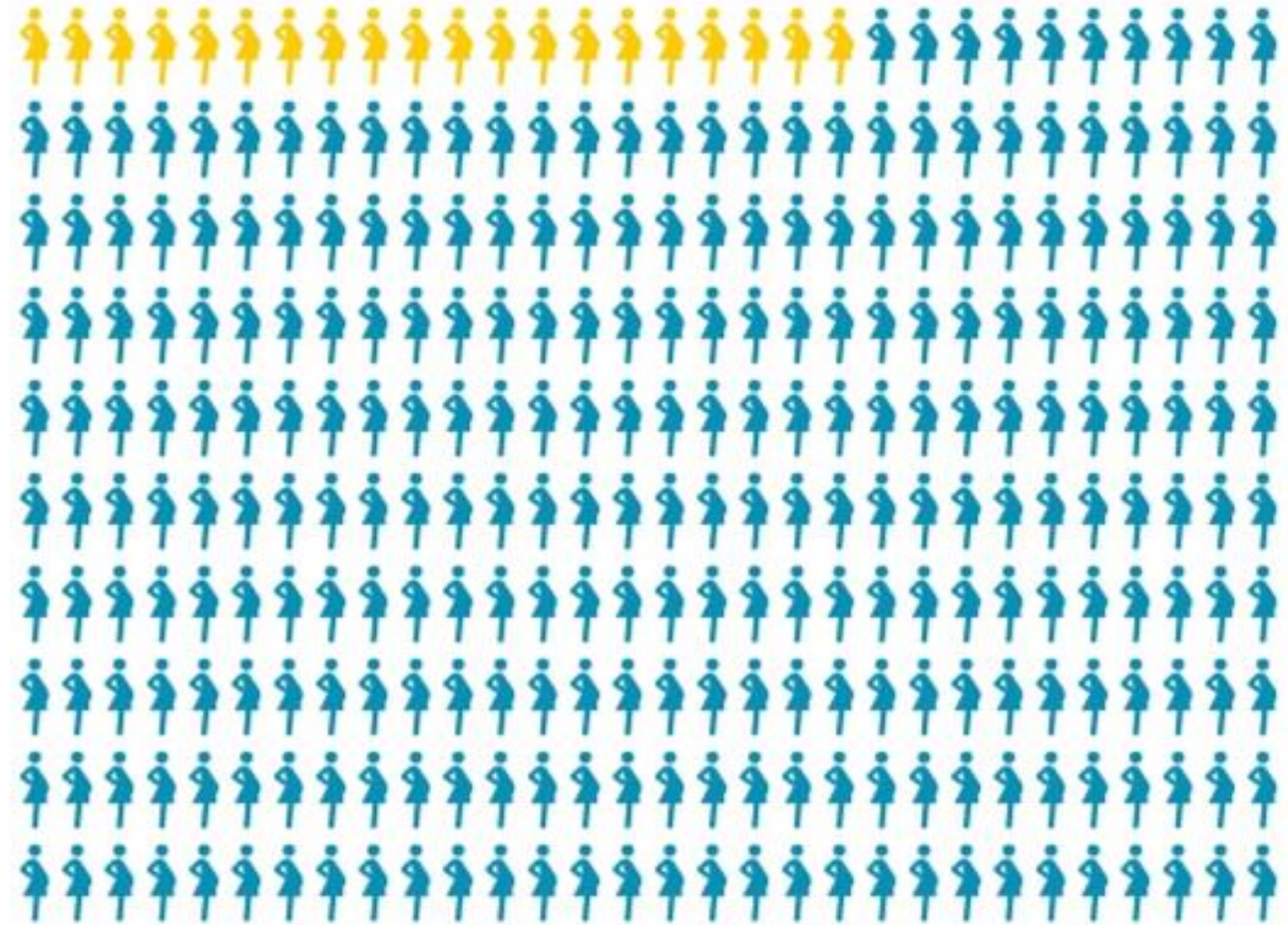


Implementation



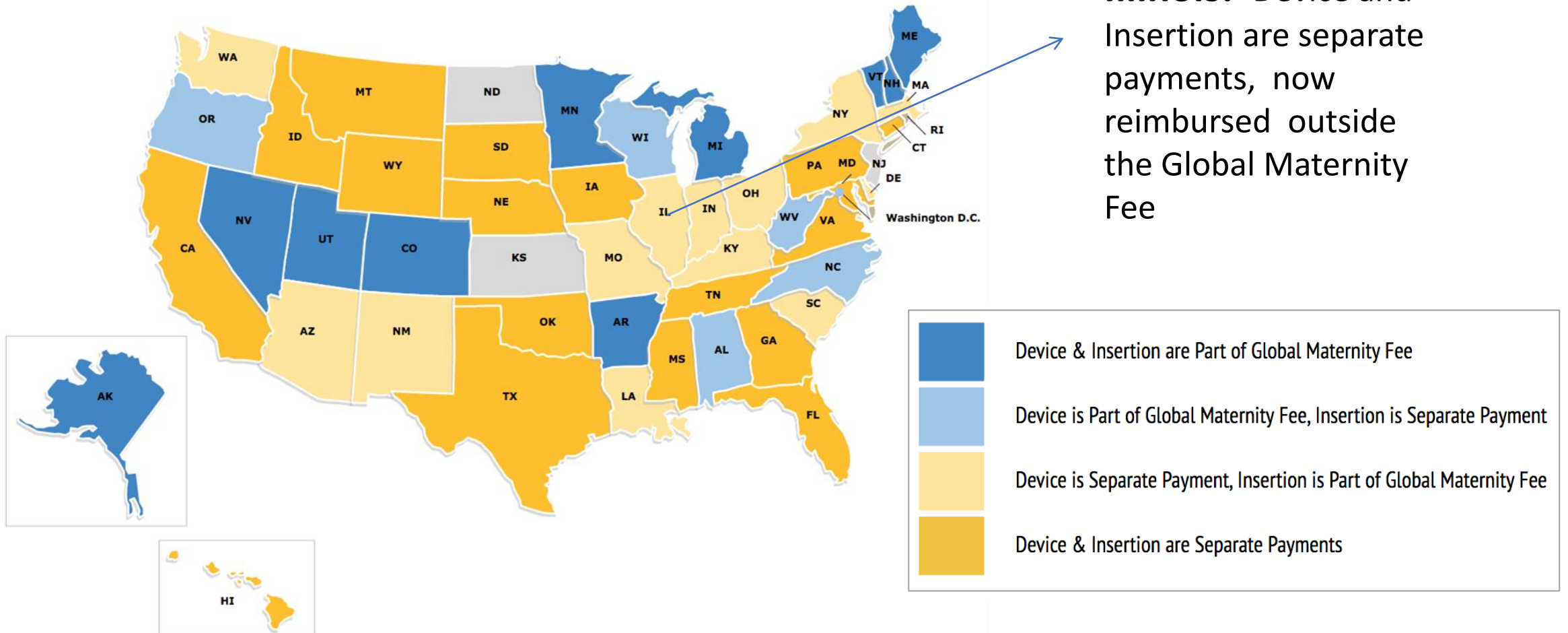
Inpatient postpartum LARC is underutilized

IUD/implant insertion is <2% tubal ligation rate



● IUD/implant ● Sterilization ● Neither

Reimbursement by Medicaid



Source | Moniz. "Reimbursement for Immediate Postpartum Contraception Outside the Global Fee." 2018.
https://ihpi.umich.edu/sites/default/files/IPLARC_021418.pdf

RESEARCH

Open Access

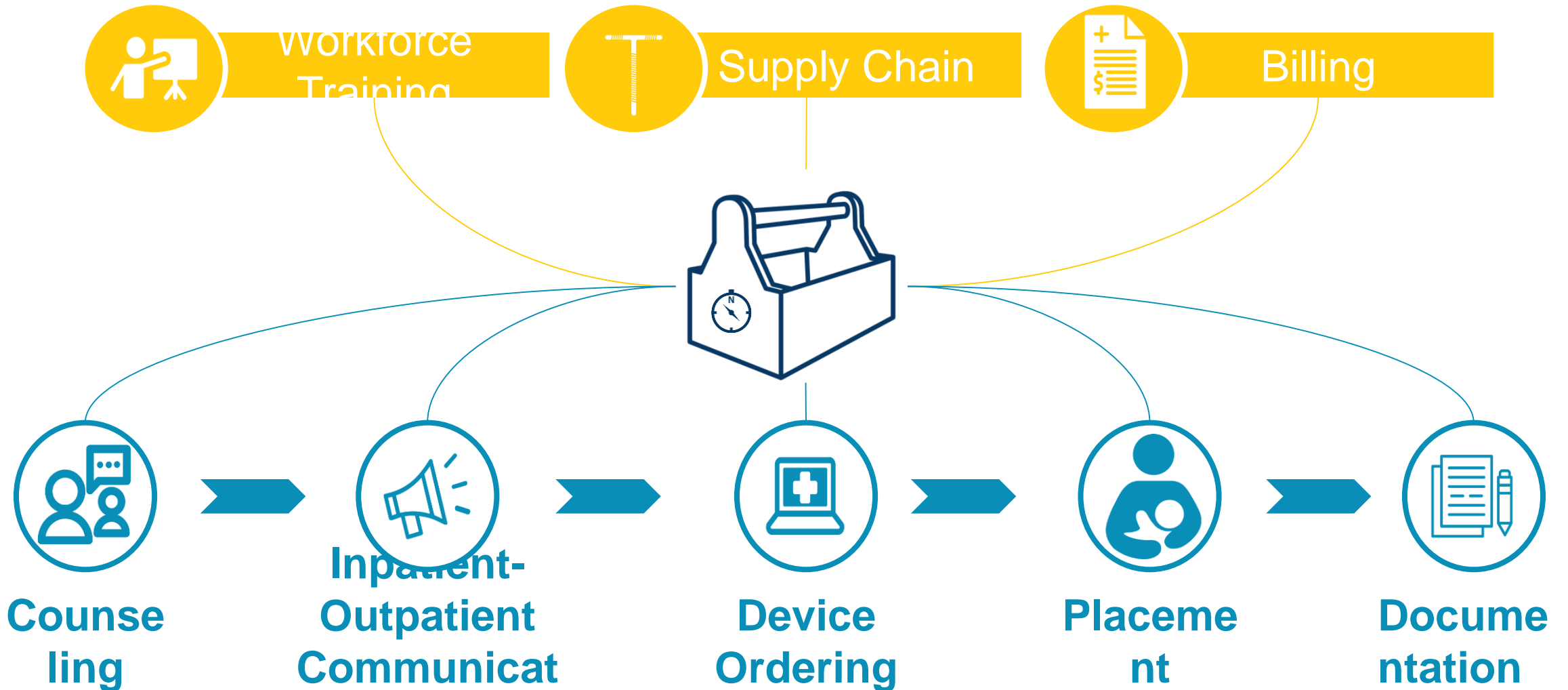
Using a multi-state Learning Community as an implementation strategy for immediate postpartum long-acting reversible contraception



CrossMark

Carla L. DeSisto^{1*}, Cameron Estrich², Charlan D. Kroelinger³, David A. Goodman³, Ellen Pliska⁴, Christine N. Mackie⁴, Lisa F. Waddell⁴ and Kristin M. Rankin¹

Implementing Immediate Postpartum LARC:



Source | Moniz et al, preliminary data

The New Mexico experience

- 2013: NM Medicaid guidance
- 2014: Birth of NMPC
- 2015: Implementation of immediate postpartum LARC at University of New Mexico



State of New Mexico
Medical Assistance Program Manual
Supplement



DATE:

NUMBER: 13-05

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM:  JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS: I. LIMITING PAYMENT FOR INDUCTIONS AND CESAREAN SECTIONS THAT ARE NOT MEDICALLY NECESSARY

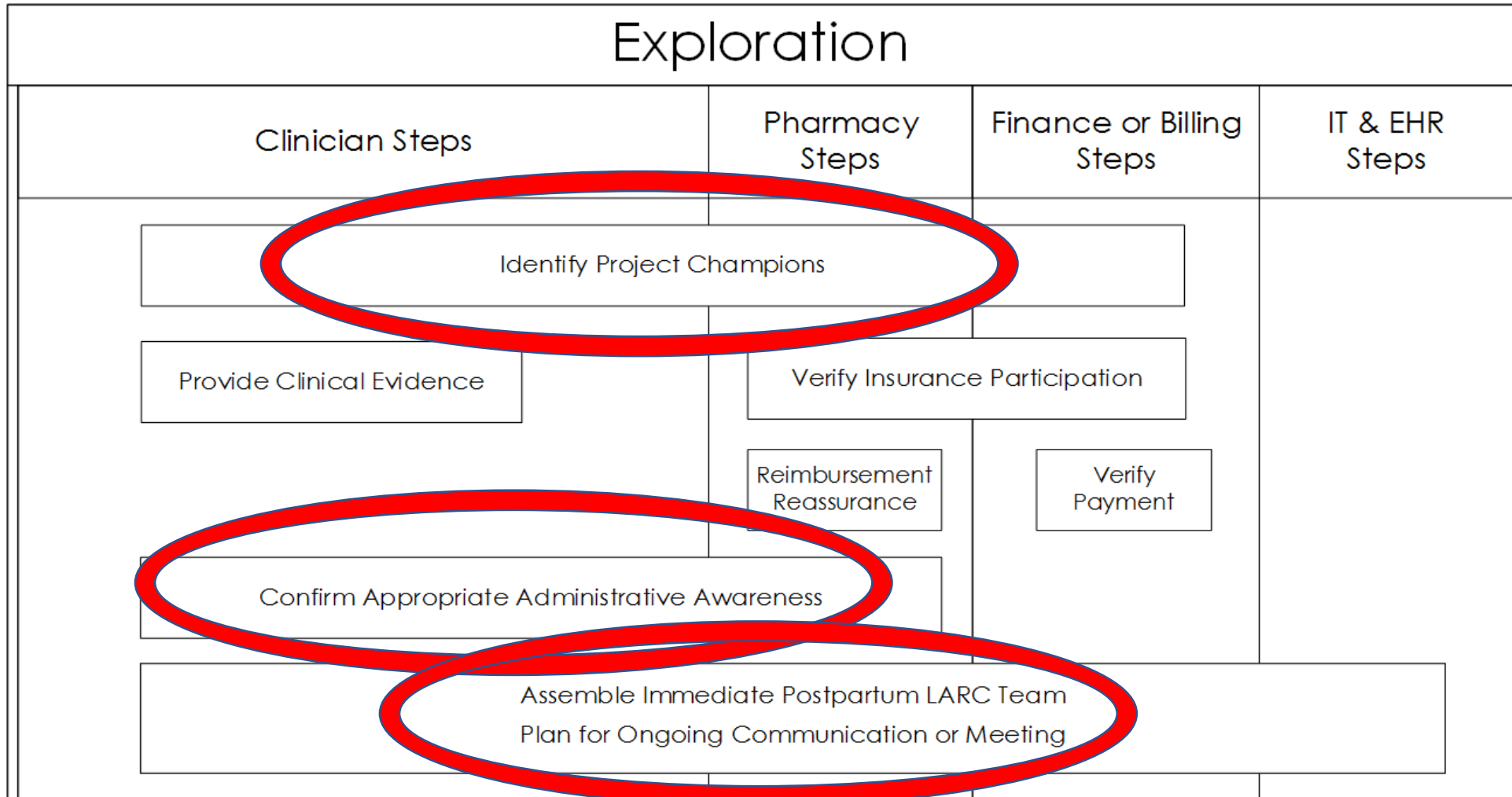
II. BILLING WHEN C-SECTIONS OR INDUCTIONS ARE MEDICALLY NECESSARY

III. HYSTERECTOMY CONSENT FORM

IV. INSERTION OF LONG ACTING REVERSIBLE CONTRACEPTIVES AT TIME OF AN INPATIENT DELIVERY STAY



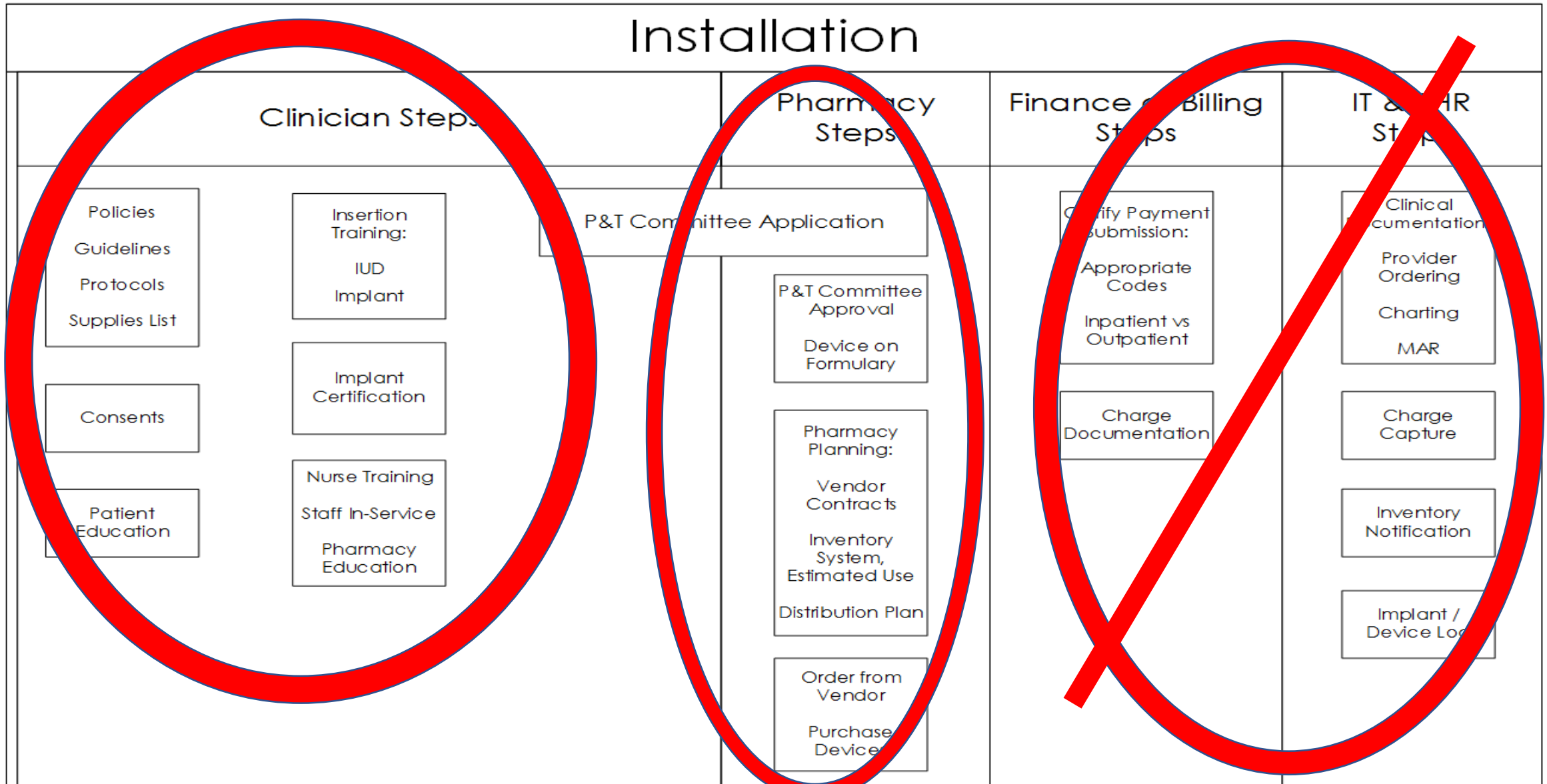
Exploration





Hospital finance

Installation



Lesson learned



Plan for
regular
evaluation of
claims data

Thanks,
Julie, can we please get an updated report of how we're doing with reimbursement for immediate postpartum LARC
by payer,
Eve

Eve Espey, MD MPH
Professor and Chair
Department of OB-GYN
University of New Mexico
Eespey@salud.unm.edu

Greetings,
I'm writing to ask again for reimbursement data on immediate postpartum LARC. You may recall that you
graciously agreed to send us quarterly data on reimbursement so we could track different payers on the
performance in reimbursing for Medicaid patients who accessed the service. We have not received data
July. Additionally, we met today with [REDACTED], one of the payers that we were experiencing difficulty with
expressed their strong commitment for paying for immediate postpartum LARC. In our negotiations with
going forward, it would be extremely helpful to have the data. Can you please let us know when we may
data. Thanks again,
Eve

Eve Espey, MD MPH
Professor and Chair
Department of OB-GYN
University of New Mexico
Eespey@salud.unm.edu

Current LARC billing data:

- Asked for quarterly, have gotten 2 reports over the last year after repeatedly asking
- Different time period each time
- Need quarterly reports to identify trends
- Last report showed 37% overall denial rate but can't tell trends over time
 - o [REDACTED] is still responsible for a disproportionate share of denials at 69% of what [REDACTED] is billed.
 - o This spreadsheet still shows 85 denials for "not covered separately" but can't tell if this is a trend over time
- Reviewed 4443 claims, because these are not just claims for LARC, rather all the claims billed for each patient for whom LARC was charged.
 - o 37 denials FOR THE TIME PERIOD THAT IS NEW (1/30/17- 5/8/17) that look suspicious, i.e. denial reasons include: "not covered separately", "not covered", "precert/auth/notification absent"
 - o Lots of denials that seem to be for coding and billing errors that have nothing to do with LARC billing outside of the DRG.



Suggested Template for LARC Claims Data Monitoring

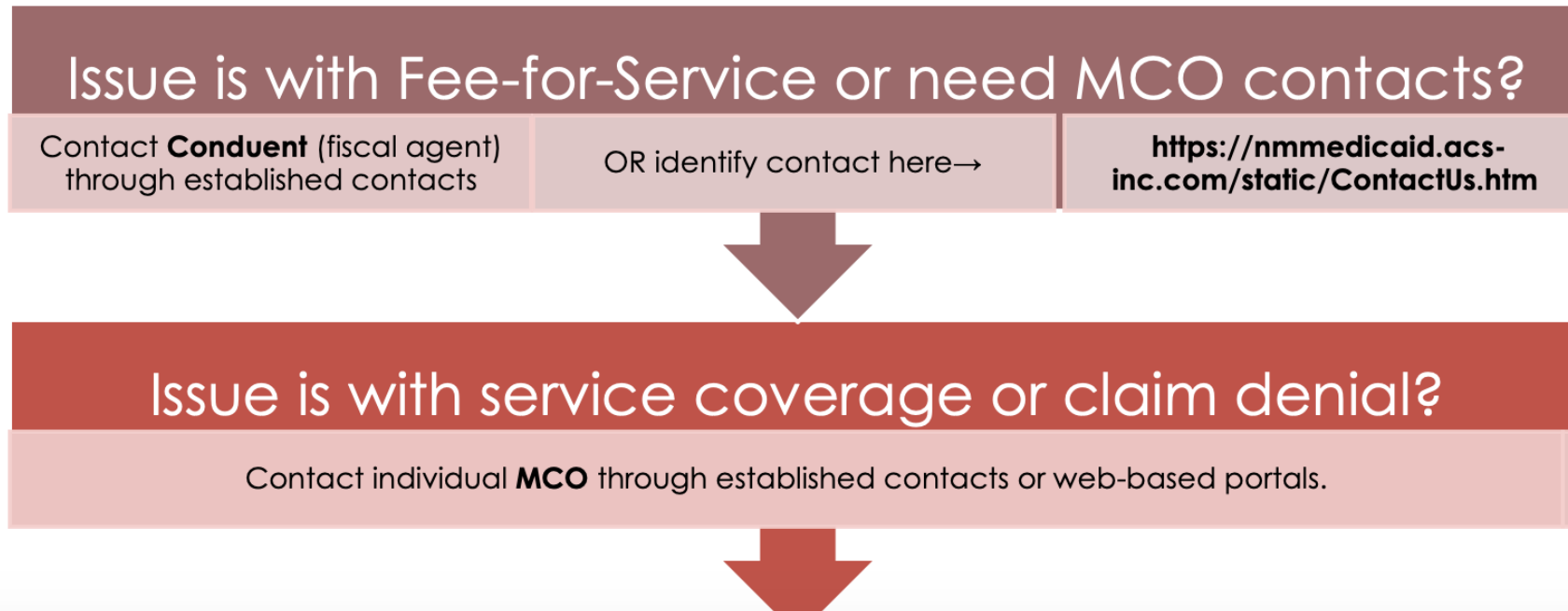
- The template below represents a summary of relevant data points.
- Also consider designing data pulls to include categories such as, **denials by payer, denial trends**, or to fit with other institutional plans for claims-data analysis.

Total Procedures IP Medicaid Primary or Secondary					
Count of Procedures	Column Labels				
Payer	J7300 (Paragard)	J7298 (Mirena)	J7297 (Liletta)	J7307 (Nexplanon)	Grand Total
<i>(All Centennial Care MCOs allow separate billing for IPP LARC.)</i>					
Grand Total					

Total Denials

Troubleshooting Claims Submission & Payment

- In order to rapidly identify any problems and/or patterns of claims denial, it is recommended that hospitals establish a plan to examine data at regular intervals on claims submitted and payment received.
- The flowchart below identifies steps in following up on any identified concerns:



Lessons learned UNM

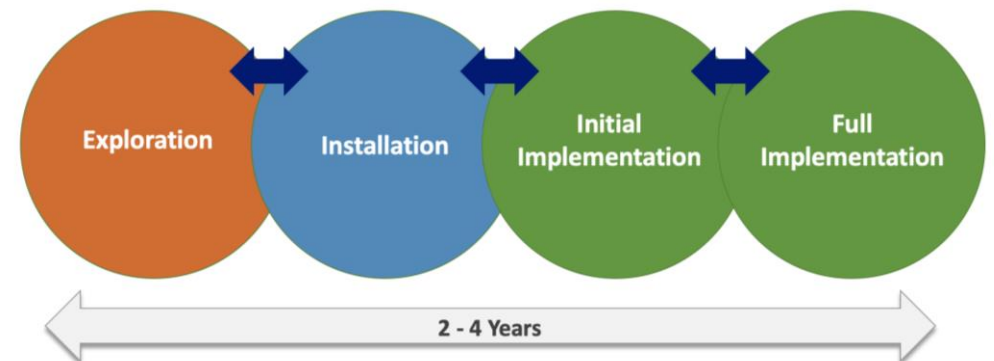


- Standardize training from the start and train yearly
 - i.e., ring forceps insertion
- Residents were the drivers for the initiative
- Session on breastfeeding for nurses and lactation support yearly
- Engage Patient finance early and often and early and often
- Engage payers – learning curve for reimbursement

Scale-up

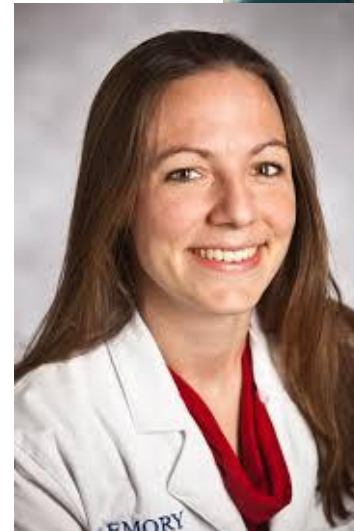


- National Institute of Reproductive Health (NIRH) grant
- Total of 75K between 2015 and 2018 (3 years)
- Grant deliverables
 - Complete implementation at UNM
 - Implementation (through initial implementation) at 3 additional NM hospitals

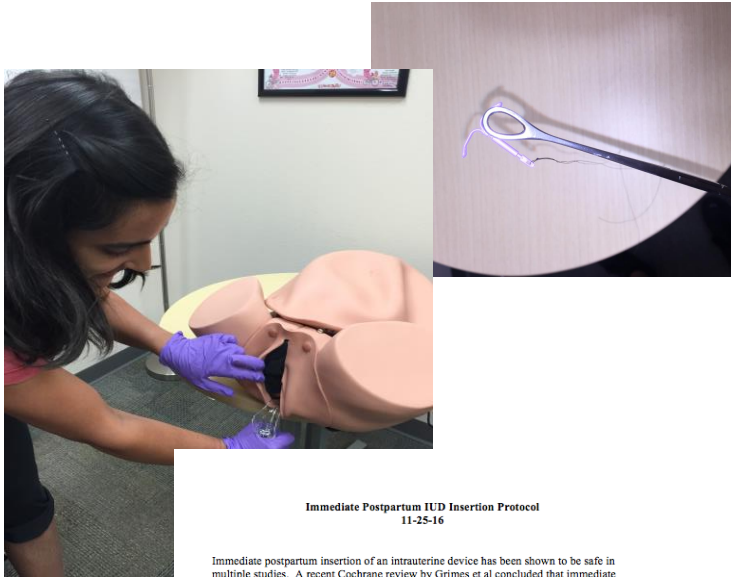


Project immediate PP LARC

- Program manager
 - Abby Reese, CNM
- Family planning faculty
 - Dr. Lisa Hofler
- Implementation toolkit
 - Technical assistance coding, billing and reimbursement
 - Clinical training in immediate PP IUD insertion



Toolkit components



Immediate Postpartum IUD Insertion Protocol
11-25-16

Immediate postpartum insertion of an intrauterine device has been shown to be safe in multiple studies. A recent Cochrane review by Grimes et al concluded that immediate post-partum intrauterine device insertion is a safe and effective means of achieving highly effective birth control. No increase in complications with immediate insertion technique was identified. Several studies showed slightly higher expulsion rates in several studies, with an average of 12-14% for insertion within 10 minutes of placental delivery. An increased expulsion rate does not correspond to increased pregnancy rates as most expulsions are identified and addressed with insertion of another IUD or initiation of another method of contraception. A study at UNM shows that high non-insertion rates occur in patients desiring a postpartum IUD. Patients benefit with immediate postpartum insertion even if the expulsion rate is increased. Consistent with our policy that contraception should be considered an "emergency," women who present requesting an IUD or choosing an IUD after counseling are often able to receive it the same day.

Women who desire an IUD immediately postpartum should be thoroughly counseled regarding the advantages and disadvantages as well as the risks & benefits of the method. In general women are good candidates for the IUD if they are at low risk for STDs and desire contraception for at least a year. Teens may be considered good candidates for an IUD. Contraindications to postpartum IUD insertion include:

- Untreated STD or treated within the prior month
- Active intrauterine infection (chorioamnionitis)
- Uterine anomaly incompatible with placement
- Ongoing postpartum hemorrhage
- Retained placenta requiring manual removal

Counseling

- Ideally, contraceptive counseling should occur during antenatal care for a

Implementing Immediate Postpartum Long-Acting Reversible Contraception Programs.

Hofler LG¹, Cordes S, Cwiak CA, Goedken P, Jamieson DJ, Kottke M.

Author information

Abstract

OBJECTIVE: To understand the most important steps required to implement immediate postpartum long-acting reversible contraception (LARC) programs in different Georgia hospitals and the barriers to implementing such a program.

METHODS: This was a qualitative study. We interviewed 32 key personnel from 10 Georgia hospitals working to establish immediate postpartum LARC programs. Data were analyzed using directed qualitative content analysis principles. We used the Stages of Implementation to organize participant-identified key steps for immediate postpartum LARC into an implementation guide. We compared this guide to hospitals' implementation experiences.

RESULTS: At the completion of the study, LARC was available for immediate postpartum placement at 7 of 10 study hospitals. Participants identified common themes for the implementation experience: team member identification and ongoing communication, payer preparedness challenges, interdependent department-specific tasks, and piloting with continuing improvements. Participants expressed a need for anticipatory guidance throughout the process. Key first steps to immediate postpartum LARC program implementation were identifying project champions, creating an implementation team that included all relevant departments, obtaining financial reassurance, and ensuring hospital administration awareness of the project. Potential barriers included lack of knowledge about immediate postpartum LARC, financial concerns, and competing clinical and administrative priorities. Hospitals that were successful at implementing immediate postpartum LARC programs did so by prioritizing clear communication and multidisciplinary teamwork. Although the implementation guide reflects a comprehensive assessment of the steps to implementing immediate postpartum LARC programs, not all hospitals required every step to succeed.

CONCLUSION: Hospital teams report that implementing immediate postpartum LARC programs involves multiple departments and a number of important steps to consider. A stage-based approach to implementation, and a standardized guide detailing these steps, may provide the necessary structure for the complex process of implementing immediate postpartum LARC programs in the hospital setting.

Vendor Contracts

- Are new or updated contracts needed in order to purchase or stock LARC?

Inventory System

-Work with IT staff to adapt system to include LARC.
-Work with clinicians to estimate appropriate order volume.

Distribution Plan

-What is the best plan to assure that devices are accessible?
-IUD placement is time-sensitive, and device must be readily available at delivery.

Hospitals implementing immediate PP LARC

- University of New Mexico
- Northern Navajo Medical Center, Shiprock
- Gallup Indian Medical Center
- Espanola Hospital, Espanola
- Gila Regional Medical Center, Silver City
- Memorial Medical Center, Las Cruces



2 years later....

- 75K
- Multiple road trips, meetings and trainings
- > 1,000 emails
- Medicaid reimbursement mechanism is not functional for New Mexico hospitals

2013



State of New Mexico
Medical Assistance Program Manual

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DATE:

TO: PROVIDERS PARTICIPATING

FROM:  JULIE B. WEINBERG, DIRECTOR

SUBJECTS: I. LIMITING PAYMENT FOR
SECTIONS THAT ARE NOT

II. BILLING WHEN C-SECTION
NECESSARY

III. HYSTERECTOMY COSTS

IV. INSERTION OF LONG-
ACTING REVERSIBLE CONTRACEPTION

DATE:

TO: HOSPITALS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECT: BILLING FOR LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)
PRODUCTS PROVIDED IN AN INPATIENT SETTING

2019?



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NUMBER:

Implementation Resources

- ACOG: Postpartum Contraceptive Access Initiative
- pcainitiative.org
- ILPQC IPLARC Toolkit (www.ilpqc.org)



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