Women's Healthcare Webinar

Prevention and Screening Measures

Contraception Update

March 31, 2020

Health Partners Plans HPP

Women’s Care Webinar Agenda

- Breast Cancer Screening
- Cervical Cancer Screenings
- Chlamydia Screening
- Opioid Use Disorder
- Long-Acting Reversible Contraception

Breast Cancer Screening (BCS)

- HEDIS measure that is an administrative measure
- The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
- Exclusion: Bilateral mastectomy

Breast Cancer Screening (BCS)

- HPP reported the following rates for the BCS measure for HEDIS 2019.
  - Medicaid: 61.13%
  - Medicare: 80.97%

- The National 95th percentile benchmarks as per the Quality Compass:
  - Medicaid: 72.24%
  - Medicare: 85.59%

- According to the CDC the incidence of breast cancer has risen slightly from 2012 – 2016 in the state of Pennsylvania and the rate of breast cancer death has remained stable

Cervical Cancer Screenings (CCS)

- HEDIS measure that is a hybrid measure:
  - Administratively via claims data
  - Medical Record Review (MRR) via chart review

- The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
  - Women 21–64 years of age who had cervical cytology performed within the last 3 years.
  - Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
  - Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
- Exclusion:
  - Total, complete, or radical hysterectomy

Cervical Cancer Screenings (CCS)

- HPP reported the following rates for the CCS measure for HEDIS 2019.
  - Medicaid: 68.36%

- The National 95th percentile benchmarks as per the Quality Compass:
  - Medicaid: 74.1%

- According to the CDC the incidence of cervical cancer has risen from 2013 – 2016 in the state of Pennsylvania

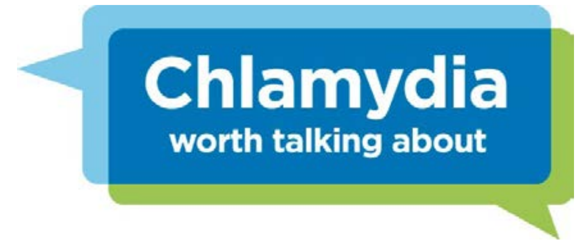
Chlamydia Screening in Women (CHL)

- HEDIS measure that is an administrative measure

- The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year:
  - Sexually active is measured in two ways; the MCO must use both methods but a woman only has to be identified by one method:
    - Pharmacy Data - Members who were dispensed prescription contraceptives during the measurement year
    - Claims/encounter data - Members who had a claim or encounter indicating sexual activity during the measurement year.

Chlamydia Screening in Women (CHL)

- HPP reported the following rates for the CHL measure for HEDIS 2019:
  - Medicaid:
    - 16 – 20 years old: 73.41%
    - 21 – 24 years old: 76.31%
    - Total: 74.84%
  - CHIP: 54.76%



- The National 95th percentile benchmarks as per the Quality Compass:
  - Medicaid:
    - 16 – 20 years old: 77.28%
    - 21 – 24 years old: 77.39%
    - Total: 77.87%
  - CHIP: 77.28%

- According to the CDC:
  - Chlamydia in females has increase from 2013 to 2017 from 619 per 100,000 to 687.4 per 100,000
  - Chlamydia in males has increase from 2013 to 2017 from 260.6 per 100,000 to 363.1 per 100,000

Chlamydia Screening in Women (CHL)

- The United States Preventive Services Task Force (USPSTF) recommends chlamydia testing for:
  - All sexually active women age 24 years and younger
  - Older woman who are at an increased risk of infection
    - Increased risk includes as:
      - Having a new sex partner
      - More than one partner
      - A partner who has had more than one partner
      - Partners with an STI
      - Inconsistent condom use

Opioid Use Disorder and Centers of Excellence

- HPP recognizes the importance of addressing the opioid epidemic.
- PA DHS has designated multiple Centers of Excellence(COEs) to help Medicaid members with opioid use disorder (OUD) throughout PA.
- The goal is to ensure members with opioid-related substance used disorder stay in treatment to receive follow-up care and are supported in their communities.
- The COEs coordinate care for Medicaid members and treatment is team-based and whole person focused, with the explicit goal of integrating behavioral health and primary care.

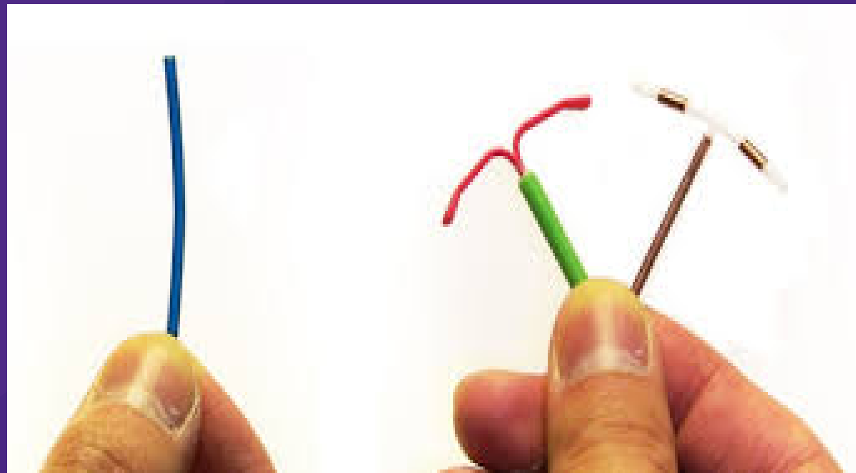
Opioid Use Disorder and Centers of Excellence

- COE services include:
  - One to one counseling
  - Intensive group therapy and education
  - Case management, screenings and assessments
- Your patient can visit a COE without talking to you, but your involvement helps increase the success of his or her recovery from opioid addiction.
- When our members visit a COE, they should bring their Health Partners Plans ID card. They can schedule an appointment or walk in but are encouraged to check the hours and days of operation before visiting a center. They will receive treatment at no cost to them. The COE will send claims directly to us for payment.
- Please refer to HPP provider website for more information for COE and OUD:
  - https://www.healthpartnersplans.com/providers/resources/the-opioid-epidemic

Opioid Use Disorder in Pregnancy

- Pregnancy can be a powerful motivator towards recovery.
- At the same time, women may be afraid to disclose their OUD for fear of involvement with Child Protectives Services
- Multiple social stressors, stigma and shame become barriers to engaging in both prenatal care and recovery.
- Baby Partners has a team of 3 community health coordinators who can help by engaging face-to-face with opioid using pregnant women, helping them to navigate care and resources, and providing social support.

Long-Acting Reversible Contraception



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Definition and Methods

LARC is contraception that provides long-lasting pregnancy prevention and is easily reversible.

The two commonly available methods are

- intrauterine devices, one of the oldest contraceptive methods known
- contraceptive implants, the newest method in current usage

Clinical Considerations: IUDs

- Enthusiasm for intrauterine devices has waxed and waned over the years, often for reasons not related to clinical efficacy.
- Recent controlled trials agree that there is an acceptably low incidence of pelvic inflammatory disease (PID) associated with IUD usage, and an acceptable risk of expulsion.

Clinical Considerations: Implants

- Hormone-elaborating subdermal implants have been available in North America since 1990. The currently available implant is Nexplanon. It is a single silicone rod, implanted subdermally in the woman's upper arm.

Making the Choice

- Careful conversation about possible adverse effects, and respectful attention to the woman's concerns, are essential in promoting user satisfaction.
- Both LARC methods have known possible adverse effects. These are not insignificant to the user, but do not threaten the woman's health. In most cases the adverse effects diminish over time.
- The discussion must include the risk of pregnancy and the benefits of the method.

Practical Considerations

- Prior authorization is not required; under the Affordable Care Act of 2010, health plans must cover these services without charging a copayment or coinsurance when provided by an in-network provider.
- LARC and other hormonal contraception do not protect against STIs. Women using LARC should be encouraged to use condoms if not in a mutually monogamous relationship.

Practical Considerations

- LARC may be safely initiated at any point in the menstrual cycle.
- Each provider should follow their practice's own guidelines for insertion.
- Earlier recommendations for STI or pregnancy testing prior to insertion are no longer current.

Immediate Postpartum Contraception

- LARC may be initiated immediately following vaginal or cesarean birth. Expulsion rates are most favorable with immediate (“post-placental”) placement.
- The contraceptive implant can be placed prior to discharge following a delivery.

ACOG Recommendations and Conclusions

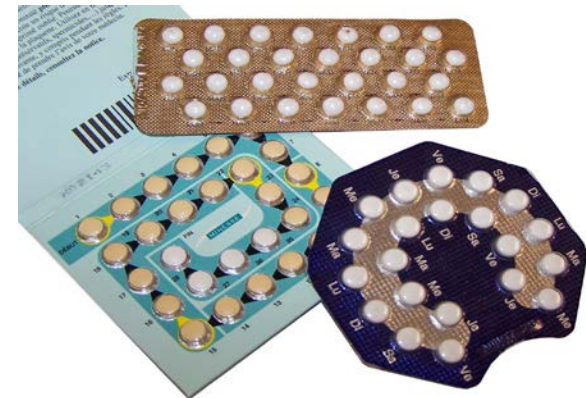
The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

i. Long-acting reversible contraceptives (LARC) have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives among women who choose to use them.
ii. Complications of intrauterine devices (IUDs) and contraceptive implants are rare and differ little between adolescents and women, which makes these methods safe for adolescents.
iii. Patient choice should be the principal factor driving the use of one method of contraception over another.

Available Methods

Brand Name	Type of Device	Duration of Use (FDA-approved)	Potential Efficacy beyond FDA approval	unintended pregnancy in first year of typical use
Kyleena	Hormonal IUD	5 years	n/a	.20%
Liletta	Hormonal IUD	4 years	1 year	.20%
Mirena	Hormonal IUD	5 years	2 years	.20%
Skyla	Hormonal IUD	3 years	n/a	.20%
Paragard	Non-hormonal IUD	10 years	2 years	.80%
Nexplanon	Hormonal implant	3 years	1-2 years	.05%

Other Effective Contraception



Hormonal Contraception

- For women who prefer not to use LARC, oral contraceptives and the vaginal ring are good alternatives.
- Both the ring and oral contraceptive pills provide non-contraceptive benefits, such as lighter menstrual flow, less dysmenorrhea and improvement in symptoms of premenstrual syndrome and premenstrual dysphoric disorder.
- Outcomes for mothers, babies and the family are improved if births are spaced at least one year apart. All women should be encouraged to have an effective and realistic contraceptive plan as part of their pre-labor planning.

Resources

- https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception
- https://www.plannedparenthood.org/planned-parenthood-mar-monte/patient-resources/long-acting-reversible-contraception-2
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183267
- https://www.nwhn.org/larcs/

Any questions?