Treatment, Recovery and Reproductive Health Services: Doesn't It Make Sense?

7th Annual Prescription Drug Abuse & Heroin Symposium

October 13, 2016

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Today's Agenda

1. Introduce Concept and Proposed Strategy
2. Scope of the problem:
   - Unplanned Pregnancies
   - Drug Exposed Babies
   - How these two issues intersect
3. Reproductive Life Plan
4. Contraception Methods
5. HIP 2.0 – Marketplace
6. Question / Feedback / Input from Participants

Proposed *Preventive* Strategy

Treatment and recovery providers caring for *women of childbearing age (14-48)*

1. Routinely ask, screen and educate about effective forms of contraception
2. Refer to Medicaid / HIP 2.0
3. Connect with reproductive health providers

Strategy Intent

- Benefits the Woman in Treatment / Recovery AND Her Potential Child
- Upstream Approach
- Takes Full Advantage of Accepted Medical Practices and New Coverage Options

Unplanned Pregnancy

Impact on Mom and Baby

- Less likely to seek early and adequate prenatal care
- More likely to use alcohol and tobacco during pregnancy
- May be at greater risk of physical abuse
- More likely to experience depression during/after pregnancy
- More likely to have an abortion
- Increased risk for economic hardship
- Less likely to achieve educational or career goals
- More likely to be dependent on public assistance

Unplanned Pregnancy

- US - 2010 45% **Indiana – estimated 41-47%**
- Highest among teens, but more than half of pregnancies to 20-24 year olds are unplanned
- Women >20 years of age, w/o high school education
- African American and Hispanics
- Low income
- Unplanned pregnancy and **birth spacing**:
  - **Babies born at less than 18 months after a previous birth had 61% increased risk of low birth weight, 40% increased risk of prematurity, and 26% increased risk of being small for gestational age (SGA)**

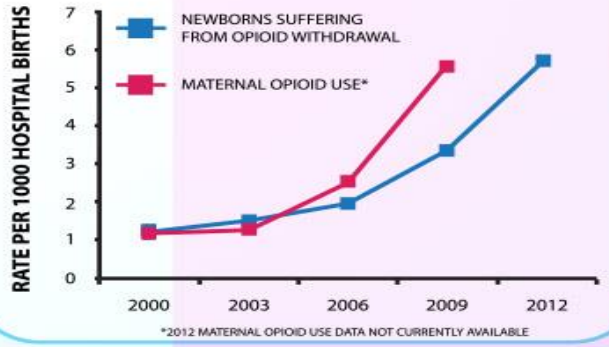
DRAMATIC INCREASES IN MATERNAL OPIOID USE AND NEONATAL ABSTINENCE SYNDROME

THE USE OF OPIOIDS DURING PREGNANCY CAN RESULT IN A DRUG WITHDRAWAL SYNDROME IN NEWBORNS CALLED **NEONATAL ABSTINENCE SYNDROME** (NAS), WHICH CAUSES **LENGTHY** AND **COSTLY** HOSPITAL STAYS. ACCORDING TO A NEW STUDY, AN ESTIMATED **21,732 BABIES** WERE BORN WITH THIS SYNDROME IN THE UNITED STATES IN 2012, A **5-FOLD INCREASE** SINCE 2000.

EVERY 25 MINUTES, A BABY IS BORN SUFFERING FROM OPIOID WITHDRAWAL.

AVERAGE LENGTH OR COST OF HOSPITAL STAY

NAS AND MATERNAL OPIOID USE ON THE RISE



NIH National Institute on Drug Abuse

Source: Patrick et. Al., JAMA 2012 , Patrick et. Al., Journal of Perinatology 2015

Fetal – Infant Mortality Review

Marion County 2013-2014

183 Deaths

- **Contributing Factors**
  - 51 (28%) Substance Abuse Lifestyle
  - 58 (32%) Unplanned Pregnancy

- **Suggestions for Prevention**
  - 85 (46%) Importance of Family Planning
  - 48 (26%) Referral for Substance Abuse

Survey of Indiana MAT Clinics

- Nearly 75% indicated women of childbearing age comprised *> 30%* of their patient population
- 100% provide services to pregnant women
- More than 25% said women were not aware of and receiving reproductive health services

What's In The Literature?

A survey of 204 Australian and New Zealand women in outpatient treatment programs found:

- Nearly 30% had six or more pregnancies.
- Only half that did not want to get pregnant were using contraception.

What's In The Literature? (cont.)

- Interviews of 946 opioid-abusing women found that 86% of pregnancies were unplanned.

- Survey of 376 UK women in substance use treatment found a lower use of *non-condom forms of contraception* and higher rates of pregnancy termination and STI's.

What's In The Literature? (lastly)

A survey of 148 women seen at 4 methadone clinics in western NC found:

- 10% were already pregnant.
- 35% were inconsistently or not using contraception.
- 50% wanted a LARC method or sterilization.
- 75% wanted contraception counseling or education.

Important Role of Contraception

Among women who are at risk for an unintended pregnancy

- 68% that *consistently* use contraception account for only 5% of unplanned pregnancies
- 18% with ***inconsistent*** use account for 41% of unplanned pregnancies
- 14% with *no* use (or have a gap of 1+ month) account for 54% of unplanned pregnancies

Reproductive Life Plan

Overview

- Developed by the CDC
- Tool for health and *human service* providers to ask about contraception, assess knowledge and promote shared decision-making
- Can be used with women and ***men***
- Importance of follow-up

Reproductive Life Plan

In Practice

- **Do you (your partner) plan to have (more) children at any time in the future?**

IF YES:

- How many would you like to have?
- How long would you like to wait until you become pregnant?
- What family planning methods do you plan to use until you are ready to become pregnant?
- How sure are you that you'll be able to use this method without any problems?

Reproductive Life Plan

In Practice

IF NO:

- What family planning method will you use to avoid pregnancy?
- How sure are you that you will be able to use this method without any problems?
- Peoples plans change. Is it possible that you could ever decide to become pregnant?

LARC

Long Acting Reversible Contraception

John W. Stutsman, MD, FACOG
Asst. Prof. of Clinical OB/GYN
Indiana University School of Medicine
Medical Director, Planned Parenthood of Indiana & Kentucky

Effectiveness of Family Planning Methods

Most Effective

Less than 1 pregnancy per 100 women in a year

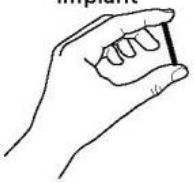
6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

Least Effective

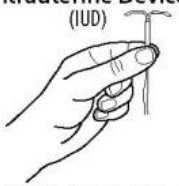
Reversible

Implant



0.05 %*

Intrauterine Device (IUD)



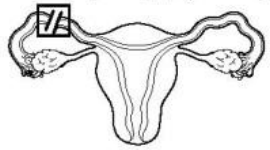
LNG - 0.2 % Copper T - 0.8 %

Permanent

Male Sterilization (Vasectomy)

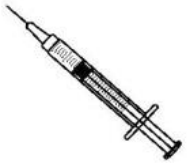
0.15 %

Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)



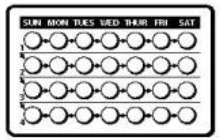
0.5 %

Injectable



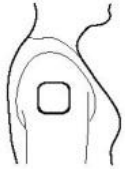
6 %

Pill



9 %

Patch



9 %

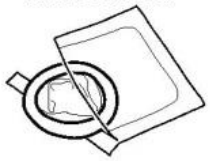
Ring

9 %

Diaphragm

12 %

Male Condom

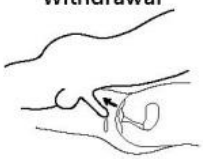


18 %

Female Condom

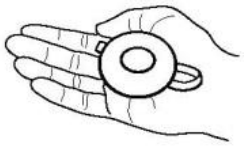
21 %

Withdrawal



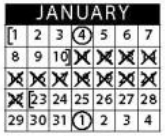
22 %

Sponge



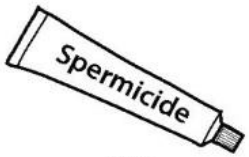
24 % parous women
12 % nulliparous women

Fertility-Awareness Based Methods



24 %

Spermicide



28 %

*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

How to make your method most effective

After procedure, little or nothing to do or remember.

Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable: Get repeat injections on time.

Pills: Take a pill each day.

Patch, Ring: Keep in place, change on time.

Diaphragm: Use correctly every time you have sex.

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.

Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

CS 242797

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

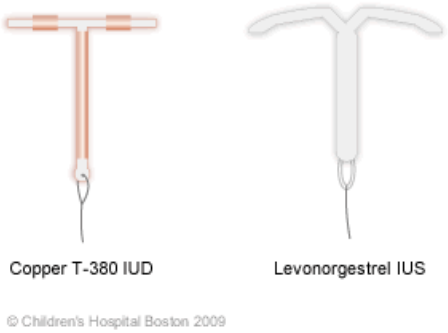
Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

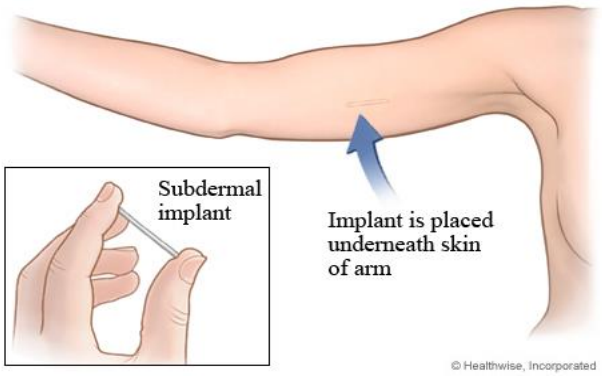
Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

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

Types of Long-Acting Reversible Contraception

- Intrauterine device (IUD, IUC, IUS)
  - Levonorgestrel (LNG) IUD
    - Mirena ® - FDA approved 5 yrs
    - Skyla ® - FDA approved 3 yrs
  - Copper IUD
    - Paraguard ®
    - FDA approved 10 years
- Subdermal implant
  - Etonogestrel subdermal implant
    - Nexplanon ®
    - FDA approved for 3 years (up to 4 years)





Dispelling Myths About IUC, IUD, IUS…

In fact, IUDs:

- *Are not* abortifacients
- *Do not* cause ectopic pregnancies
- *Do not* cause pelvic infection
- *Do not* decrease the likelihood of future pregnancies
- *Can* be used by nulliparous women

- *Can* be used by women who have had an ectopic pregnancy
- *Do not* need to be removed for PID treatment
- *Do not* have to be removed if inflammatory changes or Actinomyces are noted on a Pap test

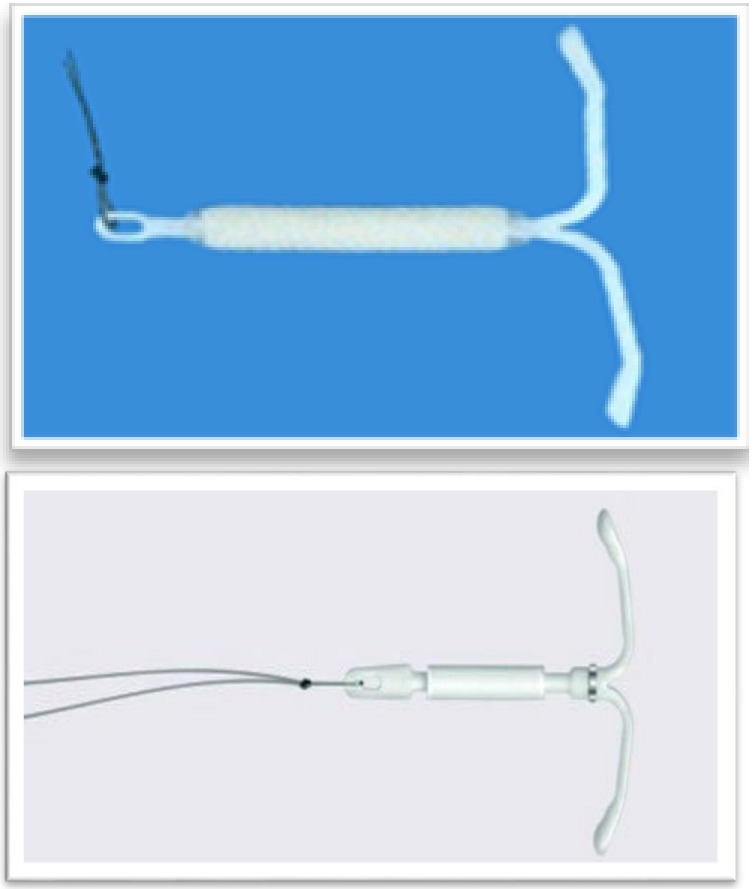
Duenas JL. *Contraception*. 1996; Forrest JD. *Obstet Gynecol Surv*. 1996; Hubacher D. *N Engl J Med*. 2001; Lippes *J. Am J Obstet Gynecol*. 1999; Otero-Flores JB. *Contraception*. 2003; Penney G. *J Fam Plann Reprod Health* Care. 2004; Stanwood NL. *Obstet Gynecol*. 2002; WHO. 2009.

IUC Available in the United States

- Copper T 380A IUD
  - Copper ions
  - Approved for 10 years of use
    - May use up to 12 years

ParaGard® PI. 2013; Teva. 2013.

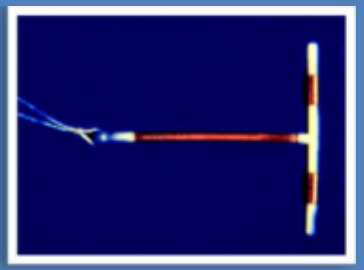
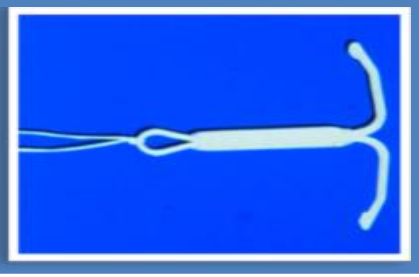
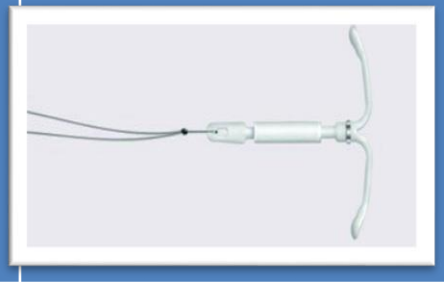
IUC Available in the United States



- LNG 52 IUS
  - Releases 20 µg of LNG per day
  - Approved for 3 (Liletta) or 5 (Mirena) years of use (up to 7 years)
- LNG 13.5 IUS
  - Releases 14 µg of LNG per day
  - Approved for 3 years of use

Mirena® PI. 2013; Skyla™ PI. 2013.

IUC Mechanism of Action

Mechanism of Action	Copper T IUD	LNG 52 IUS	LNG 13.5 IUS
			
Primary	• Prevents fertilization • Reduces sperm motility and viability • Inhibits development of ova	• Inhibits fertilization • Causes cervical mucus to thicken • Inhibits sperm motility and function	
Secondary	• Inhibits implantation (?)	• Inhibits implantation (?)	

Ortiz ME. *Contraception*. 2007; Alvarez F. *Fertil Steril.* 1988; Segal SJ. *Fertil Steril*. 1985; ACOG. 1998; Jonsson B. *Contraception*. 1991; Silverberg SG. *Int J Gynecol Pathol*. 1986.

Percentage of Women with Fertilized Eggs in Oviducts After Midcycle Coitus

Group	Normal development (%)	No development (%)	Abnormal development (%)
Control (n = 20)	50	15	35
IUC* (n = 14)	0	64	36

*IUDs studied included Copper T 200 (4 women), Lippes loop (5 women), and progestin IUDs (5 women)

Alvarez F. *Fertil Steril*. 1988.

LARC and Birth Spacing

- Women who used LARC vs. less effective contraceptive methods had almost 4 times the odds [95% CI, 3.55-4.26] of achieving an optimal birth interval
- Subdermal implant was associated with longer interpregnancy interval in adolescents compared with less effective methods (18.7 mo. vs. 11.9 mo.)

Thiel de Bocanegra H, Chang R, Howell M, et al. Interpregnancy intervals: impact of postpartum contraceptive effectiveness and coverage. Am J Obstet Gynecol 2014;210:311.e1-8.

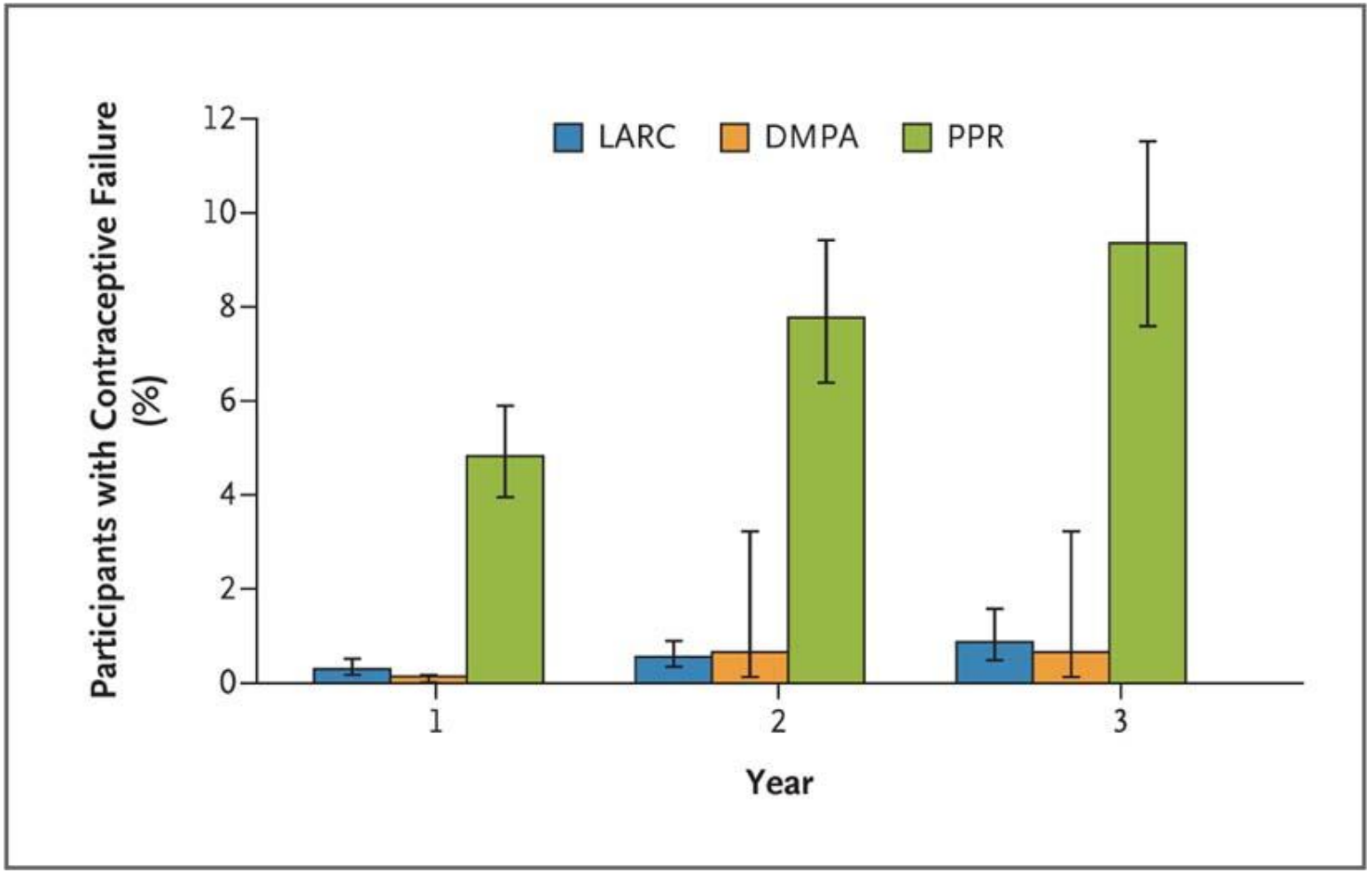
Baldwin M, Edelman A. The effect of long-acting reversible contraception in rapid repeat pregnancy in adolescents: A review. *J Adolesc Health.* 2013;52:S47-S53.

LARC Usage by Adolescents in St. Louis Missouri (CHOICE)

- Contraceptive CHOICE Project
  - Longitudinal, observational study of women's choice, use, and continuation of available contraceptive methods
  - All methods were offered to study participants at NO cost
- Among adolescents aged 14-20, 62% choose LARC method (658/1054)
- Young women aged 14-17 years preferred implant over IUD

Mestad R, Secura G, Allsworth J, Madden T, Zhao Q, Peipert J. Acceptance of long-acting reversible contraceptive methods by adolescents participants in the Contraceptive CHOICE project. Contraception 2011; 493498: 84.

Effectiveness of LARC Methods (CHOICE)



Winner B, Peipert JF, Zhao Q, et al. Effectiveness of Long-Acting Reversible Contraception. *N Engl J Med.* 2012;366:1998-2007

The Contraceptive CHOICE Project

- Longitudinal study from 2008-2013 that followed 1,404 teenagers aged 15 to 19 years old for 2-3 years after choosing their contraceptive method.
  - 72% chose an IUD or implant (rate increased at end of study)

Secura, G, Madden, T, McNicholas C, Mullersman, J, Buckel, C, Zhao Q, Peipert, J. Provision of No-Cost, LARC and Teen Pregnancy. NEJM. Oct 2014. 371(14): 1316-23.

Mean annual rate per 1000 teens	CHOICE participants	Typical U.S Teen
pregnancy rate	34.0	158.5
birth rate	19.4	94.0
abortion rate	9.7	41.5

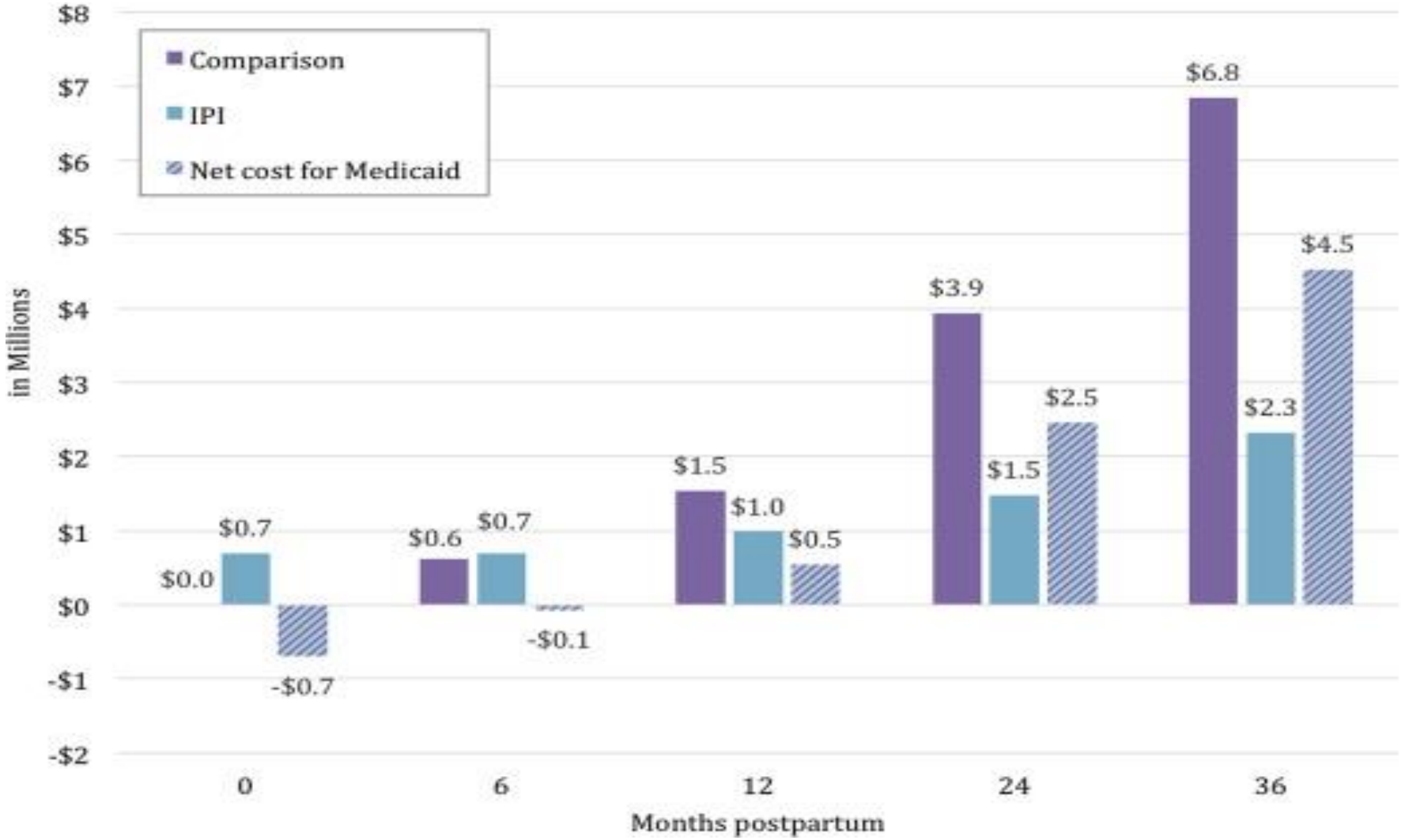
Adolescent LARC Usage in Colorado

- ***How Colorado's teen birthrate dropped 40% in four years***
  - "Since 2009, the state has provided 30,000 contraceptive implants or intrauterine devices (IUDs) at low or no cost."
  - "**teen abortion rate fell by 35** percent between 2009 and 2012"
  - "**the state saved $42.5 million** in health-care expenditures associated with teen births."

- Tocce KM, Sheeder JL, Teal SB. ***Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference?***
  - Prospective longitudinal trial
  - the relative risk of repeat pregnancy at 12 months after delivery was **5.0 times greater** (95% confidence interval [CI], 1.9–12.7) for the control group compared to those who received an immediate postpartum implant

Tocce KM, Sheeder JL, Teal SB. Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference? Am J Obstet Gynecol 2012;206:481.e1-7.
http://www.washingtonpost.com/news/morning-mix/wp/2014/08/12/how-colorados-teen-birthrate-dropped-40-in-four-years/

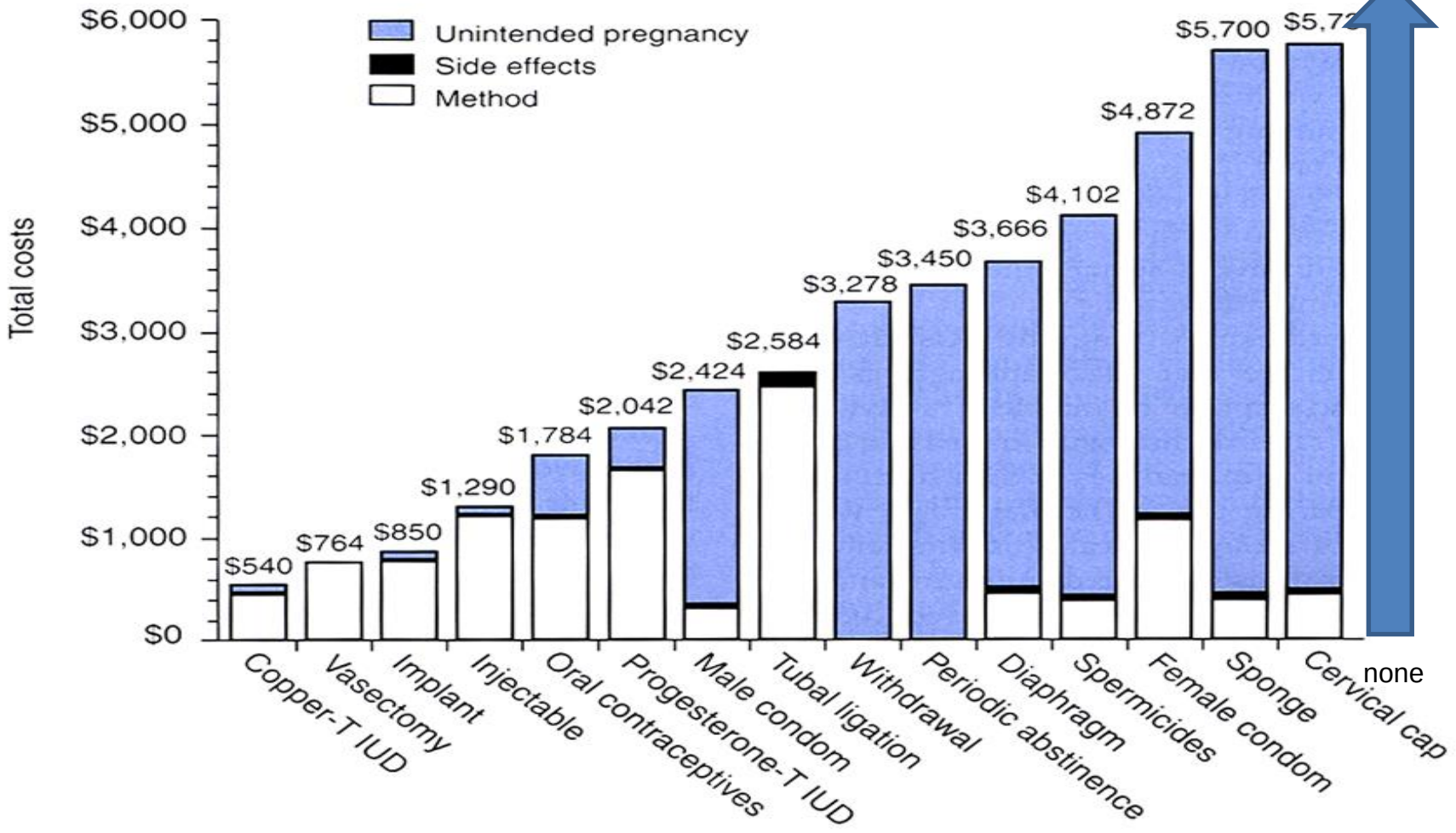
Cost Effectiveness of LARC



Han. Cost-effectiveness of immediate postpartum Etonogestrel implants. Am J Obstet Gynecol 2014.

5-Yr Costs Associated with Contraceptive Methods in the Managed Payment Model

$14,663



From: Trussell J, Leveque, JA, and Koenig, JD: *Am J Public Health* 85 (49):494, 1995

LARC - Advantages

- Extremely effective
- Immediately reversible
- Can be placed immediately postpartum and used while breastfeeding
- Few contraindications
- Non-hormonal option (ParaGard)

LARC - Disadvantages

- Requires a visit to a medical provider
- Minimally invasive (but invasive) procedure
- Chance of side effects or complications (mainly bleeding/spotting)
- Upfront COT

Coverage Options

HIP 2.0 and the Marketplace

Marci Toler, B.S.
Director of Coalition Development & Support
Covering Kids and Families, Indiana

How did we get here?

HIP 1.0: *This is a test. This is only a test*.

The ACA comes to Indiana

- SBE and Medicaid expansion debates
- Navigator regulation

The Cover Indiana campaign

HIP 2.0

- The introduction
- The first date
- Going steady

HIP 2.0: A tug-of-war among multiple views & interests

Result?
A compromise product

covering kids & families of Indiana

But somehow we got here…

covering kids & families of Indiana

…and here

	HIP Employee Benefit Link	HIP Plus	HIP Basic	State Plan
Who's eligible?	**Optional for individuals with access to cost-effective employer-sponsored insurance** Exception: Medically fragile	• Income up to 138% FPL • Consistent POWER Account contributions	• Income below 100% FPL only • Fail to make POWER Account contribution	**Individuals with complex medical or behavorial conditions** • Very low income parents • Pregnant women
How do you pay?	**Enhanced POWER Account can be used for premiums, co-payments or deductibles**	**POWER Account contributions** No co-payments, except: Non-emergency ER visit: $8-25	**Copayments for most services** More expensive than HIP Plus	**Copayments *or* POWER Account contribution** • Exception: Pregnant women are exempt from cost-sharing
What are the benefits?	**Employer plan benefits**	**Comprehensive medical benefits incl. maternity** • Vision & dental benefits • Increased service limits • Comprehensive drug benefit	**Comprehensive medical benefits incl. maternity** • Lower service limits • Limited drug benefit	**Comprehensive medical benefits incl. maternity** • Current Medicaid benefits as required by federal law • Enhanced behavioral health services

HIP 2.0 at a glance

- Able-bodied adults ages 19-64 up to 138% FPL
- Different tiers of coverage: HIP Plus, HIP Basic, HIP Link
- Salient differences between 2.0 and traditional Medicaid: cost-sharing, non-payment penalties, no retroactive coverage, no NEMT, graduated ED copays
- Financed by Hospital Assessment Fee
- CMS STC requires 3rd party payments and expanded PE capacity

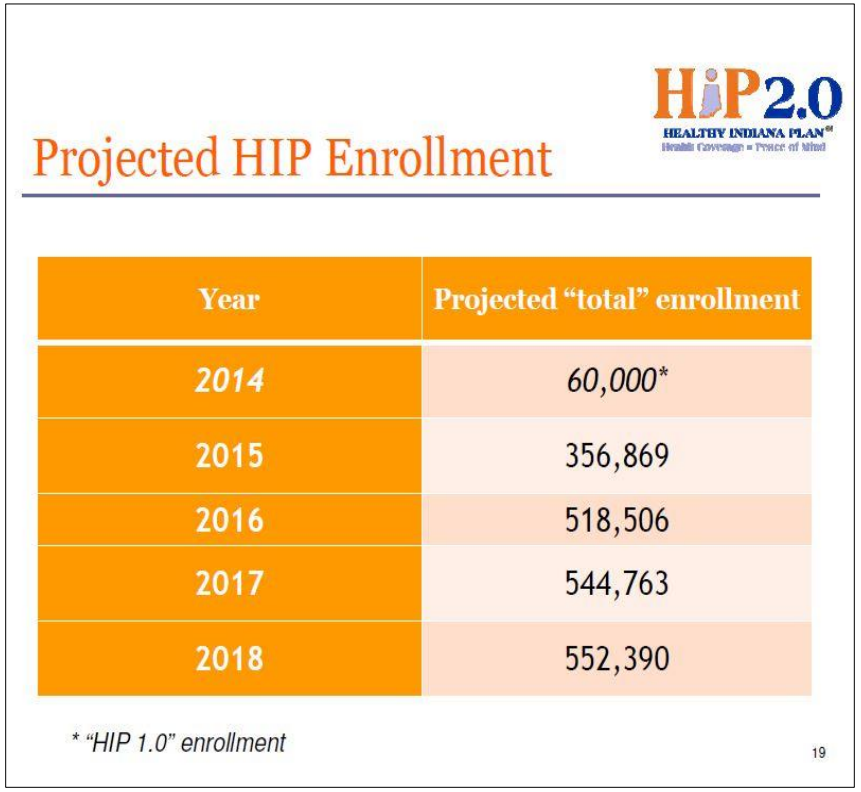
Where are we now?

Total enrollment over 400,000

- Over 60% making contributions
- 83% below 100% FPL

3,600 new providers/locations joined IHCP

20 day average eligibility determination



HIP 2.0
HEALTHY INDIANA PLAN

Projected HIP Enrollment

Year	Projected "total" enrollment
2014	*60,000**
2015	356,869
2016	518,506
2017	544,763
2018	552,390

* "HIP 1.0" enrollment

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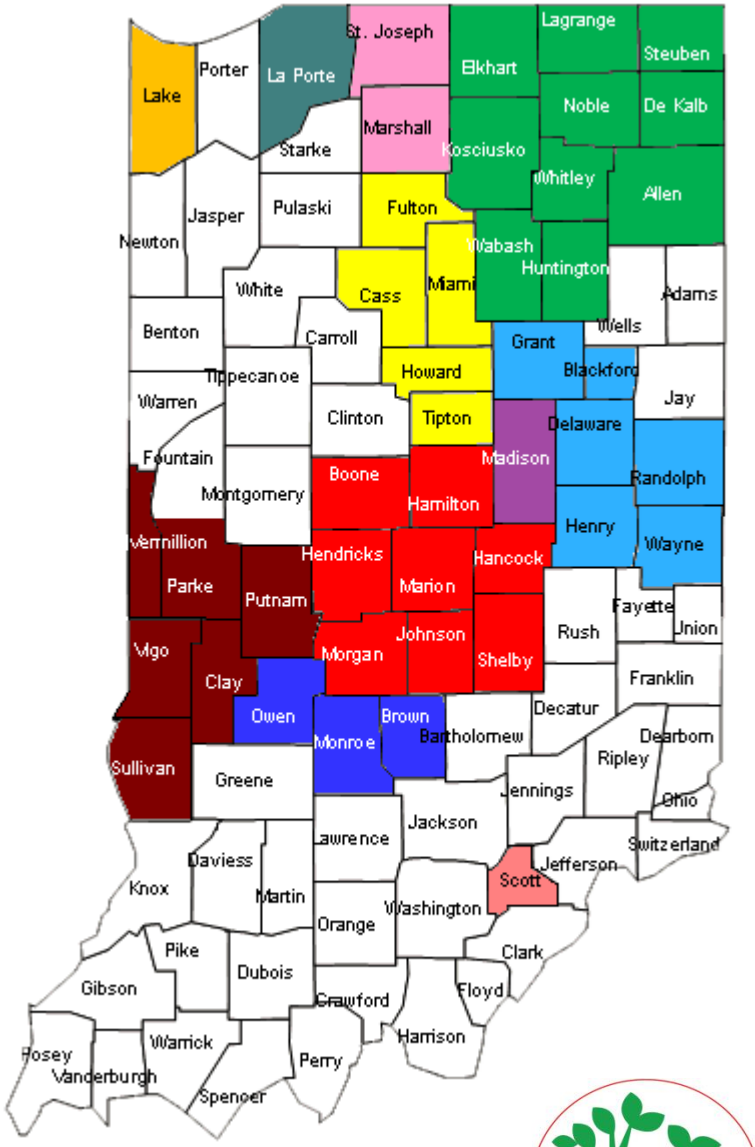
COVERING KIDS & FAMILIES LOCAL COALITIONS Rev. 06/27/2016

- Area Five CKF
- Central Indiana
- East Central Indiana
- Lake County
- LaPorte County
- Northeast Indiana
- North Central Indiana
- Madison County
- West Central Indiana
- Monroe, Owen & Brown Counties
- Scott County



Local Coalitions Reach 44 Counties

Central Indiana serves 8 counties:
Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, & Shelby
Northeast Indiana serves 10 counties:
Allen, De Kalb, Elkhart, Kosciusko, Huntington, Lagrange, Noble, Steuben, Wabash & Whitley
East Central Indiana serves 6 counties: Blackford, Delaware, Grant, Henry, Randolph and Wayne
West Central Indiana serves 6 counties: Clay, Parke, Putnam, Sullivan, Vermillion and Vigo

covering kids & Families of Indiana

To become a partner or to learn more about CKF-IN and local Coalitions visit

www.ckfindiana.org

100% CAMPAIGN
covering kids & families of Indiana

covering kids & families of Indiana

Local Coalitions

Area Five CKF Coalition:
Cass, Fulton, Howard,
Miami, & Tipton Counties Coalition
Lead Agency: Area Five Agency on Aging & Community Services
Phone: 574-722-4451
www.areafive.com

Central Indiana Coalition:
Boone, Hamilton, Hendricks,
Marion, Hancock, Morgan,
Johnson & Shelby
Lead Agency: Health & Hospital Corp of Marion County
Phone: 317-221-3117
www.hhcorp.org

East Central Indiana Coalition:
Blackford, Delaware, Grant,
Henry, Randolph & Wayne
Lead Agency: Open Door Health Services
Phone: 765-286-7000
www.opendoorhs.org

Lake County Coalition
Lead Agency: Community HealthNet Health Centers
Phone: 219-789-4163
www.garychc.org

LaPorte County Coalition
Lead Agency: Healthy Communities of LaPorte County
Phone: 219-877-4451
www.healthycommunitieslpc.org

Madison County Coalition
Lead Agency: United Way of Madison County
Phone: 765-608-3060
www.unitedwaymadisonco.org

Monroe, Owen & Brown Counties Coalition
Lead Agency: South Central Community Action Program
Phone: 812-339-3447 ext. 233
www.insccap.org

North Central Indiana Coalition:
St. Joseph & Marshall
Lead Agency: United Health Services
Phone: 574-247-6047
www.uhs-in.org

Northeast Indiana Coalition:
Allen, DeKalb, Elkhart, Huntington,
Kosciusko, LaGrange, Noble, Steuben,
Wabash & Whitley
Lead Agency: Brightpoint
Phone: 260-423-3546 ext. 276
www.mybrightpoint.org

Scott County Coalition
Lead Agency: Scott County Partnership
Phone: 812-752-6365
www.scottcountypartnership.org

West Central Coalition:
Clay, Parke, Putnam, Sullivan, Vermillion & Vigo
Lead Agency: West Central Indiana Economic Development District, Inc. Phone: 812-917-3140
www.westcentralin.org

CKF-IN Coalition Enrollment Services

- FREE in person assistance for:
  - Hoosier Healthwise
    - Up to 250% FPL
  - HIP 2.0
    - Up to 138% FPL
  - Marketplace
    - Up to 400% FPL
      - Cost Sharing after 138% FPL

Indiana's Federally Facilitated Marketplace

2016 Marketplace Plans

- All Savers
- Anthem
- CareSource
- IU Health
- Mdwise Marketplace
- Physicians Health Plan
- MHS

2016 Insurers by County

- Marketplace Insurance Providers by County for 2016

2017 Marketplace Filings

- Anthem Insurance Companies
- CareSource Indiana Inc.
- MHS
- MDwise Marketplace

Resources

HIP 2.0 – Health Care Coverage

- http://www.in.gov/fssa/hip/2450.htm (free brochures)
- http://www.in.gov/healthcarereform/2468.htm
- https://www.ckfindiana.org/resources

Contraception

- http://thenationalcampaign.org/
- https://bedsider.org/
- http://www.choiceproject.wustl.edu/#CHOICE

Reproductive Health Care Providers

- https://www.ifhc.org/
- https://www.plannedparenthood.org/planned-parenthood-indiana-kentucky
- http://www.indianapca.org/

Reproductive Life Plan

- http://www.cdc.gov/preconception/reproductiveplan.html
- http://beforeandbeyond.org/toolkit/reproductive-life-plan-assessment/

References

- https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states
- https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states
- http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/women-alcohol-and-other-drugs-and-pregnancy
- http://sys.mahec.net/media/onlinejournal/Contraceptive%20Choices.pdf
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052960/
- http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0116231
- http://www.popline.org/node/534933
- http://link.springer.com/article/10.1007%2Fs10995-010-0646-z

Questions???