



Increasing Access to Reproductive Health Services in New Jersey

July 1, 2020
12:00pm – 1:00pm EST

Featured Speakers:
Quality Institute Policy Associate
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Presenters



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Agenda

- Welcome and Introductions
- Overview of Contraceptive Care and Access in New Jersey
- Prioritizing Reproductive Justice
- Understanding Patient and Provider Barriers
- Strategies and Best Practices
- Q&A

Objectives



By the end of this presentation you will be able to:

- Describe the importance of access to comprehensive reproductive health care, focusing on the full range of contraceptive methods.
- Discuss barriers to reproductive health services, including patient-driven and operational barriers to care.
- Identify strategies to increase access to reproductive health services using patient-centered care, shared-decision making and promoting the pillars of reproductive justice.

NJ-RHAP

An illustration of a person with dark skin and hair in a bun, wearing an orange cardigan over a blue top, sitting at a large, light-orange desk. To the left of the person is a blue computer monitor displaying three white horizontal lines and three small white circles. The background is a light blue semi-circle.

The New Jersey Reproductive Health Access Project (NJ-RHAP) is a statewide initiative created to expand access to the full range of contraceptive options available.

The goal of NJ-RHAP is to reduce the policy and payment system barriers that prevent individuals from accessing the contraceptive method(s) they most desire through provider education efforts and promotions of policy change that supports patient-centered reproductive health care.

➤ NJ-RHAP is led by the [New Jersey Health Care Quality Institute](#) and supported by [Arnold Ventures](#).

NJ-RHAP Provider Access Commitment Toolkit

The NJ-RHAP PACT provides education and support for the implementation of best practices to increase access to reproductive health services, including long-acting reversible contraception (LARC), centering the concepts of shared-decision making and the promotion of reproductive justice.

The full toolkit and NJ-RHAP Resources are available here:

<https://bit.ly/QIResourcesNJRHAP>

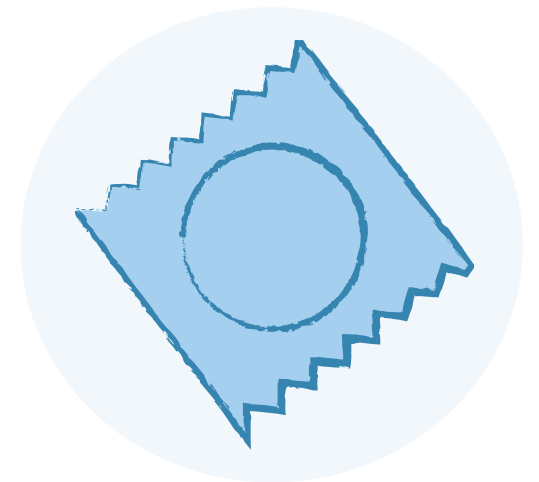
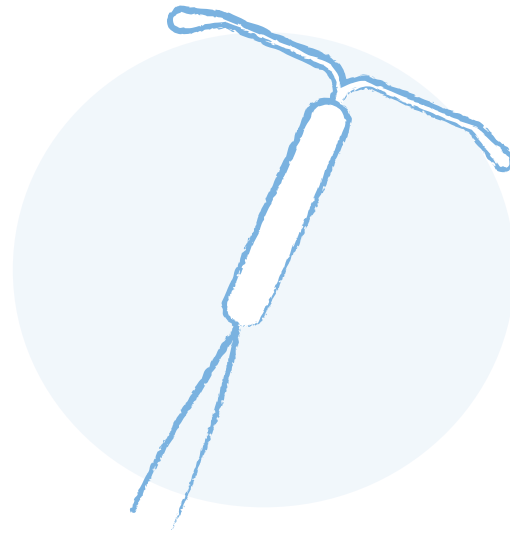
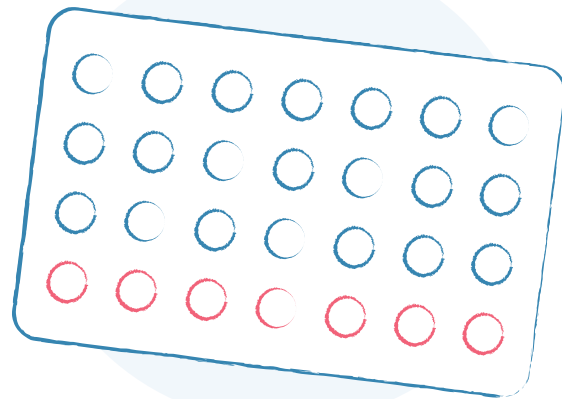
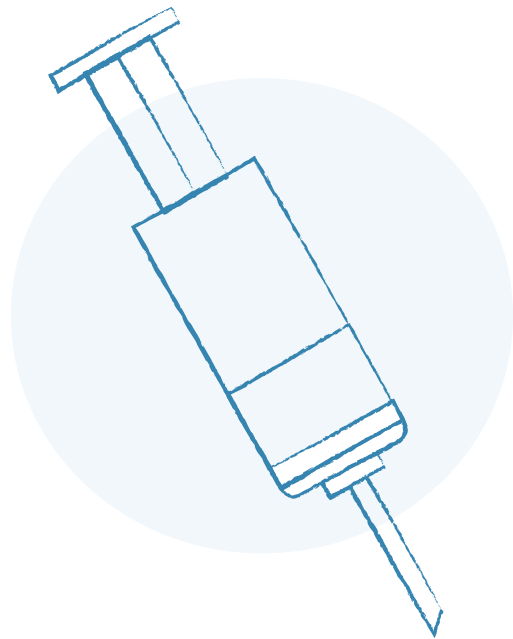


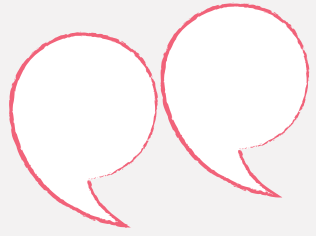
NJ-RHAP PACT Resources

- *Billing and Coding Guide for Contraceptive Services*
- *National Women's Health Network (NWHN)-SisterSong Joint Statement of Principles on LARCs*
- *10 Steps to Verify Coverage for Contraceptive Services*
- *Reproductive Health Services for Uninsured and Underinsured Individuals in New Jersey*
- *LARC 'Buy and Bill' Models: Key Points and Considerations*
- *5 Steps for Increasing Same-Day Access to LARC*
- *Priority Setting Worksheet for Front Desk Staff*
- *Community Engagement Planning Worksheet*
- *NJ-RHAP PACT Pledge*



Overview of Contraceptive Care and Access in New Jersey





* Key Quote

“Birth control, as a core component of family planning, is one of the most important public health success stories of our generation.”

*- Georges Benjamin, MD
Executive Director
American Public Health Association*

Public Health Impact of Contraceptive Access

- The CDC named family planning, including access to modern contraception, one of the 10 great public health achievements of the 20th century.
- It is estimated that for every \$1 invested in family planning programs, federal and state governments save over \$7.00 in part due to the prevention of unintended pregnancies from publicly supported contraception care.
- Contraception access accounts for 86% of the recent decline in teenage pregnancy across the country.
- Oral contraceptive use has consistently been found to be associated with a reduced risk of ovarian and endometrial cancers.

Source: [Planned Parenthood Birth Control Fact Sheet](#)

Personal Impact of Contraceptive Access

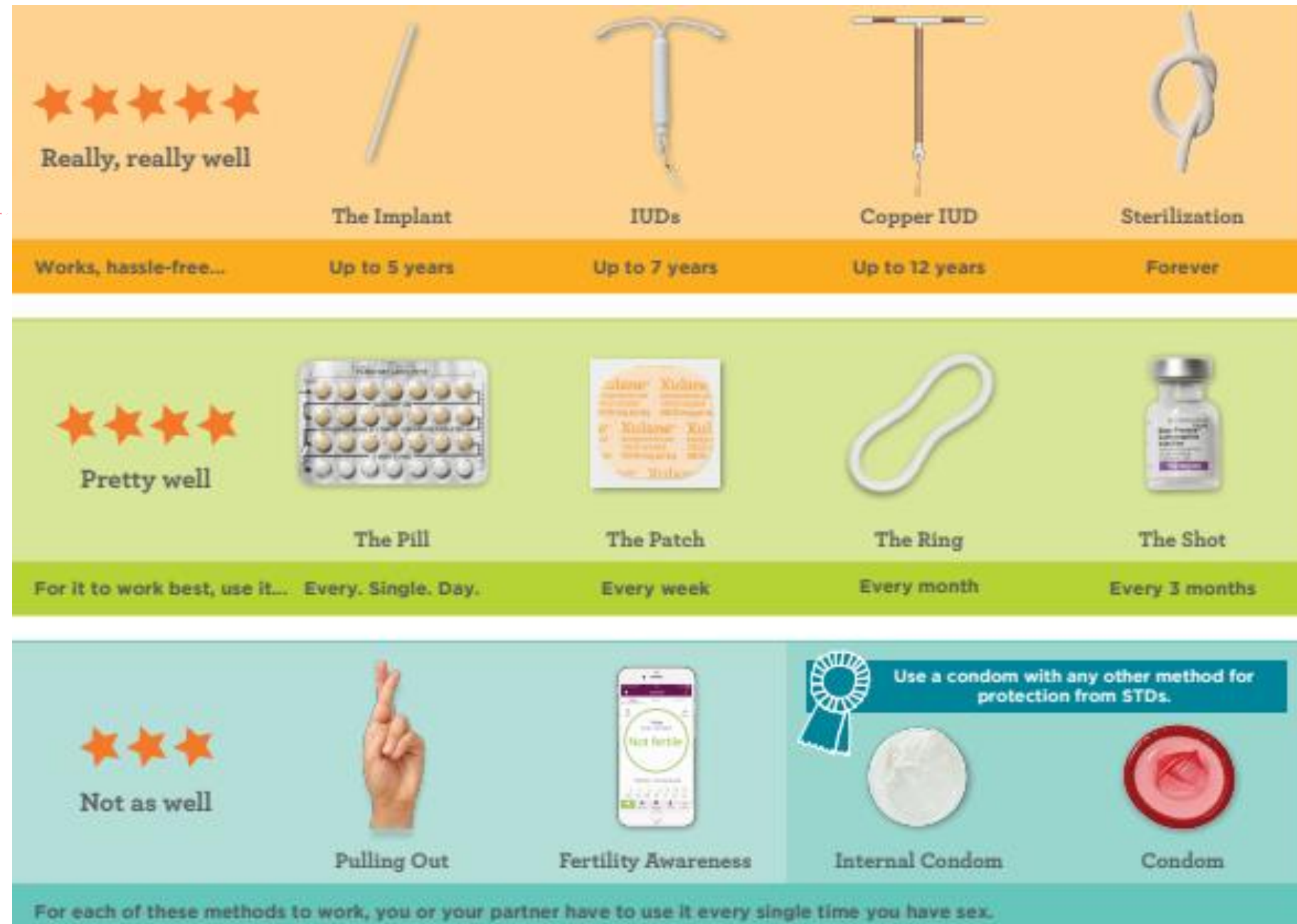
- Accessible and affordable contraception gives individuals the ability to make educated decisions about their reproductive health and decide if and when they would like to have children.
- This type of empowerment is directly tied to increased financial stability as well as improved health and education outcomes for individuals, families, and communities.

Prioritizing Access Over Utilization

- Initiatives around contraceptives services must be focused on increasing **access** to all forms of contraception and promoting patient-centered decision making.
- The focus should **not** be on utilization of contraceptives as a whole or on specific forms of contraception.
- This is especially true when working with people who have been marginalized, such as BIPOC, due to past **injustices** around forced sterilization and other oppressive policies and procedures that limited reproductive choice.

Contraceptive Methods

While it is important to explain the effectiveness of each method for preventing pregnancy, **the best method of contraception is the one that meets the needs of an individual and is used appropriately.**

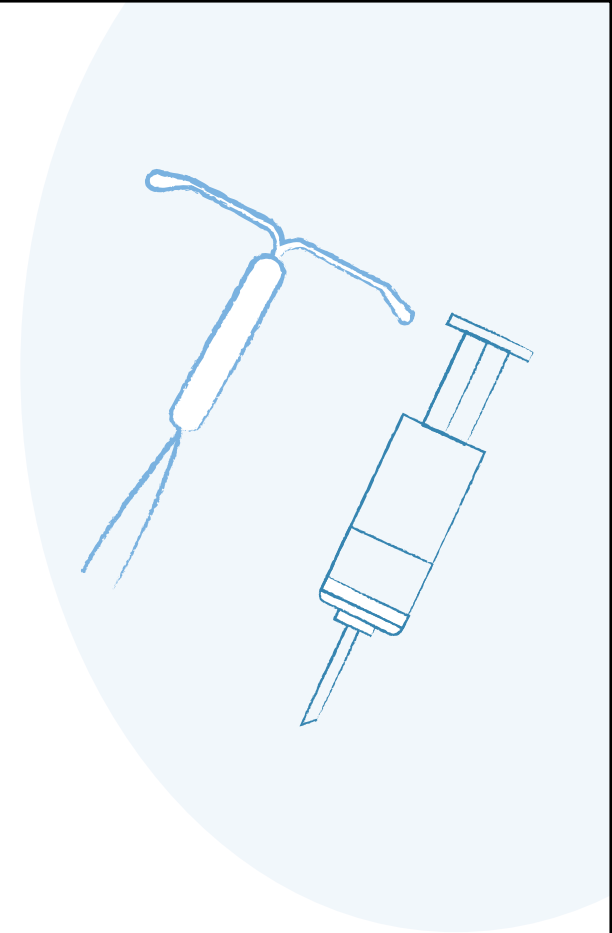


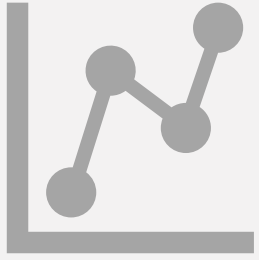
The Role of LARCs

LARC stands for long-acting reversible contraception.

- LARCs provide continuous contraceptive coverage over a period from 3-12 years depending on the product.
- There are two types of LARCs:
 - An implant that is placed under the skin, and
 - An intrauterine device placed in the uterus.
- Implants and IUDs require insertion and removal by a qualified health care professional. They can be removed at any time, after which a patient will shortly return to their baseline fertility.

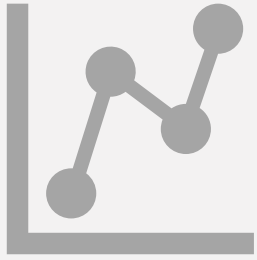
For many patients and providers, there are increased barriers to LARC services due to the cost and process to obtain them, and the need for provider engagement to initiate and remove the devices.





Key Data: New Jersey

- While the rates of unintended pregnancy nationally and in New Jersey have decreased over the past few years, **25.3%** of pregnancies in the state are unintended.
- 2017 data from Guttmacher indicated that **72.1%** of New Jersey women (age 18-49) who were at risk of an unplanned pregnancy were using some form of contraceptive.
 - **27%** of these women were using the least effective contraceptives, while **17.8%** were using only moderately effective contraceptives, and **10.6%** were using highly effective methods.



Key Data: Contraceptive Choice

A 2016 national study of women in family planning and abortion clinics identified characteristics of contraceptive methods which were “**extremely important**” to them.

- Of 23 total items, the method’s **effectiveness** at preventing pregnancy was the item that most (89%) said was “**extremely important.**”
- The next most important characteristics were if the method is **easy to get** (81%), **affordable** (81%), and **easy to use** (80%).
- Other characteristics, such as a method’s potential side effects, non-contraceptive benefits, partner preference and peer experiences were also considerations.

Prioritizing Reproductive Justice

Reproductive Justice



- Reproductive justice, a concept defined in 1994 by SisterSong, is the human right for people to maintain personal bodily autonomy, to have children or not have children, and to parent those children in safe and sustainable communities. It combines the concepts of reproductive rights and social justice.
- There has been a long history of reproductive injustice in the United States, especially toward BIPOC and other people who have been marginalized.
 - It is a manifestation of systemic racism in the medical field as well as in our society as a whole.

Reproductive Justice

- As recently as the 1990s, documentation shows practices of sterilization without consent and coercion with financial or other incentives (such as reduced prison sentences, or as a requirement for receiving welfare) to have LARC inserted.
- These efforts were often supported or funded by federal or state governments.
- Contributed to distrust of providers offering contraceptive services

Key Practice Considerations for Prioritizing Reproductive Justice



- At all levels of policy development, implementation, and service delivery, prioritizing reproductive justice means evaluating policies to assure they are grounded in evidence, support individual rights and avoid coercion through processes that promote shared decision-making and patient centered care. It includes:
 - Avoiding policies which, though well-meaning, may have negative unintended consequences.
 - Utilizing best practices to ensure patient rights, education and access are at the forefront
 - Recognizing and addressing systemic racism, explicit and implicit bias in all of our healthcare systems.

Balancing LARC Zeal and Access Barriers

- “LARC Zeal” has been described by the National Women’s Health Network as institutional or provider enthusiasm for LARCs to the exclusion of other methods, which runs the risk of hampering an individual’s ability to decide what methods are best for their unique circumstances and can heighten the possibility of coercion.
- When providers keep at the forefront the knowledge the negative impact that emphasizing LARCs as a preferred form of contraceptive can have on individuals, particularly those who are the most vulnerable, they can provide services without fear of “LARC ZEAL”.



Key Question

What is Shared Decision Making in Reproductive Health?

“The process of shared decision-making (SDM) requires clinicians to set aside their personal biases or preferences for care, offer balanced information about all treatment options, and help patients navigate that information to arrive at their own decisions. All reproductive health decision-making takes place within the power dynamics and social structures of patients’ lives, including the history of reproductive coercion, forced sterilization, and bias between patients and providers. Using a shared decision-making model in reproductive health is a patient-centered step toward addressing that social context.”

— Innovating Education in Reproductive Health: Changing the Conversation: Shared Decision-Making in Reproductive Health



The **SHARE** Approach

5 Essential Steps of Shared Decision Making



Shared Decision Making and Patient-Centered Care



- **Patient-centered care**, places the individual's health needs, quality of life concerns, and desired health outcomes at the forefront of care and respects the patient's viewpoints and preferences
- Patient-centered care promotes active listening on the part of providers as a tool to promote true collaboration and shared decision-making and uses language that is most appropriate for the patient.
 - Recognizes provider “privilege” which can affect the way clinicians present or “package” information and impact the intersection of client interactions with systems of care
 - Avoids the possibility of provider bias/assumptions influencing the decision about what information/which methods to discuss with patients

Patient-Centered Contraceptive Counseling

- As individuals' lives and needs change, continued counseling is needed to ensure that the most appropriate contraception is accessible for that stage in life.
- **The best contraception method is the one that the individual will use,** so it is important to acknowledge changing needs and priorities of each patient throughout their life.
- Shared decision-making models are fundamental to the provision of all medical care, but especially contraceptive counseling.



Key Question:

What is Reproductive Coercion?

Reproductive coercion is a type of domestic abuse that includes explicit behaviors to promote pregnancy that is unwanted by the woman, interfering with contraception, and pregnancy coercion, including threats of abandonment if pregnancy does not occur.

The abuses can be physical or psychological and do not only come from a male partner. In some cultural circles, extended family, especially older female relatives, control reproductive decision-making.

- As many as 1 in 4 women who present at a sexual health clinic report having experienced this type of abuse.**
- Younger individuals, as well as racial minorities, are particularly at risk for reproductive coercion.**
- Almost 1 in 8 females who sought care from a school health center experienced recent reproductive coercion.**

Reproductive Coercion

Examples of Reproductive Coercion:

- Partners who cajoles that sex feels better without a condom, or who secretly remove a condom during sex
- Partners who lie that they have had a vasectomy
- Partners who promise to withdraw before ejaculation and do not
- Partners who pierce condoms or other barrier methods
- Partners who forcefully remove, destroy, or hide contraceptive methods
- Partners who force abortions

Recommended Screening Questions:

- Has your partner or others in your life ever forced you to do something sexually that you did not want to do or refused your request to use contraception?
- Has your partner or others ever tried to get you pregnant when you did not want to be pregnant?
- Are you worried your partner or others will hurt you if you do not do what they want with the pregnancy?
- Does your partner or others in your life support your decision about when or if you want to become pregnant?



Patient, Provider, and Systemic Barriers



Patient Barriers to Contraceptive Care

- Coverage Limitations
 - *Example: Lack of health insurance, lack of contraceptive coverage, out of pocket costs*
- Lack of knowledge about options
 - *Example: Limited consumer education about birth control options and what is accessible and appropriate for them*
- Fear of side effects
 - *Example: Poor experiences of certain methods shared by friends/family, concerns about ability to stop or remove a method*
- Population based and cultural challenges
 - *Example: Limited acceptance of contraceptive use from different cultures, lack of culturally competent providers and educational materials, prior negative experiences with healthcare systems/history of trauma*

Provider/Systemic Barriers to Contraceptive Care

- Clinical Misconceptions
 - *Example: A false belief in an association between IUDs and an elevated likelihood of pelvic inflammatory disease.*
- Lack of Experience/Comfort with Services
 - *Example: Many clinicians will opt to refer out to family planning clinics that are more experienced in LARC procedures.*
- Inadequate Reimbursement Policies
 - *Example: Limited reimbursement for contraceptive counseling by some health plans, and reimbursement for LARCs below wholesale acquisition cost (WAC) can disincentivize providers from offering certain services.*

LARC Barriers



- While LARCs are most effective at preventing pregnancy, costs of the device, supply chain to obtain a device, and the provider involvement needed to initiate and remove the device present additional barriers to access to this form of contraception.
- Many provider offices do not offer LARC services, and patients are often faced with having to find a different provider or choosing a different, and possibly less effective, form of contraception.

Two Visit Experience for LARCs



- Providers that do offer LARCs in their offices, typically have patients come in for one appointment where an IUD or implant is selected as their contraceptive of choice and then return for a second visit to initiate the method.
- After the initial visit, the office THEN orders a device for a patient through their insurance and has it delivered to the office.
- Between the first and second visit, a patient might become pregnant or be unable to return to the office due to childcare, transportation, or employment concerns.
 - The patient might also select a different form of contraception if they do not want to or are unable to come back for a second visit.

LARC Purchasing

“White Bagging”

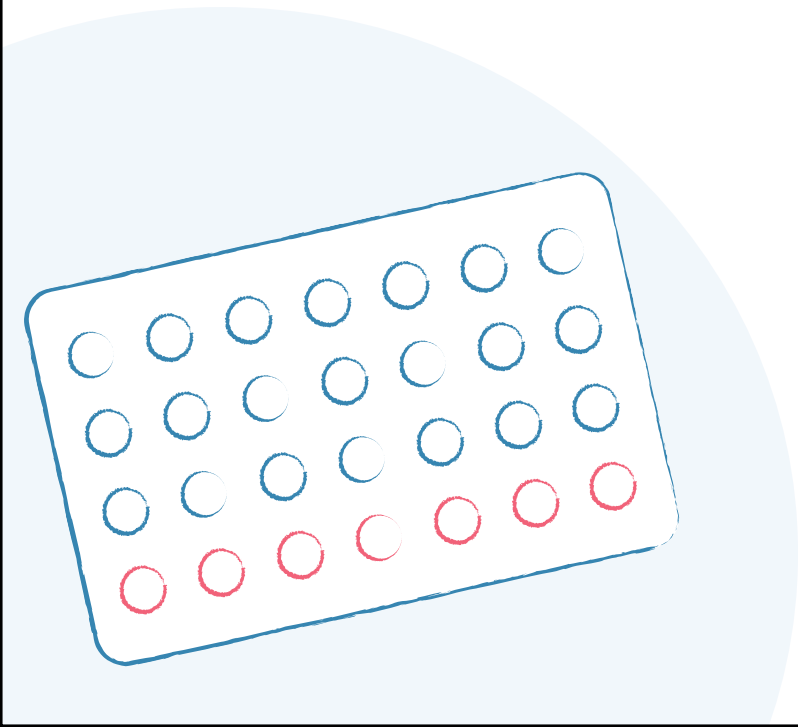
- A provider/office orders the devices through a specialty pharmacy after it is prescribed.
- Under this model, a device is ordered for a specific patient and the pharmacy bills the insurer directly for the cost of the device.
- However, this process takes time and patients must return for a follow-up appointment to receive their LARC.

“Buy and Bill”

- A provider/office purchases devices from manufacturers to have on hand.
- After a device is inserted, the practice seeks reimbursement for the device from the insurer and/or patient.
- This practice allows for same-day access to LARC but requires up-front purchasing by the practice which can raise concerns about cash flow and potential costs of unused devices.

Regardless of the process used to obtain a device and whether same-day access to a form of contraception is available, providers should educate patients about all options and use a **shared decision-making** approach to help the patient make a choice that is best for them.

Best Practices and Strategies



Maximize the Full Care Team

- All professionals engaged in a patient's reproductive health care play an important role in ensuring access to high-quality services.
- **What does this look like?**
 - Health System Leadership: Subsidizing training programs that increase provider competency, investment in stocking practices which support increased access to services, and use of scheduling models that allow providers to have additional time with patients when necessary
 - Practice Management: Promoting best practices to increase access to care through on-going staff training opportunities and ensuring there are informative and culturally competent materials
 - Front Desk/Support Staff: Setting the tone for the patient experience, non-leading and judgement free word choice, information collection and scheduling considerations

Increase Provider Skills and Comfort



- Providers who feel confident in their skills for all forms of contraception are more likely to provide comprehensive and high-quality services to their patients.
- **What does this look like?**
 - Seeking out training opportunities and hands-on experience to increase comfort with services and learn about current best practices
 - Talking with practice leadership and other physicians about opportunities to provide the full range of services in our office to ensure patients have more access and providers are able to remain confident in their abilities

Prioritize Patient-Centered Care

- Prioritizing patients' priorities and choices and recognizing them as experts in their own lives and leads to more productive conversations with their provider about their concerns or questions.
- Centering the concepts of reproductive justice ensure that these choices and decisions are respected
- **What does this look like?**
 - Scheduling models which allow for sufficient time for contraceptive counseling
 - Adhering to policies that ensure that providers can speak to patients without a partner/other person present
 - Use of shared decision making models to ensure that contraceptive counseling is a collaborative process with the patient

Engage Your Community



- When providers and organizations engage beyond their typical environment and more within their community, they can develop true partnership, create greater trust, improve patient satisfaction, and increase effective organizational decision-making that reflects community needs.
- **What does this look like?**
 - Participation in local health fairs and community events
 - Invitations to community leaders to participate in advisory boards
 - Hosting support groups or education sessions that are open to the community (content of groups can be determined by community input)

Next Steps

- Review the NJ-RHAP PACT and NJ-RHAP PACT Resources:
[bit.ly/QIResourcesNJRHAP](https://www.njchqi.org/wp-content/uploads/2020/05/NJRHAP-Tool-9-Pledge.pdf).
- Print, Sign, and Share the NJ-RHAP PACT Pledge:
<https://www.njchqi.org/wp-content/uploads/2020/05/NJRHAP-Tool-9-Pledge.pdf>
- Look out for our next webinar about best practices for billing and coding for contraceptive care coming August/September 2020.
- Reach out for more information or to request trainings or technical assistance from the NJ-RHAP team:
 - Email: blee@njchqi.org



Q&A

Thank You

Find this recording and other COVID-19 Resources at
<https://bit.ly/QICCOVID19Resources>

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