

CDC's Winnable Battle



CDC NCSL meeting
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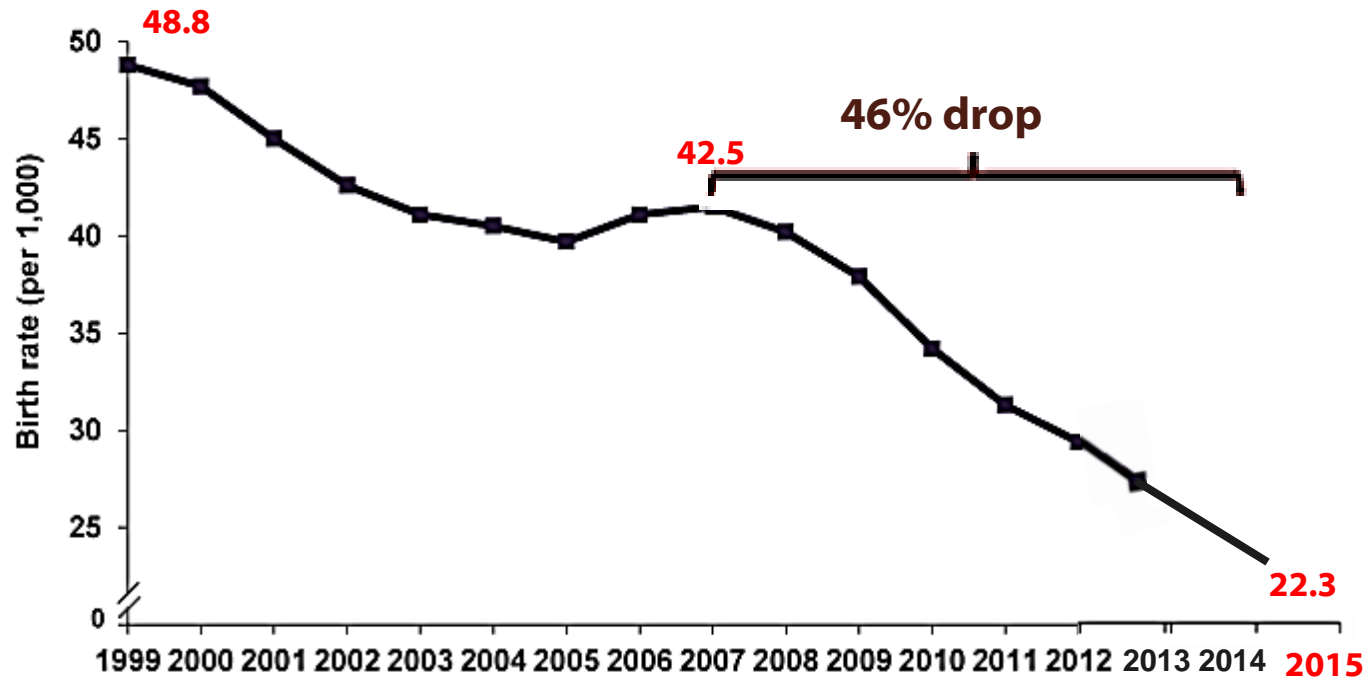
Division of Reproductive Health
Office of the Director



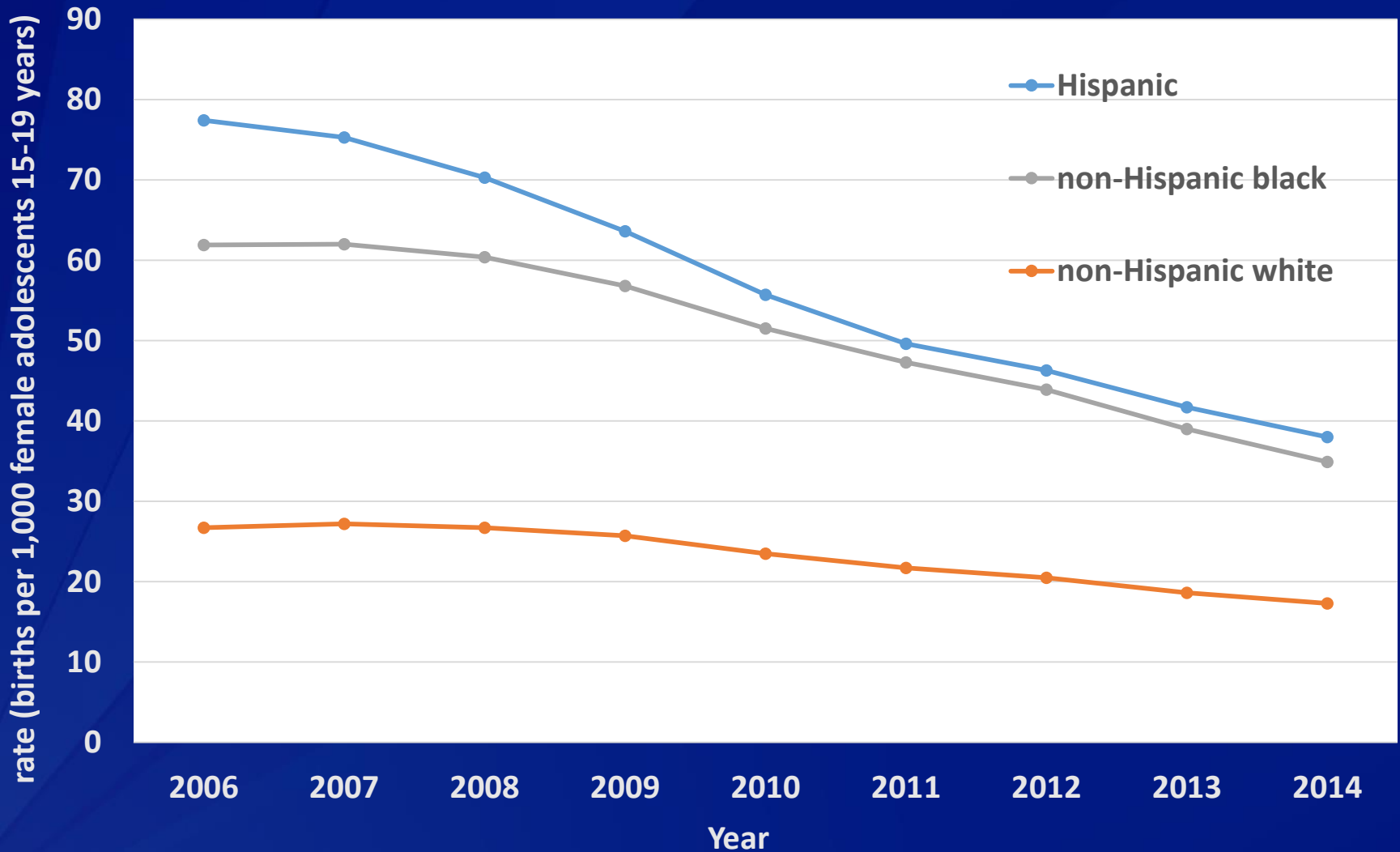
Progress in Teen Pregnancy Prevention

Major decrease in teen births
between 2007-2015

-46%



Birth Rates for Females Aged 15-19 Years—United States, 2006-2014



Source: CDC's National Center for Health Statistics. National Vital Statistics System data.

What CDC is Doing To Prevent Teen Pregnancy?

Teen Pregnancy Winnable Battle: Priority Areas

1

- Support multi-component approaches to teen pregnancy prevention and evaluate impact of improvement in clinical services for adolescents

2

- Strengthen effective clinical interventions and promote the use of highly effective contraceptive methods

3

- Explore the impact of the consequences and costs of teen pregnancy

4

- Support systems change approaches

5

- Expand the analytic agenda

How states can support the TPWB Priority Actions:

- Integrate services, programs, and strategies through community-wide efforts
- Use evidence-based guidance to improve teens' access to contraception and the quality of services provided
- Educate providers LARC is safe and effective for teens
- Increase access to contraceptive services to low and no-income women by systems change
- Continue to ask “why” and “how” questions to improve teen pregnancy prevention efforts



Federal Initiatives to Increase LARC

CDC's 6/18 Initiative

- Evidence-based payment strategies to improve health and cost outcomes

CDC's ASTHO LARC Learning Collaborative

- 13 states to identify the opportunities, challenges, and TA needs through a multi-state learning community to implement post-partum LARC.

CMCS' Maternal and Infant Health Initiative

- 14 states funded to facilitate data collection/report on contraceptive measure

MCHB's COIIN focused on reducing infant mortality

- 29 states are addressing increased access to contraception

OPA's Quality Improvement Initiative

- 15-20 Title X grantees aligned with the state Medicaid programs funded by CMCS

HRSA's Bureau of Primary Health Care

- Strengthening the quality of contraceptive services provided by community health centers

Centers for Medicaid/CHIP Services (CMCS); Maternal and Infant Health Initiative (MIH); Maternal and Child Health Bureau (MCHB); Collaborative Improvement & Innovation Network (COIIN) to Reduce Infant Mortality (COIIN); Office of Population Affairs (OPA); Health Resources and Service Administration (HRSA)

Prevent Unintended Pregnancy

THE 6|18 INITIATIVE



Proposed Payer Interventions

Address Inadequate Reimbursement Rate

1. Reimburse providers for actual cost of providing contraceptive services for women of childbearing age.
 - Screening for pregnancy intention
 - Contraception counseling
 - Insertion, removal, replacement, or reinsertion of LARC
 - Follow-up
2. Reimburse providers for the actual cost of LARC or other contraceptive devices in order to provide the full range of contraceptive methods.

Expand Coverage

3. Reimburse for immediate postpartum insertion of LARC by unbundling payment for LARC from other postpartum services.

Remove Barriers

4. Remove administrative and logistical barriers to LARC.
 - Prior authorization requirements
 - Medical management
 - High acquisition & stocking costs

THE 6|18 INITIATIVE
Accelerating Evidence into Action

The Centers for Disease Control and Prevention (CDC) is partnering with health care purchasers, payers, and providers to accelerate the adoption of evidence-based prevention interventions to improve health and control health care costs. The effort extends the reach of proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. This initiative will align evidence-based preventive practices with value-based payment and delivery models.

Six high-burden health conditions are targeted: tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancy, and diabetes. Within these six areas, specific interventions are highlighted below.

HIGH-BURDEN HEALTH CONDITIONS AND EVIDENCE-BASED INTERVENTIONS

<p>REDUCE TOBACCO USE</p> <ul style="list-style-type: none"> ▪ Expand access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and digital/print resources and behavioral assessment, as endorsed within 2008 Public Health Service Clinical Practice Guidelines. ▪ Remove barriers that impede access to covered cessation treatments, such as one-time copay and prior authorization. ▪ Promote increased utilization of covered treatment benefits by tobacco users. 	<p>PREVENT HEALTHCARE-ASSOCIATED INFECTIONS</p> <ul style="list-style-type: none"> ▪ Require antibiotic stewardship programs in all hospitals and other care settings. ▪ Develop hospital/patient-related infections through remediable coverage for insertion of permanent dialysis ports. 	<p>PREVENT UNINTENDED PREGNANCY</p> <ul style="list-style-type: none"> ▪ Reimburse providers for the actual cost of providing the full range of contraceptive services (e.g., counseling for pregnancy intention, risk of conception counseling, insertion, removal, replacement, or reinsertion of long-acting reversible contraception (LARC) or other contraceptive devices, and follow-up) for women of childbearing age. ▪ Reimburse providers or health systems for the actual cost of LARC or other contraceptive devices in order to provide the full range of contraceptive methods. ▪ Reimburse for immediate postpartum insertion of LARC to avoid potential coverage of LARC from other postpartum services. ▪ Remove administrative and logistical barriers to LARC (e.g., remove preapproval requirements to use longer-acting and manage high acquisition and stocking costs).
<p>CONTROL HYPERTENSION</p> <ul style="list-style-type: none"> ▪ Promote strategies that improve access and adherence to evidence-based medical management for individuals whose asthma is not well-controlled (e.g., asthma-based medical management alerts). ▪ Expand access to home visits by licensed professional or qualified health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled (with guidelines based on medical management and evidence-based management education). 	<p>CONTROL ASTHMA</p> <ul style="list-style-type: none"> ▪ Promote evidence-based asthma medical management in accordance with the 2007 National Asthma Education and Prevention Program guidelines. ▪ Promote strategies that improve access and adherence to evidence-based medical management alerts. ▪ Expand access to home visits by licensed professional or qualified health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled (with guidelines based on medical management and evidence-based management education). 	<p>CONTROL AND PREVENT DIABETES</p> <ul style="list-style-type: none"> ▪ Expand access to the National Diabetes Prevention Program, a lifestyle change program for preventing type 2 diabetes. ▪ Promote counseling for high blood glucose in those who are overweight or obese as part of a comprehensive risk assessment.

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Prevent Unintended Pregnancy

THE 6|18 INITIATIVE



Supporting Cost Evidence

- **51% of US births paid for by Medicaid, Children's Health Insurance Program and Indian Health Service (2010)**
- **\$21 billion in direct medical costs**
- **\$15.7 billion saved from preventing unintended pregnancies**
 - **\$7.09 is saved for every public dollar spent on family planning to prevent unintended pregnancy**
 - **2.2 million unintended pregnancies prevented**
 - **287,500 closely spaced**
 - **164,190 preterm or low birth weight births**
- **Immediate postpartum LARC placement**
 - **\$2.5 million saved (at 24 months)**
 - **\$3.54 saved for every dollar spent**
- **Improved use of LARC generate health-care cost savings by reducing inconsistent contraceptive use. \$288 million per year would be saved in total health-sector costs if 10% of women aged 20–29 years switched from oral contraception to LARC**

Sonfield A and Kost K. Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010. New York: Guttmacher Institute, 2015. Accessed 2015 Sep 21. Available at <http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>

Sonfield A, Kost K, Gold R, Finer L. The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 2011; 43:94–102.

Sonfield A, Zolna MR, Finer LB. Return on investment: a fuller assessment of the benefits and cost savings of the U.S. publicly funded family planning program. *The Millbank Quarterly*. 2014; 92(4):696–749. doi: 10.1111/1468-0009.12080 of \$13.6 billion.

Washington CI, Jamshidi R, Thung SF, Nayeri UA, Caughy AB, Werner EF. Timing of postpartum intrauterine device placement: a cost effectiveness analysis. *Fertility and Sterility*. 2015;103(1):131–7. doi: 10.1016/j.fertnstert.2014.09.032.

www.cdc.gov/teenpregnancy



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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

National Center for Chronic Disease Prevention and Health Promotion

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