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NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Welcome!

Implementation of the "Obstetric Care for Women with Opioid Use Disorder" AIM Bundle

AIM/ERASE Monthly Webinar

December 10, 2020

NH DIVISION OF
Public Health Services
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Agenda

- **Setting the Stage: NH Public Health Perspective**
  David Laflamme PhD, MPH, Maternal & Child Health Epidemiologist,
  NH DHHS Division of Public Health Services
- **Overview of the AIM Opioid Bundle**
  Timothy J. Fisher MD, MHCDS, NNEPQIN Medical Director & OB/GYN, DHMC
- **Structuring our NH-AIM work & Rapid Rollout of Naloxone Distribution**
  Daisy Goodman CNM, DNP, MPH, CARN-AP, Dept of OB/GYN, DHMC
- **Examples of Successful Naloxone Programs in Ob/Gyn**
  Wentworth Douglass Hospital, Dover, NH, Katie White, RN
  Coos County Family Health/Androscoggin Valley Hospital, Berlin, NH, Deb Alonzo, RN
  Dartmouth Hitchcock-OB/GYN, Lebanon, NH, Daisy Goodman,
  Pen Bay Medical Center, Rockport, ME, Jennifer McKenna, MD
  Perinatal Quality Collaborative For Maine (PQC4ME), Jay Naliboff MD, FACOG

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Why NH-AIM? David Laflamme PhD, MPH

NH Maternal Mortality Statistics

- **Eleven of the twelve** pregnancy-associated deaths reviewed from 2016-2017 occurred during the **postpartum** period and one was during pregnancy.
- The **leading causes** of pregnancy-associated deaths in NH are **accidental drug overdose and suicide**
- **Seven** pregnancy-associated deaths *since 2012* have been determined to be **pregnancy-related**

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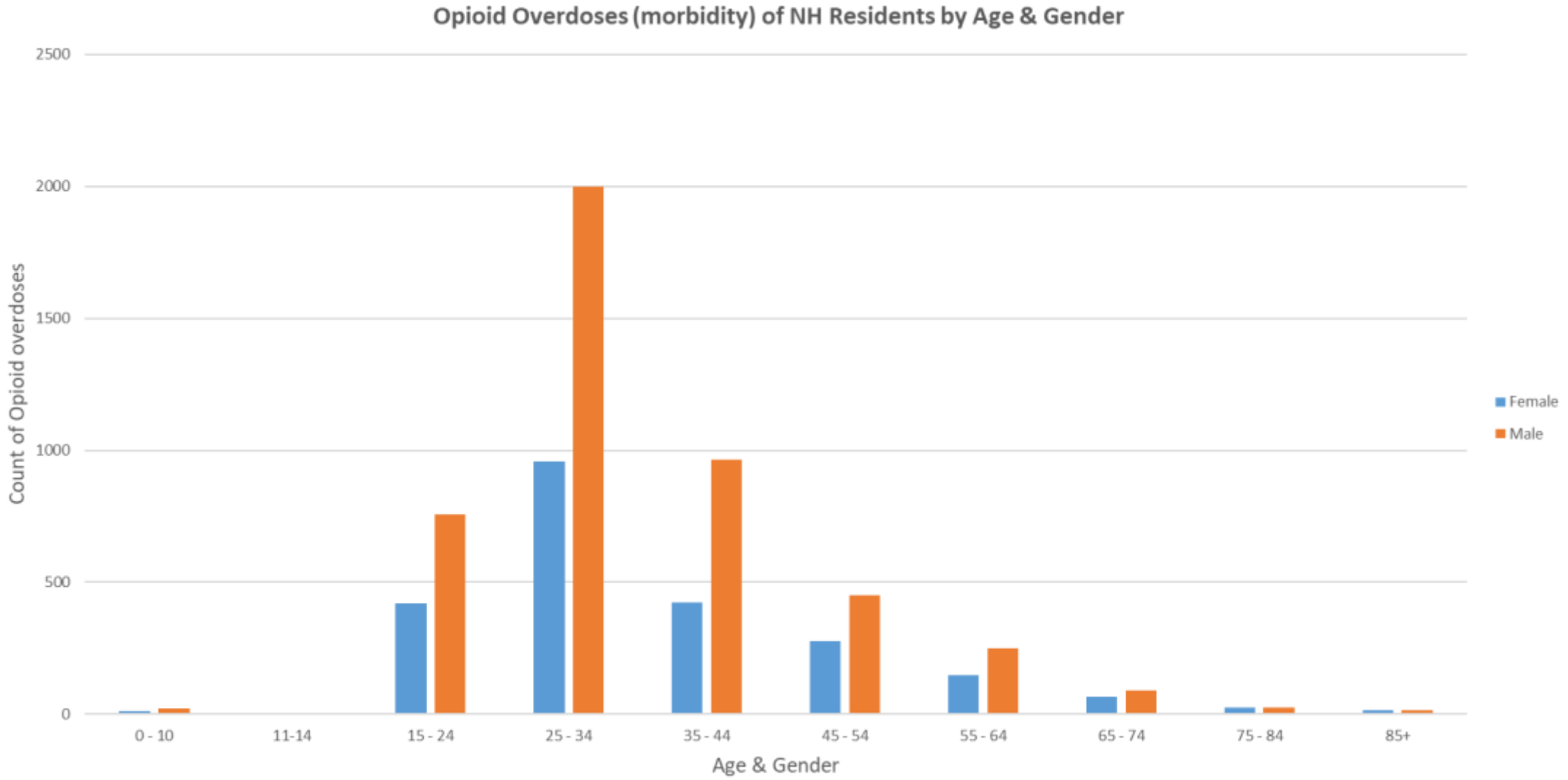

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Data provided by: Xiaohui Geng, DrEPi, MSE, New Hampshire Opioid Overdose Surveillance Coordinator/OD2A Principal Investigator

Why NH-AIM?

NH SUD/OUD Pregnancy Statistics

- **6.5%** of infants born in NH hospitals between May 1 and Oct 31, 2020 were monitored for effects of in utero substance exposure (i.e. **clinical concern**)
- **2.6%** of infants were identified as being **affected** by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder

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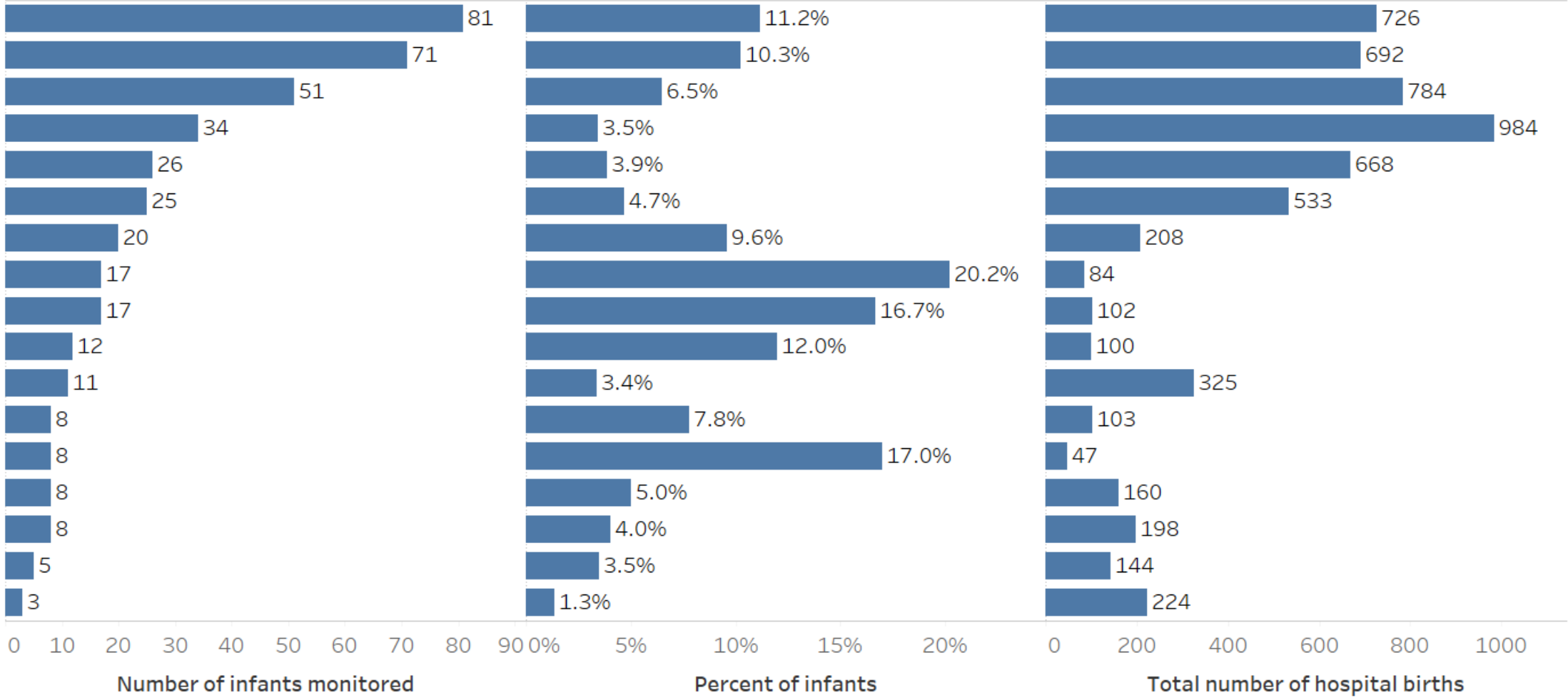
82A: Was the infant monitored for effects of in utero substance exposure? (by Hospital)

Infant born 5/1/2020 to 10/31/2020
Data refreshed: 11/18/2020 8:27:37 AM
Data source: VR_BIRTH (EBI_DATAMART.VR_BIRTH)+ (EBI_DATAMART)



405

6.7%

6,082

David.Laflamme@unh.edu

Delivery Payer

- [x] Medicaid
- [x] NH CHIP
- [x] Other (specify)
- [x] Other Government
- [x] Private Insurance
- [x] Self-pay
- [x] Unknown

iDOB Start Date
5/1/2020

iDOB End Date
10/31/2020

-Occurrent births
-NH Res and Non-Res
-Hospital Births

Why NH-AIM?

- *Cross-border issues*
  - Reviewing pregnancy-associated deaths where care and events (birth/death) occur in different states brings about data sharing challenges
  - UNH Health Law & Policy Program team working on this issue

- *Regional collaboration*
  - Jan-Nov 2020 births in New Hampshire to residents of:
    - **Maine 326**
    - **Vermont 561**

82A: Was the infant monitored for effects of in utero substance exposure?

Infant born 5/1/2020 to 11/30/2020
Data refreshed: 12/9/2020 4:35:52 PM
Data source: VR_BIRTH (EBI_DATAMART.VR_BIRTH)+ (EBI_DATAMART)

	MAINE	VERMONT
Yes	12 (5.3%)	44 (12.2%)
No	213 (94.7%)	317 (87.8%)
Total	225 (100.0%)	361 (100.0%)

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Timothy Fisher, MD, Medical Director, NNEPQIN

Alliance for Innovation in Maternal Health

Half of maternal deaths are preventable.

Save lives by teaming up with AIM.

MISSION

Continually improve patient safety in women's health care through multidisciplinary collaboration that drives culture change

VISION

Safe health care for every woman

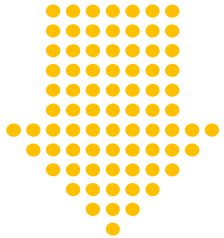
RESOURCES

12 patient safety bundles

Tools to facilitate effective review of severe maternal morbidity and mortality

https://safehealthcareforeverywoman.org/about-us/council-members/

AIM's Primary Objective



Reduce preventable maternal deaths and severe maternal morbidity (SMM) in the United States.

By:

- Promoting safe care for every U.S. birth.
- Engaging multidisciplinary partners at the national, state and hospital levels.
- Developing and providing tools for implementation of evidence-based patient safety bundles.
- Utilizing data-driven quality improvement strategies.
- Aligning existing efforts and disseminating evidence-based resources.

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AIM Patient Safety Bundles

Patient Safety Bundles can be found on the [Council on Patient Safety in Women's Health Care]() Website

Accompanied by resources and implementation supporting documents

Will be undergoing updates and template format changes over the next year

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AIM Bundle Components

Readiness

Recognition and Prevention

Response

Reporting and Systems Learning

Respectful Care

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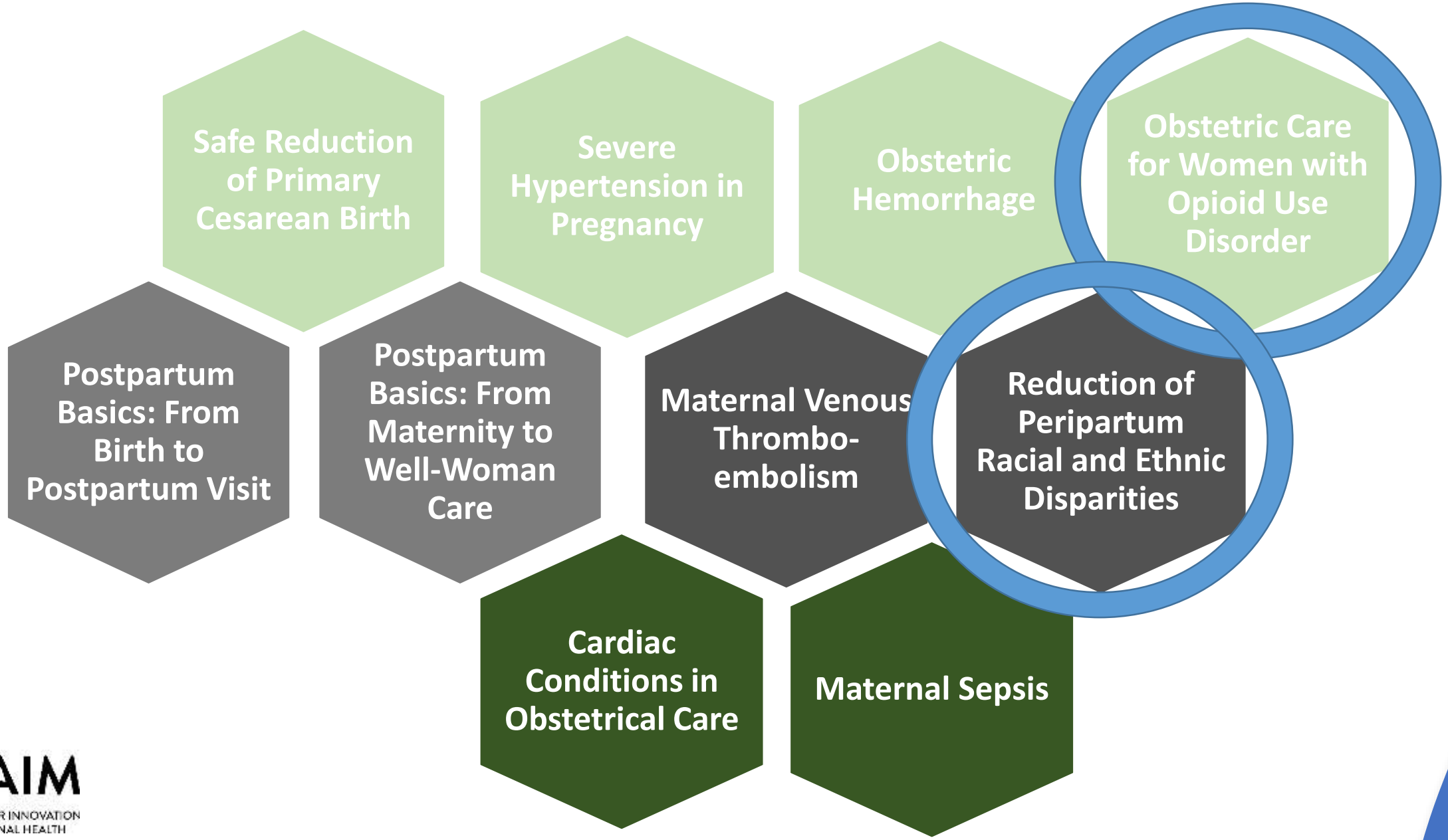
AIM Patient Safety Bundles



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AIM Patient Safety Bundle: Obstetric Care for Women with Opioid Use Disorder

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READINESS

Every patient/family

- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
  - Emphasize that substance use disorders (SUDs) are chronic medical conditions
  - Emphasize that opioid pharmacotherapy and behavioral therapy are effective treatments
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
- Engage appropriate partners (i.e. social workers, case managers) to assist patients and families in the development of a “plan of safe care” for mom and baby.

READINESS

Every clinical setting/health system

- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
  - Emphasize that SUDs are chronic medical conditions that can be treated.
  - Provide training regarding trauma-informed care.

- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.

- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

READINESS

- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substance use during pregnancy.
- Know federal (Child Abuse Prevention Treatment Act – CAPTA), state and county reporting guidelines for substance-exposed infants.
- Know state, legal and regulatory requirements for SUD care.
- Identify local SUD treatment facilities that provide women-centered care.
- Investigate partnerships with other providers to assist in bundle implementation.

RECOGNITION & PREVENTION

Every provider/clinical setting

- Assess all pregnant women for SUDs.
  - Incorporate a screening, brief intervention and referral to treatment (SBIRT) approach in the maternity care setting.

- Match treatment response to each woman's stage of recovery and/or readiness to change.

- Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities.
  - Ensure the ability to screen for infectious disease
  - Ensure the ability to screen for psychiatric disorders, physical and sexual violence.
  - Provide interventions for smoking cessation.

RESPONSE

Every provider/clinical setting/health system

- Ensure that all patients with OUD are enrolled in a woman-centered OUD treatment program.
  - Establish communication with OUD treatment providers and obtain consents
- Incorporate family planning, breastfeeding, pain management and infant care counseling, education and resources into prenatal, intrapartum and postpartum clinical pathways.
  - Provide breastfeeding and lactation support
  - Provide immediate postpartum contraceptive options prior to hospital discharge.

RESPONSE

- Ensure coordination among providers during pregnancy, postpartum and the inter-conception period
  - Provide referrals to providers for identified co-morbid conditions.
  - Identify a lead provider responsible for care coordination
  - Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff

- Engage child welfare services in developing safe care protocols tailored to the patient and family's OUD treatment and resource needs.

REPORTING & SYSTEMS LEARNING

Every clinical setting/health system

- Develop mechanisms to collect data and monitor process and outcome metrics to ensure high quality healthcare delivery for women with SUDs.
- Create multidisciplinary case review teams to evaluate patient, provider and system-level issues.
- Develop continuing education and learning opportunities for providers and staff.
- Identify ways to connect non-medical local and community stakeholders with clinical providers and health systems to identify ways to improve systems of care.

Required Measures (All AIM Participants)

Outcomes

O1: Severe Maternal Morbidity

O2: Severe Maternal Morbidity

O3: Pregnancy Associated Opioid Deaths

O4: Average length of stay for newborns with Neonatal Abstinence Syndrome (NAS)

Process

P1: Percent of women with OUD during pregnancy who receive medication assisted treatment MAT or behavioral health tx

P2: Percent of Opioid Exposed Newborns receiving mother's milk at newborn discharge

P3: Percent of Opioid Exposed Newborns who go home to biological mother

P4: Universal Screening at Prenatal Care Sites

Structure

S1: Universal Screening on L&D

S2: General pain management practices

S3: OUD pain management guidelines

State Surveillance

SS1: Percent of newborns diagnosed as affected by maternal use of opiates

SS2: Percent of newborns diagnosed with NAS

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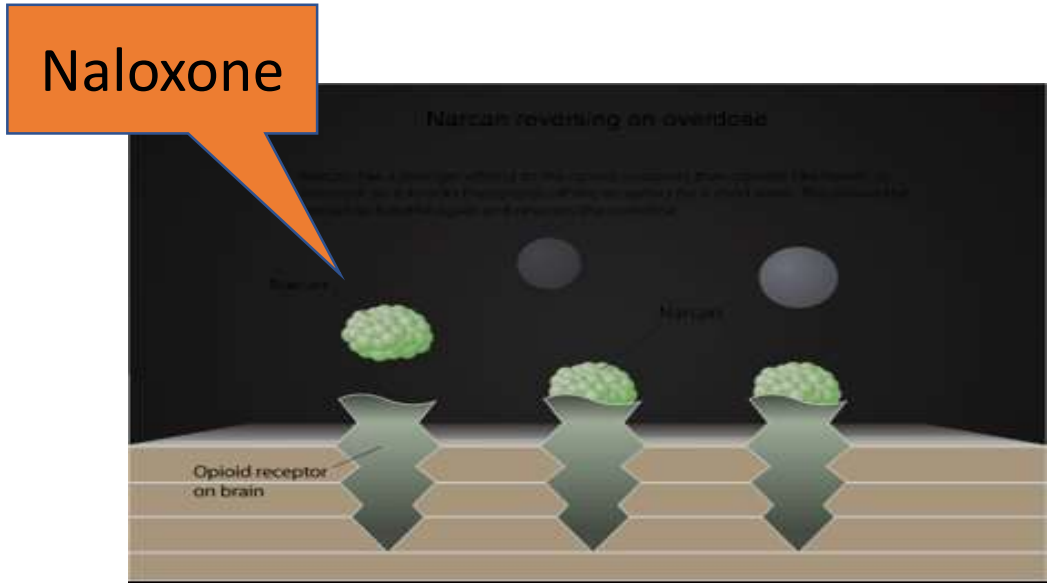
Preventing Pregnancy Associated Opioid Deaths

Daisy Goodman, CNM

- Focus on rapid distribution of naloxone to families impacted by opioid use disorders
- Specific Aim: 100% of postpartum people with OUD are offered access to naloxone



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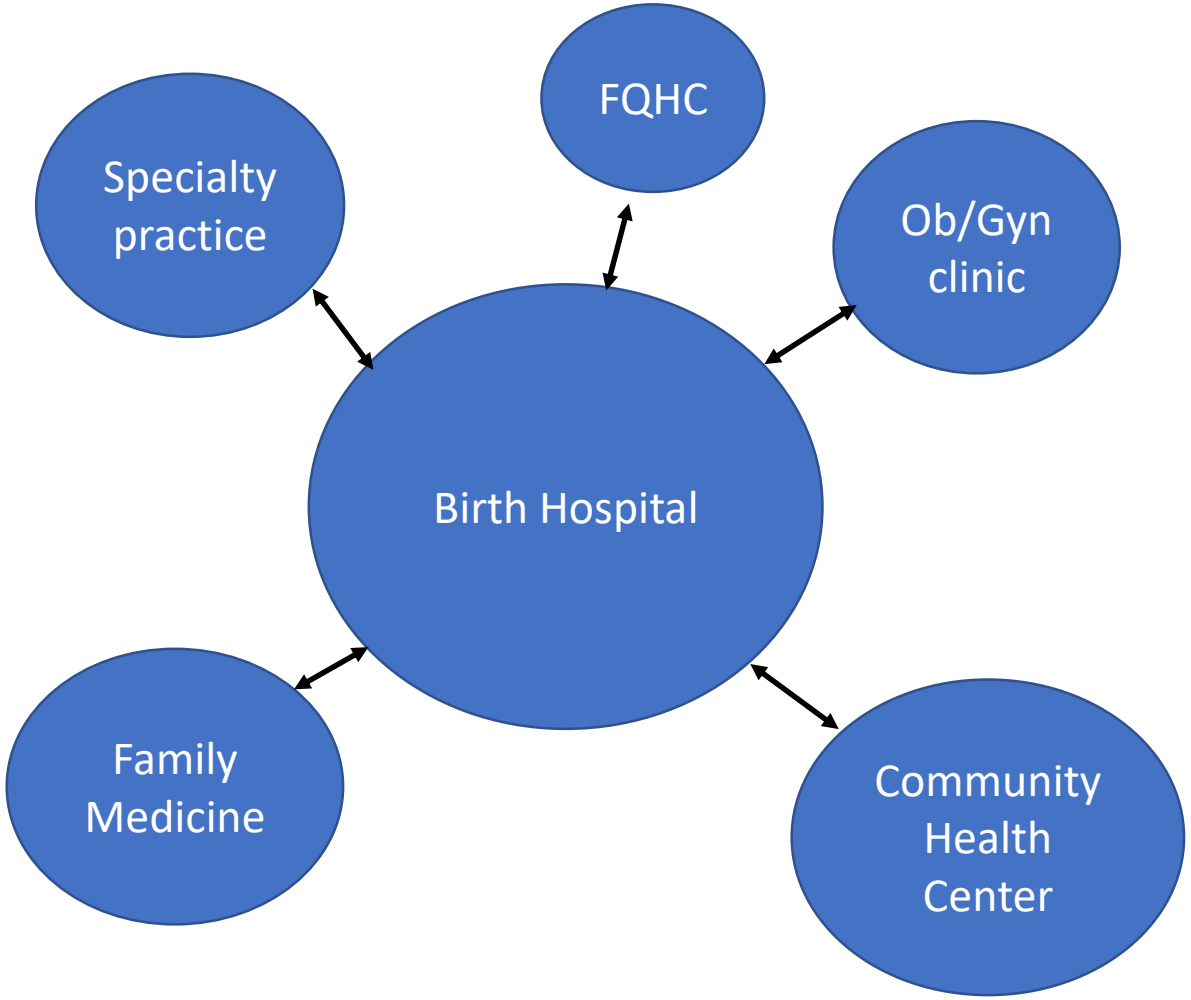
Structuring this work

- Focus extends across prenatal, hospital, and postnatal settings
- Measure: naloxone access at time of delivery
  - Prescribed
  - Dispensed
  - Discussed and already has Rx
  - Declined



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Examples of Current Naloxone Distribution Processes

Ambulatory Clinic

- Wentworth Douglass Hospital, Dover, NH, Katie White, RN
- Coos County Family Health/Androscoggin Valley Hospital, Berlin, NH, Deb Alonzo, RN
- Dartmouth Hitchcock-OB/GYN, Lebanon, NH, Daisy Goodman, CNM

Hospital Maternity Unit

- Pen Bay Medical Center, Rockport, ME, Jennifer McKenna, MD
- Perinatal Quality Collaborative For Maine (PQC4ME), Jay Naliboff MD, FACOG

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DISTRIBUTION OF NALOXONE TO PREGNANT AND POSTPARTUM WOMEN WITH OPIATE USE DISORDER

Katie White, Perinatal NAS / SUD RN Care Coordinator
Women and Children's Unit
Wentworth Douglass Hospital
Dover, NH
December 10th 2020

- **Prenatal OB**
- **Doorway**
- **Inpatient / Discharge**

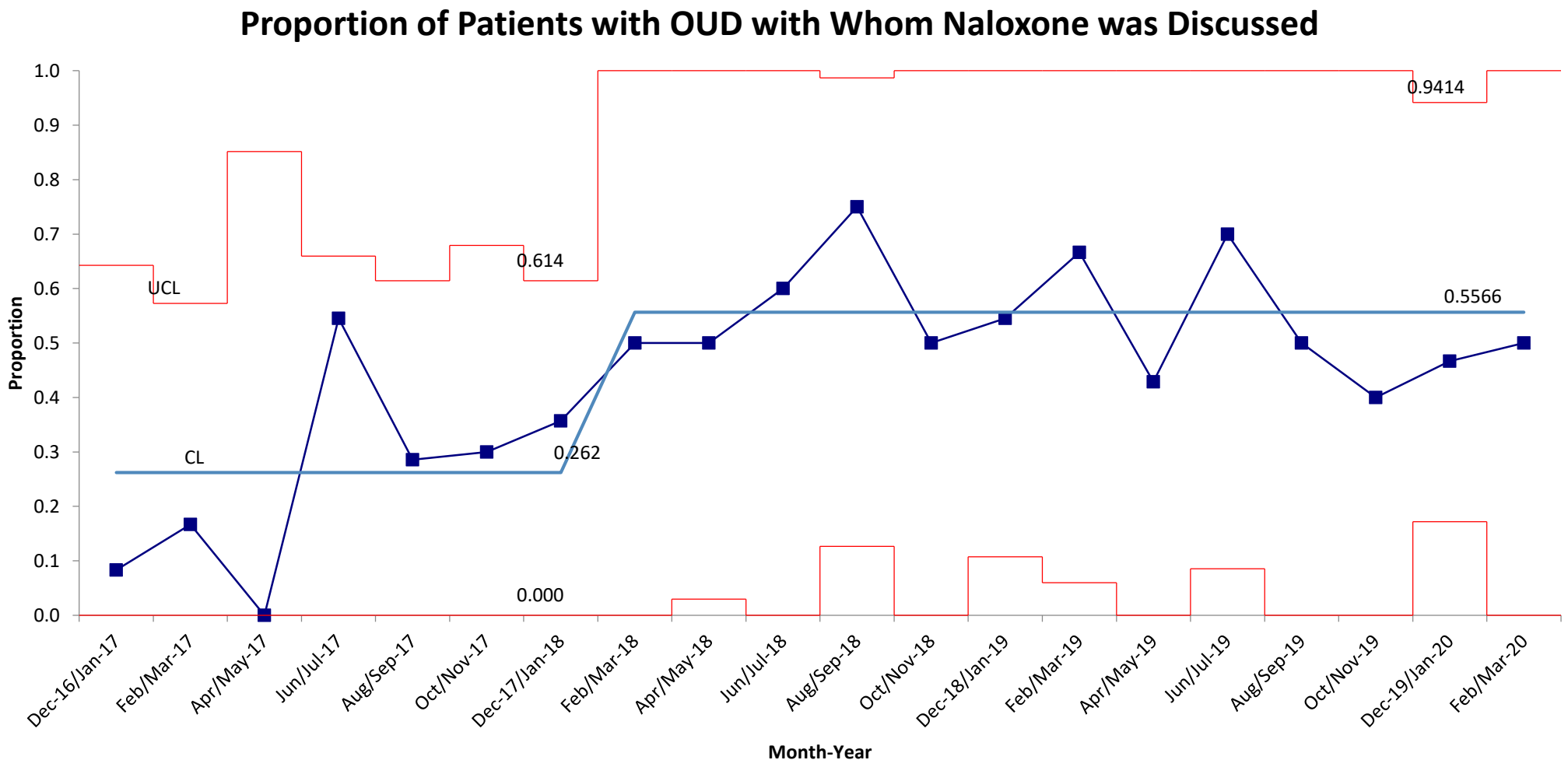
WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

coös county Family Health

Autumn Croteau, RN
MAT Program Coordinator
Coos County Family Health Services

Deb Alonzo, RN
Perinatal Nurse Manager
Androscoggin Valley Hospital

Access to Naloxone for Perinatal Patients with Opioid Use Disorder- DHMC data



DHMC Ob/Gyn Clinic Outpatient Naloxone Program

- Naloxone kits supplied through NH Doorways program
- Two questions added to SBIRT-screening during the initial prenatal visit:
    - *"Are you, or is someone you know, at risk of experiencing an opioid overdose?"*
    - *"Would you like to talk to someone about naloxone?"*
- Naloxone kits available in prenatal clinic to patients at risk or who have a family member at risk of overdose
    - MD, CNM, or APRN dispenses kit to patient
    - Registered nurse provides naloxone education
- Naloxone education added as annual nursing competency

Next Steps for D-H Ob/Gyn

Sustainability

- Nurse manager trained as naloxone trainer
- Annual competency for nursing staff
- Education for all clinical staff as part of onboarding

Tracking Success

- % of patients screened
- # of kits dispensed
- % of pregnant patients with OUD who have access to naloxone

Pen Bay Medical Center Experience with Naloxone

JENNIFER MCKENNA, MD

Naloxone

Rebirth program – Prenatal care/ Group/ CNM with X waiver

State program – Free Naloxone Kits in office for distribution

Hospital discharge – EMR with opioid order set

Hospital policy - standing order allowing pharmacy to dispense Naloxone Rescue Kits to individuals at risk of experiencing or witnessing an Opioid-Related Overdose.

Rebirth

Women's recovery Group for Outpatient IMAT Program

Includes pregnant and postpartum women

Patients are stable on their IMAT program

Group (currently Zoom meetings) coordinated with prenatal care

Patients receive buprenorphine/naloxone prescriptions at OB visits

Currently, all 4 patients in group have Naloxone kits

Supported by Maine Behavior Health Hub and Spoke model

Office Naloxone kits

State supplied free kits for distribution are stocked in Women's Health, Pediatrics and Primary care offices

We have preprinted Standard MaineHealth handout with administration instructions

Offices have Naloxone kits for administration in the clinic for suspected overdose

EMR

Smartsets for opioid prescribing upon discharge include reminder about Naloxone

Any patient prescribed an opioid gets Safe use of Opiate Medication discharge instructions

EMR - example of orders

Opiate Risk Assessment Data

Admission Alcohol and Opiate Use Screening

In the four days prior to admission

Consumed alcohol: No
If yes, have trouble going without alcohol:
Used non-prescribed opiate, suboxone or heroin: No
If yes, have trouble going without opiates:

Opioid Risk Assessment Score (if available):

OPIOID RISK SCORE - Low Risk 0-3 Moderate Risk 4-7 High Risk >8: (not recorded)

Substance History

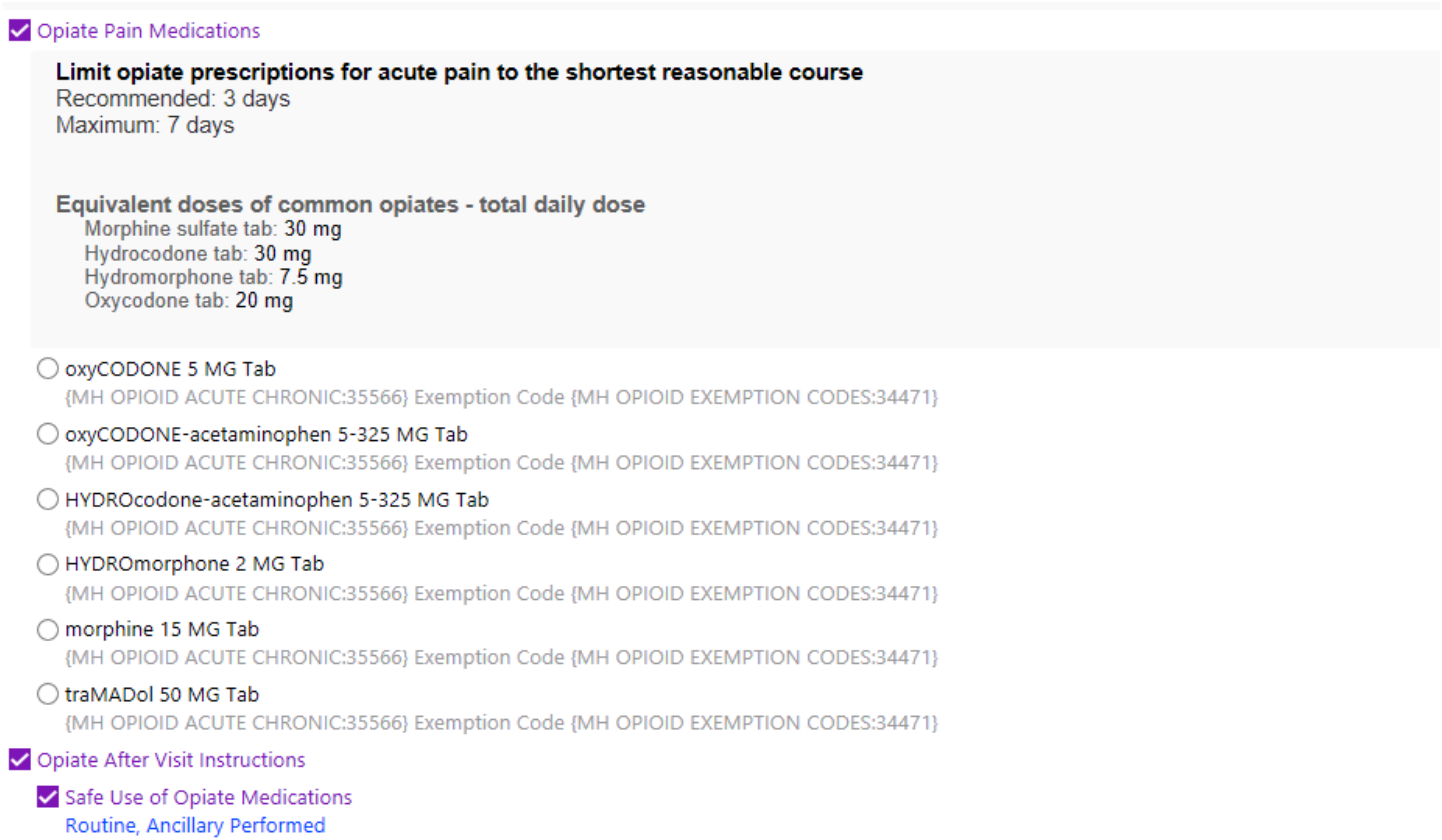
Smoking Status: Current Every Day Smoker
Smokeless Tobacco Status: Former User
Quit Smokeless Tobacco:
Alcohol use: No
Drug use: Not Currently

Recent Opiate Medication Administrations

Opiate Pain Medication Administrations (last 24 hours) If none, confirm on MAR

None

EMR - example of orders



EMR Discharge Instructions:
Safe Use of Opiate Medications

We have given you a prescription for an opioid to help with your pain. Opioids are prescribed to help when other strategies or medications do not work well enough to keep you comfortable. For safety and best effect, follow all of your medication instructions.

Activities at home can make your symptoms worse. You can keep your pain under control by resting and not overexerting yourself. Changing positions frequently can be helpful and you should ask for help with activities that make your pain worse.

Pain medicines may help with your pain, but usually will not take away pain completely. Talk to your provider about using other pain management techniques such as:

Relaxation techniques

Meditation

Physical or occupational therapy

Over the counter medications such as Acetaminophen (Tylenol) or Ibuprofen (Advil)

EMR Discharge Instructions: Safe Use of Opiate Medications

Opioid medications have risks and side effects.

Risks of opioid use include:

Tolerance (needing more medication over time for pain relief)

Physical dependence (withdrawal symptoms)

Addiction (which can result in uncontrolled substance use, cravings, disability, and early death)

Overdose (which can hurt your body or cause death).

EMR Discharge Instructions: Safe Use of Opiate Medications

Side effects can include:

Constipation, dry mouth, sleepiness, dizziness, itching and sweating.

Serious side effects to **call your doctor's office** for include:

- Nausea and vomiting

Severe constipation

Constant sleepiness, dizziness or confusion

Depression

EMR Discharge Instructions: Safe Use of Opiate Medications

Do not take opioids at the same time as:

Alcohol

Benzodiazepines

Muscle relaxants

Sedatives

Other prescription opioids

EMR Discharge Instructions: Safe Use of Opiate Medications

It is important for you to:

Take your opioids as prescribed. If your opioid medications are prescribed to be taken as needed, **only** take them when other medication or comfort options aren't helping.

Do not stop taking these medications all at once if you have been taking them for a few weeks because you may have withdrawal symptoms.

Tell your doctor about your past and current use of pain medication and alcohol so that your pain can be best managed.

Keep your medication in a locked cabinet and away from children, pets, and the elderly.

Do not keep any leftover pills and do not share them with anyone. The majority of people misusing opioids got them from family and friends.

You should choose one of these methods for throwing opioids out:

Bring them to your local police station OR

If this is not available, follow these steps to safely throw them away at home:

- Put medicine in a plastic or metal container with a lid

Mix medicine with coffee grounds, kitty litter or add water and liquid soap and then throw out the container

Scratch out all personal information on the prescription label of your empty pill bottle to make it unreadable, then dispose of pill bottle

EMR - example of orders

☑ Naloxone nasal spray for high risk patients

Consider prescribing take home naloxone for patients with any of the following risk factors:

- History of overdose, injection drug use or opioid use disorder
- Alcohol use disorder
- Prescription for greater than 50 mg morphine equivalents per day
- Use of benzodiazepine or barbiturate
- Co-morbid conditions that lead to respiratory compromise (such as sleep apnea or COPD)

○ Naloxone (Narcan) - typically preferred for patients with insurance, including MaineCare

◉ Naloxone Kit - typically least expensive for patients who self-pay or use FreeCare

☑ Naloxone 2mg/2mL Rescue Kit with Nasal Atomizer
Spray 1 mL into each nostril; repeat 2nd dose in 2 to 3 minutes if the person does not respond, Disp-2 Syringe,R-0, Normal

☑ Instructions for Naloxone Kit
Naloxone is a medication that can be used to reverse the effects of opiate pain medications in an overdose. Overdose is always an emergency. Overdose symptoms may include: · slowed breathing, or no breathing; · very small or pinpoint pupils in the eyes; · slow heartbeats; or · extreme drowsiness, especially if you are unable to wake the person from sleep. Even if you are not sure an opioid overdose has occurred, if the person is not breathing or is unresponsive, give naloxone right away and then seek emergency medical care (call 911). If you are a caregiver or family member giving naloxone nasal to another person, read all instructions when you first get this medicine. Naloxone nasal should be sprayed into the nose while the person is lying on his or her back. . Do not assume that an overdose episode has ended if symptoms improve. You must get emergency help after giving naloxone nasal. You may need to give another dose every 2 to 3 minutes until emergency help arrives. You may need to perform CPR (cardiopulmonary resuscitation) on the person while you are waiting for emergency help to arrive. Store at room temperature away from moisture and heat. Do not use this medicine if the expiration date on the label has passed.

Pharmacy standing order policy

PURPOSE: To help reduce mortality due to opioid overdose by making Naloxone more accessible to patients, or caregivers, friends, and families of those at risk for overdose.

POLICY: Naloxone is indicated for the reversal of respiratory depression or unresponsiveness caused by an opioid overdose. It may be delivered intranasally as a spray or with the use of a mucosal atomizer device or intramuscularly with use of a needle.

Take-home naloxone rescue kits can be dispensed by a pharmacist without a prescription under this standing order to any individual at risk of an opioid overdose or witnessing an opioid overdose.

Pharmacy standing order policy

Indications for dispensing naloxone

Procedure for dispensing kits

Counseling items

Naloxone kit options

Future Strategies

Identify care gaps for at risk women

Continue developing system-wide recourses for providers

Universal Maternal Overdose Prevention

Perinatal Quality Collaborative For Maine

(PQC4ME)

Maine Medical Association Center For Quality Improvement

Leadership

- Jay Naliboff MD, FACOG- Director (jnaliboff@me.com)
- Nell Tharpe CNM, MS, FACNM- Improvement Advisor
- Kayla Cole- Director. MMA Center for Quality Improvement- Project Coordinator

Aim Statement

- To reduce postpartum maternal mortality due to drug overdose and improve women's postpartum experience by providing harm reduction and bias education to obstetrical providers and staff and by offering a "first aid kit" containing naloxone and recovery resources information to every postpartum woman.
- Goals: 1. Provide harm reduction and bias education to 80% of OB staff and providers.
- 2. Offer naloxone "first aid kit" to 80% of postpartum women
- 3. Make harm reduction education normative when onboarding new hires

The Gap

- The Covid-19 pandemic has made the problem of opioid use and the potential for overdose worse. Social isolation, transportation difficulties, job and insurance loss, have all conspired to increase stress on an already vulnerable population. Drug overdose deaths in Maine have increased 23% from last year.
- Maine Governor Mills has supported greater access and penetration into the community of naloxone for reversal of opioid overdose.

Postpartum Women
A Unique Population

- The postpartum period is uniquely stressful and may precipitate opioid use or relapse
- 18% of maternal mortality in Maine and 40% of maternal mortality in New Hampshire is due to opioid overdose in the postpartum period
- In a recent Massachusetts study one half of opioid overdoses in the first twelve months postpartum occurred in women without identified opioid use disorder (https://onlinelibrary.wiley.com/doi/abs/10.1111/add.14825)

The Project

- We propose a demonstration project at a single Maine rural community hospital doing approximately 225 deliveries a year
- Harm reduction education will be given to obstetrical unit providers and staff to explore implicit bias and reduce stigmatization of women who use drugs
- Harm reduction education will also be given to the current educational staff at the hospital's community health organization and the nurse educator as a "train the trainer" module so that all new hires can be trained going forward.

The Project

- All postpartum women will receive naloxone education and be offered a naloxone “first aid kit” at discharge. The kit will contain naloxone, educational materials, and a list of community recovery resources.
- Offering naloxone to all postpartum women reduces the stigmatization of women with OUD, increases community saturation with naloxone which may save other family members or friends lives, and recognizes the potential for overdose in women without previously identified opioid use.

The Project

- This project will last one year
- Data to be collected include number and % of OB staff and providers who receive harm reduction education, number and % of women who are offered naloxone, and number and % of women who accepted the Naloxone first aid kit.
- Harm reduction education effectiveness will be assessed by pre and post presentation validated surveys
- Data will be recorded in the REDcap data base and be accessible to other Northern New England Perinatal Quality Improvement Network (NNEPQIN) members.
- Because of small numbers we do not anticipate demonstrating a reduction in maternal overdose deaths.

Next steps for NH- AIM Sites

- Identify nearest Doorway site as possible source
- Complete baseline practice survey
- Identify clinical lead(s) at each site
- Schedule calls with clinical leads and NH-AIM team

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Thank you for all you are doing to keep families safe…

Let’s stay in touch!

- daisy.j.goodman@hitchcock.org
- victoria.a.Flanagan@hitchcock.org

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SAVE THE DATE

February 11, 2021

NNEPQIN Virtual Winter Meeting