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- Vicki Flanagan will monitor the chat box and call on you to unmute yourself.
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NNEPQIN

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Maternity Mortality Surveillance & Harm Reduction

NH AIM/ERASE Monthly Webinar
October 14, 2021



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Our presenters have no conflicts of interest to disclose.



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Agenda

- ❖ Introduction
 - ❖ Defining Pregnancy Associated and Pregnancy Related deaths
 - ❖ Role of the maternal mortality review process in AIM work
- ❖ Maternal Mortality Review
 - ❖ New Hampshire
Ellen Stickney, RN, BSN, RNC-OB
 - ❖ Vermont
Emily Fredette, BA
 - ❖ Maine
Anne Watson PhD, BSN, RN
- ❖ Harm Reduction
 - ❖ Kerry Nolte, PhD, FNP-C
- ❖ Discussion

Role of the MMRC

A key part of understanding maternal mortality is to accurately count pregnancy-related deaths, understand the factors that contributed to each death, and determine how they could have been prevented.

Maternal Mortality Review is a comprehensive process to identify, review, and analyze deaths during pregnancy, childbirth, and the year postpartum; disseminate findings; and act on results.

The MMRC is a group of experts and stakeholders in maternal health that convene regularly to review deaths and identify key learnings and opportunities to prevent future deaths.

<https://reviewtoaction.org/learn/7-things-to-know>





Defining Pregnancy Associated Death

A **Pregnancy Associated Death** is defined as the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause.

The Pregnancy Mortality Surveillance System (PMSS) defines **Pregnancy-Related Death** as the death of a woman while pregnant or within 1 year of the end of pregnancy, regardless of the outcome, duration, or site of the pregnancy — from any cause related to or aggravated by the pregnancy or its management

<https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

Critical Collaborations: NNEPQIN, ERASE and AIM



Created from a Centers for Disease Control, Division of Reproductive Health source



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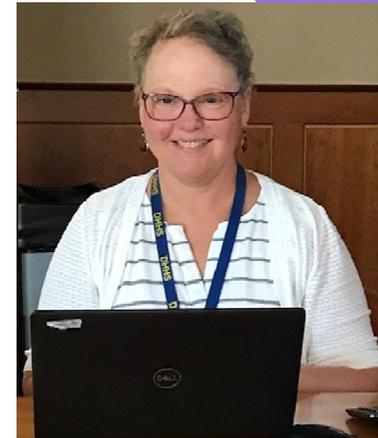
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Maternity Mortality Surveillance

New Hampshire Presentation

Ellen Stickney, RN, BSN, RNC-OB

Ellen.T.Stickney@dhhs.nh.gov



New Hampshire's Identification and Reporting of Maternal Deaths

Maternal deaths in New Hampshire are reported to the NH Maternal Child Health Section of the Department of Public Health Services via:

- ❑ Direct report from a hospital, non-emergency walk-in care center, ambulatory surgical center, or birthing center
- ❑ Field on death certificate indicating pregnancy within one year of death
- ❑ Data Linkage between death certificate and maternal information on certificate of live birth
- ❑ O-code on the death certificate. A section containing diagnosis codes related to "Pregnancy, childbirth and the puerperium".
- ❑ Case finding reported to Maternal Child Health section from a member of the Maternal Mortality Review Committee
- ❑ Other source such as medical provider, family member, or media outlet



Per RSA 132:31 II – Administrative Rule He-P 3013.03, Hospitals, Non-Emergency Walk-in Care Centers, Ambulatory Surgical Centers, or Birthing Centers shall complete and send a “ Maternal Mortality Initial Report” form to the Department either by secure fax or paper format within 10 business days of a maternal death. Maternal death is defined as death during pregnancy through one year postpartum. Call 603-271-4532 for further information.

Form should be faxed to 603-271-8705, attention Ellen Stickney, RN – MCH Section OR mailed to the attention of Ellen Stickney, RN, Maternal Child Health Section, 29 Hazen Drive, 2nd Floor East, Concord, NH 03301.

1. Hospital, Birth Center, or Ambulatory Surgical Center Name:
1. Date Initial Report sent to the Department:
1. Date Event Occurred:
1. Date Event Discovered:
1. Name of Patient:
1. Date of Birth:
1. Patient Admitting Diagnosis:
1. Location (i.e. unit/floor/wing/department, OR #, satellite address etc.) of where event took place:
1. Adverse Event Brief Description:
1. Hospital, Birth Center, or Ambulatory Surgical Center Contact Person Name & Title:
1. Hospital, Birth Center or Ambulatory Surgical Center Contact Email & Phone #:

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Maternity Mortality Surveillance

Maine Presentation



Maternal, Fetal and Infant Mortality Review Panel (MFIMR) - Maine

Pregnancy Associated Deaths

10/14/21

Anne Watson, PhD, BSN, RN

Panel Coordinator

anne.watson@maine.gov



PAD Determination Process

- **Death Certificate**
 - Death Certificate Number
 - Year of Death
 - Pregnancy Status Checkbox
 - Pregnant at time of death
 - Pregnant within 42 days of death
 - Pregnant 43 days to 1 year prior to death
 - Not pregnant within 1 year of death
 - Unknown if pregnant within 1 year of death
 - Underlying Cause of Death – ICD-10 “O” codes
 - Notes
- **MFIMR Panel**
 - ID Number
 - Records Requesting and Case Summary
 - Review and Decision
 - Decision Date
 - Reason for Decision

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Maternity Mortality Surveillance

Vermont Presentation



Vermont's Maternal Mortality Review Panel Case Identification

- Data analyst in the Division of Health Surveillance identifies cases through Vital Records
 - Cause of death
 - Pregnancy check box
 - Matches from the death file to birth/fetal death file
- Information from the death file and birth/fetal death file for cases that can be linked, are compiled
- Coordination with Office of The Chief Medical Examiner to confirm cases that have been autopsied and share summary of findings
- No formal process for identifying cases outside of Vital Records, but if members find out about a death, we will investigate to ensure the case has not been missed.



Questions?

Emily Fredette, Injury and Violence
Prevention Program Manager

Email: Emily.Fredette@Vermont.gov

Phone: 802-865-7729

Web: Healthvermont.gov

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Welcome!

Kerry Nolte, PhD, FNP-C



Harm Reduction in the Perinatal Period



Presented By:

Kerry Nolte, PhD, FNP-C

Disclosures

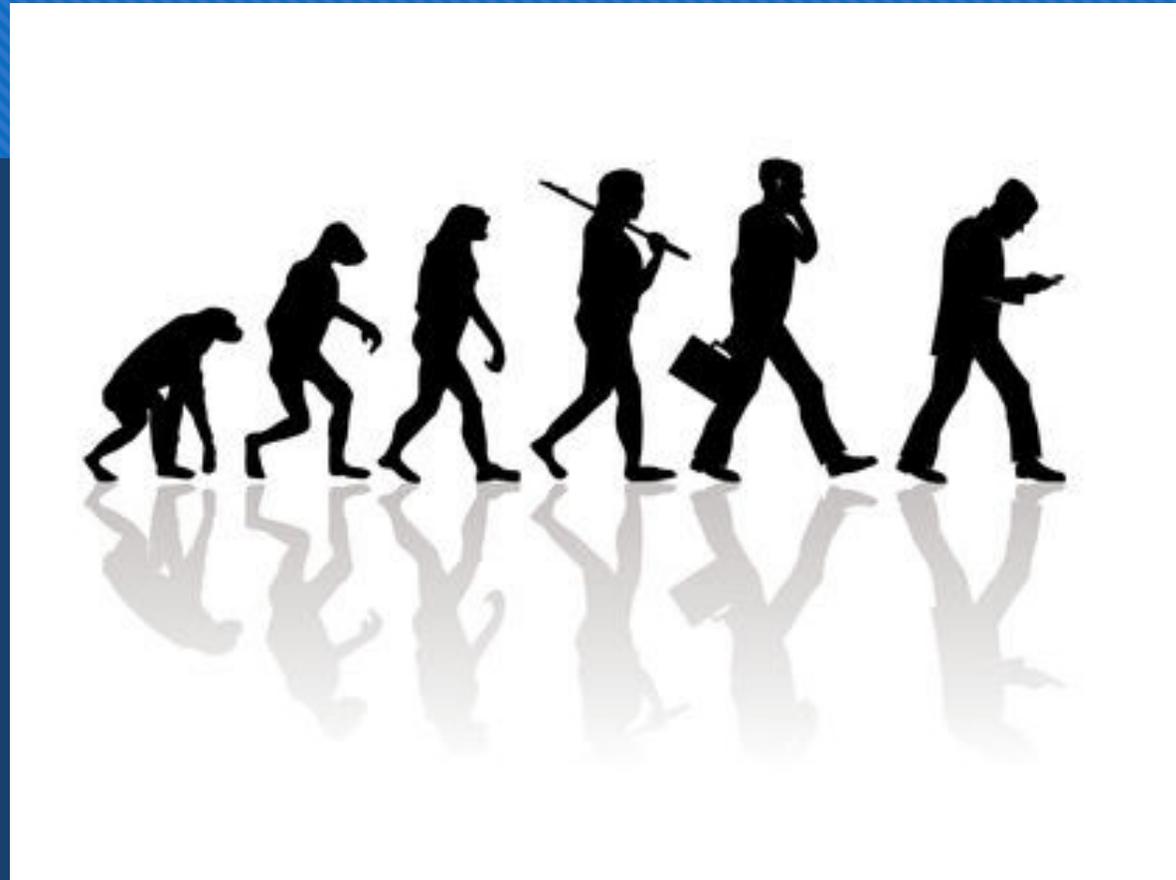
The following individuals have responded that they have nothing to disclose:

- **Kerry Nolte**

Objectives

- Describe Harm Reduction as a set of practical strategies aimed at reducing negative consequences associated with drug use.
- Identify two harm reduction strategies which are aligned with the AIM SUD Patient Safety Bundle and discuss how they might be incorporated into maternity care practice.

**Our own story of
understanding
substance
use/addiction/ harm
reduction: an
evolutionary tale...**



Harm Reduction is...

Familiar!

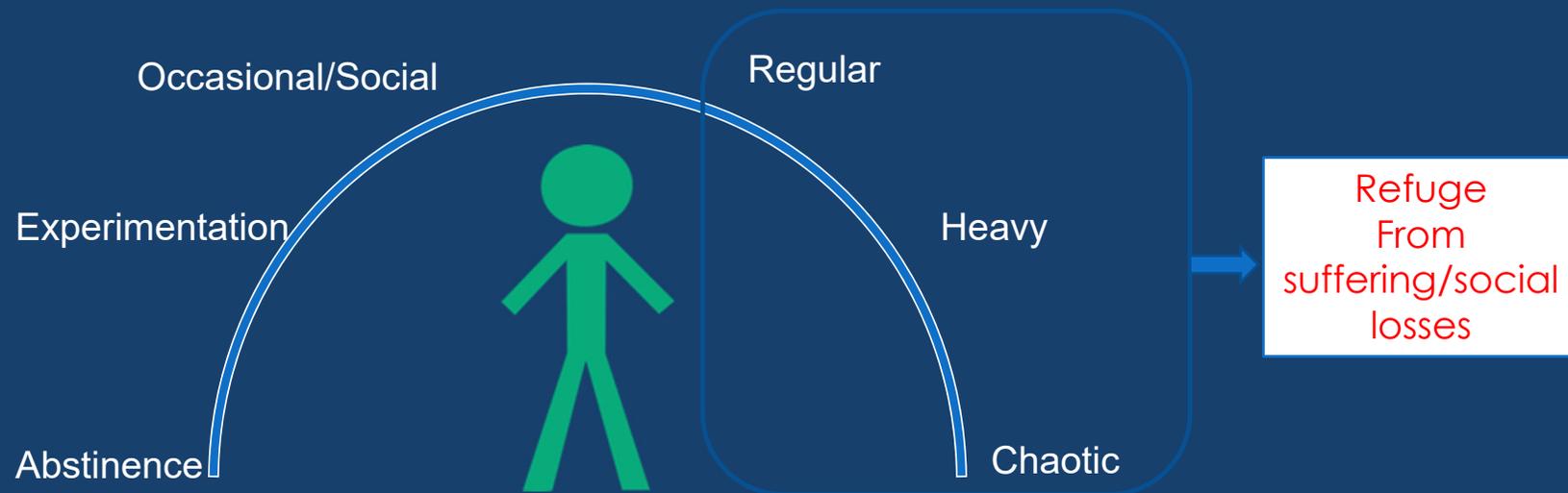


Harm Reduction Principles



- Practical strategies aimed at reducing negative consequences associated with drug use
- Social justice movement that respects the rights of people who use drugs
- Accepts that drug use is part of our world and works to minimize harm rather than ignore or condemn
- Understands drug use is complex with a continuum of behaviors and some ways of using drugs are safer than others
- Non-judgmental approach to empower drug users to share info and support each other

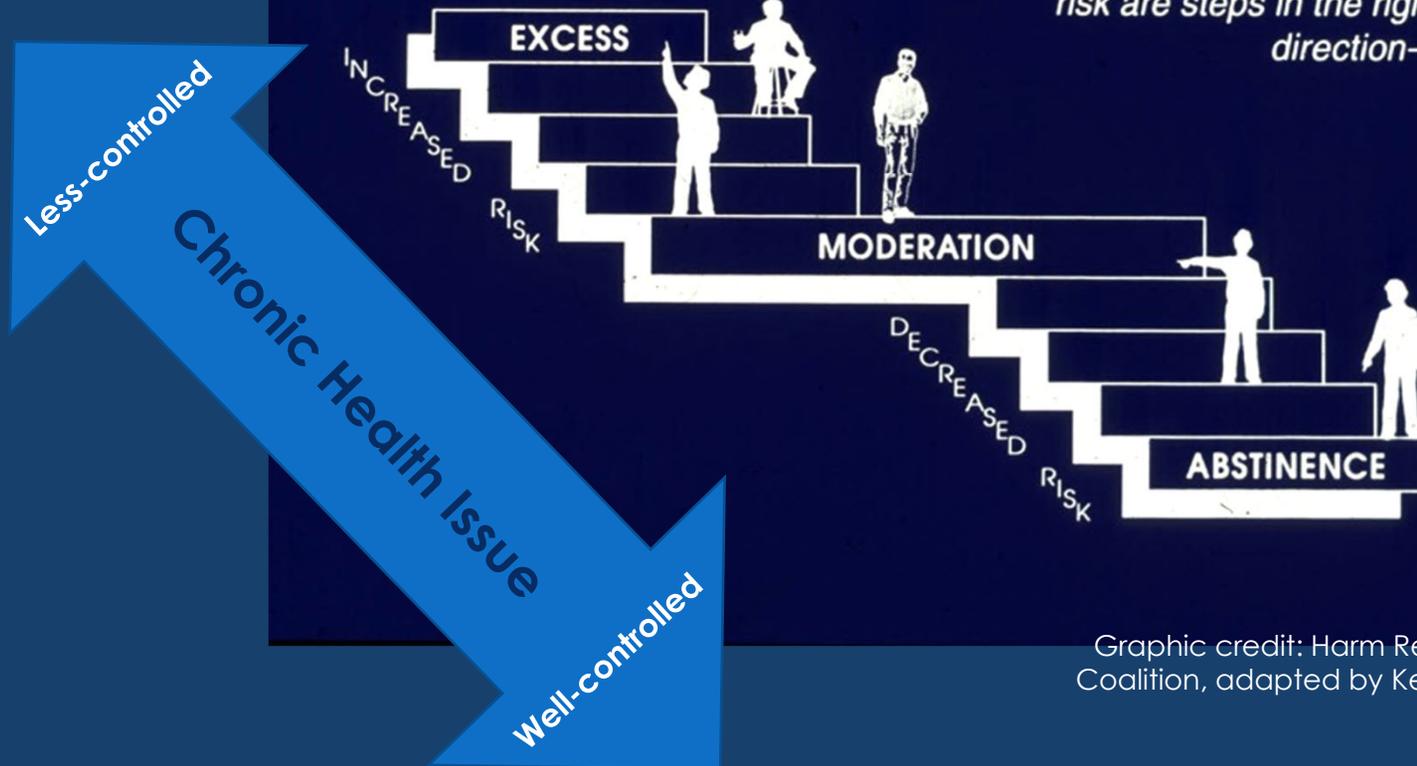
A Continuum of Substance Use (and other behaviors)



Adapted Graphic credit: Kevin Irwin

Continuum of Excess, Moderation, and Abstinence

—Any steps toward decreased risk are steps in the right direction—



Graphic credit: Harm Reduction Coalition, adapted by Kevin Irwin

Be a Resource to People Who Use Drugs¹¹

ATTITUDE

"I know the right thing for you."
I have the right to determine what is best for you

RECEPTION



ACTION

- Narrow scope of care
- Lost opportunities

OUTCOME

Individual might disconnect from care



"Here's what you should do – how does that sound?"
I will "give" you an opportunity to participate in my decision



- "Sell" a particular product or idea
- Narrow scope of options

Individual may say what they think the provider wants to hear, instead of reality



"You know better than me. Let me help you decide/improve/get where you want you to be."
I can learn from you



- Educating
- Aligning

Individual and provider share in goal setting



Every Interaction Can Be An Opportunity to Engage



- Client goals are most likely to be achieved
 - Untimely push for abstinence = lower engagement
- PWUD are interested and capable of making changes to improve health and safety
 - Safety messages shared spread rapidly through a social network
- Recognize and support readiness to change, whether safer injecting or recovery
- PWUD often report wanting to tell their story but little if any openness

Reframing the Starting Point: Engagement in Care

Acceptance

- ◆ Provider Humility
- ◆ Curiosity to Learn About SUD

→ Supportive and Pragmatic
Conversation

TRY THIS

Instead of saying...

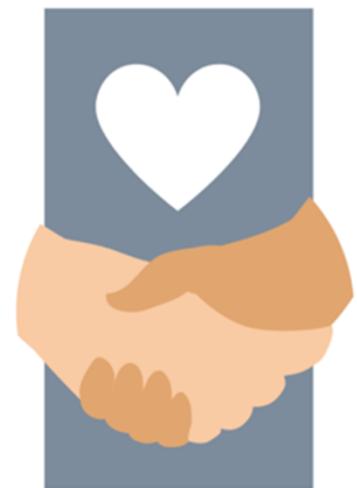
Now that you're pregnant you need to stop smoking.

Say...What do you think about your smoking now that you're pregnant?

Instead of saying...

If you loved your children you'd stop using.

Say... I know you love your children. What can we do to help you parent them the way you want to?





HHS Public Access

Author manuscript

Obstet Gynecol. Author manuscript; available in PMC 2019 August 01.

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Obstet Gynecol. 2018 August ; 132(2): 466–474. doi:10.1097/AOG.0000000000002734.

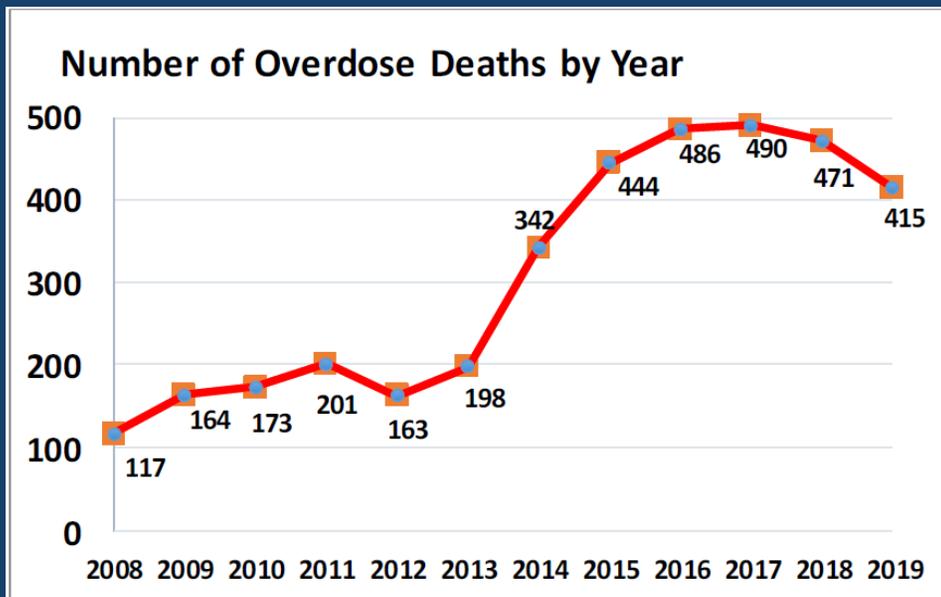
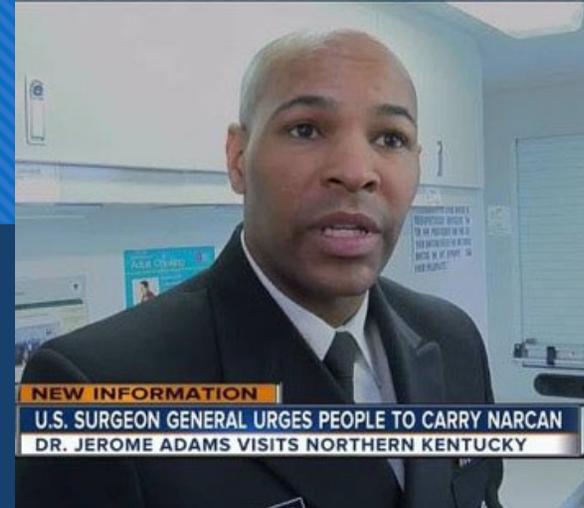
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

David M. Schiff, MD, MSc^{1,2}, Timothy Nielsen, MPH³, Mishka Terplan, MD, MPH⁴, Malena Hood, MPH³, Dana Bernson, MPH³, Hafsatou Diop, MD, MPH³, Monica Bharel, MD, MPH³, Timothy E. Wilens, MD⁵, Marc LaRochelle, MD, MPH⁶, Alexander Y. Walley, MD, MSc^{3,6}, and Thomas Land, PhD^{3,7,8}

“Targeted interventions that promote non-judgmental, universal screening for OUD during pregnancy, longitudinal care of women through pregnancy and their families into the postpartum period which emphasizes pharmacotherapy, mental health treatment, supportive housing, overdose education and naloxone access to support long-term recovery and safety should be implemented.”

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6060005/pdf/nihms969171.pdf>

Strategy 1: Overdose Prevention



Stateline

For Addicted Women, the Year After Childbirth Is the Deadliest

STATELINE ARTICLE August 14, 2018 By: [Christine Vestal](#) Topics: [Health](#) Read time: 5 min

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AUTHOR



Christine Vestal
Staff Writer
Stateline



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<https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest>

Overdose Prevention

ASTHO Brief

Exploring critical issues in state and territorial public health.

April 2020

Preventing Fatal Overdoses in Postpartum Populations

Introduction

In 2016, approximately 70% of maternal deaths involving opioids occurred during pregnancy or up to 42 days postpartum. While opioid use during pregnancy has received increased attention in recent years, less attention has been given to overdose-related deaths during the postpartum period. A 2012-2014 study of postpartum women showed [declines](#) in overdose-related deaths during pregnancy and a

outcomes following findings that many maternal deaths, including those linked to overdose and suicide, occur in the postpartum period.

Even for those with access to affordable healthcare, there are still not sufficient services in place to address opioid use disorder in pregnant and postpartum populations. Among the few substance use treatment centers that offer

Association of State and Territorial Health Officials

<https://www.astho.org/ASTHOBriefs/Preventing-Fatal-Overdoses-in-Postpartum-Populations/>

Post Partum Overdose

SECTION 6: POSTPARTUM OVERDOSE

Some people taper off of methadone or buprenorphine after their pregnancy because they or their providers think they no longer need it. However, this is often dangerous and increases risks of relapse, overdose and death. In one study in Massachusetts, **overdose rates were highest among people 7-12 months after delivery of a baby.** It can be hard to talk with loved ones about your substance use, and sometimes you might feel like you're letting people down if you start using after taking a break. **Try and find someone you can trust, a family member or friend, a counselor or provider, and discuss a plan for how you can cope with triggers and stay safe if you use.**

<https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/#section6>

Strategy 2: Safety Planning Specific to Postpartum Period

Your health and life matter.

BUILD A SAFETY PLAN

Anyone who uses drugs can overdose. These tips can help you build a safety plan that works for you.

Know the facts.

Fentanyl is in the drug supply.

- Fentanyl is 50-100 times stronger than heroin.
- A small amount of fentanyl can cause an overdose.
- Fentanyl is mixed into heroin and can be added to other drugs such as pills, cocaine, and crystal meth.
- Naloxone DOES reverse the effects of fentanyl.

Tolerance

When a drug is used repeatedly over time, a larger dose of the drug is often needed to reach the same desired effect.

A drug-free period will lower your tolerance.

- Your tolerance can drop in 1-2 days if you stop using opioids for any reason, such as if you take a break for a few days, detox, are in the hospital or put in jail.
- Using the same amount of drug after taking a break puts you at higher risk for an overdose.

Mixing drugs, medications and alcohol increases the risk of overdose.

- Alcohol and benzos (such as: Xanax, Klonopin, Ativan, Valium) mixed with any opioid can be deadly.
- They can change how you think, so you may not remember or care how much you have used.

Carry naloxone (Narcan).

- Naloxone will reverse an opioid overdose. Have it out and ready to use if needed.
- Naloxone can be sprayed into the nose or injected.
- If you are out of naloxone, get a new kit. Go to your local syringe exchange program or find a drug store near you at: www.health.ny.gov/overdose
- Tell those you trust how to use naloxone.
- The 911 Good Samaritan Law protects people against being charged for drug possession if they call 911 or if someone calls 911 for them.

Find a buddy.

- Take turns using so someone is ready to give naloxone if needed.
- If you use alone, let someone you trust know where you are.
- Ask them to text, call or check-in on you 3-5 minutes after you use drugs to make sure you are ok.

I'M ON MAIN STREET.

CALL ME IN 5 MINUTES.

Talk about it.

- An overdose can cause many feelings for the person who overdosed and those around them.
- You are not alone. Talking to someone can help you cope, and get the support you need.
- The National Suicide Prevention Lifeline is a network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. 1-800-273-TALK (8255) or text "GOTS" to 741741 to start a conversation.
- Many community programs can help you find services such as food, rides, and health care, etc.

My safety plan.

I keep my naloxone kit:

My Tips (e.g., name of syringe exchange program (SEP) counselor, phone number, and other resources):

SEP hours:

HARM REDUCTION + PARENTING

GENERAL HARM REDUCTION STRATEGIES

Keep track of how much you use. This may reduce your use, even if that was not your original goal.



Set limits on when and where you use, like waiting until after 5:00 to drink.



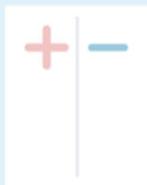
Avoid driving or making important decisions when using drugs.



Make a parenting plan. Before any substance use - including alcohol use - arrange for childcare if necessary.



Make a list of the pros and cons of stopping and continuing to use.



Attend support groups like Moderation Management, SMART Recovery, Narcotics Anonymous, or Alcoholics Anonymous.



Take good care of your body in general, like eating healthy and getting enough sleep, exercise, and water.



Switch to a safer method.

See [Getting Off Right Safety Manual](#). 



Avoid using opioids, benzos, alcohol, or other depressants (downers) when you are alone, if possible.



Set personal limits of how often and how much you use. For example, you won't use more than 2 bags of heroin every 8 hours.



https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf

Parenting Specific Support Options



Parenting Journey in Recovery

- In Parenting Journey in Recovery, a small group of parents and caregivers meet for 2 hours a week for 14 weeks. (Offered Digitally during COVID)
- The program includes activities, discussions, a family-style meal, and complimentary childcare.
- Parents and caregivers living with addiction face the additional challenge of building strong, positive relationships with their children while maintaining their recovery, which can be both rewarding and daunting.
- Parenting Journey in Recovery provides a valuable source of fellowship and support and enhances awareness of potential triggers that may escalate re-occurrence.

Safety Planning: What if?

Never Use Alone

Meeting people where they are, on the other end of the line, one human connection at a time.

[Home](#) [About](#) [Contact Us](#) [Log In](#) [Register](#) [Profile](#)

NO JUDGEMENT, NO SHAMING, NO PREACHING, JUST LOVE!

(800) 484-3731

If you are going to use by yourself, call us! You will be asked for your first name, location, and the number you are calling from. An operator will stay on the line with you while you use. If you stop responding after using, the operator will notify emergency services of an "unresponsive person" at your location.

[FACEBOOK](#)

[CONTACT US](#)

○ <https://neverusealone.com>

BEST PRACTICES Human Milk and Substance Exposure



www.perinatalharmreduction.org/NANN

SUBSTANCE	BEST PRACTICES	EVIDENCE	REFERENCE
Alcohol 	Pump or feed before you drink. Wait 3-4 hours after each alcohol serving before providing milk to the baby. ¹⁻²	Alcohol is present in human milk and has been linked to many of the same problems seen with prenatal exposure. Alcohol does not increase milk production or let-down. ¹	<ol style="list-style-type: none"> ACOG (2011) Liston (1998) Uguz (2021) AAP (2013) AAP (2012) ACOG (2017)
Benzodiazepines 	Take medication as prescribed. Feed the baby. Watch for signs of sedation. ³	Most benzodiazepines are considered safe or moderately safe at therapeutic doses. ³ Infants exposed to benzodiazepines via breastmilk may exhibit signs of sedation, such as apnea. ⁴	<ol style="list-style-type: none"> Reece-Stretma and Marinelli (2015) Hill and Reed (2013)
Cannabis 	It is safest to reduce or eliminate use during the lactation period. ^{5, 6, 7} However, in the case of continued medical or recreational use, experts agree that the proven benefits of human milk likely outweigh the risk of cannabis exposure. It is unacceptable to withhold lactation support. ^{8, 9}	Cannabis transfer rate into human milk is estimated to be 0.8-1% of maternal dose. ^{8, 10, 11, 12} Bioavailability is incomplete in infants' GI tract. So infants absorb 0.1% of the parent's dose. ¹¹ Little data on the effects of exposure via breast milk, with inconclusive results. ^{13, 14}	<ol style="list-style-type: none"> Metz and Stickrath (2013) Perez-Reyes (1982) Bertrand (2018) D'Apolito (2017) Astley and Little (1990)
Opioids 	Long- or short-term opiate use is not a contraindication to breastfeeding, regardless of dose. ^{15, 16} Because of individual differences in metabolism, codeine is not recommended while breastfeeding, due to risk of infant overdose. ¹⁶	Most opioids transfer into human milk at rates estimated at 1-3% of maternal dose. ¹⁷ Because bioavailability is poor in infants' gastrointestinal tracts, it is likely that even less is absorbed.	<ol style="list-style-type: none"> NIDA (1985) Darke, et al. (2007) LoctMed ABM (2012)
Stimulants 	Abstinence during lactation is recommended. In the case of a relapse, wait 24 hours after cocaine use and 48 hours after methamphetamine use to provide milk. ^{16, 18} Caffeine doses of ≤ 200mg are considered safe for lactation. ¹⁹	Caffeine, cocaine, and methamphetamine are present in the human milk of parents who use them. Infant exposure should be limited by feeding or pumping before use. ^{16, 18, 19, 20}	<ol style="list-style-type: none"> LLL (2006) Temple, et al. (2017)
Smoking 	Despite the risks, breast/chestfeeding while smoking is considered safer than formula feeding while smoking because of the proven health benefits of human milk, including a 50% reduction in the incidence of SIDS. ^{5, 21, 22}	Smoking during lactation has been associated with decreased milk supply, shorter lactation duration, altered composition of milk, increased incidence of SIDS, and asthma in offspring. ^{5, 23}	<ol style="list-style-type: none"> Dorea (2007) Vennemann, et al. (2009) Nopieral (2016)



Joelle Puccio BSN RN [✉ Joelle@perinatalharmreduction.org](mailto:Joelle@perinatalharmreduction.org)

[Link to References](#)

<https://www.perinatalharmreduction.org/nann>

Strategy 3: Empower

YOUR RIGHTS as a PREGNANT PATIENT and PERSON WHO USES SUBSTANCES

PATIENT AUTONOMY

You have the right to make decisions about your body and your health care. You are the expert. You know your body better than anyone else. You know your health history and understand what works well for you and what doesn't. You deserve health care from providers who appreciate that and respect your right to make the decisions that are best for you right now.



You have the right to trauma-informed health care. Gynecological care can be invasive and uncomfortable. If you have experienced trauma before, medical visits can bring back memories - and bring up powerful and overwhelming emotions. Because the medical environment is potentially traumatic, you have a right to talk about it with your health care providers. It is important for you to work with them to feel as comfortable and empowered as you can. Good providers will do their best to support you, listen to your needs, and help you feel safe, comfortable, and empowered.

PREGNANT PEOPLE WHO ARE USING DRUGS OR ALCOHOL HAVE RIGHTS

People who use drugs or alcohol or have a history of substance abuse or a substance use disorder may face additional barriers to respectful health care and freedom from violations during pregnancy and labor. Examples of this include: being told you can't have pain relief during labor, being told to stop medication assisted treatment during pregnancy or lactation, being drug tested without consent, or having your confidential medical information shared.



Even if I am using drugs or alcohol, I have the right to...

- receive medications that are helping me, including medication-assisted treatment for substance use.
- be administered pain relief during labor.
- prevent law enforcement from accessing my medical records and exams without my consent.
- maintain confidentiality in my medical records, including any history of substance use treatment.
- receive information about the risks, benefits and alternatives of various procedures or treatments, including drug tests.
- refuse treatments, tests, or medical procedures.
- be treated with respect and dignity.
- remain silent and not speak to the police.

Academy of Perinatal Harm Reduction

https://56861659-e968-4f0b-9ee4-a8ec93fddd29.filesusr.com/uqd/f31cc3_6d0b480eefdb406d91985dd8fea6e1f5.pdf

Birth Rights

[https://birthrightsbar.org/resources/Documents/BIRTH%20RIGHTS-](https://birthrightsbar.org/resources/Documents/BIRTH%20RIGHTS-%20A%20resource%20for%20everyday%20people%20to%20defend%20human%20rights%20during%20labor%20and%20birth.pdf)

[%20A%20resource%20for%20everyday%20people%20to%20defend%20human%20rights%20during%20labor%20and%20birth.pdf](https://birthrightsbar.org/resources/Documents/BIRTH%20RIGHTS-%20A%20resource%20for%20everyday%20people%20to%20defend%20human%20rights%20during%20labor%20and%20birth.pdf)

Strategy 4: Trauma Informed Care and Depression/ Mood Disorder Screening

Postpartum:
in the community,
through the first
year after delivery

- Include a focus on parent-child relationships in all interventions. Clients with a history of abuse or trauma have a higher likelihood of not bonding well. However, they are able to increase attachment over time.¹
- Assess for postpartum depression and other mood disorders. Women and childbearing people with a history of trauma are more likely to develop postpartum depression.¹¹⁻¹⁴

https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf

I was 12 years old...My father gave me a line of oxycodone...he just broke it out and said here, sniff this. And I said, uh how? And he showed me how he did it, and I did it. (Jacob, 24M)

Normalization of Drug Use within the Family and Community

My god it's horrible. I literally can remember...thinking that [this town] was a great area to grow up in and raise a family. And maybe I was just really extra oblivious then but, uh, it's, drugs were like scarce. [Using drugs] was the exception. Now people that don't do drugs are the exception. There's more drugs or people using... everywhere. (Amanda, 29F)



So they took me in and did surgery and they put me on, um oxycontin 60 milligrams four times a day...And that's why I got addicted. I was on it for two or three years, and then finally they shut me off...They supposedly got a call saying that we were abusing meds or selling them or whatever...I know like four or five people that... all got shut off the same day...I tried to find the pill if I had the money. But yeah, you couldn't. ... Yes, so I went to the heroin. (Michelle, mid-50s F)

Abrupt Discontinuation of Opioid Prescriptions

Transition to Illicit drugs

And then the doctor took them away from me and I was in pain. I was sick, throwing up... physically was sick from it, from not having it. And where did I go? I went to the streets to find them. And then that became too expensive. And then I went to heroin. (Jessica, 32F)

Trauma

Escalation of use

Last year I lost my baby...it was a stillborn...before that I lost my best friend's dad who was like a father to me growing up... just three weeks ago my mothers' boyfriend shot himself in the head in front of my mom. But it's just a lot of trauma happening lately...it's just a lot of things piling up. Life's pretty unforgiving sometimes. (Matt, 24M)

Key:

Themes Subthemes

Nolte, K., Drew, A.L., Friedmann, P.D., Romo, E., Kinney, L.M., & Stopka, T.J. (2020). Opioid initiation and injection transition in rural northern New England: A mixed-methods approach, *Drug and Alcohol Dependence*, 217. <https://doi.org/10.1016/j.drugalcdep.2020.108256>



Strategy 5: Discuss Safer Supplies

- Ask: “Are you able to get clean supplies (needles, cookers, cottons)?”
 - If needles have to be reused, HCV can be reduced and HIV eliminated with bleach.⁷
 - Risk dramatically reduced with rinsing 3 times with water
 - Advise using clean, single use works
 - Cottons, cookers, and clean water (sterile)
- NH law allows pharmacists to dispense/sell syringes (no limit) to anyone over 18 without a prescription.

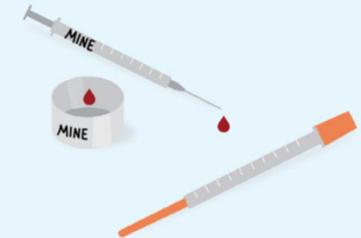
Safer Injecting Strategies

**Use Sterile Injection Equipment.
Avoid Reusing or Sharing.**



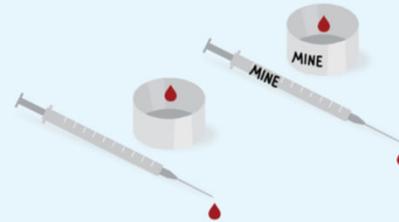
Your blood may end up on any item you touch or use when injecting, including syringes, cookers, cottons, water, and ties. Use new, sterile equipment each time you inject.

Have a New Spare Sterile Syringe To Split Drugs.



Get an extra syringe for splitting drugs. Use an extra sterile syringe to split drugs, using your own cooker and cotton. Avoid drawing up from a cooker if someone else has used it. There may still be blood on it.

**If You Must Reuse Equipment,
Then Mark Yours.**



Avoid sharing any injection equipment. **The virus is alive in blood outside the body.** If you must reuse, keep a set of works with markings on it so you know it's yours.

**If You Must Share a Syringe,
Then Bleach It.**



If you must share a syringe, then clean it with bleach and sterile water.
Step 1: Rinse the syringe with sterile water.
Step 2: Rinse the syringe with bleach.
Step 3: Rinse again with (new) sterile water.

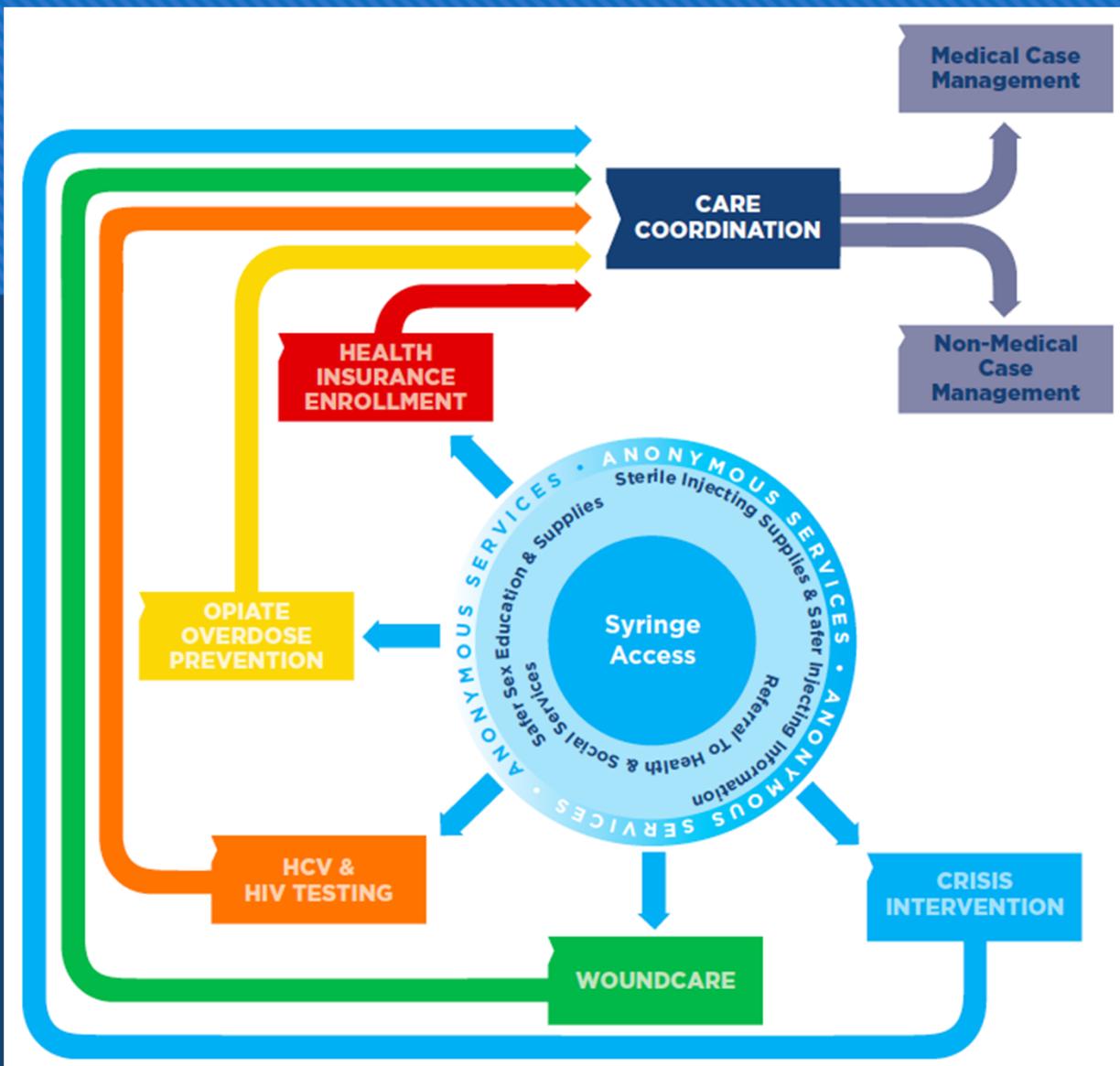
https://harmreduction.org/wp-content/uploads/2016/05/hrc_hcv_brochure_2-up_english.pdf

Microscope View of Needle After Use



<https://imgur.com/Rh7RY>

Refer to Syringe Services Programs



Strategy 5: Discuss Alternative Routes of Drug Use

Methods of Administration

Heroin can be administered in several different ways.
The potency of it will depend on the method used:



Injected

Most immediate and intense high



Smoked

Quick-acting and long-lasting high



Snorted

Quick high, risk of severe nasal cavity damage



Orally

Slow-acting and not as powerful of a high

Strategy 6: Discuss Safer Injecting Practices

- Ask: "How do you prevent injury to your veins and infections?"
 - Wash hands or use hand sanitizer/ alcohol
 - Tourniquet improves vein access (fewer needle sticks, less risk for infection)
 - Bevel up to avoid going through the vein
 - Recognize valves in veins and inject above
 - Recognize infections and when to seek care for wound/ illness/ infection

SHOOTING UP & NOT F*ING IT UP

A SKIN CARE GUIDE FOR PEOPLE WHO INJECT DRUGS

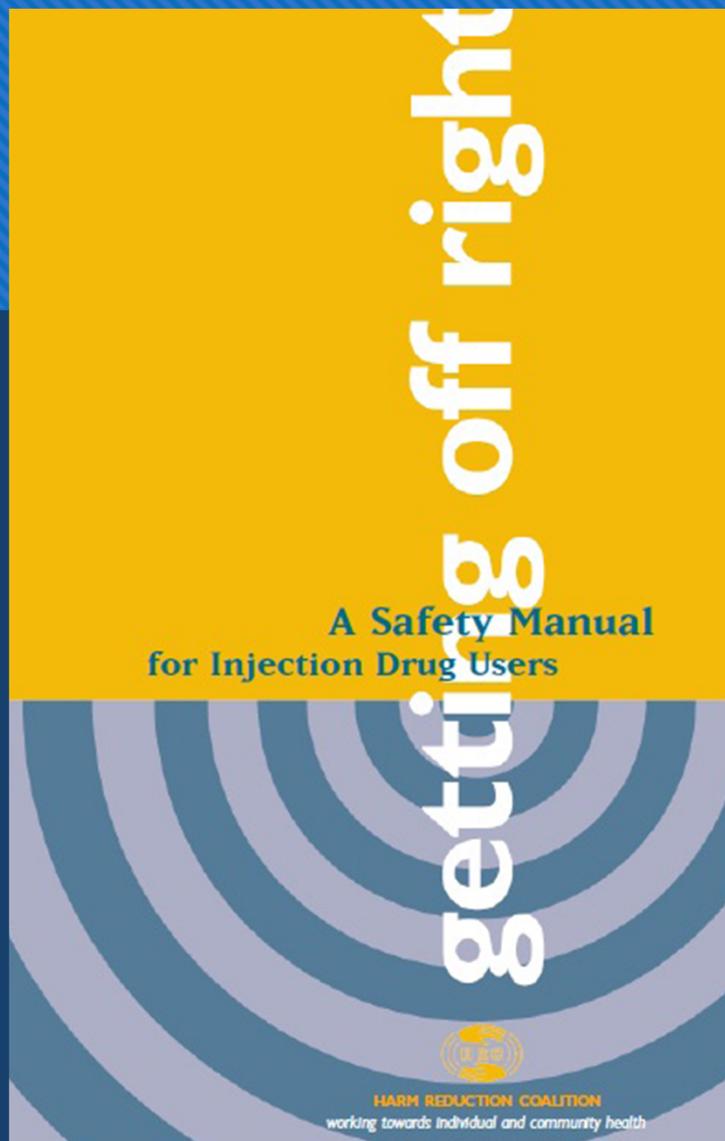
developed by nursing students at the University of New Hampshire



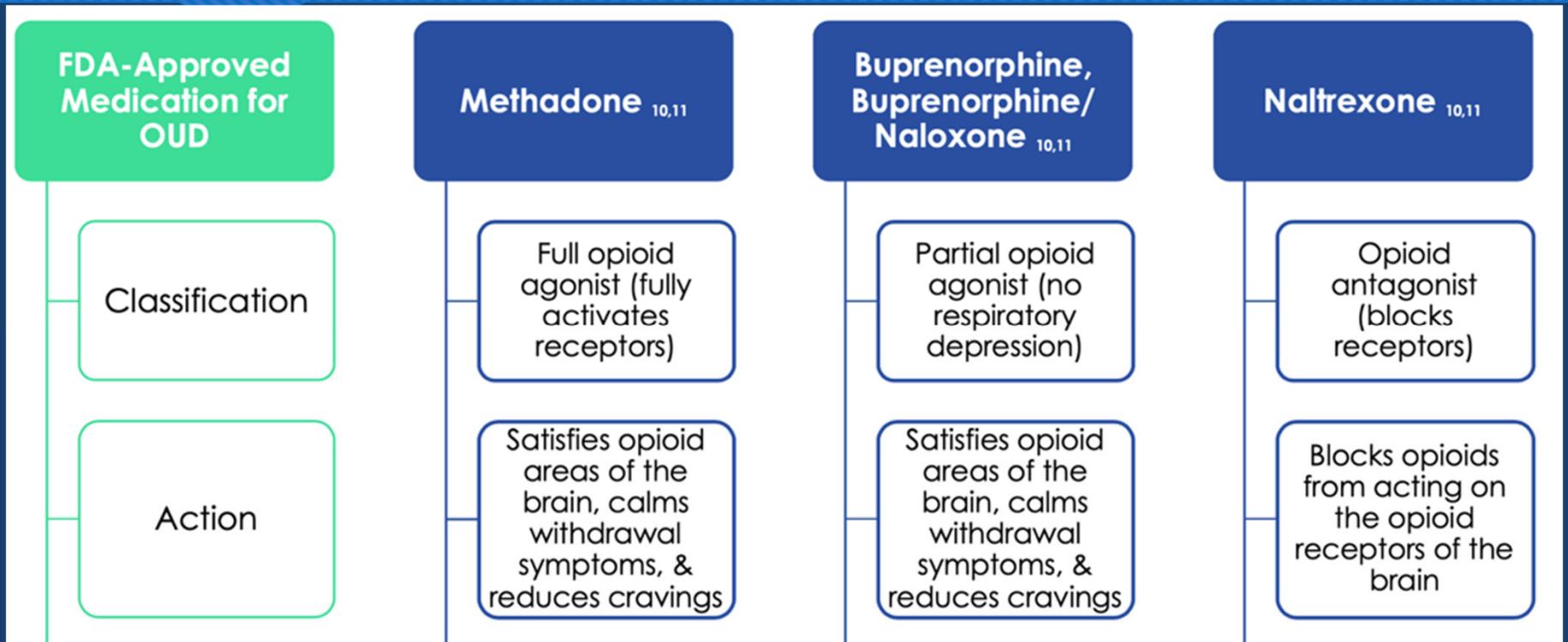

<p>THINGS THAT PROBABLY WON'T KILL YOU</p> <ul style="list-style-type: none"> • A little redness • A bit swollen • Itchiness • Open skin • Red skin • Warmth 	<p>MINOR SKIN ISSUES</p>  <p>scrapes</p>  <p>rashes</p>  <p>small sores</p>	<p>CARING FOR MINOR SH*T</p> <ul style="list-style-type: none"> • Wash with soap & water • Apply a warm & wet face cloth every 2 hours • Rest & use pillows to elevate arm/leg • If skin is not open, apply oatmeal or baking soda mixed with water, reapply every 4 hours
<p>NOPE.</p> <ul style="list-style-type: none"> • Try not to scratch • Avoid antibiotics that haven't been prescribed (only certain antibiotics are helpful for skin infections) • Avoid cutting or opening your own wound (often makes infection worse) • Avoid injecting in the same arm or leg as skin issue 	<p>GET YOUR A** TO A HOSPITAL <i>(Or a clinic, or physician, or any damn medical place)</i></p> <ul style="list-style-type: none"> • Fever • Grey/blue/pale skin of hands/feet • Numbness/tingling • If affected area gets bigger/spreads • If you can see bone/muscle 	<p>ULCER</p> <p>May start as a small open sore or wound that doesn't heal or gets bigger</p>  <p>CELLULITIS</p> <p>Area of redness, swelling, warmth & pain that starts out small & spreads</p> 
<p>ABSCESS</p> <p>Swollen & painful area of the skin that is filled with pus</p> 	<p>NECROTIZING FASCIITIS</p> <p>"Flesh-eating disease", destroys tissue & appears blackened. GET EMERGENCY HELP.</p> 	<p style="text-align: center;">FIND MORE INJECTION SAFETY TIPS @ NHHRC.ORG</p> <p style="text-align: center;">NHHRC NH Harm Reduction Coalition</p> 

FOR MORE ON SAFER
INJECTION
PRACTICES

Find at
HarmReduction.org



Strategy 7: Review MOUD/ MAT Options Postpartum



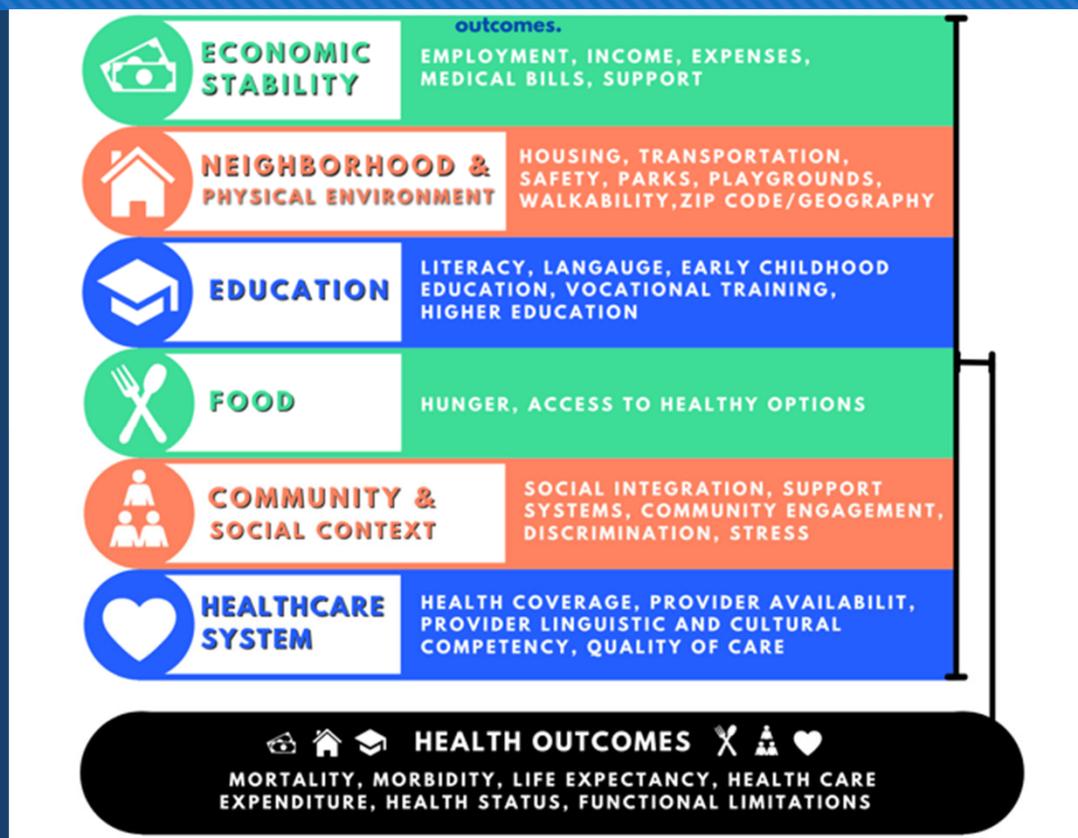
https://mypages.unh.edu/sites/default/files/harmreductionproject/files/compassionate_care_detailing_6.23.19_0.pdf

Compassionate Pharmacology for Opioid Withdrawal

<p>Anxiety/Sweating</p> 	<ul style="list-style-type: none"> • Clonidine (Rx) start 0.1 mg by mouth every six hours PRN, not more than 0.4 mg/ day Avoid if blood pressure is <90/<50 mm Hg or heart rate is <50 bpm ¹² • Lofexidine (Rx) Start 3 (0.18 mg) tablets every 5-6 hr as needed (max 16 tablets/day) Taper dose over 2-4 days to stop [Only FDA approved med for opioid withdrawal] ¹³
<p>Insomnia</p> 	<ul style="list-style-type: none"> • Trazodone (Rx) 50-100 mg by mouth at bedtime ^{12,14}
<p>Diarrhea</p> 	<ul style="list-style-type: none"> • Loperamide (OTC) 4mg by mouth initially, then 2mg with loose stools (max 16mg/day) ^{12,14} • Bismuth subsalicylate (OTC) 524mg by mouth every 30min-1 hr ^{12,14}
<p>Nausea/vomiting</p> 	<ul style="list-style-type: none"> • Ondansetron (Rx) 4mg by mouth every 8 hours as needed ^{12,14} • Promethazine (Rx) 25mg by mouth or rectally every 6 hours as needed ^{12,14} • Prochlorperazine (Rx) 5-10mg by mouth every 4 hours as needed ^{12,14}
<p>Abdominal cramping</p> 	<ul style="list-style-type: none"> • Dicyclomine (Rx) 20mg by mouth every 6-8 hours as needed ^{12,14}

https://mypages.unh.edu/sites/default/files/harmreductionproject/files/compassionate_care_detailing_6.23.19_0.pdf

Strategy 8: Collaboration



Strategy 9: Ongoing implementation of harm reduction strategies

Training Guide

PREGNANCY AND SUBSTANCE USE: A HARM REDUCTION TOOLKIT

This toolkit was written in collaboration with Academy of Perinatal Harm Reduction. For a full list of authors, see the acknowledgements. For visuals and worksheets, you can download the full toolkit. Check out APHR's website for more resources.



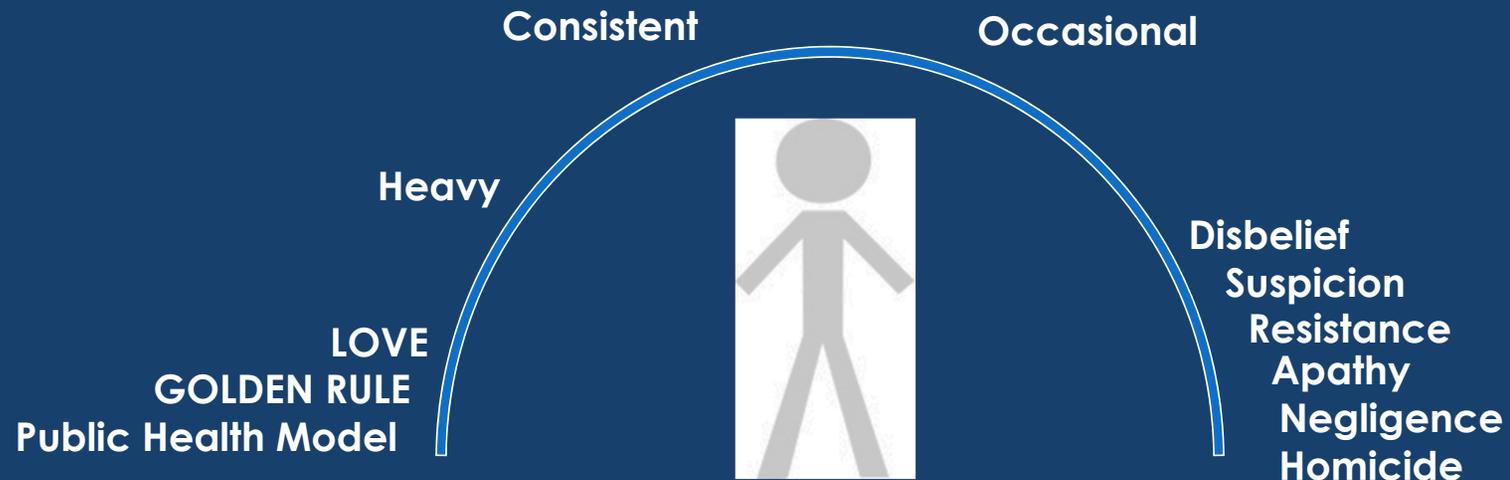
Academy of Perinatal
Harm Reduction

Your source for evidence-based, stigma-free education and support.

https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf

<https://www.perinatalharmreduction.org/>

A Continuum of Harm Reduction Integration



QUESTIONS

The screenshot shows the NHHRC website homepage. At the top is a dark blue navigation bar with the NHHRC logo on the left and a menu on the right containing: HOME (underlined), ABOUT US, DONATE, RESOURCES, SYRINGE SERVICES PROGRAMS (with a dropdown arrow), CONTACT, and COVID-19 RESPONSE. Below the navigation bar is a white main content area. On the left side of this area is the NHHRC logo, which consists of the text 'NHHRC' in a bold, blue, sans-serif font, followed by a blue hand icon with a white heart in the palm. Below the logo is the text 'NH Harm Reduction Coalition'. To the right of the logo is a section titled 'Upcoming webinars!' in a bold, dark blue font. Below this title is a list of three webinars: 'Enhancing Provider Skills in Serving Active Substance Users' (June 17th: 3-4pm), 'June 24th: 6-7pm', and 'July 9th: 4-5pm'. Below the webinars is another section titled 'NHHRC's Covid-19 Response' in a bold, dark blue font, with a sub-headline 'Learn more about how the NHHRC is responding the COVID-19 outbreak.' Below this section are three orange circular icons arranged horizontally. The first icon is a white padlock with an open keyhole, labeled 'Access' below it. The second icon is a white person silhouette with a checkmark, labeled 'Engagement' below it. The third icon is a white scale of justice, labeled 'Rights and Dignity' below it.

NHHRC
NH Harm Reduction Coalition

[HOME](#) [ABOUT US](#) [DONATE](#) [RESOURCES](#) [SYRINGE SERVICES PROGRAMS](#) [CONTACT](#) [COVID-19 RESPONSE](#)

Upcoming webinars!

Enhancing Provider Skills in Serving Active Substance Users
June 17th: 3-4pm
June 24th: 6-7pm
July 9th: 4-5pm

NHHRC's Covid-19 Response

Learn more about how the NHHRC is responding the COVID-19 outbreak.


Access


Engagement


Rights and Dignity

To Receive CME/CNE Credit for today's session Text **603-346-4334**

Enter Activity Code: **Qgch** *(Good for this Live Session Only)*

Need help? clpd.support@hitchcock.org

Signing in on-line? <http://www.d-h.org/clpd-account>

Our presenters have no conflicts of interest to disclose with the exception of Ellen Stickney who is the PI for the ERASE Maternal Mortality Grant.



Stay in touch....

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