WELCOME!

- We will begin shortly.
- **Please type your name and email into the chat box for attendance.**
- Reminder, we will be recording this session.
- Please mute your line upon entering and chat in your comments or questions.
- Vicki Flanagan will monitor the chat box and call on you to unmute yourself.
- If you have trouble connecting, please email **karen.g.lee@Hitchcock.org**

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Maternity Mortality Surveillance & Harm Reduction

NH AIM/ERASE Monthly Webinar
October 14, 2021

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

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.

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

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

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

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

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

Critical Collaborations: NNEPQIN, ERASE and AIM

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts

Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies

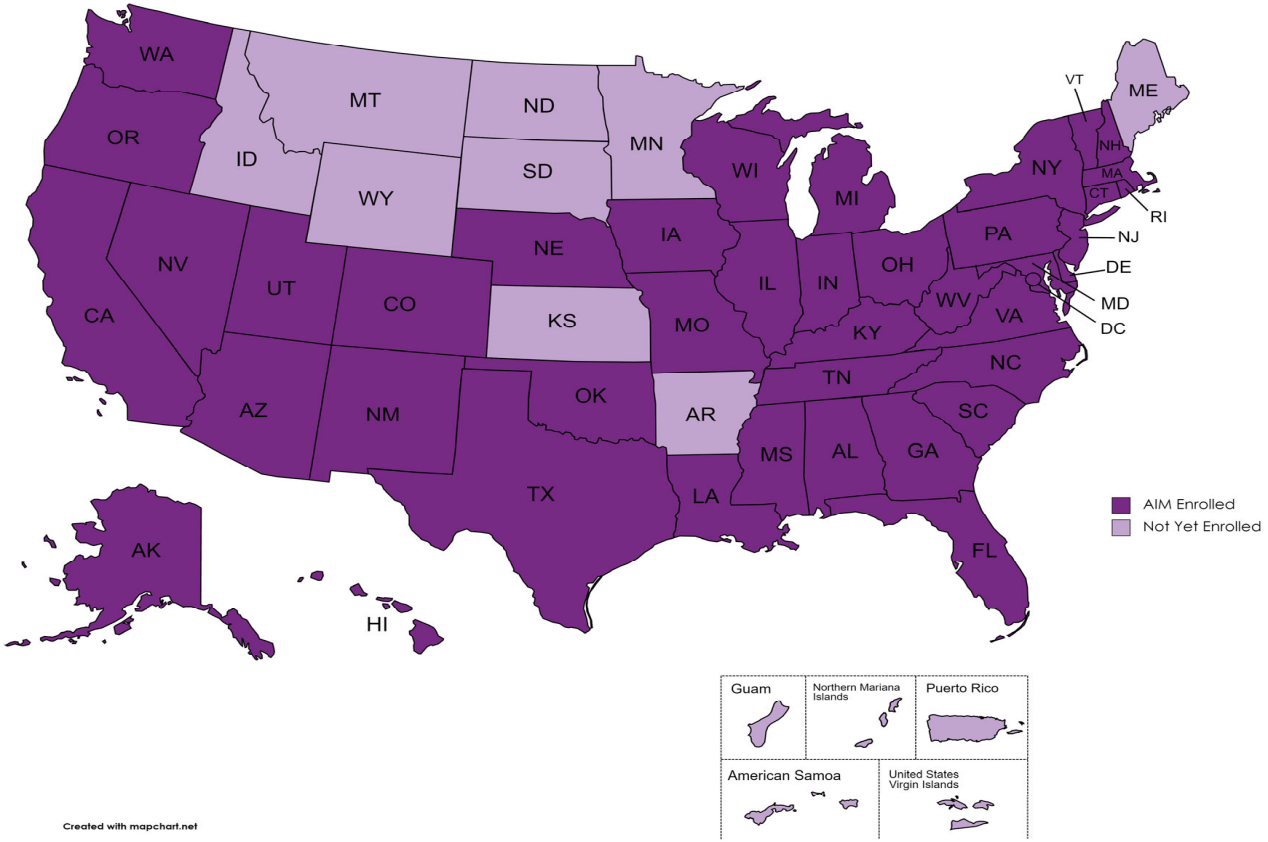
Created from a Centers for Disease Control, Division of Reproductive Health source

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Current AIM States



https://safehealthcareforeverywoman.org/aim/about-us/aim-state-participation-2/

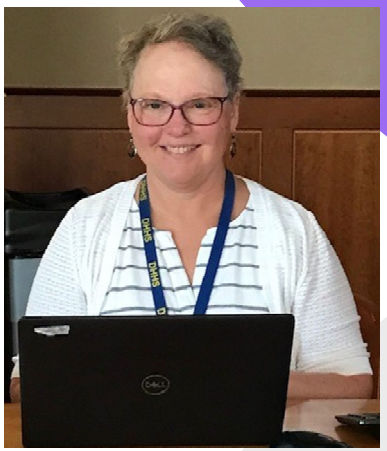
AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Maternity Mortality Surveillance

New Hampshire Presentation



Ellen Stickney, RN, BSN, RNC-OB

Ellen.T.Stickney@dhhs.nh.gov

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

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 #:

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Maternity Mortality Surveillance

Maine Presentation

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

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

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Maternity Mortality Surveillance

Vermont Presentation

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

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.

VERMONT
DEPARTMENT OF HEALTH

Questions?

Emily Fredette, Injury and Violence Prevention Program Manager

Email: Emily.Fredette@Vermont.gov

Phone: 802-865-7729

Web: Healthvermont.gov

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Welcome!

Kerry Nolte, PhD, FNP-C

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all

Harm Reduction in the Perinatal Period

Presented By:

Kerry Nolte, PhD, FNP-C

Disclosures

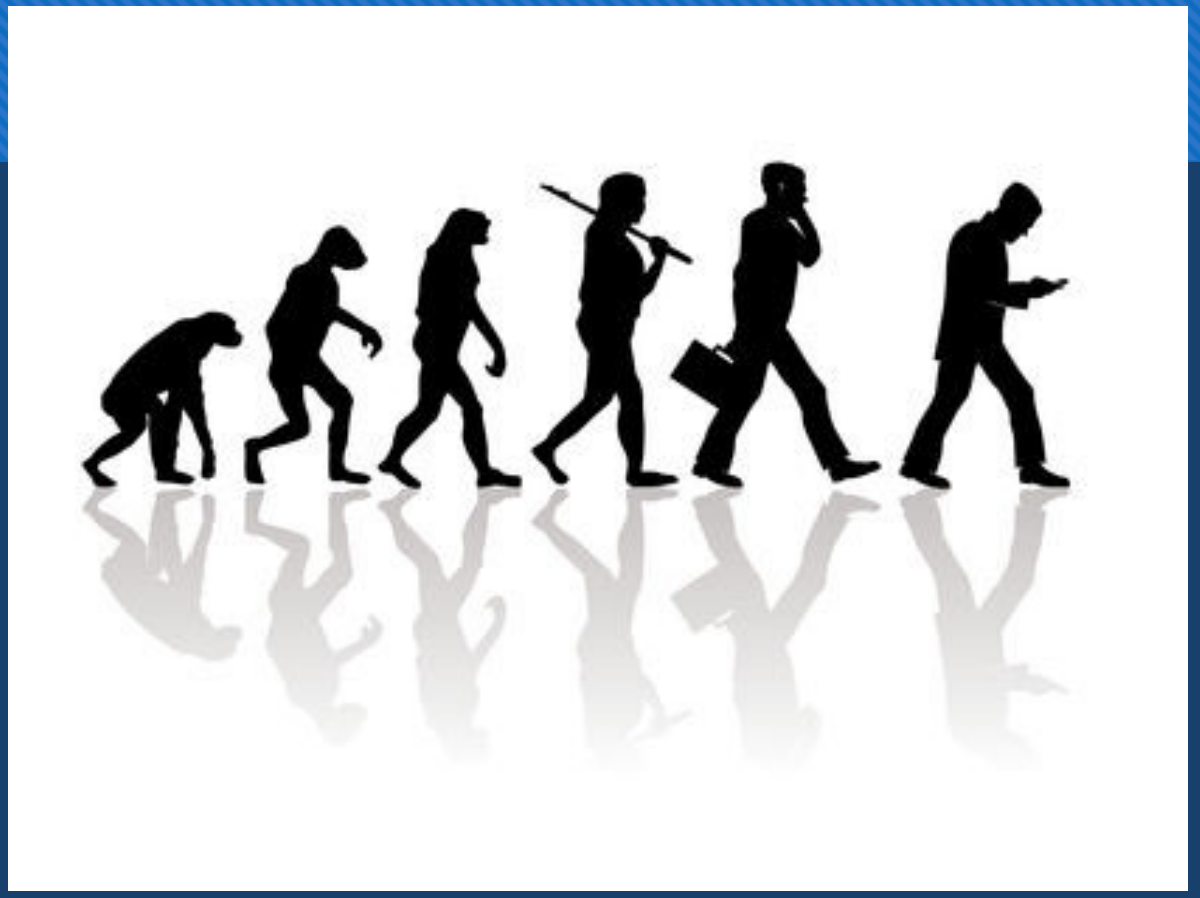
The following individuals have responded that they have nothing to disclose:

- **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…



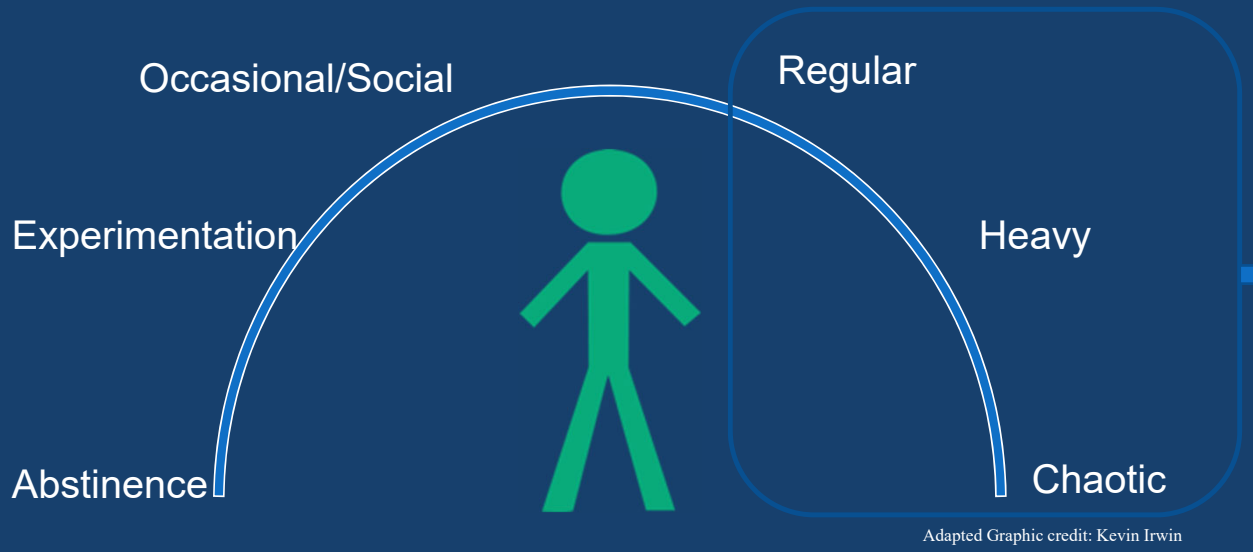
Harm Reduction is…

Familiar!

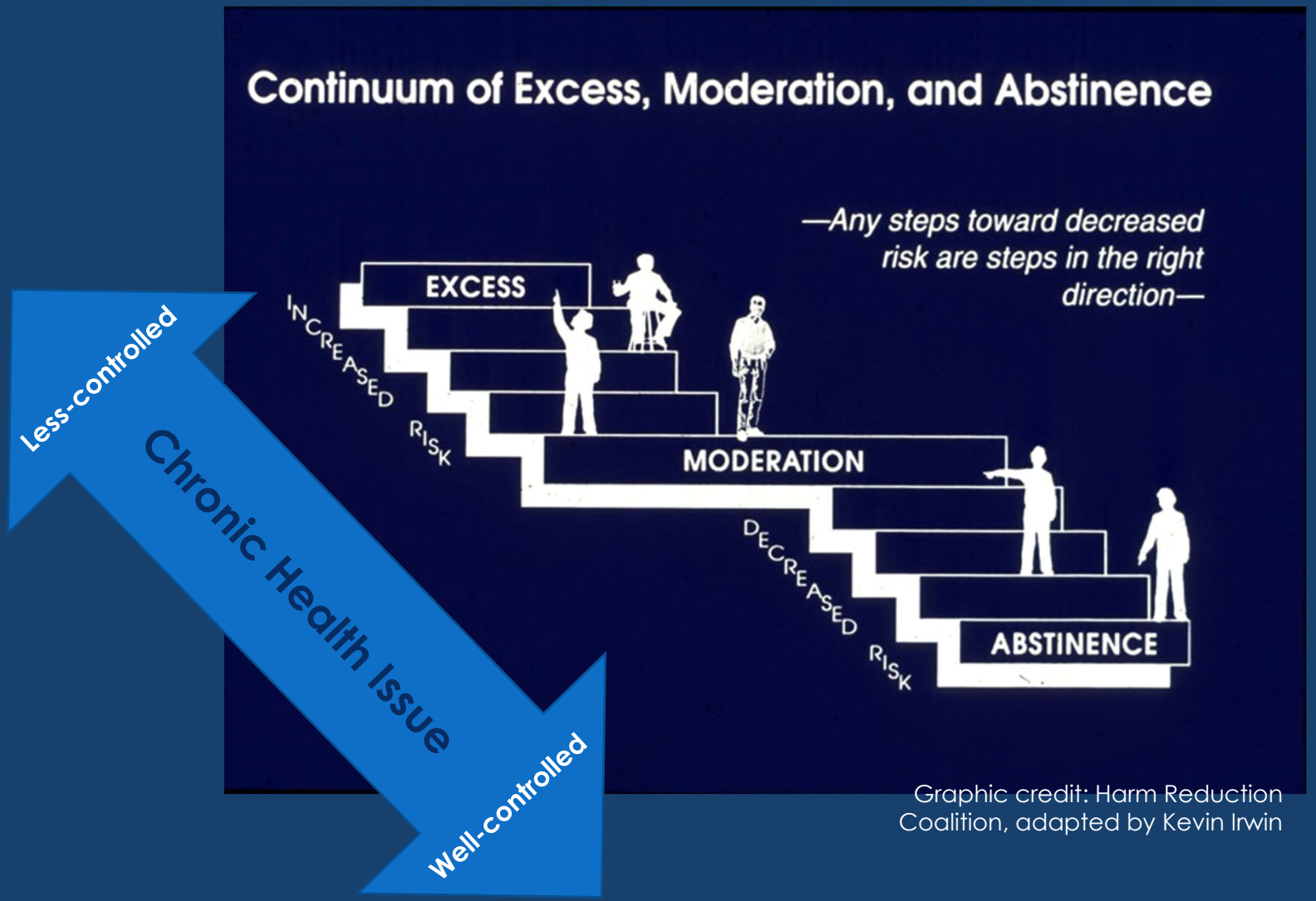
Harm Reduction Principles

- 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)



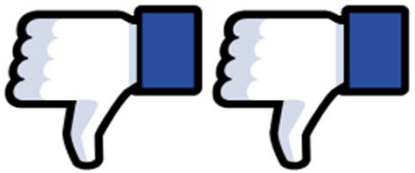
Adapted Graphic credit: Kevin Irwin



Graphic credit: Harm Reduction Coalition, adapted by Kevin Irwin

Approaches to PWUD

Be a Resource to People Who Use Drugs[11]

ATTITUDE	**"I know the right thing for you."** *I have the right to determine what is best for you*	**"Here's what you should do — how does that sound?""** *I will "give" you an opportunity to participate in my decision*	**"You know better than me. Let me help you decide/improve/get where you want you to be."** *I can learn from you*
RECEPTION			
ACTION	• **Narrow scope of care** • **Lost opportunities**	• **"Sell" a particular product or idea** • **Narrow scope of options**	• **Educating** • **Aligning**
OUTCOME	**Individual might disconnect from care** 	**Individual may say what they think the provider wants to hear, instead of reality** 	**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...

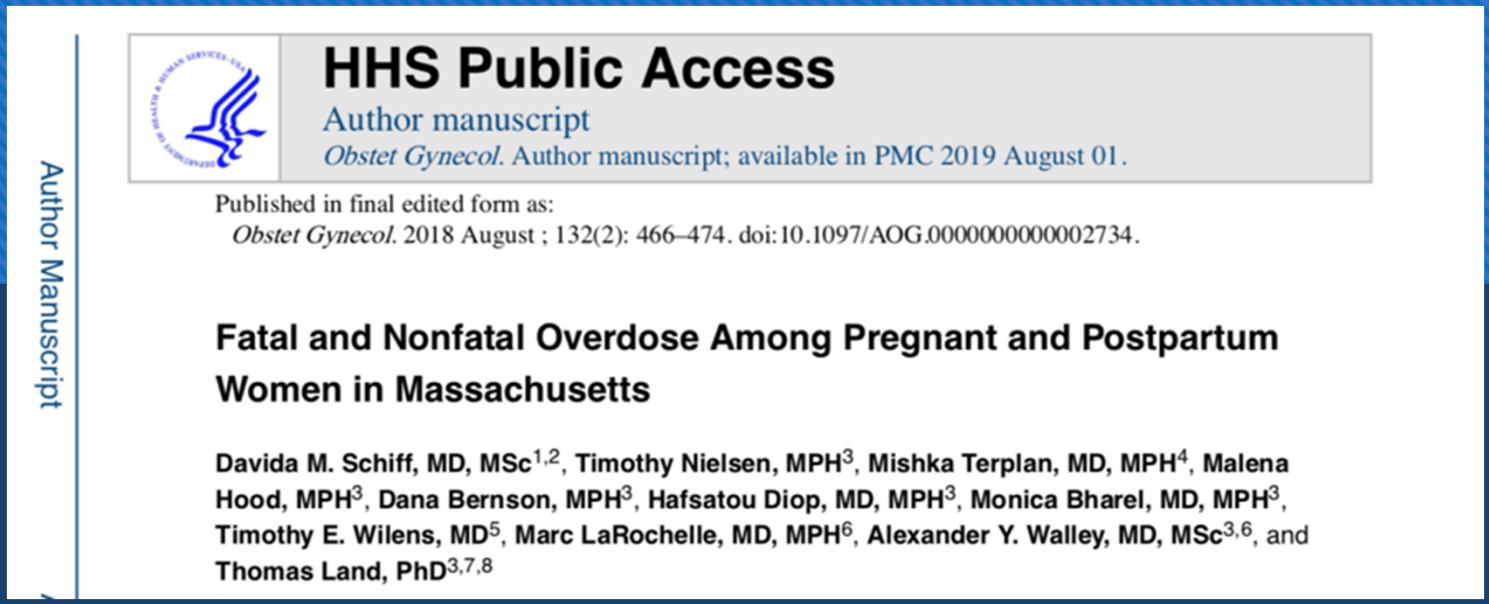
Now that you're pregnant you need to stop smoking.

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?



Author Manuscript

HHS Public Access

Author manuscript

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

Published in final edited form as:

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

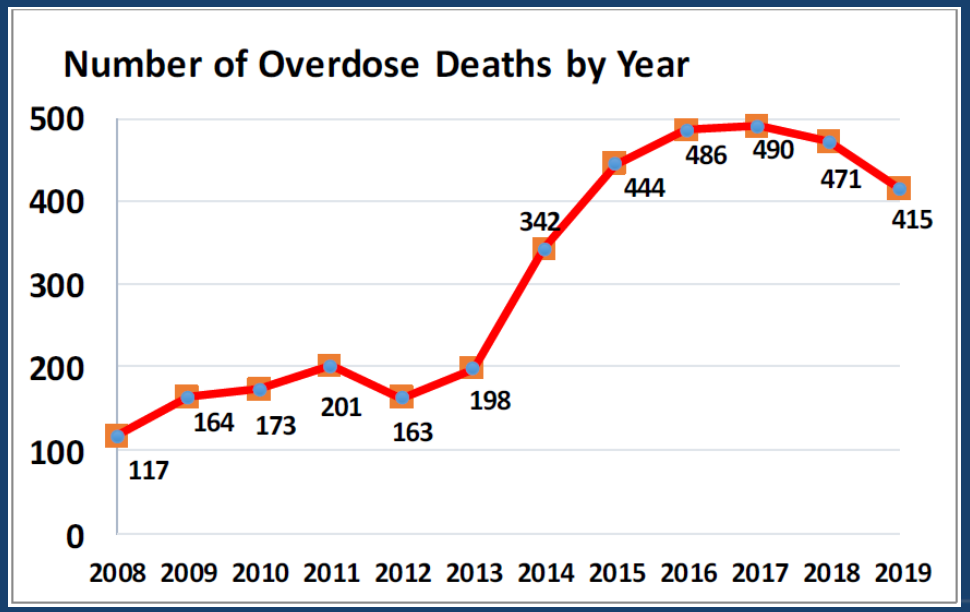
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Davida M. Schiff, MD, MSc[1,2], Timothy Nielsen, MPH[3], Mishka Terplan, MD, MPH[4], Malena Hood, MPH[3], Dana Bernson, MPH[3], Hafsatou Diop, MD, MPH[3], Monica Bharel, MD, MPH[3], Timothy E. Wilens, MD[5], Marc LaRochelle, MD, MPH[6], 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."

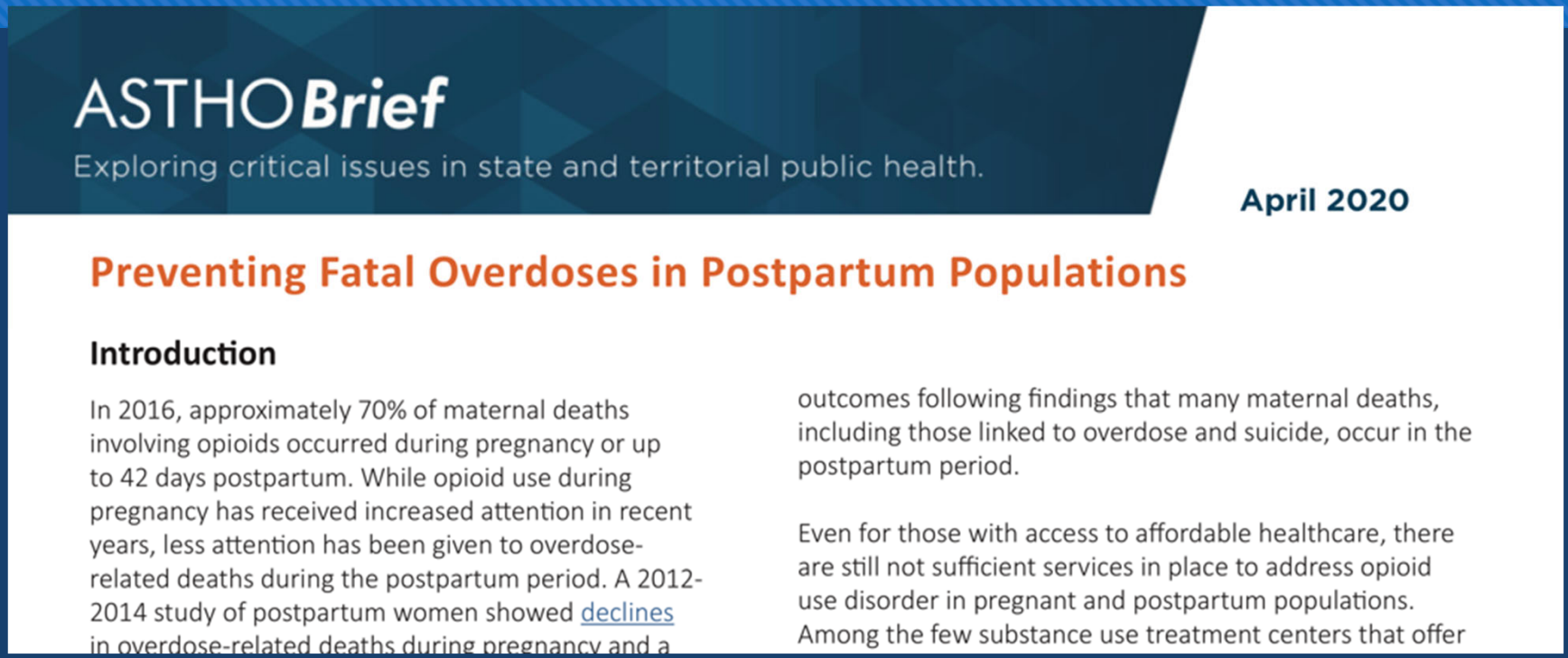
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6060005/pdf/nihms969171.pdf

Strategy 1:
Overdose Prevention



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

- https://www.health.ny.gov/publications/9895.pdf

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.

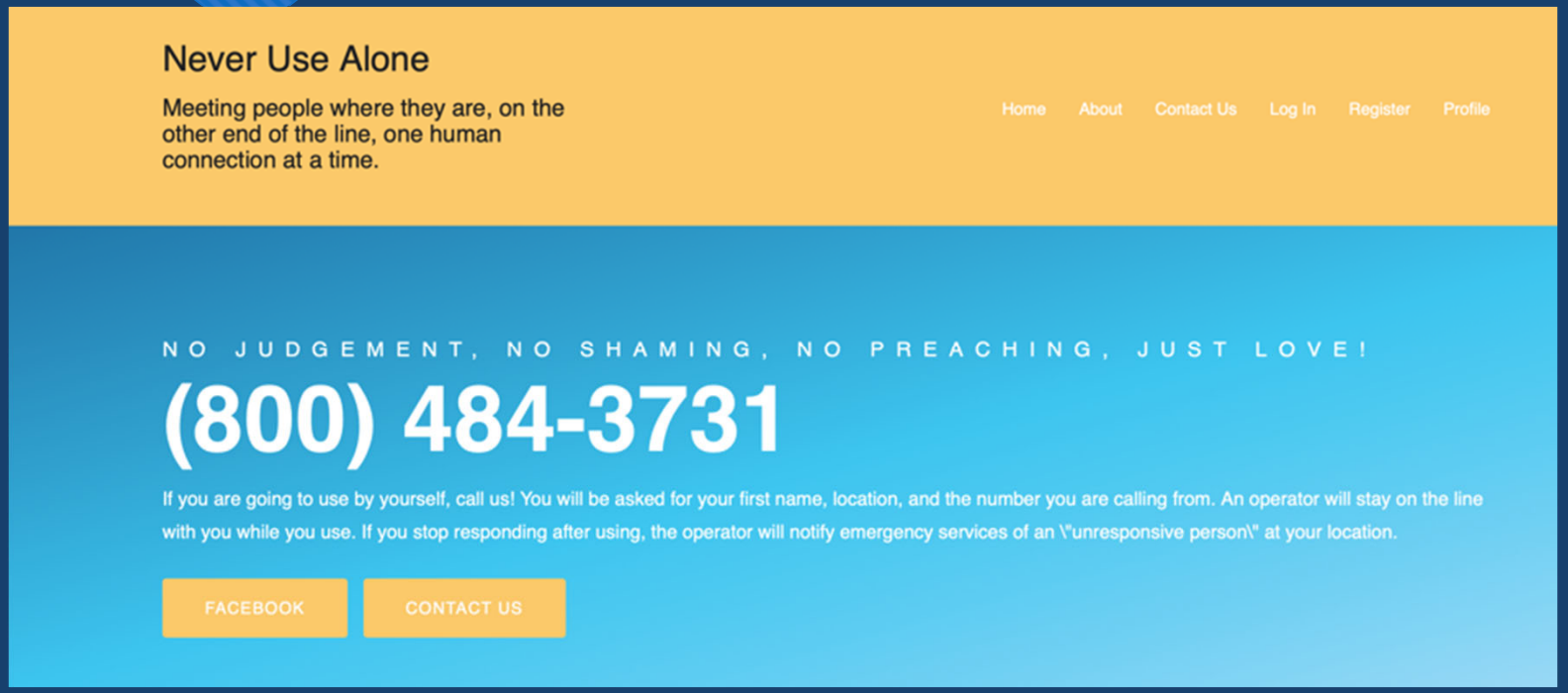
https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf

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?



- https://neverusealone.com

BEST PRACTICES

Human Milk and Substance Exposure

www.perinatalharmreduction.org/NANN

SUBSTANCE	BEST PRACTICES	EVIDENCE
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]
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]
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]
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.
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]
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]

REFERENCE

1. ACOG (2011)
2. Liston (1998)
3. Uguz (2021)
4. AAP (2013)
5. AAP (2012)
6. ACOG (2017)
7. Reece-Stremtan and Marinelli (2015)
8. Hill and Reed (2013)
9. Metz and Stickrath (2013)
10. Perez-Reyes (1982)
11. Bertrand (2018)
12. D'Apolito (201
13. Astley and Little (1990)
14. NIDA (1985)
15. Darke, et al. (2007)
16. LactMed
17. ABM (2012)
18. Bartu, Dusci, and Ilett (2008)
19. LLL (2006)
20. Temple, et al. (2017)
21. Doreo (2007)
22. Vennemenn, et al. (2009)
23. Napieral (2016)

Joelle Puccio BSN RN 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.

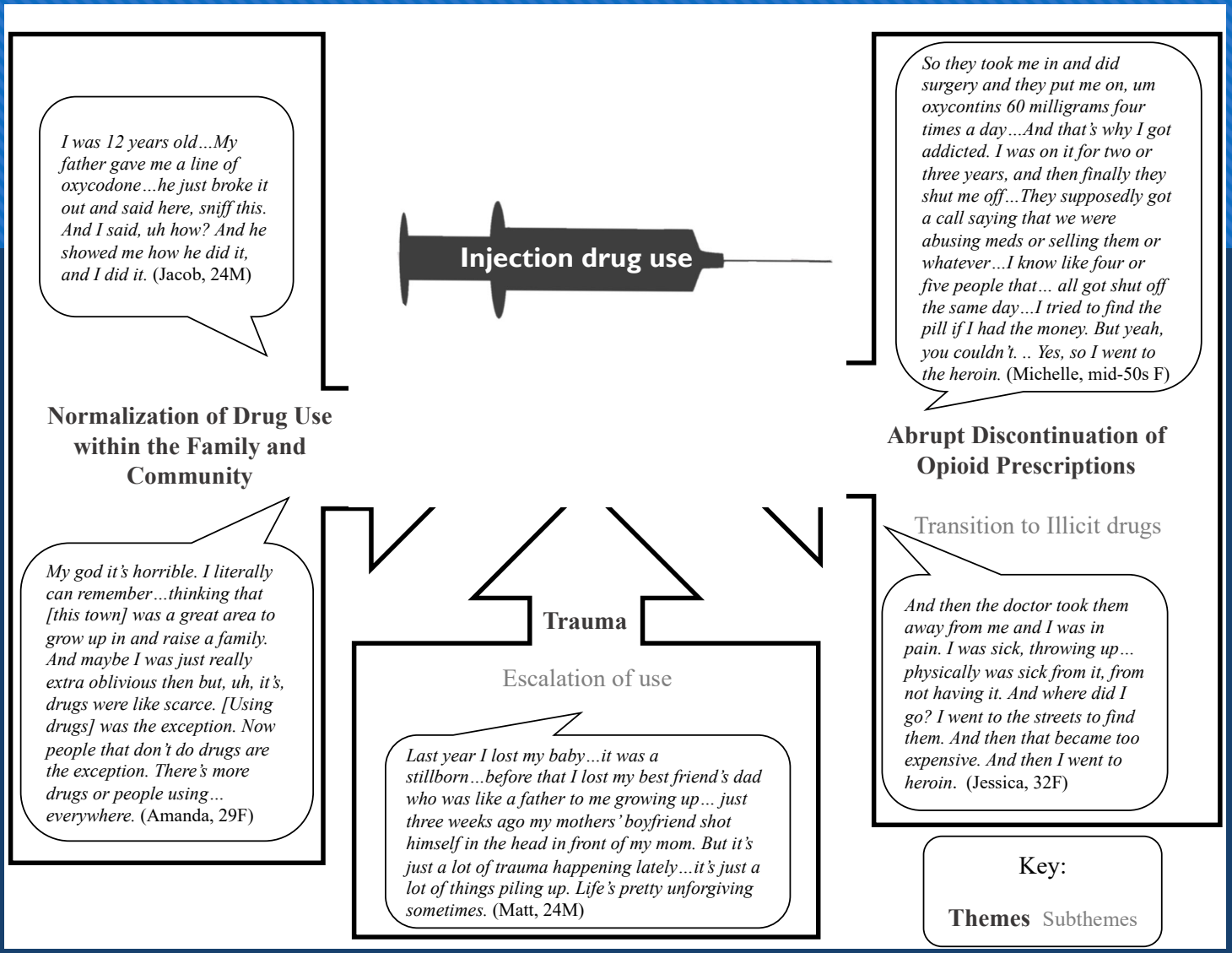
Academy of Perinatal Harm Reduction
https://56861659-e968-4f0b-9ee4-a8ec93fddd29.filesusr.com/ugd/f31cc3_6d0b480eefdb406d91985dd8fea6e1f5.pdf

Birth Rights
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



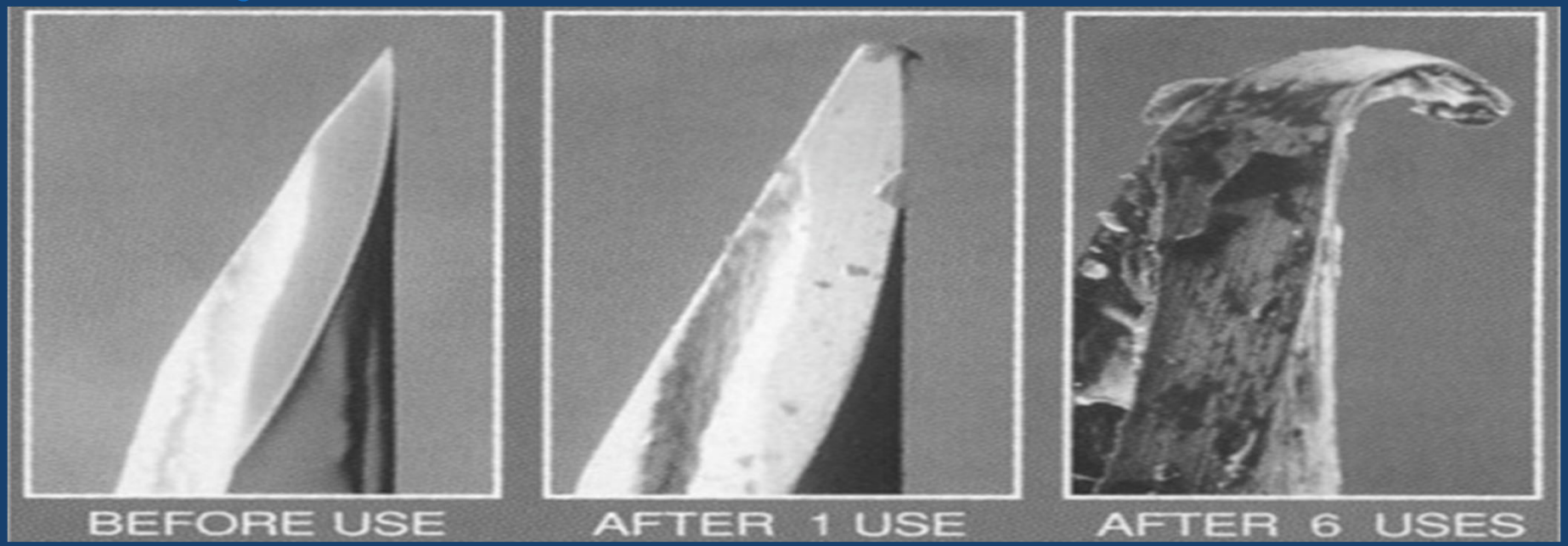
Nolte, K., Drew, A.L., Friedmann, P.D., Romo, E., Kinney, L.M., & Stopka, T.J. (2020). Opioid initiation and injection transition in rural northern New England: A mixed-methods approach, Drug and Alcohol Dependence, 217. https://doi.org/10.1016/j.drugalcdep.2020.108256

Strategy 5: Discuss Safer Supplies

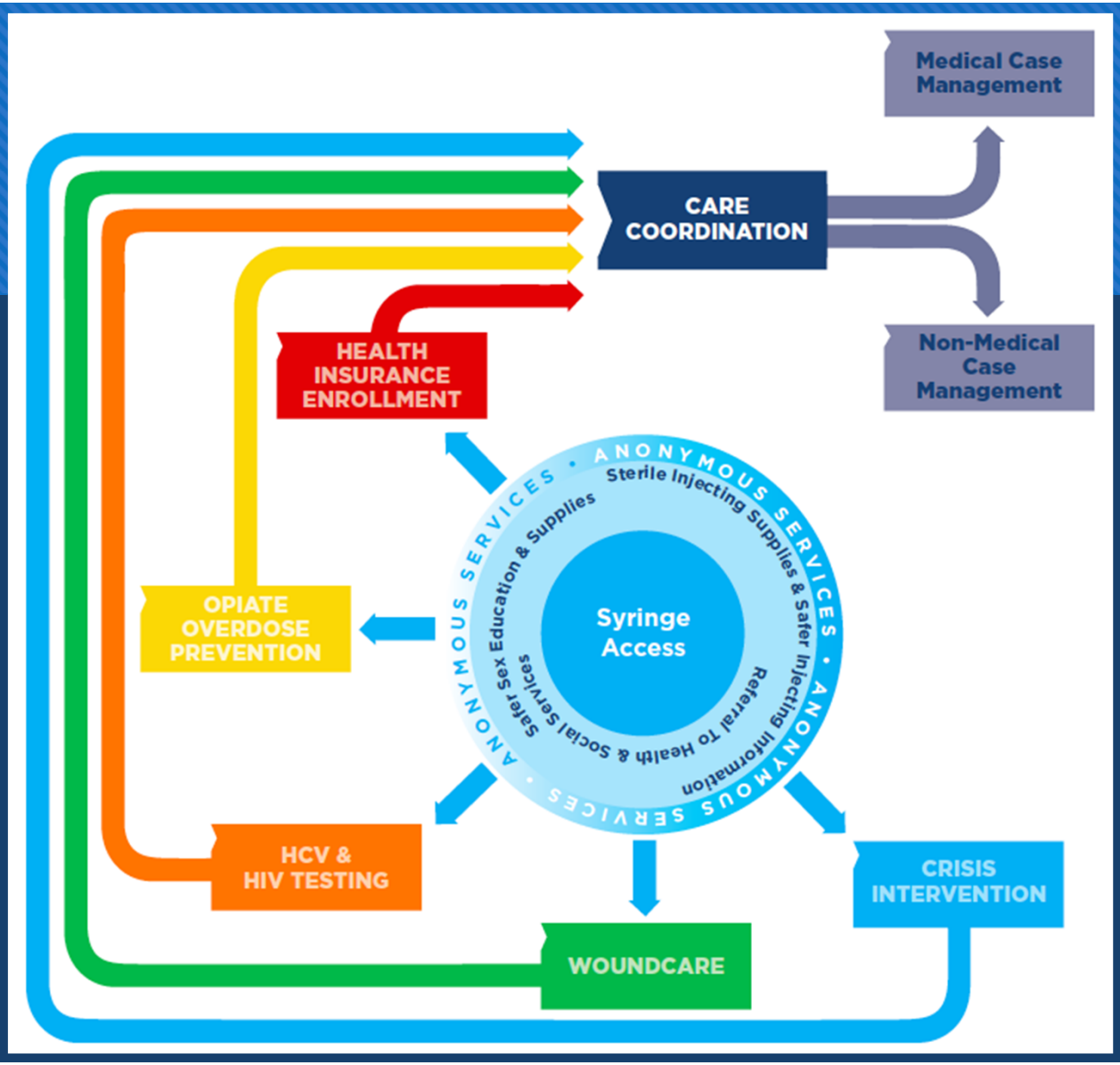
- Ask: "Are you able to get clean supplies (needles, cookers, cottons)?"
  - If needles have to be reused, HCV can be reduced and HIV eliminated with bleach.[7]
    - Risk dramatically reduced with rinsing 3 times with water
  - Advise using clean, single use works
    - Cottons, cookers, and clean water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

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

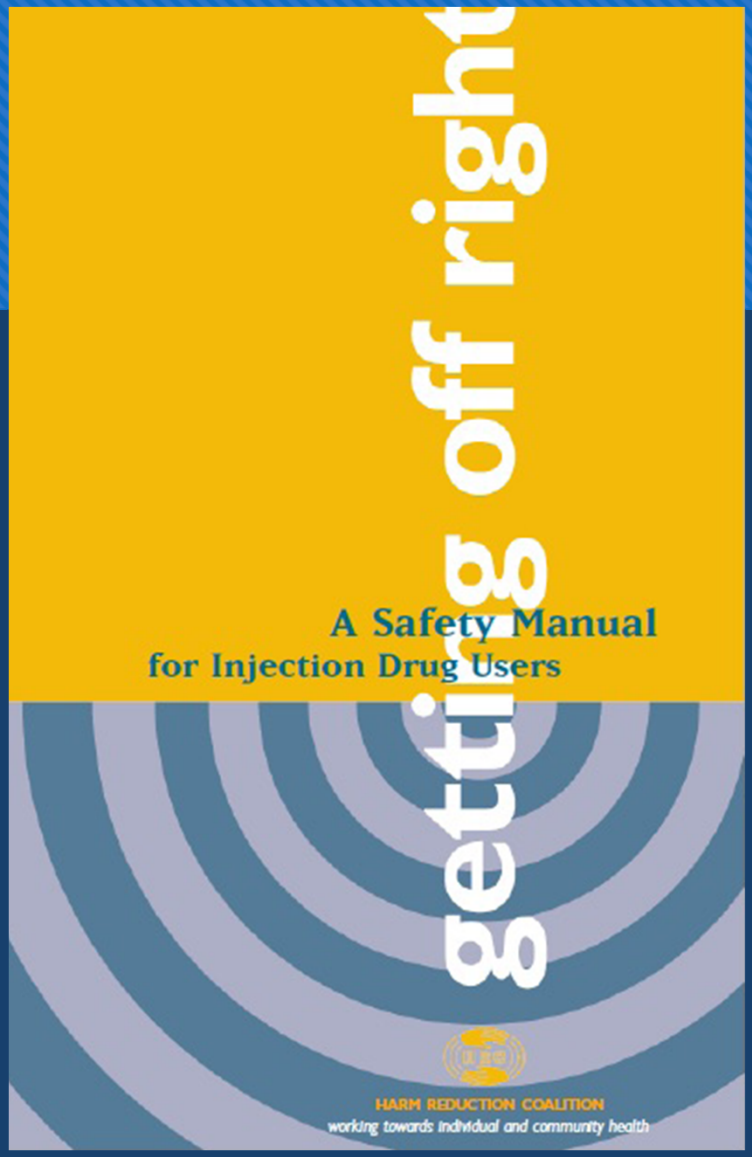
Strategy 5: Discuss Alternative Routes of Drug Use

Strategy 6: Discuss Safer Injecting Practices

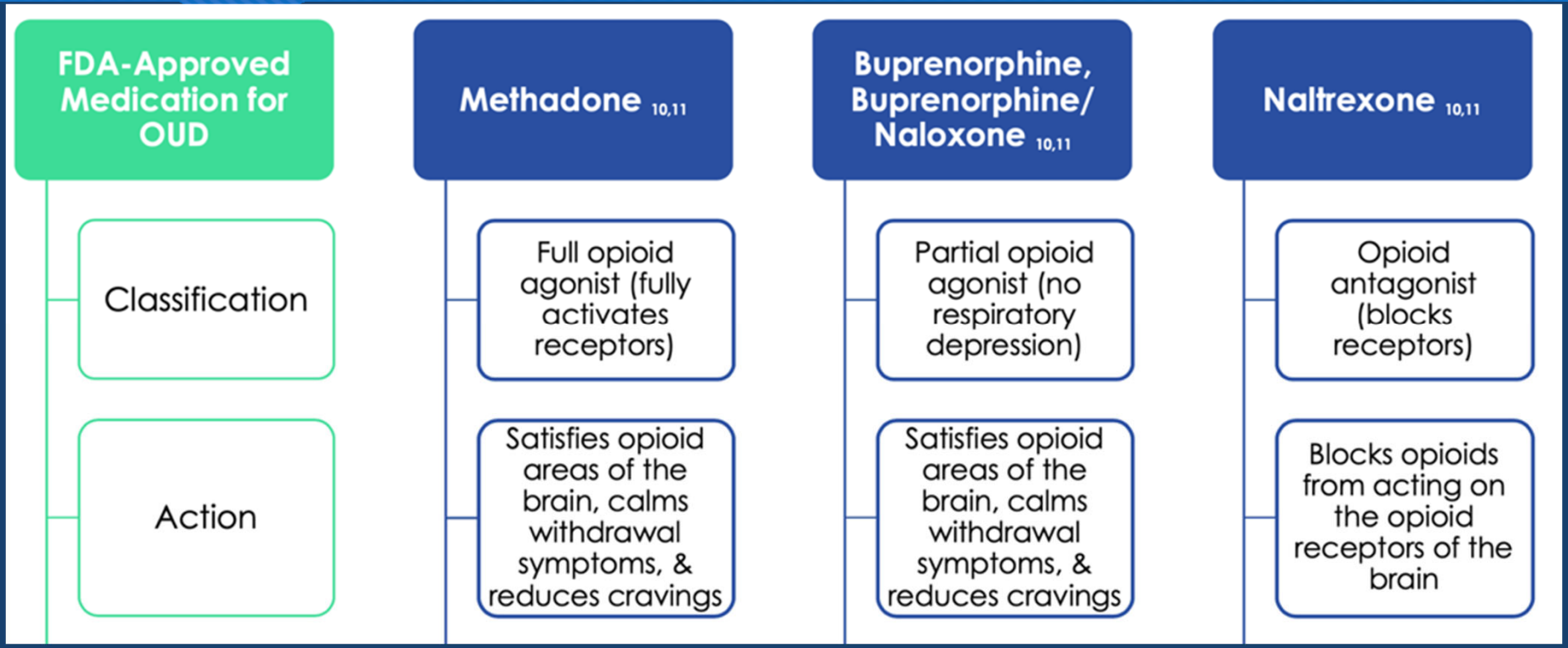
- Ask: "How do you prevent injury to your veins and infections?"
  - Wash hands or use hand sanitizer/ alcohol
  - Tourniquet improves vein access (fewer needle sticks, less risk for infection)
  - Bevel up to avoid going through the vein
  - Recognize valves in veins and inject above
  - Recognize infections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

FOR MORE ON SAFER INJECTION PRACTICES

Find at
HarmReduction.org



Strategy 7: Review MOUD/ MAT Options Postpartum



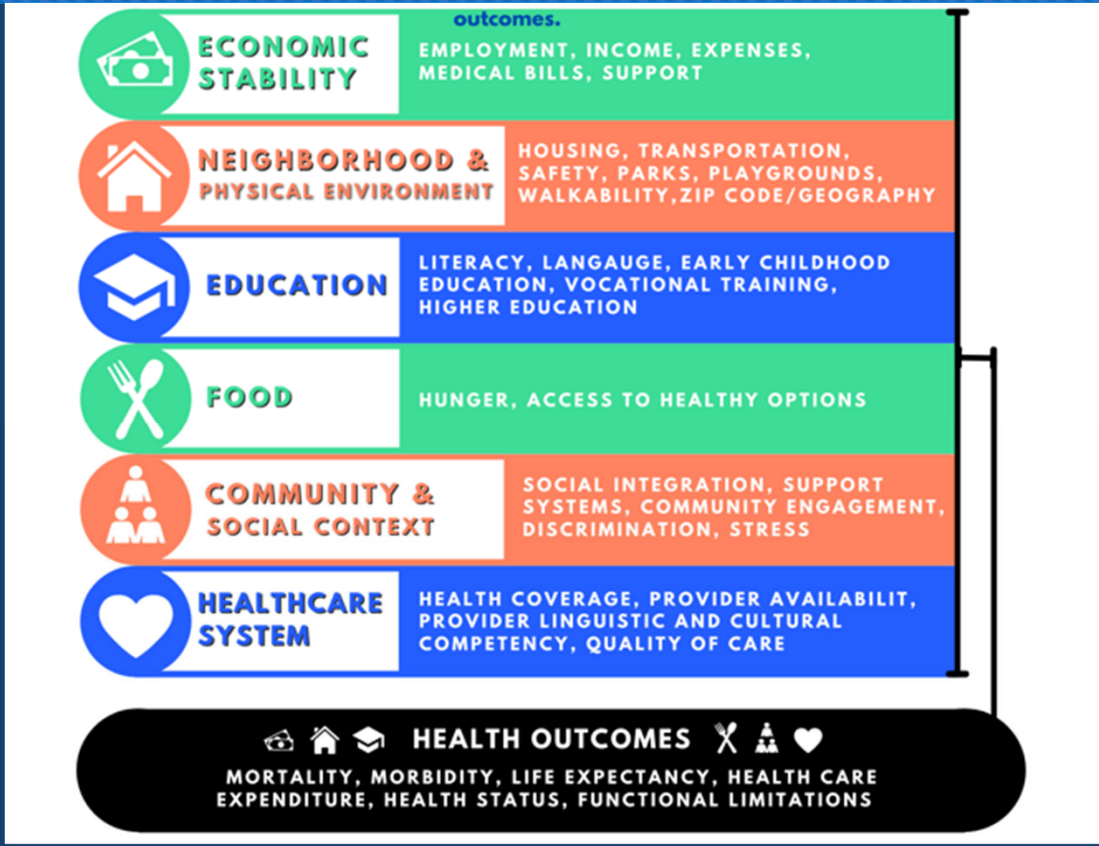
https://mypages.unh.edu/sites/default/files/harmreductionproject/files/compassionate_care_detailing_6.23.19_0.pdf

Compassionate Pharmacology for Opioid Withdrawal

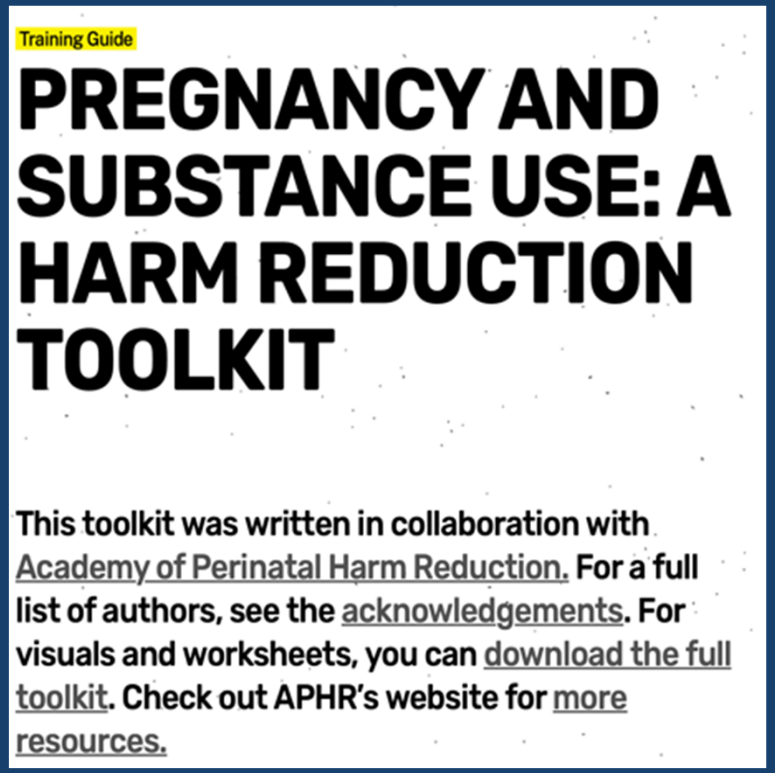
Anxiety/Sweating 	• **Clonidine** (Rx) start 0.1 mg by mouth every six hours PRN, not more than 0.4 mg/ day Avoid if blood pressure is <90/<50 mm Hg or heart rate is <50 bpm [12] • **Lofexidine** (Rx) Start 3 (0.18 mg) tablets every 5-6 hr as needed (max 16 tablets/day) Taper dose over 2-4 days to stop [Only FDA approved med for opioid withdrawal] [13]
Insomnia 	• **Trazodone** (Rx) 50-100 mg by mouth at bedtime [12,14]
Diarrhea 	• **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]
Nausea/vomiting 	• **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]
Abdominal cramping 	• **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

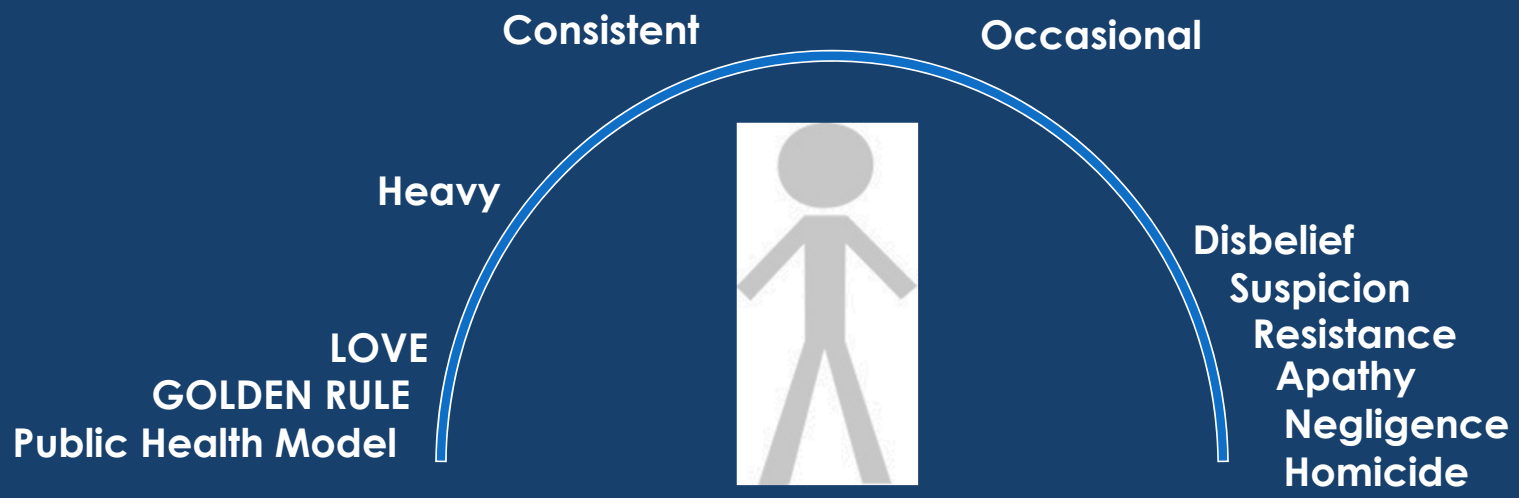
PREGNANCY AND SUBSTANCE USE: A HARM REDUCTION TOOLKIT

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.

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


NHHRC
HOME
ABOUT US
DONATE
RESOURCES
SYRINGE SERVICES PROGRAMS
CONTACT
COVID-19 RESPONSE
NHHRC
NH Harm Reduction Coalition
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.

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Stay in touch….

Victoria.A.Flanagan@hitchcock.org
Daisy.J.Goodman@hitchcock.org

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK