WELCOME!

• We will begin shortly.
• **Please type your name and email into the chat box for attendance.**
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• 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
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.
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.

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.
Current AIM States

Maternity Mortality Surveillance
New Hampshire Presentation

Ellen Stickney, RN, BSN, RNC-OB
Ellen.T.Stickney@dhhs.nh.gov
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 #: 
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
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
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)

Abstinence
Occasional/Social
Experimentation

Regular

Heavy
Chaotic

Refuge From suffering/social losses

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 Drugs**

**ATTITUDE**

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

**RECEPTION**

- Narrow scope of care
- Lost opportunities

**ACTION**

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

**OUTCOME**

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

- Individual might disconnect from care

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

- Educating
- Aligning

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

- 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?
“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.”

Strategy 1: Overdose Prevention
For Addicted Women, the Year After Childbirth Is the Deadliest

Overdose Prevention

.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/
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.

Strategy 2: Safety Planning Specific to Postpartum Period

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 ODOS reverses the effects of fentanyl.

A drug-free period will lower your tolerance.
- Your tolerance can drop in 1-2 days (You still take opioids for any reason, such as if you take a break for a few days, days, are in the hospital or in jail).
- Using the same amount of drug often reduces the risk of an overdose.
- Mixing drugs, medications, and alcohol increases the risk of overdose.
  - Alcohol and drugs (such as Xanax, Adderall, Xolair, 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 of an affected person.
- 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/drug_overdose.
- Tell those you trust how to use naloxone.

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 test, call or check in on you 3-5 minutes after you use drugs to make sure you are ok.

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 social crisis or emotional distress 24 hours a day, 7 days a week. 1-800-273-TALK (1-800-273-8255) or text “SOS” 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 kits:

My tips (e.g., name of syringe exchange program [SIP] contact, phone number, and other resources):

SIP hours:

GENERAL HARM REDUCTION STRATEGIES

- Keep track of how much you use. This may reduce your use, even if that was not your original goal.
- Make a list of the pros and cons of stopping and continuing to use.
- Avoid using opioids, benzos, alcohol, or other depressants (downers) when you are alone, if possible.
- Set limits on when and where you use, like waiting until after 5:00 to drink.
- Attend support groups like Moderation Management, SMART Recovery, Narcotics Anonymous, or Alcoholics Anonymous.
- 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.
- Avoid driving or making important decisions when using drugs.
- Take good care of your body in general, like eating healthy and getting enough sleep, exercise, and water.
- Make a parenting plan. Before any substance use - including alcohol use - arrange for childcare if necessary.
- Switch to a safer method. See Getting Off Right Safety Manual.

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.

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.

https://neverusealone.com
# Best Practices

## Human Milk and Substance Exposure

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### Substance

<table>
<thead>
<tr>
<th>Substance</th>
<th>Best Practices</th>
<th>Evidence</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Pump or feed before you drink. Wait 3-4 hours after each alcohol serving before providing milk to the baby.</td>
<td>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.</td>
<td>1, 2</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Take medication as prescribed. Feed the baby. Watch for signs of sedation.</td>
<td>Most benzodiazepines are considered safe or moderately safe at therapeutic doses. Infants exposed to benzodiazepines via breastfeeding may exhibit signs of sedation, such as apnea.</td>
<td>3</td>
</tr>
<tr>
<td>Cannabis</td>
<td>It is safest to reduce or eliminate use during the lactation period. 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.</td>
<td>Cannabis transfer rate into human milk is estimated to be 0.8-1% of maternal dose. Bioavailability is incomplete in infants' GI tract. So infants absorb 0.1% of the parent's dose. Little data on the effects of exposure via breast milk, with inconclusive results.</td>
<td>5, 6, 7</td>
</tr>
<tr>
<td>Opioids</td>
<td>Long- or short-term opiate use is not a contraindication to breastfeeding, regardless of dose. Because of individual differences in metabolism, codeine is not recommended while breastfeeding, due to risk of infant overdose.</td>
<td>Most opioids transfer into human milk at rates estimated at 1-3% of maternal dose. Because bioavailability is poor in infants' gastrointestinal tracts, it is likely that even less is absorbed.</td>
<td>10, 16</td>
</tr>
<tr>
<td>Stimulants</td>
<td>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. Caffeine doses of ≤ 200mg are considered safe for lactation.</td>
<td>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.</td>
<td>14, 18, 19, 20</td>
</tr>
<tr>
<td>Smoking</td>
<td>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.</td>
<td>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.</td>
<td>5, 23</td>
</tr>
</tbody>
</table>

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**Joelle Puccio BSN RN**  
Email: Joelle@perinatalharmreduction.org

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[Link to References](https://www.perinatalharmreduction.org/NANN)
Strategy 3: Empower

Academy of Perinatal Harm Reduction
https://56861659-e768-4f0b-9ee4-93fddd29.filesusr.com/ugd/f31cc3_6d0b48ee5fb406d915d82e6de1f5.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

- 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

Abrupt Discontinuation of Opioid Prescriptions

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)

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)

Trauma

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)

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)

Injection drug use

So they took me in and did surgery and they put me on, um oxycontins 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)

Escalation of use

So they took me in and did surgery and they put me on, um oxycontins 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)

Key:
Themes Subthemes

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.
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
FOR MORE ON SAFER INJECTION PRACTICES

Find at HarmReduction.org
Strategy 7: Review MOUD/ MAT Options Postpartum

**FDA-Approved Medication for OUD**

- **Classification**
- **Action**

**Methadone**
- Full opioid agonist (fully activates receptors)
- Satisfies opioid areas of the brain, calms withdrawal symptoms, & reduces cravings

**Buprenorphine, Buprenorphine/Naloxone**
- Partial opioid agonist (no respiratory depression)
- Satisfies opioid areas of the brain, calms withdrawal symptoms, & reduces cravings

**Naltrexone**
- Opioid antagonist (blocks receptors)
- Blocks opioids from acting on the opioid receptors of the brain

Compassionate Pharmacology for Opioid Withdrawal

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
<th>Dosing Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/Sweating</td>
<td>Clonidine (Rx)</td>
<td>Start 0.1 mg by mouth every six hours PRN, not more than 0.4 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoid if blood pressure is &lt;90/&lt;50 mm Hg or heart rate is &lt;50 bpm</td>
</tr>
<tr>
<td></td>
<td>Lofexidene (Rx)</td>
<td>Start 3 (0.18 mg) tablets every 5-6 hr as needed (max 16 tablets/day)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taper dose over 2-4 days to stop [Only FDA approved med for opioid withdrawal]</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Trazodone (Rx)</td>
<td>50-100 mg by mouth at bedtime</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide (OTC)</td>
<td>4 mg by mouth initially, then 2 mg with loose stools (max 16 mg/day)</td>
</tr>
<tr>
<td></td>
<td>Bismuth subsalicylate (OTC)</td>
<td>524 mg by mouth every 30 minutes-1 hr</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>Ondansetron (Rx)</td>
<td>4 mg by mouth every 8 hours as needed</td>
</tr>
<tr>
<td></td>
<td>Promethazine (Rx)</td>
<td>25 mg by mouth or rectally every 6 hours as needed</td>
</tr>
<tr>
<td></td>
<td>Prochlorperazine (Rx)</td>
<td>5-10 mg by mouth every 4 hours as needed</td>
</tr>
<tr>
<td>Abdominal cramping</td>
<td>Dicyclomine (Rx)</td>
<td>20 mg by mouth every 6-8 hours as needed</td>
</tr>
</tbody>
</table>

Strategy 8: Collaboration

- **Economic Stability**: Employment, income, expenses, medical bills, support
- **Neighborhood & Physical Environment**: Housing, transportation, safety, parks, playgrounds, walkability, zip code/geography
- **Education**: Literacy, language, early childhood education, vocational training, higher education
- **Food**: Hunger, access to healthy options
- **Community & Social Context**: Social integration, support systems, community engagement, discrimination, stress
- **Healthcare System**: Health coverage, provider availability, provider linguistic and cultural competency, quality of care

**Health Outcomes**: Mortality, morbidity, life expectancy, health care expenditure, health status, functional limitations
Strategy 9: Ongoing implementation of harm reduction strategies


https://www.perinatalharmreduction.org/
A Continuum of Harm Reduction Integration

Consistent

LOVE
GOLDEN RULE
Public Health Model

Heavy

Disbelief
Suspicion
Resistance
Apathy
Negligence
Homicide

Occasional
QUESTIONS
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….

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