HRSA
Health Resources & Services Administration

Perinatal Substance Use Disorder (SUD):

Practice, Policy, and Equity Considerations for Providing Care in the Fourth Trimester and Beyond

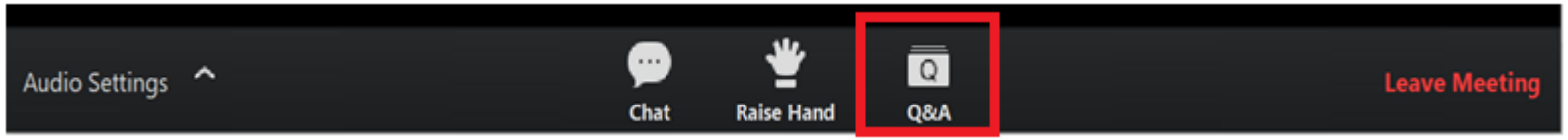
Friday, June 17, 2022

1:00 – 2:00 p.m. ET

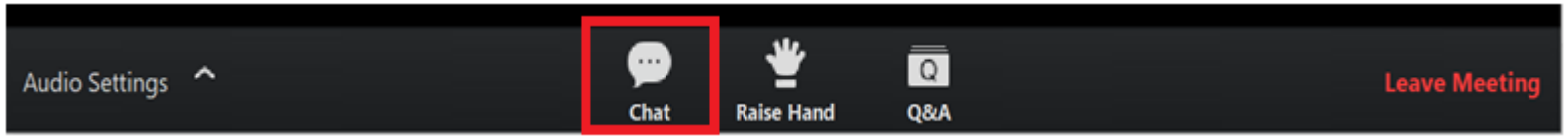
Vision: Healthy Communities, Healthy People

Submitting Questions and Comments

- Submit questions by using the Q&A feature. To open your Q&A window, click the Q&A icon on the bottom center of your Zoom window.



- If you experience any technical issues during the information session, please message us through the chat feature, or email healthcenter_BHTA@jbsinternational.com.



Continuing Education (CE)

- We will be offering **1 CE credit** for attending today's workshop session.
- You **must** complete the Health Center Satisfaction Assessment at the end of the workshop.
- We will provide more information about how to complete the Satisfaction Assessment and details about applying for CEs at the end of the workshop.

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

Agenda

- Introductions and overview
- Data and risk factors related to SUD in maternal morbidity and mortality in the fourth trimester
- Barriers to treatment and recovery
- Practice recommendations to decrease stigma and to improve screening
- Federal and state policy levers and resources
- Q&A and wrap-up

HRSA Opening Remarks

Larry Horlamus
Deputy Director of the Quality Division
Office of Quality Improvement
Bureau of Primary Health Care (BPHC)
HRSA

Health Center Workforce Well-being Survey

- Will Launch in Fall 2022
- Developed in Collaboration with Health Center Staff
  - Listening sessions
  - Cognitive testing
  - Pilot testing
- Your Voice Matters!
  - All full-time and part-time staff at HRSA-funded health centers will be invited to give input on factors that affect workforce well-being, job satisfaction, and burnout

Submit questions about the survey or the Workforce Well-being Initiative via the BPHC Contact form or call 877-464-4772 from 8:00 a.m. to 8:00 p.m. ET, Monday-Friday (except federal holidays).

HRSA Health Center Program

Executive Summary

2020 UDS Data

Increased Access to Care

+ 770 service delivery sites for a total of 13,555

1 in 5 rural residents are served via the health center program

Improved Delivery of Services

+ 1,267 MAT eligible providers for a total of 8,362

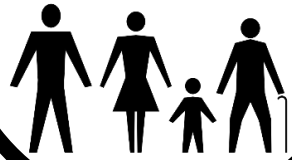
+ 2,144 full-time equivalents for a total of 255,012

Advanced Quality of Care

79% of health centers met or exceeded one or more national benchmarks

55% of HCs improved in **5** or more Clinical Quality Measures

Addressed Public Health Emergency



99.05% of health centers offered telehealth services

3,732,745 health center patients received diagnostic tests for novel coronavirus

Source: Uniform Data System, 2020.
Note: 1,370 health centers were funded in 2019 & 2020.

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Behavioral Health Access Summary

2019 to 2020

Behavioral Health and Telehealth

- ✓ **51.75%** Mental Health visits were virtual
- ✓ **33.06%** SUD visits were virtual
- ✓ **Over 90%** of Health Centers offered Mental Health and/or SUD services via telehealth

Substance Use Disorder

+ **8.81%** in providers offering treatment and care

Mental Health

+ 15.11% in visits

+ 6.97% in providers

Source: Uniform Data System 2019 & 2020, Tables 5, 6A, 6B, 7

* New Measure for 2020 UDS

HRSA Health Center Program

Presenter

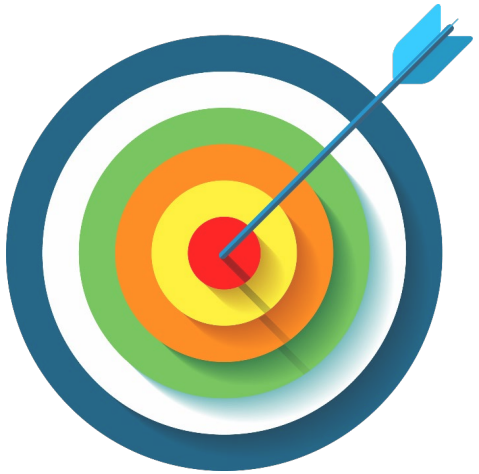
Kari Earle, MEd
Technical Expert Lead
JBS International, Inc. (JBS)

Perinatal SUD:

Practice, Policy, and Equity Considerations for Providing Care in the Fourth Trimester and Beyond

HRSA Health Center Program

Objectives



Source: iStock

Participants of this webinar will be able to:

- Recognize SUD-related risk factors contributing to the rise of maternal morbidity and mortality in the fourth trimester
- Identify barriers to treatment and recovery within postpartum individuals with SUD
- Detect strategies that can advance evidence-based care to better support postpartum individuals with SUD
- Discover federal and state policy levers and resources that are available to improve maternal health outcomes and address health care inequities experienced by pregnant and parenting individuals with SUD

Understanding How SUD Contributes to Maternal Morbidity and Mortality in the Fourth Trimester

Data and Risk Factors

Moms Are Not Okay!

Mental and substance use disorders, suicide, and overdoses are the leading cause of preventable maternal deaths in the United States.

A recent study that examined 33 states from 2010-2019 found drug-related deaths, suicide, and homicide accounted for 22.2% of pregnancy-associated deaths. All 3 causes of death **increased** over the study period, with drug-related, pregnancy-associated deaths increasing 190%.

(Campbell et al., 2021; Margerison et al., 2022)

Moms Are Not Okay! (cont.)

Up to 1 in 5 women suffer from maternal mental health (MMH) disorders in the U.S. each year. Research shows this number doubled during the pandemic.

- Pregnant people or people who may become pregnant are especially vulnerable to SUDs. Women are most at risk of developing an SUD during their reproductive (18–44) year .
- Among women of childbearing age who have SUDs, the unintended pregnancy rate is approximately 80%.

(Motrico et al., 2021; Forray, 2016; Krans & Patrick, 2016)

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Risk Factors

The social controversy surrounding how pregnant women with SUD are viewed in the U.S.—as criminals rather than as women suffering from a treatable illness—has created a barrier to accessing prenatal services.

Women who use opioids and/or illicit substances during pregnancy have higher mean hospitalization costs and poorer maternal and fetal birth outcomes.

Women with SUD are at higher risk for perinatal mood and anxiety disorders.

(Nussey et al., 2020; Fältmarch et al., 2019; McKee et al., 2020)

Postpartum – The 4th Trimester

While pregnancy is a “window of opportunity” for enhanced maternal investment in behavior change, postpartum is a time of “unique vulnerability” that is associated with increased risk of relapse and treatment discontinuation.

- Increased stress associated with motherhood, newborn care, sleep deprivation
- Limited social support and resource availability
- Increased financial demands
- Pain and physical recovery from delivery
- Physiologic transition from pregnant to nonpregnant state

Additional Risk Factors

Trauma:

- Childhood, historical, and intimate partner violence

Stigma:

- Stigma from providers, community, and self

Pregnancy Complications:

- Preeclampsia, infection, low birth weight, and premature delivery

Inadequate Prenatal Care:

- Pregnancy unplanned or undetected and fear of punitive or shaming response

Social Determinants of Health (SDOH):

- Poverty, homelessness, lack of social support, unemployment, language and cultural barriers

Identifying Barriers to Treatment and Recovery

Individual, Cultural, and Systemic

Individual Barriers

Pregnant and parenting individuals with SUD experience extreme stigma associated with maternal identity on multiple levels:

- External stigma - disparate or inequitable treatment or care based on others' judgement.
- Internal stigma - shame and fear of being perceived as a "bad mother"
- Disclosure stigma - anticipated discrimination if symptoms or diagnosis are disclosed to others

(Moore et al., 2017)

Cultural Barriers

- Individuals who face racial or economic inequities more likely to experience MMH conditions, including SUD, but less likely to get help.
- Historical traumas creating barriers for women seeking care:
  - Cultural transmission is disrupted.
  - Intergenerational trauma affects one's physiological being, behavior, mental, spiritual, emotions, and social
  - Substance use is a prime factor in most of the child welfare cases among American Indian and Alaska Native communities.
- Mistrust of the health care and social serving systems:
  - SUD in pregnancy possibly leading to multiple system encounters (e.g., health care, child welfare, and justice systems)
  - Drug testing without consent
  - Fear of losing children after forced removals of the past
- Mistrust of medication to treat SUD (MAT/MOUD)

Systemic Barriers

- Screening for SUD in pregnancy is limited and unevenly applied.
- Even when an SUD is identified, referral and linkage to treatment does not occur.
- Fewer than 25% of treatment facilities provide specialized care for pregnant individuals suffering from SUD, and only 8% offer dedicated treatment and 1 or more medications approved for opioid use disorder, such as buprenorphine.
- Even fewer treatment facilities accept Medicaid and offer childcare or residential beds for their patients' children.

Systemic Barriers (cont.)

Reimbursement and Financing Complexity

Workforce Limitations

Provider knowledge of this population

Staffing shortages

Maternal and child health “deserts”

Barriers to Collaboration

Competing priorities

Information and data sharing

Conflicting values

Cultural Responsiveness

Decreasing Stigma, Improving Screening, Integrating Care, and Better Care Coordination

Practice Recommendations

"The parent-child connection is the most powerful mental health intervention known to mankind."

- Bessel van der Kolk

Source: Microsoft® PowerPoint®

Reducing Stigma

Assess	Assess policies and practice that are rooted in stigma rather than in science.
Engage	Engage in honest and open discussions about values and beliefs.
Identify	Identify any areas of disagreement.
Offer	Offer education and training to resolve misunderstanding.
Ensure	Ensure supportive practices and policies.
Use	Use person-centered language.

Source: Microsoft® PowerPoint®

Supporting Postpartum Mothers

- Understand guilt, shame, and stigma.
- Recognize and address anxiety and mood disorders.
- Ensure all needed services are available to women postpartum.
- Allow mothers and children to remain together, whenever possible.
- Understand that parenting in recovery requires new skills and ongoing support.

Mom Is Medicine!

- **Rooming-in should be offered to all mother-baby dyads:**
  - Reduces need for medication
  - Shortens hospital stay
  - Facilitates breastfeeding
- **Breastfeeding is safe in most cases:**
  - Breastfeeding has positive physical and behavioral effects for the mother-infant dyad.
  - The amount of medication to which the baby is exposed via breast milk is extremely small, while the risk of harm to the infant from the mother's return to substance use is much greater.
  - Women who are stable on buprenorphine, combination buprenorphine/naloxone, or methadone should be advised to breastfeed, if appropriate.
  - Women living with HIV or with ongoing, illicit drug use should not breastfeed.

Coordinated Discharge Planning

MOTHER

- Screen for and address any existing maternal comorbid medical or psychiatric condition.
- Recognize that physiological changes after delivery, stress, and sleep deprivation may exacerbate these conditions or trigger a return to some form of substance use.
- Develop a safe-care plan. Include strategies for the new mother to get immediate and nonjudgmental assistance if she feels she is or may become unstable.

BABY

- Mothers who have been discharged but whose infants remain in the hospital for pharmacotherapy should be invited to stay with their infants, as this promotes rooming-in and other nonpharmacological interventions.
- Discharge plans should include home visitation and early intervention services.
- Referrals should be made to health care professionals and peer specialists, who are knowledgeable about neonatal abstinence syndrome (NAS) and accessible to the family immediately after discharge.

Mother and infant should leave the hospital at the same time.

Collaborative Partners and Resources

- The Woman and Her Family
- Health Providers (OB/Gyn, Pediatrician, Family Practice)
- MOUD/MAT Providers
- SUD Treatment Providers
- Key Agencies/Community-Based Support

Partnering With Mom and Other Caregivers

- Invite members of the collaborative team to meet with the pregnant woman and other family members before delivery; she should know the whole team.
- After delivery, continue to establish a therapeutic relationship with parents/caregivers and engage and empower parents to be involved with the care of their newborn.
- Include peer recovery coaches.
- Provide:
  - Education and support for the benefits to the baby of breastfeeding and skin-to-skin contact
  - Education on the importance of a healthy home environment and how to connect with home visiting
  - Information about family planning and contraception options
- Develop a dyad-centered plan of safe care.

Partnering With Other Health Care Providers

- Educate clinical providers and staff regarding:
  - NAS/neonatal opioid withdrawal syndrome identification, evaluation, and treatment of the newborn
  - Supportive, nonjudgmental interactions with parents
- Educate all providers and administrative staff on opioid use disorder (OUD) in pregnancy and on strategies for caring for patients with OUD and develop protocols that address all team members' roles.
- Provide health care providers with anti-stigma education/resources.
- Communicate directly with the outpatient primary care provider, prior to the newborn leaving the hospital, to review the hospital course and to discuss follow-up.
- Implement a warm-handoff strategy to follow at time of discharge.

Partnering With Key Agencies and Community-Based Supports

- Identify community care resources for the mother and her newborn and appropriate partnering agencies and services in the community.
- Maintain an updated list of outpatient resources (federal, state, and local) that families can access.
- Inform and educate mothers and other caregivers, as appropriate, on these referrals, and highlight the benefits of these programs.
- Recommend early intervention programs, child-serving social services, and/or health care services to cover neurodevelopmental, psycho-behavioral, growth and nutrition, ophthalmologic, and family support assessments.
- Ensure linkage to home visitation programs or that other in-home supports are in place.
- Include a comprehensive release of information consent signature page to facilitate timely information sharing and coordination between organizations to ensure shared understanding and accountability.

Community Supports for Recovery

- Mutual aid/recovery support
- Housing that supports recovery
- Family preservation services
- Child care
- Transportation
- Legal aid
- Employment support
- Insurance coverage
- Temporary Assistance for Needy Families (TANF)/ Supplemental Nutrition Assistance Program (SNAP)/ Women, Infants, and Children (WIC) linkages
- Food and nutrition resources
- Cultural supports
- Connections to faith-based organizations, as appropriate and desired

Elements of Best Practice

- Integrated Perinatal and Behavioral Health Care
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Peer Support (Doulas, Peer Recovery Specialists, and Community Health Workers)
- Supportive Rather Than Punitive Response
- Harm Reduction
- Preservation of the Mother-Baby Dyad
- Whole Family Care

Improving Maternal Health Outcomes and Addressing Health Care Inequities

Policy Levers and Resources

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Policy Levers

- Extended postpartum care
  - The American Rescue Plan Act of 2021 gives states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP, beginning April 1, 2022.
- Medicaid policy:
  - Pilots innovation through 1115 waivers
  - Engages managed care organizations as partners
  - Expands coverage to a wider array of treatment benefits (e.g., peer support, telehealth)
  - Adopts a no-wrong-door approach
  - Addresses SDOH

Current Initiatives: White House

White House Call to Action to Reduce Maternal Morbidity and Mortality

- Expansion of Medicaid postpartum coverage
- Recommendation to CMS to establish a "birthing-friendly" hospital designation
- Investments in maternal health care and workforce innovations

White House Proclamation on Black Maternal Health Week

The President's discretionary funding request includes significant funding to reduce maternal mortality and morbidity rates, improve health equity, and end race-based disparities nationwide.

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Current Legislation: Congress

Into the Light for MMH and SUD Act (S. 3824/H.R. 7073)

- Reauthorize and fund existing MMH programs
- Fund states to create programs to address MMH conditions (e.g., psychiatric consultation services for obstetric providers, resources and referral programs, training for frontline providers)
- Expand allowable uses to include assistance for mothers receiving treatment, coordination with existing maternal and child health programs, programs that address disparities, and outreach and awareness
- Authorize a dedicated MMH Hotline, first appropriated in the FY21 Consolidated Appropriations Act (P.L. 116-260)

Moms Matter Act (S. 484/H.R. 909)

- Address MMH equity
- Create grants for community prevention, intervention, and treatment of MMH
- Grow and diversify the MMH workforce
- Passed House as part of the Build Back Better Act

Current Legislation: Congress (cont.)

TRIUMPH for New Moms Act (S. 2779/H.R. 4217)

- Improve federal MMH coordination
- Establish a National MMH Task Force to eliminate duplication and to identify opportunities to integrate MMH into existing federal programs
- Develop a strategy and recommendations for governors to improve MMH

FY23 Appropriations Requests

- Continue funding hotline and state grants
- Ask for:
  - Additional $2M for MMH Hotline text services, culturally appropriate support, and public awareness
  - Additional $5M for 5 more state grantees and technical assistance (TA) to nongrantee states

MATERNAL MENTAL HEALTH HOTLINE

Individuals experiencing MMH conditions have a new resource:
A National 24/7/365 Maternal Mental Health Hotline.
The MMH hotline -- staffed by Postpartum Support International -- provides voice and text support in both English and Spanish.

The MMH Hotline is staffed by licensed and credential mental health, medical, and community-based providers, as well as certified peer specialists.

Hotline staff will provide confidential support, information, brief intervention, and resources and referrals.

The Hotline is available for pregnancy, postpartum, and post-loss support.

Read the announcement from the Department of Health and Human Services.

1-833-9-HELP4MOMS
(1-833-943-5746)

Clipped from the 5/11/22 newsletter of the ***Maternal Mental Health Leadership Alliance | www.mmhla.org***

HRSA Health Center Program

Current Funding Opportunity

Reducing Maternal Deaths Due to Substance Use Disorder (Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services, Office on Women's Health)

- Deadline: July 11, 2022
- Funds projects designed to strengthen perinatal and postnatal support structures for patients with SUD through the following activities:
  - Partnering with hospital and community-based organizations to implement evidence-based interventions for patients with SUD to improve health outcomes and to reduce deaths
  - Creating a technologically innovative education and outreach product to provide support accessible to perinatal and postpartum patients with SUD at home and on the go to reduce triggers, decrease stress, and increase feelings of support
- Award ceiling: $300,000 per year, 3 years, with an option for a competitive fourth year

Q&A

TA Opportunities for Health Centers

- One-on-One Coaching
- Communities of Practices (CoPs)
- Virtual Intensive Training and TA (T/TA)
- SDOH Roundtables
- Office Hours
- Webinars

Accessing Additional T/TA Opportunities

BPHC BH TA PORTAL ONLINE REQUEST FORM

https://bphc-ta.jbsinternational.com/ta-request-form

EMAIL

healthcenter_BHTA@jbsinternational.com

BH TA WEEKLY UPDATE

healthcenter_BHTA@jbsinternational.com

Upcoming TA Opportunities in June/July 2022

Virtual Office Hours

June 23, 2022, from 12:00-1:00 p.m. ET

Pain Management Approaches in the Context of Integrated Health Care

https://bphc-ta.jbsinternational.com/event-calendar/pain-management-approaches-context-integrated-health-care

July 15, 2022, from 1:00-2:30 p.m. ET

Depression & Suicidality Among Men

https://bphc-ta.jbsinternational.com/event-calendar/depression-suicidality-among-men

CoPs

May 24 – August 30, 2022 (8 sessions),
from 2:00-3:30 p.m. ET

CoP 4: Addressing Substance Misuse and Use Disorder in a Healthcare Setting

https://us06web.zoom.us/meeting/register/tZYud-GprDgqHNH6cO8jO63ptcr55KpktgxP

INTENSIVE TA

Request Link: https://bphc-ta.jbsinternational.com/ta-request-form

CE Revisited

- We will be offering **1 CE credit** for attending today's training.
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Health Center Satisfaction Assessment

- **You MUST complete the Health Center Satisfaction Assessment after this session to receive CEs.**
- The link to the Satisfaction Assessment will automatically open in your browser at the conclusion of this webinar.
- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature; click the link now to have the browser open.
- We will also email you a link to the Satisfaction Assessment.

Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.

Thank you!

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Thank You!

Kari Earle, JBS Technical Expert Lead

References (in the order cited)

- Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *Journal of Women's Health, 30(2)*, 236–244. https://doi.org/10.1089/jwh.2020.8875
- Margerison, C. E., Roberts, M. H., Gemmill, A., & Goldman-Mellor, S. (2022). Pregnancy-associated deaths due to drugs, suicide, and homicide in the United States, 2010-2019. *Obstetrics & Gynecology, 139(2)*, 172–180. https://doi.org/10.1097/AOG.0000000000004649
- Motrico, E., Bina, R., Domínguez-Salas, S.,…& Mesquita, A. (2021). Impact of the Covid-19 pandemic on perinatal mental health (Riseup-PPD-COVID-19): Protocol for an international prospective cohort study. *BMC Public Health, 21*, 368. https://doi.org/10.1186/s12889-021-10330-w
- Forray, A. (2016). Substance use during pregnancy. *F1000Research*, 887. https://doi.org/10.12688/f1000research.7645.1
- Krans, E. E., & Patrick, S. W. (2016). Opioid use disorder in pregnancy: Health policy and practice in the midst of an epidemic. *Obstetrics & Gynecology, 128*(1), 4–10. https://doi.org/10.1097/AOG.0000000000001446
- Nussey, L., Hunter, A., Krueger, S., Malhi, R., Giglia, L., Seigel, S., ... & Darling, E. K. (2020). Sociodemographic characteristics and clinical outcomes of people receiving inadequate prenatal care: a retrospective cohort study. *Journal of Obstetrics and Gynaecology Canada*, *42*(5), 591–600. https://doi.org/10.1016/j.jogc.2019.08.005
- Fältmarch, S., Perttilä, I., Tuomi, U., Kautiainen, H., Gissler, M., Pennanen, P., ... & Laine, M. K. (2019). Use of opioids during pregnancy and effects of pregnancy outcomes. *Pharmacoepidemiology and Drug Safety*, *28*(9), 1239–1245. https://doi.org/10.1002/pds.4848
- McKee, K., Admon, L. K., Winkelman, T., Muzik, M., Hall, S., Dalton, V. K., & Zivin, K. (2020). Perinatal mood and anxiety disorders, serious mental illness, and delivery-related health outcomes, United States, 2006-2015. *BMC Women's Health, 20*(1), 150. https://doi.org/10.1186/s12905-020-00996-6
- Moore, D., Drey, N., & Ayers, S. (2017). Use of online forums for perinatal mental illness, stigma, and disclosure: An exploratory model. *JMIR Mental Health, 4(1)*, e6. https://doi.org/10.2196/mental.5926