Opioid Response Network

Tribal Response to Caring for Pregnant Woman and Families

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Opioid Response Network

Introduction

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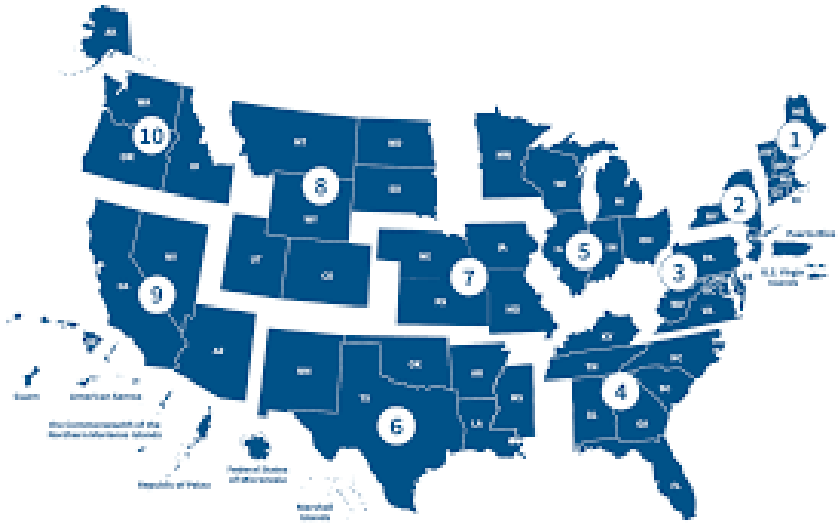
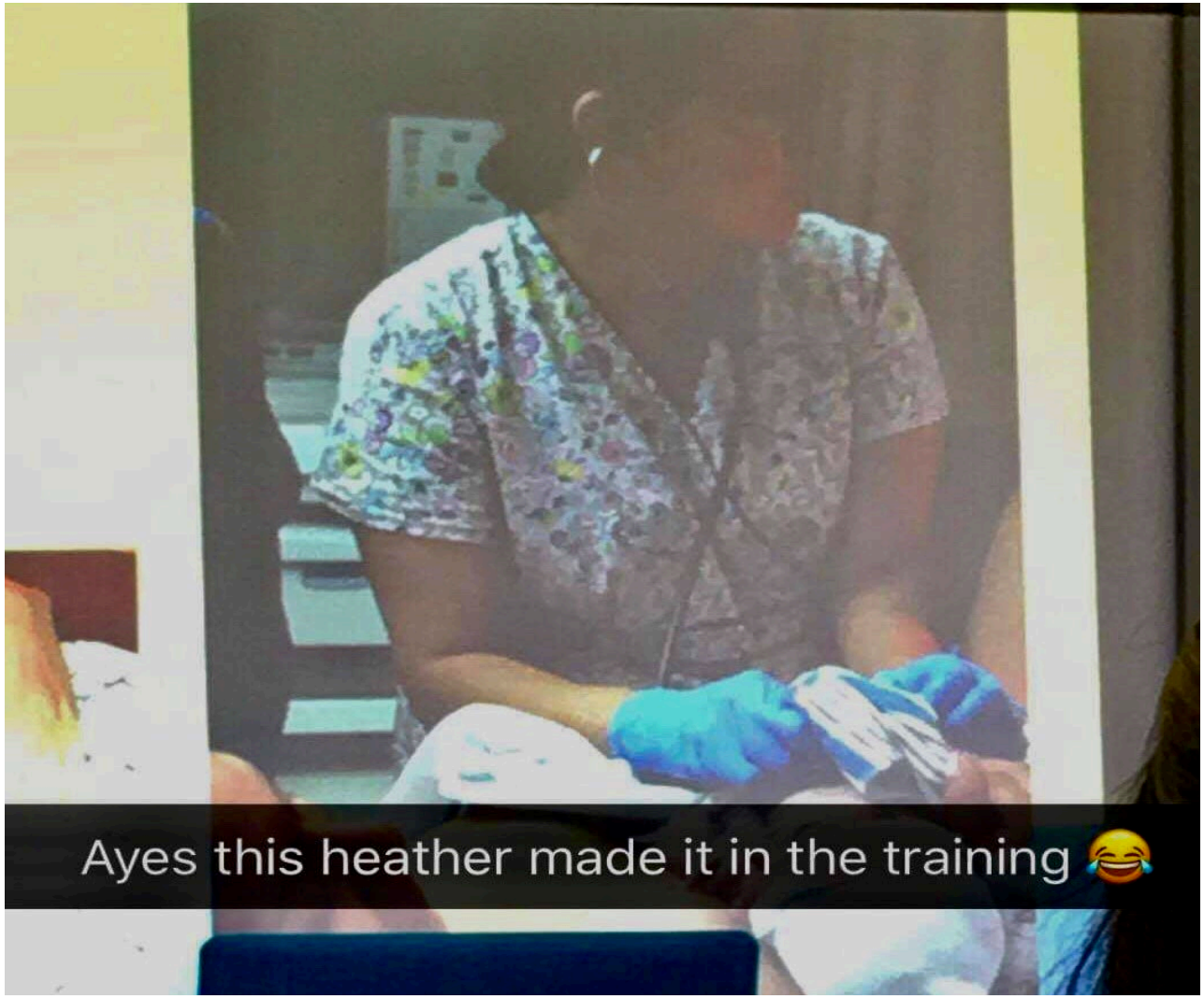


Nurse Heather



Working with communities.

- The SAMHSA-funded *Opioid Response Network (ORN)* assists states, organizations and individuals by providing the resources and technical assistance they need locally to address the opioid crisis and stimulant use.
- Technical assistance is available to support the evidence-based prevention, treatment and recovery of opioid use disorders and stimulant use disorders.

Working with communities.

- The *Opioid Response Network (ORN)* provides local, experienced consultants in prevention, harm reduction, treatment and recovery to communities and organizations to help address this opioid crisis and stimulant use.
- *ORN* accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Contact the Opioid Response Network

- To ask questions or submit a technical assistance request:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org
  - Call 401-270-5900

Substance Abuse and Mental Health Services Administration (SAMHSA)

Funding for this initiative was made possible (in part) by grant no. 1H79TI085588-02 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Approach: To build on existing efforts, enhance, refine and fill in gaps when needed while avoiding duplication and not "re-creating the wheel."

Overall Mission

To provide training and technical assistance via local experts to enhance **prevention**, **treatment** (especially medications like buprenorphine, naltrexone and methadone) and **recovery** efforts across the country addressing state and local - specific needs.

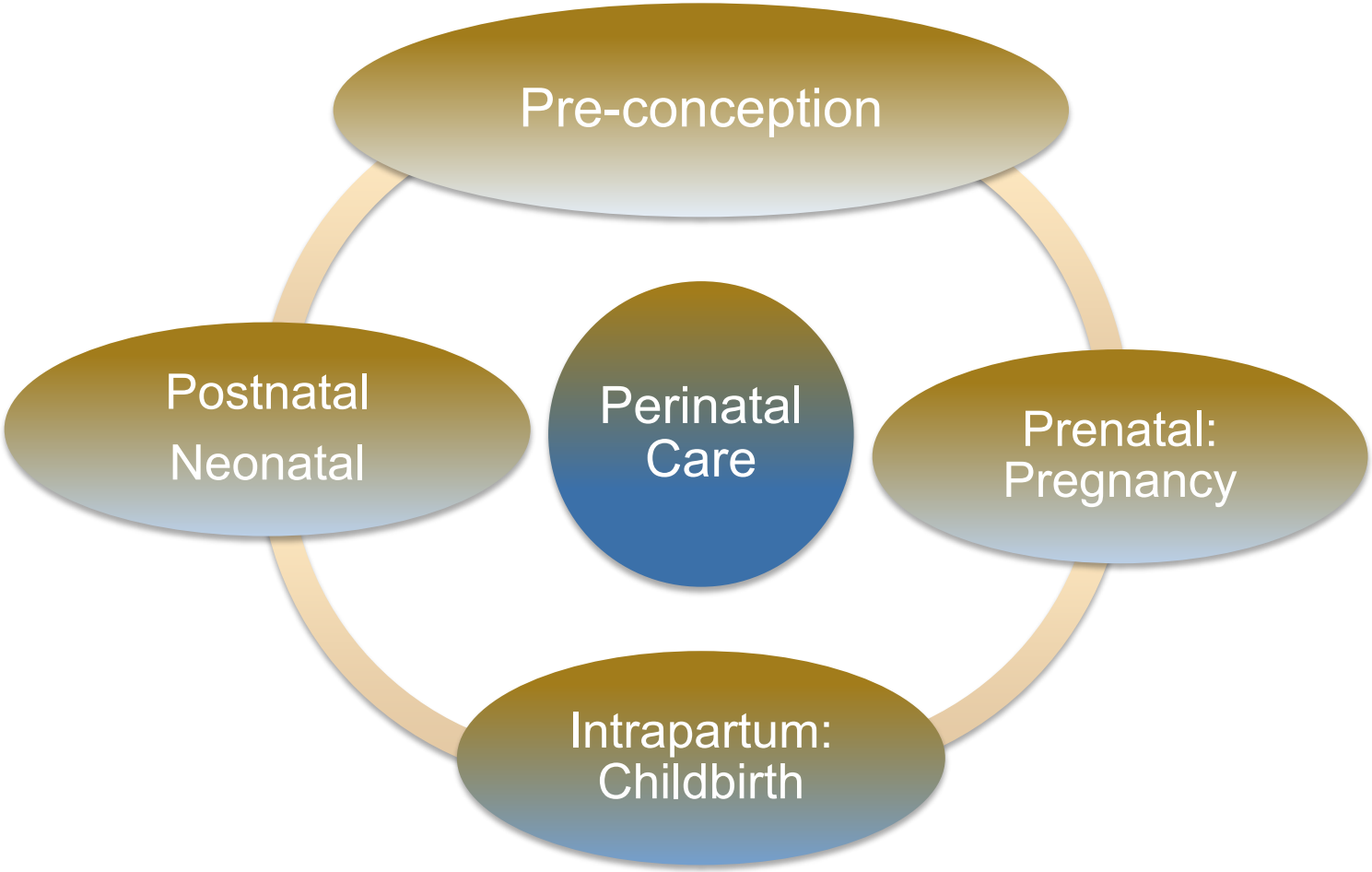
Objectives

- Identify one (1) goal of Maternal Health.
- Name four (4) perinatal care concepts
- Identify two (2) Causes of Pregnancy-related deaths among the AI/AN population.
- Identify two (2) risk assessment tools used in perinatal care.
- Identify two (2) culturally adapted resources available to guide AI/AN perinatal care.

Maternal Health #Goals

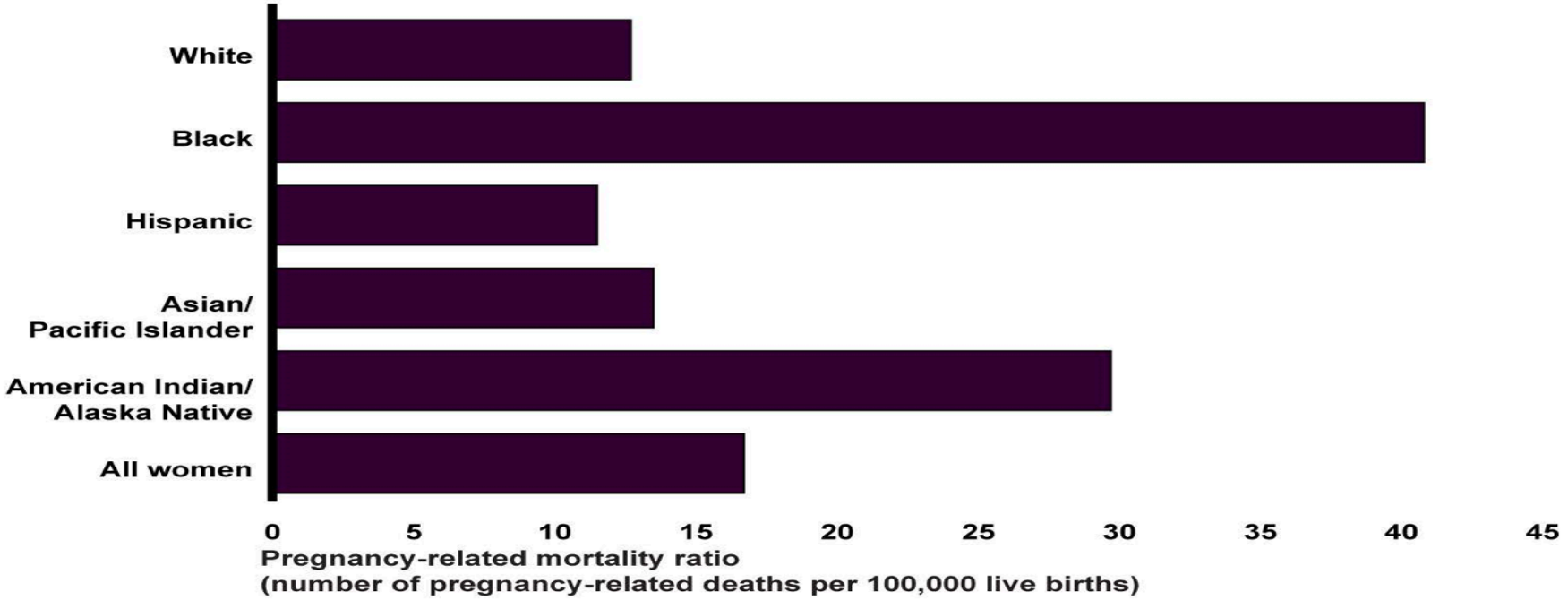
Prevent maternal and neonatal death and disease.

Perinatal Care
Preconception - Prevention



Morbidity and mortality report in pregnancy related deaths

Figure: Pregnancy-Related Deaths per 100,000 Live Births by Racial/Ethnic Group, 2007-2016



Source: Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, September 2019. | GAO-20-248

Pregnancy-related deaths among AI/AN

Table 1. Underlying causes of pregnancy-related death among American Indian or Alaska Native persons, data from Maternal Mortality Review Committees in 36 US states, 2017-2019.[1]

	N	%
Mental health conditions[2]	5	31.3
Hemorrhage[3]	3	18.8
Amniotic fluid embolism	2	12.5
Infection	2	12.5
Cardiac and coronary conditions[4]	1	6.3
Collagen vascular/autoimmune diseases	1	6.3
Conditions unique to pregnancy[5]	1	6.3
Injury[6]	1	6.3

Mental Health Conditions

- Suicide
- Overdose/poisoning related to substance use disorder,
- other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder.

CDC, 2022

Landscape of opioid Use Disorder in American Indian Maternal Child Care

- Since 1999, every racial demographic has seen an increase in overdoses.
- American Indian and Alaska Native (AI/AN) women have the **highest risk** of dying from a prescription opioid overdose.
- Low-income women and women of color are at higher risk for barriers to appropriate care for substance use disorders during pregnancy. **Native women with opioid use disorder (OUD) encounter specific barriers to accessing services for treatment.**
- The Centers for Disease Control and Prevention reports that between 2011 and 2015 approximately 700 women died from pregnancy- related complications each year in the US. On average, 10 to 13 of those deaths each year were American Indian and Alaska Native women.

IHS, 2017

Landscape of opioid Use Disorder in Maternal Child Care

- In 2015 there were more past-year initiates of **prescription opioid misuse among women**
  - (1.2 million – 0.9%) than men (0.9 million – 0.7%)(2)
- There are still more male than female adults who use heroin, **heroin use is increasing twice as fast among women than men**(2)
- Nearly **50%** of pregnant substance use disorder treatment admissions are for opioids(1)
- **Overdose** mortality has surpassed **hemorrhage, pre-eclampsia and sepsis** as a cause of pregnancy-associated death(2)

Prevention is #goals

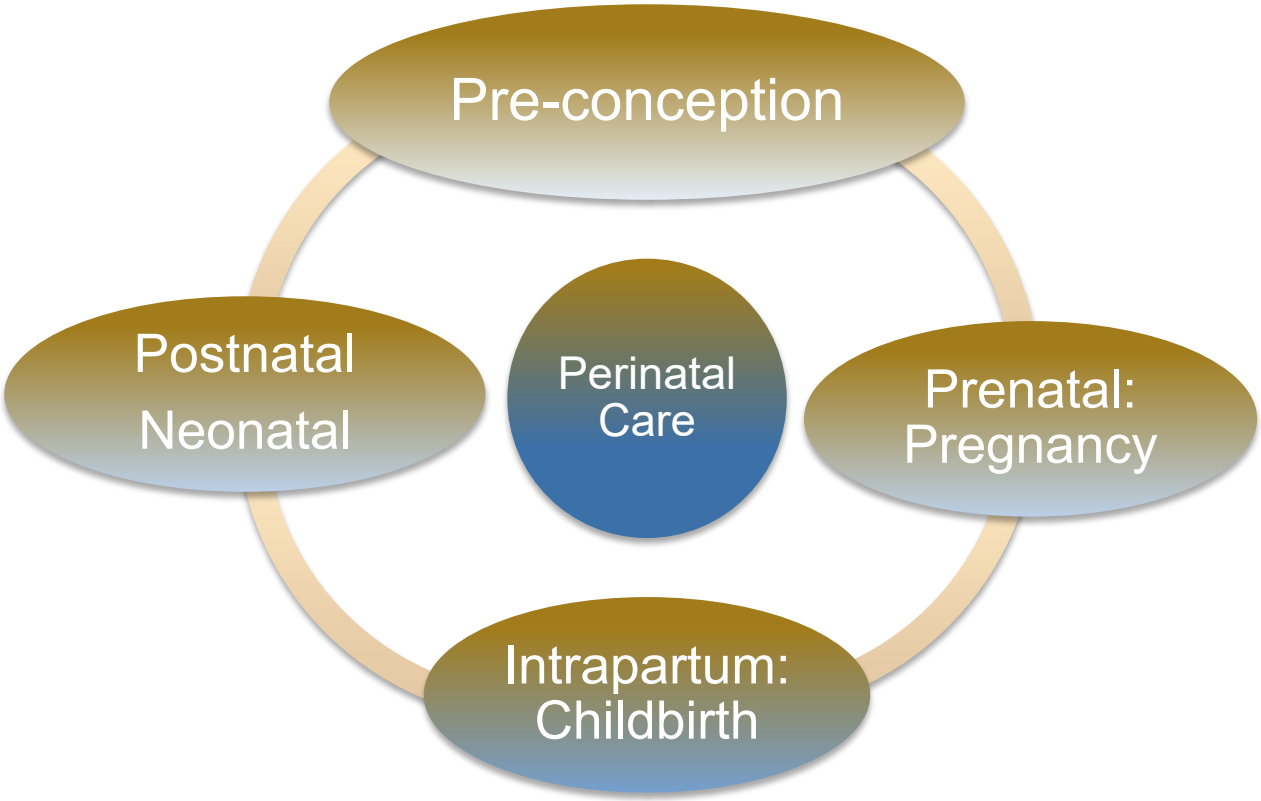
(93%) of the deaths were determined to be preventable, specifically in the American Indian/Alaska Native Population.

Maternal Health #Goals

Prevent maternal and neonatal death and disease

Access to Prenatal Care

Perinatal Care
Access to Pre-natal Care

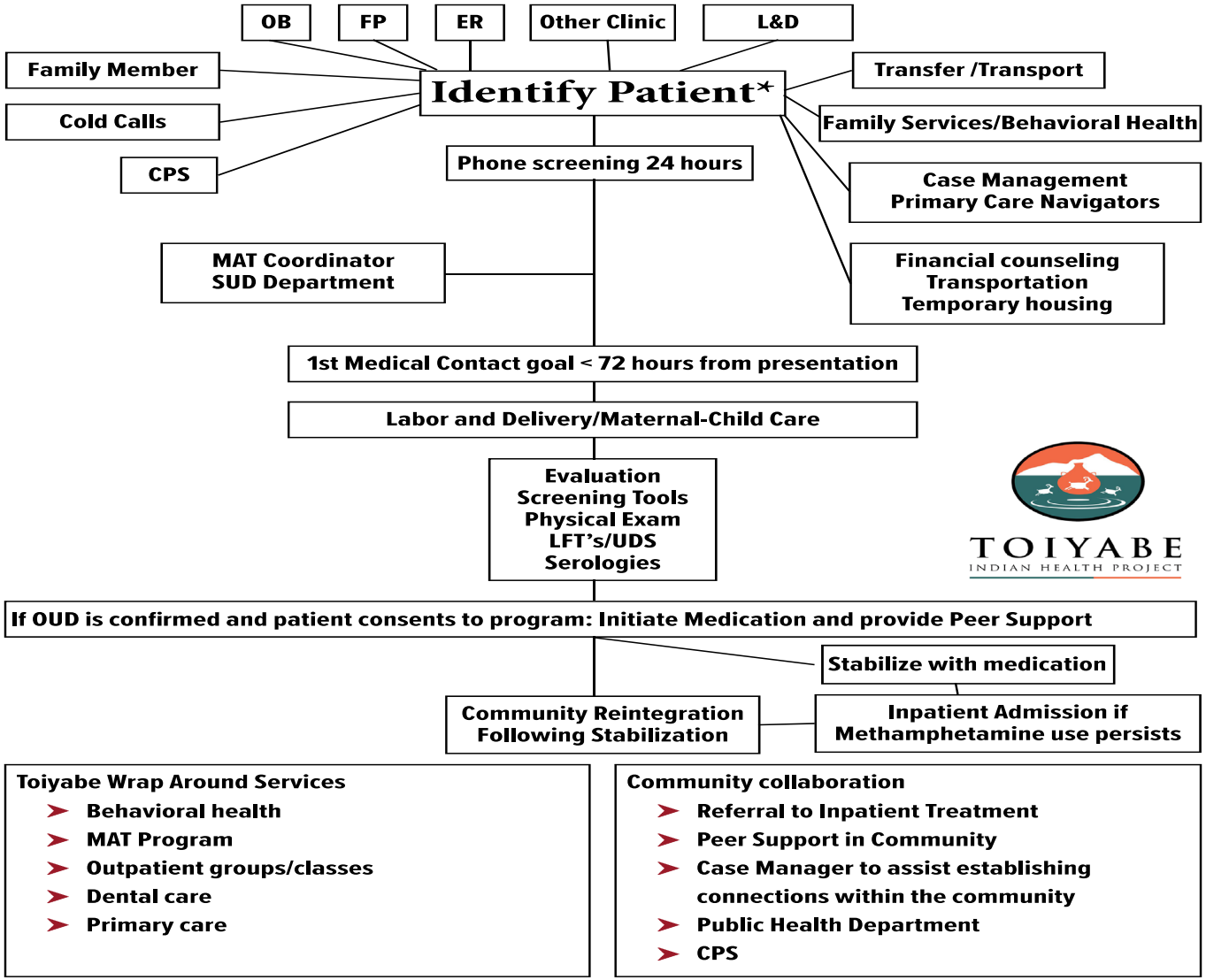


Maternal child Health in American Indian Communities

Albuquerque Area:
12+ Healthcare centers
Navajo Nation Area:
12 Health care Centers
Phoenix Area:
!2 Health Care Centers
Tuscon Area

Type of Facility	IHS	Tribes
Hospital	24	22
Health Center	51	279
Health Station	24	79
Alaska Village Clinic	0	59
School Health Center	12	6
Youth Regional Treatment Centers	6	6

IHS, 2024


OB
FP
ER
Other Clinic
L&D
Family Member
Cold Calls
CPS
Identify Patient*
Transfer /Transport
Family Services/Behavioral Health
Case Management
Primary Care Navigators
Financial counseling
Transportation
Temporary housing
Phone screening 24 hours
MAT Coordinator
SUD Department
1st Medical Contact goal < 72 hours from presentation
Labor and Delivery/Maternal-Child Care
Evaluation
Screening Tools
Physical Exam
LFT's/UDS
Serologies
TOIYABE
INDIAN HEALTH PROJECT
If OUD is confirmed and patient consents to program: Initiate Medication and provide Peer Support
Stabilize with medication
Community Reintegration
Following Stabilization
Inpatient Admission if
Methamphetamine use persists
Toiyabe Wrap Around Services
Behavioral health
MAT Program
Outpatient groups/classes
Dental care
Primary care
Community collaboration
Referral to Inpatient Treatment
Peer Support in Community
Case Manager to assist establishing connections within the community
Public Health Department
CPS

How do we Assess the Risk?

- Evidence based Approach
  - Utilize Validated Tools

- When Do I screen?

  First prenatal visit

  OB Triage/ED visit, primary care, SUD setting

Screening Tools

- Urine Drug Screen(UDS) is not a screening tool
  - Using “risk factors” to obtain a UDS could cause mistrust between provider and pregnant family.

- 5 P’s
- SBIRT
- NIDA Quick Screen
- CRAFFT

5 P's

- 1. Did any of your **PARENTS** have problems with alcohol or drug use?
- 2. Do any of your **PEERS** have problems with alcohol or drug use?
- Does your **PARTNER** have a problem with alcohol or drug use?
- Before you were pregnant did you have problems with alcohol or drug use? (**PAST**)
- In the past month, did you drink beer, wine, liquor, or use other drugs? (**PREGNANCY**)

Follow up Questions

- 1. Have you used opioids, narcotics or pain medications in the last year? Were they prescribed and unprescribed? Have you used any other drugs or unprescribed medicine in the past year?
- 2. Patients with positive answers who used unprescribed opioids in pregnancy or on prescribed opioids for longer than one month need the referral to MAT

Taylor

Background:

Taylor is a 25-year-old, G2P1 who presents to the clinic after being discharged from OB triage 2 days ago. She presented to ED for abdominal cramping and was surprised to find out she is pregnant. Taylor's last pregnancy was two years ago which resulted in a 38week uncomplicated vaginal delivery. Child protective services were involved with her care due to a positive drug screen in her last pregnancy. She has a history of methamphetamine use disorder, depression and anxiety but otherwise no chronic health conditions. No history of surgeries. She has not been in to see a medical provider since her last pregnancy. She denies any history of overdose or SUD treatment.

Upon review of OB triage records: FHR 145, contractions were non-palpable by nurse but toco showed uterine irritability for 45mins which resolved with PO fluids. VSS, UDS: + MET, +AMP, +Oxy, No further medication was offered at time of discharge.

LMP: "about three or four months ago"

Taylor cries, "I didn't know I was pregnant."

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How to Respond

	Past & Pregnancy	Partner & Past	Parents/Peers
Suggested verbal responses	*"Thank you for sharing." "Would it be OK if I ask _____ to come and talk with your responses?"*	*"Thank you for sharing. Sometimes when others close to you have a problem with substance use, it can make it hard for a person to not to join in as well. Has this been a concern for you?"*	*"Thank you for sharing. Sometimes when parents or friends have a current or past problem with substance use, it can put you at risk for substance use as well. Has this been a concern for you?"*
Recommended Actions if "YES"	Brief Intervention. Contact SW. Start checklist.	Assess risk.	Discuss increased risk for substance use.

Know your Community Resources

- What resources are available to Taylor?
- Do I have cards or pamphlets available?
- Is there a direct contact in place?
  - “CPS sounds SCARY! but they are a support to you.”
- Provide education about all resources and process to follow up.
- Try to understand culture and family norms.

Brief Negotiated Interview

1) Build Rapport & Bring It Up	One health issue we discuss with all pregnant patients is alcohol and drug use. Having an honest conversation about these behaviors helps us provide you and your baby the best possible care. You don't have to answer any questions if you feel uncomfortable. Would it be okay to talk for a minute about whether alcohol/drugs are part of your life?
2) Pros and Cons **Summarize**	People use alcohol and drugs for lots of reasons • Help me understand what you like about using [X]? • What do you like less about using [X]? "Is there anything you don't like about using {X}? • So, on the one hand [PROS], and the other hand [CONS].
3) Information & Feedback **Elicit** **Provide** **Elicit**	I have some information on the risks of drinking and drug use during pregnancy. Would it be OK if I shared them with you? (Refer to appropriate handouts/cards as needed) There is no known amount of alcohol that is safe to drink during pregnancy or when trying to get pregnant. Drinking anything containing alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorders which include physical problems, intellectual and behavioral disabilities. Use of drugs during pregnancy can also increase the risk for other pregnancy complications and health problems for your baby, and behavioral and developmental problems in childhood. Use of drugs and alcohol while breastfeeding can also have negative effects on your baby Do you have any thoughts you'd like to share on that?

Brief Negotiated Interview, cont.

4) Readiness Ruler	This Readiness Ruler is like the Pain Scale we use in the hospital. On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any kind of changes in your [X] use? **NOT READY** **VERY READY** 1 2 3 4 5 6 7 8 9 10
Reinforce positives	You marked ___. That's great. That means you are ___ % ready to make a change.
Ask about lower #	Why did you choose that number and not a lower one like a 1 or a 2?
5) Action Plan	What are some steps you could take to reduce the things you don't like about using [X]? What ideas do you have to keep you and your baby healthy and safe?
Affirm ideas	Those are great ideas! Is it okay for me to write down your plan, your own **prescription for change**, to keep it with you as a reminder?
Write down steps	What should I write down on here?
6) Seal the Deal	I have some additional resources that people sometimes find helpful. Would you like to hear about them?
Offer appropriate resources	• Introduce the SW team Offer a warm handoff if possible. • Offer handouts or brochures as appropriate.
Thank patient	Thank you for talking with me today.

Taylor Case

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Clinical considerations?

Treatment plan?

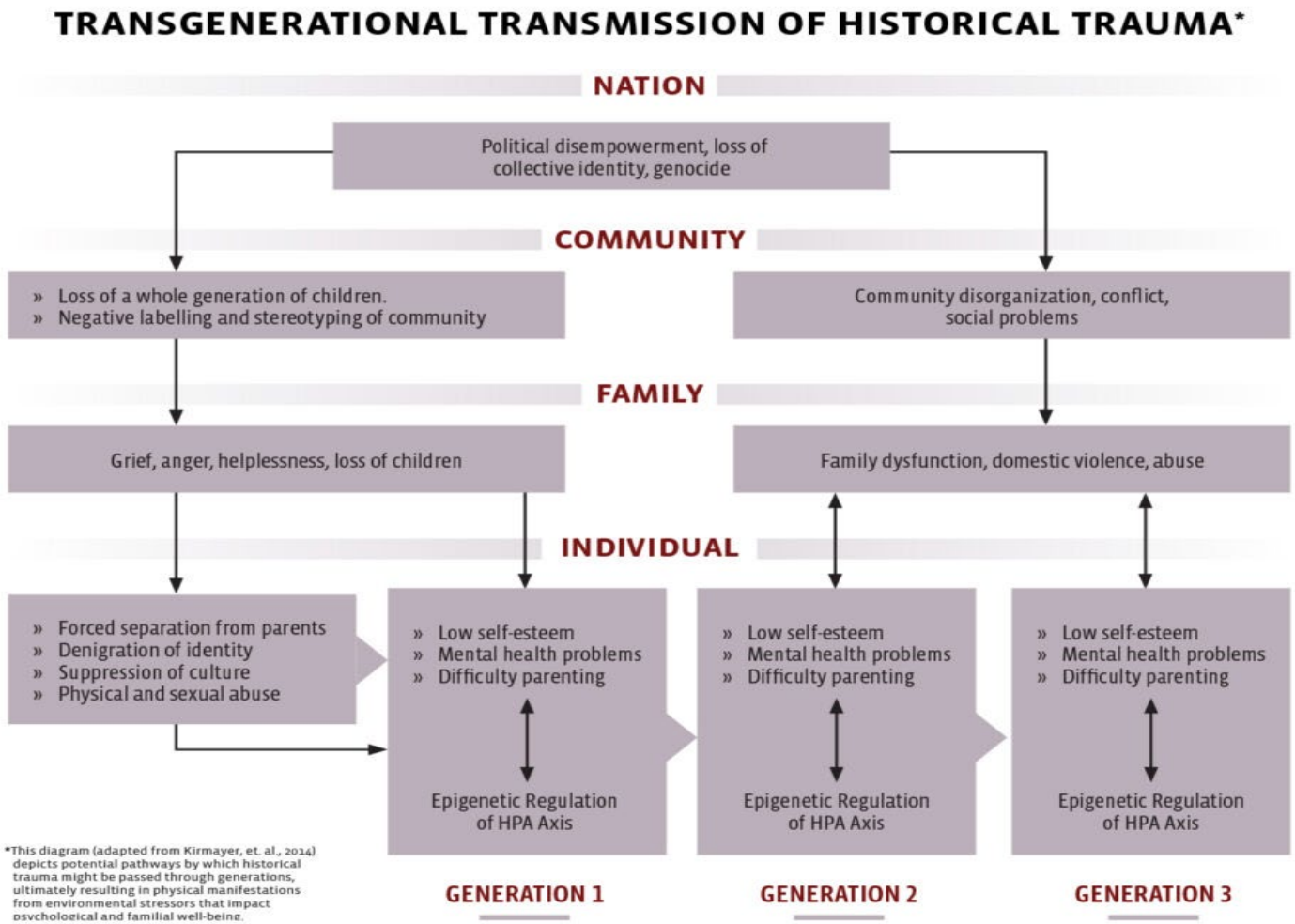
Medications?

Maternal Health Goal: Prevent maternal and neonatal death and disease.

The Pregnant Family

Interrupted Roles in the Family

Interrupted Roles in the Family



Intervention

A woman born in Montana's Blackfeet Nation begins using two drugs readily available on her reservation following the tragic death of her boyfriend.

Health Prevention initiatives foster change

BECOMING BABY FRIENDLY 2012

Statement to the Senate committee on Indian Affairs

November 19, 2014

"Protecting our Children's Mental Health: Preventing and Addressing Childhood Trauma in Indian Country"

Drug and Alcohol Exposure during Pregnancy

To identify women who are using alcohol and drugs during pregnancy, IHS healthcare facilities conduct screening during routine women's health and prenatal encounters. In FY 2013, 65.7 percent of all AI/AN females ages 15 to 44 were screened for alcohol use. In one IHS service unit, approximately 54 percent of women tested positive for drug use while pregnant and 52 percent of the infants born tested positive for drugs. To combat this problem, IHS has drafted policies and coordinated efforts for a comprehensive and multidisciplinary response to provide services to mothers and families including prenatal services, treatment, and home visiting programs to promote healthy lifestyles.

Sec. 240-D. Endangering an unborn child - substance abuse.

- (a) A person commits this offense by:
  (1) Intentionally inhaling, injecting, ingesting or otherwise introducing into her bloodstream any illegal substances, drugs, non-prescribed pre- scription drugs, intoxicants, or any other dangerous drug as defined in 7 CCOJ 413-B knowing that she is pregnant.
  (2) Intentionally ingesting alcoholic bever- ages so as to raise her blood alcohol content to any measurable level, knowing she is pregnant.
  (3) Providing any illegal substance, drug, nonprescription drug, intoxicant, or alcoholic beverage to a pregnant female, knowing that the female is pregnant.
  (4) Obtaining narcotics without notifying the medical provider that she is pregnant.

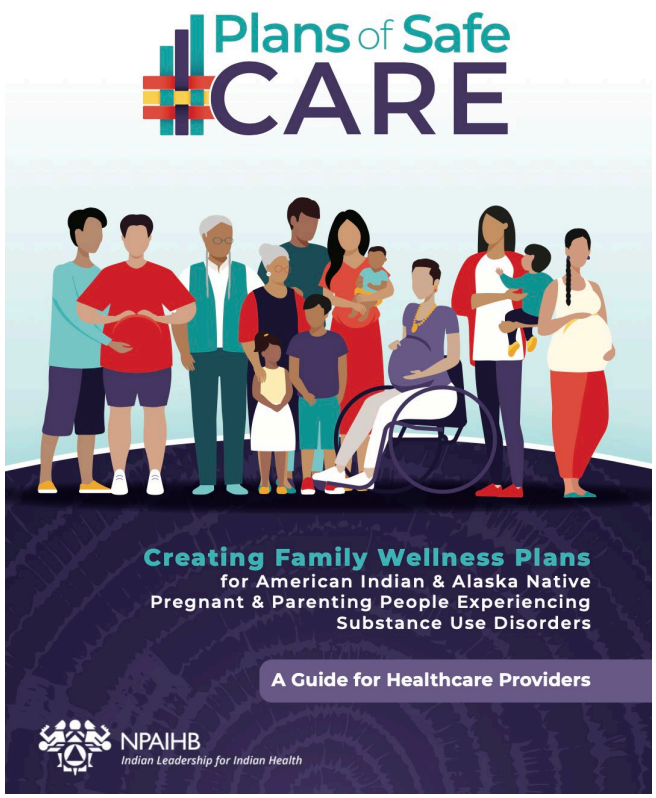
- (b) Refusal to submit to analysis of breath, blood or urine upon the request of a law enforcement officer having probable cause to suspect violation of this Section shall be prima facie evidence of guilt. However, the consequences of such refusal must be explained to the person.
- (c) Upon probable cause, samples of blood or urine taken in furtherance of investigation into possible violation of this Section may only be taken by trained medical persons.
- (d) A person found guilty under this Section is guilty of a felony.
- (e) At the time of sentencing, the Court may sus- pend part of the sentence if the person completes a court-ordered alcohol or other drug treatment program and parenting classes. If the person does not complete the program, the Court shall issue an Order to Show Cause why the suspended portion of the sentence should not be served.
- **(AS PER RESOLUTION NO. 28-0702-2016- 05; DATED 5/23/2016)**

Identifying Interventions

- Creating a Coalition (Key staff, community advocates/leaders, etc.)
  - Obstetric and Neonatal Advocacy (OANA)
  - Increased awareness regarding our services
    - Hospital's Harm Reduction: we want you to come to prenatal care
- Created workflow
  - Identifying those at risk.
- Collected Data
  - Obtained correct drug screens
- Advocated for Medication for Addiction Treatment

Creating Family Wellness Plans

For American Indian & Alaska Native Pregnant & Parenting People Experiencing Substance Use Disorders



https://www.indiancountryecho.org/plans-of-safe-care-toolkit/

Neonatal Opioid Withdrawal Syndrome

Neurologic	Gastrointestinal	Autonomic
High pitched cry	Vomiting	Diaphoresis
Irritability	Diarrhea	Nasal congestion
Sneezing	Dehydration	Temperature instability
Tremor	Poor weight gain	Hyperthermia
Hyperreflexia	Poor feeding	Increased respiratory rate
Frequent Yawning	Uncoordinated suck and swallow	Increased blood pressure
Seizures		Sweating

Modified from Hudak ML, Tan RC. Neonatal drug withdrawal. *Pediatrics*. 2012;129(s):e540-60

Table 2. Estimated Onset of Signs of Withdrawal

Drug	Approximate time to onset of withdrawal signs following birth
Barbiturates	Range from 1-14 days
Cocaine	Usually none, decreased arousal and physiologic stress can occur at 48-60 hours of life and can last for months
Alcohol	3-12 hours
Heroin	Within 24 hours
Marijuana	Usually none
Methadone	3-7 days, severity is not correlated to maternal dosage
Methamphetamines	Usually none. Decreased arousal, increased physiologic stress, feeding dysregulation, and poor quality of movement can occur 48-60 hours of life and can last for months
Opioids other than Methadone and Buprenorphine	1-3 days
Methadone and Buprenorphine	2-6 days
Sedatives	1-3 days
Synthetic Opioids	Unknown

Modified from Hudak ML, Tan RC. Neonatal drug withdrawal. Pediatrics. 2012;129(s):e540-60

Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder

The following recommendations can be ascertained from this report:

- **Screening for opioid use disorders using a validated screening tool in women of reproductive age offers opportunities for intervention across the life course.**
- **Initiation of medication-assisted therapy (MAT) is recommended for all pregnant women with opioid use disorder along with access to counseling and mental health services.**
- **Treating mothers and infants as a dyad is recommended postpartum to improve the course of neonatal opioid withdrawal syndrome (NOWS).**
- **Opioid use disorder is a chronic, relapsing and remitting medical illness that can be managed successfully with a combination of behavioral therapy, MAT, and recovery support.**

https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

Questions