Lessons learned in Massachusetts on System Improvement for Care of Patients with SUD in Pregnancy

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Vice-chair, Obstetrics, Boston Medical Center
Conflict of interest

I have no financial disclosures or conflicts of interest
Today’s Presentation

• Explain the “why”
• Finding tools
• Data loop
• Organizing the work
Pregnancy associated mortality from substance is increasing

Percent of Pregnancy-Associated Deaths Related to Substance Use by Year

- 2005: 8.7%
- 2014: 41.4%

Massachusetts DPH
Substance use is involved in mortality more often than obstetric causes.
Most substance-use associated pregnancy mortality is after delivery.
Massachusetts SMM21 OUD by Non-white/white*

Statewide OUD Rates Among White and Non-White Races 2016-2018*

- SMM21 White: 225.5
- SMM21 NonWhite: 452.8

*first 3 quarters of 2018

Betsy Lehman Center, 2019
Black and Hispanic women have a lower rate of MOUD

Get involved!

Summits
OUD in Pregnancy Webinars

Monthly Agenda Overview
12:00 - 12:05: Welcome/ Introductions
12:05 - 12:15: Updates from the teams on QI projects + collaborative
12:15 - 12:30: Brief QI teaching, Assignment
   Ronald Iverson, MD, MPH – OUD Bundle Components Overview, Stakeholders
12:30 - 12:55: Guest Topics: 20 minute presentations + 5 mins for questions
   Nicole Smith, MD, MPH – OUD Screening Options
12:55 - 1:00: Closing/ Final Comments
<table>
<thead>
<tr>
<th>Date</th>
<th>QI Topic</th>
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<tr>
<td>7/21/20</td>
<td>OUD Bundle Components Overview &amp; Stakeholders</td>
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<tr>
<td>8/18/20</td>
<td>Developing a Project AIM</td>
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<td>9/15/20</td>
<td>Measures for Improvement</td>
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<td>10/20/20</td>
<td>Key Driver Diagram</td>
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<td>11/17/20</td>
<td>Developing interventions</td>
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<td>12/15/20</td>
<td>Understanding Run Charts</td>
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<td>1/19/21</td>
<td>Understanding Data Control Charts</td>
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<td>2/16/21</td>
<td>Using the PDSA Cycle</td>
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<td>3/16/21</td>
<td>PDSA: Making Adjustments</td>
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<td>4/20/21</td>
<td>Scale and Spread Up</td>
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- OUD Screening Options
- Plans of Safe Care
- Caring for Patients with OUD - Using the Checklist
- Linkages to Care
- Equity Consideration in OUD Care: Start Where you are
- Centering Patient Voice
- OUD SMM Data
- Early Head Start
- MAT
- Pain Relief During Pregnancy, Labor, Surgery, Post-op
- SBIRT Check in
Bring in state resources

- MASBIRT - SBIRT trainings
- CARE – TIC trainings
- OBAT - MAT trainings
- IHR - Locator, initial site for our toolkit
- MCPAP for Moms
- Moms Do Care
- Healthy Start
Assess all pregnant women for SUDs

- Screen for polysubstance use among women with OUD.
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
Coordinated Approach to Resilience and Empowerment (CARE clinic)

C.A.R.E. Clinic

The mission of the C.A.R.E. Clinic (Coordinated Approach to Resilience and Empowerment) is to transform the way healthcare, healing, and hope are delivered to survivors of domestic violence, sexual assault, and human trafficking.

Our approach is collaborative and trauma-informed. We understand that seeking care can often be re-traumatizing for survivors so we partner with them to navigate the healthcare system and leverage community resources. Together, we develop personalized care plans and provide compassionate advocacy to eliminate barriers to care and support.

Our work is dedicated to coordinating and collaborating across all medical disciplines and with community service providers to ensure the voices of the patients are heard and that each patient drives their personal care plan and service.
Provider MOUD training
Pregnant Women & Families

Safe Care

What is The Plan of Safe Care (POSC)?
The Plan of Safe Care is a document created jointly by a pregnant or parenting woman, and her provider. This document helps women to think about what services or supports they might find useful, to record their preparations to parent and organize the care and services they are receiving.

A POSC can be any family service plan that covers both the parents’ behavioral health/recovery services (including addiction and mental health supports) and family or child-focused services (such as referral to Early Intervention and prenatal care appointments).

Who Might Coordinate a POSC?
A POSC coordinator is simply the person who works with the woman/parent/caregiver on creating and maintaining a plan, and identifying and accessing desired resources. Any provider working with perinatal clients (including recovery coaches, case managers, home visitors, doulas, Early Intervention staff, treatment providers, medical providers, etc.) can serve as a POSC coordinator, provided they have the availability to meet regularly for a period of time with the client/patient and are equipped to make warm referrals to needed services.

BSAS-licensed and/or contracted providers who have relationships with clients that last longer than 30 days are expected to make sure that all clients who are pregnant or parenting an infant have a POSC. Other perinatal service providers and healthcare providers are encouraged to screen pregnant and parenting women for
Healthy Start

Celebrate the Healthy Start program’s 25th anniversary. Our achievements include:

- Reducing infant mortality
- Addressing the differences in health between the general population and racial/ethnic minorities

We serve communities with:

- Infant mortality rates at least 1.5 times the U.S. national average
- Maternal and infant health issues including low birth weight, pre-term delivery, maternal morbidity and mortality
- High rates of poverty, low education, limited access to care, and other socioeconomic factors
Peer mentorship

MOMS DO CARE
Consultation from SPH teams

BUSPH: MC802 Student Consulting Team (BUSPH)
Fall 2019

Project RESPECT

Boston University School of Public Health
Consultants: Jenna Barrus, Himani Byregowda, Ebosele Eromosele, Caroline Ezekwesili
Nursing education on racial bias in care and how to improve

Speak Up for Black Women

Strategies to Dismantle Racism, Provide Quality Equitable Care, and Eliminate Perinatal Disparities
Collaboration with specialized treatment sites

The Brigham Health Bridge Clinic

The Brigham Health Bridge Clinic is a rapid-access, low barrier clinic for patients with Substance Use Disorders (SUDs), including alcohol, opioids, benzodiazepines, cocaine, amphetamines, etc. We embrace a harm reduction and compassionate approach for patients in all stages of recovery.

We are conveniently located at the main entrance of Brigham and Women’s Hospital at 75 Francis Street, Boston, MA.

Massachusetts General Hospital
HOPE Clinic
Look at what other PQCns are doing!

NNEPQIN

CMQCC
California Maternal Quality Care Collaborative

AIM
Alliance for Innovation on Maternal Health

IL-PQC
Illinois Perinatal Quality Collaborative
MOUD for mothers of OENs

**Medication-Assisted Therapy in Mothers of Opioid-Exposed Newborns**

- **Numerator:** Number of newborns exposed to prescribed methadone or prescribed buprenorphine during pregnancy
- **Denominator:** All newborns at risk for NAS due to in-utero opioid exposure
- **Goal:** In general, higher is better

![Graph showing percent of mothers of OENs on Medication Assisted Therapy (MAT) over time.](image)
Exclusive MOUD for mothers of OENs
Pharmacologic therapy for NAS

Pharmacologic Therapy for NAS
Numerator: Number of newborns requiring a pharmacologic agent for treatment of NAS
Denominator: All newborns at risk for NAS due to in-utero opioid exposure
Goal: In general, lower is better

Percent of Opioid-Exposed Newborns Requiring Pharmacologic Therapy for NAS

Base (52.6%)  Change 1 (36.9%)

% Pharm Therapy


Month

UCL  LCL

3σ Limits

Two out of three points in a row in Zone A or beyond
LOS for term OENs

Length of Hospital Stay Among Term Newborns

Numerator: Total number of days term newborns spent in hospital
Denominator: All newborns with gestational age 37 weeks or greater at risk for NAS due to in-utero opioid exposure
Goal: No specific numeric target

Average Length of Stay Among Term Opioid-Exposed Newborns

Baseline (14.4 days) | Change 1 (12.0 days)

3σ Limits

UCL

LCL

S

Month

Discharge home with biologic parent

Discharge Home with Biologic Parent

Numerator: Number of newborns who were discharged home with their biologic parent
Denominator: All newborns at risk for NAS due to in-utero opioid exposure
Goal: In general, higher is better
Getting this all done

Appetizer

Sides

Protein

Carbohydrate

Drinks

Table prep

Dessert
## OUD in Pregnancy Progress Tracking

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<th>Action/Follow Up</th>
<th>Responsible</th>
<th>Status</th>
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<tr>
<td><strong>Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.</strong></td>
<td>Emphasize that substance use disorders (SUDs) are chronic medical conditions, treatment is available, family and peer support is necessary and recovery is possible. Emphasize that opioid pharmacotherapy (i.e. methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.</td>
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<td><strong>Provide education regarding neonatal abstinence syndrome (NAS) and newborn care to patients with OUD.</strong></td>
<td>Awareness of the signs and symptoms of NAS Interventions to decrease NAS severity (e.g. breastfeeding, smoking cessation)</td>
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<td><strong>Engage appropriate partners (i.e. social workers, case managers) to assist patients and families in the development of a “plan of safe care” for mom and baby.</strong></td>
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<td><strong>Provide staff-wide (clinical and non-clinical staff) education on SUDs</strong></td>
<td>Emphasize that SUDs are chronic medical conditions that can be treated. Emphasize that stigma, bias and discrimination negatively impact</td>
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Thank you