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PLANS OF SAFE CARE (POSC): DEVELOPING POSC WITH A PATIENT-CENTERED APPROACH

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Plans of Safe Care (POSC): Developing POSC with a Patient-Centered Approach [video transcript]

00:08
And I will turn this over to Dr. Kelly Ramsey from New York State OASAS, and she will introduce herself and start the training. Take it away.

00:17
Thanks. Hi, everyone. Thank you for coming. I don't have any relevant financial disclosures. And as mentioned, I'm going to be talking about plans of safe care today. Whatever questions we don't get to, I will take the questions and answer by email, if we don't get into any answers by the end of the webinar. So I'm going to talk about plans of safe care, developing plans of safe care with a patient centered approach. So first, the learning objectives. Explain to providers how to develop plans of safe care, identify the steps to creating adequate plans of safe care, review plans of safe care that patients may have already worked to develop, and discuss ways to connect with substance use providers and other community providers to support patients at discharge.

01:04
So first, let's go over some background information to support providers in developing plans of safe care and understanding the patient population. So this is a pretty wordy slide, so I'm not going to go over every single point in it, but I think it's important that people understand that this is not the first opioid epidemic among women in the US. The actual first opioid epidemic in the US was from the end of the 18th century. So pretty much as soon as morphine was isolated and heroin was synthesized and then the hypodermic needle was synthesized or created after that, we have noted dependence to opioids. So they were actually commercially produced throughout the early 1900s in the US. So both opioid, so products that came from the opium poppy, so opiate products, as well as synthesized opiates, and cocaine products or coca products were marketed as unregulated medicinal tonics for use particularly marketed towards women and children for common maladies. So, for example, for cough, they prescribed a variety of opiates, and for fatigue, they prescribed a variety of coca products. And so these were commonly prescribed, again, and we're sold over the counter primarily to white upper class and middle class women. So they did notice that there was an increase in the incidence of opioid use disorder amongst women as early as the early 19th century, but they did not think that women could become pregnant. They assumed that because opioids could lead to loss of sexual desire, and it does actually interfere with menstruation and with both female and male hormones, they assumed that women would be infertile due to opioid use disorder. So actually the first reported case of an effected neonate with what we now would call NOWS, neonatal opioid withdrawal syndrome, was born in 1875. They labeled it at that time congenital morphinism, and they had no idea how to treat it and the infant died. However, by 1903, they tried giving an infant morphine and found that the infant survived their physiological withdrawal due to exposure to opioids during pregnancy with treatment with morphine, which is still, generally speaking, the standard of care for treatment today if an infant with NOWS does need pharmacotherapy.

03:41
On this slide, this is looking at the current opioid epidemic. As you can see, overdoses are rising in both males and females, and more so the numbers are higher in males, but the increase particularly among synthetic opioid deaths among women and prescription opioid deaths among women have increased greatly from the decade of 2007 to 2017.

04:10
So if we look at opioid misuse among women, this is looking at data from 2019, we don't have 2020 data yet, and you can see that there is high use among particularly the 18 to 25 year old age group. Again, it is also prevalent in older age groups, but particularly notable in the 18 to 25 year old group. If we look at substance use and its interplay with mental health issues in women, on the left hand side we see poly substance use and mental health issues. So the red bars show no past year opioid use and then the blue bars show past year opioid use. And you can see that where there is past year opioid use, you can see in those categories that there's a frequency of other substance use, as well as other mental health diagnoses. On the right hand side is looking at co occurring use and mental health issues. You can see when someone has no mental health issues, there's less use regardless of which substance we're talking about. And any mental illness is associated with increased use among all substances. And then if someone is diagnosed with serious mental illness, they have more use than the other categories with respect to all substances. And then this is looking at the unfortunate gap between high prevalence of both mental health diagnoses, as well as substance use disorders, yet huge treatment gaps. So you can see with respect to any mental illness, only about 50% of people ever receive treatment. And we're talking specifically among women, so only about 50% ever received treatment for their mental health issue. And that gap is even greater when we look at substance use disorder. So only about 11% of individuals with a substance use disorder, and in this case, we're specifically referring to women, ever access treatment during their lifetime for their substance use disorder. This is looking at pregnancy and prescription opioid misuse, as well as marijuana use during pregnancy. So you can see there's been a huge increase in the use of marijuana during pregnancy. And opioid use disorder rose four times among pregnant women between the years of 1999 and 2014.

06:43
This is looking at the prevalence of opioid use disorder per 1000 delivery hospitalizations. And again, you can see that precipitous increase starting in the early 2000s. And if you look at the map on the right, it is showing that increase in prevalence, the states that are darker blue are the states with the highest prevalence of opioid use disorder per 1000 delivery hospitalizations. And you can see that New York State is actually not one of the highest states with that prevalence. And then this is looking at substance use specifically among pregnant persons. So on the left hand side is past month of substance use, looking at illicit drugs, tobacco, and alcohol. And you can see that amount of people using substances while pregnant has been variable over time, actually, it was a little bit decreased in 2019, with the exception of marijuana, compared to other years. And then if we look at marijuana use by pregnancy status, you can see that it's pretty common in both pregnant and nonpregnant persons, however much more common in non pregnant persons than in pregnant persons. On the left hand side here is looking at sort of what naturally tends to occur among pregnant persons with respect to

substance use. So generally speaking, when persons become pregnant, they tend to decrease their substance use by trimester. So in other words, they increasingly decrease their use as each trimester passes. So you can see the blue bar is use when people are not pregnant, the red bar is first trimester, the greenish bar, yellowish, greenish bar is second trimester, and the purple is third trimester. So that's sort of what naturally happens. So how do you tease out substance use versus substance use disorder in pregnant persons? So the vast majority of pregnant persons are motivated to maximize their own health and the health of their developing fetus. Those pregnant persons who can't cut back or quit using, likely have a substance use disorder. So continued use in pregnancy could indicate a substance use disorder.

09:00
So when we look at substance use disorder treatment during pregnancy, most pregnant persons do not receive treatment for substance use disorder. So here you see comparing pregnant and nonpregnant persons, and then needing treatment and actually receiving treatment. So you can see that about double the people, among pregnant people, needed treatment than non pregnant people. And with respect to receiving treatment, pregnant persons were more likely than non pregnant persons to receive treatment, but again, you see this is at exceedingly low percentages.

09:38
So what are some of the other issues that come up for persons with SUD in pregnancy? So there's a high comorbidity of mental health issues. So two thirds of the population of pregnant persons with SUD have co occurring mental health diagnoses. Most commonly, major depressive disorder, generalized anxiety disorder, and PTSD. The majority have a history of childhood trauma, and that's typically pre adolescent sexual or physical trauma. And there's a high level of intimate partner violence in the last year. With respect to their reproductive health, the vast majority of these pregnancies are unplanned pregnancies, about 80%. And there are low rates of contraception use. Often, contraception falls pretty low on the hierarchy of needs with someone who has an active substance use disorder. There is commonly other substance use, particularly tobacco use, so greater than 90% of persons with SUD who are pregnant, also have comorbid tobacco use disorder. And then there are disparities with respect to social functioning, so often inadequate social support, social isolation, and previous exposure to poor parenting models.

10:54
So another thing that is important to understand is the maternal mortality rates in the United States. So unfortunately, despite the fact that all other developed nations in the world have had decreasing maternal mortality, the maternal mortality in the United States has been increasing since at least the year 2000. So it is much higher compared with other industrialized countries. As you can see, the US on the right hand side is down at the bottom with the highest rate of maternal mortality. This is looking specifically at maternal mortality due to fatal overdose. So this is data from Massachusetts, so you can see that during the second trimester, the rates of opioid related overdose are lowest in the second and third trimester. In the third trimester to the first six weeks postpartum, opioid related overdose rates increase fourfold. And then in the period postpartum between 180 and 365 days postpartum, so basically six months to a year

postpartum, is the highest rate of opioid related overdose. So, again, is that because there's decreased acquired tolerance or non agonist used? In other words, are people not on MOUD with either methadone or buprenorphine for their opioid use disorder? Or have they not been retained in care? Or is it just the stressor of having an infant and not receiving adequate supports?

12:40
So another topic that's really important to discuss with respect to pregnant persons and substance use disorder is stigma. So unfortunately, there is a lot of stigma, I find particularly pregnant and parenting persons to be the most stigmatized groups with respect to substance use disorder. So here's some examples of news coverage. So pill popping mamas, many pregnant women take opioids CDC finds, and number of mothers using opioids while pregnant is rising in Tennessee. So again, this may be stating facts, but the way that it's done is often in a way that negatively depicts the pregnant person, and is stigmatizing about the pregnant person, and also sort of sets up a dichotomy between the fetus that the pregnant person is carrying and the pregnant person herself. And so that sets up an unfortunate pitting of one's needs against the others, and not understanding that they are a dyad.

13:49
So language is really important when we are interacting with our patients, and bad language perpetuates stigma. So here is just one example of appropriate usage of language and what terms to avoid. There are many iterations of this that you can find online and they vary a little bit, so I'm going to focus on some of the ones that I think are more important. So most of the 'A' words that we use to refer to people who use drugs should be abandoned. So things like abuser, a drug abuser, or an addict, or an alcoholic, none of those terms should be used any longer. They are really dated, and they're stigmatizing. So instead, we should be using person first language which acknowledges that a person with substance use disorder is just part of who they are, it does not define them. So a person with a substance use disorder, a person with an opioid use disorder. We should never be using the terms clean or dirty to refer to either our patients, referring to their time using versus not using, or to their urine toxicologies. Again, there are no other groups of people, or for example, results in medicine that we would ever use the terms clean and dirty. So we should be referring to urine toxicologies with neutral terms, such as appropriate or inappropriate or expected or unexpected. And as I said, time using to either the person is currently using or the person is currently not using. Sometimes our patients will use these terms themselves, and this is often something that's perpetuated in self help group meetings. And again, once I have a relationship with a patient, I challenged them on these terms and we talk about how using this self stigmatizing language can also often cause internalized stigma that perpetuates, for example, poor self esteem and poor self efficacy. I'm not going to address the other two, because those are a slightly more controversial, but I've covered what I think I needed to cover on that slide.

16:07
So again, we have a misrepresentation and inflammatory use of language within the press. So there's a misrepresentation of neonatal opioid withdrawal syndrome, with terms like newborn's death sentence or addicted baby. So again, there's no such thing as an addicted baby, a baby

may be born with physiological withdrawal because they were exposed to a substance in utero. So with respect to NOWS, if a baby develops symptoms consistent with NOWS, it is predictable and it is treatable, and there are not long term consequences of it, so we should not be describing it in that way. Addiction requires a set of behaviors and a compulsion to use over which you have no control. And obviously, a baby does not demonstrate those behaviors. It also pits the parent versus the child, rather than seeing the birth parent and the child is a dyad. So stigma is not benign, stigma leads to dehumanization, which can lead to then discrimination and prejudice, and ultimately punishment of pregnant persons.

17:22
So let's talk about state policies on substance use during pregnancy. 23 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child welfare statutes, and three consider it grounds for civil commitment. So that means incarcerating a pregnant person against their will and violating their civil liberties to protect their fetus. So obviously, New York does not do that, but three states still consider it grounds to incarcerate a pregnant person until they deliver. 24 states and the District of Columbia require healthcare professionals to report suspected prenatal drug use and eight states require them to test for prenatal drug exposure if they suspect drug use. On the flip side, 19 states have either created or funded drug treatment programs specifically targeted to pregnant persons, and 17 states and the District of Columbia provide pregnant persons with priority access to state funded drug treatment programs. New York State is one of those states. 10 states prohibit publicly funded drug treatment programs from discriminating against pregnant persons.

18:37
So in New York state, we have State SAPT Block Grant Funding recipients and they are required to have admission preference for pregnant persons. So with respect to priority for admission, pregnant persons who inject substances have first priority, pregnant persons with substance use disorders, generally speaking, but who are not injecting have second priority. Individuals who inject substances have third priority, and all others with substance use disorder have fourth priority. And the right hand side goes into a little bit more specific language on what those admission policies need to state and that can be found on the website listed.

19:22
So is punishment of pregnant persons really best practices? So obviously, it's not. So first of all, it's discriminatory. So persons of color and poor persons are more likely to be prosecuted despite white person's being more likely to use during pregnancy. It is not evidence based. So risks of illicit substances are often exaggerated in comparison to the risks of legal substances, such as alcohol and tobacco. Unintended consequences are inevitably a result of these policies. So punitive policies drive pregnant persons away from SUD treatment and prenatal care out of fear, fear of many things. Fear of having their child removed from their care, fear of discrimination, fear of stigmatization, etc. And they don't promote engagement. So if somebody engages in prenatal care, that actually counteracts the adverse effects of substance use during pregnancy. So this is a very wordy slide, so I'm not going to read this entire excerpt, but this comes from the American Society of Addiction Medicine, and it's looking at stigma and engagement or lack thereof in prenatal care. So I'm just going to read the first part of the quote.

So research has identified the stigma around NOWS, and substance use disorders in general, serve as a significant barrier to treatment for pregnant persons. Many pregnant persons do not self disclose their drug use during pregnancy due to stigma, complicating the treatment process. In addition, when they do reach out for help, they often encounter misinformation, denial, inaction, and even judgmental and punitive attitudes toward their substance use. In some cases, policies that initiate punitive responses to pregnant persons with substance use disorders also create barriers to treatment.

21:21
So here's a slide illustrating that engagement in prenatal care counteracts the effects of substance use. So if we look at the category of someone who's actively using drugs during pregnancy and receives no prenatal care, 48% of the time their infant is born with low birth weight. However, if someone has no drug use and doesn't receive prenatal care, their baby has low birth weight 19% of the time. If a person who is actively using drugs has prenatal care, they have the same risk of having a low birth weight baby as someone who doesn't use drugs and receives no prenatal care. The best outcome is someone who has no drug use and engages in prenatal care, with having a low birth weight baby 14% of the time. But you can see how much prenatal care engagement, even with active substance use, really mitigates considered bad outcomes like low birth weight in the baby.

22:26
So this is just a reminder that the opioid epidemic is really expensive. And this was a modeling looking at the costs of the opioid epidemic. So the highest costs are due to loss of productivity due to both non fatal and fatal overdoses, but you can see that child and family assistance, and welfare, and Child Protective Services, adds a substantial cost to the system. That's one of the costs of the opioid epidemic.

23:00
So what are some components of patient centered and family centered care? So on the left hand side, with our pregnant person, the infant and family at the center, components of patient centered care involve many different factors. So they involve MAT, or substance use disorder services, physical health services, mental health services, parenting and child development resources, child welfare, supportive services, and sometimes criminal justice. So that requires care coordination between all of these sectors, and all of the sectors practicing trauma informed care. And this is throughout the continuum from pre pregnancy, through pregnancy, through postpartum, postnatal services, and at the time of delivery. And then putting that family in the center at the right hand side, we can see that there are many factors that play into family centered care, you know, who is making the decisions? Where are they getting information from? Who has the care burden and how resilient is this family? What are sibling needs, if they have other children? What are the stressors on the parents? What are some of the cultural or spiritual aspects of their care? What are their parenting styles? How is their quality of life? And what are their social supports?

24:26

So let's look at creating a plan of safe care with a patient centered and family centered approach. So what is it? What is the plan of safe care? A plan of safe care is a document which identifies how a provider, family, and a community can support the safety and well being of the infant and the person who gives birth. How do I make it person centered and family centered? A plan of safe care should be individualized and should address basic needs, identify current supports, and anticipate future needs, and coordinate supports, and include other resources and community based supports. So again, you can reference the previous slide. Therefore, knowing a patient and their individual needs is imperative in creating an effective and actionable plan. Who can create a plan of safe care? Any health care provider or social services provider can develop a plan of safe care in collaboration with a pregnant person. So ideally, this would be done prenatally, and with an anticipatory lens for needs postpartum, and shared with the hospital birth center. If someone is working already with a pregnant person, then they're going to know that person better than whoever is interacting with them in the context of requiring a plan of safe care at the time of delivery or postpartum. So you know, if a plan of safe care is not done prenatally and is required delivery, then the hospital birth center should ensure that the person who gave birth has a warm handoff in the community to necessary supports to create a plan of safe care. So OASAS does have a service bulletin on plans of safe care, we are actually going to be revising it, but that is where it is posted currently. So ideally, this would get done beforehand.

26:20
So who needs a plan of safe care? So pregnant individuals who are diagnosed with a substance use disorder, or are receiving medication for addiction treatment, so MAT for substance use disorder, or are under the care and supervision of a health care provider that has prescribed opioids, all need a plan of safe care. So what is the purpose of the plan of safe care? It is a tool that can be used to support families impacted by substance use or taking medications to treat substance use disorder. So the purpose of the plan of safe care is to ensure that families are receiving comprehensive support, care, and treatment to meet their individualized needs. Remember, substance use and/or a substance use disorder in and of itself is not an indicator of child abuse, or maltreatment, or neglect. So let's look through the steps in creating adequate plans of safe care.

27:25
So what does this process look like? So New York State is about to release information that will be similar to what I'm sharing, but it has not done so yet. And so I'm using New Hampshire's information which is similar. So this is the overview of a plan of safe care process. So baby is born. So it is best practice to develop the plan of safe care prenatally. Is the infant affected by prenatal drug and/or alcohol exposure? So if the answer is no, then no plan of safe care is required by law, though it is best practice to develop a plan of safe care for all mothers and infants to identify care needs. So is the infant affected by prenatal drug and or alcohol exposure? So if the answer is yes, then notification has to occur, and I'm not going to go into that detail today, but a plan of safe care is developed. Now in New York State, that hospital or birthing center would do a warm handoff to a community based agency in order to do the plan of safe care. So is a mandatory report made? So if no, then the plan of safe care is sent home with the mother upon discharge, or again to the agency to develop the plan of safe care with the

mom. If a mandatory report is required, then that would be made to the local child welfare agency. And again, that warm handoff would happen to develop the plan of safe care.

29:07
So how can we create a framework to support pregnant persons, families, and infants? So how do we engage pregnant persons in a collaborative process to plan for healthy outcomes? How can we work with existing supports and coordinate new services to help infants and families stay safe and connected? And how can plans of safe care support pregnant persons and their infants during pregnancy, delivery, safe transition home, and in parenting? So the overarching goal of the plan of safe care is family centered care plan development and implementation. So there should be dedicated policies and procedures for doing so. There should be the consideration of individual family context. There should be patient family and care provider collaboration. And there should be illness specific education. So when is a plan of safe care developed with the pregnant person? So plan of safe care must be developed when an infant is born identified as being affected by substance use, or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum syndrome. However, best practices support developing a plan of safe care prenatally to serve as a living document throughout the pregnancy and after birth, especially when there is a risk of prenatal exposure to substance use. So again, what is the purpose of a plan of safe care? So for the parents and the infant, the safety and well being of the family, to address health and substance use treatment needs, to make appropriate referrals, and deliver appropriate multidisciplinary health care and social services. And a plan of safe care must account for whether the infant's prenatal exposure is due to prescribed medication, so for instance, due to prescribe buprenorphine or prescribed methadone that she receives at an OTP, and whether the person who gave birth is or will be actively engaged in treatment upon discharge.

31:20
So what are best practices with respect to the plan of safe care process? So notify, so notify public health of the birth of exposed and affected infants as requested on the birth certificate. Develop a plan of safe care with all pregnant persons and/or caregivers early in the pregnancy. And it must be developed, again, when an infant is born with and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder. Provide a copy of the plan of safe care to the person who gave birth and the infant's primary care provider upon hospital discharge. Coordinate the parents referrals and access to appropriate supports and services. Submit the plan of safe care to CPS or the local office of OCFS when a report of child abuse or neglect is made, and include the plan of safe care in information provided to the parent's supports and services, as authorized, and be sure to have the parents sign a 42 CFR Part Two consent form, which covers substance use disorder. So again, these come from New Hampshire. So this is how to engage with your patient prenatally in a plan of safe care. So it goes over why create a plan of safe care, and who creates it, and whether it's required and what happens to it, etc. So having a pamphlet that talks about this is helpful. Again, there will be forthcoming information from the New York State Department of Health on talking with your patients about plans of safe care.

33:01

So what are possible components to consider in a plan of safe care? So first of all, demographic information. So who are the parents? Who are other caregivers? Who are the health care providers, which may include the OB GYN, the primary care provider, pediatrician, and an MAT or MOUD provider? Other friends, family, community supports, household members, and emergency contacts. It may also include current supports and services that the client is receiving. New referrals needed for services, so either based on current needs or anticipated needs at delivery, and link with services prenatally and postnatally. Strengths and goals, both for the pregnant and parenting person and for the newborn. The patient's thoughts about the plan of safe care. And again, have patients sign of 42 CFR Part Two consent as applicable so the plan of safe care can be shared and discussed with other health care providers and social services providers participating in the care. Encourage patients to discuss their plan of safe care with important persons involved in their lives, their community and their care. So what are some potential needs to consider? Breastfeeding support, MAT or MOUD for their specific substance use disorder treatment, peer recovery supports, counseling or mental health supports, vocational training, or support in finding employment, housing assistance, educational supports, parenting skills training and/or supports, family resources or supports, health insurance, WIC, safe sleep education or planning, childcare, home visiting services, family planning or birth control, financial assistance or temporary assistance, smoking cessation or no smoke exposure education, transportation, legal assistance, car seat or additional infant supplies, domestic violence or in intimate partner violence resources, and a PCP provider. For example, does the patient have a primary care provider? These are just some of the potential needs to consider.

35:10
So how to assess the plan of safe care that patients may have already worked to develop? So does the patient's plan of safe care need anything added to it? Does the plan include all significant parties in the patient's life? Is the information on the plan of safe care all still current? Does the plan incorporate current needs and services utilized? Is the infant and his or her needs and needed referrals included in the plan of safe care? Have new needs arisen that were not previously identified in the plan of safe care? Are new referrals needed? Has a warm handoff been arranged? Does the patient know whom to contact if things don't go as planned? Have we done everything possible to best support this parent, this family, and this infant?

36:02
So assessing a plan of safe care in given scenarios. So this is if a plan of safe care was developed prenatally. So the plan of safe care was developed prenatally, the consent was signed prenatally, and the plan of safe care is part of the electronic medical record or the patient chart was sent to the hospital birthing center with the plan of safe care. At delivery, the plan of safe care is incorporated into the discharge plan for the parent and infant.

36:31
So this is assessing it in a situation where the plan of safe care was not developed prenatally. So it was not developed, at delivery there is no plan of safe care. Facilitate a warm linkage with a community based provider to create a plan of safe care for the person who gave birth and the infant. Who in the community can develop a plan of safe care with a patient? A care manager, someone with a CASAC, a primary care provider, a MAT provider, a social worker, a doula, a

visiting nurse, a public health nurse, a discharge planner, etc. There are no specific qualifications for someone who can develop a plan of safe care. So really, anybody who is helping the patient in the community based setting can do a plan of safe care with a patient.

37:17
So how to connect with substance use and other community providers to support patients at discharge? So persons with substance use disorder in pregnancy. So pregnant persons with substance use disorder obviously have a unique set of needs across multiple domains that we discussed previously in patient centered care slide. And those domains affect both their obstetric health end outcomes and their substance use disorder treatment. So care needs to address all of those complex needs, ideally, are colocated with integrated services. So how do we identify substance use disorder during pregnancy? So, the recommendation is universal screening with all pregnant persons, so not risk based screening. So this is verbal screening, and this would be ideally with a validated screening tool. So ideally, we would identify at risk persons early and then we would utilize motivational interviewing skills to address substance use with patients. Ideally, we would normalize questions and embed them in the electronic medical record and we would, again, use validated screening tools. So some I've listed here, so the DAST, the MAST, the Four P's Plus is specific to pregnancy, and the CRAFFT is specific for adolescents. Urine toxicology is not recommended for screening, and this is for myriad reasons. Urine toxicologies have a short detection window, they require confirmation testing, and they may not capture intermittent use or binge use, or they may capture one time use. So again, they are rife with problems. And there are ethical issues. There have been cases where a urine toxicology was taken without the person's consent, and that has led to legal challenges, and there's actually a court case that supports the need for there to be informed consent if a urine toxicology is done. So again, universal verbal screening is what is recommended for identifying substance use during pregnancy. There are also patient and provider barriers to screening. So there are patient's fears of discrimination, mistreatment, and calls to CPS that are not necessarily warranted. And then there's provider lack of training, time, and knowledge regarding, for example, how to address positive results, whether that's positive toxicology results or positive screening results.

39:54
So what is the standard of care for the treatment of opioid use disorder during pregnancy and post partum? So that would be medication for addiction treatment with either, specifically for opioid use disorder, with either methadone or buprenorphine. So pregnant persons do not need to meet DSM five criteria for opioid use disorder in order to receive medication for opioid use disorder during pregnancy. And medication is endorsed by the CDC, WHO, SAMSA, ACOG, ASAM, AAFP, AAP, essentially all professional medical organizations. So access to behavioral counseling as an adjunctive treatment if needed. So people often misinterpret that you are required to be engaged in substance use disorder treatment or to be receiving counseling, in addition to either methadone or buprenorphine, and that is absolutely not the case. So supportive counseling should be happening with whoever is doing the medication for the patient. If the patient is stable on medication, but has other identified needs and is willing to accept a referral, then certainly they could be referred for additional support to mental health resources, to specifically substance use disorder treatment program, or a dual diagnosis program.

41:18

And don't forget about the fourth trimester. So I want to talk a little bit about postpartum care for the postpartum person. So first of all, there's a reality check. So caring for a newborn is challenging, there may be breastfeeding issues, there may be bonding issues, the person may be experiencing mood changes, sleep disturbances and other physiologic changes. And then there are very challenging cultural norms and a lot of stigma towards, again, pregnant and parenting persons who use drugs or have a substance use disorder diagnosis. So there is a ton of pressure to be the ideal perfect parent, and often their social isolation and limited social support. And even sometimes when, again, it is not indicated, there is CPS involvement. So often calls are made from the hospital, during the delivery time period, even when a person is receiving appropriate medication for their opioid use disorder and they're on buprenorphine or methadone, often calls are made to CPS just because they're on buprenorphine or methadone, which again, is not indicated. And in fact, is showing us how much stigma indeed there is towards pregnant persons. So often, in this time period too, there's less focus on the person who gave birth. So there's a shift of attention from the parent with prenatal care, to the baby with pediatric care. 40% of persons who give birth missed their postpartum visit, so that data comes from ACOG. And care often shifts to social services agencies, like WIC for instance. And often the MAT or the MOUD provider is the only continuity of care for that parent. And then also remember about contraception, so often, long acting reversible contraception, such as an IUD, would be a birth control method of choice. So from ACOG regarding opioid use and opioid use disorder in pregnancy, it is important to advocate for this often marginalized group, so pregnant persons with opioid use disorder, particularly in terms of working to improve availability of treatment and to ensure that pregnant persons with opioid use disorder who seek prenatal care are not criminalized. Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.

44:00

So if a patient is actively using or is known to have substance use disorder, what are some aspects that should happen during your interaction with them? So ask about their substance use in a way that's non judgmental, assess their risk for overdose. So dispense or prescribe Naloxone, and that is regardless of what their intended substance of choice, so fentanyl or fentanyl analogs are added to the majority of all drugs that are purchased on the street. So if the substance use is only with alcohol or marijuana, that would be the one exception to not dispensing or prescribing Naloxone, but with any other intended substance use, Naloxone should be prescribed and overdose education done with the patient. Assess the need for PEP and PrEP, so Post Exposure and Pre-Exposure Prophylaxis. Vaccinate for Hepatitis A, Hepatitis B, TDAP, and any other vaccines or link them with vaccine services. Test and treat for hep C and HIV, and link to care. Currently, there are no medications approved for pregnant persons for hep C treatment, but they certainly could be diagnosed during pregnancy and a warm handoff given to a Hep C treatment provider, so that Hep C treatment can be initiated postpartum. Dispense or prescribe condoms, refer to a syringe service program or prescribe needles and syringes for someone who's actively injecting. Again, this should be a warm handoff with a

specific referral, so a brochure to a specific location and hours of a program, but prescribing needles and syringes is a New York State Department of Health best practices for people who inject drugs. Make a safety plan, so the DOH has a make a safety plan, it's called actually build a safety plan that's can be found online. And council on not using alone, council also on the use of medication for opioid use disorder to decrease the risk of overdose. So counter any voiced internalized stigma by the patient regarding medication for opioid use disorder with facts, and address any other acute needs of the patient. And above all, just listen and be non judgmental. This is that pamphlet called Build a Safety Plan that goes over all the key aspects of overdose education that should be discussed with a patient. These can be ordered in both English and Spanish for free, up to 500 copies at a time online.

46:46
So where should I refer patients? So the ideal scenario is that a patient comes with a plan of safe care and is already linked with community supports, and the patient continues that community based care. So if a patient is actively using and needs harm reduction services, locate your local syringe service program. And if you don't know where that is, you can contact the Harm Reduction Coalition or the New York State Office of Drug User Health through the Department of Health to find out where you can refer people. If a patient has a substance use disorder and is interested in substance use disorder treatment, you can contact OASAS. So there's a 24/7 Hopeline, and you can also text them or you can go online. So that treatment facility locator allows individuals to search by region and for gender specific programs that have a family centered focus, and some programs allow kids to accompany parents into care. You can also contact the OASAS Ombudsman on the CHAMP Helpline or email them for assistance in finding a program.

47:55
So if a patient has opioid use disorder and is interested in primary care based buprenorphine treatment, you can utilize the SAMSA buprenorphine practitioner locator. If a patient is interested in support from a certified peer recovery advocate, contact OASAS from the information on the prior slide. If a patient has mental health issues and is interested in an engagement in services, you can contact the Office of Mental Health and you can reach out specifically to the local field office. So remember, it's always better to provide a warm handoff with a name and an appointment and preferably direct contact. You can do that with telehealth, for instance with a new provider, rather than giving people a list of names and numbers and sort of letting them fend for themselves.

48:45
So what are some conclusions on developing a patient centered plan of self safe care? To develop an effective plan a safe care it's important that we understand the patient population of people who use drugs and the stigma they face in the healthcare system. Ideally, a plan of safe care is developed prenatally with a pregnant person's input and acts as a living document throughout the pregnancy. Engagement in prenatal care improves outcomes, regardless of active substance use or engagement in substance use disorder treatment, and decreasing stigma increases engagement in care. Pregnant persons with substance use disorder, in my opinion, experience discrimination and scrutiny on an unparalleled level. Care ideally is co

located, multidisciplinary, non judgmental, and patient centered. And if care is not co located, a warm handoff facilitates care engagement. The intention of the plan of safe care is to identify how a provider, family, and community can support the safety and well being of the infant and the person who gave birth. Remember, substance use and/or substance use disorder in and of itself is not an indicator of child abuse or maltreatment or neglect.

50:01
So, what is a more comprehensive health care approach for pregnant and parenting persons? So think about structural level changes. So, in creating structural level changes, what are some supportive policies that we can do? They should provide better reimbursement for comprehensive services, access to appropriate identification, assessment, and treatment for substance use disorder across the lifespan, not just during pregnancy for instance. Access to whole body, whole person health care, so avoiding compartmentalization, which unfortunately, our healthcare system often does. Responsible, safe prescribing by medical providers and training on substance use disorder diagnosis and treatment for medical providers. Tobacco cessation support. And hospital policies and protocols with respect to neonatal opioid withdrawal syndrome that supports the parent child dyad staying together and avoiding unnecessary or unnecessarily long NICU stays.

51:00
So if you're not aware of it, I wanted to just draw your attention to the pregnancy and substance use harm reduction toolkit that was developed in late 2020. I recommend you check that out. It's free and available online. There is also the SAMSA resource, the clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. Here is my email if you have any questions, and I'm happy to take questions now. And here's information on the CEI warm line. And I am happy to take any questions that have come up, and thanks a lot for your attention.

51:44
So MAT so. So MAT stands for, historically it stood for Medication Assisted Treatment, which is a really, really unfortunate term, because it makes it sound like the medication isn't treatment in and of itself. And the medication is treatment in and of itself. So medication may be all somebody needs to stabilize their substance use disorder. There may be other people that need additional supports, as I mentioned, whether it's supportive counseling around their substance use disorder, or engagement in more formal treatment of their substance use disorder, or whether it's mental health engagement or dual diagnosis, but not everybody needs that. So there is a shift in trying to change that term to Medication for Addiction Treatment. So same acronym, so people don't go crazy with a changing acronym. So that is a more appropriate term because it states what it's being used for. Sorry, my cat is biting on my cord there. And also ASAM is making a movement to change the name to just Addiction Medication. So again, you may see different terms in the literature, but if you are going to use the term MAT, it's better to utilize it as Medication for Addiction Treatment, then Medication Assisted Treatment. And let me just see if any other questions came in. I don't see any other questions. So again, we have about three more minutes. So I am happy to answer anything else that comes up.

53:25
I have a question. Do you know the timeline on when those New York State Guidelines might be released?

53:32
Yes. So I don't have a formal date yet. What's happening is that New York State OASAS, New York State OCFS, so that's the Office of Children and Family Services, and New York State Department of Health are working collaboratively in order to come to agreement on how and when the implementation will happen. So everything is ready to go on the Department of Health's part. So we will be hopefully, hopefully fingers crossed, rolling that out later this summer. It may be in July, but it may not be until August, but I'm very hopeful that the information will be sent out to all the hospital birthing centers. There will also be a general all prescriber letter sent out from the Department of Health, and then it will be posted on the Department of Health website, and I'm sure OASAS will also link to those documents, as will OCFS. But it's just to be sure that there are community resources in place and knowledgeable for people to be able to be referred locally and be able to get to the kind of supports that they need. Because if people say they are not engaged in prenatal care, and again, this is going to be a very small bucket of people, but say there's a group of pregnant persons who are not engaged in prenatal care during their pregnancy, actively using, show up for delivery at the hospital. So again, that's going to be a very small bucket of people, most people will be engaged in treatment or will have their substance use identified during pregnancy. And then hopefully, the plan of safe care developed at a time. For that small bucket of people, we just have to be sure that the supports are in place throughout the state on a local basis to be sure that there is someone to hand that patient to for adequate support. So those are the details that are going to be worked out, and I'm confident that that's going to happen. And so I'm hopeful that we will have that information out statewide in the next couple of months. There will be a Department of Health sponsored webinar series regarding the implementation of that legislation. And so there will be a talk on completely on stigma and implicit bias, there will be a talk, I will be doing this same plan of safe care talk. There will be another webinar on how to report and who needs to report and what needs to be reported, and then just sort of on the legislation in general on CAPTA CARA. So I believe it's going to be four webinars and they will probably be separated by a week, four weeks in a row. So my guess is hopefully August that'll happen. Great.

56:24
I want to again thank Dr. Ramsey for this fantastic and really informative, very necessary presentation. Thank you so much.

56:32
Thanks everyone. Have a great day.

[End]