MNO-OB Teams Call: Strategies for successful navigation of pregnant women with OUD to MAT/BH services – The warm hand off matters

April 22nd, 2019
12:30 – 1:30pm
Call Overview

• ILPQC May 2019 Face-to-Face Meetings
• MNO-OB Data Review
• Krisanna Deppen
• MNO: Strategies for Successful Navigation of Pregnant Women with OUD to MAT/BH Services- the warm hand off matters
• Team Talk
• QI Corner
You’re Invited!

2019 OB & Neonatal Face-to-Face Meetings

Nurses, Providers, & Staff
join us for an interactive day of collaborative learning for current ILPQC initiatives!

OB Teams: May 29, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - OB (MNO-OB)
Immediate Postpartum LARC (IPLARC)
Improving Postpartum Access to Care (IPAC)

Neonatal Teams: May 30, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - Neonatal (MNO-Neonatal)

Register now! https://ilpqc.eventbrite.com

Abraham Lincoln DoubleTree Hotel,
Springfield, IL

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation (08N-001-91)
Register here [www.ilpqc.eventbrite.com](http://www.ilpqc.eventbrite.com) for the F2F Today!

If we can measure it, we can move it.
Storyboard Instructions

- **Storyboards must fit into a space approximately 28 x 40 inches.** It may be created from a collection of letter-sized sheets (print outs of your power point slides or word documents) that are convenient for carrying while traveling. About six 8x10 inch sheets can fit in the available space. Large post-it sheets and tape will be provided at the meeting.

- **Share your story:** about your hospital, about your team, describe your goals for this initiative, include process flow diagram draft, can include any barriers you have identified and opportunities for improvement, PDSA cycles and results, next steps or action items for your team

- **Keep it simple:** the Storyboard is not meant to be an extremely time-consuming project.

**Display Tips**

- Be creative- there is no wrong way!
- Use fewer words and more pictures and graphics
- Include photos, collages, and illustrations (including a photo of your team)
- Use the largest font size as possible for readability
- Use color to highlight key messages (If you don’t have a color printer, use bright highlighters)
- Clear titles and labels if you use graphs (X and Y axes, dates, brief explanation of what it shows)
Storyboard Instructions

- Your hospitals may be participating in multiple OB & Neonatal initiatives at in 2019. We encourage teams to bring one OB AND one NEO storyboard addressing:

- OB Teams:
  - MNO- OB
    - Process flow for OUD protocol
    - Progress on structure measures and key process measures including MAT at delivery and OUD clinical care checklist in chart
  - IPLARC Wave 1 or 2
    - Wave 1: Include information about comprehensive contraceptive counselling & documentation (prenatal and on L&D), process flow, and GO LIVE date.
    - WAVE 2/IPAC: Include team goals, next steps, draft process flow, 30-60-90 day plan- where are you starting, what do you want to accomplish next?
MNO-OB DATA REVIEW
MNO in 2019

Systems Change: Key system changes in place
- Screening
- SBIRT
- Mapping
- Checklist
- Education

Covered in 2018

Strategies for Culture Change
- Educate providers / nurses: screening, SBIRT, stigma
- Improve patient navigation for MAT and behavioral health counseling/recovery services
- Improve engaging providers in OUD Clinical Care Checklist
- Standard system wide response for screen positive (OUD protocol)
- Buprenorphine prescribing

Improve Patient Care
Work towards goals in 2019
- Increase # of women screened & linked to care
- Increase # of women on MAT and behavioral health counseling/recovery services
- Increase # women with completed checklist
- Increase # women engaged in Opioid exposed newborn Care

How do we begin to make progress?
# MNO-OB Data Reporting

<table>
<thead>
<tr>
<th>Month</th>
<th>Patient-Level Data*</th>
<th>Structure Measures</th>
<th>Screening for OUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>350 patients (70 teams)</td>
<td>63 teams</td>
<td>57 teams</td>
</tr>
<tr>
<td>July 2018</td>
<td>88 patients (65 teams)</td>
<td>55 teams</td>
<td>61 teams</td>
</tr>
<tr>
<td>August 2018</td>
<td>117 patients (67 teams)</td>
<td>54 teams</td>
<td>60 teams</td>
</tr>
<tr>
<td>September 2018</td>
<td>96 patients (61 teams)</td>
<td>62 teams</td>
<td>62 teams</td>
</tr>
<tr>
<td>October 2018</td>
<td>92 patients (67 teams)</td>
<td>49 teams</td>
<td>57 teams</td>
</tr>
<tr>
<td>November 2018</td>
<td>65 patients (67 teams)</td>
<td>48 teams</td>
<td>55 teams</td>
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<tr>
<td>December 2018</td>
<td>72 patients (59 teams)</td>
<td>49 teams</td>
<td>56 teams</td>
</tr>
<tr>
<td>January 2019</td>
<td>60 patients (60 teams)</td>
<td>51 teams</td>
<td>56 teams</td>
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<tr>
<td>February 2019</td>
<td>57 patients (59 teams)</td>
<td>44 teams</td>
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<tr>
<td>March 2019</td>
<td>48 patients (43 teams)</td>
<td>36 teams</td>
<td>33 teams</td>
</tr>
</tbody>
</table>

*NOTE: Team count includes teams with patient-level data & teams who reported ‘no cases’
May 2019 QI Awards!

• ILPQC will be giving out Data Completion QI Award Certificates at the OB & Neonatal Face-to-Face Meetings (May 29, 30).

• To qualify for a MNO-OB Data Completion QI Award, you must have submitted ALL monthly patient data, monthly sample of screening for OUD, and structure measures from (1)Baseline 2017 & (2)July 2018 – March 2019 Data by April 30th, 2019.

• If you have any questions regarding your data completion status, please email Dan Weiss at Dweiss@northshore.org or info@ilpqc.org
Systems Changes needed to show improvement in process/outcome measures

MNO-OB STRUCTURE MEASURES
Screening & Linkage to Care: Standardized Screening Tool on L&D (Structure Measure)

**AIM:** Increase proportion of all pregnant women screened with a universal validated screener on L&D

**ILPQC MNO Initiative:**
Percent of hospitals that have implemented a standardized, validated self-report screening tool for screening all pregnant women for OUD on units caring for pregnant women
All Hospitals, 2018-2019

- **Baseline (2017):** 76%
- **Jul-18:** 29%
- **Aug-18:** 23%
- **Sep-18:** 16%
- **Oct-18:** 6%
- **Nov-18:** 4%
- **Dec-18:** 4%
- **Jan-19:** 0%
- **Feb-19:** 0%

Legend:
- In place
- Working on it
- Have not started
Screening & Linkage to Care:
Standardized Screening Tool Prenatal Care Sites (Structure Measure)

AIM: Increase proportion of all pregnant women screened with a universal validated screener during prenatal period

ILPQC MNO Initiative:
Percent of hospitals that have provided to affiliated prenatal sites options for standardized self-report substance use screening tools for screening pregnant and postpartum women for OUD
All Hospitals, 2018-2019

<table>
<thead>
<tr>
<th>Month</th>
<th>In place</th>
<th>Working on it</th>
<th>Have not started</th>
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<tbody>
<tr>
<td>Baseline (2017)</td>
<td>5%</td>
<td>11%</td>
<td>85%</td>
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<tr>
<td>Jul-18</td>
<td>4%</td>
<td>39%</td>
<td>58%</td>
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<tr>
<td>Aug-18</td>
<td>2%</td>
<td>35%</td>
<td>64%</td>
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<tr>
<td>Sep-18</td>
<td>3%</td>
<td>28%</td>
<td>69%</td>
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<tr>
<td>Oct-18</td>
<td>8%</td>
<td>27%</td>
<td>65%</td>
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<tr>
<td>Nov-18</td>
<td>10%</td>
<td>24%</td>
<td>65%</td>
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<tr>
<td>Dec-18</td>
<td>18%</td>
<td>22%</td>
<td>60%</td>
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<tr>
<td>Jan-19</td>
<td>23%</td>
<td>13%</td>
<td>64%</td>
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<tr>
<td>Feb-19</td>
<td>32%</td>
<td>6%</td>
<td>62%</td>
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</tbody>
</table>
Screening & Linkage to Care: Standardized SBIRT
(Structure Measure)

**Aim:** Increase proportion of women with OUD receiving MAT and Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge

**ILPQC MNO Initiative:**
Percent of hospitals that have implemented a SBIRT protocol/process flow for women who report or screen positive for OUD to assess and link to MAT / Behavioral Health Counseling / Recovery Services
All Hospitals, 2018-2019

<table>
<thead>
<tr>
<th>Month</th>
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<tbody>
<tr>
<td>Baseline (2017)</td>
<td>85%</td>
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<tr>
<td>Jul-18</td>
<td>42%</td>
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<td>Aug-18</td>
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<td>Sep-18</td>
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<tr>
<td>Oct-18</td>
<td>21%</td>
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<td>Nov-18</td>
<td>14%</td>
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<td>Dec-18</td>
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<td>Jan-19</td>
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<tr>
<td>Feb-19</td>
<td>9%</td>
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<table>
<thead>
<tr>
<th>Milestone</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Jul-18</td>
<td>42%</td>
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<tr>
<td>Aug-18</td>
<td>35%</td>
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<tr>
<td>Sep-18</td>
<td>27%</td>
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<td>Oct-18</td>
<td>21%</td>
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<tr>
<td>Nov-18</td>
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<td>Jan-19</td>
<td>12%</td>
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<tr>
<td>Feb-19</td>
<td>9%</td>
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</tbody>
</table>
Screening & Linkage to Care: Mapping Community Resources (Structure Measure)

ILPQC MNO Initiative:
Percent of hospitals that have completed ILPQC Community mapping tool to map local community resources (MAT/Behavioral Health Counseling/Recovery Services) for pregnant/postpartum women with OUD
All Hospitals, 2018-2019

<table>
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<tbody>
<tr>
<td>Baseline (2017)</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>20%</td>
<td>56%</td>
<td>24%</td>
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<tr>
<td>Aug-18</td>
<td>19%</td>
<td>60%</td>
<td>21%</td>
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<tr>
<td>Feb-19</td>
<td>6%</td>
<td>36%</td>
<td>57%</td>
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</tbody>
</table>
Optimizing Care: Standardized OUD Checklist on L&D (Structure Measure)

AIM: Increase proportion of women with an OUD clinical care checklist completed prenatally or during delivery admission

ILPQC MNO Initiative:
Percent of hospitals that have implemented standardized protocol and/or checklist for optimal management of patients with OUD during labor and postpartum
All Hospitals, 2018


In place  Working on it  Have not started

6%  8%  4%  8%  8%  8%  10%  22%  22%  18%  31%  44%  50%  54%  67%  70%  65%  65%  76%  61%  52%  42%  38%  24%  20%  13%  13%  0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

AIM: Increase proportion of women with an OUD clinical care checklist completed prenatally or during delivery admission
Optimizing Care: Standardized Education for Women with OUD (Structure Measure)

**AIM:** Increase proportion of women with OUD receiving OUD/NAS education prenataally or during delivery admission

**ILPQC MNO Initiative:**
Percent of hospitals that have standardized use of materials for educating pregnant women with OUD regarding OUD/NAS, importance of breastfeeding, and importance of mothers role is NAS newborn care

All Hospitals, 2018-2019

<table>
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<td>Baseline (2017)</td>
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<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Jul-18</td>
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<td>44%</td>
<td>3%</td>
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<tr>
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<td>44%</td>
<td>55%</td>
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<td>Feb-19</td>
<td>20%</td>
<td>54%</td>
<td>0%</td>
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</table>
Optimizing Care: Cumulative Provider & Nursing Education on OUD care protocols (Structure Measure)

ILPQC MNO Initiative:
Average cumulative proportion of providers and nurses educated on OUD care protocols (including stigma & bias)
All Hospitals, 2018-2019
Culture Change is needed to show improvement in process/outcome measures – we must change the outpatient/inpatient care provided to moms with OUD

MNO-OB PROCESS & OUTCOME MEASURES
Screening & Linkage to Care:
Sample of Documentation of Screening for OUD on L&D

MNO-OB Monthly Sample of Documentation of OUD Screening on L&D
All Hospitals, 2018-2019

BENCHMARK = ≥ 80%
Screening & Linkage to Care: Sample of Documentation of Screening for OUD Prenatally

**MNO-OB Monthly Sample of Documentation of OUD Screening Prenatally**
All Hospitals, 2018-2019

**BENCHMARK = ≥ 80%**
Screening & Linkage to Care: Women with OUD at Delivery in MAT (Outcome Measure)

ILPQC MNO Initiative: Percent of Women with OUD at delivery in medication assisted treatment (MAT) prenatally or by delivery discharge
All Hospitals, 2018-2019


41.0%  40.5%  42.7%  34.1%  39.6%  37.7%  42.3%  46.4%  63.6%  50.0%

BENCHMARK = ≥ 70%
Review of data on MAT by Delivery (Jan-Apr 2019)

• 172 women with OUD, of these women:
  – 88 were connected to MAT
  – 71 were Not connected to MAT, of those:
    • 6 said MAT counseling not provided
    • 1 said MAT not available
    • 12 said MAT wasn’t indicated
    • 10 said patient declined MAT
    • 23 said unknown
    • 19 blank
  – 6 were ‘Unknown’
  – 7 were blank
Screening & Linkage to Care: Women with OUD at Delivery Connected to Behavioral Health Counseling/Recovery Services

ILPQC MNO Initiative: Percent of Women with OUD connected to Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge
All Hospitals, 2018-2019

BENCHMARK = ≥ 80%
Review of data on BH Counseling-Recovery Services (Jan – Apr 2019)

- 172 women with OUD, of these women:
  - 92 were connected to BH/RS
  - 47 were Not connected to BH/RS, of those:
    - 4 said BH/RS not offered
    - 8 said BH/RS not indicated
    - 10 said patient declined
    - 4 said unknown
    - 21 were blank
    - 26 were ‘Unknown’
    - 7 were blank
ILPQC MNO Initiative:
Percent of Women with OUD Receiving Narcan counseling/offer, Contraception counseling and plan documented, BH/Social Work counseling, and Hep C Screening Counseling Documented Prenatally or During Delivery Admission
All Hospitals, 201

BENCHMARK = ≥ 70%
Optimizing Care: Maternal OUD/NAS Education (Process Measure)

ILPQC MNO Initiative:
Percent of Women with OUD Receiving Education on OUD and NAS Infant Care Prenatally or During Delivery Admission
All Hospitals, 2018-2019

BENCHMARK = ≥ 80%
Optimizing Care: OUD Clinical Care Checklist Included in Medical Record

ILPQC MNO Initiative:
Percent of Women with OUD with an OUD Clinical Care Checklist Included in the Medical Record
All Hospitals, 2018-2019

** Strategies to improve success of OUD Checklist Implementation focus of the June MNO Webinar **

BENCHMARK = ≥ 70%
MNO Data Sharing Update

As with the Maternal Hypertension Initiative, ILPQC participates in the National ACOG Alliance for Innovation on Maternal Health (AIM) program. Our participation in this program allows for statewide comparisons of quality data across participating AIM states. For MNO, we will share aggregate de-identified hospital-level data (we will not share hospital name/ID and AIM will not be able to identify individual hospitals; patient level data will not be shared). MNO data will be shared with AIM by default (no DUA required). If you do not wish for us to share your hospital’s de-identified data please let us know in writing by April 30 via an email from the project lead and nurse lead and/or physician lead. As in the past, if your hospital would like a DUA with ILPQC, please contact us at info@ilpqc.org for a template. ILPQC does not require DUAs.
THE WARM HAND-OFF MATTERS

ACHIEVING SUCCESS WITH SBIRT AND LINKING TO TREATMENT, SERVICES, & SUPPORT
What is a “warm-hand off”?

It is NOT:
• Providing a phone number to the patient and having the patient call
• Giving a list with resources to the patient
• A phone call to a social worker with no additional follow up

Warm-hand off includes:
• Helping in the process
• Making sure the patient has an appointment and follow-up set up
• If patient declines MAT or BH/Recovery service, schedule a short-interval follow-up with the OB provider
Key steps for OB Providers in the MNO-OB OUD Protocol:

- Screen and document positive result
- Provide SBIRT risk assessment and brief counseling re: benefits of treatment, next steps for linking patient to care
- Activate care coordination and navigation to link woman to MAT, and behavioral health counseling/recovery programs
- Insert and complete OUD clinical care checklist in electronic medical record (or paper chart) (prenatal / L&D)
- Provide patient education re: OUD and NAS, and engaging in newborn care via neonatology consult, counseling, hand-outs.

Activating the OUD protocol for every screen positive woman, every time:

- Increasing % of mothers with OUD on MAT saves lives
- Implement & activate OUD protocol to improve care
Achieving our AIMS

• Structure measures
  – Successfully implement universal screening inpatient / outpatient settings
  – Successfully implement SBIRT with providers and staff (inpatient and outpatient settings)

• Outcome measures
  – Increase % of women with OUD referred to MAT
  – Increase % of women with OUD referred to Behavioral Health Counseling / Recovery Services
Implementing SBIRT Providers/Staff education is key

- Brief Intervention Training Video
  - Online Module to train healthcare providers in SBIRT with pregnant women
  - Click here

- SBIRT 1-Pagers/Pocket Cards
  - Example script
  - Documentation, how to bill
Key Steps for SBIRT / linking women with OUD to treatment/Services

• Screen all patients, document screening

• Providers / staff assess and counsel patients who screen positive for “at risk for SUD/ OUD”, with SBIRT “brief intervention” and document SBIRT

• Assess diagnosis of SUD/ OUD and severity
  – DSM-V criteria is helpful

• Warm handoff for MAT / Behavioral Health and Recovery Services all patients with SUD / OUD
  – Mild refer to Behavioral Health*
  – Mod/Sev refer to MAT/ BH / Recovery Services*

• Sign consent for OB providers to communicate with SUD/OUD providers / behavioral health

*Depends on established referral process flow
Everyone who screens in the “at risk” category needs a Brief Intervention.
Patient education tool

“What All Pregnant Woman Need to Know”

• Patient education tearpad that is written for all pregnant women to better understand risks of pain medicine / opioids in pregnancy, better understand OUD & NAS

• Tools for teams to use
  • Consider providing this to all patients with the screening tool
  • Can use this for women who screen positive for “at risk” when providers do SBIRT / Brief Intervention

• More tearpads available for teams at the Face to Face Meeting May 29
Diagnosing Opioid Use Disorder

- **Definition of Opioid Use Disorder:**
  - “A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following (see chart), occurring within a 12-month period.” (DSM-V)

### DSM-V Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-V Diagnostic Criteria</th>
<th>Present/Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids are often taken in larger amounts or over a longer period than was intended.</td>
<td></td>
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<tr>
<td>There is a persistent desire or unsuccessful efforts to cut down or control opioid use.</td>
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<td>A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.</td>
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<td>Craving, or a strong desire or urge to use opioids.</td>
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<tr>
<td>Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.</td>
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<tr>
<td>Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.</td>
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<tr>
<td>Important social, occupational, or recreational activities are given up or reduced because of opioid use.</td>
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<tr>
<td>Recurrent opioid use in situations in which it is physically hazardous.</td>
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<tr>
<td>Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.</td>
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<tr>
<td>Tolerance, as defined by either of the following:</td>
<td></td>
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<tr>
<td>a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.</td>
<td></td>
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<tr>
<td>b. A markedly diminished effect with continued use of the same amount. (This may also be true for those taking prescribed opioids, in which case this should not be considered diagnostic of opioid use disorder)</td>
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<tr>
<td>Withdrawal, as manifested by either of the following:</td>
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<tr>
<td>a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).</td>
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<tr>
<td>b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms (see above – this may also hold true for those taking prescribed opioids).</td>
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</tbody>
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**DSM - V Diagnostic Criteria for OUD** can be helpful when determining OUD diagnosis & severity

- **Mild:** Presence of 2–3 symptoms
- **Moderate:** Presence of 4–5 symptoms
- **Severe:** Presence of 6 or more symptoms

Gratefully adapted from NNEPQIN
http://www.nnepqin.org/clinical-guidelines/
Different options and levels of care

- **Office-based treatment**
  Combines behavioral treatment with buprenorphine/naloxone or buprenorphine monotherapy. Physicians can complete special training to be eligible for a waiver to prescribe buprenorphine for this purpose. Recent changes in Federal legislation allow Nurse Practitioners and Physicians Assistants to undergo similar training to obtain a buprenorphine waiver, starting in 2017.

- **Methadone maintenance programs**
  Combine behavioral treatment with daily observed treatment with methadone. In the United States, methadone can only be provided for the treatment of addiction at Opioid Treatment Programs certified by the Substance Abuse and Mental Health Services Administration.

- **Intensive Outpatient Program**
  Usually consists of 9 hours of treatment for substance use disorders per week, although programs vary. Clients often begin treatment in IOP/IOT programs and graduate to weekly office-based treatment once doing well.

- **Residential Treatment Program**
  Offer daily treatment in a residential setting. Residential programs may or may not be gender-specific. A few residential programs are also equipped to accommodate children whose mothers are seeking treatment.

- Additional information about levels of treatment for OUD
Choosing right levels of care

Example process flow from NNEPQIN’s toolkit to help providers chose the right level of care for pregnant women with OUD

Gratefully adapted from NNEPQIN
http://www.nnepqin.org/clinical-guidelines/
What is a “warm-hand off”?

**It is NOT:**
- Providing a phone number to the patient and having the patient call
- Giving a list with resources to the patient
- A phone call to a social worker with no additional follow up

**Warm-hand off includes:**
- Helping in the process
- Making sure the patient has an appointment and follow-up set up
- If patient declines MAT or BH/Recovery service, schedule a short-interval follow-up with the OB provider
Consent to share information with Treatment Providers

**Things to know:**

- Once OUD has been diagnosed and a patient referred or treatment started, **consent to share information between members of the care team is essential** (listed in ILPQC Clinical Care Checklist)

- Additional federal rules protect the privacy and confidentiality of substance use treatment records. The **consent to release this information differs from an Authorization to Release Medical Records form normally used between providers**

- A summary of these rules and a sample consent form may be accessed through the following:
  - **American Osteopathic Academy of Addiction Medicine**
  - A fillable electronic version of the same form is available through PCSS-MAT
Strategies for successful navigation of pregnant women with OUD to MAT
The “warm handoff” matters

Krisanna Deppen, MD
• Program Director, OhioHealth-Grant Addiction Medicine Fellowship
  • Medical Director, Maryhaven Addiction Stabilization Center
“May you live in interesting times.”

~Ancient Chinese Curse
Newborn drug dependence soars

Newborns whose mothers used drugs during pregnancy are at risk of neonatal abstinence syndrome (NAS), which can cause breathing problems, seizures, tremors and excessive crying. The number of Ohio babies born drug-dependent has soared along with the opiate epidemic.

**NAS hospitalization rate per 10,000 live births**

Sources: Ohio Hospital Association; Ohio Department of Mental Health and Addiction Services

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*Image from OhioHealth*
Pregnancy Recommendations
(Basic assumptions I’m making for this presentation)

• Medication-assisted therapy is standard of care
  – Methadone
  – Buprenorphine
• Routine prenatal care (also standard of care!) 😊
  – Consider more frequent visits
• Substance use disorder treatment
  – In addition to MAT, best practice is additional treatment (counseling, group visits, trauma therapy, etc)
• Preparation for neonatal abstinence syndrome (NAS)
• Among women with recent drug use, pregnant women are more likely to need treatment
• Pregnant women are no more likely to receive it
• While many policies state that pregnant women are to receive preferential treatment, there is no evidence that they do
Entry to treatment: No “wrong door”

- Prenatal care hotline (Step One)
  - Screen for substance use disorder
- Addiction treatment providers
  - Inpatient unit that will accept pregnant patient
  - Providers aware of ”requirements”-ultrasound, NST later gestational age
- L&D (triage)
  - Engage residents
- Prenatal care
  - Work to link to addiction treatment (difficult door to open)
- Drug court system
Gold Standard:

- Comprehensive co-located service delivery
- Close collaboration between substance use disorder treatment provider and prenatal care provider
Perinatal Opioid Addiction Treatment
(at my health system)

- Grant Family Medicine Residency (Columbus)
  - Co-located care through 12 months postpartum with infant
  - Currently see ~20 actively pregnant women
  - Utilize community health worker to link to resources & recently hired chemical dependency counselor
- Riverside OB & Family Medicine Residencies (Columbus)
  - Co-located prenatal & MAT
  - Currently see 6-8 actively pregnant patients and then transition care to another provider postpartum
  - Social worker on team
- O’Bleness (Athens)
  - Collaborating between MAT provider and primary OB clinic for several years
- Grady Memorial (Delaware)
  - Currently working to build community collaboration, hiring nurse navigator for pregnant women with substance use disorders
What are ”levels of care” in Addiction Treatment?

- Great way to discuss and understand levels of care
- Not every level of care is available in every community
- Not every provider is comfortable caring for pregnant women (also limiting this continuum)
What is the “warm handoff?”
Is this possible?

• Provider refers patient by directly introducing to behavioral health/addiction treatment provider to patient

• Barriers:
  – Privacy rules
  – Silos
  – “Atypical” partners
Improving the hand-off (Lukewarm handoff?)

- Develop relationships
  - Local treatment providers
  - Jails/drug courts
- Embed connectors in office
  - CHW, nurse navigator, peer recovery supporters
- Offer education
  - Health care (local residencies, L&D nurses, ED providers)
  - Addiction treatment providers
  - The “others” (judges, children’s services, drug courts)
- Early release of information
QUESTIONS?
TEAM TALK
MNO: Where Are We Now

Amita Alexian Brothers Medical Center
Women and Infants Services Team

Peggy Farrell MSN RN NE-BC
Kristin Yates BSN RNC-MNN
AMITA Health Care System

AMITA Health Regions

AMITA Health Northwest Region
- St. Alexius Medical Center, Hoffman Estates
- Alexian Brothers Medical Center, Elk Grove Village
- Saint Joseph Hospital, Elgin
- Mercy Medical Center, Aurora
- Adventist Medical Center GlenOaks, Glendale Heights

AMITA Health Chicago Region
- Saint Francis Hospital, Evanston
- Saint Joseph Hospital, Chicago
- Saints Mary & Elizabeth Medical Center, Chicago
- Resurrection Medical Center, Chicago

AMITA Health South Region
- Saint Joseph Medical Center, Joliet
- Saint Mary’s Hospital, Chicago
- Adventist Medical Center, Bolingbrook
- Adventist Medical Center, Hinsdale
- Adventist Medical Center, La Grange
OUR MNO TEAM

- Susan Fulara MSN, RNC-OB, NE-BC Manager L&D
- Laura Bravos MSN, RNC-NIC, CNL Manager M/B- SCN
- Kristin Yates BSN, RNC-MNN L&D Educator
- Peggy Farrell MSN RN M/B-SCN Educator
- Valerie A. Sanchez MSW, LSW, LCSW Social Worker
- Mary Tillema MD Neonatologist
What have we done?

- Staff completed survey on Assessment of Substance Abuse Disorder (Oct 2018)
- Provide room for mom after discharge: Mom and baby stay together (Nov 18)
- Non-Pharmacological intervention for NAS (Nov 18)
- Support of Breastfeeding during methadone use (Nov 18)
- Education for pediatricians for discharge of baby (Dec 18)
- Provide ILPQC resources for families- brochures (Dec 18)
- OB providers given ILPQC assessment form to complete (Jan 19)
- OB providers continue to be educated on MNO project and resources available
- 5 P’s screening in L&D began (Feb. 2019)
- Ongoing education by support of Perinatal Center, Loyola with web-based learning for staff. (Jan and up to now)
What have we done?

• Social worker mapping out services available for patients- both for provider offices and hospital entry point.

• Hospital based OPIOD handout given to all patients at discharge

• Post partum mood and anxiety disorder counselors in house for evaluation and recommendations as needed.

• Discharge readiness built into EMR for newborn discharge planning

• MNO is a Standing agenda item on subset perinatal and nursery meetings

• Upcoming CME planned for May 17th Opioids and Neonatal Abstinence Syndrome

• Prescription Monitoring Program has become part of the EMR.

• MFM/Neonatology/OB antenatal navigation for MNO referral patients.
DATA AND OUTCOMES: 5 P’s

MNO 5P’s Screening Results ABMC

1. Did any of your Parents have problems with alcohol or drug use?
   ___ No ___ Yes
2. Do any of your friends (Peers) have problems with alcohol or drug use?
   ___ No ___ Yes
3. Does your Partner have a problem with alcohol or drug use?
   ___ No ___ Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (Post)
   ___ No ___ Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (Pregnancy)
   ___ No ___ Yes

February 2019:
- Screened 84 patients
  - Question #1: 4 yes (4%)
  - Question #2: 1 yes (1%)
  - Question #3: 1 yes (1%)
  - Question #4: 1 yes (1%)
  - Question #5: 1 yes (1%)

March 2019:
- Screened 119 Patients
  - Question #1: 8 yes (6.7%)
  - Question #2: 0
  - Question #3: 0
  - Question #4: 1 yes (0.08%)
  - Question #5: 1 yes (0.08%)
Future:

- Working on ESC integrated into EMR
- Continue to provide resources/education to providers and staff (SBIRT training and ILPQC resources to providers)
  - Provide OB offices to use the 5 P’s screening tool
  - Reach out to community OB clinics that the patients transition and deliver for same resources as in-house providers (assess current process and resources)
  - Continue to review and update policies
- AMITA/Ascension is also working on addressing the opioid crisis. AMITA is investigating opportunities to decrease inpatient opioid use through the Enhanced Recovery After Surgery (ERAS) program. It is currently being done at another AMITA hospital.
Screen and document positive result

Educate staff and providers on SBIRT risk assessment and how to counsel patients re: benefits of treatment, next steps for linking patient to care

Implement care coordination and navigation to link woman to MAT and behavioral health counseling/recovery programs.

Insert and complete OUD clinical care checklist in electronic medical record (or paper chart) (prenatal / L&D)

Discharge Planning: Provide patient education re: OUD and NAS, and engaging in newborn care via collaboration with pediatrician, neonatology consult (when indicated), counseling, hand-outs

*Adapted from the ILPQC OUD Protocol.
QUESTIONS?
THANK YOU

Contact information for our team members:

Peggy.farrell@amitahealth.org
Kristin.yates@amitahealth.org
QI CORNER
Chart reviewed using the missed opportunity form and the following noted:

- A positive screen was documented in LD during a prenatal admission for influenza
- Patient was referred for social work consult

Opportunities for improvement:

- Patient counselling/SBIRT from OB provider on treatment options
- Warm hand-off to MAT and SUD support from navigator to ensure initial engagement in services
Follow up conversations with care team revealed the need to provide further training OB Providers on SBIRT and care team on hospital’s OUD protocol including warm hand-off process

The team has decided on the following:

• **Review the screening tools** used at all prenatal care sites and outpatient providers.

• Provide **SBIRT training resources** to all OB providers and outpatient sites in the ILPQC

• Host a **ILPQC Grand Round**s with a requested focus on SBIRT

• **QI work:** Perform small test of change with the following:
  – PDSA cycle at one outpatient site with one provider after the SBIRT training
  – PDSA cycle on each LD shift using the ILPQC SBIRT guide
<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>February</td>
<td>Implementing the Perinatal OUD Protocol, a standard system wide response for OUD screen positive pregnant patients: Navigate to MAT, Clinical Care Checklist, Patient Education</td>
</tr>
<tr>
<td>March*</td>
<td>Engaging OB Providers in MNO: Strategies to standardize education on stigma and OUD as a chronic disease, understand importance of MAT and completion of clinical care checklist to reduce maternal morbidity/mortality and improve outcomes for mom / baby</td>
</tr>
<tr>
<td>*Special Date 3/11/19 12:30-1:30pm</td>
<td></td>
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<tr>
<td>April</td>
<td>Strategies for successful navigation of pregnant women with OUD to MAT / Behavioral Health Counselling/Recovery Services – the warm hand off matters</td>
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<tr>
<td>May</td>
<td>Face-to-Face Meeting</td>
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<td>June</td>
<td>Strategies to increase completion of the OUD Clinical Care Check list</td>
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<td>Date</td>
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<tr>
<td>July</td>
<td>Optimize the L&amp;D OUD protocol: pain control in labor/postpartum for women with OUD, L&amp;D care plan, managing MAT on L&amp;D/postpartum</td>
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<tr>
<td>August</td>
<td>Strategies to optimize Non-Pharmacologic care for Mom/Baby: Empowering moms to participate in non-pharmacologic care of opioid-exposed newborn through standardized education for moms, systems changes to support rooming in and Eat/Sleep/Console</td>
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<tr>
<td>September</td>
<td>Optimizing postpartum care for moms with OUD: supporting safe discharge planning, linkage to support services and appropriate follow up.</td>
</tr>
<tr>
<td>October</td>
<td>Prevention webinar – reducing opioid prescribing at delivery</td>
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<tr>
<td>November</td>
<td>Prevention – educating providers / patients risk of OUD, PMP look up/documentation</td>
</tr>
<tr>
<td>December</td>
<td>No Call- Christmas Eve.</td>
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ILPQC Team Tools

1. **ILPQC Clinical Care Checklist**
   - ILPQC OUD Clinical Care Checklist reflects current recommendations and clinical guidance for the treatment of pregnant women with OUD and their infants that connects to data collection

2. **OB Provider/Outpatient Packet**
   - Contains the tools your OB providers/prenatal sites will need to provide evidence-based care for this high-risk population in the outpatient setting

3. **SBIRT 1-pager Tool**
   - Useful tool for all providers to reference when providing a brief intervention including interview guidelines, example documentation language, billing codes and helpline contacts

4. **Missed Opportunity Form**
   - QI tool for your MNO-OB hospital team to use to identify causes of missed opportunities and areas of growth in the care of pregnant women with OUD!
THANKS TO OUR SPONSORS

IDPH  
Illinois Department of Public Health

CDC  
Centers for Disease Control and Prevention

DHS  
Illinois Department of Human Services

JB & MK PRITZKER  
Family Foundation

Email info@ilpqc.org * Visit us at www.ilpqc.org