New Beginnings: Implementing Trauma-Informed Care for High Risk Women

ACES (Adverse Childhood Events) in Practice

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Santa Rosa, CA

March of Dimes 17th Annual Birth Conference
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Objectives

- Learn how adverse childhood experiences (ACES) can impact women during the perinatal period and affect birth outcomes
- Understand how we can apply this knowledge to improve our care of high risk pregnant women and reduce the risk of childhood trauma in their offspring
- Understand the components of evidenced-based care for pregnant women with substance use disorder (SUD)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

"Never before in the history of medicine have we had better insight into the factors that determine the health of an individual from infancy to adulthood, which is part of the life course perspective—a way of looking at life not as disconnected stages but as integrated across time."

Building Resiliency
Preventing Adverse Childhood Experiences (ACEs)

ACES Overview

Adverse Childhood Experiences (ACE) Study

Centers for Disease Control and Kaiser Permanente in San Diego, 17,300 Adults
Tracked health outcomes based on childhood ACEs

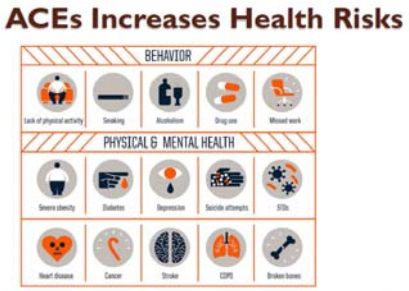
75% Caucasian, 39% college graduates, 36% some college, living wage jobs with insurance; median age 57 yr. old

What are the Adverse Childhood Experiences?

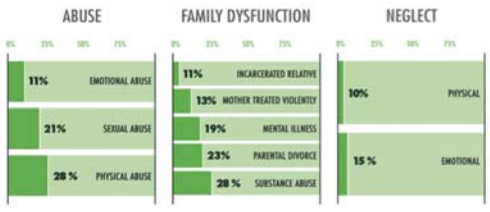
1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse
4. Physical Neglect
5. Emotional Neglect
6. Mentally ill, depressed or suicidal person in the home
7. Drug addicted or alcoholic family member
8. Witnessing domestic violence against the mother
9. Loss of a parent to death or abandonment, including abandonment by divorce
10. Incarceration of any family member

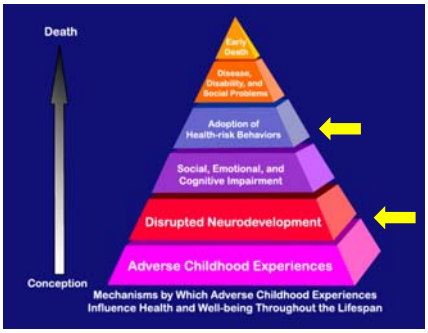
Quick Review -

Quick Review -

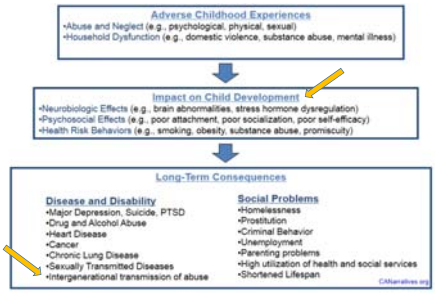


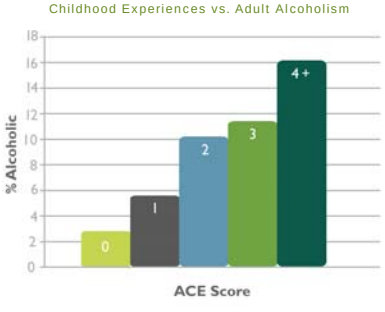
Adverse Childhood Experiences are Common





How the ACES Work





Prevalence

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

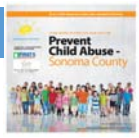
Centers for Disease Control and Prevention

Household dysfunction
- Substance abuse 27%
- Parental separation/divorce 23%
- Mental illness 19%
- Battered mother 13%
- Incarcerated household member 5%

Abuse
- Psychological 11%
- Physical 28%
- Sexual 21%

Neglect
- Emotional 15%
- Physical 10%

DATA from LOCAL HELPERS (BLUE RIBBON EVENT May 2015)

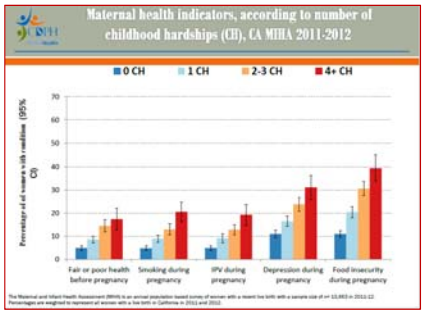


Abuse		
Psychological	11%	53%
Physical	28%	23%
Sexual	21%	28%
Neglect		
Emotional	15%	25%
Physical	10%	12%
Household Dysfunction		
Substance Abuse	27%	51%
Parent Absent	23%	46%
Mental Illness	17%	47%
Domestic Violence	13%	16%
Criminal Behavior	6%	9%

Hidden Crisis Report on ACEs

Results for Sonoma County
- Napa/Sonoma data combined
- Estimated prevalence of 22% have 4 or more ACEs
- Increased risk for depression, suicide attempts, drug and alcohol use, heart disease, stroke, COPD, diabetes, and Alzheimer's

Why Do We Care About ACES?



Source: "**Considering Maternity Care through the Lens of the Social Determinants of Health**", Dr. Connie Mitchell, CDPH, October 2014

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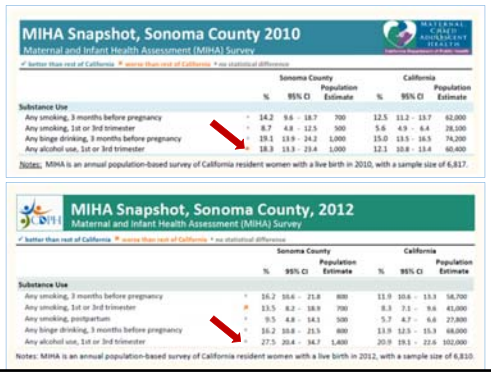

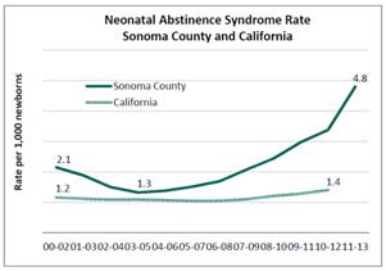

California and Sonoma County, 2000-2012
Neonatal Abstinence Syndrome[1] (NAS) Rates per 1,000 Newborns[2]
NAS: ICD9-CM Diagnosis Code of 779.5 (drug withdrawal syndrome in a newborn)
Data Source: OSHPD Patient Discharge Data, 2000-2012

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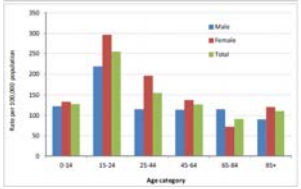
INJURY FACT SHEET: Drug Overdose Deaths

Updated July 2013

Figure 4—Unintentional opiate overdose hospitalization rate, 3 year moving average, Sonoma County and California 2000-2011

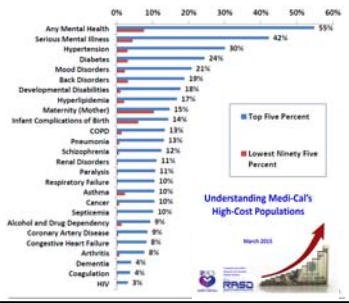
Figure 3—Age-specific drug overdose ED visits rate by sex, 3 year average, Sonoma County 2008-2011



Sonoma County Department of Health Services
Public Health Division

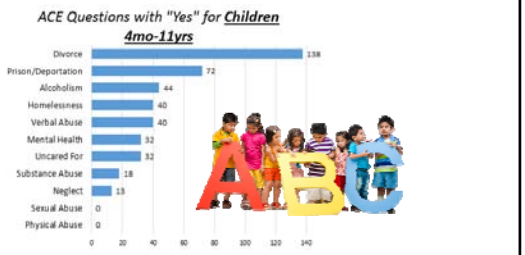
Source: California Department of Public Health, Death Statistical Master Files, 2000-2010

Prevalence of Major Disease Among the Most Costly 5% and Least Costly 95% Individuals Eligible For Medi-Cal Only , Participating In FFS
Eligibles = 2,547,370, Total Spending = $8.9 Billion

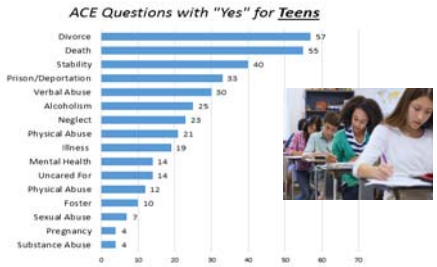


In California, the **Department of Health Care Services** issued a slightly more conservative summary for a presentation coordinated by the California HealthCare Foundation, which publishes *California Healthline*. DHCS officials said the top 5% account for 51% of Medi-Cal spending.

LOCAL data: Children 0-11yo



LOCAL data: Teens



ACES and Birth Outcomes

BMC Medicine

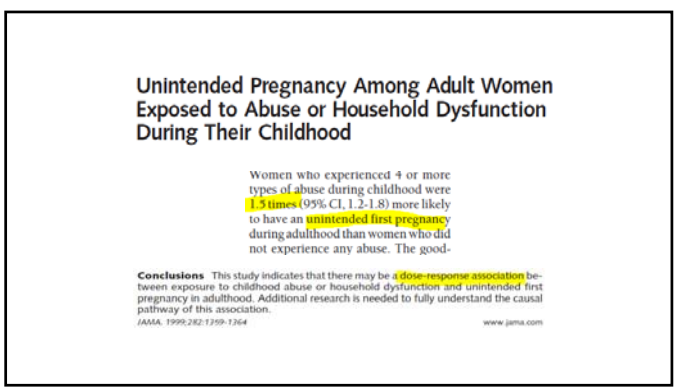
RESEARCH ARTICLE Open Access

Adverse childhood experiences are associated with spontaneous preterm birth: a case–control study

Inge Christiaens[1], Kathleen Hegadoren[2] and David M Olson[3*]

Results: Multivariate analysis showed that exposure to two or more adverse childhood experiences (ACEs) was associated with a two-fold risk of preterm birth, regardless of maternal age, smoking status, educational status, and history of miscarriage (adjusted OR, 2.09; 95 % CI, 1.10–3.98; $P = 0.024$). The adjusted odds ratio for the ACE score was 1.18 (95 % CI, 0.99–1.40), suggesting that for every increase in childhood adverse event endorsed, the risk of preterm birth increased by 18 %. Lifetime physical and emotional abuse was also associated with spontaneous preterm birth in our study population (adjusted OR, 1.30; 95 % CI, 1.02–1.65; $P = 0.033$).

Conclusions: A strong relationship between ACEs and preterm birth was observed. It has been shown that two or more ACEs have a notable two-fold increase in the risk of spontaneous preterm birth. These data demonstrate that stressors throughout life can have a significant effect on pregnancy outcomes such as preterm birth.



Unintended Pregnancy Among Adult Women Exposed to Abuse or Household Dysfunction During Their Childhood

Women who experienced 4 or more types of abuse during childhood were 1.5 times (95% CI, 1.2-1.8) more likely to have an unintended first pregnancy during adulthood than women who did not experience any abuse. The good-

Conclusions This study indicates that there may be a dose-response association between exposure to childhood abuse or household dysfunction and unintended first pregnancy in adulthood. Additional research is needed to fully understand the causal pathway of this association.

JAMA. 1999;282:1359-1364 www.jama.com

Child Abuse & Neglect

Research article

Adverse childhood experiences and prescription drug use in a cohort study of adult HMO patients

Research article

Life course pathways of adverse childhood experiences toward adult psychological well-being: A stress process analysis

BMC Public Health

The relationship of adverse childhood experiences to a history of premature death of family members

Journal of Substance Abuse Treatment

Commentary

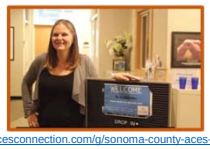
Women, Co-occurring Disorders, and Violence Study: A case for trauma-informed care

The Association Between Adverse Childhood Experiences and Adolescent Pregnancy, Long-Term Psychosocial Consequences, and Fetal Death

Susan D. Hillis, PhD, MS*; Robert F. Anda, MD, MS*; Shanta R. Dube, MPH*; Vincent J. Felitti, MD, FACP†; Polly A. Marchbanks, PhD*; and James S. Marks, MD, MPH*

Sonoma County ACEs Connection

Annjané's Story



http://www.acesconnection.com/g/sonoma-county-aces-connection/home

https://www.youtube.com/watch?v=fM4QWb3MBPU

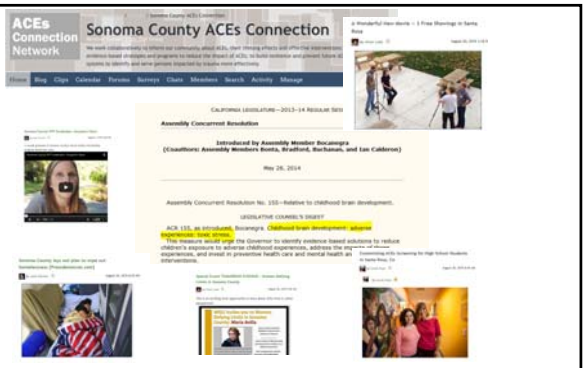
RESILIENCE

"Understanding a parent's adverse childhood experience takes nothing away from understanding her resilience. It puts into perspective how spectacularly resilient she may be, the strengths she is building on for the next phase of her life, and opens the space to talk about the life she wants for her family and her new baby." -Laura Porter

NEUROSCIENCE
EPIGENETICS
ADVERSE CHILDHOOD EXPERIENCES
RESILIENCE

NEAR@Home

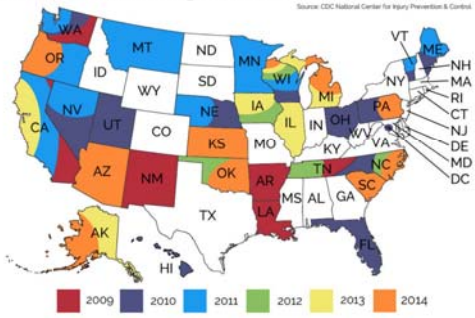
http://www.acesconnection.com/blog/**near-home-toolkit-a-guided-process-to-talk-about-trauma-and-resilience**-in-home-visiting-thrivewa-org



Mind Full, or Mindful?

States Collecting ACEs Data 2009 - 2014

Source: CDC National Center for Injury Prevention & Control



Widespread interest and uptake

ACES Connection social networking site
- Almost 10,000 members from 50 states and many countries
- 18 interest- and 39 geographic-based groups

Building a Trauma-Informed Nation
- Federal Partners committee on trauma – 100+ members from 40 divisions of 13 federal agencies
- 2,000 participants each day
- 83 amplifier sites in 30 states

Robert Wood Johnson initiatives
- Culture of Health
- Mobilizing Action for Resilience Communities
- Trauma-informed primary health care

Sonoma County, CA Universal Screening Tool

- Created in 2012 with multidisciplinary task force through a grant from the CDC as part of the CityMatch Practice Collaborative to Prevent Substance Exposed Pregnancies
- Adapted from the 5 – P's validated screening tool for SUD in pregnancy with expanded questions on MJ and ETOH use
- Also added single questions about mood disorder sx's in past month and current or past violence
- 10 self-report questions with local resources for providers on same form to encourage referral for any positive screening questions
- Have collected screening data now on over 5,000 women

Results from Confidential Women's Health Questionnaire: Perinatal — Sonoma County 2014-2016

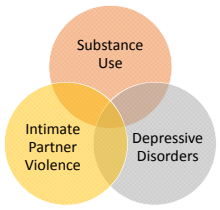
Percent of women screening positive for select risks on perinatal women's health questionnaire by their reported parents' substance use history (n=4892) , Community Clinics, Sonoma County 2014-2016

	All women screened		Women screened reporting Parent(s) had a problem with substances		Women screened reporting Parent(s) did not have a problem with substances			
	n	%	n	%	n	%	Risk Ratio	95% Confidence Interval
Total women screened	4892	100	915	18.7	3977	81.3	-	-
Depressed in past month	742	15.2	255	27.9	485	12.3	2.2*	1.9-2.4
Tobacco use in past 3 months	587	12	223	24.4	361	9.1	2.4*	2.1-2.7
Ever had difficulties due to substance use^	364	7.4	209	22.8	155	3.9	3.7*	3.3-4.1
Marijuana use in past 3 months	486	10	207	22.7	279	7.1	2.6*	2.3-2.9
Alcohol use in past month	727	14.9	177	19.4	549	13.9	1.4*	1.2-1.6
Intimate partner violence ever	401	8.2	165	18.1	235	5.9	2.5*	2.2-2.8
Other drugs in past 3 months	216	4.4	91	10.0	123	3.1	2.4*	2.0-2.7

Source: Sonoma County Confidential Women's Health Questionnaire: Perinatal, 2014-2016; Accessed 2-27-2017

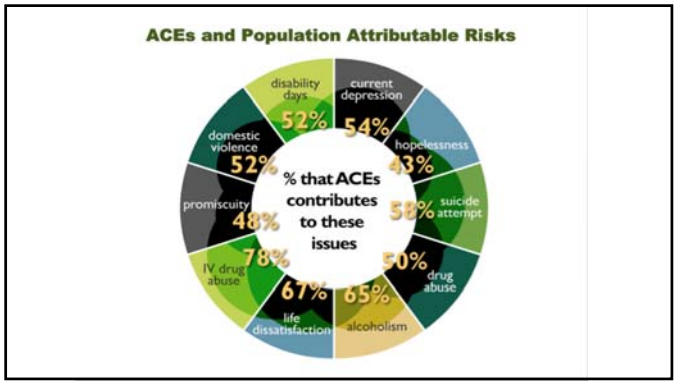
^Substances: alcohol, marijuana or other drugs

X Significant p<.0001



- Women screened ⊕ for risky ETOH - 59% experienced DV/SA
- Physically abused women - >7x risk of ETOH in pregnancy
- Women with IPV - 20-38% have symptoms of depression
- Teens in physically abusive relationships - 3-5x↑ risk of pregnancy

Source: Family Violence Prevention Fund



How do ACES Apply to Our Work?

Women, Substance Use and ACES

- Women are more likely than men to initiate substance use because of traumatic life events
- Women are more likely than men to be drawn into substance use by either family members or partners who use
- Women whose partners continue to use will have a harder time quitting
- Women with substance use disorders are more likely than men to have poor self-esteem
- Co-morbid psychiatric conditions such as depression, anxiety, bipolar disorder and PTSD are more common among female substance users than men

Ashley, O.S., Marsden, M.E, & Brady, T.M. (2003)

Substance Use Disorder and ACES

- Prior traumatic experiences from exposure to physical, sexual or emotional violence are common among women with SUD
- Studies suggest between 50-85% of women with SUD have significant trauma histories
- Pregnancy can be a vulnerable and triggering time for women w/ trauma histories
- One study of pregnant or recently delivered women with SUD showed all women reported adverse childhood events and 77% reported prior sexual abuse
- Ongoing adult traumatic experiences are also common in this population w/ many experiencing intimate partner violence during pregnancy

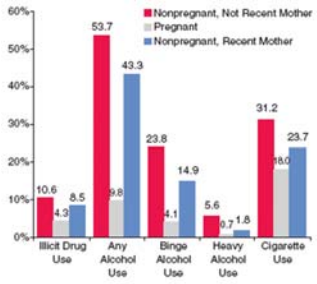
Torchalla et al, 2015

Substance Use Disorder and Pregnancy

- Many women who use drugs or alcohol pre-pregnancy are able to stop on their own, but those with substance use disorder often unable to quit without help
- 5.4% of pregnant women are current users of illicit drugs
- Rates decrease by trimester (9%, 4.8% and 2%)
- Rates are highest in pregnant teens 15-17 (14.6%) followed by women 18-25 (8.6%)
- Many obstetric risks are increased for those who continue to use, specifically preterm delivery, low birth weight, NICU admission
- Women continuing to use substances are much more likely to present late to prenatal care or receive none at all

Helmbrecht and Thiagarajah, 2008; SAMHSA - NSDUH results 2013

Rates of Past Month Substance Use by Women 15-44 by Pregnancy Status



Source: SAMHSA – NSDUH 2002

Barriers to Care in Pregnancy

- Unintended pregnancies, late pregnancy awareness
- Unreliable transportation
- Increased social stigma of using drugs while pregnant
- Fear of criminal or child welfare consequences if use discovered
- Lack of access to gender-specific substance use treatment
- Limited child-care availability at treatment facilities
- Lack of providers with obstetrics and addiction treatment expertise
- Low income women and women of color are at highest risk of barriers to care, may explain disproportionately poor birth outcomes in this population

Brady & Randal, 1999; Burns et al, 2004; Schempf, 2008; Young, et al, 2007.

Barriers to Disclosure of Substance Use

- Fear of exposure and reporting to child welfare authorities or police
- Feelings of shame, fear and low self-esteem corrode the trust necessary for full disclosure of substance use
- Co-morbid depression, anxiety and trauma can impede formation of a therapeutic alliance with care providers
- Past negative experiences with judgement or stigma from providers
- Past involvement with child welfare services
- Denial that level of use is a problem

ACOG committee opinion, No. 422, 2008; Kandall, S., 1996; Jessup, 2003.

Importance of Prenatal Care

- Regular prenatal care improves obstetric outcomes whether or not a woman is able to stop using drugs during her pregnancy
- Multiple studies show a reduction in preterm delivery rates when women using substances receive adequate prenatal care compared to those receiving late or no prenatal care
- Large cohort studies support a policy of universal screening for substance use at the first prenatal visit and subsequent assessment and treatment integrated into prenatal visits to optimize obstetric outcomes

Andres & Larrabee,1996; Andres, et al, 1992; Racine, Joyce & Anderson,1993; Goler, et al. 2008; Sweeney, et al, 2000.

Kaiser Early Start Program

- Began as a pilot program in 1990
- Implemented across Kaiser Permanente Northern California over subsequent years
- By time the study was published in 2008, Early Start was the standard of care across 40 KPNC obstetric clinic sites, screening over 40,000 women annually
- Three key components:
  - Placing a licensed substance abuse expert into the department of OB/GYN whose assessment appointments are linked to the patient's prenatal visits
  - Universal screening of all women for alcohol and drugs by screening questionnaire and (with signed consent) a urine toxicology test
  - Education of all providers and patients about the effects of drugs, alcohol and cigarette use in pregnancy

Goler et al. 2008

Kaiser Early Start Study

- Retrospective Cohort Study – 21 Kaiser Northern CA sites with active Early Start Programs, included nearly 50,000 female Kaiser patients completed initial screening questionnaires over 4.5 year period
- Screen positive group includes women who either screened positive for use of drugs of abuse on self-report or who tested positive on the initial urine drug screen (universally administered)
- All screen positive women were referred for assessment with Early Start Specialist
- Following that assessment women in the treatment group had at least 1 follow-up visit with the Early Start Specialist

Goler et al. 2008

Kaiser Early Start Results

	Controls-Screened Negative (46,533)	Screened, Assessed and Treated (2,073)	Screened and Assessed Only (1,203)	Screened Positive Only (156)
Low Birth Weight	4.7%	6.5%	7.7%	12.4%
Preterm Delivery	6.8%	8.1%	9.7%	17.4%
NICU Admission	10.3%	16.4%	15.3%	21.4%
Placental Abruption	0.9%	0.9%	1.1%	6.5%
IUFD	0.6%	0.5%	0.8%	7.1%

Goler et al. 2008

Importance of SUD Treatment in Pregnancy

- Women who receive SUD treatment early in pregnancy are more likely to stop using and have improved outcomes compared to women not receiving treatment
- Retrospective study in Massachusetts, 2003-2007
  - 375,851 deliveries
  - SUD rate of 5.5%
  - Only 66% of these women received treatment pre-delivery
  - Women with SUD were poorer, less educated, had more health problems
  - Women with SUD utilized less prenatal care but more ER visits and hospitalizations
  - Increased risk of prematurity and Low Birth Weight among women with SUDs
- Women with SUD treatment prenatally had lower risk of preterm birth (AOR 0.61), low birth rate (AOR 0.54) and neonatal mortality (AOR = 0.49), compared to women with SUD not receiving treatment

SAMHSA/CSAT, 2001; Kotelchuck, et al. 2016

Gender Sensitive SUD Treatment

- For decades most substance use treatment was tailored with men in mind
- Willpower driven
- Beat you down before building you up
- Recent research shows that gender sensitive treatment programs that are trauma-informed are more effective for women
- Specifically address the common comorbidities that affect women and barriers to treatment that are more common for women
- Attention to relationships is essential to engaging women in treatment as well as helping achieve long term recovery

[redacted]

Components of Gender-Specific Treatment for Women with SUD

- Groups and education aimed at dealing with relationships, parenting and women's health
- Treatment services delivered at times that are convenient for women with child-rearing responsibilities and for women who work
- Case management
- Outreach to assist women in attending treatment
- Availability of mental health treatment for domestic violence, trauma or childhood sexual abuse
- Child care, transportation, primary health care, issue-specific treatment may be available

Mandell & Werner, 2008

Co-morbid mood disorders

- Approximately 45% of women with SUDs have co-occurring mood disorders, especially depression and anxiety
- Infants of untreated, depressed mothers have demonstrated the following:
  - Lower scores for motor adaptation and self-regulation
  - Higher arousal scores
  - More difficult to console
  - Developmental delay
  - Poor attachment
- Recent case study looked at challenges of providing obstetric care to women w/ PTSD and SUDs and stressed the importance of early screening and coordinated, multidisciplinary care to improve outcomes for mother-infant dyad

ACOG Practice Bulletin 2008; Goodman et al, 2015

Opioid Use Disorder in Pregnancy on the Rise

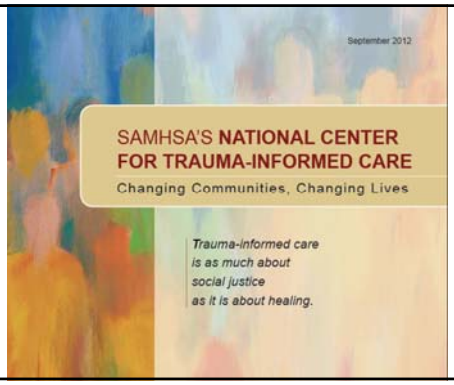
- From 2002-2013 the largest increase in heroin use was among US women
- Current rate of opiate use in pregnancy is 0.9% compared to non-pregnant women of childbearing age 2.6%. ~5-fold increase since 2000
- Rates of neonatal abstinence syndrome have also increased 5-fold over the past 15 years
- >85% of pregnancies among women with opioid use disorder were unintended
- Opioid agonist therapy in pregnancy is standard of care and results in improved engagement in addiction treatment, prenatal care and in-hospital delivery

CDC, MMWR 2015; Patrick, et al. 2012; Heil, et al. 2011; Jones, et al. 2008; Smith & Lipari, 2017.

Trauma Informed Care

- Idea that treatment and service delivery is designed with an understanding of the significance of victimization and trauma
- Six Key Components of a Trauma-informed Approach
  - Safety
  - Trustworthiness and Transparency
  - Peer Support
  - Collaboration and Mutuality
  - Empowerment, voice and choice
  - Cultural, historical and gender issues

SAMHSA 2014



A "Trauma Lens" can help to better understand a patient's behavior

A shift in perspective from:

"What is wrong with this person?"

to

"What has this person been through?"

Knowing about ACEs changes what people believe about themselves

- They weren't born bad.
- They weren't responsible for the things that happened to them when they were children.
- They coped appropriately, given that they were offered no other ways – it kept them alive.
- They can change.

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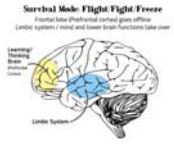
Examples of Trauma Informed Language

We Say and Do	Patient Experiences	Trauma Informed Alternative
"Your drug screen is dirty"	"I'm dirty" "I failed"	"Your drug screen shows the presence of drugs"
"You were late to your appointment"	"I can't do anything right"	"It looks like it was hard for you to get here today, we're glad you made it"
Make patient wait a long time before being seen	Increased agitation, feels undervalued	Provide activities for patient to do while waiting, have ancillary staff connect with them while waiting
"Did you take your medicine today?"	"What's wrong with me? Why does no one care about how they make me feel?"	"Are the medications you were prescribed working well for you?"
"Are you still smoking?"	Shame about being unable to quit, feeling of failure	"How is it going with your smoking?"

Seeking to Cope



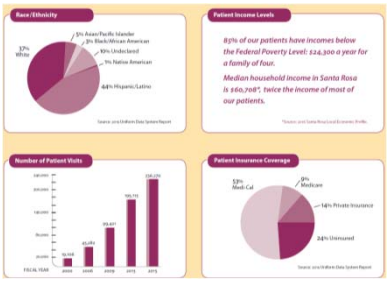
- The risk factors/behaviors underlying these adult diseases are actually effective coping strategies
- What is viewed as a problem is actually a **solution** to bad experiences
- Dismissing these coping devices as "bad habits" or "self destructive behavior" misses their functionality.

Regional Child Abuse Prevention Councils 2011

New Beginnings: Implementing Trauma-Informed Care in Pregnancy

Santa Rosa Community Health Centers

- Largest FQHC in Sonoma County, CA
- Provide health care to >25% of Santa Rosa's population
- 236,270 pt visits in 2015
- 53% Medi-cal
- 24% uninsured
- 63% racial/ethnic minority
- 85% living below the federal poverty level



OB Care at SRCHC

- Staff providers deliver over 700 babies/yr
- Two major clinic sites care for >1000 prenatal patients/yr
- All care provided by family medicine physicians
- Clinical home for family medicine residency program with 36 residents
- 5 surgically trained family physicians provide majority of surgical and high risk obstetrics care for the clinic
- FP-OB providers at SRCHC offer high risk consultations and surgical back-up to surrounding community FQHC's and local birth center CNM's
- Back-up OB/GYNs affiliated with Sutter Hospital provide consultative and surgical back up for the highest risk cases
- Maternal fetal medicine consultations through California Pacific Medical Center but no on-site MFM at delivering hospital
- Level III NICU at Sutter Santa Rosa accepts babies 27 weeks GA and above

new beginnings Clinic for pregnant women

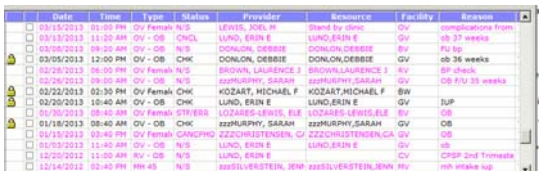
- Founded in March of 2015 at Vista Family Health Center
- Largest SRCHC clinic site and home of the family medicine residency
- Needs Assessment: HROB chart review process identified many high risk women receiving sub-standard care
- Frequent no-shows, lack of continuity among providers, poor follow-up on community referrals, poor documentation about treatment plans or status of substance use disorders

Traditional Model of Care

- Primary OB provider identifies medical and social risks at initial OB visit
- Referral to Mental Health for management of mood disorders and counseling
- Referral to SUD treatment
- Referral to social services (if available)
- Standard OB referrals for labs, genetic screening, ultrasounds, diabetes management, antenatal testing, etc….

When the Traditional Model Fails

Patients who are late to care or have frequent no-shows are labeled "non-compliant" and getting standard OB care completed often becomes the priority rather than addressing barriers to care and ongoing mood disorders or SUD



	Date	Time	Type	Status	Provider	Resource	Facility	Reason
	03/15/2013	01:00 PM	OV Female	N/S	LEWIS, JOEL M	Stand by clinic	GV	complications from
	03/13/2013	11:20 AM	GV - OB	CNCL	LUND, ERIN E	LUND,ERIN E	GV	ob 37 weeks
	03/05/2013	09:20 AM	OV - OB	N/S	DONLON, DEBBIE	DONLON,DEBBIE	BV	FU bp
	03/05/2013	12:00 PM	OV - OB	CHK	DONLON, DEBBIE	DONLON,DEBBIE	GV	ob 36 weeks
	02/28/2013	06:00 PM	OV Female	N/S	BROWN, LAURENCE J	BROWN,LAURENCE J	RV	BP check
	02/26/2013	09:00 AM	GV - OB	N/S	zzzMURPHY, SARAH	zzzMURPHY,SARAH	GV	OB F/U 35 weeks
	02/22/2013	02:30 PM	OV Female	CHK	KOZART, MICHAEL F	KOZART,MICHAEL F	BW	
	02/20/2013	10:40 AM	GV - OB	CHK	LUND, ERIN E	LUND,ERIN E	GV	IUP
	01/30/2013	08:40 AM	OV Female	STP/ERR	LOZARES-LEWIS, ELE	LOZARES-LEWIS,ELE	BV	OB
	01/18/2013	08:40 AM	GV - OB	CHK	zzzMURPHY, SARAH	zzzMURPHY,SARAH	GV	OB
	01/15/2013	03:40 PM	OV Female	CANCPHO	ZZZCHRISTENSEN, GI	ZZZCHRISTENSEN,CA	GV	OB
	01/03/2013	11:40 AM	GV - OB	N/S	LUND, ERIN E	LUND,ERIN E	GV	ob
	12/20/2012	11:00 AM	RV - OB	N/S	LUND, ERIN E		CV	CPSP 2nd Trimeste
	12/14/2012	02:40 PM	MH 45	N/S	zzzSILVERSTEIN, JENN	zzzSILVERSTEIN,JENN	MV	mh intake iup

Providing Multidisciplinary Care for High Risk Pregnant Women

- Wrap-around services at time of the obstetrics visit
- Increase access to mental health services, prenatal education, community resources
- Increased frequency of prenatal visits for highest risk patients
- Decrease barriers to care and active case management to engage patients in care when no-shows occur
- Consistent continuity care by providers experienced in caring for women with SUDs, trauma histories, mental health conditions
- Collaboration with community treatment facilities, public health nurses, jail, hospital social workers, and child welfare department

New Beginnings Clinic

- Specifically designed for women at high risk for adverse maternal, obstetric and neonatal outcomes due to psychosocial risk factors
  - Recent or active substance use disorders
  - Homelessness
  - Incarceration
  - Active intimate partner violence
  - Significant mental health disorders

- Most of our patients meet criteria for multiple of the above risks and nearly all have histories of adverse childhood experiences

New Beginnings Clinic Structure

- Meets every Tuesday afternoon 1:30-5:30
- Schedule up to 30 patients/shift includes OB, postpartum and newborn visits
- Typically about 60-70% show rate
- Team includes 2 fellowship trained FP-OB Faculty, 1 rotating FM resident (R2 or R3), 1 OB RN case manager, 1 mental health provider (LCSW), 3 medical assistants
- Additional resources: onsite pharmacy, clinical team assistant (helps with prior auths, CURES 2.0 reports), Smoke Free Babies (smoking cessation counselor), Drug Free Babies (perinatal placement coordinator), public health nurses, psychiatry (in house)

New Beginnings Clinic Process

- RN previews the schedule and notes active issues for each patient
- Team huddle in first 20 min of clinic
- Patients leave urine drug screen (in house) at each visit, send out confirmations done on all positives and randomly for negatives
- Patients seen by FP-OB provider, RN and LCSW nearly every visit, Q1-3 wks
- Patients have specific appointment times but we see them whenever they arrive, with or without an appointment, many typically come late
- SRCHC OB team member along with family medicine resident on call will deliver them at Sutter Santa Rosa Regional Hospital
- Mom and baby receive follow-up care in New Beginnings for at least 6-12 months following delivery and then are gradually transitioned into regular PCP care within the same clinic

Logistics of the Clinic

- Multidisciplinary team helps limit times patients are waiting alone in a room or lobby
- FP-OB provider sees patient each visit and bills for care
- MH provider sees all new patients and patients with active issues (ongoing substance use, MH symptoms, postpartum depression, other crises)
- RN Case manager helps with collaboration w/ outside resources both during and between clinic, also provides brief targeted perinatal education during the visits and connects women with in-house birth prep and lactation resources if they are in a place to accept that
- MA's coordinate the flow to make sure patients seen by each necessary team member and ensure appropriate follow-up appointments are made

Primary Goals of New Beginnings Clinic

- Provide a welcoming, safe, non-judgmental space for high risk women to receive compassionate prenatal and postpartum care
- Identify risks to mother-infant dyad early in pregnancy and provide resources early
- Partner with the patient to help her achieve her goals for a healthier pregnancy
- Encourage women with active SUD to enter appropriate treatment programs as early as possible
- Help women with opioid use disorders access medication assisted treatment (MAT) with either referral to local methadone clinic or prescription for buprenorphine

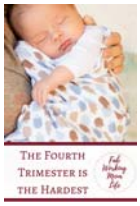
Additional Goals of New Beginnings Clinic

- Reduce risk of maternal/child separation at time of delivery by helping women achieve sobriety, find stable housing, eliminate exposure to violence, be mentally healthy and acquire the needed resources to be ready to parent
- For women failing to achieve these goals, continue to offer prenatal care to reduce negative effects of ongoing substance use, increase her likelihood of entering treatment following delivery and offer options for adoption as an alternative to child welfare system involvement
- For all of our patients following delivery we strongly advise use of Tier 1 contraceptive methods (sterilization, implants or IUD's) due to high rates of unintended pregnancy in this population

Successes with New Beginnings Clinic

- Increased number of prenatal visits for our patients compared to similar risk patients not referred to our clinic
- More frequent visits lead to more opportunities to provide motivational interviewing around behavior change, harm reduction and perinatal education
- Improved identification and focused treatment of co-morbid PTSD, depression and anxiety disorders
- Increased retention of patients after transitions into/out of jail or residential treatment programs due to collaborative relationships
- Role modeling high quality collaborative care of this population for family medicine residents
- Recent expansion of access to allow for consistent postpartum and newborn care for our patients in the first 6-12 months postpartum

The 4th Trimester - Postpartum



- Critical Time
  - Newborn care, breastfeeding, bonding
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, "the ideal mother", in conflict with what it is actually like to have newborn
  - Increased risk of relapse and PPD in women with SUD
- Neglected Period
  - Traditional care shifts away from frequent visits w/ OB provider to pediatric care provider
  - Care becomes less "medical" for mom, shifts to other agencies (WIC, etc)
  - Insurance and welfare realignment
  - Early return to work
  - Attention of friends and family shifts from mom to the baby

Breastfeeding

- For women able to stop using illicit substances and alcohol during pregnancy who are engaged in visits at New Beginnings and/or outside drug treatment programs, we strongly encourage breastfeeding
- Reduces severity and duration of treatment for baby with neonatal abstinence syndrome if mom is on buprenorphine or methadone maintenance therapy
- Breastfeeding encourages ongoing sobriety for mother
- Improved maternal-infant bonding
- Improved maternal self esteem
- If maternal relapse (especially on stimulants), advise cessation, caution with rapid weaning if mom on chronic opioids as may cause mild withdrawal in baby

What's Next?
Where Do We Need To Go?

Reducing ACES for Future Generations

Advocacy and Ongoing Projects

- Advocating for needed change within our community
  - Acceptance of women on MAT into residential treatment facilities
  - Allowing women to continue MAT in all child welfare cases
  - Changing attitudes towards this patient population by staff on L&D and in clinic
  - Increased community awareness about the availability and success of treatment
- Resource for providers at other facilities
- Curriculum and clinical experience for family medicine residents
- Working to increase access to LARCs in our hospital setting
- Need for improved data collection on our population to compare outcomes with local/national populations

Recommended Components of Care for Pregnant Women with Substance Use Disorder

- Access to opioid agonist treatment options for women with Opioid Use Disorder
  - Methadone or buprenorphine
- Access to obstetric care
  - Recovery-affirming and trauma-informed
  - Comprehensive obstetric and addiction medicine services
- Access to psychiatry consultation: assessment and treatment options for co-occurring disorders
- Access to behavioral health counseling: individual or group
- Resource guides for community-based relapse prevention
  - Mutual aid support groups
  - Mothers-in-recovery groups
- Development of enhanced postpartum care: program development to intensify recovery support potentially utilizing peer supports
  - Close follow-up (<2 weeks from delivery)
  - Allow for multiple postpartum visits (every 2 weeks for 3-6 visits)
  - Breastfeeding/lactation support
  - Screening/treatment for postpartum depression
  - Transition to primary care provider familiar with substance use disorder and its treatment

Saia, K.A. et al, 2016

A Call to Action

- Help close the gap in services for women with mental health and SUD in pregnancy
- Screen everyone for SUD, depression and domestic violence in pregnancy, think about ACES with positive screens and refer for treatment
- Increase the number of buprenorphine-waivered obstetric providers and educate our colleagues and ancillary staff about buprenorphine in pregnancy. Find course info at: https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
- Expand comprehensive obstetric and addiction medicine models of care
- Reduce barriers to care within our control (scheduling, front desk & call center staff attitudes, no-show and late policies, transportation options, child friendly practices)
- Become a trauma-informed practice

Advocacy Needs

- Strive to reduce stigma associated with SUD and mental health problems in pregnancy; educate our patients, colleagues, families and communities
- Fight against state or local efforts to criminalize drug use in pregnancy and instead advocate for expanded gender-sensitive treatment and recovery options
- Advocate for our patients' rights when child welfare services becomes involved and work to keep mother and infant together whenever possible (and safe)
- Increase referrals to SUD treatment as currently only 10% of pregnant women engaged in SUD treatment were referred by their medical providers

Policy recommendations for addressing ACES

(1) Increase awareness of ACEs and their impact on health within both the professional and public spheres;

(2) Increase capacity of health care providers to assess for the presence of ACEs and appropriate response;

(3) Enhance capacity of communities to prevent and respond to ACEs through investments in evidence-based prevention programming, trauma interventions, and increasing access to needed mental health and substance abuse services; and

(4) Increase funding for ACE-specific surveys in order to increase their utility and scope.

Questions & Answers

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