Colorado Perinatal Care Quality Collaborative

Colorado Perinatal Substance Use Disorders (SUD): Building "Next Level" Initiatives

FEBRUARY 2, 2024

CPCQC overview

Perinatal substance use rates are increasing

At CPCQC, we are on a mission to ensure that mothers, birthing individuals, and their families in Colorado receive culturally relevant, safe, equitable, high-quality care no matter who they are or where they live.

We aim to improve care for pregnant and postpartum patients in Colorado by addressing major causes of maternal mortality, including mental health concerns and substance use.

CPCQC Approach

Evidence-Based

Implementation of proven guidelines and standards from nationally recognized organizations using a structured quality improvement framework.

Collaborative

Facilitation of continuous learning, sharing, and improvement for perinatal health professionals, health systems, policy development, and accountability in Colorado.

Data-Driven

Access to statewide data supported by real-time, ongoing analysis, collection, and dissemination.

Trusted

Involvement from individuals and organizations that are reputable experts in clinical specialties, public health, quality improvement, and change management, as well as those who share their lived experience of the perinatal journey.

COLORADO PERINATAL CARE QUALITY COLLABORATIVE

ADVANCING HEALTH EQUITY IN COLORADO

1 MISSION & VISION

Ensure that ALL birthing individuals and their families receive **culturally relevant, safe, equitable, high-quality care** no matter who they are or where they live. We do this through quality improvement, systems change, and community and patient engagement.

2 PERINATAL QUALITY COLLABORATIVES

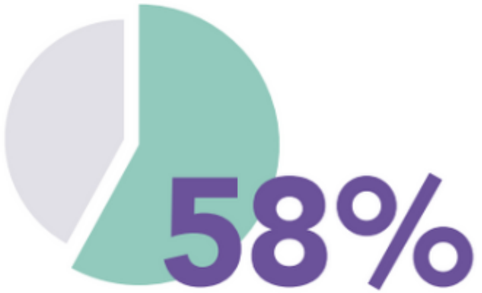
Work to improve the quality of care for birthing people and infants through collaborative learning, rapid response data, and quality improvement to achieve systems-level change.

Our goal is to **engage 100% of CO hospitals.**

3 QUALITY IMPROVEMENT

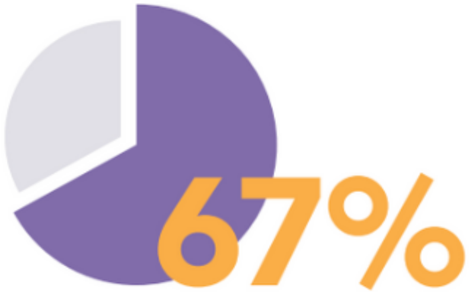
Lead quality improvement (QI) in CO birthing hospitals and communities. QI standardizes processes to reduce variation, achieve predictable results, and advance best practices among providers and healthcare systems for **better patient experiences and outcomes.**

PARTICIPATION



58%

of Colorado's birthing hospitals are actively engaged in our programs



67%

of Colorado's live births took place in hospitals participating in our programs

CPCQC collects data on healthcare delivery and outcomes by race, ethnicity, location, and payor. CPCQC uses this data to facilitate targeted quality improvement in hospitals and communities to address disparities in care and outcomes.

STRATEGIC FOCUS

- **Healthcare Access and Patient Safety**
- **Data Accountability and Equitable Outcomes**
- **Community and Patient Engagement**
- **Maternal Mortality and Morbidity**
- **Infant Health and Safety**
- **Systems Change and Innovation**

HEALTHCARE ACCESS, DELIVERY, AND OUTCOMES ARE NOT EXPERIENCED EQUALLY

9 OUT OF 10

MATERNAL DEATHS ARE PREVENTABLE

3x **American Indian/Alaska Natives** are nearly 3x more likely to die during pregnancy or within 1 year postpartum than the overall population of those giving birth in CO

2x **Black people** are 2x more likely to die during pregnancy or within 1 year postpartum than the overall population of those giving birth in CO.

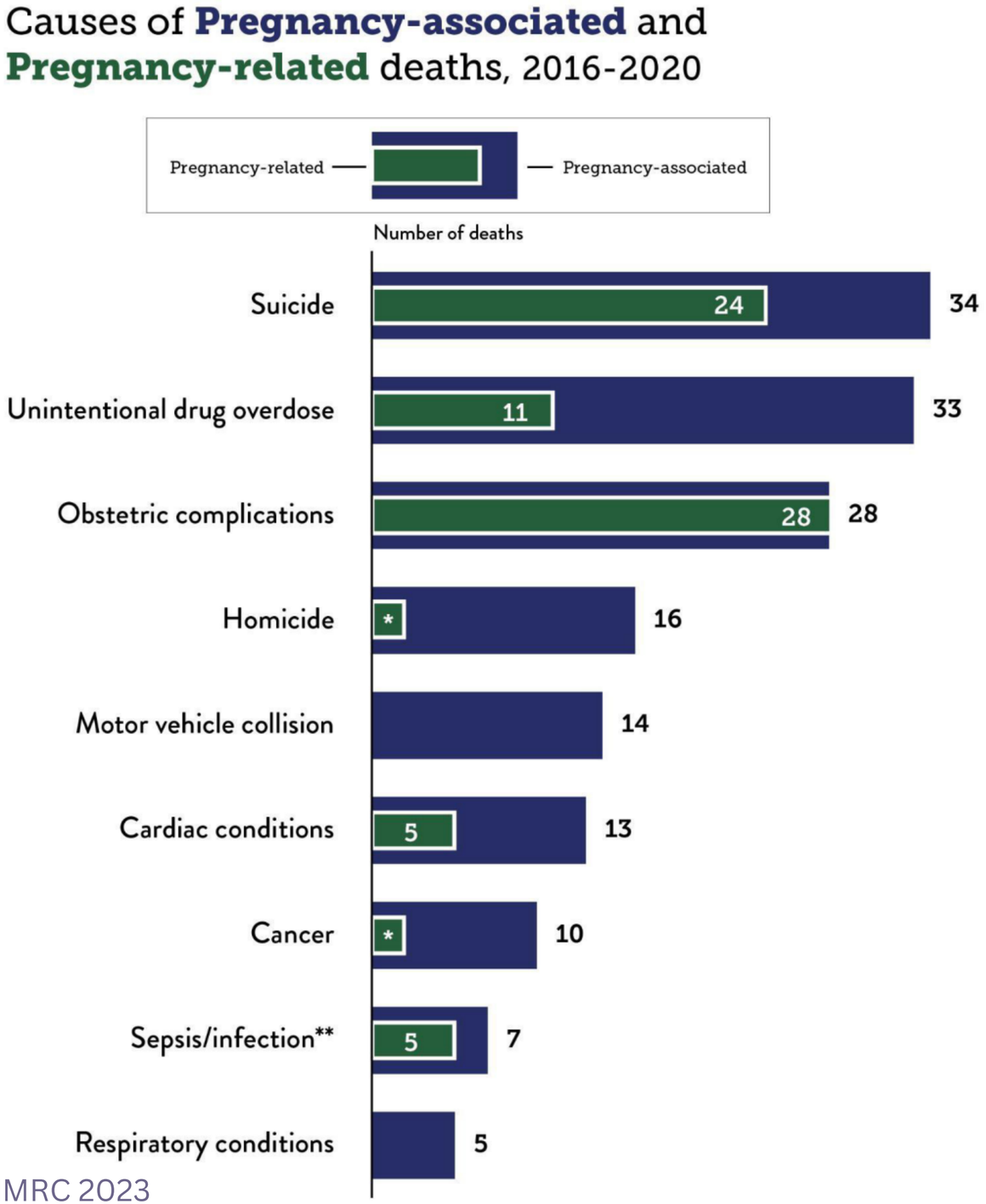
1/2 **Discrimination** contributes to 1/2 of all pregnancy-associated deaths in CO

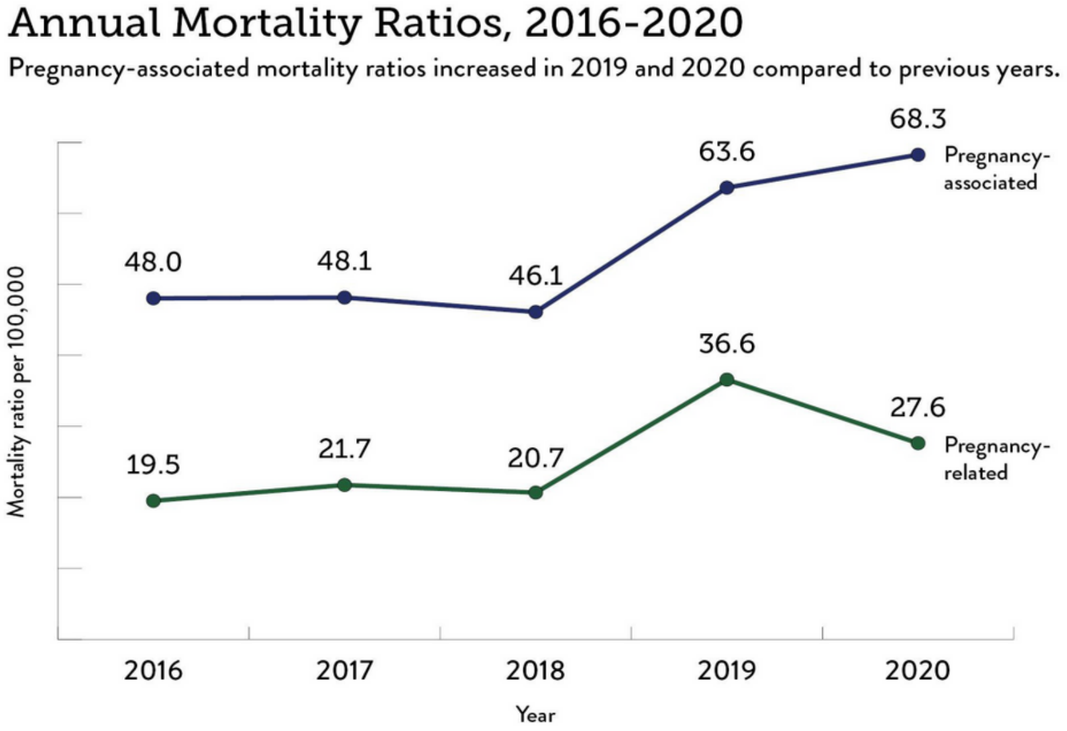
Birthing people living in frontier counties were **3.6X** more likely to die from pregnancy-related causes than those who lived in urban counties

People with Medicaid as payment at delivery were **2.6X** more likely to die during pregnancy or within one year postpartum than those with private insurance.

Trends in maternal mortality and substance use disorders (SUD)

Maternal Mortality in Colorado



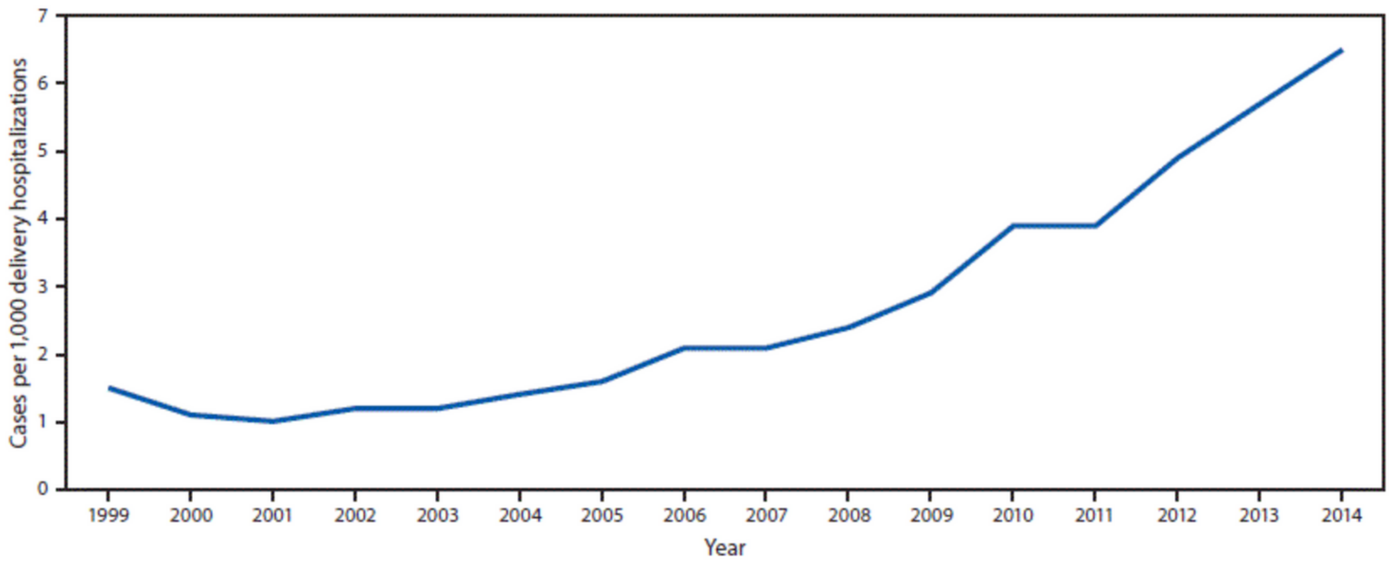


Perinatal substance use rates are increasing

Accidental overdose is the second leading cause of death for pregnant and postpartum Coloradans (19%)

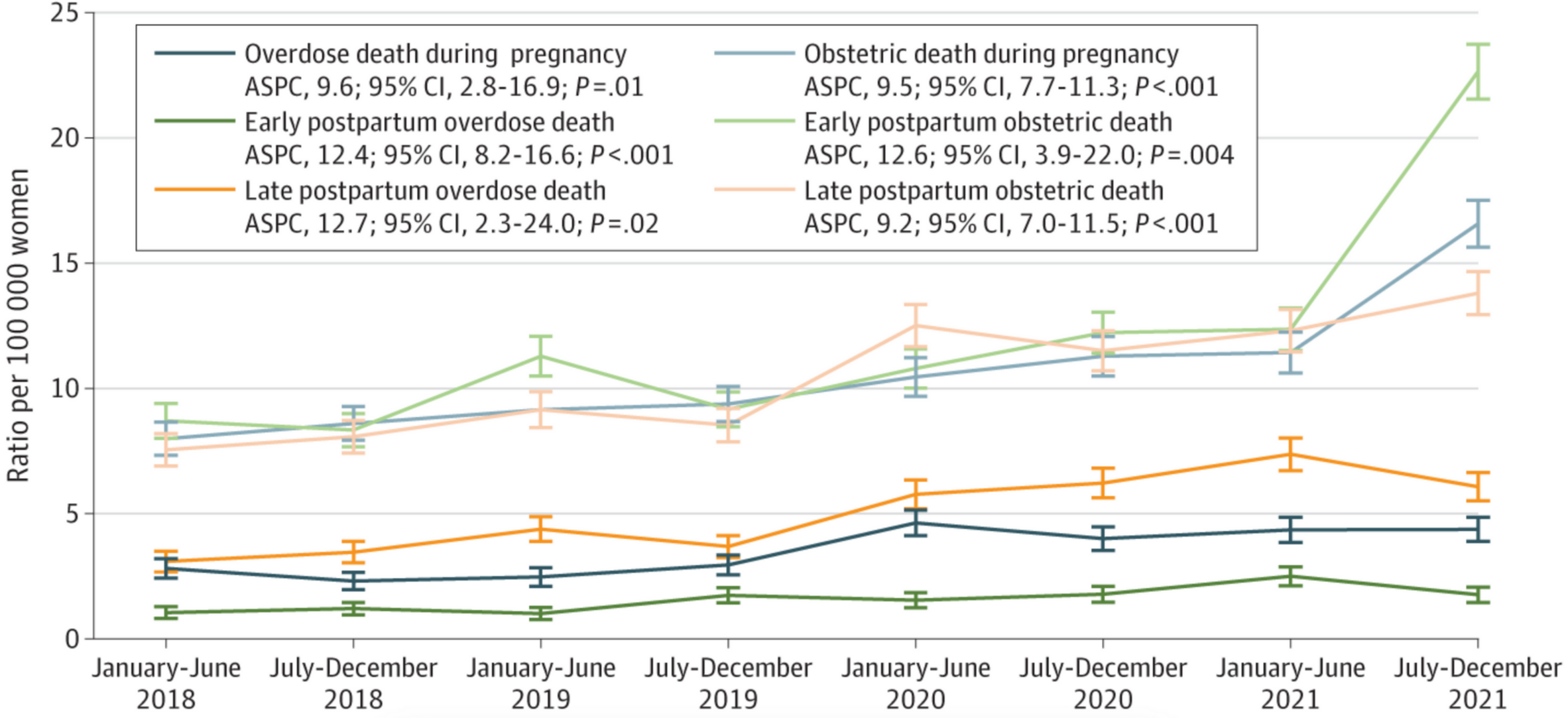
- **Second only to suicide (20%)**
- **More than all obstetric complications combined (16%)**
- **Mental health conditions contribute to 50% of maternal deaths.**
- **Neonatal opioid withdrawal syndrome (NOWS) increased by 433% from 1999 to 2014**

FIGURE 1. National prevalence of opioid use disorder per 1,000 delivery hospitalizations* — National Inpatient Sample (NIS),† Healthcare Cost and Utilization Project (HCUP), United States, 1999–2014



MMRC 2023, CDC 2014

National Maternal Mortality and Overdose



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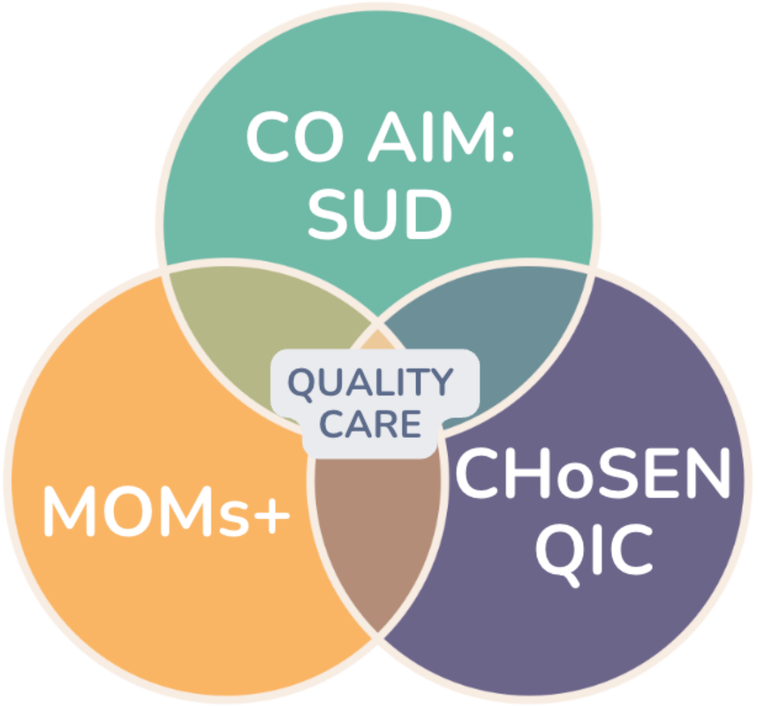
CPCQC's Clinical QI SUD Initiatives

A more holistic approach to perinatal substance use

PERINATAL SUBSTANCE USE QUALITY IMPROVEMENT IN COLORADO



cpcqc.org

Colorado AIM Substance Use Disorder

- Hospital-based patient safety bundle promoting universal screening, brief intervention, and clinical care for perinatal substance use.
- Structured quality improvement program built upon the Institute of Healthcare Improvement's Model for Improvement.
- Includes quality improvement coaching, data analysis and feedback, and collaborative learning among hospitals L&D units throughout CO.

Maternal Overdose Matters+

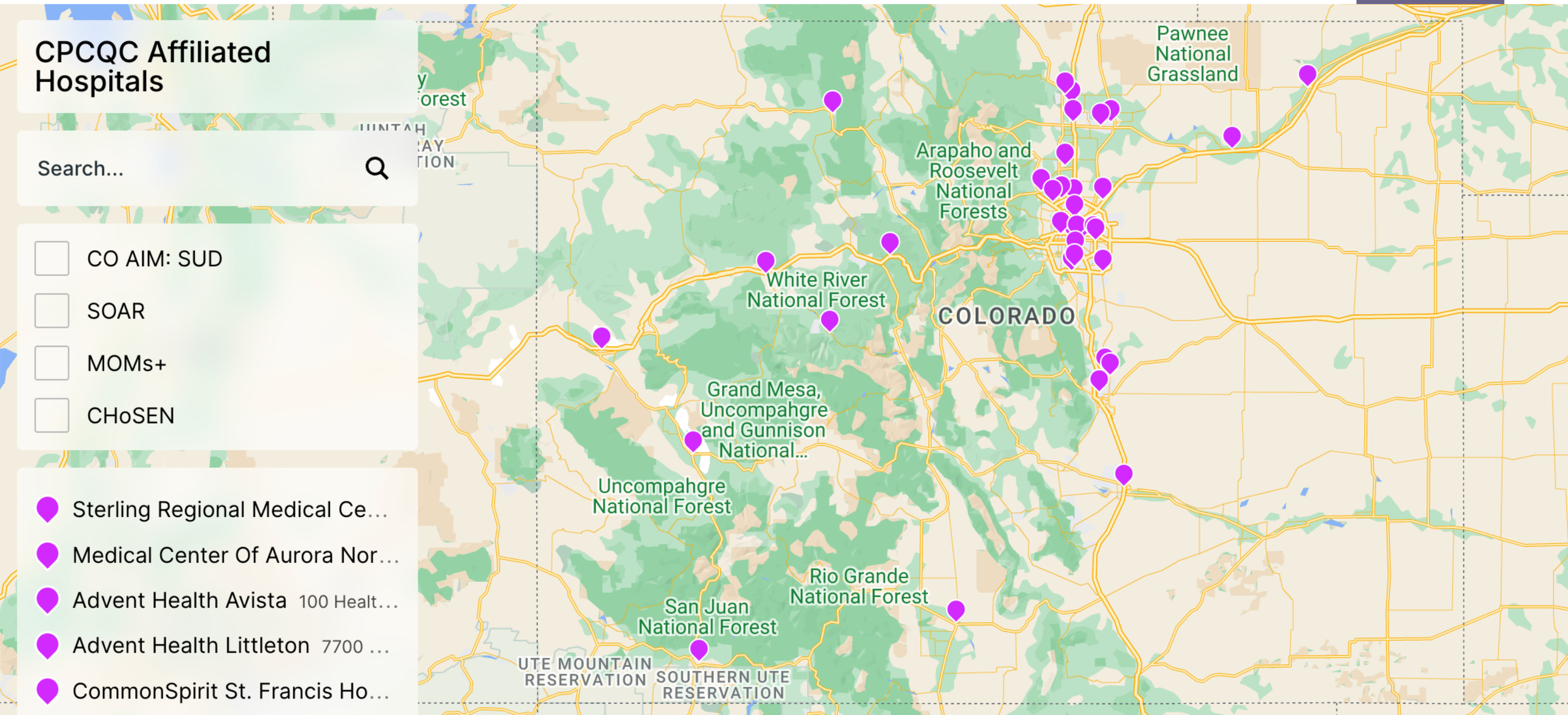
- An overdose prevention program focused on helping birthing hospitals provide equitable access to treatment and recovery for perinatal patients with substance use disorders.
- Tailored technical assistance for the initiation of medication substance use disorders and harm reduction strategies such as Naloxone distribution.
- Promotes the transition to outpatient recovery with community providers through referrals and warm handoffs.
- Builds upon the foundation of CO AIM: SUD.

Colorado Hospital Substance Exposed Newborns Quality Improvement Collaborative

- A quality improvement program to improve the hospital care of substance exposed newborns through the consistent implementation of best practices in the L&D and NICU settings.
- Promotes a bundle of care practices along with robust data collection and analysis to measure the impact of efforts.
- Collaboration through open sharing of practices and data is encouraged and supported by regularly publishing toolkits of best practices and resources, community webinars, and twice-yearly statewide forums.

cpcqc MOMs+ (Maternal Overdose Matters) CHoSEN

All CPCQC Affiliated Hospitals



TWO PROGRAMS, ONE GOAL: PREVENT MATERNAL OVERDOSE

CO AIM: SUD

Perinatal SUD Care 101: AIM Patient Safety Bundle

MOMs+

Perinatal OUD + SUD Care 201: Treatment of OUD + SUD, QI work within CO AIM: SUD framework

Universal Screening + SBIRT

Harm Reduction / Naloxone

Treatment and referral to care

Integrated

- QI approach
- Data collection
- Learning & evaluation
- Staff education

Shared commitment to reducing stigma and integrating peer support and living experience

MOMs + (Maternal Overdose Matters)

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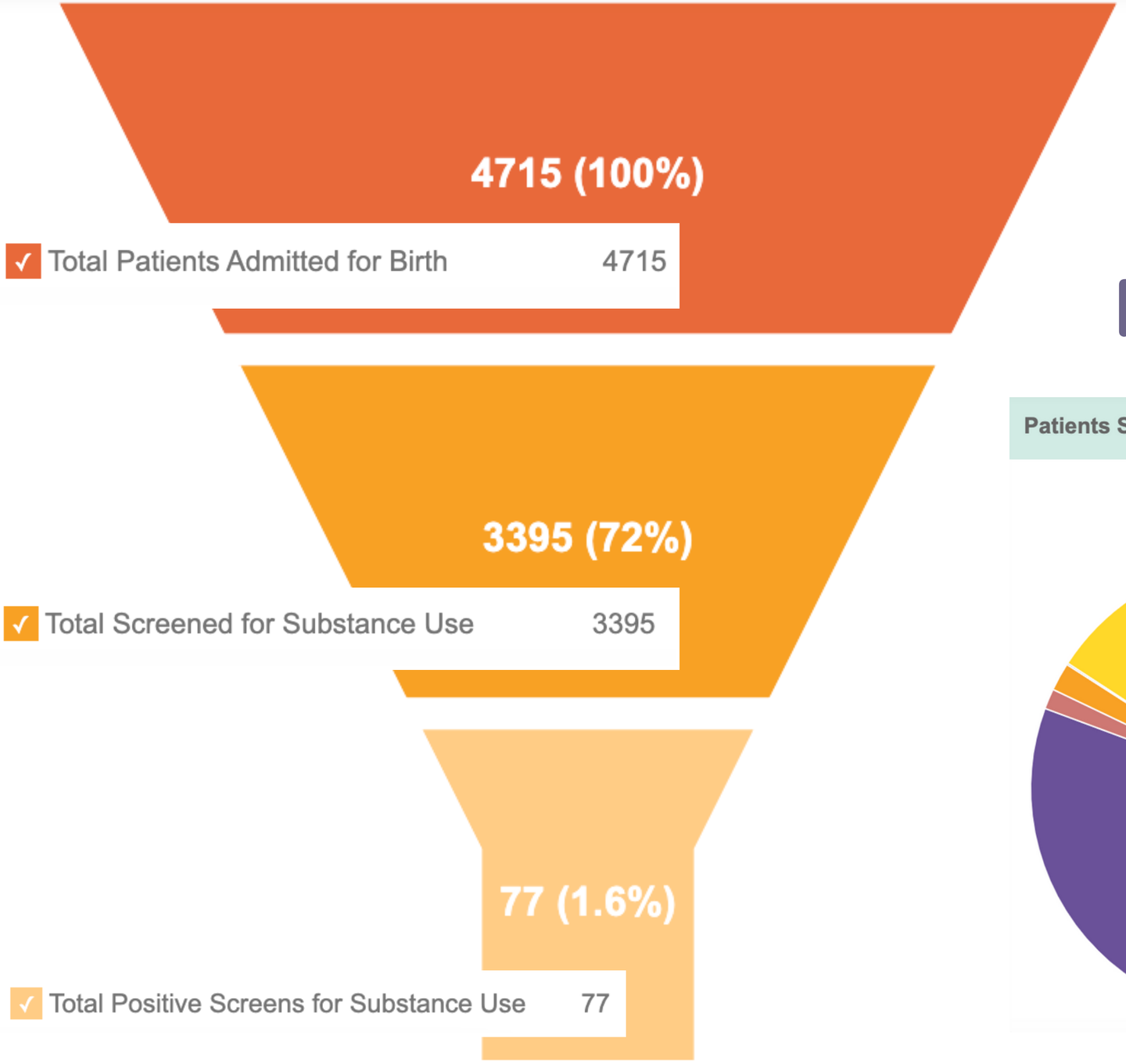
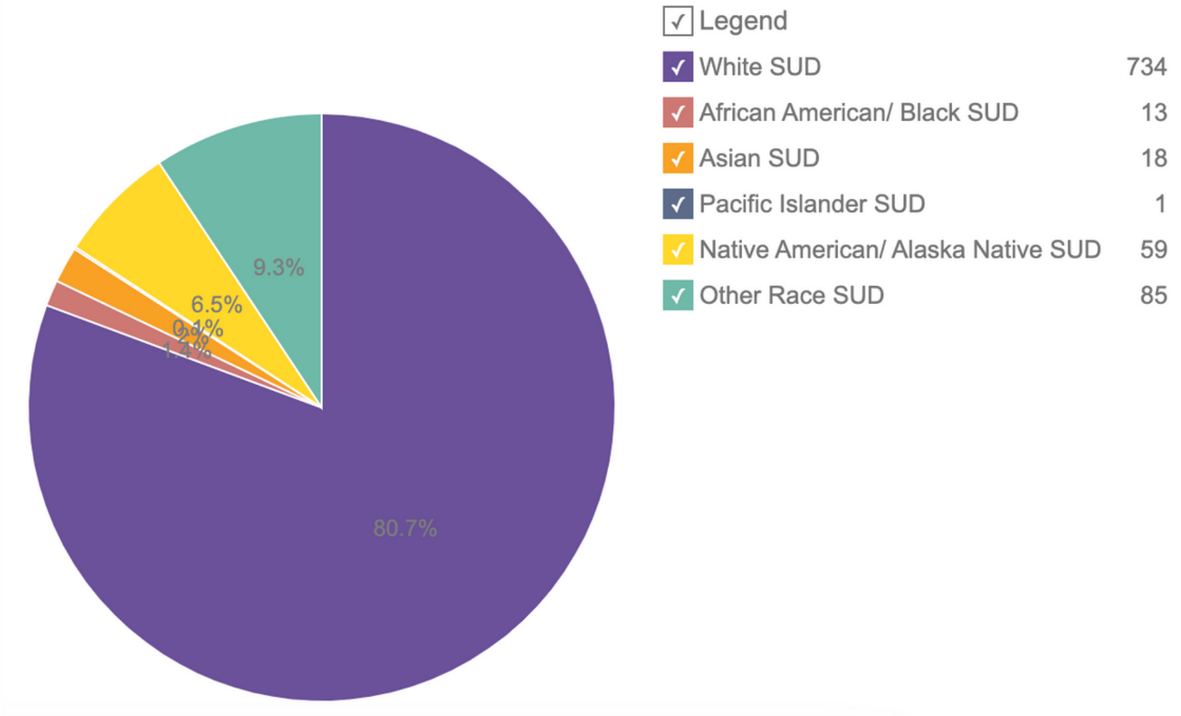
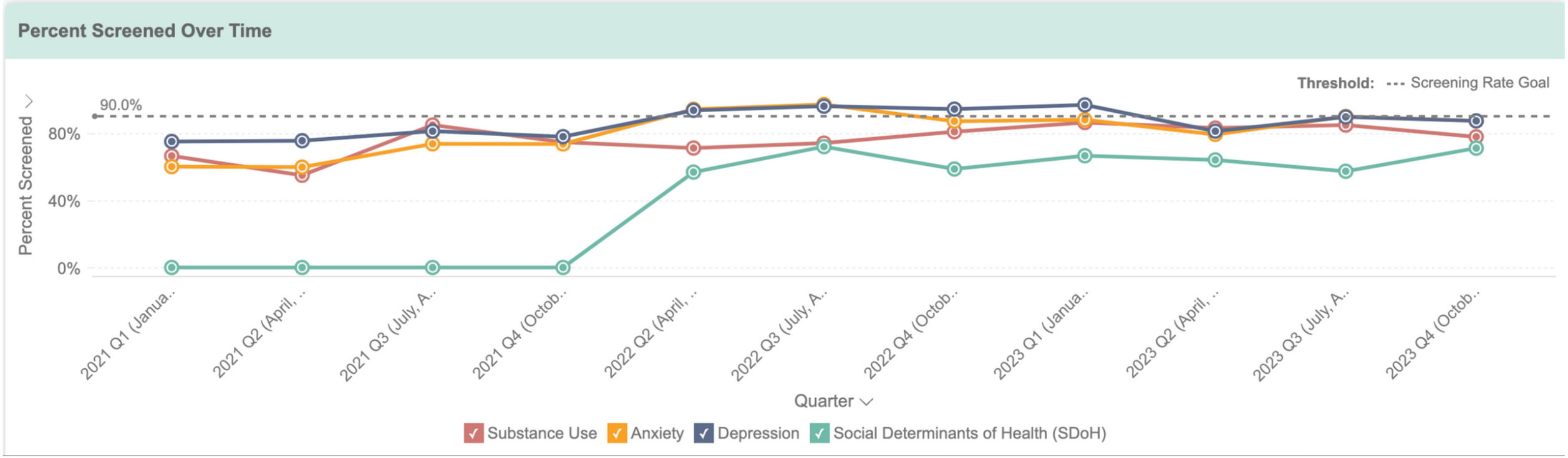
Program Outcomes



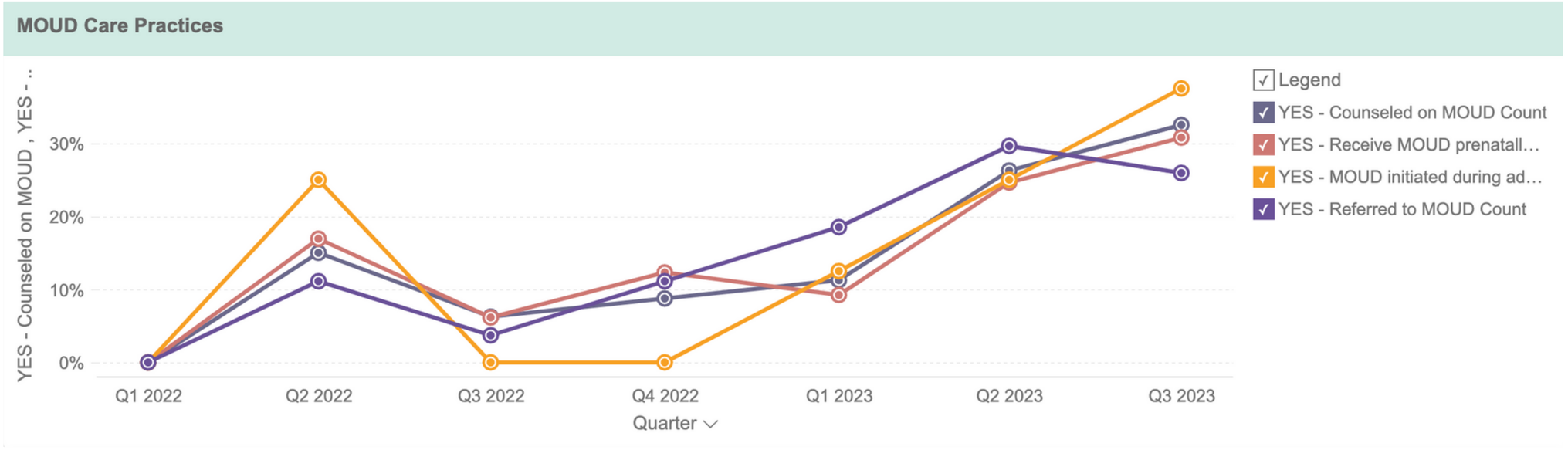
Patients Screened for SUD

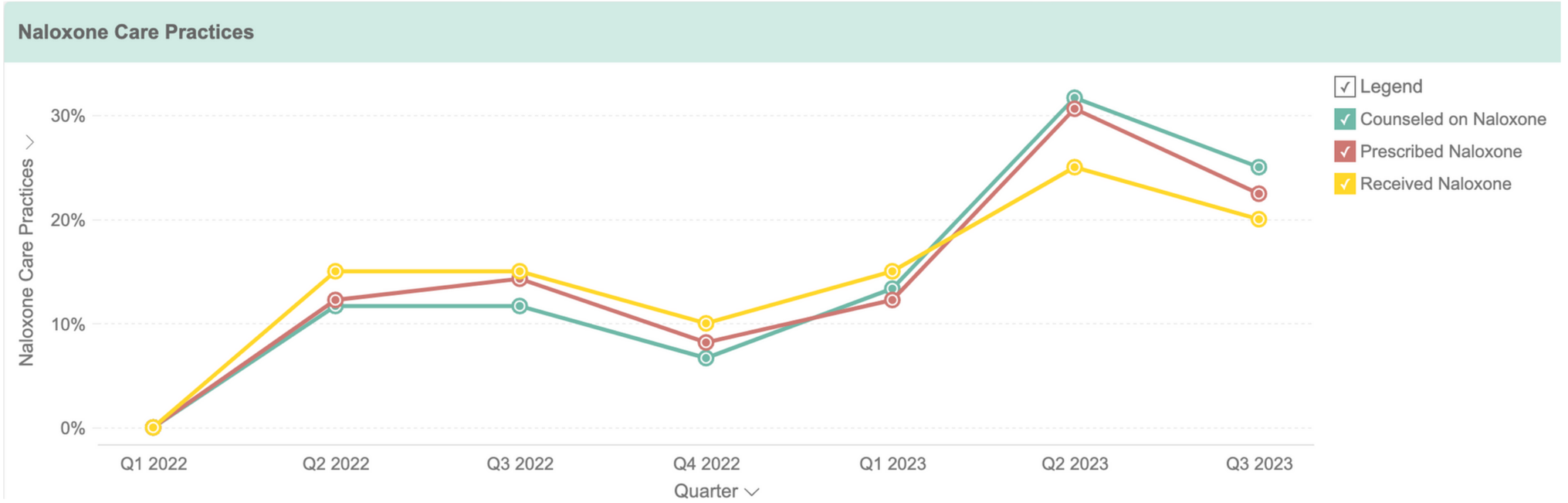


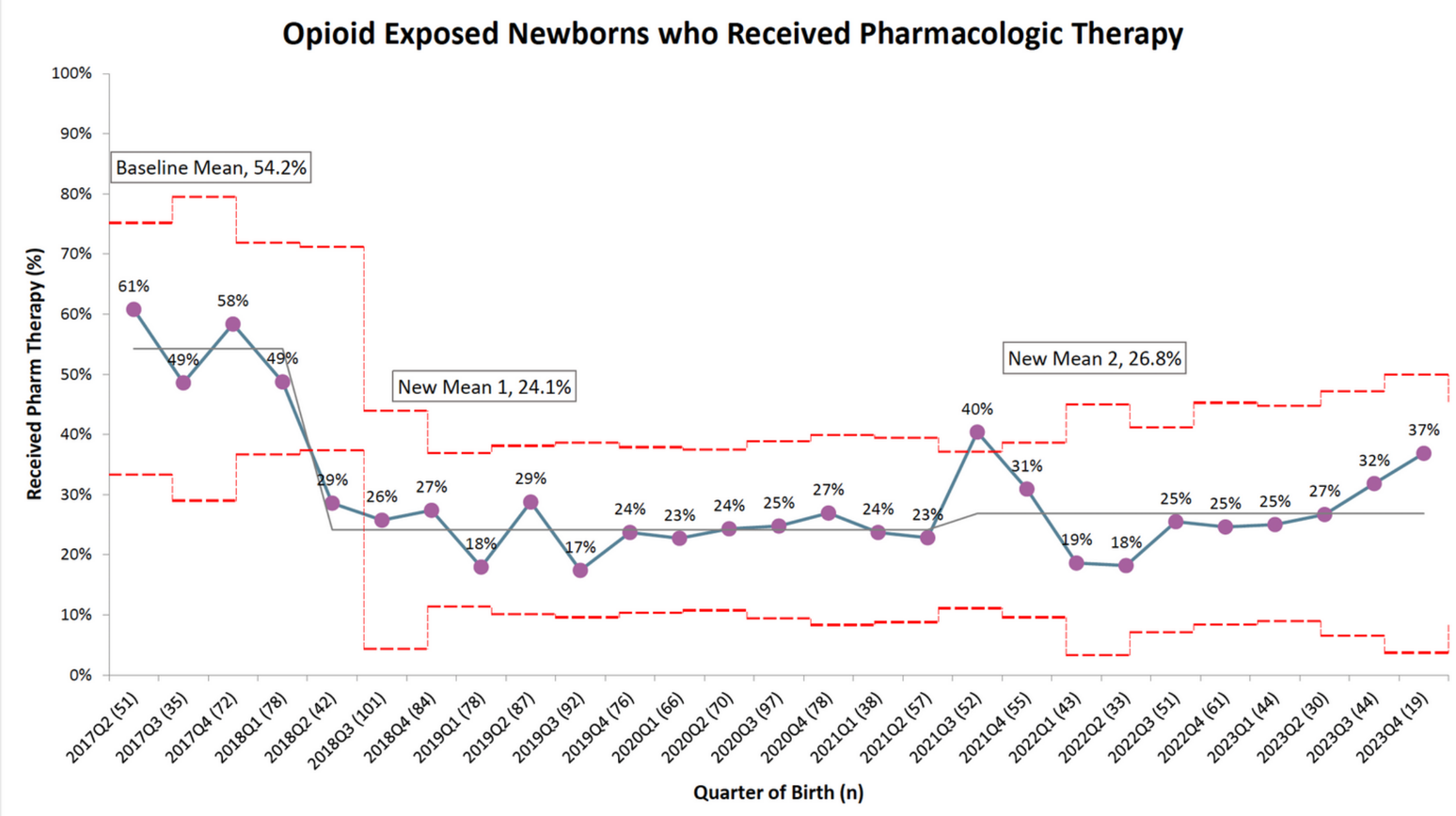
COAIM: SUD screening rates over time

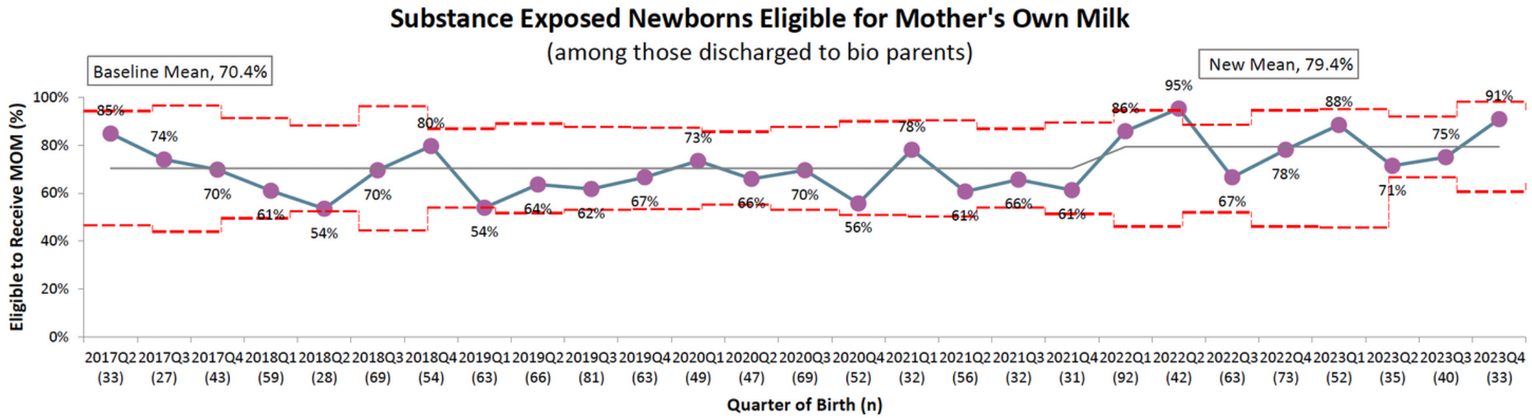


GOAL: improve rates of MOUD treatment and harm reduction









CHoSEN QIC
Eat Sleep Console and Mother's Own Milk Programming

2,161 substance exposed newborns identified since 2017

Nursing staff WANT training on Perinatal SUD

"I feel that our hospital and nursing staff specifically are **lacking in training** for all of this we get patients regularly that are on methadone/suboxone or beginning suboxone therapy with us or to withdraw form meds, **with no training** on how to care for or what to look for."

"I feel [hospital] doesnt help facilitate outpatient F/U or do adequate education/screening for this population."

"I would like to see these mothers **get more information** on what their baby will go through after delivery."

"Our providers do not participate in helping moms with SUD, with the exception of one MFM provider. The rest run from it and view it as **someone's else problem** to deal with."

"I feel like we have all of the resources in place, but **nobody knows where they** are at. "

"Those of us who work intrapartum often have **very little if any knowledge** of the specific education provided during the antenatal time period."

"I have **little knowledge** on the programs mentioned. The staff definitely needs more education on these issues and programs."

"Our community as well as others **need more substance abuse education**, as well as more mental health help for all communities"

"**Need more education** on our and medically assisted treatment for addiction"

"**More training** to nursing staff about all of this"

"We definitely **need more education** and guidelines for these moms."

"We **need more education** and resources for all staff and providers"

"Provide a guideline that we can follow that will **help us learn** and educate our patients about this topic."

"Please continue to **give us more education** on this topic as it comes in."

"Our thoroughness in this area, especially f/u, is **lacking**."

"In 4 yrs I've **never received ANY education** regarding this."

"**Provide more education** to nurses/staff"

"**Need more instruction** in hospital setting and education for staff"

"A lot of information that isn't put out there for staff"

"**I do not think the nursing staff is well educated** on IUD and SUD"

Stigma & Bias Forums

111 attendees over 3 pilot sessions

Of the 43 who filled out our post-training survey:

- 95.24% agree or strongly agree that they plan to modify their behavior when interacting and caring for patients with SUD.
- 92.86% agree or strongly agree that they feel more confident about intervening when their colleagues display biases toward patients with SUD.

Scan and sign-up to learn more!

2024 Plans:

- Training ALL Denver Health RNs in March
- Trainings in HSR 12 with Valley View RNs and home visitors in April
- Received requests for training from many hospitals
- Currently seeking sustainable funding to provide the training to large teams at a low cost

> "This was by FAR the best training I have had. Really appreciate the information and the vulnerability of those that lead the training. I am so inspired by Hard Beauty"

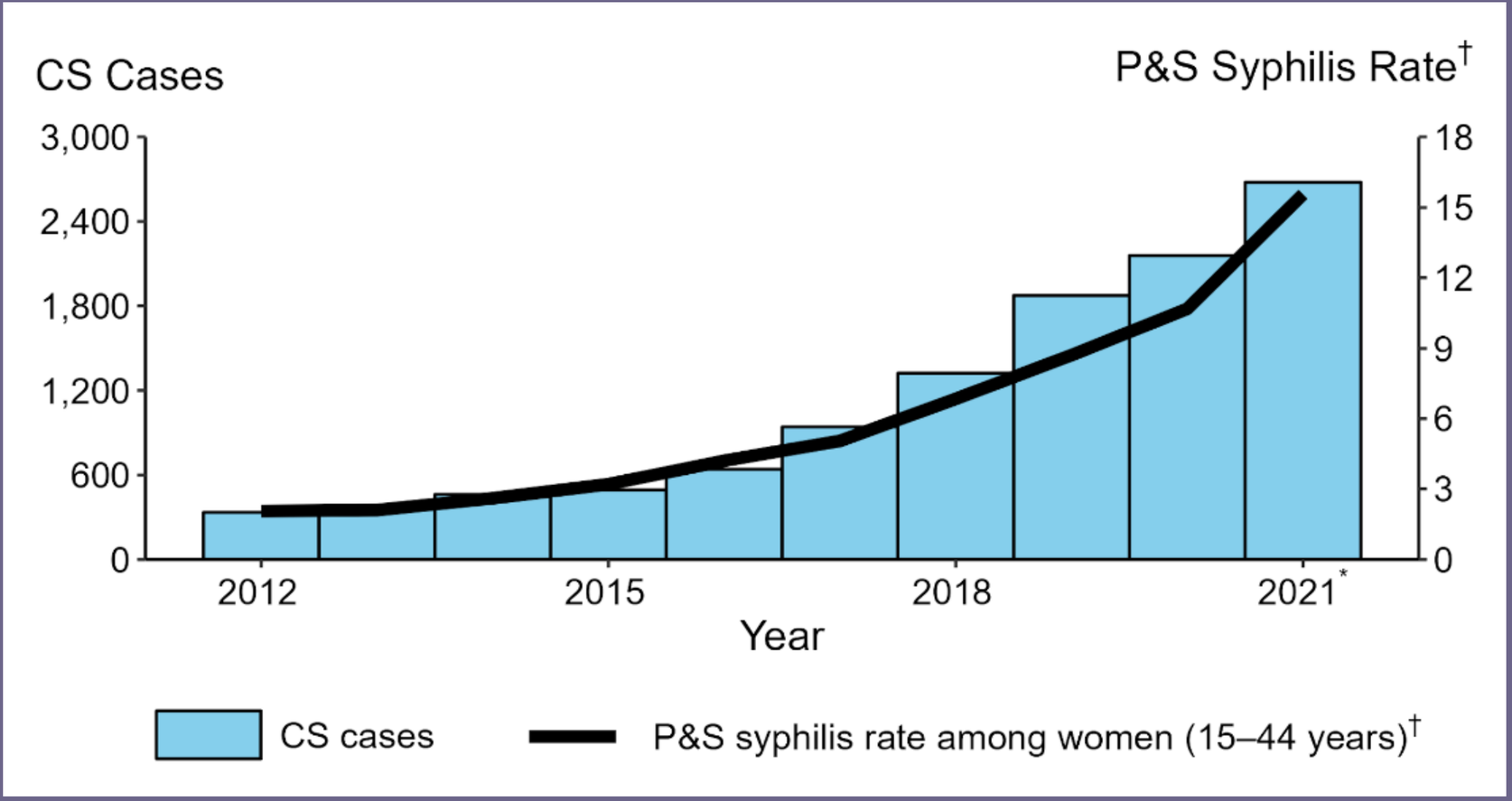
Clinical SUD QI Next Steps

- Shared objectives for Clinical Programs - Maternal and Infant:
  - Innovation in dyadic care
  - Comprehensive perinatal team-based approach
  - Ideal addiction medicine that is de-siloed within and across care facilities
  - Streamlining messaging and funding
  - Increased excitement with hospital teams
  - Shared data and analytics for coaching and impact assessment

- Next Steps:
  - Developing a program model and approach
  - Exploring STI wrap-around
  - Piloting the 3-program model with a few hospitals

Emerging issues

Congenital Syphilis



Goals:

- Screening all patients for syphilis
- Screening positive patients for neurosyphilis
- Early treatment and followup

CHoSEN QIC PERINATAL CANNABIS USE & BREASTFEEDING RECOMMENDATIONS

KEY SUMMARY OF RECOMMENDATIONS

Increased legalization of cannabis has led to increased prevalence of use, including among pregnant and birthing individuals.

- Cannabis use through pregnancy may remain stable, or decrease, and often increases postpartum, similar to other substance use in pregnancy.
- There is public perception of safety of cannabis use, and patients seek information from online non-medical resources that often promote perinatal use.
- A long history of stigmatization with substance use, including cannabis, warrants thoughtful shared decision making between healthcare providers and birthing parents regarding perinatal cannabis use.

Major medical and public health professional societies recommend abstaining from cannabis use during pregnancy and lactation or significantly limiting exposure (e.g., occasional/infrequent use) {ACOG, AAP, ABM, AAFP, CDC}.

- THC, the psychoactive component of cannabis, crosses the placenta to the fetus, and is excreted and concentrated in breastmilk.
- There is wide variation in THC concentration in breastmilk, and prolonged excretion up to six weeks after abstention.
- Cannabis use in pregnancy is associated with SGA (small for gestational age) infants, and negative effects on cognition, behavior, and attention later in childhood.
- **There is no known safe amount of cannabis use during pregnancy/lactation.**

Universal verbal screening for cannabis use is recommended for all birthing individuals prenatally and postpartum with a validated tool e.g. 5ps, CUDIT-R.

- Assess patterns of use (route, frequency, potency), reasons for use and possibility of cannabis use disorder.
- Screen for anxiety and mood disorders, provide resources/referrals as needed.
- Counsel on other health effects of cannabis use- e.g., pulmonary effects, anesthesia considerations.
- Assess intent to breastfeed, counsel for safe breastfeeding, and encourage cannabis cessation early in pregnancy.
- Identify need for additional supports- behavioral therapy, community support organizations, referral to Addiction Medicine.

Abstention of cannabis use during pregnancy and postpartum should be encouraged, and anticipatory guidance surrounding cannabis should be provided for all birthing parents, regardless of their ability to abstain from use.

- Safe storage of cannabis products away from children.
- Identify safe and sober caregiver for children, do not drive impaired.
- Review safe infant sleep practices- do no sleep with infant while impaired.

Provide harm reduction strategies to reduce problems related to cannabis use, when abstention is not realistic or achievable.

- Identify reasons for use, pros/cons of continued use versus cessation.
- Reduce cannabis use to occasional or infrequent use.

Teams want clear guidance on perinatal cannabis use

CHoSEN QIC Perinatal Cannabis Use and Breastfeeding Recommendations

Main goals:

- Identify perinatal cannabis use
- Educate patient on risks
- Screen for cannabis use disorders
- Refer to addiction medicine when necessary

CPCQC - Community Continuum of Care Initiatives

IMPACT BH

IMprove Perinatal Access, Coordination, and Treatment for Behavioral Health

Program aimed at strengthening the "connective tissue" within the perinatal continuum of care by supporting & investing in:

- birthing hospitals
- primary healthcare clinics
- community-based organizations

The program is intended to create an integrated delivery system that supports the patient through increased access to behavioral healthcare and treatment, wrap-around services, perinatal navigation, and increased community and peer support.

BHA

cpcqc

Future work

- Increased hospital participation and scale for clinical QI SUD programs
- Reductions in barriers to accessing treatment
- Population focused efforts
- Reimbursement for team-based care
- Addressing the scope of postpartum care

QUESTIONS?