HEALTH MANAGEMENT ASSOCIATES

# The Intersection of HIV and Substance Use:

## *Enhancing the Care Continuum with Evidence-Based Practices*

**Training Series: Session 4**
**November 23, 2022**



DEPARTMENT OF HUMAN SERVICES

# Utilizing Zoom

- **Ensure your audio is linked to your Zoom participant ID.**
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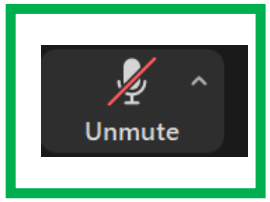
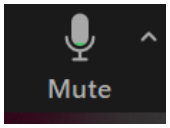
- **Ensure you are on MUTE and your camera is ON.** On the bottom left corner of your screen, you will see a red line through the microphone.




**ON MUTE**

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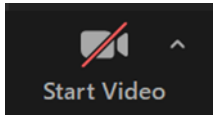


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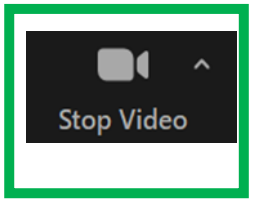
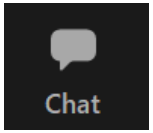
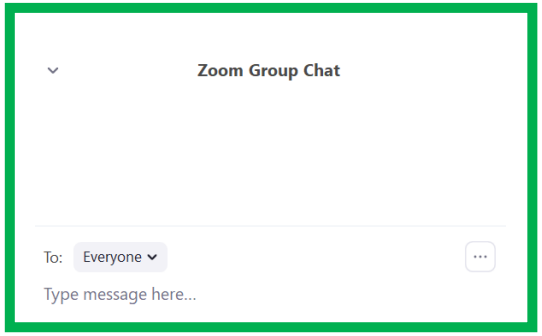



**Camera ON**

- **Your participation throughout today via chat is appreciated!**

  **Locate the chat box.** On the bottom middle of your screen, click on the chat icon. This will open the "Zoom Group Chat" pane on the right side of your screen. You will see messages throughout the webinar on there. When prompted by the presenters, type in your answers or questions there.



# Housekeeping

- Today is **Session 4**

- This series is eligible for both **CEUs** and **CMEs**
  - *These activities have been approved for CEUs by the Minnesota Board of Behavioral Health and Therapy for 3 hours of credit for LADCs and LPC/LPCCs (total of 12 hours if all four sessions are fully attended)*
  - *These activities have been approved for CMEs by the American Academy of Family Physicians for 3 hours of credit (total of 12 hours if all four sessions are fully attended)*

- **Please complete the evaluation for the webinar that will be sent out via email after each session.**
- **You will be receiving a PDF of today's presentation.**

- Follow-up questions?

  Contact Ryan Maganini: rmaganini@healthmanagement.com

# Acknowledgments



We would also like to thank our **community partners** for their support in developing this curriculum.



Indigenous Peoples Task Force

RAINBOW HEALTH

RAN
RURAL AIDS ACTION NETWORK
Providing Care, Service, and Support

TURNING POINT
AN AFRICAN AMERICAN ORGANIZATION
SUPPORT SERVICES | HOUSING | CHEMICAL HEALTH | TRAINING

# Land Acknowledgment

Every community owes its existence and vitality to generations from around the world who contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference.

We begin this effort to acknowledge what has been buried by honoring the truth. **We are standing on the ancestral lands of the Dakota people**. **We want to acknowledge the Dakota, the Ojibwe, the Ho Chunk, and the other nations of people who also called this place home.** We pay respects to their elders past and present.

Please take a moment to consider the treaties made by the Tribal nations that entitle non-Native people to live and work on traditional Native lands. Consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. Please join us in uncovering such truths at any and all public events.*

*This is the acknowledgment given in the USDAC Honor Native Land Guide – edited to reflect this space by Shannon Geshick, MTAG, Executive Director Minnesota Indian Affairs Council

# Today's Presenters

**Charles Robbins, MBA**
**(he/him/his)**
*Principal*
Health Management Associates

**Akiba Drew, MPH**
**(she/her/hers)**
*Associate*
Health Management Associates

**Helen DuPlessis, MD, MPH**
**(she/her/hers)**
*Principal*
Health Management Associates

**Rob Muschler, MPA**
**(he/him/his)**
*Associate*
Health Management Associates

# Disclosures

| Faculty | Nature of Commercial Interest |
|---|---|
| Charles Robbins, MBA | Mr. Robbins discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. |
| Akiba Drew, MPH | Ms. Drew discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. |
| Helen DuPlessis, MD, MPH | Dr. DuPlessis discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. She is also a Board Member of Blue Shield of California Health Plan. |
| Rob Muschler, MPA | Mr. Muschler discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. |
| Jeanene Smith, MD | Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. |

# Agenda for Webinar Series

| Session | Topics |
|---|---|
| **#1**<br>**WEDNESDAY, NOV 2**<br>12:00 pm to 3:00 pm | ❑ Understanding HIV<br>❑ HIV Testing and Treatment<br>❑ The Science of Addiction<br>❑ Screening, and Assessment |
| **#2**<br>**WEDNESDAY, NOV 9**<br>12:00 pm to 3:00 pm | ❑ HIV Risk Reduction<br>❑ SUD Harm Reduction<br>❑ HIV and Stigma<br>❑ Motivational Interviewing<br>❑ Ethical and Legal Issues<br>❑ Funding and Policy Considerations |
| **#3**<br>**WEDNESDAY, NOV 16**<br>12:00 pm to 3:00 pm | ❑ Medications for Addiction Treatment<br>❑ Working with Justice Involved Persons<br>❑ Mental Health Treatment and Counseling<br>❑ Stimulant Use<br>❑ Chem Sex |
| **#4**<br>**WEDNESDAY, NOV 23**<br>12:00 pm to 3:00 pm | ❑ **Cultural, Racial and Sexual Identities**<br>❑ **Pregnancy and HIV, SUD/OUD**<br>❑ **Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota** |

# CHATTER FALL

Please respond to following prompt by typing into the chat box

***Please share a curiosity you bring with you today regarding the topics we are covering***

**Type your response and**

**don’t click enter.**

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Picture from Unsplash

# *Cultural, Racial and Sexual Identities, HIV Positivity, Pregnancy, and SUD, Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota*

Let's begin!

# Glossary of Terms (revisited)

- **Sexual orientation –** a person's identity in relation to the gender or genders to which they are sexually attracted (straight, gay, lesbian, asexual, bisexual, pansexual)
- **Gender identity and/or expression** - internal perception of one's gender; how one identifies or expresses oneself.
  - **Cisgender** – a term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth
  - **Transgender** – refers to an individual whose current gender identity and/or expression differs from the sex they were assigned at birth (may have transitioned or be transitioning in how they are living)
  - **Gender Expansive -** refers to an individual who expresses identity along the gender spectrum (genderqueer, gender nonconforming, nonbinary, agender, two spirit)
- **Sexual Minority** – refers to a group whose sexual identity orientation or practices differ from the majority of and are marginalized by the surrounding society.

SOURCE: Centers for Educational Justice and Community Engagement, UC Berkeley

- **Race** - is usually associated with inherited physical, social and biological characteristics. In this context that means race is associated with biology. Institutionalized in a way that has profound consequences (**White, African American, American Indian Alaskan Native, Native Hawaiian or Pacific Islander**)"
- **Ethnicity** - a term used to categorize a group of people with whom you share learned characteristics and identify according to common racial, national tribal, religious, linguistic, or cultural origin or background. (**Hispanic, Non-Hispanic Black, Non-Hispanic Black**, etc.)

SOURCE: US Office of Management and Budget: Federal Register Vol. 62(210): 58782

# Glossary of Terms (revisited)

**Health Insurance Portability and Accountability Act (HIPAA)** - required the creation of national standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent and includes a Privacy Rule addressing disclosure of and access to PHI; the Security Rule protects disclosure of and access to electronic PHI (e-PHI) a subset of information covered by the Privacy Rule

**Code of Federal Regulations, Title 42, Part 2 (42 CFR Part 2)** – a complicated set of regulations that strengthen the privacy protections afforded to persons receiving alcohol and substance use treatment (in addition to the more general privacy protections afforded in HIPAA). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11)

**Family Education Rights Protection Act (FERPA)** - protects the privacy of student education records in public or private elementary, secondary, or post-secondary school and any state or local education agency that receives funds under an applicable program of the US Department of Education.

SOURCES: Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Services Administration

# Common Acronyms (revisited)

ART – Antiretroviral therapy
AUD – Alcohol use disorder
IDU – Injection or intravenous drug use
MAT – Medication assisted treatment or
Medications for addiction treatment
MSM – Men who have sex with men
OUD – Opioid use disorder
PEH – Person(s) experiencing homelessness
PEP – Post-exposure prophylaxis
PrEP – Pre-exposure prophylaxis
PLWH – Person(s) living with HIV
PMTCT – Perinatal maternal to child transmission (of HIV)
PWID – Person(s) who injects drugs
SUD – Substance use disorder

# Cultural, Racial, and Sexual Identities

# Learning Objectives:

## Cultural, Racial, and Sexual Identities

I

**Summarize HIV & SUD prevalence among people of color and transgender individuals compared to other populations**

II

**Describe the connections between structural inequities and disparities in HIV**

III

**Explain how cultural considerations can influence treatment engagement**

IV

**Identify at least three major health care challenges for this population**

# Context for Today

**Previous Sessions**

- HIV – Transmission, Testing, Treatment, Harm Reduction & Prevention
  - Key to ending HIV is to diagnosis, treat, prevent, respond
- SUD/OUD – Neuroscience, MAT, Stimulant Use, Chem Sex, Risk Reduction
- Ethical and Legal Issues surrounding HIV and SUD
- Stigma Abatement and Motivational Interviewing

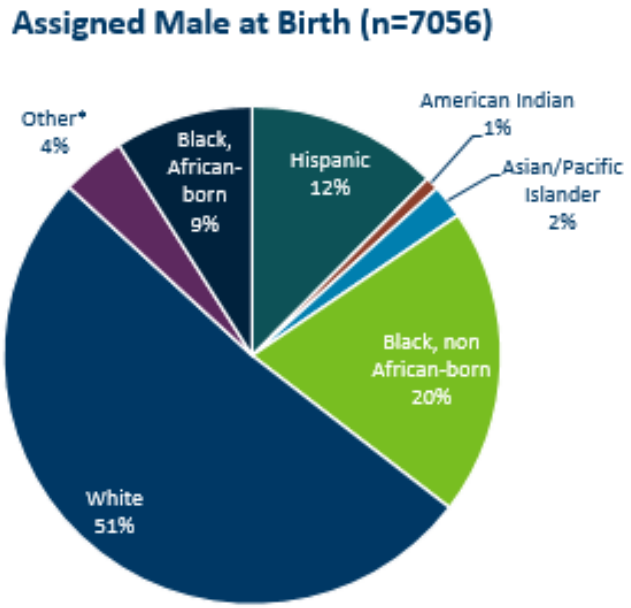
**Today**

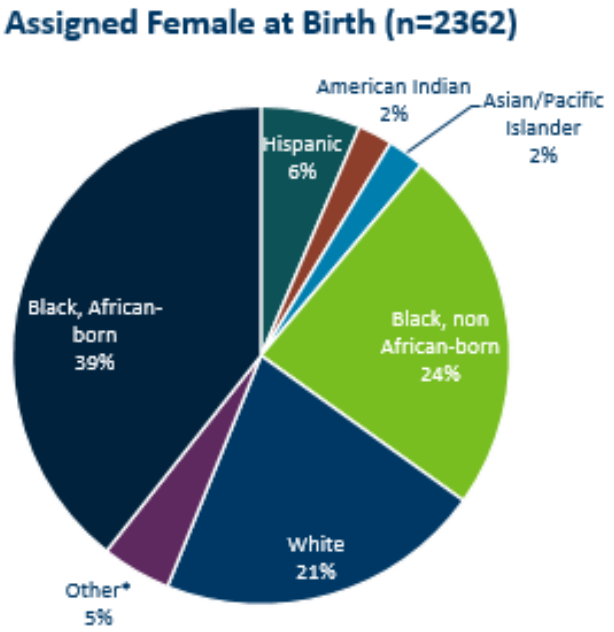
- Populations most impacted and resources for you

**Disparities among individuals at risk of and living with HIV as well as individuals who have a substance use disorder**

# Epidemiology by Race

**People Living with HIV/AIDS in Minnesota by Sex Assigned at Birth and Race/Ethnicity**




*Other includes multi-racial people and people with unknown race

^Race/ethnicity information missing for 4 PWH. Race is a social construct. While there are health disparities between racial and ethnic groups, these are driven by underlying factors relating to historical traumas and current systematic impacts of those traumas.

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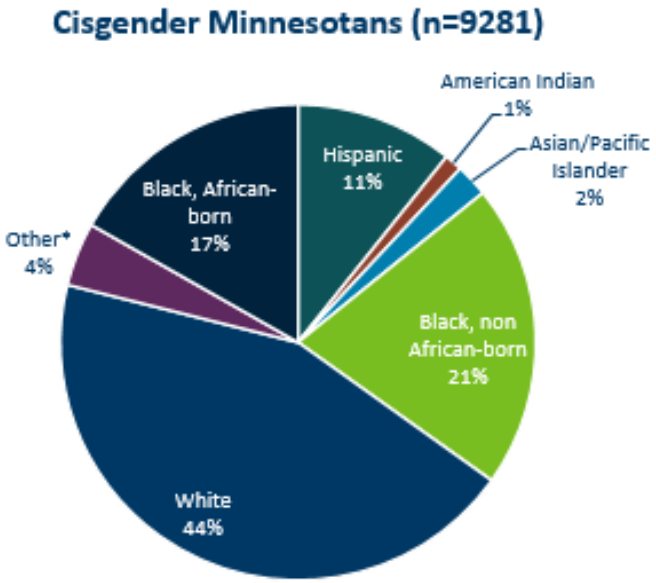
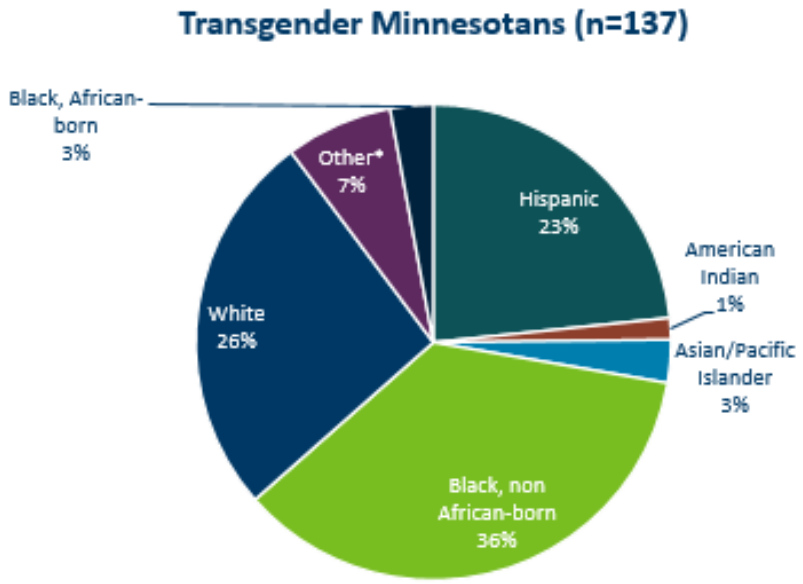
# Epidemiology by Race

**People Living with HIV/AIDS in Minnesota by Gender Identity** and Race/Ethnicity**




*Other includes people who identify as multi-racial and people with unknown race
^Race/ethnicity information missing for 4 PWH. Race is a social construct. While there are health disparities between racial and ethnic groups, these are driven by underlying factors relating to historical traumas and current systematic impacts of those traumas.
**Current gender was not reportable until 2009, so may be incomplete for HIV cases reported before that time. Because current gender is incomplete for a large number of cases, there may be misclassification of transgender Minnesotans in the cisgender group.

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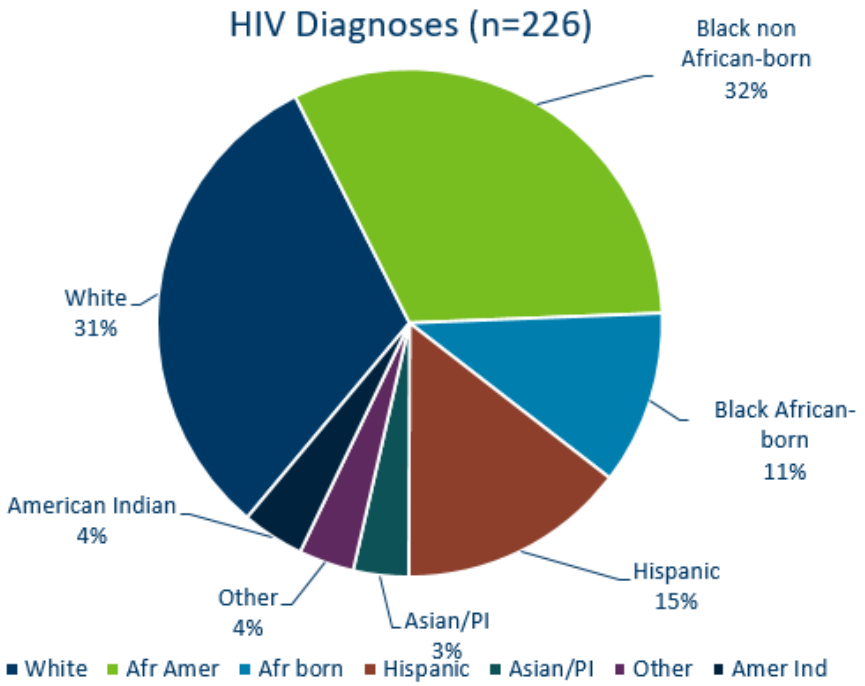
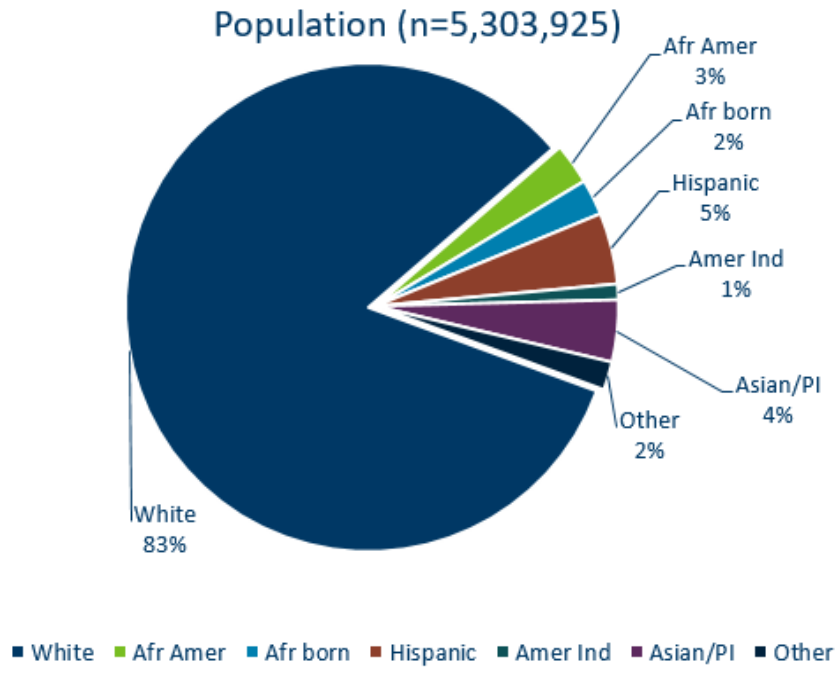
# Epidemiology by Race

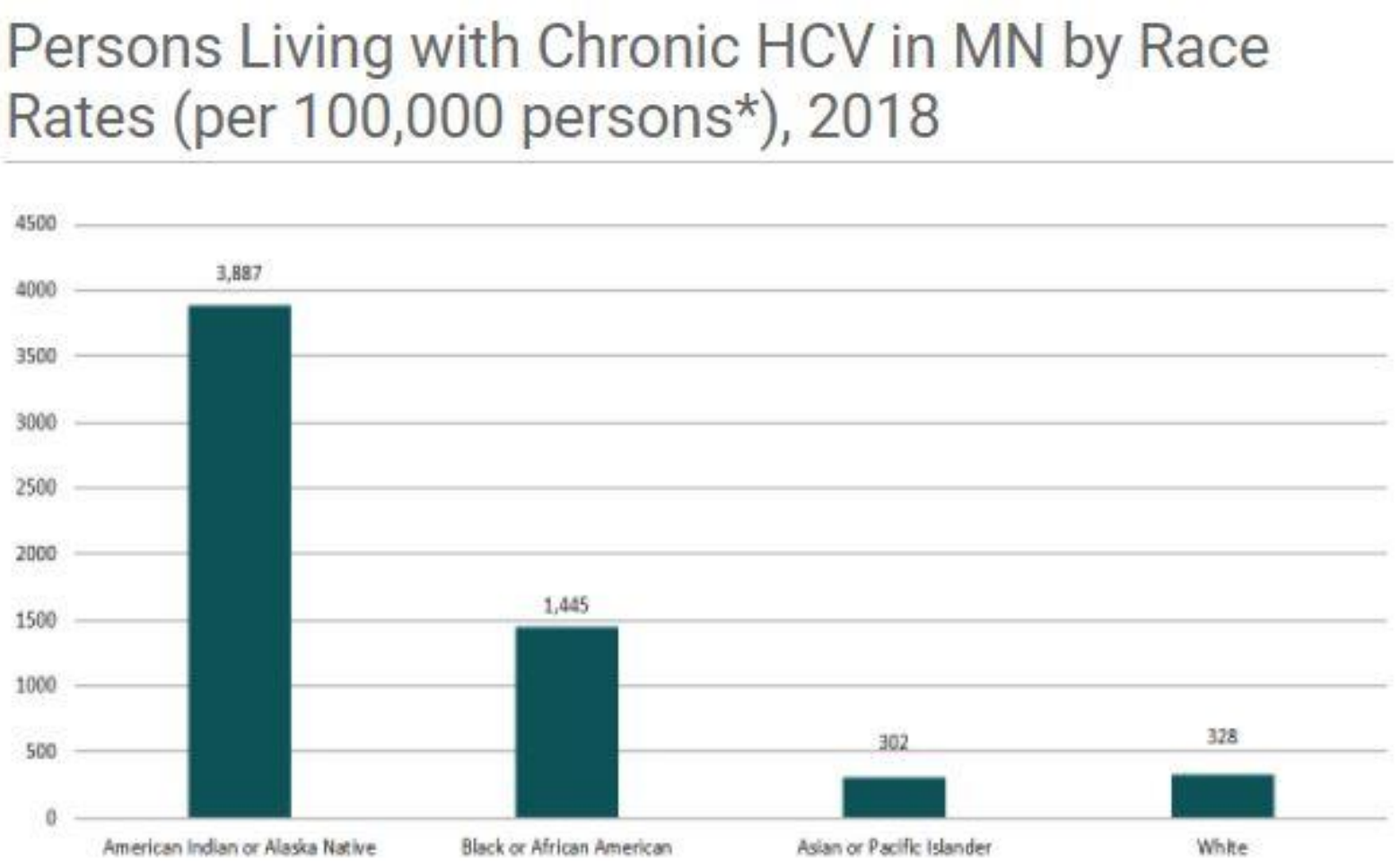
**HIV Diagnoses* in Year 2020 and General Population in Minnesota by Race/Ethnicity**



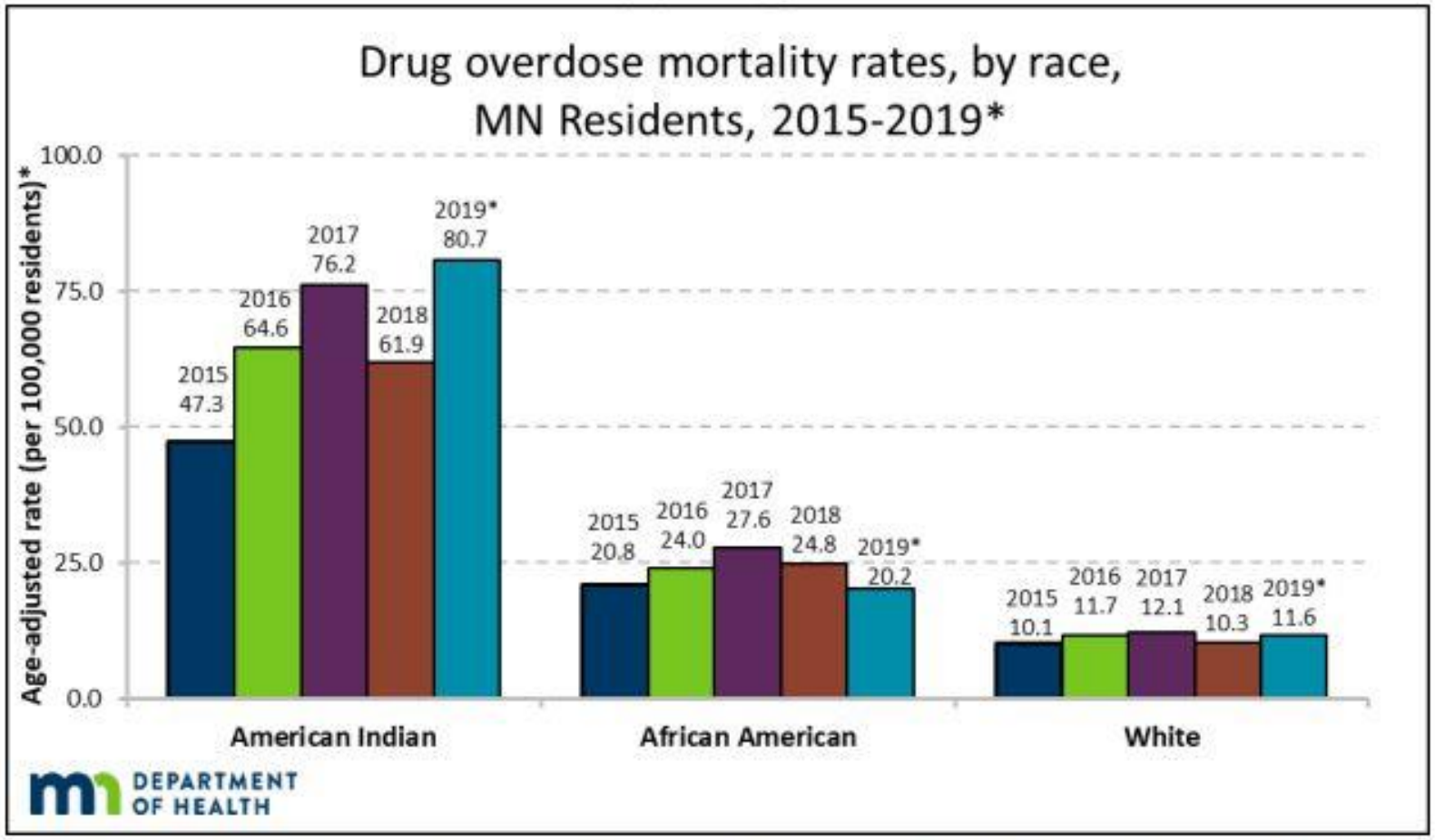

* HIV or AIDS at first diagnosis ǂ Population estimates based on 2010 U.S. Census data. (n = Number of people

# Epidemiology by Race




*Rates calculated using 2017 U.S. Census ACS data. Excludes persons with multiple races or unknown race, n=10,990.

# Epidemiology by Race



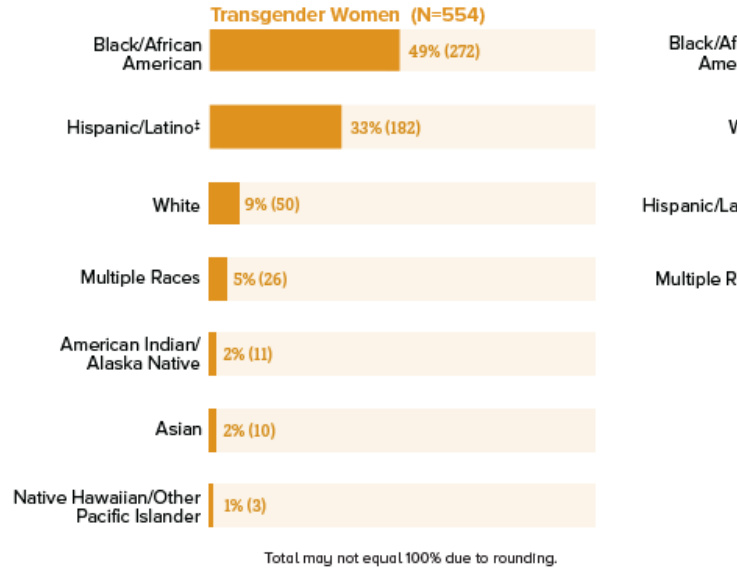

SOURCE: Minnesota death certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2015-2019*

African Americans were almost **two times** more likely to die of a drug overdose than whites. American Indians were **seven times** more likely to die of drug overdose than whites.

# Epidemiology by Race


Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, 2% (601) were among transgender people.

## Most new HIV diagnoses among transgender people were among Black/African American people.†




Total may not equal 100% due to rounding.

* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.
‡ Hispanic/Latino people can be of any race.
** In 41 states and the District of Columbia.

**Centers for Disease Control and Prevention**
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

# Epidemiology by Race

## HIV Prevalence Among Transgender Women in 7 US Cities, 2019-2020

**Racial and ethnic disparities exist among transgender women with HIV.**

**Among transgender women interviewed, 42% had HIV.**

- 62% of Black/African American transgender women had HIV
- 35% of Hispanic/Latina transgender women had HIV
- 17% of White transgender women had HIV

Source: CDC. HIV infection, risk, prevention, and testing behaviors among transgender women–National HIV Behavioral Surveillance–7 U.S. Cities, 2019-2020. *HIV Surveillance Special Report* 2021.

# Sexual Minorities and Cultural Considerations

# Sexual Minorities and SUD

- Most recent data from the National Survey on Drug Use and Health (NSDUH, 2015) indicates sexual minorities use substances at the following rates (compared to the overall US population)

| SUBSTANCE | USE RATES (sexual minority vs. general population) |
|---|---|
| Alcohol | 12.4% vs 10.1% |
| Marijuana | 37.6% vs 16.2% |
| Past year opioid use (includes misuse of prescription opioids as well as heroin use) | 9% vs 3.8% |
| Misuse of Prescription opioids (>26 yo) | 9% vs 6.4% |

- Compared to a heterosexual population, sexual minorities:
  - Enter treatment with more severe SUD (i.e., persistent) compared to
  - Have higher rates of co-occurring mental health disorders including mood disorders, self-harm behaviors (e.g., cutting), suicidality
  - Have a greater risk of HIV infection (men, women and nonbinary)
- There are far more intervention programs designed and evaluated specifically for White Gay men than there are for other sexual minorities

# Sexual Minorities and SUD

## TRANSGENDER PERSONS AND SUBSTANCE USE

- Trans persons are at elevated risk for developing problems with substance use
  - Up to 72% develop problems with alcohol use
  - Up to 34% develop problems with marijuana use
  - Up to 26% develop problems with prescription drug use
- Both trans Women and people who engage in anal sex are at increased risk for HIV
  - Risky sexual behaviors and prevalence of IV drug use are often a consequence of risk and behavior stressors (violence victimization, transphobia, exchange sex, stigmatization, and stressful live events )
  - *Remember that SUD treatment is associated with managing drug use and facilitating safer sex practices!*

# Sexual Minorities and SUD

## TRANSGENDER PERSONS AND SUBSTANCE USE: Theoretical Models

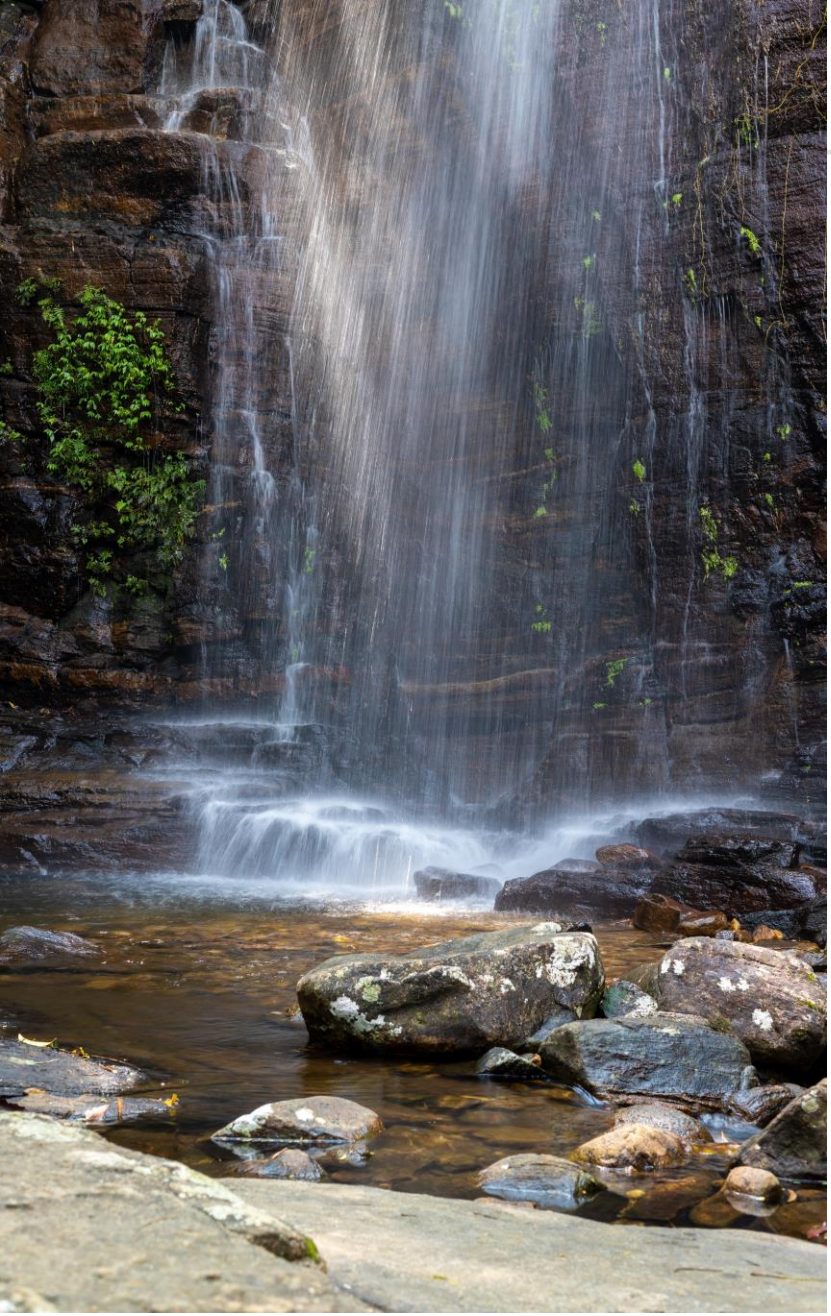
- The Minority Stress Model (Hendricks and Testa, ) – poses that prolonged exposure to prejudice and discrimination → adverse mental health MH outcomes and risk behaviors
- The Syndemic or Multiplicative Model – risk for a significant adverse outcome (e.g., HIV infection) is a function of multiple, co-occurring problems that multiply to increase the risk
  - We know that risky sexual behaviors can be exacerbated by substance use
  - This multiplier effect argues for a focus on the most effective ways of intervening in SUD as a vehicle for reducing HIV incidence

"Perhaps the most important conclusion of this review is that well-designed, theoretically informed culturally sensitive research focused on developing and rigorously testing interventions for substance use among transgender individuals is alarmingly scarce." – *T.R Glynn, 2017*

# Sexual Minorities and SUD

## BARRIERS TO SUD TREATMENT FOR TRANSGENDER PERSONS

- Lack of knowledge among personnel in SUD treatment about Trans-specific realities and experiences
- SUD treatment providers who stigmatize or have negative attitudes toward Trans persons
- Victimization of Trans individuals (e.g., verbal, physical, and sexual abuse by other clients and staff),
- Discrimination (e.g., room & board, bathroom rules, being required to wear clothes judged as appropriate for their birth sex)
- Little formal/organized education for staff about the needs of Trans persons
- **False reporting of specialized treatment services for Trans population**
  - Most programs fail to even collect information on gender identity



# Chatterfall

Please take a minute to type your response in the Zoom Group Chat, but **don't** click enter.

***What strategies do you have in place or are you considering to meet the SUD treatment needs of Trans women?***

When instructed, **please click enter**.

Picture from Unsplash

# Sexual Minorities and SUD

## ADDRESSING THE TREATMENT NEEDS OF TRANSGENDER PERSONS WITH SUD

"Trans individuals (especially women) who feel they are in Trans-friendly programs are more likely to stay in treatment" – *Lyons, et al, 2017*

- Provide education and training programs for staff on the Trans-specific realities, experience and sensitivity (including health-related issues such as street hormones and needle use)
- Prevent discrimination and stigmatizing behaviors by healthcare providers
- Develop policies that address discrimination, bathrooms, sleeping arrangements, conduct in treatment and other group settings, collection of gender-identity data, name and pronoun preference – many of these should be posted
- For programs that are not trans-specialized, work to develop and model a culture that is affirming, inclusive, psychologically safe
- Hiring diverse staff representative of the population
- Allow continued use of hormones and encourage medical care for those using street hormones
- Be transparent about the degree of your programs' services for Trans persons

# Health Disparities in HIV

- Despite prevention efforts, some groups of people are affected by HIV, viral hepatitis, STIs, and TB more than other groups of people
- The occurrence of these diseases at greater levels among certain population groups more than among others is often referred to as a **health disparity**
- Social determinants of health like poverty, unequal access to health care, lack of education, stigma, and racism are linked to health disparities
- Differences may occur by:
  - gender
  - race or ethnicity
  - education
  - income
  - disability
  - geographic location
  - sexual orientation

# Health and Structural Inequities

**Health inequities**

systematic differences in the health status of different population groups

**Structural inequities**

personal, interpersonal, institutional, and systemic drivers—such as, racism, sexism, classism, able-ism, xenophobia, and homophobia

# The Connection

- The impact of structural inequities follows individuals “from womb to tomb.”
  - Socioeconomic factors that contribute to poor health
  - Social stigma
  - Mistrust of the healthcare institution

- HIV has had a disproportionate impact on minority communities, and studies have documented a pattern of disparities in care for minorities
- This makes the issue of treatment of minorities with HIV a particularly timely and pressing one

# Cultural Considerations

**How do cultural considerations influence treatment engagement?**

"An approach to care that uses a cultural competence framework enhances communication between minority patients and their providers, endeavors to use a more diverse array of staff members, proactively enhances the likelihood of receipt of ART, and uses an evidence-based approach to thinking about adherence will improve the likelihood that minority patients will engage in care, be satisfied with care, and have positive HIV-related outcomes".

# Cultural Considerations: Provide Culturally Humble HIV Care

- Clinicians must be aware of the particular health-related cultural beliefs and practices of the minority groups within his or her HIV/AIDS practice
- Adopt a culturally competent framework
  - Identify the patient's core cultural issues
  - Explore the meaning of the illness to the patient – question what they think has caused the problem and how it affects their lives
  - Explore the patient's social context
  - Negotiate across the patient-physician culture to develop a treatment plan that is agreeable to both sides (ensure the key issues of the patient are heard and valued)

# Cultural Considerations: Enhancing Communication in Clinical Care

- Research shows that minority patients are less satisfied with their HIV/AIDS care than are other patients
- Although many issues may contribute to this lower satisfaction, one issue that comes up repeatedly is ***patient-provider communication***
- Minority patients report that they needed more time to make HIV treatment decisions and more information about HIV treatment options
- Providers should endeavor to spend more time with our minority patients with HIV, and should spend more of that time listening to the patient

# Cultural Considerations: Diversify the clinical staff

- Important to diversify HIV clinical staff
- Very few HIV physicians are racial/ethnic minorities
- No matter how welcoming an HIV care site is, minority patients will feel even more comfortable if at least a few clinical or peer support staff members are of their own racial/ethnic background





# Cultural Considerations: Optimizing the Receipt of Care and ART

- Minority patients have reported more problems getting the HIV care they needed and have been less likely to receive medications to treat HIV
- Disparities in receiving ART have persisted
- Medical providers should be aware of the data regarding disparities in the receipt of ART
- Should use strategies in the clinical setting to optimize the likelihood that minority patients will be ***offered***, ***prescribed***, and actually ***take*** antiretroviral medications.

# Cultural Considerations: Enhance Adherence to Treatment

- Stereotypes among HIV care providers that minority patients were less likely to be adherent to ART than were other patients
- Because of this, ART was, at times, withheld from minority patients because of these preconceptions regarding their ability to adhere to it
- Need to eliminate bias (these biases and stereotypes affect providers' treatment decisions and result in failure to treat some minority patients)

# Cultural Considerations: Minority Patients with HIV and Clinical Trials

- Minority patients have historically been underrepresented in HIV-related clinical trials, despite their overrepresentation among those living with HIV infection
- Legacy of abuses in past research studies, distrust of the health care system broadly, and beliefs regarding conspiracies continue to fuel the HIV epidemic in minority communities
- There is no easy answer to engaging minorities in clinical trials
- Providers can make efforts to proactively approach all patients about participation in clinical trials and answer their questions/ address any concerns they may have

# Time for a Poll


**Which cultural consideration will you commit to implementing in your practice and work to influence treatment engagement?**

A. Provide culturally humble HIV care
B. Enhancing communication in clinical care
C. Diversify the clinical staff
D. Optimizing the receipt of care and ART
E. Enhance adherence to treatment
F. Engage Minority patients with HIV in clinical trials

# Trauma Informed Considerations to Enhance Care and Support

**Trauma-Informed Care Concepts**

1. A basic understanding of trauma
2. Emotional and environmental safety
3. A strengths-based approach to services

# Trauma Informed Considerations to Enhance Care and Support

# Trauma Informed Considerations to Enhance Care and Support

## Trauma-Informed Responses

**Safety Skills**

**Emotional Management Skills**

**Grieving and Imagination**

**Leadership Skills**

**Communication Skills**

**Cognitive Skills**

**Judgment Skills**

# Trauma Informed Considerations to Enhance Care and Support


**Resiliency is how well we cope with adversity and stress. We can build or lose resiliency throughout our lives.**






45

# Group Discussion

***Now that you have a better understanding of cultural and trauma informed considerations, what can we do as service providers to enhance care for racial and sexual minorities?***

Use the “raise your hand” feature in Zoom or simply come off mute.


Picture from Unsplash

# HIV, Pregnancy and SUD/OUD

*Throughout this presentation, the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing people identify as mothers or women. We believe all birthing people are equally deserving of patient-centered care that helps them attain their full potential and live authentic, healthy lives*

# Learning Objectives:

## HIV, Pregnancy and SUD/OUD

I

**Summarize at least 3 major considerations (important headlines) for HIV+ pregnant persons with SUD**

II

**List 3 approaches to reduce the risk of HIV transmission from a birthing person to an infant during pregnancy, breastfeeding**

III

**Compare the effectiveness of and considerations for using MAT and other treatments for SUD in pregnant and parenting persons**

# CHATTER FALL

Please take a minute to type your response in the Zoom Group Chat, but **don't** click enter.

***What information do you need to better prepare you to care for pregnant/parenting persons with OUD, SUD, HIV and their affected children?***

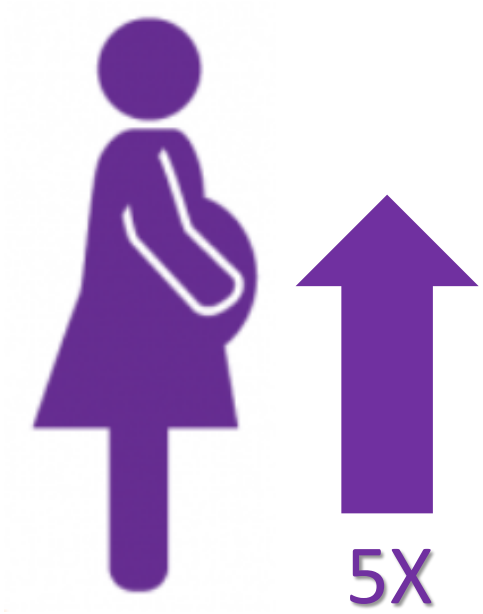
When instructed, **please click enter**.

HEALTH MANAGEMENT ASSOCIATES



Picture from Unsplash

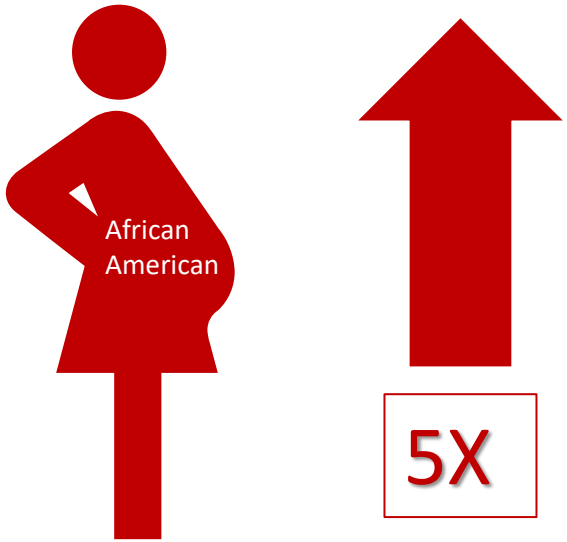
# Epidemiology of SUD During Pregnancy



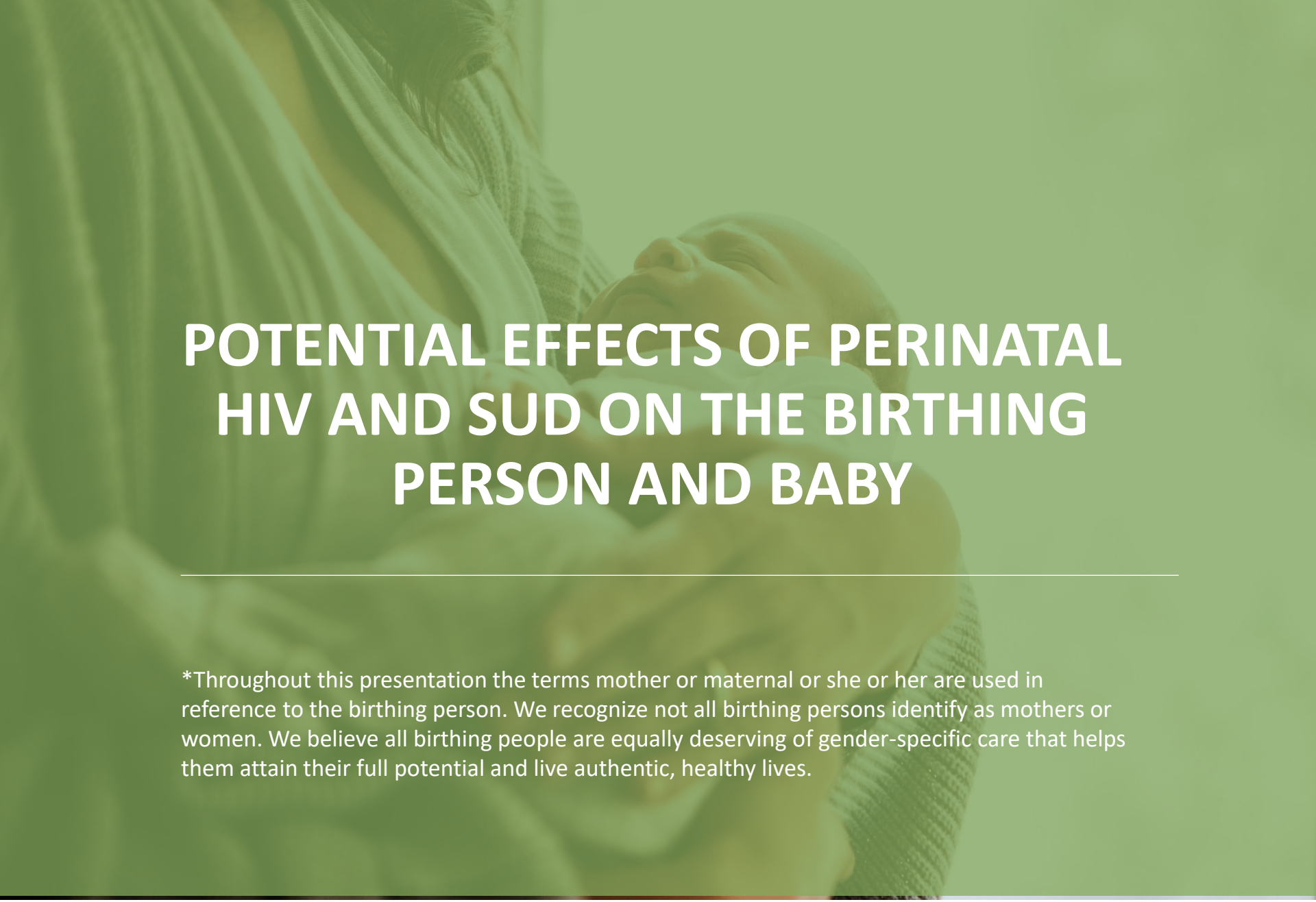

- SAMHSA data: > 400,000 infants are exposed to alcohol and other potential substance of abuse during pregnancy
- Number of pregnant women with OUD increased from 1.5/1000 → 8.2/1000 live births (1999-2017)
- Twenty-seven (27%) percent reported they wanted to cut down or stop using but didn't know how
- In MN the prevalence of Neonatal Abstinence Syndrome (NAS) was 10.3/1000 live births (7.3/1000 in US)
- Eight percent (8%) of women with OUD/SUD receive needed treatment (most are never screened)

Sources: SAMHSA and National Survey on Drug use and Health, 2019

# Epidemiology of HIV During Pregnancy in the United States




- Approximately 8,000 HIV+ women give birth in the US every year and fewer than 50 infants are born with HIV
- Transmission of HIV can occur throughout pregnancy, during childbirth and with breastfeeding (Perinatal Transmission)
- While the US and Europe have experienced steep declines in perinatal HIV transmission (to <1%), African American infants have 5X the incidence of perinatal HIV transmission versus white infants
- In MN the incidence of HIV infected neonates has been ZERO since 2018
- Considerations about approaches to Perinatal Maternal to Child Transmission (PMTCT) prevention vs. treatment approaches



# POTENTIAL EFFECTS OF PERINATAL HIV AND SUD ON THE BIRTHING PERSON AND BABY

*Throughout this presentation the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing persons identify as mothers or women. We believe all birthing people are equally deserving of gender-specific care that helps them attain their full potential and live authentic, healthy lives.

# Case: Kayla

Kayla is 23-year-old HIV+ woman with a positive pregnancy test during a primary care visit for persistent nausea. Upon examination, Kayla is found to be 11 weeks pregnant. She states the pregnancy was not expected but she wants to keep the child. **In response to questions from an evidence-based verbal screening tool**, she indicated that she takes both oxycodone and hydrocodone for persistent back pain that resulted from a car accident when she was 19. She is still complaining of back pain and is worried that as the pregnancy goes on, her back pain will worsen. Kayla is mostly compliant with her ART, but occasionally skips her specialty follow-up visits. She acknowledges that she takes more than the prescribed amounts of opioids. Although concerned her pain may exacerbate during pregnancy, she would like assistance with her opioid misuse and is concerned about the risk of HIV transmission to her infant.

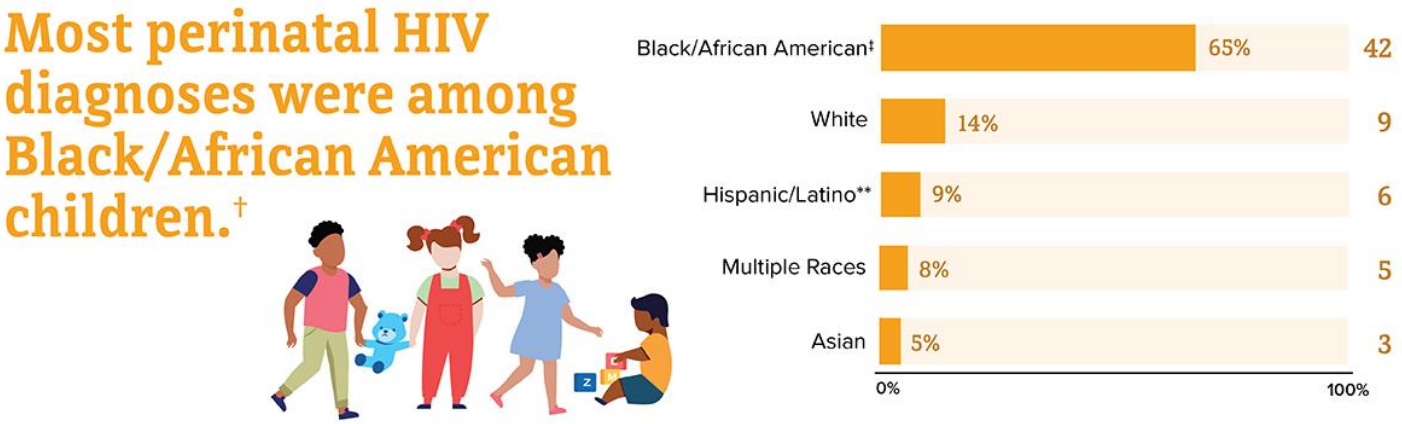
# HIV Positive Pregnancies: Where have we been?

- By 1987 the approval for AZT (zidovudine) enabled the treatment and prophylaxis of pregnant women with HIV in the US and globally*
- By the 1990s, short course ART or single does AZT was available across the globe
- We watched Perinatal Maternal to Child Transmission (PMTCT) rate decrease from 25% to less that one percent (<1%) in the US and other high-income countries


SOURCE: free.unaids.org

# Where Have We Failed in Addressing Perinatal HIV/AIDS?

## Perinatal HIV Infections in the US and Dependent Areas by Race/Ethnicity, 2018

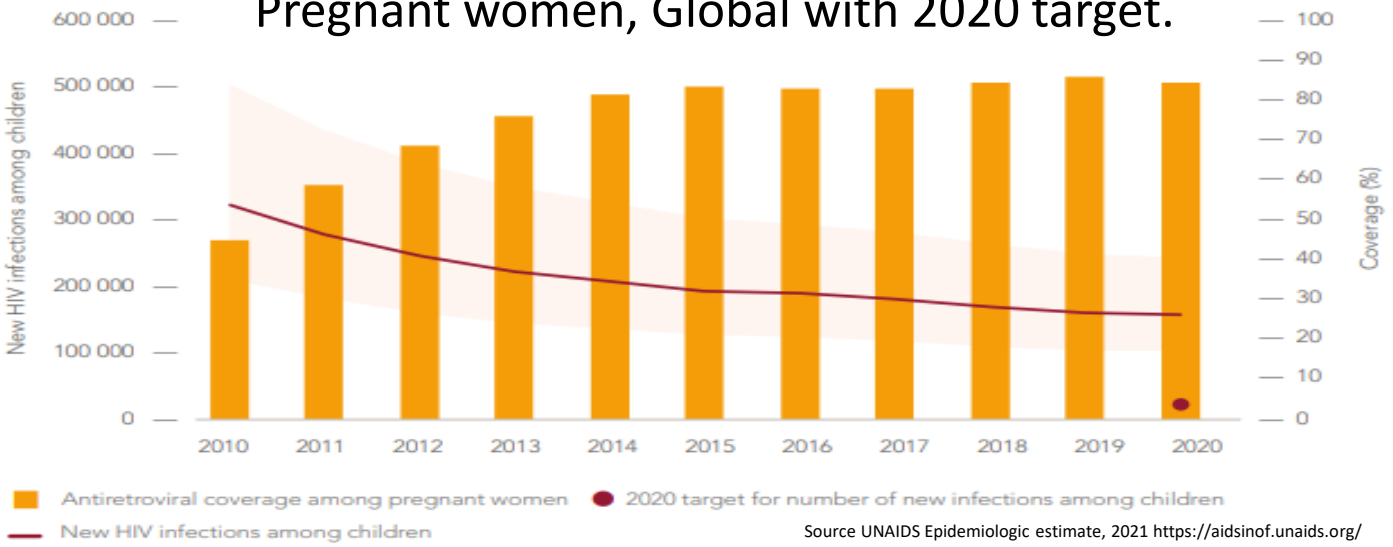



Source: CDC HIV Surveillance Report, 2020;31

- Overall, the number of infants and young children infected from perinatal transmission continues to decline: from 141 cases in 2014 to 65 cases in 2018 (and has been ZERO in MN for the past few years)
- In the United States, the overwhelming majority of new cases of HIV in children occurs among Black/African American Children
  - The racial/ethnic disparity of HIV diagnosed children under 13 years is greater than for adults (60% of children are Black/African American vs 57% of adults)

# Where Have We Failed in Addressing Perinatal HIV/AIDS Across the Globe?

New HIV Infections among Children and ART coverage among Pregnant women, Global with 2020 target.




Source UNAIDS Epidemiologic estimate, 2021 https://aidsinof.unaids.org/

- The World Health Organization (WHO) and other Global HIV/AIDs guidelines have focused for decades on the prevention of PMTCT – some would say to the exclusion of treatment
- The PMTCT cascade of tests and treatment are managed in the US and high and middle-income countries, but the necessary systems are immature to non-existent in low to middle-income countries
- Integrating PMTCT and Maternal-Neonatal-Child Health programs and simplification for WHO guidelines has improved timely initiation of ART, but post-partum engagement of HIV infected/exposed mothers and infants is still problematic

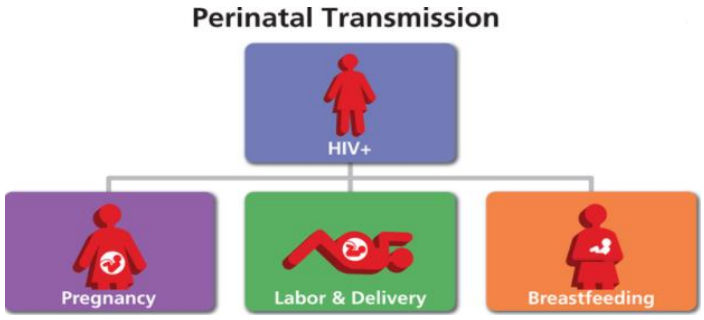
# Important Facts to Know About HIV Positivity During Pregnancy and Perinatal Transmission

HIV infection can be:

- Passed vertically from mom to fetus during pregnancy
- Spread through contact with blood and bodily fluids during childbirth
- Passed through breastmilk

- Routine HIV screening of all sexually active persons with childbearing potential as early as possible during pregnancy (opt-out)

- Because of disparities in access to screening, prevention and treatment, we should ensure that individuals from other countries receive information during pre-conception counseling and offered screening and treatment




SOURCE: clinicalinfo.hiv.gov

# Considerations when Pregnancy, HIV, and SUD Coexist

- Some substances are more detrimental to those at risk for or who have HIV than others
  - Stimulants have been associated not only with increased risky behavior, but with accelerated HIV disease progression, poor ART adherence and lack of viral suppression
  - Alcohol, benzodiazepine and opioid use all increase risky behaviors associated with HIV; cannabis does not appear to have the same significant effect
- Screening for SUD should be part of routine clinical care of persons with HIV

# Considerations when Pregnancy, HIV and SUD Coexist (cont.)

**Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection *and* Interventions to Reduce Perinatal HIV Transmission in the United States**

- Individuals on Medications for Addiction Treatment (MAT) are more likely to initiate and maintain ART regimens
- Ongoing SUD is NOT a contraindication to prescribing/using ART
  - Use of low risk, easy ART regimens are preferred
- ART agents that inhibit or induce the CYP system (liver enzymes) may interact with methadone and buprenorphine (no such interaction with naltrexone)
- PrEP should always be used for high-risk encounters including during pregnancy and breastfeeding for HIV negative persons

# 5-minute stretch break!

# Perinatal SUD

*Throughout this presentation, the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing people identify as mothers or women. We believe all birthing people are equally deserving of patient-centered care that helps them attain their full potential and live authentic, healthy lives*

# CHATTER FALL

**Medications for Opioid Use Disorder (MOUD) generally should..**

**a)** Be increased during pregnancy

**b)** Be decreased during pregnancy

**c)** Not be used during pregnancy

When instructed, please click enter.

HEALTH MANAGEMENT ASSOCIATES



Image provided by Unsplash Photos

# Medications for Addiction Treatment (MAT): Evidence-base and Impact

| MAT | Overdose Deaths | Retention in Treatment | Pregnancy Outcomes | Neonatal Abstinence Syndrome (NAS) |
|---|---|---|---|---|
| Detoxification/ Withdrawal | | | | |
| Methadone | | | | |
| Buprenorphine (Mono) | | | | |
| Buprenorphine/ Naloxone | | | | |
| Naltrexone | | | | |

*MAT is the standard of care for the treatment of pregnant women with OUD*

| | |
|---|---|
| | Research indicates use is contraindicated and/or that risks of poor outcome outweigh benefits of use |
| | Research is insufficient to conclude that benefits outweigh risks or that benefits exceed those of other MATs |
| | Research indicates that benefits do outweigh risks or that benefits do exceed those of other MATs |

# Additional Consequences of Opioid Use During Pregnancy

- Fetus exposed to unstable opioid levels
- Mother less likely to get prenatal care
- Fetus & mother more likely to be exposed to morbidity & mortality from IDU & risky behaviors
  - HIV, HCV
  - Endocarditis, cellulitis
  - Trauma

# BENEFITS of MOUD use During Pregnancy

- Reduced complication of IDU
- Seventy-five percent (75%) less likely to die related to their addiction
- Improves adherence to prenatal care & addiction
- Safer and healthier communities
- Reduced cravings
- Reduced illicit opioid use
- Reduced OD events
- Reduced criminal behavior
- Reduced risk of obstetric complications

# Case Study: Kayla's Newborn

- Baby M was born in February 2019
- Initially ambivalent, Kayla warmed to the idea of being a mom
- Mom is HIV+ (adherent on ART) with undetectable viral load 1 week prior to delivery. She has not been adherent with buprenorphine and has continued intermittently using pressed opioid pills and occasional alprazolam
- Total infant stay was 28 Days
- Total morphine need was:
  - 50.6 mg total
  - 18.7 mg/day
  - 2.3 mg/dose
- Infant stayed on 4 different hospital units
- Kayla felt judged, inadequate and powerless

# Consequences of Perinatal SUD

| | Preterm Labor | Low Birthweight | Fetal demise | Cognitive or Developmental Effects | Other |
|---|---|---|---|---|---|
| Tobacco | X | X | X | | Birth defects |
| Alcohol | X | X | | X | Fetal Alcohol Spectrum Disorders (FASD) |
| Cannabis | | X | X | X* | Mood/ behavioral disorders |
| Opioids | X | X | | X* | Abruption, Neonatal Abstinence Syndrome (NAS) |

SOURCE: See consolidation of Perinatal Outcome References at end of this presentation

# Time for a Poll


**Which of the following statement(s) is/are most accurate about infants exposed to opioids?**

A. Infants born of mothers on medically assisted treatment (MAT), such as Buprenorphine or Methadone, for more than 6 weeks during the pregnancy are rarely born with symptoms of neonatal abstinence syndrome (NAS).

B. The modified Finnegan score is the gold standard for monitoring infants with NAS.

C. Mothers on MAT should never breast feed their infants.

D. Marijuana use causes fewer short and long-term effects than on exposed infants than do opioids.

E. A significant % of opioid exposed infants with NAS can be treated without pharmacotherapy.

# Neonatal Abstinence Syndrome (NAS): Hospital Care

***NAS is a post-birth drug withdrawal syndrome characterized by:***

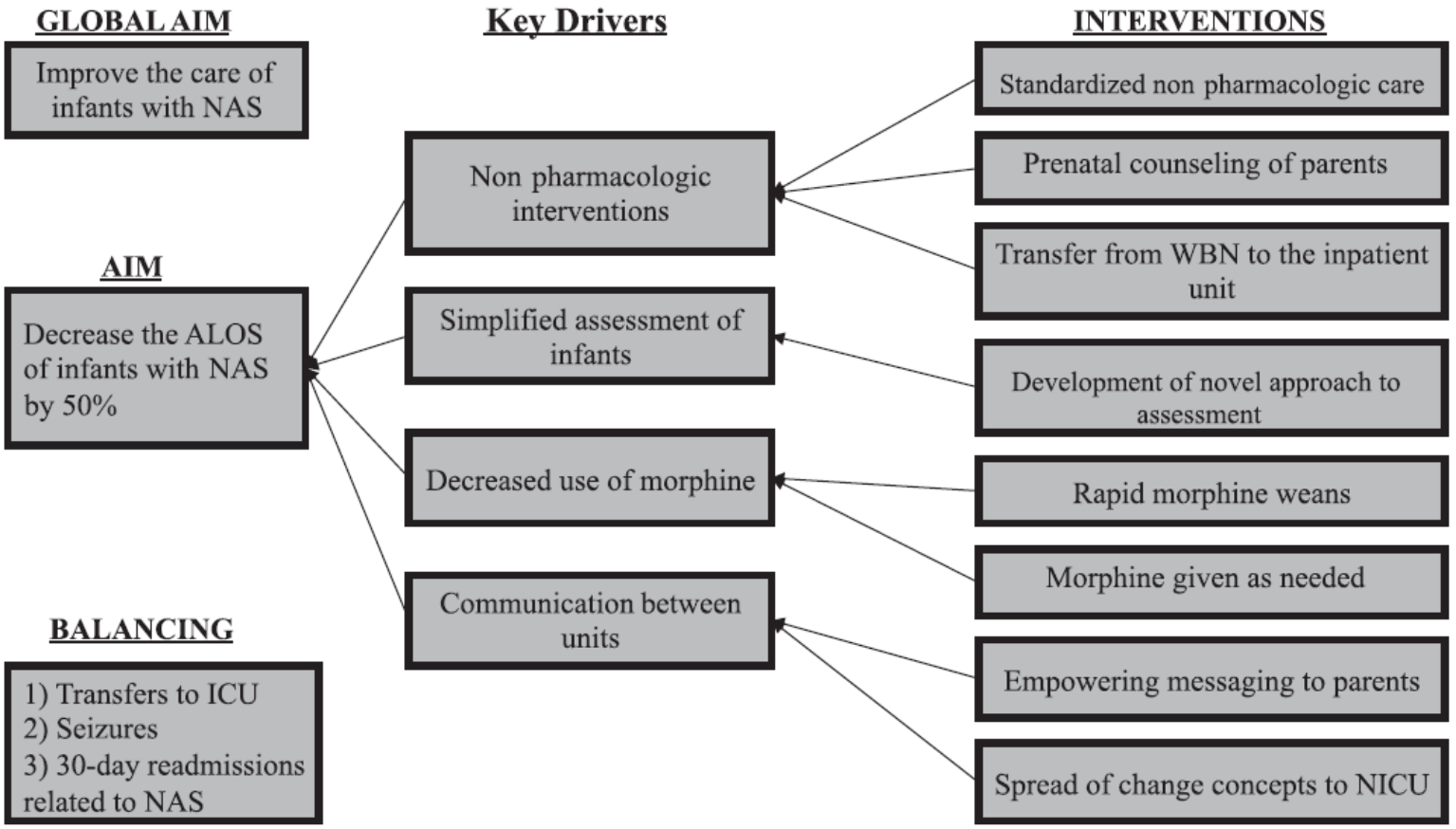
*CNS irritability*
*Autonomic hyperreactivity*
*GI dysfunction*

- NAS may not be recognized (occurs in 50-80% of exposed infants)
- Goals
  - Optimize growth and development
  - Minimize negative outcomes
  - Support secure attachment and post-discharge
  - Opportunity for health and wellbeing
  - Reduce lengths of stay and treatment*
- Having a protocol for identification and management is critical
- Historic approaches to management are giving way to new paradigms

Picture from SAMHSA.

# Changing Paradigms of Care for Neonates with NAS

**Eat -** ≥ 1 oz or full BF session
**Sleep - ≥** 1 hour between feeds
**Console** – Cease crying within 10 min. of being consoled




Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

# Changing Paradigms of Care for Neonates with NAS

- **Special ward setting** (non-ICU)
- **Staffing -** dedicated, trained
  **Mom's Roles** – assessments
- **Improved communication**
- **Comprehensive care**

**Prenatal Consultation**

↓

**Inpatient Observation & NAS Treatment while Rooming In**

↓

**Appropriate Neuro-developmental + Primary Care Follow-Up and Support**

Source: *Czynski A. Family Care Support Services, Women and Infants Hosp, RI*

# Standardized Non-Pharmacologic Care Bundle

- Support and coaching for parents (consoling support interventions)
- Proactive skin protection
- Environmental Accommodations

- Maternal presence and Rooming-in
- Dim lights
- Reduced NICU admission
- Reduced/coordinated interventions
- Reduction in white noise/sound (location)
- Limit visitors

*Outcomes realized:*

- *Better engaged, more confident parents*
- *Reduced use and absolute dosage of medication*
- *Reduced length of stay*
- *Reduced overall costs of care*

# Standardized Non-Pharmacologic Care Bundle (cont.)

- Swaddling
- Cuddler program
- Breastfeeding promotion/On demand feeds
- Non-nutritive sucking
- Establishing policies and procedures

- Non-pharmacologic interventions
- Rapid weaning protocol
- Guidelines for assessment and monitoring
- Methadone and Adjunctive therapies
- When needed (PRN) vs scheduled Morphine

*Outcomes realized:*

- *Better engaged, more confident parents*
- *Reduced use and absolute dosage of medication*
- *Reduced length of stay*
- *Reduced overall costs of care*

# Educate Staff about NAS and Emerging Practices

*Identification, evaluation, and treatment*

- Clinical providers and staff with strong foundation of knowledge can educate and support families
- Positive interactions with families of newborns with NAS contribute to better outcomes and reduced LOS
- Provider and staff interactions with families should be supportive and non-judgmental
- Families can play valuable role in care, including mothers being encouraged to breastfeed if on stable MAT dose

**Language Matters Information Sheet**
*nationalperinatal.org*

OPIOIDS and NAS
When reporting on mothers, babies, and substance use
LANGUAGE MATTERS

### I am not an addict.

I was exposed to substances in utero. I am not addicted. Addiction is a set of behaviors associated with having a Substance Use Disorder (SUD).

### I was exposed to opioids.

While I was in the womb my mother and I shared a blood supply. I was exposed to the medications and substances she used. I may have become physiologically dependent on some of those substances.

### NAS is a temporary and treatable condition.

There are evidence-based pharmacological and non-pharmacological treatments for Neonatal Abstinence Syndrome.

# Empowering Messages to Partners

"On the inpatient unit, we explained that our first-line and most important treatment would center around measures to comfort the infant and that these should be performed by a family member. Parents were told that they were the treatment of their infants and must be present as much as possible. Nurses and physicians focused on supporting and coaching parents on the care of their infants."

Grossman MR et al. An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome. Pediatrics. 2017;139(6):e20163360

# Breastfeeding and Parental SUD and HIV

# Benefits of Breastfeeding

Breastfeeding reduces the risk of:

- Respiratory infections and otitis media
- Gastrointestinal infections
- Sudden infant death syndrome
- Protection against allergic disease
- Celiac disease, inflammatory bowel disease
- Obesity, diabetes (types 1 and 2)
- Adverse neurodevelopmental outcomes

- Maternal benefits: reduced risk of breast and ovarian cancer
- Maternal bonding/decreased risk of abuse
- Breastfed infants less likely to require pharmacological intervention for NAS
- Reduced symptoms of NAS
- Shorter length of stay for NAS
- Shorter duration of pharmacologic treatment when needed for NAS

# When Breastfeeding is Contraindicated

- Medical contraindications in infant (e.g., galactosemia +/- phenyl ketonuria [PKU])

- Specific Maternal infections
  - HIV*
  - Brucellosis (untreated)
  - Cracked nipples in women with HepB/C**
  - COVID-19
  - Human T-lymphocyte virus (HTLV )I or II
  - Active, untreated tuberculosis (TB)***
  - Active herpes simplex virus (HSV) lesions (including Varicella) on nipple/breast**

- Women with SUD (including cannabis) – not stable in treatment

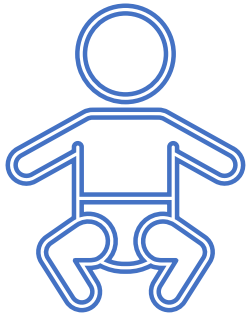
* Consensus counsels against BF in high to middle-income countries
** Pump and dump
*** Pump but avoid close contact

# What about Breastfeeding and Medication for Addiction Treatment (MAT)?

- Methadone (3%) and Buprenorphine (2.4%) pass thru breastmilk in clinically insignificant amounts
  - Encourage breastfeeding (especially during NAS)
- Limited information about Naltrexone and breastfeeding
  - Limited transfer into breastmilk (0.86%)
  - Extreme limits on bioavailability in buprenorphine combination products taken orally (po) or sublingually (SL)
- Information on long term effects of MAT exposure is still unclear
- Benefits outweigh the risks
- Communication and "informed consent"
  - Benefits: Mothers should know the benefits of breastfeeding and of taking meds while breastfeeding
  - Risks: Considerations for breastfeeding while on *any* Medications (especially other psychotropic medications)
  - Risks: Mothers should know contraindications and relative contraindications
  - Risks: Mothers should know risk of relapse and risky behaviors if not on MAT

# Factors that Influence Infant Feeding Decisions among Persons on MAT

- Social stigma surrounding MAT
- Information and misinformation from healthcare personnel
  - Mixed messages from providers
  - Overt or implicit messages from nursing and other support staff
- Court or Child Protective Services “orders” to refrain from breastfeeding
- Feedback and Information from peers



# Considerations for Breastfeeding Policy

**Counsel individual under any of the following circumstances not to breastfeed:**

- Not engaged in substance use treatment, or engaged in treatment and failure to provide consent for contact with counselor
- Not engaged in prenatal care
- Positive maternal urine toxicology screen for substances including cannabis at delivery
- No plans for postpartum substance abuse treatment or pediatric care
- Women relapsing to illicit drug use or legal substance misuse in the 30-day period prior to delivery
- Any behavioral or other indicators that the woman is actively abusing substances
- Chronic alcohol use
- Medical contraindications: HIV+, active TB (okay to pump and have others feed), open sores on nipple with HepB, HepC, varicella, other herpesviruses

# Sample Script for Addressing Marijuana use and Breastfeeding – Santa Clara Valley Medical Center

Importance of highlighting the benefits of breastfeeding and education of families, context is in caring for the mother and baby as a whole…

**Marijuana script excerpts**

*Marijuana, also known as "weed" or "pot" is now legal in California for adults over 21. But this doesn't mean it's safe for pregnant or breastfeeding moms or babies. THC in marijuana gets into breast milk and may affect your baby's brain and development…*

*Secondhand marijuana smoke is also bad for your baby. Marijuana smoke has many of the same chemicals as tobacco smoke. Some of these chemicals may cause cancer or Sudden Infant Death Syndrome (SIDS). Don't allow anyone to smoke anything in your home or around your baby…*

*If you choose to smoke, it is really important to have someone who is not under the influence watching your baby. And be sure to keep marijuana, including edibles, out of reach of children…*

*Given the concerns about possible effects on your baby's brain and development, we recommend not smoking marijuana or using marijuana edibles while you are breastfeeding.*

# Supportive Strategies for Breastfeeding for Persons with OUD/SUD

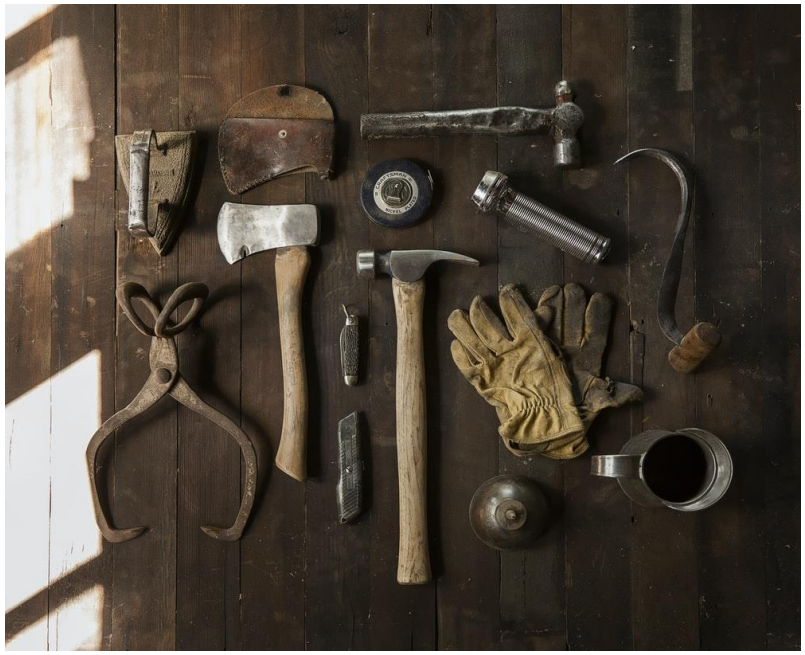
- Formulate prenatal care plan that addresses breastfeeding on MAT
- Education and training for PROFESSIONALS on breastfeeding
- Stigma abatement
  - Recognize biases among staff
  - Model and train
- Establish rational policies and procedures as a guide

- Communication and "informed consent"
  - Mothers should know contraindications and relative contraindications
  - Considerations for breastfeeding while on other psychotropic medications
  - Relapse and risky behaviors
- Trauma informed approaches

"Maternal substance abuse is not a categorical contraindication to breastfeeding. Adequately nourished narcotic dependent mothers … stable methadone or buprenorphine maintained women should be encouraged to breastfeed"… as long as there is no other contraindication to breastfeeding. *American Academy of Pediatrics & Academy of Breastfeeding Medicine*

# QUESTIONS?

# Resources



Picture from Unsplash.

- **NAS Toolkit** – 39 best practices, guidelines and protocols on perinatal SUD
  ***nastoolkit.org***
  - *Breastfeeding: Best Practice 9*
  - *NAS: Best Practices 16-24*
  - *Outcomes of exposed infants: Best Practices 28-33*
  - *Neurobiology of SUD: Best Practice 7, 8, 10, 13, 14, 37*
- HMA's SUD Website: ***addictionfreeca.org***
- CA SUD Consultation line (UCSF): https://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line/
- Minnesota Women's Recovery Services mn.gov/dhs/recovery
- SAMHSA: SAMHSA's National Helpline ***https://www.samhsa.gov/find-help/national-helpline***

# References: Perinatal HIV/AIDS


- ACOG Labor and Delivery Management of Women with Human Immunodeficiency Virus Infection. Committee Opinion Number 751, September 2018. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/09/labor-and-delivery-management-of-women-with-hiv-infection.pdf
- AVERT – Global Info and Education on HIV and AIDS. https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child
- CDC https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html
- Chi BH, Bolton-Moore C, Holmes CB. Prevention of mother-to-child HIV transmission within the continuum of maternal, newborn, and child health services. Curr Opin HIV AIDS. 2013 Sep;8(5):498-503. doi: 10.1097/COH.0b013e3283637f7a. PMID: 23872611; PMCID: PMC4049298. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4049298/pdf/nihms-592223.pdf
- Kahlert C et al. *Is breastfeeding an equipoise option in effectively treated HIV-infected mothers in a high-income setting?* Swiss Medical Weekly, 148:w14648, 2018. https://smw.ch/article/doi/smw.2018.14648
- Kellerman SE, Ahmed S, Feeley-Summerl T, Jay J, Kim M, Phelps BR, Sugandhi N, Schouten E, Tolle M, Tsiouris F; Child Survival Working Group of the Interagency Task Team on the Prevention and Treatment of HIV infection in Pregnant Women, Mothers and Children. Beyond prevention of mother-to-child transmission: keeping HIV-exposed and HIV-positive children healthy and alive. AIDS. 2013 Nov;27 Suppl 2(0 2):S225-33. doi: 10.1097/QAD.0000000000000107. PMID: 24361632; PMCID: PMC4087192. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4087192/pdf/nihms607455.pdf
- NIH https://hivinfo.nih.gov/understanding-hiv/fact-sheets/preventing-mother-child-transmission-hiv
- Paintsil E, Andiman WA. Update on successes and challenges regarding mother-to-child transmission of HIV. Curr Opin Pediatr. 2009 Feb;21(1):94-101. doi: 10.1097/MOP.0b013e32831ec353. PMID: 19242245; PMCID: PMC2650837.Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/pediatricguidelines.pdf. Accessed (insert date) [include page numbers, table number, etc., if applicable].
- Panel on Treatment of Pregnant Women with HIV Infection and Prevention of perinatal Transmission. Recommendations for Use of Antiviral Drugs in Transmission in the United Stated. Available at https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/Perinatal_GL.pdf Accessed august 24, 2021
- UNAIDS. Confronting Inequalities: Lessons for Pandemic Responses from 40 Years of AIDS. The UNAIDS Global AIDS Update|2021.
- Waitt C et al. *Does U=U for breastfeeding mothers and infants? Breastfeeding by mothers on effective treatment for HIV in high-income settings.* The Lancet HIV, advance online publication, 27 June 2018.

# References: Perinatal Outcomes


- Bada HS, Bann CM, Whitaker TM, et al. Protective factors can mitigate behavior problems after prenatal cocaine and other drug exposures [published correction appears in Pediatrics. 2013;132(1):175]. Pediatrics. 2012;130(6).
- Bakhireva LN, Holbrook BD, Shrestha S. Association between prenatal opioid exposure, neonatal opioid withdrawal syndrome, and neurodevelopmental and behavioral outcomes at 5-8 months of age. Early Hum Dev. 2019;128:69–76
- Behnke M, Smith VC and The American Academy of Pediatrics Committee on Substance Abuse and Committee on the Fetus and Newborn. Technical Report. Prenatal Substance Abuse: Short and Long Term Effects on the Exposed Fetus. PEDIATRICS Volume 131, Number 3, March 2013
- Brogly SB, Saia KA, Walley AY, Du HM, Sebastiani P. Prenatal buprenorphine versus methadone exposure and neonatal outcomes: systematic review and meta-analysis. Am J Epidemiol. 2014;180(7):673–686
- Brown MS, Hayes MJ, Thornton LM. Methadone versus morphine for treatment of neonatal abstinence syndrome: a prospective randomized clinical trial. J Perinatol 2015; 35:278-83.
- Burke S, Beckwith AM. Morphine versus methadone treatment for neonatal withdrawal and impact on early infant development. Global Pediatric Health. 2017;4:2333794X17721128
- Conradt E, Crowell SE, Lester BM. Early life stress and environmental influences on the neurodevelopment of children with prenatal opioid exposure. Neurobiology Stress. 2018; 9:48–54
- Grossman MR, Berkwitt AK,. Osborn RR, Xu Y, Esserman DE, Shapiro ED, Bizzarro MJ. An Initiative to Improve the Quality of Care of Infants With Neonatal Abstinence Syndrome Pediatrics. 2017;139(6):e20163360
- Kaltenbach K, O'Grady KE, Heil SH, et al. Prenatal exposure to methadone or buprenorphine: early childhood developmental outcomes. Drug Alcohol Depend. 2018;185:40–49
- Kuppala VS, Tabangin M, HabermanB, Steichen J, Yolton K. Current state of high-risk infant follow-up care in the United States: Results of a national survey of academic follow-up programs. Journal of Perinatology (2012) 32, 293–298
- Larson JJ, Graham DL, Singer LT, Beckwith AM, Terplan M, Davis JM, Martinez J, Bada HS. Cognitive and Behavioral Impact on Children Exposed to Opioids During Pregnancy**.** *Pediatrics* 2019;144
- Logan BA, Brown MS, Hayes MJ. Neonatal abstinence syndrome: treatment and pediatric outcomes. Clinical Obstetrics Gynecology. 2013;56(1):186–192

# References: Perinatal Outcomes (cont.)


- Hirai AH, Ko JY, Owens PL, Stocks C, Patrick SW. Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017. *JAMA.* 2021;325(2):146–155. doi:10.1001/jama.2020.24991
- Nygaard E, Moe V, Slinning K, Walhovd KB. Longitudinal cognitive development of children born to mothers with opioid and polysubstance use. Pediatric Research. 2015;78(3):330–335
- Oei JL, Melhuish E, Uebel H, et al. Neonatal abstinence syndrome and high school performance. *Pediatrics*. 2017;139(2):e20162651.
- Sherman LJ, Ali MM, Mutter R, Larson J. Mental disorders among children born with neonatal abstinence syndrome. Psychiatric Services. 2019;70(2):151
- Shonkoff JP, Garner AS, The The American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption and Dependent Care, and Section on Developmental and Behavioral Pediatrics, the Lifelong Effects of Early Childhood Adversity and Toxic Stress. PEDIATRICS Volume 129, Number 1, January 2012
- Urban Institute, Neonatal Abstinence Syndrome and Maternal Access to Treatment for Opioid Use Disorder in California Counties (2018 Wachman EM, Hayes MJ, Brown MS, et al. Association of OPRM1 and COMT single-nucleotide polymorphisms with hospital length of stay and treatment of neonatal abstinence syndrome. JAMA. 2013;309(17):1821–1827
- Czynski A. Personal correspondence, Women and Infants Hospital, Brown University, Warren Alpert School of Medicine
- https://www.cdc.gov/nchs/products/databriefs/db305.htm#:~:text=Key%20findings,Data%20from%20the&text=In%202016%2C%207.2%25%20of%20women,25%E2%80%9329%20(8.2%25).
- Azagba, S., Manzione, L., Shan, L. et al. Trends in smoking during pregnancy by socioeconomic characteristics in the United States, 2010–2017. BMC Pregnancy Childbirth 20, 52 (2020).
- https://doi.org/10.1186/s12884-020-2748-y. https://www.cdc.gov/ncbddd/fasd/data.html. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6335373/
- May PA, Chambers CD, Kalberg WO, et al. Prevalence of Fetal Alcohol Spectrum Disorders in 4 US Communities. JAMA. 2018;319(5):474–482. doi:10.1001/jama.2017.21896
- Gunn et al. Prenatal exposure to cannabis and maternal and child health outcomes: a systematic review and meta-analysis. BMJ Open 2016; 6e009986.

# References


- Albertsen, K, et al. Alcohol Consumption during Pregnancy and the Risk of Preterm Delivery, American Journal of Epidemiology, Volume 159, Issue 2, 15 January 2004, Pages 155–161, https://doi.org/10.1093/aje/kwh034
- Virji SK. The relationship between alcohol consumption during pregnancy and infant birthweight. An epidemiologic study. Acta Obstet Gynecol Scand. 1991;70(4-5):303-8. doi: 10.3109/00016349109007877. PMID: 1746254
- https://www.nih.gov/news-events/news-releases/tobacco-drug-use-pregnancy-can-double-risk-stillbirth


RESOURCES

The Clearinghouses for Evidence-based Practices

- The California Evidence-based Clearinghouse for Child Welfare. https://www.cebc4cw.org/
- Title IV-E Prevention and Services Clearinghouse. https://preventionservices.abtsites.com/

Home Visiting

- Maternal Infant and Early Childhood Home Visiting. https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview
- California Home Visiting Program. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx
- Evidence-based Practices and Resource Center (formerly National Center for Evidence-based Practices). https://www.samhsa.gov/ebp-resource-center
- Child Welfare Information Gateway. Strengthen Families and Education to Prevent Maltreatment. https://www.childwelfare.gov/pubpdfs/parented.pdf

CDC Opioid Prescribing Guidelines https://www.cdc.gov/opioids/providers/prescribing/index.html

# References: Breastfeeding


- The Impact of Breastfeeding on the Health Outcomes for Infants Diagnosed with Neonatal Abstinence Syndrome: A Review CUREUS 2018 Jul; 19(7): e3061
- The Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding an Substance Use or Substance Use Disorder, Revised 2015
- *There is an updated website for LactMed from what in listed in the Protocol – Drugs and Lactation Database (LactMed) can be accessed at https://www.ncbi.nlm.nih.gov/books/NBK501922/
- SAMHSA Has a compendium of recommendations and guidelines in their publication, “Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants,” Factsheet #11 addresses breastfeeding. The publication can be accessed at https://www.samhsa.gov/sites/default/files/topics/alcohol_tobacco_drugs/healthy_pregnancy_healthy_baby_flyer.pdf
- American Academy of Pediatrics Section on Breastfeeding Policy Statement on Breastfeeding and the Use of Human Milk, and the Transfer of Drugs and Other Therapeutics in Human Breast Milk and more. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/AAP-Policy-on-Breastfeeding.aspx
- Association of Women’s Health Obstetrical and Neonatal Nurses (AWHONN) Practice Brief #4. https://nwhjournal.org/article/S1751-4851(16)30207-0/abstract

# References: Women and Perinatal SUD


- Healthresearchfunding.org(2019) https://healthresearchfunding.org/24-opiate-addiction-recovery-statistics/ 24 Shocking Opiate Addiction Recovery Statistics.
- https://pcssnow.org/resources/clinical-tools/
- Isemann B, Meinzen-Derr J, Akinbi H . Maternal and neonatal factors impacting response to methadone therapy in infants treated for neonatal abstinence syndrome. J Perinatol. 2011;31:25-9.
- Kaltenbach K, Finnegan LP. Developmental outcome of children born to methadone-maintained women: a review of longitudinal studies. Neurobehav Toxicol Teratol 1984; 6:271-5.
- Kaltenbach K, O'Grady KE, Heil SH, et al. Prenatal exposure to methadone or buprenorphine: early childhood developmental outcomes. Drug Alcohol Depend. 2018;185:40–49.
- Kelty E, Hulse G. A Retrospective Cohort Study of Birth Outcomes in Neonates Exposed to Naltrexone in Utero: A Comparison with Methadone-, Buprenorphine- and Non-opioid-Exposed Neonates. Drugs. 2017;77(11):1211–1219. doi:10.1007/s40265-017-0763-8.
- Kremer KP, Kremer TR. Breastfeeding Is Associated with Decreased Childhood Maltreatment. Breastfeed Med. 2018;13(1):18–22.
- Mascola, M. Opioid Use and Opioid Use Disorder in Pregnancy, Am College of Obstetrics and Gynecology Committee Opinion 711 (2017) in conjunction with American Society of Addiction Medicine.
- Mascola, MA, et al. Opioid use and opioid use disorder in pregnancy. ACOG Committee Opinion 711. 2017.
- Mascola, M. Opioid Use and Opioid Use Disorder in Pregnancy, Am College of Obstetrics and Gynecology Committee Opinion 711 (2017) in conjunction with American Society of Addiction Medicine.
- May PA, Chambers CD, Kalberg WO, et al. Prevalence of Fetal Alcohol Spectrum Disorders in 4 US Communities. *JAMA.* 2018;319(5):474–482. doi:10.1001/jama.2017.21896
- Minozzi S, Amato L, Bellisario C, Ferri M, Davoli M. Maintenance agonist treatments for opiate-dependent pregnant women. Cochrane Database of Systematic Reviews 2013, Issue 12. Art. No.: CD006318. DOI: 10.1002/14651858.CD006318.pub3
- Minozzi S, et al. Maintenance agonist treatments for opiate-dependent pregnant women. Cochrane Database of Systematic Reviews 2013, Issue 12
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6335373/
- https://www.nih.gov/news-events/news-releases/tobacco-drug-use-pregnancy-can-double-risk-stillbirth

# References


- Patrick SW, et al. Increasing incidence and geographic distribution of NAS United States 2009-2012. Journal of Perinatol 2015; 35, 650-5.
- Principals of Drug Addiction Treatment: A Research Based Guide." National Institute on Drug Abuse. Ed. NIDA International Program.
- Pritham UA, Paul JA, Hayes MJ. Opioid dependency in pregnancy and length of stay for neonatal abstinence syndrome. J Obstet Gynecol Neonatal Nurs. 2012;41:180-90.
- Reece-Stremtan, S. The Academy for Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding an Substance Use or Substance Use Disorder 2015. Breastfeeding Medicine; 10,3. *updated website for LactMed from the Protocol – Drugs and Lactation Database (LactMed) https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Reece-Stremtan, S. ABM Position on Breastfeeding- revised 2015. Breastfeeding Medicine; 10,9, 2015.
- SAMHSA. Medications to Treat OUD. Treatment Improvement Protocol (TIP) Series 63, 2018.
- SAMHSA. Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants. 2018, p 30
- Substance Abuse Mental Health Services Agency. Medications to Treat Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, FullDoc. HHS Publication NO (SMA) 18-5063FULLDOC. Rockville, MD: Substance Abuse Mental Health Services Agency, 2018.
- Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. www.Safeinpregnancy.com
- Virji SK. The relationship between alcohol consumption during pregnancy and infant birthweight. An epidemiologic study. Acta Obstet Gynecol Scand. 1991;70(4-5):303-8. doi: 10.3109/00016349109007877. PMID: 1746254
- Wakeman S, et al. Comparative effectiveness of different treatment pathways for OUD. JAMA Open 3(2):e1920622. 2020
- Welle-Strand GK, et al. Breastfeeding reduces the need for withdrawal treatment in opioid-exposed infants. Acta Paediatr. 2014;102:1060-6.
- Zedler BK, et al. Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review & meta-analysis… Addiction 111, 2115-28. 2016

# Accessing, Obtaining, and Integrating Services in MN

# Learning Objectives:

## Accessing, Obtaining, and Integrating Services in MN

I

Understand and explain the key concepts of whole-person care

II

Be able to list at least 3 of the basic chemical dependency rules/regulations in Minnesota

III

Describe the continuum of recovery support services for substance use and HIV treatment in Minnesota and be able to list at least 3 resources for accessing those services

IV

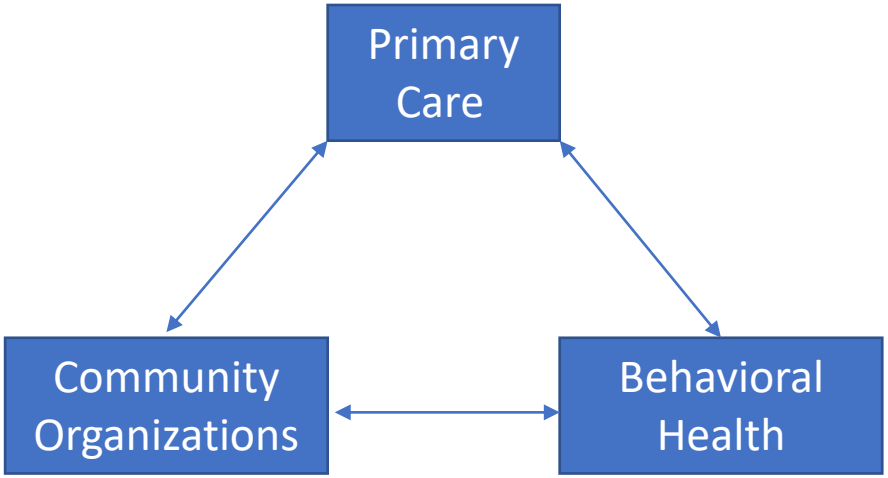
Discuss the importance of linkages, warm handoffs and case management for retention on a recovery path

# Whole Person Care


The patient centered use of diverse health care resources to deliver the physical, behavioral, emotional, and social services required to improve wholistic health.

# Whole Person Care

Involves care coordination between primary care, community-based organizations, and behavioral health providers.



# Case Management

**Case Management** is the tool that health care providers and social service organizations can use to coordinate their efforts.

A case management approach

- Recognizes that satisfying such basic needs as general health and adequate housing and food when an individual has SUD can be overwhelming
- SUD symptoms will impair a person's ability to gain access to formalized system of services
- Should be utilized in dealing with the multiple problems presented by HIV in combination with SUD
- Promotes teamwork among the various providers
- Linkages can greatly benefit the client and improve care

# Case Management and Counseling

Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation.

For specific information on economic assistance available in Minnesota visit the Department of Human Services website: http://mn.gov/dhs/.

# Discussion Question

What successes have you experienced thinking about case management and counseling of your clients?

# Health Care Coverage

In response to implementation of the Affordable Care Act, Minnesota's health care exchange, MNSURE has partnered with six health insurance agencies across the state to offer free, in-person enrollment assistance. Certified agents and navigators will be available to answer questions, recommend plan selection and work to help you complete your enrollment.

Whether you seek a competitively priced private health insurance plan, or qualify for a public program like Medical Assistance or MinnesotaCare, you can contact a lead agency listed below to schedule an appointment or request walk-in hours.

For more information please visit the MNSURE webpage at https://www.mnsure.org/, or contact MNSURE by phone at 1-855-366-7873.

# Health Care Coverage

The Ryan White Care Act provides additional coverage for those living with HIV that may be uninsured or under-insured.

For information about Ryan White Programs in Minnesota please visit the Minnesota Department of Human Services webpage: https://mn.gov/dhs/people-we-serve/seniors/health-care/hiv-aids/programs-services/

# 2021 Minnesota Statutes – Substance Use Treatment

**2021 Minnesota Statues:**
https://www.revisor.mn.gov/statutes/cite/245G/pdf

**Service Initiation**

The license holder must complete an initial services plan within 24 hours of the day of service initiation.

The plan must be person-centered and client-specific, address the client's immediate health and safety concerns, and identify the treatment needs of the client to be addressed during the time between the day of service initiation and development of the individual treatment plan.

# 2021 Minnesota Statutes – Substance Use Treatment

**Comprehensive Assessment and Assessment Summary**

A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days from the day of service initiation for a residential program or within three calendar days on which a treatment session has been provided of the day of service initiation for a client in a nonresidential program. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file.

The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines.

# 2021 Minnesota Statutes – Substance Use Treatment

**Individual Treatment Plan**

Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation

# 2021 Minnesota Statutes – Substance Use Treatment

**245G.07 Treatment Service:** A licensed residential treatment program must offer the treatment services in clauses (1) to (5) to each client, unless clinically inappropriate and the justifying clinical rationale is documented. A nonresidential treatment program must offer all treatment services in clauses (1) to (5) and document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services:

---

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;

# 2021 Minnesota Statutes – Substance Use Treatment

**245G.07 Treatment Service**

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and

(5) treatment coordination provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7.

# TRANSITIONS OF CARE

# Continuity of Care-Cross Sector Transition

Transitions of care should happen seamlessly throughout the SUD eco-system

- Emergency Department/Hospital
- Detox / Sobering Centers
- Increase/decrease in level of care intensity (residential, intensive outpatient, outpatient)
- Psychiatric care
- Primary and specialty care (including ObGyn)
- Incarceration
  - Opportunity for in reach into incarcerated settings
    - Telehealth visits
    - In person


Photo from Unsplash

# TRANSITIONS: What Immediate Needs Do Clients Have?

- Housing
- Food
- Insurance
- Medical and Behavioral Health Care
  - Where are providers located?
  - What services are provided (*REALLY)?*
  - Are they taking new patients?
  - Are they qualified to treat the disorder in question?
- SUD care
  - Medications
  - Psychosocial intervention
  - Someone to watch kids when s/he/they goes to treatment
  - Transportation to treatment
  - Support at home for SUD recovery

# CHATTER FALL

Please take a minute to type your response in the Zoom Group Chat, but **don't** click enter.

***What would make the transition from one point of contact to another more successful?***

When instructed, **please click enter**.

HEALTH MANAGEMENT ASSOCIATES



Picture from Unsplash

# TRANSITIONS: What Makes Transitions Effective?

- Creating the relationship (engagement) with the individual pre-initiation to inform, support and educate about initiation
- Begin transition and safety planning immediately
  - Interim plan - assuming individual can leave at any time for any reason
- Supporting through initiation, including education about resources, supports and next steps
- Intentional planning for referral and linkage to resources, including treatment and resources to address social determinants of health (SDOH)
- Maintaining responsibility for core care coordination roles unless or until this responsibility is intentionally transitioned to another responsible individual with consent of patient

# WARM HANDOFF: What it is and what it isn't

## What is a Warm Handoff?

- A **transition of responsibility** for care coordination
- Conducted **in person** with the patient (and family/supports if applicable) and the transferring and receiving individuals responsible for care coordination
- May, through necessity, be "virtually" in person, but **must minimally include individuals noted above**
- Recommend confirmation of transition – **or the handoff is not complete**

## What is NOT a Warm Handoff?

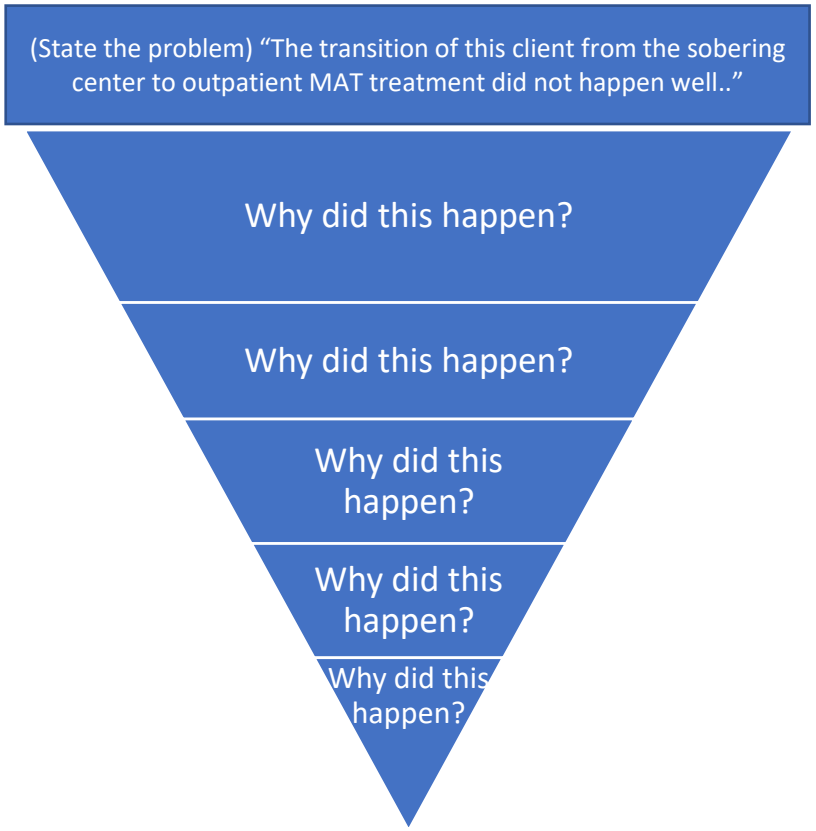
- Making a follow up appointment for the patient and telling them the time and place
- Identifying an organization vs. an Individual who is accepting responsibility for care coordination

## Why is it important? Warm handoffs:

- Engage patients and families as team members (the most important team members)
- Build relationships
- Confirm accuracy of information and build safety checks

# Retention/Referral when Transitions are Difficult

- Maintaining responsibility for care coordination until the responsibility is intentionally transitioned:
  - A referral is not an outcome
  - Did a warm handoff occur and was the referral accepted?
  - Consider contingency plans when referrals don't happen
- If transition has not been successful, assess why ("5 Whys" approach) it was unsuccessful and plan for how to make it successful to accomplish the transition – ideally with the patient
- Fundamentally – continuing to demonstrate commitment to the outcome: a successful transition of care



# Resources: Minnesota and Other

**Minnesota Department of Human Services**

- HIV/AIDS Programs/Services
- Alcohol, Drug, and Other Addictions Program Overviews

**AIDSLine**

- AIDSLine Website & HIV Resource Guide
- 612-373-2437 Twin Cities Metro area (voice) | 800-248-2437 Statewide (voice)
- aidsline@justushealth.mn
- Text AIDSLine to 839863

**Fast-Tracker Minnesota**

- Find Treatment Providers
- Rule 25 Referral Numbers

**Community Partners Supporting this Work**

Harm Reduction Sisters

Indigenous Peoples Task Force

Native American Community Clinic

Rainbow Health

Rural AIDS Action Network

Turning Point

**Additional Training Resources:**

AIDS Education & Training Center Program

# Next Steps

- **Please complete the evaluation for this session that will be sent out after via email (those requesting CEU/CME must complete the evaluations).**

Follow-up questions?

Ryan Maganini: rmaganini@healthmanagement.com

# Video – Principles or Perinatal Substance Use

https://vimeo.com/493418296

# Thank you!