Video Transcript: High Impact Practice Set (HIPS) for Outpatient Settings: Caring for People with Substance Use Disorder to Improve Maternal Health

Sydney Pelley:

Welcome, everyone. My name is Sydney Pelley. I'm with the Reproductive Health National Training Center, and I'm so excited to welcome you to today's webinar, Focus on High Impact Practices to Care for People With Substance Use Disorder and to Improve Maternal Health Outcomes. The RHNTC developed the high-impact practice set that we are going to discuss today in collaboration with the American College of Obstetricians and Gynecologists. The set is adapted from work developed by the Alliance for Innovation on Maternal Health, or AIM. So to start off, I have a few announcements, first, everyone on the webinar is muted. We'll have time for questions at the end, so please type out your questions into the chat at any time. A recording of today's webinar, this slide deck, and transcript will be available on rhntc.org within the next couple of days. To view closed captioning, you can click the CC icon at the bottom of your screen. Your feedback is extremely important to us, it helps us improve our work. So please take a second to open the evaluation link that will be put in the chat, and consider completing the evaluation in real-time. In order to obtain a certificate of completion, or CEUs, you have to complete the evaluation, and you must be logged into the rhntc.org when you do it.

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Now, I'd like to introduce our speakers in order of appearance. I'll be speaking on behalf of Meg Sheahan, who was unable to make it today. Meg is a clinical consultant at the Reproductive Health National Training Center and is a certified nurse midwife. She has been a hospitalist and an outpatient care midwife over the past 15-plus years, and directed the Title X program in the US Virgin Islands for about 10 years before joining the RHNTC. Joining me today is Jennifer Godfrey, a patient advocate who works with MoMMA's Voices, a patient advocacy coalition that amplifies the voices of those who have experienced pregnancy and childbirth complications to ensure that they're activated as partners with providers and researchers to improve maternal health outcomes. Dr. Daisy Goodman is the director of the Women's Health Services Perinatal Addiction Treatment Program and associate professor of obstetrics and gynecology at the Geisel School of Medicine at Dartmouth University. Dr. Goodman was a core contributor to the Alliance for Innovation on Maternal Health patient safety bundles on care for pregnant and postpartum people with substance use disorder. Jennifer, Dr. Goodman, thank you so much for joining us today.

So our intention is that by the end of this webinar, you'll be able to describe the impact of substance use disorder, SUD, on maternal health, including its impact on racial disparities in

maternal mortality and morbidity, describe high impact practices that sexual and reproductive health providers can implement to care for people with SUD for improved health outcomes, and describe at least two resources that sexual and reproductive health providers can use to implement high-impact practices for caring for people with SUD.

So we'd like to take a minute to see where the group is in terms of our confidence to do the first two of these objectives before we dive in. So we're going to launch a poll. Please rate your confidence from one to five, where one is not confident at all and five is very confident. Great. So I'm seeing about roughly 50% of participants are feeling like they are at three, kind of in the middle of not confident at all and very confident. So we hope that by the end of this webinar, we'll improve that a little bit. Thanks so much for participating, and let's dive right in.

So the United States is in the midst of a serious maternal health crisis. Our maternal mortality rate far exceeds that of other industrialized nations, and it continues to increase precipitously year after year after year. We also have marked disparities in maternal morbidity and mortality. Maternal mortality rates are highest by far among non-Hispanic Black women and women over the age of 40. Most pregnancy-related deaths are preventable. In fact, more than 80% of all pregnancy-related deaths between 2018 and 2020, regardless of cause, were preventable. And for these reasons, we have gathered here today to address one of the leading causes of maternal mortality in the US.

This graph clearly depicts racial disparities in recent maternal mortality rates. Each bar shows the number of deaths per 100,000 live births in a given year, separated out by race and Hispanic origin. So we can see a few things here. First, the number of deaths is rising steadily and steeply year after year. Second, the rates for non-Hispanic Black women are rising much, much more precipitously than the rates of non-Hispanic white women and Hispanic women. Third, the maternal mortality rate of non-Hispanic Black women is much, much higher than that of other groups.

Drug overdose deaths, particularly deaths involving synthetic opioids like fentanyl, reached record highs in 2020 and 2021, which likely was exacerbated by social, economic, and healthcare disruptions associated with the COVID-19 pandemic. The prevalence of pregnancy-associated deaths because of drug use increased 190% between 2010 and 2019. A study published in 2022 in the journal "Obstetric and Gynecology" found that of the nearly 12,000 pregnancy-associated deaths identified by the researchers during that time, 11.4% were due to the use of illicit or prescription drugs. And between 2018 and 2021, drug overdose mortality ratios rose more than threefold in pregnant and postpartum individuals aged 35 to 44 years, with women in the late postpartum period at greatest risk.

Substance use disorder affects the risk of severe maternal morbidity and mortality through both biological mechanisms, such as increased risk of infectious disease and poor nutrition, and through social mechanisms, such as stigma and poverty. Increases in the use of amphetamines, opioids, and cannabis have led to a rise in the number of pregnant women who develop a substance use disorder. Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. Now, SUD involves more than just opioid use disorder, but opioid use disorder is a significant driver of maternal mortality. Opioid use disorder during pregnancy has been linked with serious negative health outcomes for

pregnant women, including cardiovascular risks, preeclampsia, and hemorrhage, and for developing babies, including preterm birth, stillbirth, and neonatal abstinence syndrome.

There are disparities in SUD and in substance use treatment which impact overall and maternal health outcomes, for example, SUD is higher for American Indian or Alaska Natives than for other groups. Black and Hispanic individuals are less likely to receive SUD treatment compared to white individuals, and Black and Hispanic women undertaking treatment while pregnant were significantly less likely to complete treatment compared to white individuals. These groups experience barriers to care and treatment, barriers that include structural racism, poverty, stigma, limited availability or affordability of SUD treatment options, unmet social needs, and limited availability of culturally and linguistically effective providers. While treatment for substance use disorder is available during pregnancy, significant barriers, such as penalization, fear of losing one's children, stigma, discrimination, and limited socioeconomic resources, uniquely affect pregnant individuals. We'll hear more about this over the course of this hour. With this, I'll pass it over to Jennifer to share her experience and wisdom.

Jennifer Godfrey: Hi, my name's Jennifer Godfrey. I am a patient advocate for MoMMA's Voices. I am a family support specialist and NICU family support coordinator at Valley Medical Center in San Jose, California. I'm also a CLC, and I have six years in recovery from substance use disorder. And that's my little family right there.

So my story, well, our story, my son, Lofa, was born at 27 weeks. I was abstinent from substance use for four months when I delivered. So I had remained abstinent since nine weeks of my pregnancy, but that didn't stop the complications. I had recurring UTIs, and I developed a subchorionic bleed in my placenta, which ultimately resulted in me delivering early. So we spent 91 days in the NICU. I was in a treatment program, I was in an outpatient program and a THU at the time of my delivery. So I was already receiving care. I can tell you some of my, a little bit about my story is, i started off getting prenatal care while I was incarcerated. So I remember coming in for my full first ultrasound in the MFM, the Maternal Fetal Medicine, and I was in custody. So I came in handcuffs in my jumpsuit, and I just remember, you know, it was just not a good experience, like, right? So, and I still had to go to these places after I got released. So I got released shortly after my first scan. And I just remember, whenever I would come into any of my appointments, there was always, "Have you used in the last 24 hours? Where are you staying?" I know that most of these things were in my chart because the substance use program I was going to was actually linked to the health system that I was in. So all of these things were in the chart. They knew, I mean, if they had just taken a chance to like do a chart review before they talked to me, they would have this information, but they would just come in and say, "When was the last time you used? Are you homeless?" Like, and I would have to repeat myself over and over and over again, and it was very harrowing, it would make me feel like running away because I was like, "I have to explain my situation again. I have to receive the judgment for explaining my situation again." And, you know, the judgment and stigma. I remember when I, my son was, when I was, you know, having problems, complications with my pregnancy, I was in labor and delivery in and out of that place, like, you know, twice a week, sometimes I would stay, sometimes they would send me home, and I remember I had passed a blood clot like the size of my hand, and I brought it into labor and delivery and was like, "What's going on?" Like, "I need some answers," like, "Why is this happening? Is my baby okay?" And the nurse told me she thinks my pregnancy is terminating probably because of the drug use early on in my pregnancy. And I remember just feeling, I started to shake with, like, I was so terrified. I still feel the anxiety

come up when I talk about it. And then the doctor come in and reassured me that my baby was fine and that this was something that was going on with my placenta, and my baby was healthy, active, everything was okay. They were just gonna monitor me for a few hours. And I remember feeling relieved, but it was just that initial stigma that I received when I came into the room about, you know, my pregnancy is terminating because of, you know, and I've been doing all the right things since then, right? And I felt like I was getting no recognition. I was going to my doctor's appointments, I was staying abstinent, I was going to my meetings, I was, you know, doing all the things that I could do to make my life and my son's life better. And I just didn't, I didn't feel seen. And so, that's a, you know, a little bit about our story.

So one of the things that I've learned in my recovery and in working in the hospital with other substance use disorder moms is that peer support is like one of the best things that you can receive. I received peer support while I was here in the NICU, and it gave me hope that, it like gave me the hope that nobody else could, right? Somebody that's walked this path showed me that they had gone through it and were able to like get through it. So some of the things peer support can really do is, it can level the playing field when there is an unequal power dynamic. So we all know, as providers and as, you know, working in the medical field, that there is an authoritative stance that we have, right, or that you have. And so, when you have peer support available to these moms that like are walking through this, and empowering these moms to advocate for themself, it really does level the playing field. During meetings, family meetings, any conferences that you're gonna have with moms, you wanna have these peer support people available. It improves the chances that the clients will advocate for themselves, it amplifies their voices, and then, we also have this peer support workers available for, you know, multidisciplinary meetings and whatnot. They can help move decisions towards for more family-centered care practices. It definitely decreases stress and trauma in the NICU, especially if you have somebody that knows what this is like and can walk this with you. It improves client satisfaction and experience in the NICU. It improves client self-care, client self-advocacy, and health equity, and it increases psychological safety. So we want our moms to know that they're seen, they're heard, and that they're okay and that we're here to help them, and it creates a safe place so that they don't feel alone. And the support of someone who has walked a similar path cannot be matched.

So some of the practices that I'm really passionate about is trauma-informed care for clients with substance use disorder. Some key points I wanna point out and just for people to remember, I'm pretty sure everybody's aware of what trauma-informed care is, and if you don't, we have resources available, and we wanna work with healing intention. So we wanna make our patients feel safe, we wanna make them feel like they're heard, we wanna offer encouragement. So how you can earn trust is, you can give them a smile, a compliment, just sit down with them, have a, like a, just a chit-chatty conversation, just like a regular, like, "How are you doing? I'm so glad to see you. What's been going on?" Those things can change the whole dynamic of a interaction with a mom, right, or a client, I should say. You wanna create space and give them the chance to share their story. So, you know, when we're asking open-end open-ended questions, we wanna give them the chance to actually really express themselves, right? And that wherever that leads, let them lead the conversation. You wanna practice active listening. So we really wanna, we don't wanna have to listen to, with the intent to reply to them and have... We don't need to fix their problems, what we need to do is listen, and then we can go back and like real, and absorb what they're saying, 'cause they're the experts on themselves, right? So they know what their needs are, we just need to figure out how to listen and how to like pick out those needs, right? We like guide the conversation. One of the biggest things I encourage too when

we're working with women with SUDs or parents with SUDs is, you want to check your bias before initiating conversation. You wanna go through and remove all those emotions that you have about this, you just clear it, like, just ummm before you go and talk to a mom, I mean it just really changes 'cause you don't know this person and the trauma that they've experienced. I just wanna say that most, if not all, people who struggle with substance use disorder have experienced traumatic situations. I mean, this goes hand in hand, mental health goes hand in hand with this. And I just, you know, you really, you have to like look beyond what's on the surface because a lot of the time, these emotions that are displayed, like guilt and shame and grief, are really displayed as defensive behaviors. So you need to like chip at that. And they can show up as denial, like they're not in a place where they can actually talk about it yet because they're still trying to hide from their trauma. And I really highly encourage educating staff who work with clients that have substance use disorder about implicit bias and trauma-informed care, it's a game changer, it can really level the playing field with these moms or these patients. And that's pretty much it for me. And I thank you for your time.

Meg Sheahan: All right, can you all hear me? Can someone give me an indicator that you can hear me? Jennifer, can you? Okay, great. Thank you. So thank you, Jennifer, so much. And before I start, I'll introduce myself quickly. My name is Meg Sheahan. Thanks for being patient with my tech issues, and a big shout out to Sydney for taking charge. I'm back. Okay, why focus on SUD, specifically in the outpatient sexual and reproductive health setting? Well, there are a few good reasons. Sexual and reproductive health providers are highly likely to encounter clients with SUD, and sexual and reproductive health, or SRH, settings, including Title X agencies, are often the client's only source of care. So if clients don't receive care and connection to resources and services from the SRH provider, they might not receive them at all. Visits for sexual and reproductive healthcare present an opportunity for SUD prevention, either primary, secondary, or tertiary prevention, through care, either in-house or through linkages to care. Also, we know that individuals with SUD are less likely to use contraception and more likely to use contraceptive methods that are less effective, even when they don't desire a pregnancy at that time. And addressing SUD is an important component of preconception care, which SRH providers offer. So SRH providers have an important role and opportunity to support clients in achieving their reproductive and their broader life goals and supporting overall health. Finally, SRH providers often see clients within a year of pregnancy or during the late postpartum period, which is a vulnerable time, and it's a critical time for supporting maternal and newborn health and wellness. So there's a lot of need here, and there's a lot of opportunity here.

And if you're wondering where to begin, we've got some guidance for you. The high-impact practice sets are a series of five sets of evidence-based practices to address the leading known causes of preventable severe maternal morbidity and mortality in the United States, including SUD. The RHNTC and ACOG work together to adapt the patient safety bundles created by the Alliance for Innovation on Maternal Health, or AIM, to the outpatient sexual and reproductive health setting. And these sets are building blocks or like a roadmap for improving maternal health outcomes and reducing maternal mortality.

As I just mentioned, the high-impact practice sets address the leading known causes of preventable severe morbidity and mortality in the United States, and these include hypertension, cardiac conditions, SUD, mental health conditions, and the postpartum transition. So to support programs in implementing the high-impact practices on each topic, the RHNTC offers a

package, the package includes a webinar like this one, a job aid like the one that you see on the screenshot on this slide, and a measurement tool, which I'll explain in a little bit.

Each high-impact practice set is structured around what we call the Five Rs, which you see here. And this is how the Alliance for Innovation on Maternal Health structures their patient safety bundles. So the high-impact practices are grouped into practices that support readiness to address the issue, recognition and prevention of the issue, response to the issue, systems reporting and systems learning, and respectful care. So to carry this conversation forward, I will now pass it over to Dr. Goodman. Thanks, Dr. Goodman.

Dr. Daisy Goodman: Hi. So building on what Jennifer and Meg have both presented, there are a few fundamentals that can help ground our practice when providing respectful care for people with SUD in the sexual and reproductive health setting. So, first and foremost, to recognize that substance use disorders are chronic conditions like any other condition that a person might have when they come to you for care. And secondarily, acknowledging that substance use is not the same as having a substance use disorder, that is, people can use substances in a variety of different ways. And also, that people who have a history of substance use disorder are often living happy and healthy lives in recovery. Secondarily, for a person who tells you that they are using drugs, particularly in a way that might put their life at risk, please center harm reduction, and we'll talk about how to do that. And finally, as for any chronic medical condition, for example, asthma, diabetes, et cetera, it's our job as providers to ask about how they're doing with that, and especially to facilitate their self-management, leading to remission of their symptoms, including access to pharmacologic treatment when it's needed.

So in order to prepare ourselves to be a trustworthy source of information, it's important to really do your homework. So we need to be able to provide clients with information related to substance use disorder, and that is accurate information, harm reduction strategies and resources that meet their needs. We need to use trustworthy and unbiased sources, accessible language that is person first and respectful, it may not be exactly the same words that someone would use to refer to themselves, and we have resources to help guide choice of language, and welcoming, and we need to be welcoming and inclusive of all people's relationships with substance use along the continuum, from active use to recovery. Finally, we need to recognize that recovery is not a linear process. So sometimes substance use disorders lead to relapse or a return to use, and that they are basically a chronic condition that sometimes has ups and downs. Finally, a focus on harm reduction and avoiding an attitude of only accepting abstinence as a positive is really critical. So we need to be able to informed and able to provide naloxone and harm reduction education for our clients and to facilitate their access to harm reduction supplies when they're needed. This does require us to know what our state and community resources are, for example, are there laws in the state that allow us to provide naloxone or limit the type of harm reduction supplies that are permitted? And if harm reduction supplies are allowable and where we work, then we wanna know how to get people connected with those.

With regards to naloxone, this is one of the most powerful lifesaving tools in the harm reduction toolbox. It's also hard to treat yourself for an overdose. So naloxone being an overdose reversal medication. So we need to be able to provide education about how to use naloxone, not only to people who might need it for themselves, but also to friends and family who might be in the situation of needing to administer it to somebody who's lost consciousness. We also need to work with our staff to make sure that our staff understands about the severity of overdose

epidemic in our communities and to teach them about the importance of access to naloxone. States do have differing laws and policies around harm reductions, so understanding what those are is important, and reaching out to your local harm reduction resources can help you understand that. And finally, many of us who've been working in the field of sexual and reproductive health for a while did not learn much about substance use in our training programs, therefore, we're all on a learning journey about how to optimize respectful care for clients with SUD. And some important things that we may need to learn about are access to pharmacotherapy for SUD, for example, where clients may find a method of treatment, opportunity, or prescribers for buprenorphine or naltrexone, and also, where medications for alcohol use disorder may be available from providers in the community.

So the structure of medical care in our country, unfortunately, is such that substance use treatment is very often siloed in separate clinics or outpatient treatment programs away from regular medical care. So it's critical for us to engage, and that's also often true for sexual and reproductive health services too, right? So we know how that feels. So it's really important for us to make those alliances, to engage relevant partners and collaborate together to increase the linkage between sexual and reproductive health settings and SUD services. This way, we can meet clients where they are and make sure that they have access to really important reproductive healthcare as well as what they're receiving from their SUD program. And these allies and partners may be community-based SUD treatment programs, they may be social services, where folks go to receive other resources, or they may be state agencies. We also wanna make sure we have and maintain an accurate and up-to-date set of referral resources and foster communication with other health and social service providers to enhance services and supports for clients who have SUD, that means we need to know where those treatment resources are in the community and how we refer to them, and then to cultivate relationships with those treatment providers. So we're not just giving somebody a phone number, but we're actually sitting with them and helping them make that phone call if they're ready to engage with a treatment provider, and make sure that that's a warm handoff when a client accepts a referral. So it's never harmful to get a release so that if you need to follow up with somebody and you can't find them, and you know that they go to an area substance use treatment program, and you have a release, you may be able to get them a message, for example, about a critically important test result. Those things can only happen if we have appropriate relationships with the treatment programs that we work with in our communities and appropriate consents with our patients. Of note, there is a special consent form that is required by federal law, 42 CFR, compliant consents. And when we communicate with treatment programs, we can ask them for a copy of the appropriate consent so that we can have them on hand, and therefore, we can facilitate that exchange and make sure we have the right consent so that they could actually get a message to a client.

So I wanna turn now to the second R, recognition and prevention. So universal screening with a validated verbal screening instrument, either a digital questionnaire or potentially on paper, is best practice. And that goes along with the other ways that we screen our patients for chronic conditions when they come to see us for primary care. It's really important to differentiate between screening, as I just described, and testing, which is toxicology or drug testing. There are very few, I would say, hardly any indications clinically for use of drug testing and reproductive care settings. The one that does come to mind is that sometimes a client might request testing for legal or for other reasons. When somebody asks me for a drug test because they might need it for court or something like that, that's something that I could consider doing.

But there's really no clinical reason why we would need to perform drug testing in our practice settings.

In my clinic, we utilize a screening brief intervention and referral to treatment approach for screening for substance use. This requires us to think in terms of universal screening for everybody who walks through the door, just the use of a validated questionnaire to ask if they have any substance use in their life, and the point there being to provide education and assist them in preventing onset of harmful use. For those people who have risk factors on screening or are using but are not at a place yet where they would identify as having a substance use condition, we can provide additional education, offer resources, and work with them to mitigate a more harmful use. And then, finally, for those who disclose that substance use is a present and potentially harmful part of their lives, we can offer referral for treatment, we can make sure that they have access to harm reduction resources and education, offer naloxone, and our goal there is to keep them safe.

Here's an example of what this process looks like at our clinic. We use a questionnaire that's very similar to this NIDA quick screen. So there's a little script at the top here. Sometimes people find it uncomfortable to talk to somebody and ask them questions about substance use, so they do give you a hint. This is also available digitally. If you go to this website, you can see a digital version of this as well as a PDF version if you wanna print it out. So our screening process is that a client checks in for a visit, they get a tablet which has the NIDA a quick screen on it, that if the provider reviews the screening results, and if it's positive, then we will talk with the client about the positive screen, offer them a referral, if that seems like the right thing, if they screen in an area, a place where they might need to be referred for a treatment program or counseling. Sometimes client might say, "No, you know what? I would really rather just follow up with you. I think I'm gonna try to stop on my own," or, "I feel like it's not at the point now where it's really risky, but I appreciate talking to you about it, and thank you for caring," or it might be that somebody says, "You know what? I don't think I have any problem in this area. I'm good." In which case, I will ask permission to raise the question with them again the next time I see them. Longitudinal care and regular screening is really important. We all need to be reminded about the things in our lives that can cause us harm, and that's part of our job as primary care providers.

When somebody screens positive on the NIDA quick screen, there is a follow-up questionnaire that NIDA recommends for use, which is the ASSIST, and that asks more specific questions about specific types of substances, so you could really get a feel for what someone's is using, what impact it might have in their lives, and whether or not they're in a place where they might be interested in changing that relationship. Here, it's super important to take a very matter-of-fact and non-judgmental approach to this. And as Jennifer said, if you have difficulty doing that and you find that you have strong feelings about substances or specific substances or substance use, it's really important to think about where those are coming from and to check our biases.

So when somebody discloses to you with trust that they have a substance use condition, or you think it's very likely that they do, it's really important to make the referral for additional services and resources as warm as possible, that is to say, "I know the folks over there at the methadone clinic, and they usually see people on Mondays and Thursdays for intakes. Let me sit with you, and we'll call their intake person. I'll connect you, and hopefully, you can get in there later this

week." We also need to think about structural and social drivers of health that might actually impact their someone's ability to get into treatment. For example, I live in a rural area, and access to a methadone treatment program is very dependent on road conditions, whether or not we're having a snowstorm, whether or not somebody has a car, and whether or not they have Medicaid, which will pay for a ride or not. So it's really important for us to think about what are the things that might actually impact somebody's ability to access care, and to link clients to culturally and linguistically appropriate resources as well that align with their health literacy.

So we recommend, and it's part of the HIPS program, that screening for social determinants of health is an important part of responding to a client's disclosure of substance use. We recommend a universal screening approach for this as well. And the Centers for Medicare and Medicaid Services also recommend that. There are validated instruments available. I really like the PRAPARE Implementation and Action Tool. They have a toolkit. This particular questionnaire was developed by the Association of Community Health Centers, and it's been really well validated across multiple states and territories, and it is available in more than 25 languages, both in a paper printout version and also in digital format that has been adopted for multiple different electronic health records. So PRAPARE is widely used by federally qualified health centers and community health centers. We really like it a lot.

So here's an approach that we've been taking in our clinic. So we use tablet-based screening at check-in for all of our clients. Everybody gets alcohol and drug use screening, depression and anxiety screening, and social determinants of health. We're fortunate, in that, we use an electronic health record that can activate an alert for a provider for any critical positive screen. So those we count as substance use of scoring in the at-risk range. A high depression or anxiety score or any score at all on the suicidality question, that immediately alerts a provider. And if somebody screens positive for food insecurity, that alerts everybody that the patient sees clinically, they get an alert that says, "Your client so-and-so has screened positive for food insecurity." We actually have food, emergency food boxes in our clinic. So this can be a really helpful way of working with your clients to make sure that they walk out the door with having some pressing needs that they walked in with addressed. For all of these positive screens, we'll provide a brief intervention and a warm handoff. If that problem is lack of transportation, we'll help link to community resources. If the problem is that somebody wants to get into an opioid treatment program, we'll refer 'em to that treatment program. And we also have a behavioral health clinician embedded in our clinic. So we feel like we really have an embarrassment of riches where I work, but it's taken us a lot of years to put that in place to say.

So it's also very important to offer reproductive life planning discussions and resources to anyone who has an SUD or who is using drugs. People who use drugs have often been subjected to reproductive coercion and even to force sterilization by health systems and in the criminal legal system, we must never ever participate in that. We need to ask folks about pregnancy intention in an open-ended way. We need to provide appropriate and accurate information about the impact of substance use during pregnancy. And we must also be aware of comorbidities related to substance use that might limit the use of certain contraceptive types, for example, over 35 using tobacco. Many of my clients have a history of DVT or a pulmonary embolism, so estrogen-containing contraceptives will not be accurate, I mean inappropriate for them. And some of my patients have untreated hepatitis C, and they also should not have estrogen-containing contraception until we link them to treatment. So trauma history may also make the initiation of some types of contraception difficult to tolerate, specifically thinking there

about IUD placement. So we do a lot of shared decision-making around IUD placement in my clinic. And some clients may need confidential methods to maintain safety. For example, Depo-Provera is not obvious to a partner who might be objecting to somebody being on contraception, but it's also very effective, and it's easy to do in the clinic, and nobody knows.

So I'm gonna talk just briefly about reporting and systems learning. Obviously, we want to monitor outcomes and data related to our care for people with SUD, and we want to disaggregate that by race and ethnicity and make sure that the care that we're providing is not biased and is culturally appropriate. And I think it is particularly important. And Jennifer, I just wanna thank you so much for what you've shared, that we convene community stakeholders and people with lived experience specifically to identify opportunities and share strategies to improve the care that we provide at all levels, and specifically to help us identify where the systems-level barriers are to care, so we can improve outcomes.

Just some example metrics for SUD screening. Do we have the referral resources and communication pathways in place to enhance the services and supports for our clients with SUD? Have we trained our staff about substance use disorders to understand them as chronic conditions? And have we provided anti-stigma, anti-bias training? Are we effectively screening people using validated self-reporting screening tools, that, is universal screening really universally applied, or are we biased in the way that we're providing that screening? And are the people who screen positive receiving a warm referral for additional services or resources, and is that equitable and unbiased? We wanna look at all of those variables desegregated by ethnicity and race to make sure that we are not providing care that is discriminatory. And I would also encourage people to look at these variables by pair as well.

And finally, oops, sorry about that. And finally, it's very important for us always to center the clients that we're working with and provide person-centered, trauma-informed communication and counseling. There is, as Jennifer mentioned, a high prevalence of trauma among people who use drugs, especially among women and among LGBTQ+ community members. Stigma is especially intense against pregnant and parenting people, and there are also profound racial disparities that exist both in drug testing and in child protection reporting and in family separation. So it's really critical that we understand the intersectionality there. And finally, words really matter, so using person-first and non-stigmatizing language is important and we can model that for our partners in practice.

So just a few takeaways, sexual and reproductive health providers, including Title X agencies, can show leadership in providing respectful care for people with SUD, and this is really critically important and needed. SRH providers, as mentioned, are uniquely positioned as trusted health providers and may be the only health providers that many people see. And finally, asking about substance use, referral to treatment, and especially harm reduction save lives, and we all need to be part of that. I’m gonna hand it back over to Meg.

Meg Sheahan: All right. Thank you, thank you, Dr. Goodman. So we've got some great resources to support your implementation of these high-impact practices to care for people with substance use disorder. We'll chat the links in to these resources, and they'll be in the slides that you can download off of rhntc.org in a couple days.

So this job aid is available on rhntc.org, presents the high-impact practices that Dr. Goodman just explained along with resources to support implementation of each practice. So if you can see this on the screenshot here, on the left-hand side, you've got the high-impact practice itself. And then on the right-hand side, there are hyperlinks that will take you to resources that will help you implement each of the practices. Your agency might not be able to implement every high-impact practice right away, that's absolutely okay, it's normal, it's expected. Start with those that make sense and that are feasible within your context. I'll also point out that a couple of the high-impact practices have a little star icon next to them, so pay special attention to those because those are the ones that we consider key practices.

Next, we've got a measurement tool, and it measures the elements that Dr. Goodman just talked about, it's an Excel spreadsheet, and it was designed in collaboration with ACOG, American College of Obstetricians and Gynecologists, to help you collect and use data to track how you and your team provide care to people with substance use disorders. This sheet allows the disaggregation of data by race and ethnicity to help you identify and address disparities.

Okay, so that was a lot. What questions do you have for Dr. Goodman, for Jennifer, or for us here at the RHNTC? Please feel free to type your questions into the chat, and we will see what we can do. Give you a couple minutes to do that. Okay, so I've got a couple here for you. The first is, what should you do if someone you work with is talking about a mutual client who uses drugs in a judgmental way? I think this is for Dr. Goodman.

Dr. Daisy Goodman: A great question. I look at this as I would any biased comment that's made around me, that it's my responsibility to interrupt that way of thinking, depending on the situation, kind of choose how you're gonna do that. Humor can be really helpful. I think mirroring what is respectful language and a respectful way to think about supporting clients with substance use conditions is always, sort of lead-by-example approach is always helpful. But I also look at, when I hear bias talk around me, I often, I also use that as the basis for thinking what type of education we need to do more sort of practice-wide. So it's data for us when we design anti-bias education. Jennifer, I'd love your thoughts too, if you wanna respond to that one.

Jennifer Godfrey: This is something I've encountered in my workplace. And, you know, I think I usually just jump in and share my experience, right, you know? And I wanna remind us that statistical, the statistical significance doesn't correlate with like the clinical significance. So, you know, and I just, it's a chronic medical condition, it's just like diabetes or hypertension, and needs to be, it needs treatment. I think when I've encountered it, I share my experience, I make light of it, you know, and I just say, "You know, our birthing people need support." Birthing people, the way we treat our birthing people is going to affect the child. So we need to make sure that if we take care of the birthing person, we're taking care of the child as well. And the child's an, this is an innocent entity, right? So we need to make sure that we remain focused on that too, that this is a dyad that we're dealing with, it's not this person and their disease, it's this person and this baby that we need to treat and empower. And I just remind them that everybody needs support. We're all going through stuff, and this is a chronic condition that doesn't get better if we just talk bad about it either, it doesn't help the situation. So I usually take that into mind when I come across those conversations. And, you know, it has gotten, they have become confrontational, and I just, you know, try to empower, just enlighten them with, you know, my own experience, you know, that, you know, this isn't something that's easy to overcome, and it's

really a lifelong journey that this person's gonna be on. And it doesn't go away just because you go to treatment. I went to treatment four times before I was able to actually abstained successfully. So, you know, it's a behavioral issue too. There's mental health issues, and all of that stuff is intertwined into this condition. And I just try to, you know, let them see it from that perspective.

Meg Sheahan: Yeah, thank you, Jennifer. Those are such good points. And I wanna, actually, I wanted to go back to a chat that you had put in, Jennifer, you had entered into the chat, and it was a good point that you made. And I was wondering if you would be willing to make it out loud because I don't want people to miss it, I wanna make sure people catch it, and to share a little bit about your experience and what brought you to this point.

Jennifer Godfrey: So going back, we were talking about the screenings, I was screened probably at every visit that I went to. And I was never offered any resources from the screenings. I mean, you know, I was already abstaining from substances, but I was also like what you would consider in transitional housing and in an outpatient setting. So this isn't permanent housing. I was like, you know, the risk of homelessness was there. These things were being screened, and I wasn't offered any resources. And so, I had to navigate the social services system by myself, you know, and that can be challenging, especially when you're new in recovery, and like, first of all, you're trying to like learn how to live without using substances. And so that's the, you know, and so, like, and then having to like go to appointments and find these places on the bus and make these phone calls, and doing all these Google searches to make sure that I was going to be okay for the next few months was difficult. And I think when we're making, when we're doing these screenings, we have to have resources lined up. You know, if you are gonna refer somebody, make sure that that person is going to, if that that resource is available to them, you know, 'cause that has happened to me too, where I've been given like this resource, and I go there and like I don't qualify because of something, right?

Dr. Daisy Goodman: Yeah.

Jennifer Godfrey: And that can be so difficult, like when you're expecting something, and it doesn't happen, it's very challenging in recovery 'cause your emotions are all over the place, so you're much more sensitive to things that don't go your way. And those are challenging situations to have to face early on. And you become more resilient the longer you stay abstinent. But in those beginning months, it's very difficult to navigate those kinds of situations. And it can be that one thing that makes you relapse, you know, so.

Dr. Daisy Goodman: Yeah. Yeah, I'm really glad you said that because I feel like it's really unethical for us to screen and not have resources to respond to a positive. So that's actually the reason why, in our clinic, we started to have emergency food boxes 'cause we had people sharing that they were food insecure, and it didn't feel okay to just say, "Well, here's the address for the food pantry, you know, which you can't get to 'cause you don't have a car," you know, 'cause we live in a rural area and people can't walk places. So I 100% agree with you that that's part of the preparation for this particular bundle that we're talking about, is that you really have to do your homework and get those resources handed up, and then, you're right, make the relationships with those providers so that you're not sending somebody out into the void, and they aren't eligible for those services, like you actually can call them and say, "So-and-so is

sitting with me right now, and we're wondering if she would be eligible for your services," and put the personal touch on it.

Jennifer Godfrey: Yeah. It's just, you know, having a handle to hold while you're going through those things is, it's impactful, it can change the outcome of somebody's story. So those little things add up, and they make successful people, like we become successful because of these things that we are walking through, right? It's just those little things, just making a phone call with somebody or, you know, helping them fill out a form for like CalFresh or like whatever they're, so that they can get some food, right? Having somebody available to do that with them, or make those phone calls with them, and get them into a shelter, or find them somewhere safe to stay for a couple days, those things can really change people's outcome. And if, you know, it makes you feel like people care and they want you to do better. So, I mean.

Dr. Daisy Goodman: Yeah. I just wanna say too that what you're saying now is exactly the reason why it's really important to always have people with lived experience on your team. You know, so peer support is critical for the patient perspective, but our client perspective is also really critical for the program perspective, like I lean so heavily on partnerships with people with lived experience who work like side, we work side by side to develop the program that we have because there's a lot that I don't know.

Jennifer Godfrey: Yeah, I agree, because that's what I do here in the hospital. I work side by side with leadership on, you know, their QI projects, and I run the family- staff advisory council

Dr. Daisy Goodman: Yeah.

Jennifer Godfrey: And we get feedback from them, and we integrate it into the decisions that are made in our NICU, you know? So I just really, I think peer support or peer, just advocacy, or having a advisory council can also really benefit these decision-makings. People from the community, their voices need to be heard, they know what they need, they do. We do, we know what we need, we just need somebody to talk to about it. And we need somebody to be able to ask the right questions too to guide the conversation, you know? Sometimes we don't really know how to advocate, so we need a little push too as well.

Dr. Daisy Goodman: I think it's one of the problems that we have as health systems is that we're flailing around in the dark, making all kinds of assumptions about what patients and clients need, and getting it wrong like 50% of the time, probably more.

Jennifer Godfrey: Yeah. Like we are our own experts.

Meg Sheahan: Thank you. This is so good. I hate to change our course a little bit, but we have another question from somebody who chatted something in, and I wanna make sure we get your input on this too. Hartley asked, "Do you know of any models or resources for the community that can increase demand or help recovery community centers or harm reduction centers increase their ability to link to sexual and reproductive health programs?" And Hartley, chat me if I didn't read your question quite right, but that was my understanding.

Dr. Daisy Goodman: That's a great question. Are you thinking of harm reduction programs that do have sexual and reproductive health partners? Was that the question?

Meg Sheahan: So I think the question is, how can we help recovery centers or harm reduction centers link their clients to sexual and reproductive health programs?

Dr. Daisy Goodman: Reach out, go visit them, introduce yourself, bring your brochure, talk to people there about what they need and what would be helpful. If it's a treatment program that has a group, maybe you can go and chat with a group sometime and, you know, share what you do, and just leave your card, you know, person to person.

Meg Sheahan: Yes, perfect. Okay.

Dr. Daisy Goodman: Yeah.

Meg Sheahan: Thank you. All right, let's move on. Let's revisit this poll that we did at the beginning. Please rate your confidence now that we've had an opportunity to discuss these things. Write your confidence from one to five, where one is not confident at all and five is very confident, that you can describe the impact of SUD on maternal health, including its impact on racial disparities, and describe high-impact practices that sexual and reproductive health providers can implement to care for people with SUD. Okay, results are rolling in on our end, and I definitely see some improvement here. We've got, okay, I am looking at more than about 90% or more for both, that people feel confident or very confident, that they can describe the impact of SUD and high-impact practices that sexual and reproductive health providers can implement. So thank you. Thanks for that.

Okay. So we would love to hear just a little bit more from you. Please type into the chat, everybody, what is one thing that you can do, or that you can do differently, as a result of this discussion to strengthen your services or improve your services to care for people with a substance use disorder? So I'm seeing, I'm sure you all can read in the chat too, but remember and work on trauma-informed care. Communicate more with our Title X colleagues about our efforts in this realm. Share this information with my colleagues. Recognize my own biases before interacting with clients. Hartley said, "Don't over screen, we don't have the resources, but ask all of those." Mindfulness about screening, what is its true purpose? Many good answers here.

All right, we're at time. Thanks for joining us. Reach out to us with any questions. Jennifer, Dr. Goodman, thank you. Contact us, rhntc@jsi.com. And thanks again in advance for filling out the evaluation. Have a great day.

Jennifer Godfrey: Thank you.

Dr. Daisy Goodman: Thank you.