Overdose Prevention and Intervention Task Force

January 10, 2018

CO-CHAIRS:

DIRECTOR NICOLE ALEXANDER-SCOTT, MD, MPH, RHODE ISLAND DEPARTMENT OF HEALTH

DIRECTOR REBECCA BOSS, MA, RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS

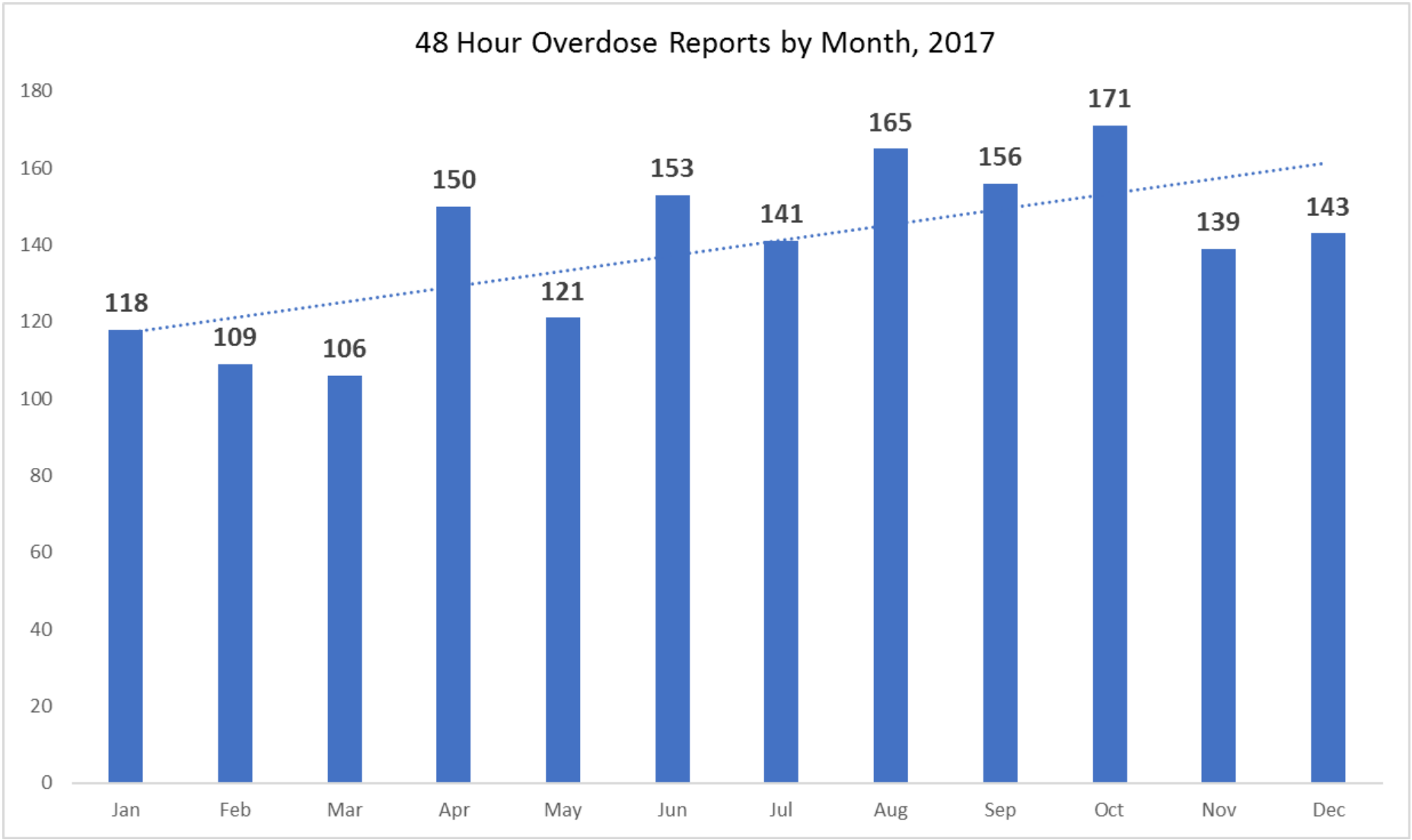
Levels of Care Designation
Level 3 Facility
Women & Infants Hospital, Care New England

48-hour Overdose Reporting System Data, 2017

Meghan McCormick, MPH
Drug Overdose Prevention Epidemiologist
Rhode Island Department of Health

January 10, 2018

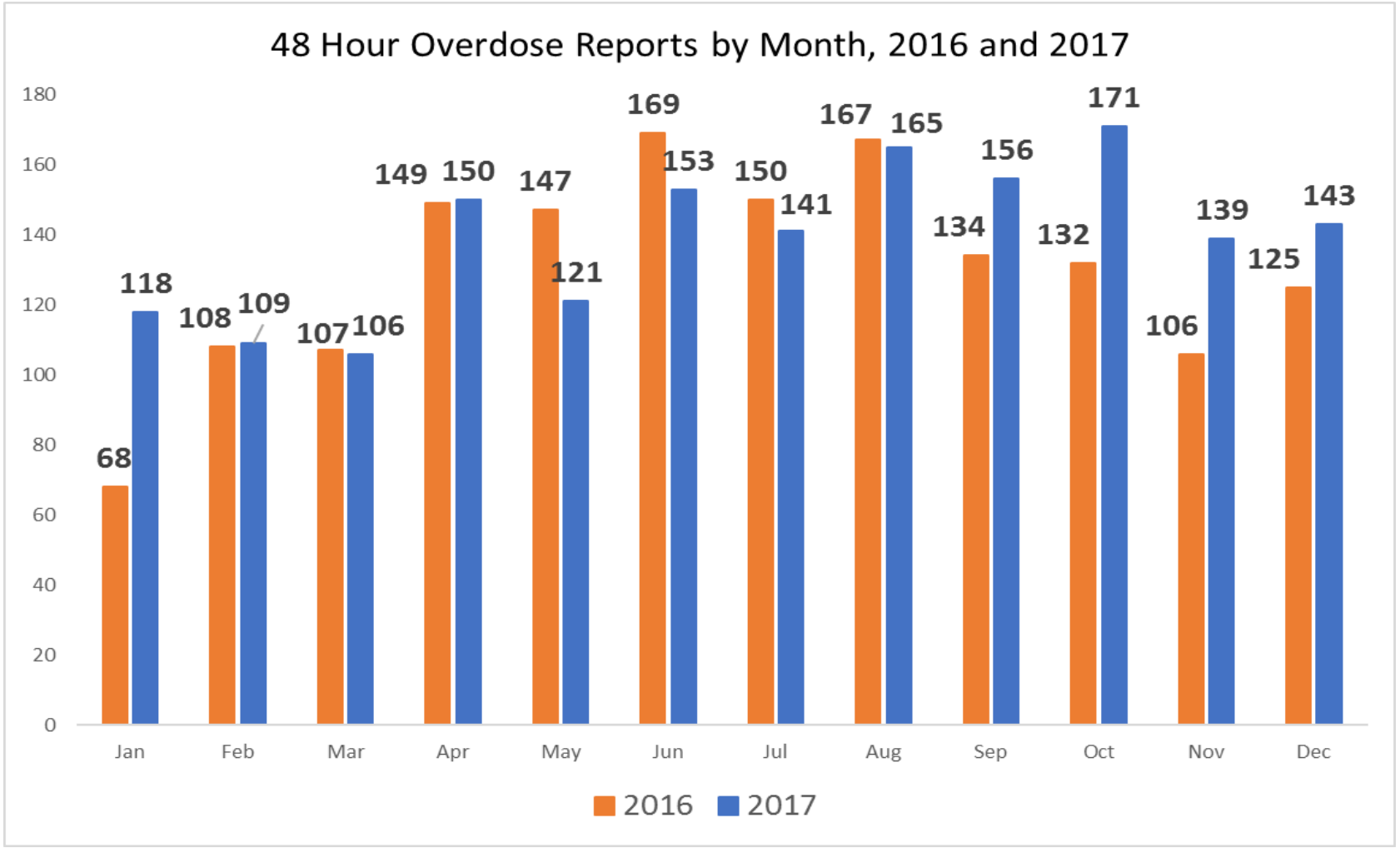
Overview



Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

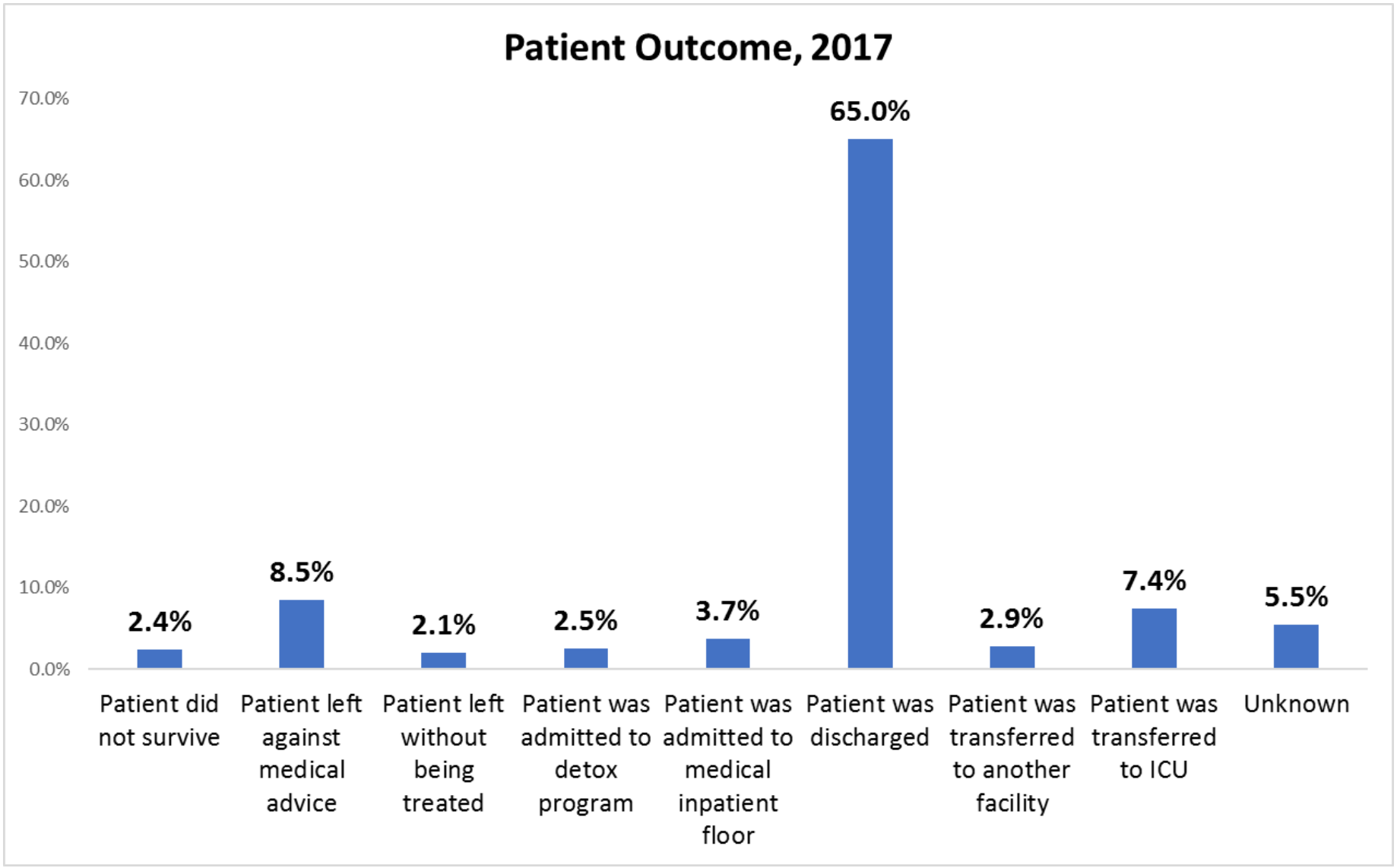
Overview

2017 Total Reports = 1,672
2016 Total Reports = 1,562



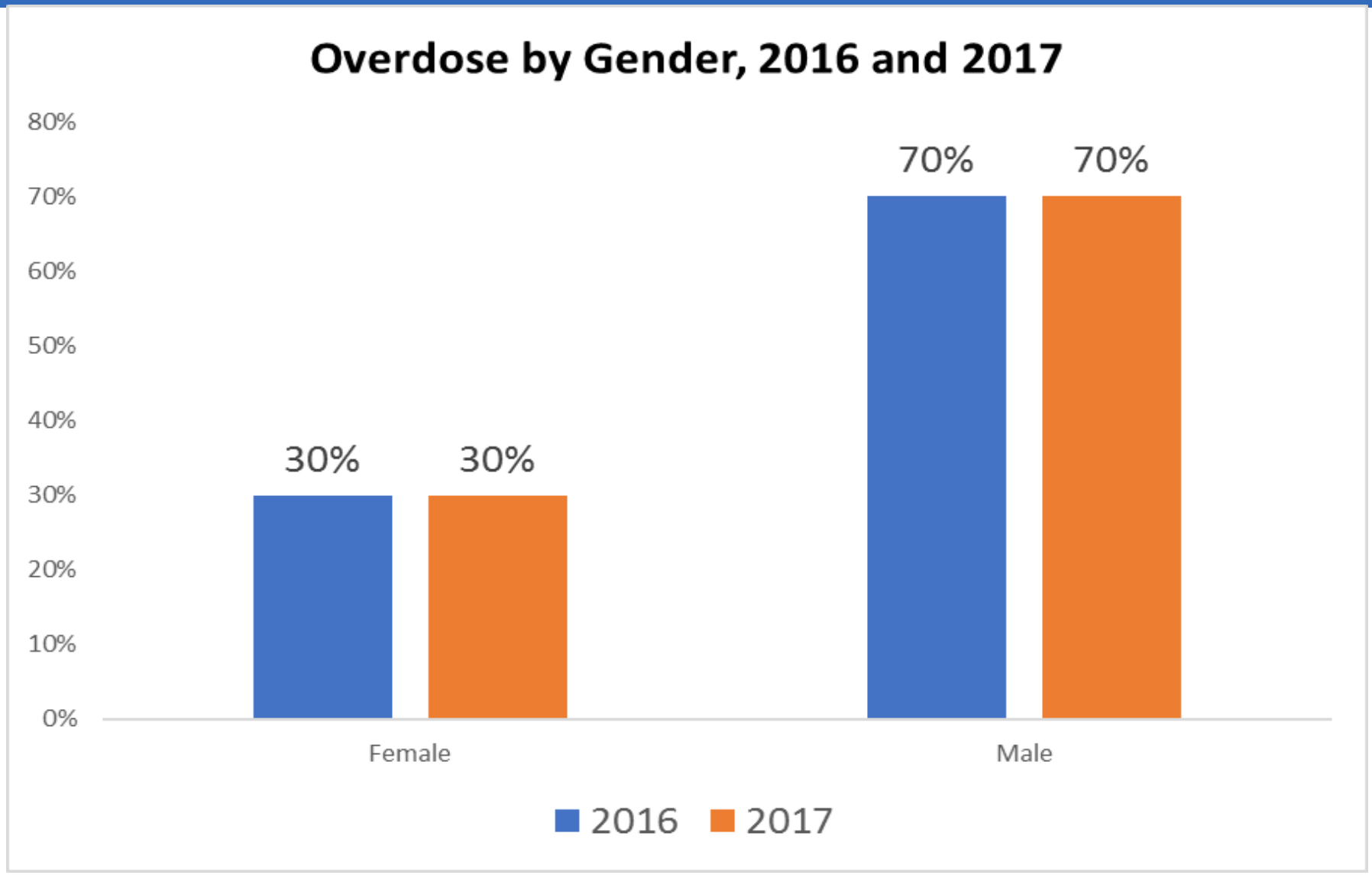
Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Overview



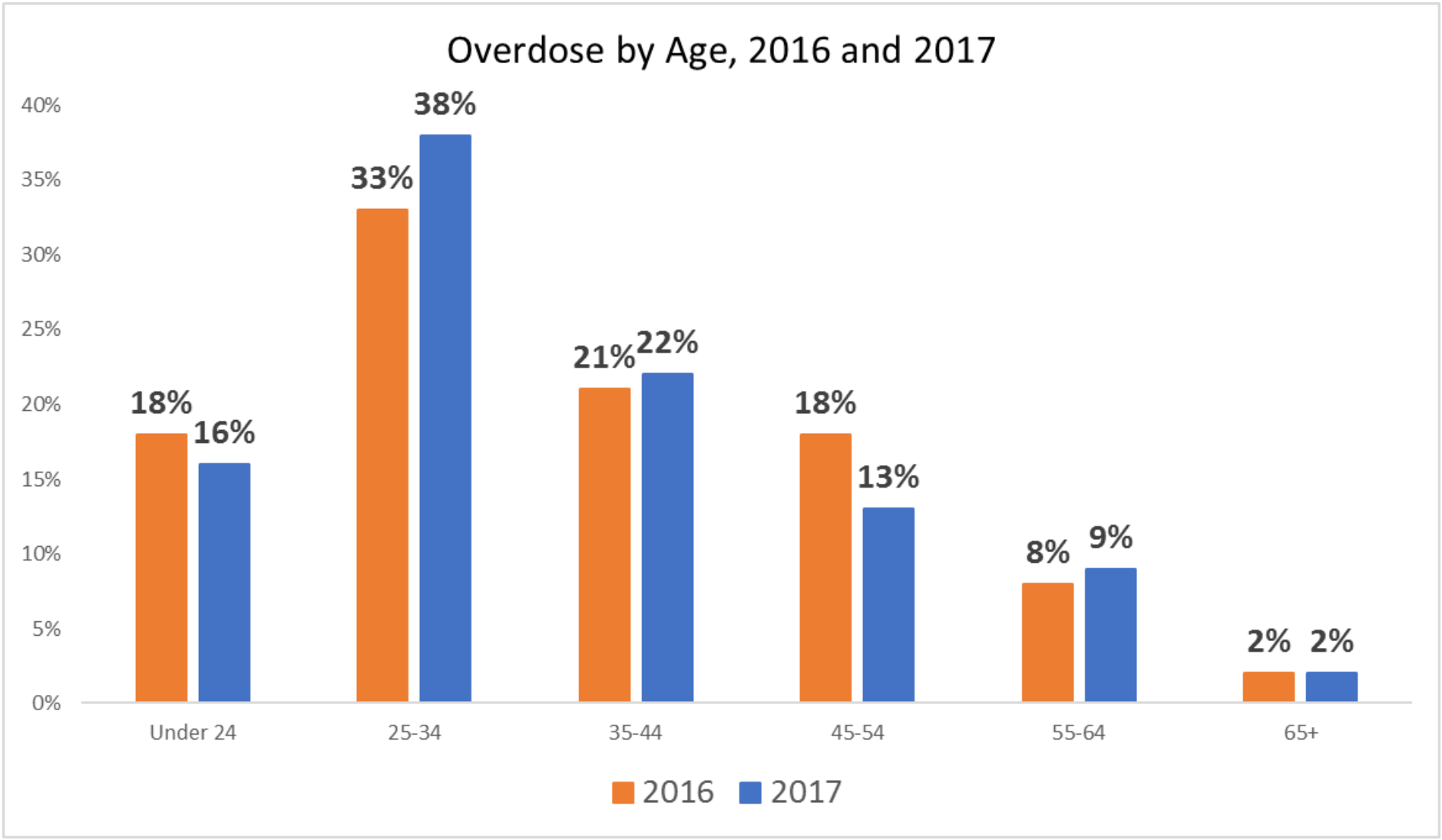
Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Demographics



Data Source: 48 -hour Overdose Reporting System, Rhode Island Department of Health

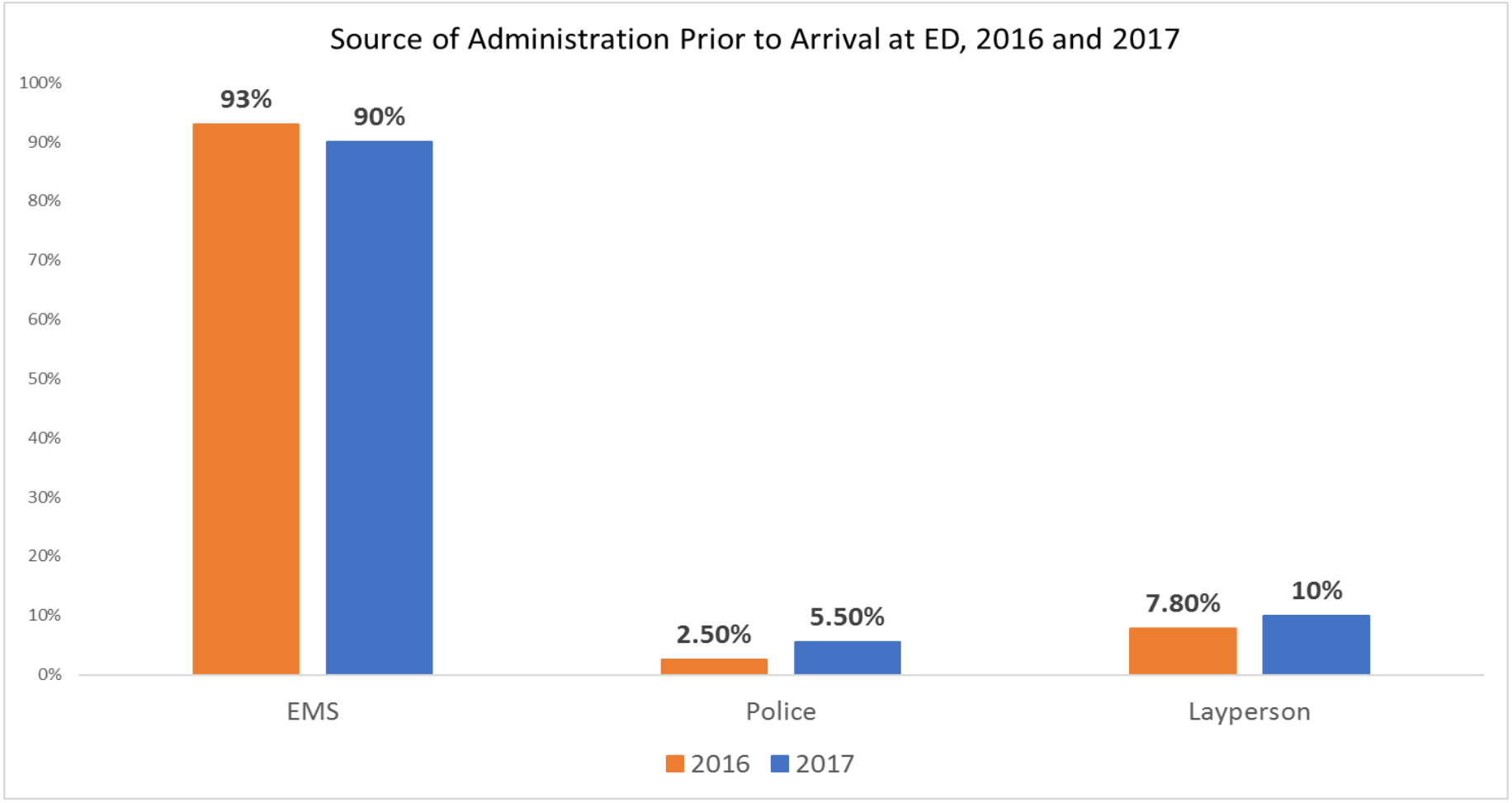
Demographics



Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Naloxone Distribution

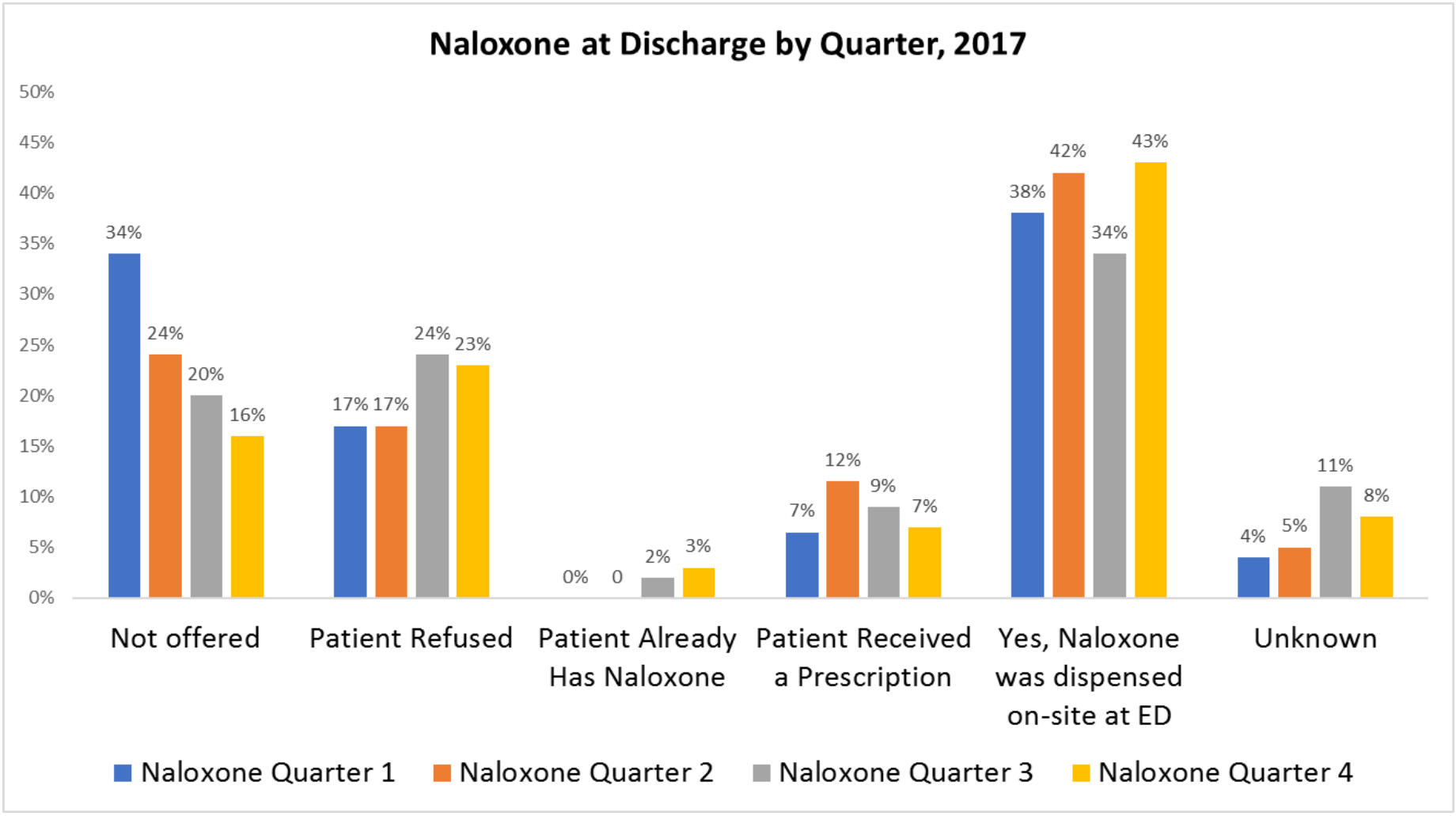
2017- 75% of reported overdoses received naloxone prior to arrival at the ED.
2016- 73% of reported overdoses received naloxone prior to arrival at the ED.



Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

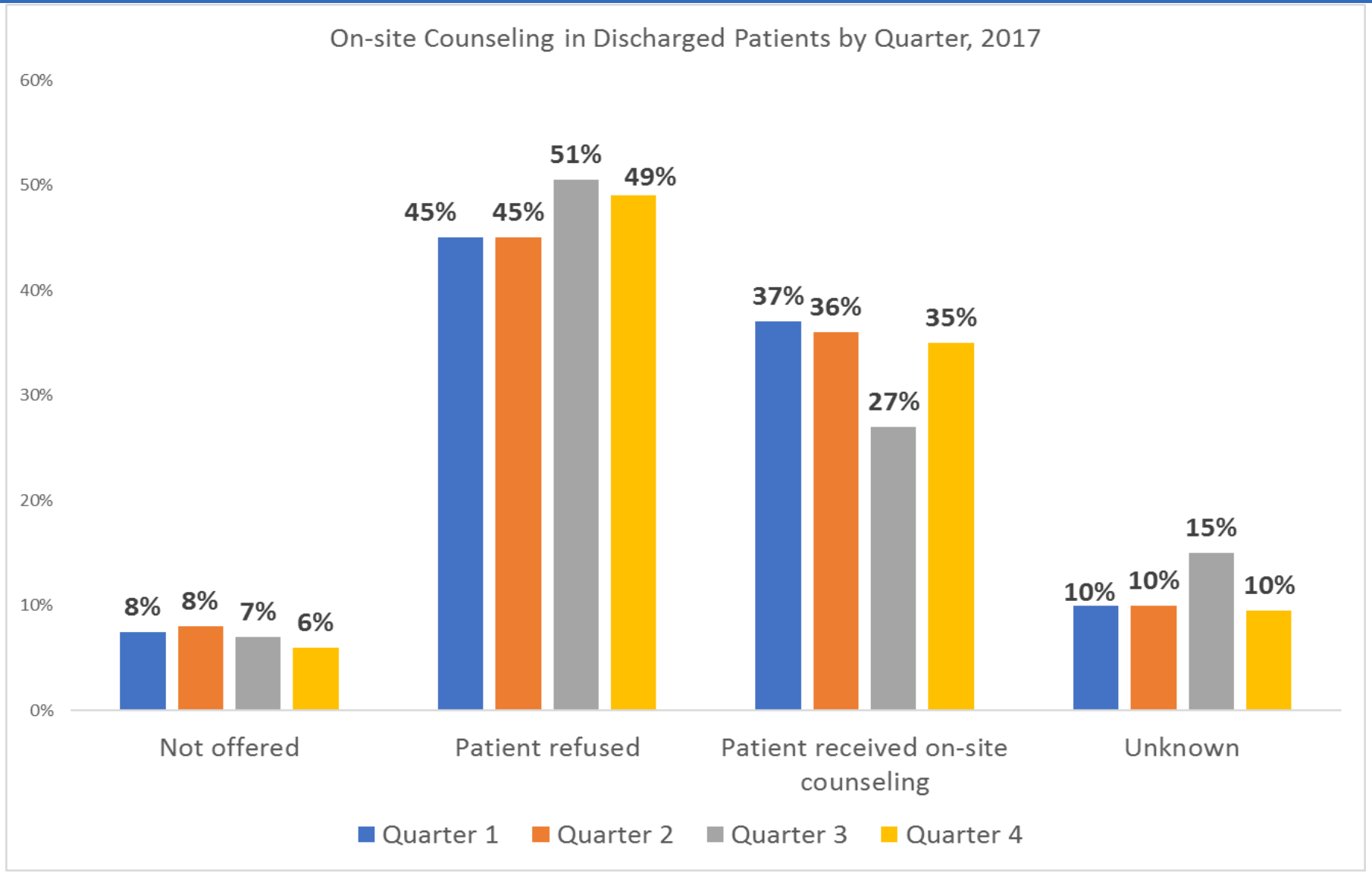
Naloxone Distribution

Naloxone distribution for 1,087 discharged patients.



Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

On-Site Counseling



Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Reporting

2017 Reporting by Hospital

	Total Number of Reports	Within 48 Hours (%)	Within 7 Days (%)	Average Reporting Time (Days)
Quarter 1	333	43%	71%	5.5 Days
Quarter 2	424	89%	99%	1.5 Day
Quarter 3	462	80%	95%	2.5 Days
Quarter 4	453	80%	96%	2 Days
2017 Total	1,672	75%	92%	2.5 Days

Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Reporting by Hospital

Hospital	Total Number of Reports	Percent of Reports within 2 Days of Overdose	Maximum reporting time (days)	Average Reporting Time (Days)
Butler	<5	100%	1	1
Hasbro	<5	0%	11	10
Kent	394	71%	26	3
Landmark	164	99%	31	1
Memorial	130	70%	13	2
Newport	33	64%	18	4
Our Lady of Fatima	52	100%	2	1
RIH	514	63%	36	3
Roger Williams	115	94%	4	1
South County	34	82%	6	2
Miriam	124	84%	24	2
Westerly	107	71%	15	2
Woman & Infants	<5	100%	1	1

Data Source: 48-hour Overdose Reporting System, Rhode Island Department of Health

Meghan McCormick, MPH
Drug Overdose Prevention Epidemiologist
Rhode Island Department of Health
Meghan.McCormick@health.ri.gov

Rhode Island Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns (SEN Task Force)

Rhode Island Overdose Prevention and Intervention Task Force

January 10, 2018

Sarah Bowman, MPH, Rhode Island Department of Health
Ailis Clyne, MD, MPH, Rhode Island Department of Health
Traci Green, PhD, Boston Medical Center

Topics Covered

- Neonatal abstinence syndrome: brief overview
- Relevant national and state data
- Rhode Island SEN Task Force: History and work overview
- Related RI initiatives
- Project Dove
- Future directions

Neonatal Abstinence Syndrome (NAS)

- In-utero exposure to certain substances can cause withdrawal symptoms shortly after birth when the exposure ends.

- NAS:
  - A drug withdrawal syndrome
  - Occurs primarily among opioid-exposed infants
  - Presents shortly after birth
  - Can occur from in-utero exposure to other substances like benzodiazepines, barbiturates, and alcohol

NAS Symptoms

Withdrawal symptoms from opioid exposure most commonly occur 48-72 hours after birth and include:

- Tremors, hyperactive reflexes, and/or seizures
- Excessive or high-pitched crying, irritability, yawning, stuffy nose, sneezing, and/or sleep disturbances
- Poor feeding and sucking, vomiting, loose stools, dehydration, and/or poor weight gain
- Increased sweating, temperature instability, and/or fever

Additional Effects of Opioid Exposure

Before birth:

- Poor fetal growth
- Preterm birth

After birth:

- Prolonged hospitalization (including NICU admission)
- Poor postnatal growth, dehydration, and seizures

Long term:

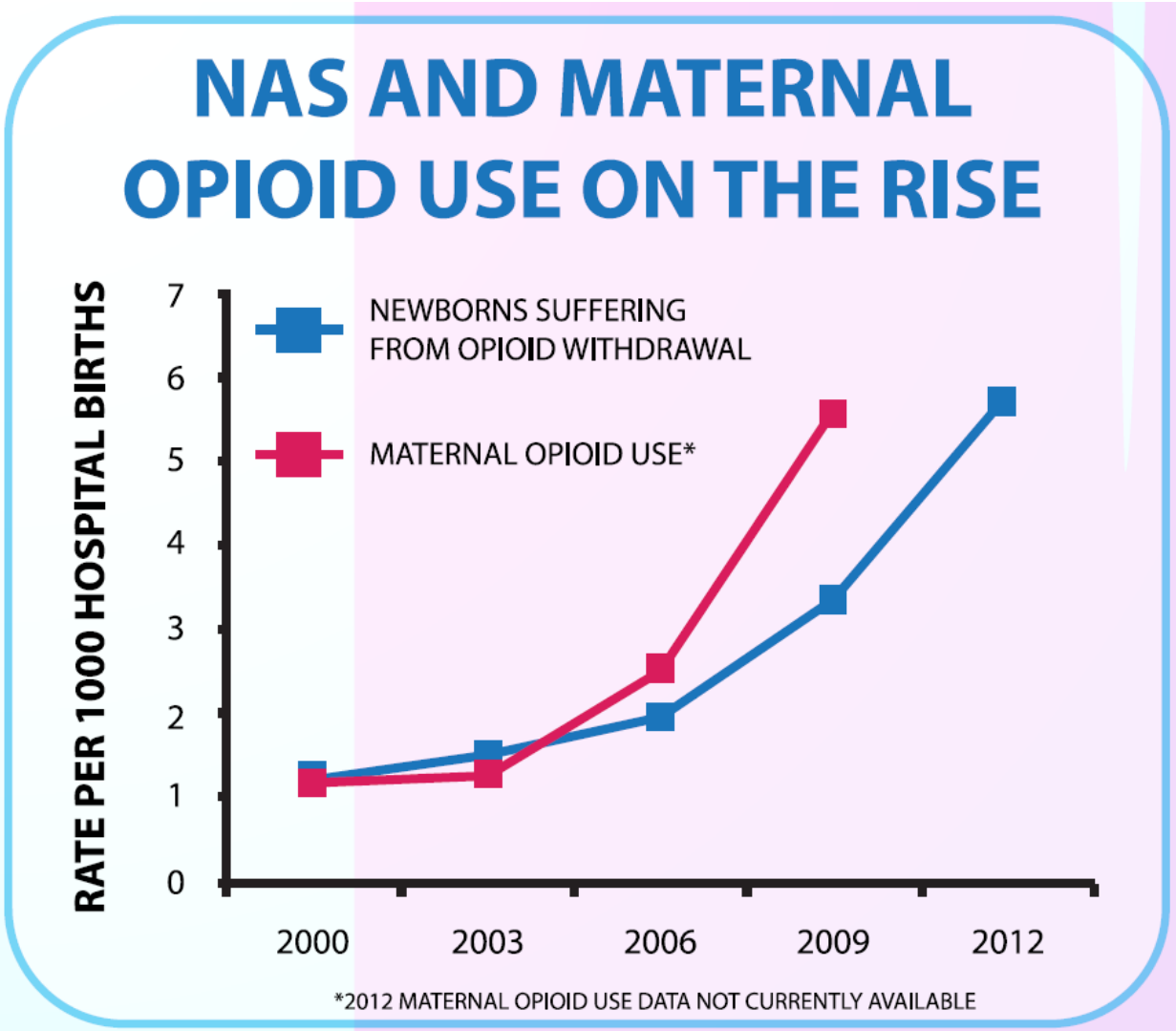
- Data on long-term developmental outcomes related to NAS are limited.

National and Local Trends

Nationally, and in Rhode Island, there is increasing public health, medical, and political attention paid to the parallel rise in the following trends:

- Prevalence of **substance use disorder**
  (including prescribed and illicit substances)
- Incidence of **overdose**
- Incidence of **neonatal abstinence syndrome (NAS)**
- Impact on families affected by SUD and NAS

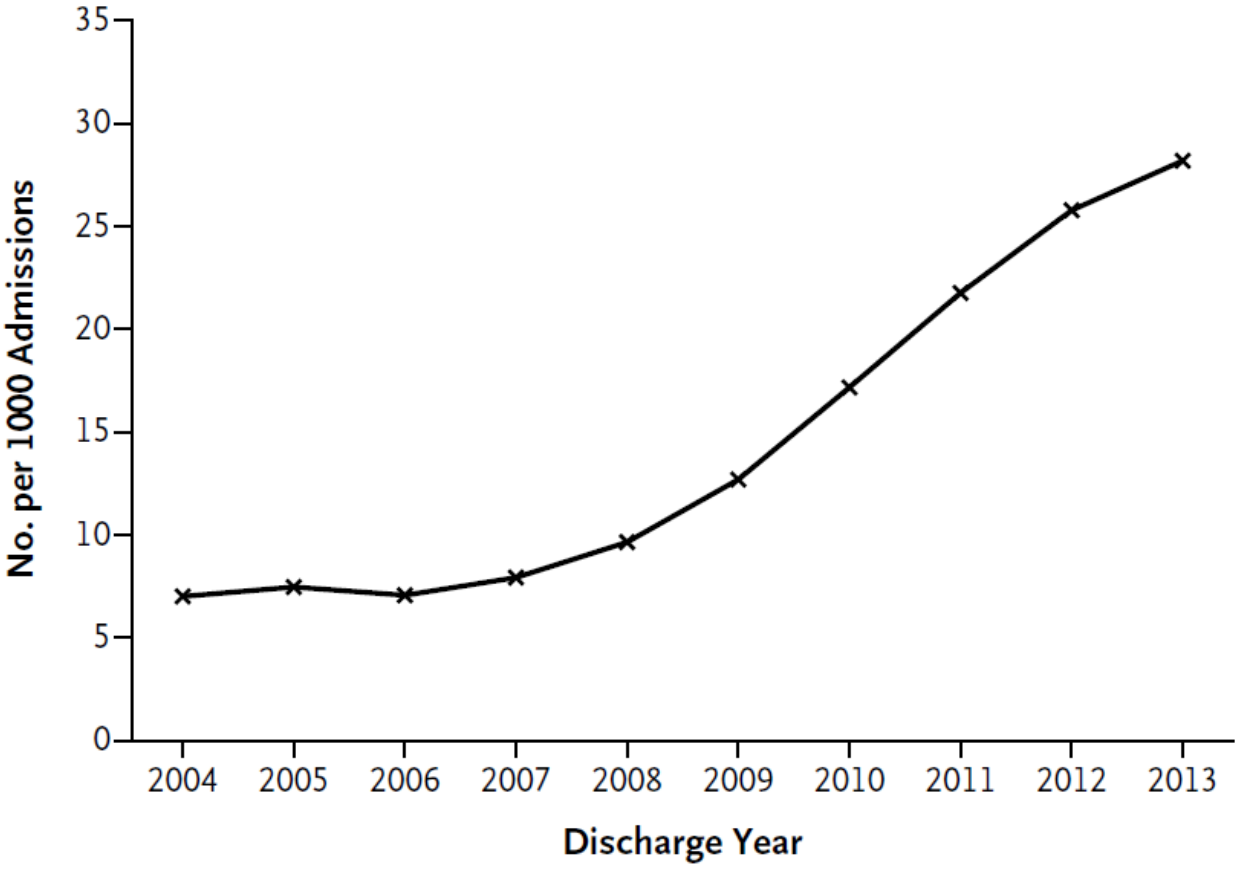
National Trends



Patrick et. Al., JAMA 2012, Patrick et. Al., J Perinatology 2015

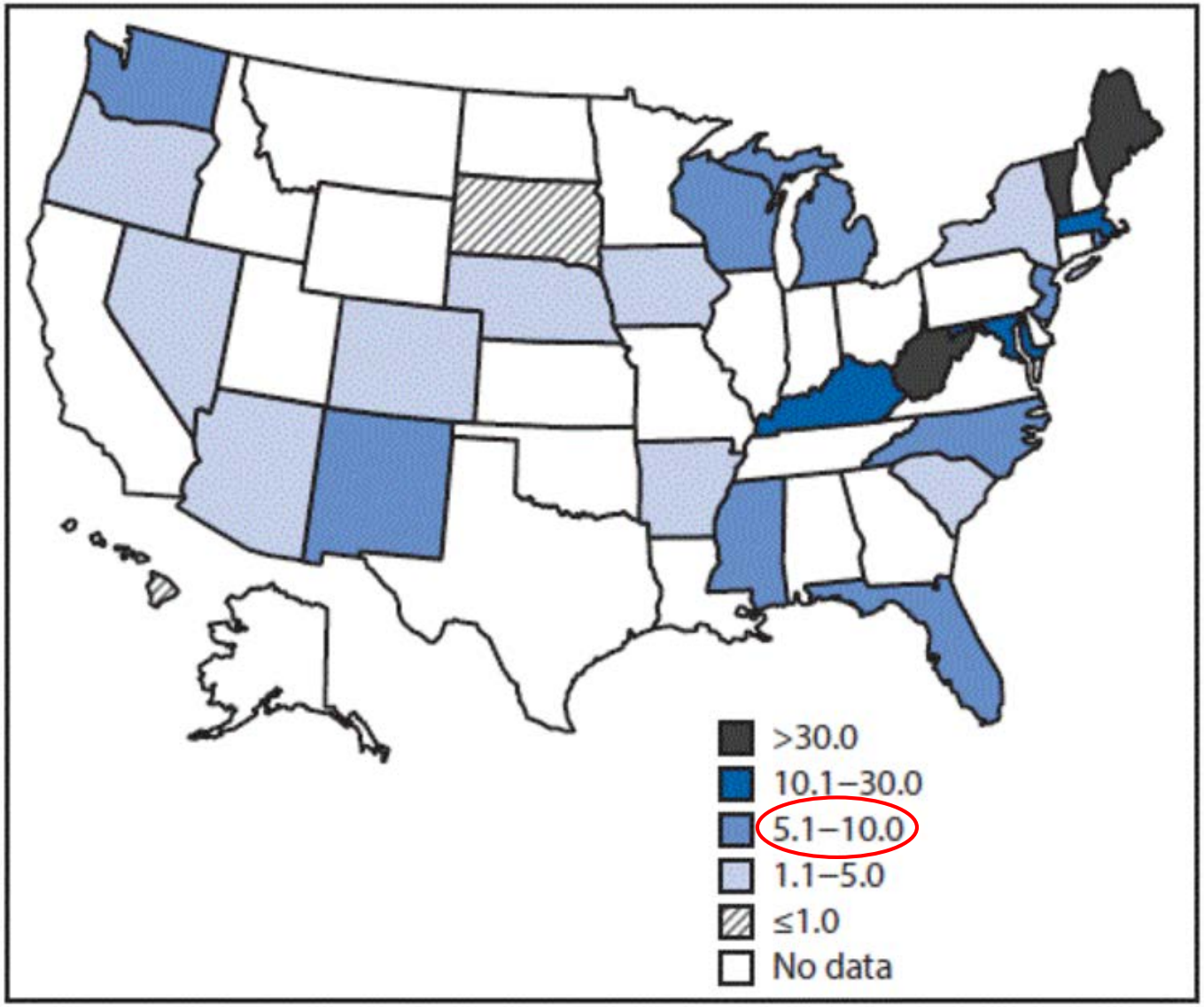
National Trends

NICU Admissions for NAS



Tolia et. al, *New England Journal of Medicine* 2015; 372: 2118-2126

NAS Incidence Rates 25 states, 2012-2013



From 1999–2013, NAS incidence **increased 300%.**

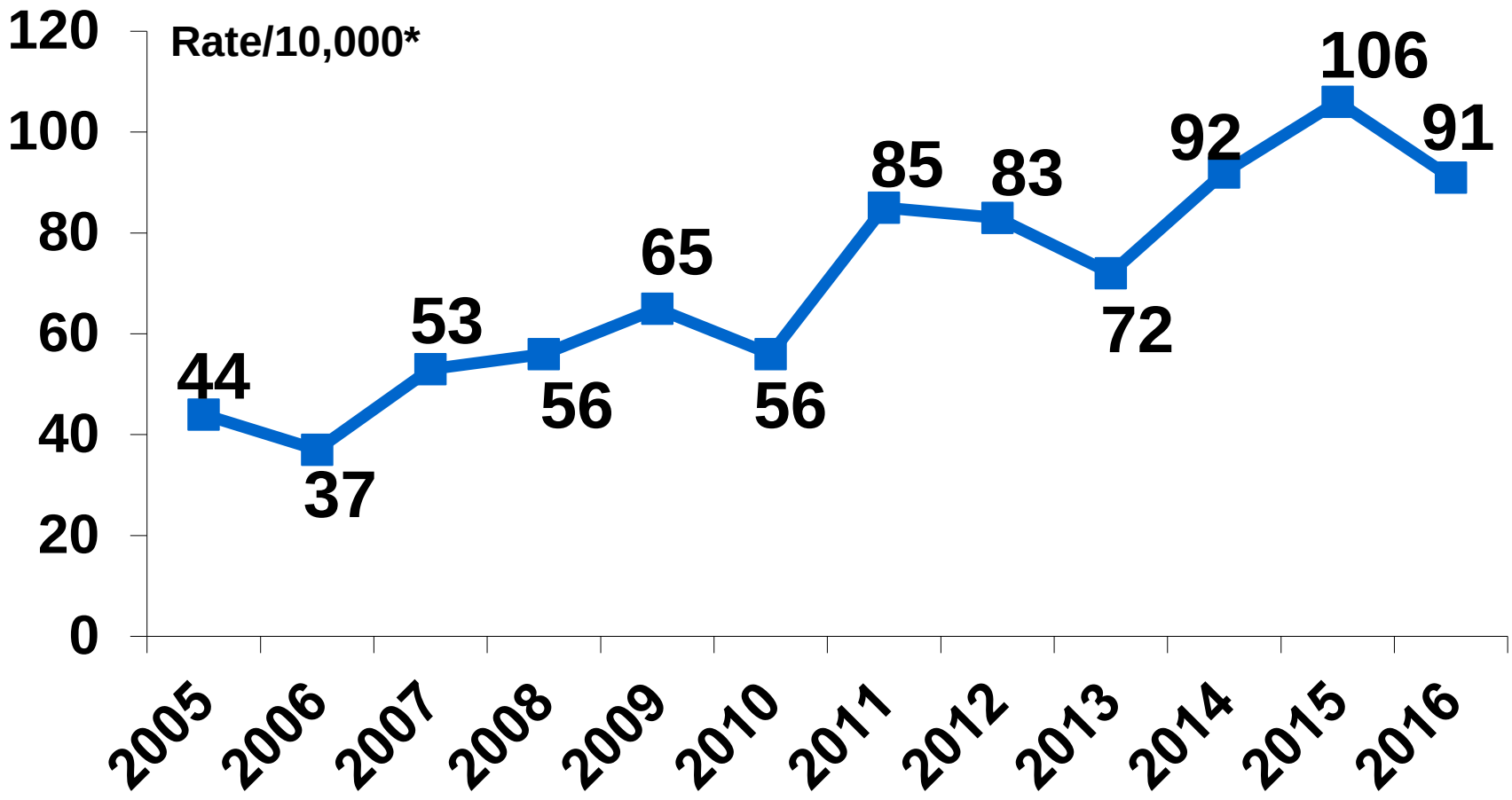
1999: 1.5 per 1,000 hospital births

2013: 6.0 per 1,000 hospital births

2013 RI: 7.2 per 1,000 births

Source: State Inpatient Databases, Healthcare Cost and Utilization Project.

NAS Incidence Rates
Rhode Island, 2005-2016



*Note: Rate = Number of Rhode Island infants with NAS (ICD-9 code 779.5 or ICD-10 code P96.1) per 10,000 live births

Source: Hospital Discharge Database, Rhode Island Department of Health

NAS Rhode Island 2007-2016

Maternal Race/ Ethnicity	% (n = 837)
White	76%
Black	3.7%
Other	0.7%
Asian	0.1%
Hispanic	6.0%

Municipality	(n = 837)
Providence	169
Warwick	81
Cranston	76
Woonsocket	65
Pawtucket	62
West Warwick	42
Kingstown	35
E. Providence	33
Newport	27
Westerly	27
N. Providence	22
Johnston	20
Coventry	19
Central Falls	15

NAS Rhode Island 2013-2016

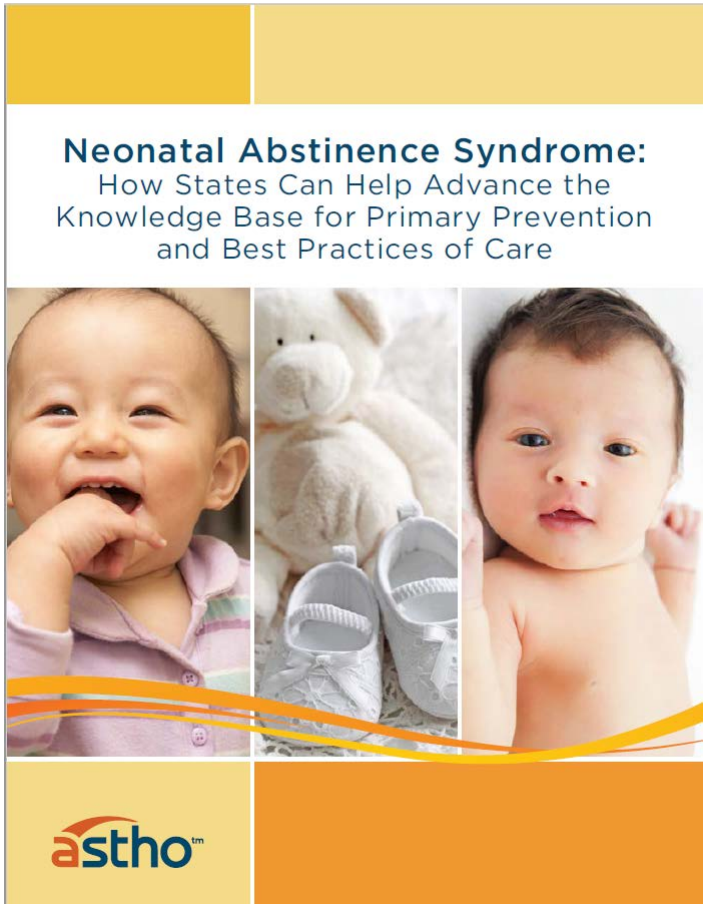
Birth Hospital	2013 to 2016 Babies Diagnosed with NAS	
	Number	%
Women & Infants	279	72.8%
Kent	74	19.3%
Memorial	18	4.7%
Newport	7	1.8%
South County	5	1.3%
Landmark	0	0
Total	**383**	**100%**

Rhode Island SEN Task Force

- 2014: The Association of State and Territorial Health Officials (ASTHO) released an issue brief on addressing NAS.

- RIDOH responded by convening a stakeholder group and forming the Rhode Island NAS Task Force.
  - Work groups
  - Annual conference 2016, 2017

- 2017: Name change from NAS to SEN Task Force



Rhode Island SEN Task Force Participants

The SEN Task Force brings together families and people with a variety of backgrounds to improve coordination of supports and treatment that is respectful and family-centered:

- State agencies: BHDDH, DCYF, EOHHS, RIDOH
- Medical professionals
- Substance use treatment providers
- Peer recovery coaches
- Early intervention
- Family home visiting
- Early child care and education
- Child welfare
- Family court
- Health insurance plans

SEN Public Health Approach

- **Primary Prevention:**
  Reducing the occurrence of in-utero opioid exposure
  - Access to contraception
  - Responsible opioid prescribing
  - Tobacco cessation

- **Secondary Prevention:**
  Treating known in utero opioid exposure to reduce the severity of consequences
  - Screening, brief intervention, and referral to treatment

- **Tertiary Prevention:**
  Ensuring positive long-term health outcomes for children and families
  - Decrease variability in treatment
  - Prevent readmission

Source: Patrick SW, Dudley J, Martin PR, et al. *Pediatrics*. 2015 May;135(5).

SEN Public Health Approach

Pre-Pregnancy → Pregnancy → Birth → Neonatal → Childhood+

NAS treatment has
focused on birth

Rhode Island SEN Task Force Mission

Mission: The Task Force seeks to establish a coordinated system for early identification and referral to support and treatment for impacted women, children and families to support the best health and social outcomes for children and families.

- Emphasis on comprehensive cross-sector care coordination
- Focus on pregnant women (families) with substance exposed newborns (not specific to presence of NAS)

SEN Task Force Resource Mapping

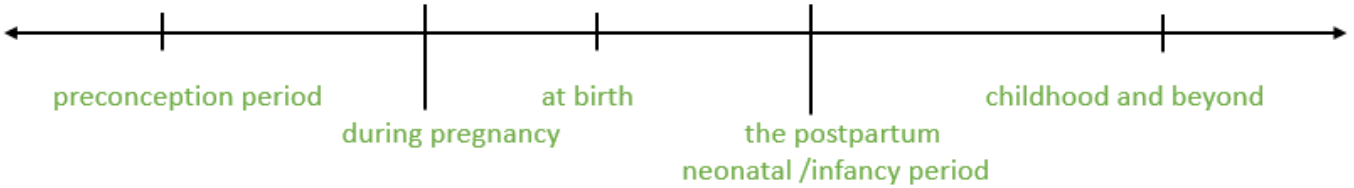
Best Practices to Guide the work of the NAS Task Force Preconception through Hospital Discharge

Goal: Best practices will guide all training guidelines and help to align efforts across work groups, may not reach consensus

DRAFT Working Document 4/1/16

Preconception	Prenatal	@ Birth
All Providers including medical, mental health and substance use treatment providers, especially prescribers, Obs, CNW and PCPs, **Screen and address pregnancy intention** •Screen all women of child bearing age for pregnancy intention using the One Key Question protocol. •*One Key Question: " Would you like to become pregnant in the next year?"* •IF NO: review protocol and discuss/link to desired contraceptive (if applicable) •IF YES: review protocol. **Screen and address substance use (rx and non rx)** •Conduct standardized VERBAL screening of all patients for alcohol/substance use (especially women of child bearing age) •Assess concurrent conditions and prescribed medications as appropriate to care being provided •Evaluate need for substance use treatment and support access for women of childbearing age, especially if considering pregnancy •Align screening for pregnancy intention and	**Substance Use Treatment Providers** •Routine VEBRAL standardized screening of women of child bearing age for pregnancy and pregnancy intention using the One Key Question (not currently universal practice) [How often, 1 Q protocol?] •Routine pregnancy test at enrollment, and prior to administrative discharge **If pregnant (or planning on it):** • Ensure prenatal care initiation as early as possible • Ensure referral to appropriate social/parenting support *Recovery Coaches, Family Visiting, WIC, Counseling support, etc.* *Support connection with birthing hospital SW* • Discuss treatment plan during pregnancy and postpartum • Discuss possibility of NAS and establish birth plan • Note: automatic extended stay at birthing hospital for NAS • Child **may** receive toxicology screen following delivery • Offer referral for consultation with neonatologist to discuss implications of medications for parents, fetus, neonate. **Prenatal care providers (PCP, Ob, CNM, etc.)** (other providers see preconception guidance) •Limit prescription opioid use for ALL pregnant women •VERBALLY screen ALL patients for substance use at each prenatal visit (ask ALL to reduce screening stigma) •*NOTE: URINE screens aren't evidence based best practice for determining parenting capacity nor appropriateness of maternal child contact or entry into treatment* (recommendation not universal practice) **If substance use presents:**	**Family Care Considerations:** •Routine and appropriate screening and assessment of NAS severity •Support Family Centered Care for maternal/child dyad • Rooming in • Promote and support skin to skin • Promote and support breastfeeding •Deliver appropriate care for baby based on symptom severity • Severe [NAS] – medical detox [varies across hospitals (studies)] • Mild – drug free options •Provide option to flag record if mother has opioid use disorder and wants to avoid opioids during/after delivery, requires override of standard orders *[Ideally optional, competing concern flag will prompt stigma]* **Prior to Discharge** **DCYF Considerations:** • Advocate to keep mother and child together, or at least in contact, with consideration of infant mental health implications of separation. • Facilitate accommodations for breastfeeding at mothers discretion and as medically appropriate

- Cross sector exercise including collaborating state agencies and community partners to discuss and outline best practices to support adults of child bearing age and families from pre-conception through early childhood



- *Participants included: RIDOH, BHDDH, DCYF, EOHHS, MAT providers and other substance use treatment providers, birthing hospitals (Obs and SW), family visiting.*

SEN Task Force Resource Guidance

Family Focused Supports in Rhode Island – "Build your team"

Focus is on families with parents in recovery or medication/substance exposed newborns but supports are not limited to these experiences
All supports listed are available at no cost to the participating family

SEN Task Force Work Groups

- **Professional Education**
- **Referral and Care Coordination**
- **Hospital Policies**
- **Recovery Coaches for New and Expecting Parents**

SEN Task Force Work Groups

Professional Education

- Annual meeting in 2016 and 2017 at RIC
- Topics presented: Stigma, SUD and NAS treatment, public health program work, and family experiences
- Networking

Referral and Care Coordination

- Started with prenatal focus, now expanding
- Service mapping
- Referral processes and communication between services
- Family-centered/responsive to family needs and respectful of family wishes

SEN Task Force Work Groups

Hospital Policies

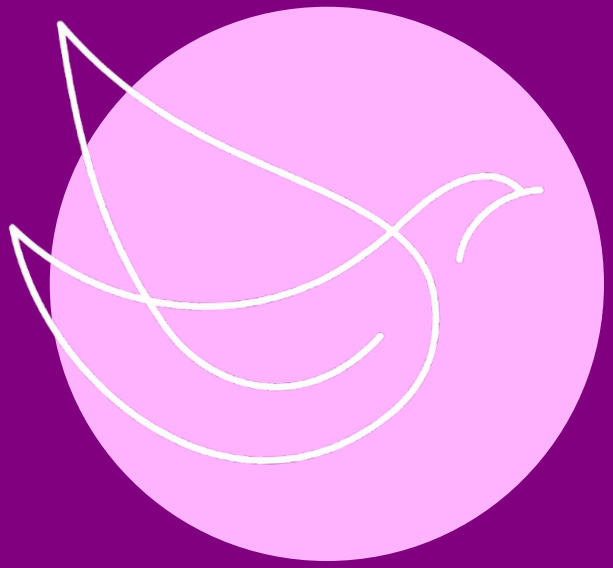
- Screening for maternal substance use disorder and newborn substance exposure
- Family-centered NAS care
- Child welfare referrals
- Transition to post-hospital supports

Recovery Coaches for New and Expecting Parents

- Peers with a lived experience
- Modeled after peer recovery coach program offered in EDs
- Delivered training to coaches focused on coaching during pregnancy and while parenting

Related Initiatives

- Project Dove professional education
- NAS follow-up program at the Brown University Center for the Study of Children At-risk



PROJECT DOVE

Improving Maternal and Neonatal Health Through Safer Opioid Prescribing

Project Dove is an effort to improve maternal and neonatal outcomes related to opioids in pregnancy in Rhode Island.

The project includes:

- **A continuing education course for medical providers**
- **Academic detailing for providers in five study communities**

Partners

Support

Bureau of Justice Assistance,
Department of Justice
Grant # PM-BX-Koo4

Advancements in treating pregnant women have been made in recent years. The Project Dove online course includes:

- Evidence-based best practice recommendations
- Simulated patient videos
- Downloadable clinical support tools

Target audience: Physicians, nurses, and midwives who provide care to pregnant patients and women of childbearing age (15–44 years)

Continuing Medical Education and Continuing Nursing Education Credit Course Modules

1

Understanding Opioid Issues in Pregnancy
Opioid prescribing and Medication Assisted Treatment in pregnancy, screening/monitoring, and legal issues

2

Discussing Concerns, Developing a Plan
Videos for three patient cases discussing concerns and developing treatment plans

3

Treatment Adjustment, Perinatal Care
Follow-up visit videos, pain management in childbirth, and NAS assessment and treatment

PATIENT 3

Angela

Age 34

Existing OB/GYN patient last seen 1 year prior for annual exam

Brief history

- Pregnant; estimated 10 weeks gestation
- Eighteen months prior to visit, experienced a tibia/fibula fracture when struck by a car. Multiple subsequent painful conditions in past year (dental pain, injuries/falls).
- History of anxiety and past heavy alcohol use.
- Prescription Drug Monitoring Program (PDMP) shows opioids from multiple providers in the past year, including three in past three months. Two months prior she was taking up to 200 morphine milligram equivalents (MME)/day; her prescriptions have become inconsistent since then.

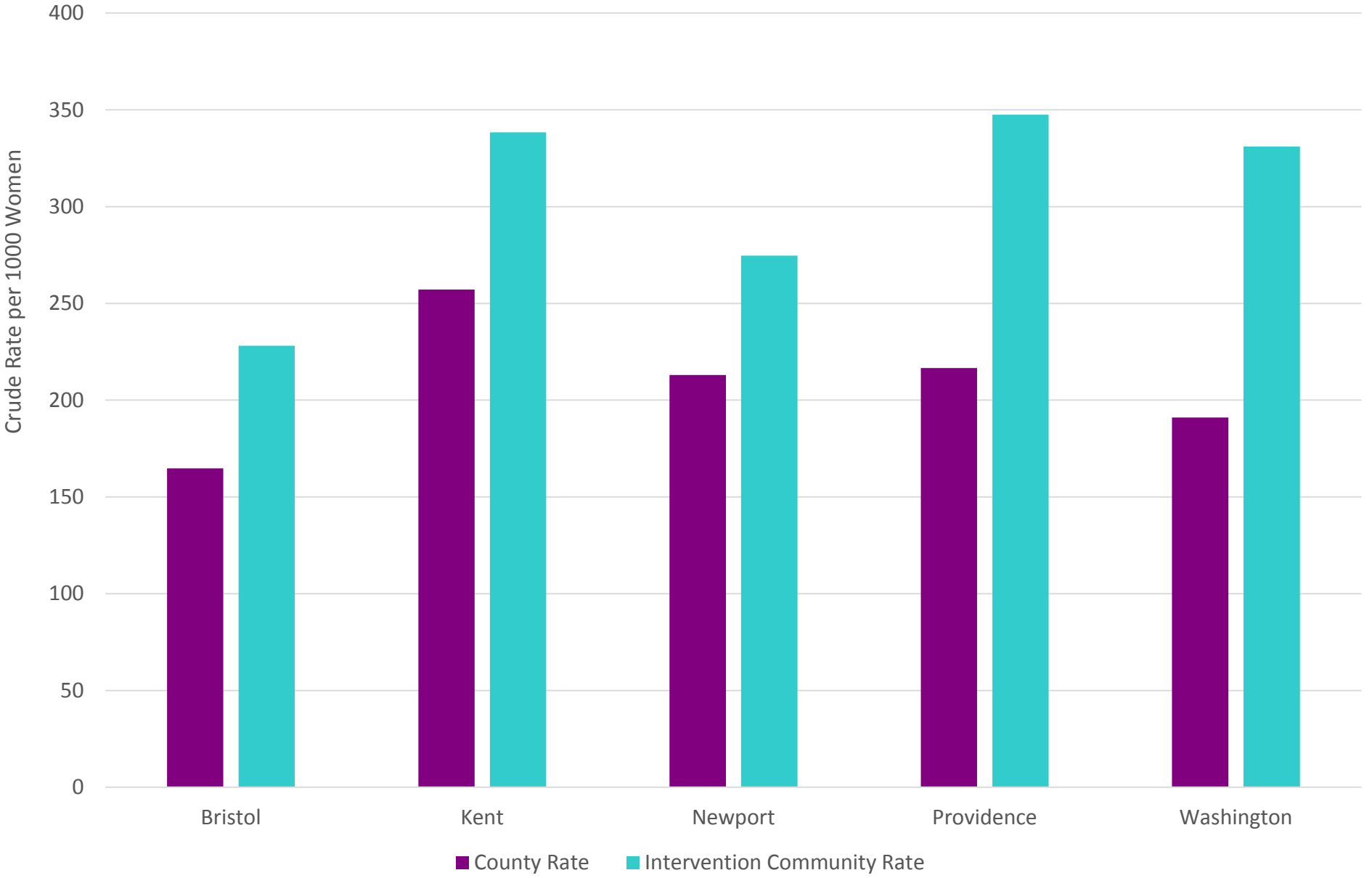
Purpose of visit

- Seeking opioid prescription and prenatal care

Project Dove: www.brown-cme/opioids-pregnancy

- **Online CME**: Available now
- **Downloadable resources**: Available now
  - Screening and monitoring tools
  - Clinical support tools
  - Patient educational handouts
  - Rhode Island-specific referral resources

Six-month Opioid Prescribing Rates to Women 15-44 Years by County and Study Community



Materials and Resources

Clinical Support Tools

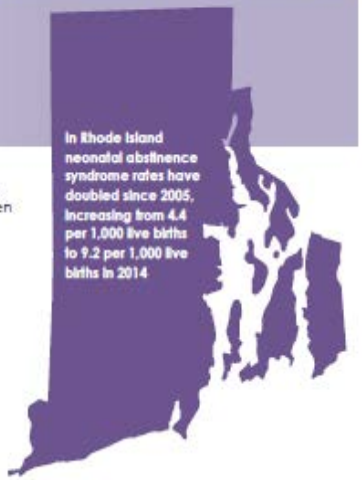
Opioids in Pregnancy

Improving Maternal and Neonatal Health in Rhode Island

During pregnancy medical providers must respond to women's pain management and behavioral health needs while minimizing potential risks to the fetus. This balance is further complicated when opioid use disorder is present.

Project Dove is a 3-module case-based course that includes evidence-based best practice recommendations, simulated patient videos, and downloadable clinical support tools.

Target audience: Physicians, nurses, and midwives who provide care to pregnant patients and women of childbearing age



To access the Project Dove course visit
www.brown-cme/opioids-pregnancy

About the Program

Module 1
Understanding Opioid Issues in Pregnancy

- Opioid prescribing in pregnancy
- Identifying opioid use disorder
- Legal considerations
- Pharmacological treatment for opioid use disorder in pregnancy
- Three patient cases are introduced

Module 2
Discussing Concerns, Developing a Treatment Plan

- Videos demonstrating initial visits for the 3 patient cases
- Information on discussing clinician and patient concerns and developing treatment plans for each case

Module 3
Treatment Plan Adjustment and Perinatal Care

- Videos demonstrating follow-up visits for the 3 patient cases
- Information on treatment plan and medication adjustment
- Pain management in childbirth
- Neonatal abstinence syndrome assessment and treatment

Resource Documents for Download:

- Patient-provider interaction videos
- Screening and monitoring tools
- Clinical support tools and provider checklists
- Patient educational handouts

PROJECT DOVE

Improving Maternal and Neonatal Health Through Safer Opioid Prescribing

Opioid Agonist Treatment in Pregnancy

2 medications are available to treat opioid use disorder during pregnancy:

Methadone

and

Buprenorphine

Benefits of Opioid Agonist Treatment in Pregnancy

Prevents erratic maternal opioid levels from illicit use, lessening fetal exposure to repeated withdrawal (cycling)

Increases participation in prenatal care and services

Reduces drug craving and helps patients avoid risks related to illicit substance use, including Hepatitis C/HIV exposure and overdose.

The primary risk of opioid agonist treatment is neonatal abstinence syndrome (NAS), an expected and treatable condition that follows exposure to opioid agonists.

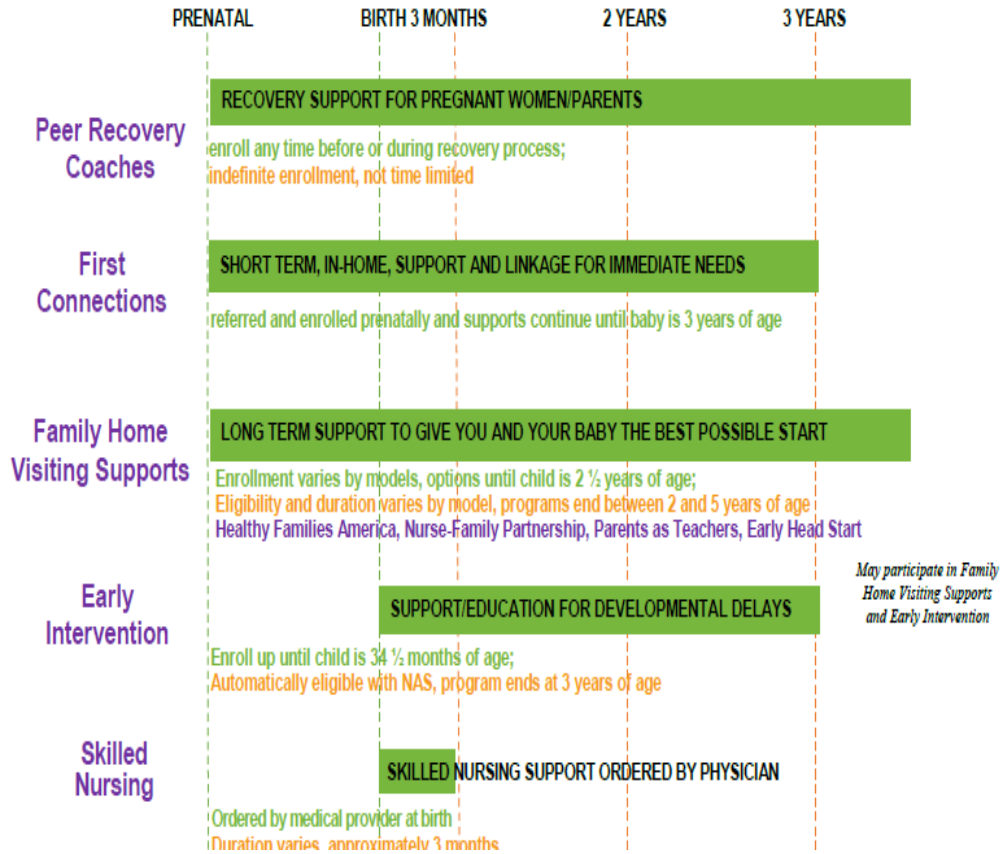
The benefits of opioid agonist treatment to the mother/infant dyad are considered to outweigh the risks. Opioid agonist treatment is the standard of care for opioid use disorder in pregnancy, supported by current clinical guidelines.

Comparing Methadone and Buprenorphine

Rhode Island & Patient Resources

Family Focused Supports in Rhode Island – "Build your team"

Focus is on families with parents in recovery or medication/substance exposed newborns but supports are not limited to these experiences
All supports listed are available at no cost to the participating family



PROJECT DOVE

Improving Maternal and Neonatal Health Through Safer Opioid Prescribing

Rhode Island Substance Use Disorder Treatment Resources

Referring Patients to Treatment

Rhode Island also has a "warm line" to help connect patients to treatment. The line is staffed by a licensed counselor 24 hours a day, 7 days a week, in English and Spanish.

(401) 942-STOP (7867)

1. Call the warm line or together with the patient select one of the treatment locations on the back page of this document
2. Make a call while the patient is with you to set up an appointment at the most appropriate and convenient treatment location
3. Hand the phone to the patient if the treatment provider requests additional details
4. Print the list of treatment programs and mark the location of the appointment
5. Refer the patient to peer recovery services for additional support

Finding Out More

Rhode Island Department of Health provides materials to aid in the referral process

http://www.health.ri.gov/healthrisks/addiction/for/providers/

Rhode Island has a central platform called Prevent Overdose RI

Provider resources include substance use disorder treatment lists and maps and information related to addressing opioid issues

http://preventoverdoseri.org

thank you!

Bja.projectdove@gmail.com
www.brown-cme/opioids-pregnancy

Future Directions

The Protect Our Infants Act of 2015 is a federal, bipartisan law introduced specifically to combat the NAS epidemic. This law… has succeeded in bringing national attention to NAS. However, it fails to offer any tangible short-term solutions to the rapidly growing problem.

Brown, J D, PharmD, MS et. al. Rates of Neonatal Abstinence Syndrome Amid Efforts to Combat the Opioid Abuse Epidemic, *Journal of the American Medical Association Pediatrics*. 2016 Nov 1; 170(11): 1110–1112.

Future Directions

Tailoring of interventions to **pregnant women** or **women of childbearing age** should be included as a **priority of national and state efforts** to address **substance use** and **opioid use disorder** because of the **increasing occurrence of NAS** and the potential for lifelong effects in substance exposed newborns.

Ailis Clyne MD, MPH

Ailis.clyne@health.ri.gov

Kristine Campagna, MEd

Kristine.campagna@health.ri.gov

The Family Task Force

Saving Lives, Ending Stigma

Governor Raimondo's Overdose Prevention and Intervention Task Force

Lisa Conlan Lewis, Executive Director, Parent Support Network

January 10, 2018

The Family Task Force is a strong group of active and informed family members of youth, young adults and adults who have or have had opioid and/or a substance use disorder and are now raising public awareness, educating, and advocating for policy reform, accessible and effective substance use prevention, rescue, treatment, and recovery.

Mission

- **Family members** who have a youth, young adult or adult with substance use challenges, in treatment or recovery from, or who have lost a loved one to opioids and/or addiction.
- **Advocates and partners** committed to supporting and assisting with the Family Task Force priorities and action steps.
- **Co-Chairs**: Lisa Conlan, Parent Support Network Executive Director, and Trisha Suggs, Associate Administrator, Project Director, State Youth and Young Adult Treatment, Division of Behavioral Health, BHDDH
- **The Family Task Force Coordinator**: Melissa Paiva, Parent Support Network of Rhode Island

Family Task Force Membership

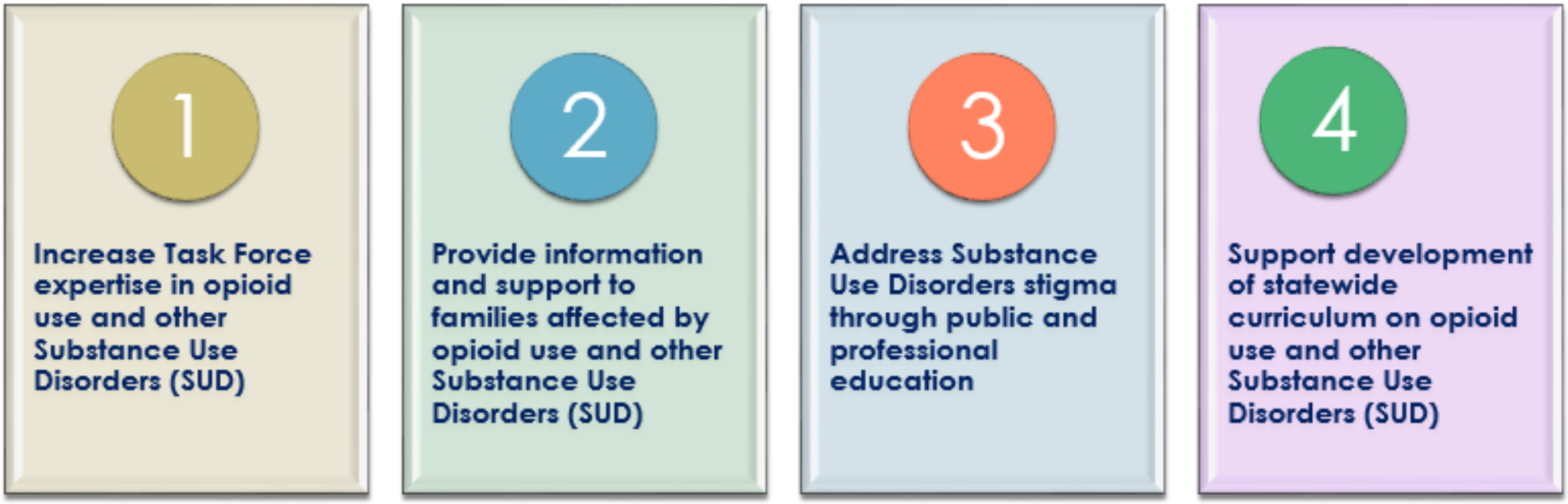
- Governor Raimondo and the Governor's Overdose Prevention and Intervention Task Force
- Parent Support Network of Rhode Island
- State Youth Treatment Implementation Grant with the Substance Use Mental Health Services Administration (SAMHSA)

Family Task Force Partnership

- Families
- Advocacy Organizations
- Mutual aid/support groups
- State government agencies
- Local municipalities
- Healthcare clinics
- Hospitals
- Foundations

- Schools/Rhode Island Student Assistance Services
- Higher education/Colleges
- Law enforcement
- Emergency response
- Faith-based organizations
- Funeral homes
- Treatment and recovery service providers
- Social services
- Communications and media

Family Task Force: Outreach and Collaboration



The Family Task Force: Priority Focus Areas

Invite speakers to the Family Task Force meetings to increase knowledge and expertise of our membership and to discuss policy and practice recommendations.

The Family Task Force met with Governor Raimondo and State Directors preceding the Opioid Community Overdose Engagement (CODE) Summit on December 12, 2017.

Priority Action Step A

Work with The Miriam Hospital's Preventing Overdose and Naloxone Intervention (PONI) program to be trained as Family Task Force Naloxone Trainers.

Trainers will deliver statewide naloxone training and promote the dissemination of the overdose reversal drug, naloxone.

Priority Action Step B

Develop informational resources and a crisis tool box to educate families and communities on the prevention, rescue, treatment, and recovery of substance use disorders.

Disseminate resources in hard copy and electronically on The Family Task Force website: thefamilytaskforce.org

Priority Action Step C

Learn about and promote existing family support resources, recovery services, and groups.

Expand the number of family support and recovery services and groups statewide.

Build upon family support group model, Resources Education Support Together (REST) in Bristol and Warwick.

Priority Action Step D

Develop and share important key messages and share families' stories and experiences with the public to decrease stigma and promote prevention, rescue, treatment, and recovery.

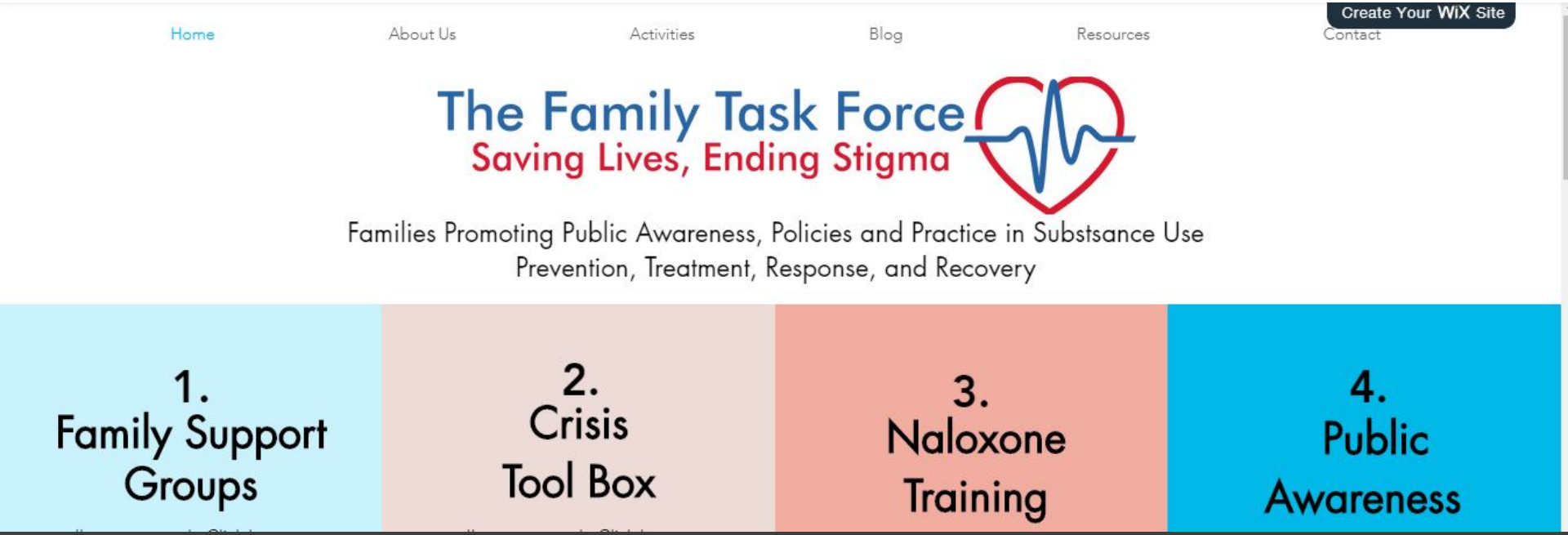
Conduct public awareness events, create videos, publish press releases, and utilize social media and the arts.

Priority Action Step E

Collaborate with schools, colleges, and the Rhode Island Student Assistance Services (RISAS) to expand access to prevention programming for high-risk students.

Work with the state, higher education, and local school districts to develop a curriculum on the prevention and treatment of substance use disorder. The proposed curriculum will be mandated in schools and colleges/universities.

Priority Action Step F



Our new website coming soon!

thefamilytaskforce.org

- **Melissa Paiva**, Family Task Force Coordinator Parent Support Network, m.paiva@psnri.org or 401-889-3112

- **Lisa Conlan**, Family Task Force Co-Chair, Executive Director Parent Support Network, l.conlan@psnri.org

- **Trisha Suggs**, Family Task Force Co-Chair, Associate Administrator, Project Director, State Youth and Young Adult Treatment, Division of Behavioral Health, trisha.suggs@bhddh.ri.gov

Contact Us for More Information

PUBLIC COMMENT