Duke
MARGOLIS CENTER
for Health Policy

Session III—
Opportunities and Barriers to Expand Treatment for Vulnerable Populations

Moderator: Regina LaBelle, Duke-Margolis Center for Health Policy

Panelists:

Marc Fishman, Maryland Treatment Centers

Kaylin Klie, University of Chicago

Kailee Fretland, Indian Health Service

Jennifer Clarke, Rhode Island Department of Corrections

Join the conversation at **#OUDTreatment #EndTheStigma**

Polling Question #4

What is the highest priority issue that must be addressed first to improve evidence-based OUD treatment for vulnerable populations? (Choose the best answer)

a) Resources for delivering culturally-appropriate care
b) Development of models or standards of care
c) Improving care coordination or transitions to care
d) Trust between communities and healthcare or government organizations
e) Patient reluctance to seek or engage in care
f) Other

In person attendees—participate by entering the following URL into your web browser on your phone or laptop: **http://bit.ly/dukemargolis**
Webcast—participate via chat box at the bottom right of your screen.

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OPPORTUNITIES AND BARRIERS TO TREATMENT FOR VULNERABLE POPULATIONS: PREGNANT WOMEN

Kaylin A Klie, MD, MA, FASAM
Assistant Professor, Department of Family Medicine
University of Colorado School of Medicine

Substance Use in Pregnancy

- 2/3 of women with co-occurring mental health concerns
- High rates of trauma, specifically childhood sexual abuse: 50-90%
- >60% women with SUD report history of—or current-intimate partner violence
- Low rates of reproductive health care = >80% pregnancies unplanned
- Higher rates of infectious disease, poverty/unstable housing, correctional system involvement, toxic stress

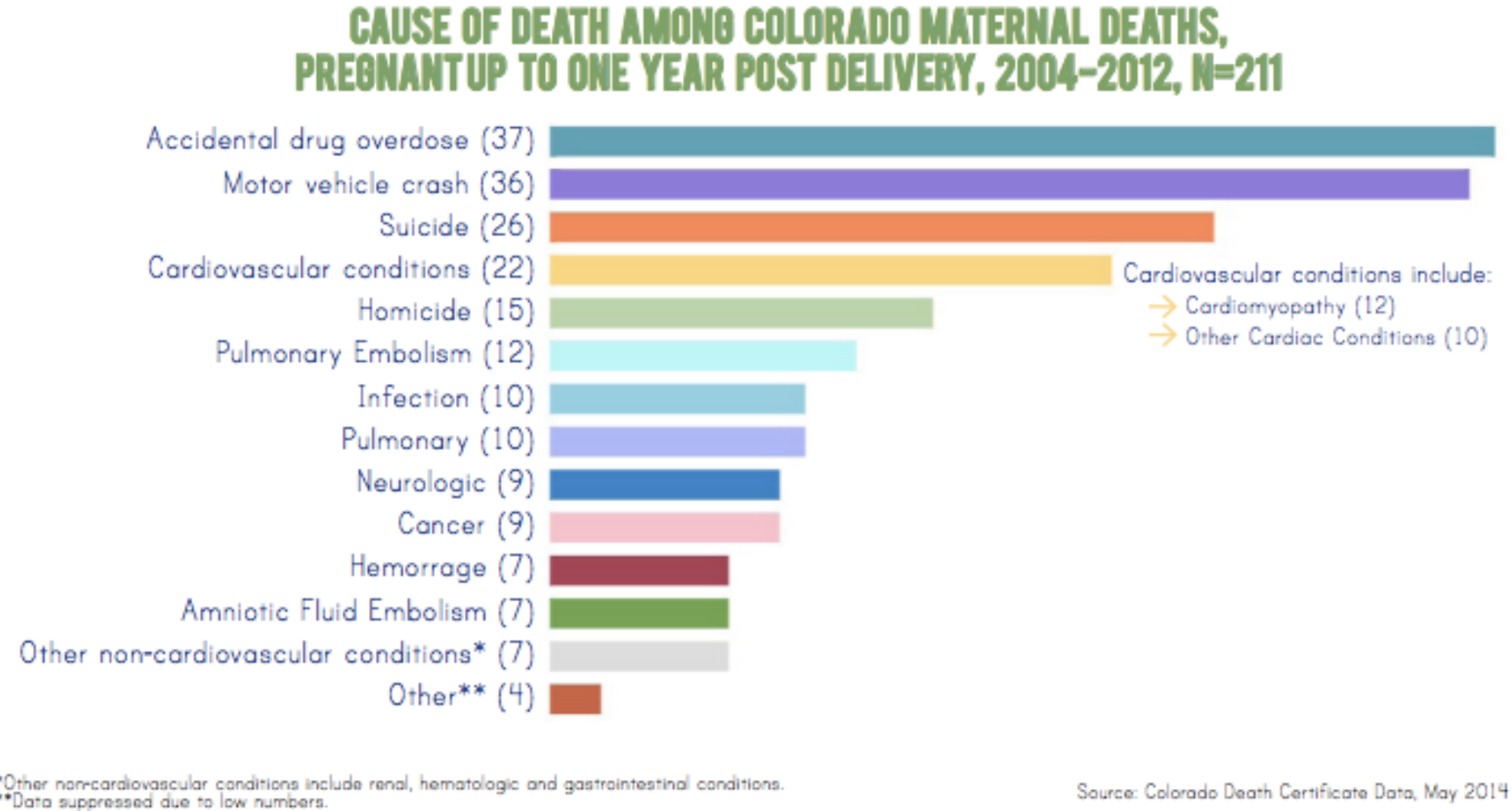
OUD and Pregnant Women

- Universal screening for substance use in pregnancy
- For pregnant women with Opioid Use Disorder:
  - Pharmacotherapy is the evidence-based treatment Recommendation
    - Methadone
    - Buprenorphine
  - Withdrawal (detox) from opioids is not recommended
    - Risk for avoidable maternal-fetal stress
    - High rates of relapse
    - Higher risk for overdose/death after period of abstinence
- All care providers have a role in evaluating and caring for pregnant women with substance use

Barriers to Engagement in Care

- Stigma typically associated with substance use <<<Use in Pregnancy
- Avoidance of “the radar” (prenatal care, substance treatment, pregnancy support programs, mental health care) due to fear of detection, and subsequent involvement with Social Services
- Many women associate any detection of use with immediate loss of custody of child (other children at home and/or child of current pregnancy)
- General lack of access to treatment in non-urban areas

Local Data: Colorado Maternal Mortality



Canary in The Coal Mine

- Texas: 64/382 maternal deaths between
- 2012-2015 due to overdose makes overdose

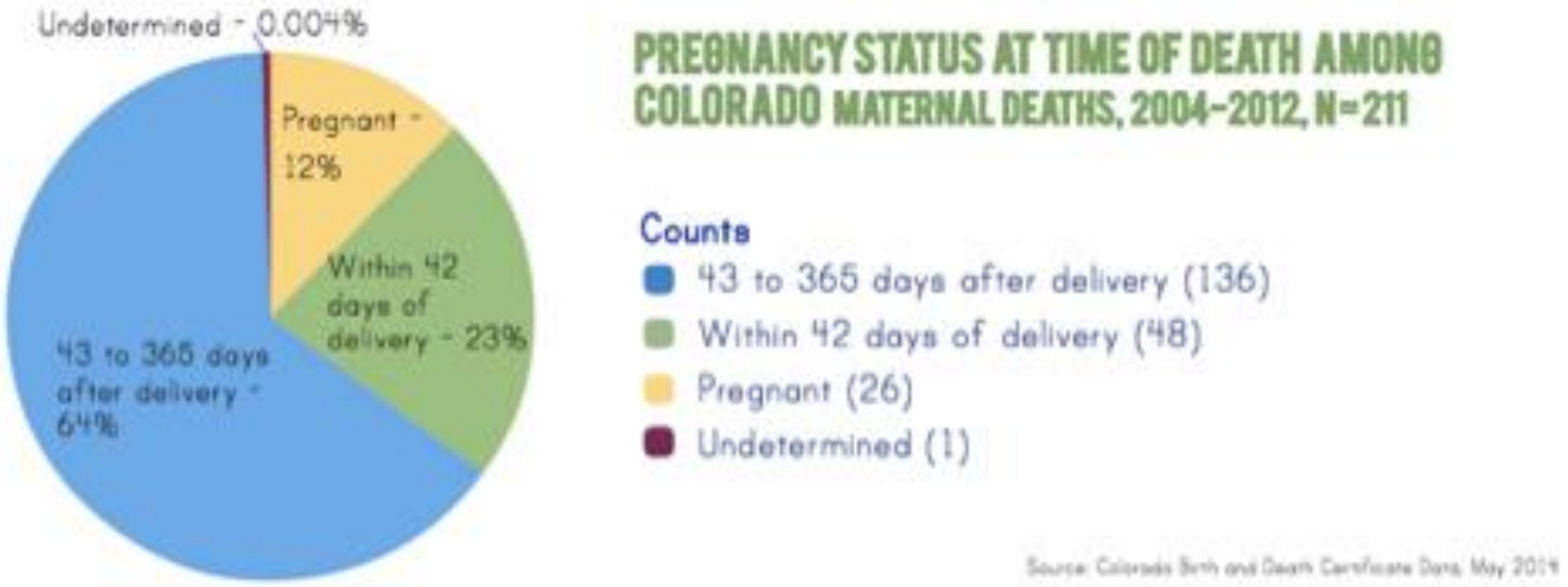
most common cause of death. 80% occurring >60 days postpartum

- Virginia: 25% maternal deaths from 1997-2007
- related to substance use
- Alaska, California, Florida, Massachusetts, and North Carolina have also published data with substance use as a major factor in maternal mortality

Timing Is Everything

- Highest risk time for relapse and overdose: postpartum
- States without Medicaid expansion: pregnant women at risk for losing insurance coverage postpartum
- Funding for Special Connections tied to pregnancy episode, and not available for women who are postpartum, miscarry, or terminate
- “The Fourth Trimester” concept is a start

Timing is Everything



Priority Population?

Although many states identify pregnant women as a “priority population”, what does this mean for an individual woman in need?

- Pregnant women are more likely to need treatment with MAT (severe OUD)
- But no more likely to receive it (<20%)

PREGNANT AND NON-PREGNANT WOMEN WITH SUBSTANCE USE DISORDERS: THE GAP BETWEEN TREATMENT NEED AND RECEIPT

Mishka Terplan, MD, MPH[1], Erica J. McNamara, MPH[2], Margaret S. Chisolm, MD[1]

Journal of Addictive Diseases, 31:342–349, 2012

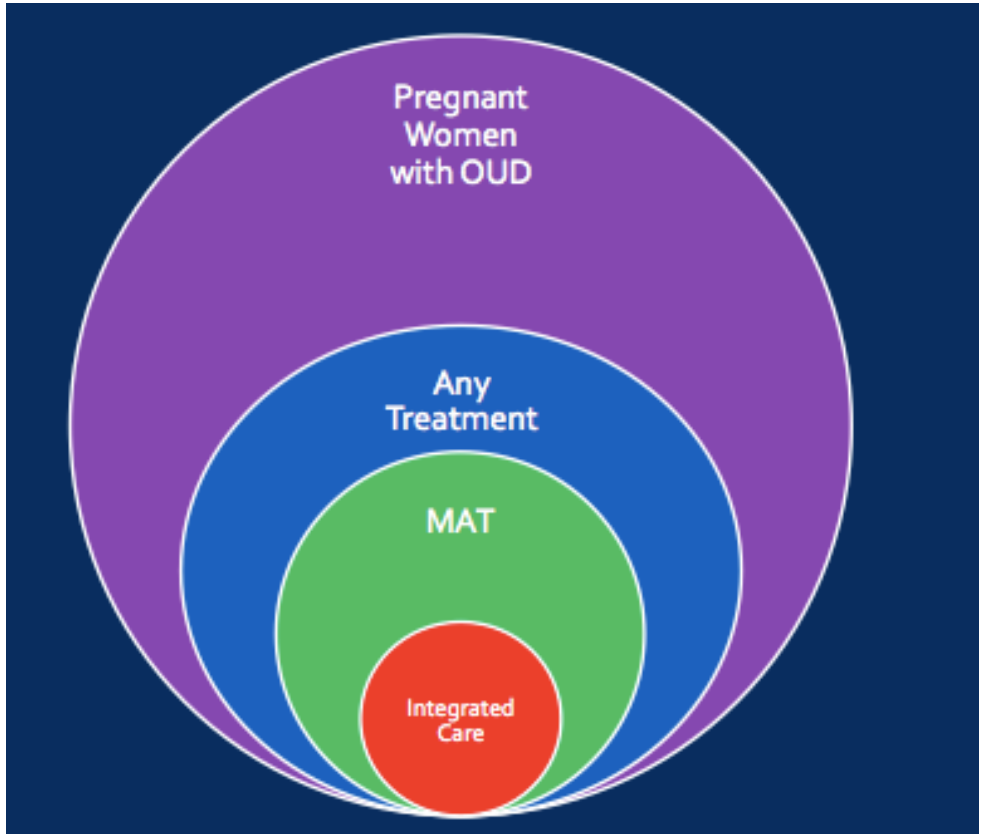
Policy	Number of States
Substance Use Considered Child Abuse	24+DC
Substance Use Grounds for Civil Commitment	3
Mandatory Reporting	23+DC
Targeted Programs for Pregnant Women	19
Pregnant Women Given Priority Access	17+DC
Pregnant Women Protected from Discrimination	9

Guttmacher Institute April 1 2017

Future Needs: Integration of Services

Treatment models exist: and work!

Comprehensive, integrated services are needed for pregnant women—but not only for time-limited event of pregnancy, and should include:
-substance use treatment/MAT
-peripartum medical care
-mental health care
-parenting support/child care services
-reproductive health/contraception support
-legal, housing, resource support
-trauma-informed, gender specific care



Terplan ASAM Presentation 2017

Models for Care

- Integrated Models are out there, but we lack a truly comprehensive national system:
  - Kaiser Early Start-California
  - Center for Addition and Pregnancy-Maryland
  - UNC Horizons Program-North Carolina
  - VCU Health Obstetrical Addiction Program
  - Milagro Clinic-New Mexico
  - CUPW Program- Seattle, Washington
  - Women and Family Services- Denver, CO
    - OB/Family Medicine, SUD, corrections, psychiatry, pediatrics

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FOR LIFE'S JOURNEY

Future Needs

- Research to expand options for MAT in pregnancy: naltrexone?
- Further collaborative efforts toward providing reproductive health care and substance use treatment co-located/integrated
- Continued policy reform and legislation that promotes treatment of addiction as a disease, not a defect that needs punitive correction—including substance use in pregnancy

Thank You!

Kaylin.Klie@ucdenver.edu

References

ACOG Committee Opinion No 711: Opioid Use and Opioid Use Disorder in Pregnancy; August 2017

Benningfield MM, Dietrich MS, Jones HE, et al. Opioid Dependence during Pregnancy: Relationships of Anxiety and Depression Symptoms to Treatment Outcomes. Addiction (Abingdon, England). 2012;107(0 1):74-82. doi:10.1111/j.1360-0443.2012.04041.x.

Jones HE, Martin PR, Heil SH, et al. Treatment of Opioid Dependent Pregnant Women: Clinical and Research Issues. Journal of substance abuse treatment. 2008;35(3):245-259. doi:10.1016/j.jsat.2007.10.007

Substance Abuse and Mental Health Services Administration. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Terplan M, Kennedy-Hendricks A, Chisolm MS. Prenatal Substance Use: Exploring Assumptions of Maternal Unfitness. Substance Abuse: Research and Treatment. 2015;9(Suppl 2):1-4. doi:10.4137/SART.S23328.

Martin CE, Longinaker N, Terplan M. Recent trends in treatment admissions for prescription opioid abuse during pregnancy. Journal of substance abuse treatment. 2015;48(1):37-42. doi:10.1016/j.jsat.2014.07.007.

References

[3] Pregnancy-Associated Maternal Death in Virginia, 1999-2001. Virginia Department of Health, Office of the Chief Medical Examiner. Retrieved on March 9, 2015 at: http://www.vdh.virginia.gov/medExam/pdfs/MMRT9901-FINAL.pdf

[4] Pregnancy-Associated Mortality in Alaska, 2000-2011. Department of Health and Social Services, http://www.epi.alaska.gov/bulletins/docs/b2013_17.pdf
Division of Public Health. State of Alaska Epidemiology Bulletin (17); July 9, 2013. Retrieved on March 9, 2015 at: http://www.epi.alaska.gov/bulletins/docs/b2013_17.pdf

[5] Wolfe EL, Davis T, Guydish J, Delucchi KL. Mortality risk associated with perinatal drug and alcohol use in California. Journal of Perinatology 2005;25:93-100.

[6] Hardt N, Wong TD, Burt MJ, Harrison R, Winter W, Roth J. Prevalence of prescription and illicit drugs in pregnancy-associated non-natural deaths of Florida Mothers, 1999-2005. Journal of Forensic Sciences 2013;58:1536-1541.

[7] Maternal Mortality and Morbidity Review in Massachusetts, In Brief: A Guide for Safe Motherhood. Massachusetts Department of Public Health. May 2002. Retrieved on March 9, 2015 at: http://www.mass.gov/eohhs/docs/dph/com-health/prego-newborn/safe-mom-preg02rg.pdf

[8] Meyer, RE, Ha5per, MA. Maternal deaths attributable to violence and injury in North Carolina. NC Med J 2010;71(6):581-583. Retrieved on March 9, 2015 at: http://www.ncmedicaljournal.com/archives/?maternal-deaths-attributable-to-violence-and-injury-in-north-carolina

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THE INDIAN HEALTH SERVICE:
IMPROVING ACCESS TO TREATMENT FOR OPIOID USE DISORDER

IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE Committee)

CDR Kailee Fretland, PharmD, BCPS
Acting Pharmacy Director, Red Lake IHS
IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE), Sub-Committee Lead Medication Assisted Treatment

Mission

To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level

Overview

- Serve members of **573** federally recognized Tribes
- **2.3 million** American Indians and Alaska Natives (AI/AN)
- Annual Patient Services (Tribal and IHS facilities)
  - Inpatient Admissions: 39,367
  - Outpatient visits: 13,811,171

- 45 Hospitals
- 335 Health Centers
- 134 Alaska Village Clinics
- 83 Health Stations
- 43 Urban Programs

National Institute on Minority Health and Health Disparities
Advancing the Science of Minority Health and Health Disparities

NIMHD Minority Health and Health Disparities Research Framework

Adapted to reflect historic and socio-cultural influences for American Indian and Alaska Native Nations

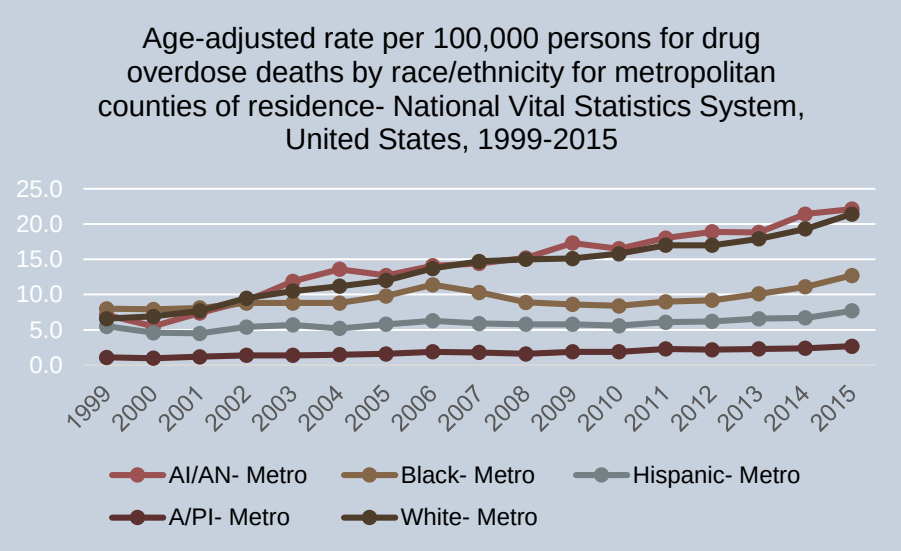
Spero M. Manson, Ph.D., University of Colorado Denver's Anschutz Medical Center

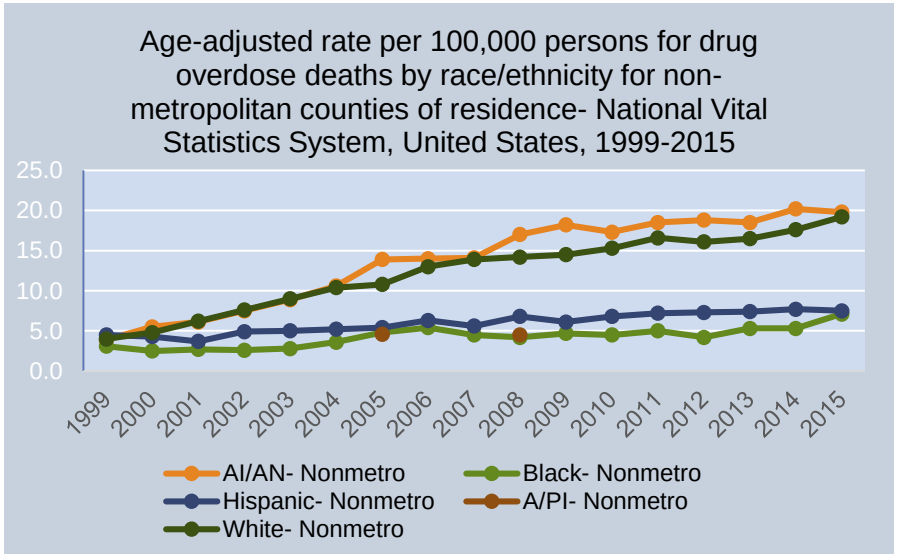
Domains of Influence	Levels of Influence: Individual	Interpersonal	Community	Societal
Biological	Biological Vulnerability and Mechanisms ***Metabolic Syndrome***	Caregiver-Child Interaction ***Out-of-Indian Home Adoption*** ***Grandparent / Child Rearing*** Family Microbiome	Community Illness Exposure ***Exxon Valdez Oil Spill*** ***Gold King Mine Waste Water Spill*** Herd Immunity	Sanitation Immunization Pathogen Exposure ***Uranium and Coal Mining***
Behavioral	Health Behaviors ***External Locus of Control*** ***Drug Preferences*** Coping Strategies ***Resilience*** ***Spirituality*** ***Community-mindedness***	Family Functioning ***Extended Family*** School / Work Functioning	Community Functioning ***Collective Resilience*** ***Cultural Forms of Social Control*** ***Language Revitalization***	Policies and Laws ***Termination and Relocation 1953*** ***Indian Self-Determination & Education Assistance Act 1975*** ***American Indian Religious Freedom Act 1978***
Physical/ Built Environment	Personal Environment ***Subsistence Activities***	Household Environment ***HUD Housing Clusters*** School / Work Environment ***Boarding School Education***	Community Environment ***Natural Resources*** Community Resources ***Gaming*** ***Tribal Commercial Enterprise***	Societal Structure ***Matrilineal, Patrilineal, & Bilateral Systems of Descent and Jural Authority***
Sociocultural Environment	Sociodemographics ***Per Capita Payments*** Limited English Cultural Identity Response to Discrimination ***Historical Trauma***	Social Networks Family / Peer Norms ***Traditional Men's / Women's Societies*** Interpersonal Discrimination ***Stereotyped Threat*** ***Racial Prejudice***	Community Norms ***Progressives and Traditionalists*** ***Alcohol Prohibition*** Local Structural Discrimination ***Border town Economics***	Societal Norms ***Hollywood Indian*** ***Firewater Myth*** Societal Structural Discrimination ***Sports Mascots***
Healthcare System	Insurance Coverage Health Literacy Treatment Preferences	Patient-Clinician Relationship ***Implicit Bias*** Medical Decision-Making ***Cultural Construction of Health***	Availability of Health Services ***Direct, Contracted, and Compacted Services*** Safety Net Services	Quality of Care Healthcare Policies ***Reimbursement of Tribal Healing Ceremonies*** ***Indian Health Care Reauthorization Act***
Health Outcomes	**Individual Health**	**Family/Organizational Health**	**Community Health**	**Population Health**

Lifecourse

Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority
Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region

Drug-Related Death Rates



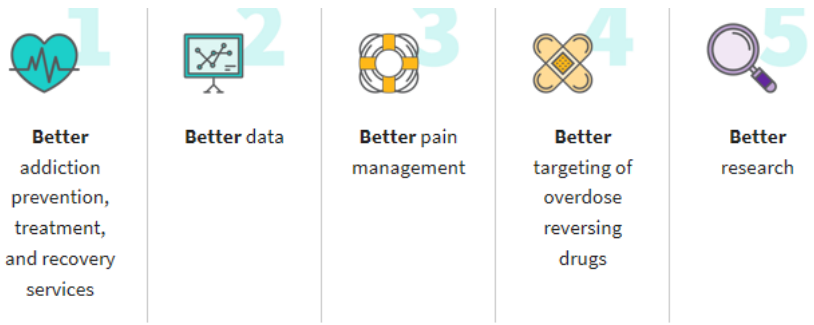


Mack KA, et. al., Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in metropolitan and Nonmetropolitan Areas- United States, *MMWR*, Vol 66 (19) October 20, 2017, pp 1-12.

HHS Opioid Strategy

HHS 5-Point Strategy To Combat the Opioid Crisis

1. **Access: Better Prevention, Treatment and Recovery Services**
2. Data: Better Data on the Opioid Epidemic
3. Pain: Better Pain Management
4. Overdoses: Better Targeting of Overdose Reversing Drugs
5. Research: Better Research on Pain and Addiction



CARE MODELS AND CHALLENGES FOR INCREASING ACCESS TO OUD TREATMENT

IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE)

- IHS Committee created in March 2017
- Evolved out of the Prescription Drug Abuse Workgroup
- Membership: physicians, pharmacists, behavioral health providers, nursing, epidemiologists, and injury prevention
- Goals:
  - Promote appropriate and effective pain management
  - Reduce overdose deaths from heroin and prescription opioid misuse
  - Improve access to culturally appropriate treatment

Improve Access to Culturally Appropriate Treatment

Medication Assisted Treatment (MAT)

1. Increase access to FDA approved MAT
2. Expand and share best and promising practices surrounding MAT
3. Encourage development of local action plans to coordinate access to services
4. Encourage integrated programs that include behavior health, traditional healing and cultural practices
5. Guidance for AI/AN pregnant women and women of childbearing age with OUD

Improve Access to Culturally Appropriate Treatment

Traditional medicine *is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (World Health Organization).”*

Improve Access to Culturally Appropriate Treatment

Workforce Development

1. Expand staff capacity to support MAT Services
   - IHS Essential Training on Pain and Addiction (ETPA)
   - IHS Chronic Pain and Opioid Management TeleECHO Clinic
   - ASAM supported training material
2. Trauma Responsive Care
3. Early Identification: expand screening for SUD, intervention and referral to treatment

Education and Awareness

1. Provide patient and community education to increase awareness and reduce stigma

Improve Access to Culturally Appropriate Treatment

Challenges

1. Remote Location
   - Majority of IHS and AI/AN populations are in rural locations, considered hardship sites or identified as health professional shortage areas (HPSA)
   - Internet Eligible Controlled Substance Prescriber policy
2. Data Extraction
   - Barriers to extract “real-time” data on Opioid related metrics

Strengths

1. Resiliency
2. Partnerships with Tribal Communities

Resources

IHS Websites

- Pain and Opioid Use Disorder www.ihs.gov/opioids/
  - Combined website that includes resources and tools in regards to:
    - Pain Management
    - Opioid Dependence Management
    - The HOPE Committee
- TBHCE https://www.ihs.gov/telebehavioral/seminararchive/

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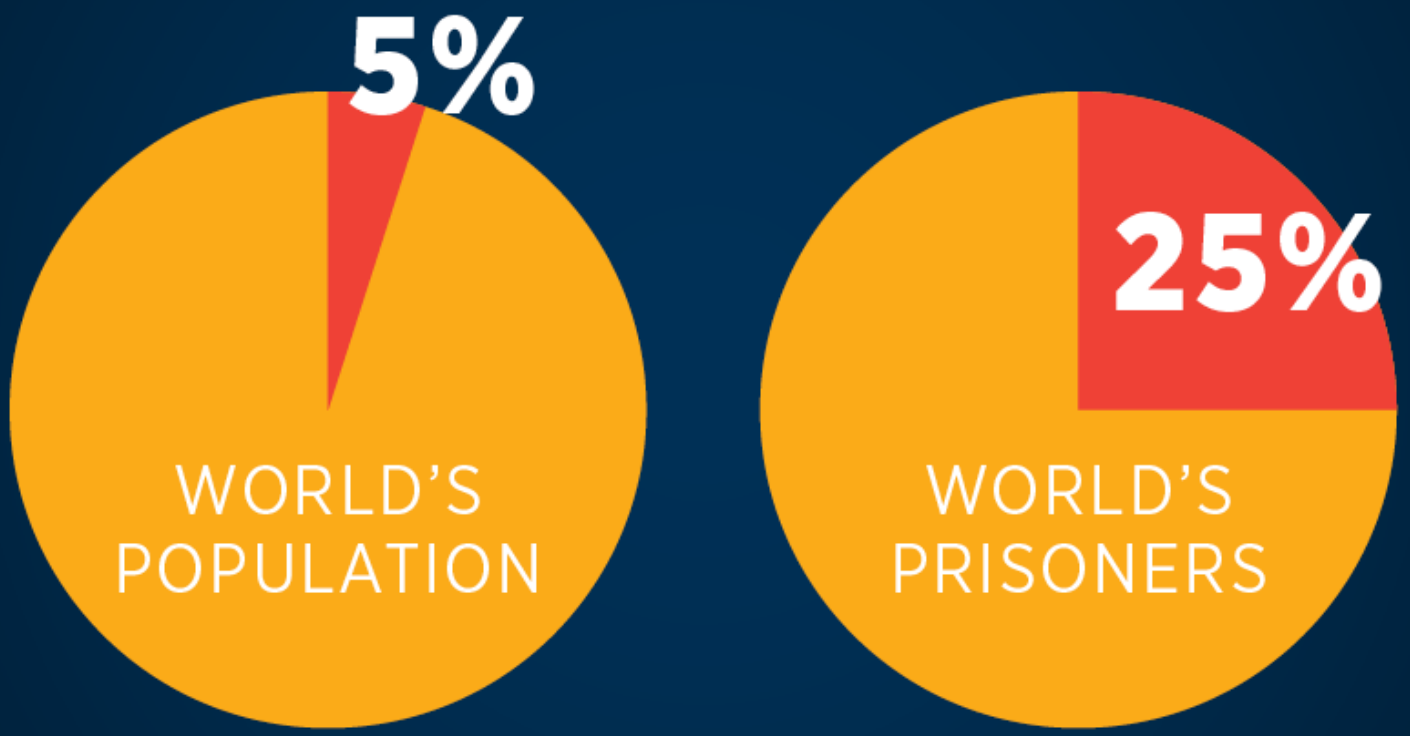
RIDOC BASED MAT FOR OPIATE USE DISORDERS

Jennifer Clarke MD MPH FACP
Medical Program Director RI DOC
Associate Professor of Medicine Brown University

Financial Disclosures

- I have no financial disclosures

THE UNITED STATES HAS:



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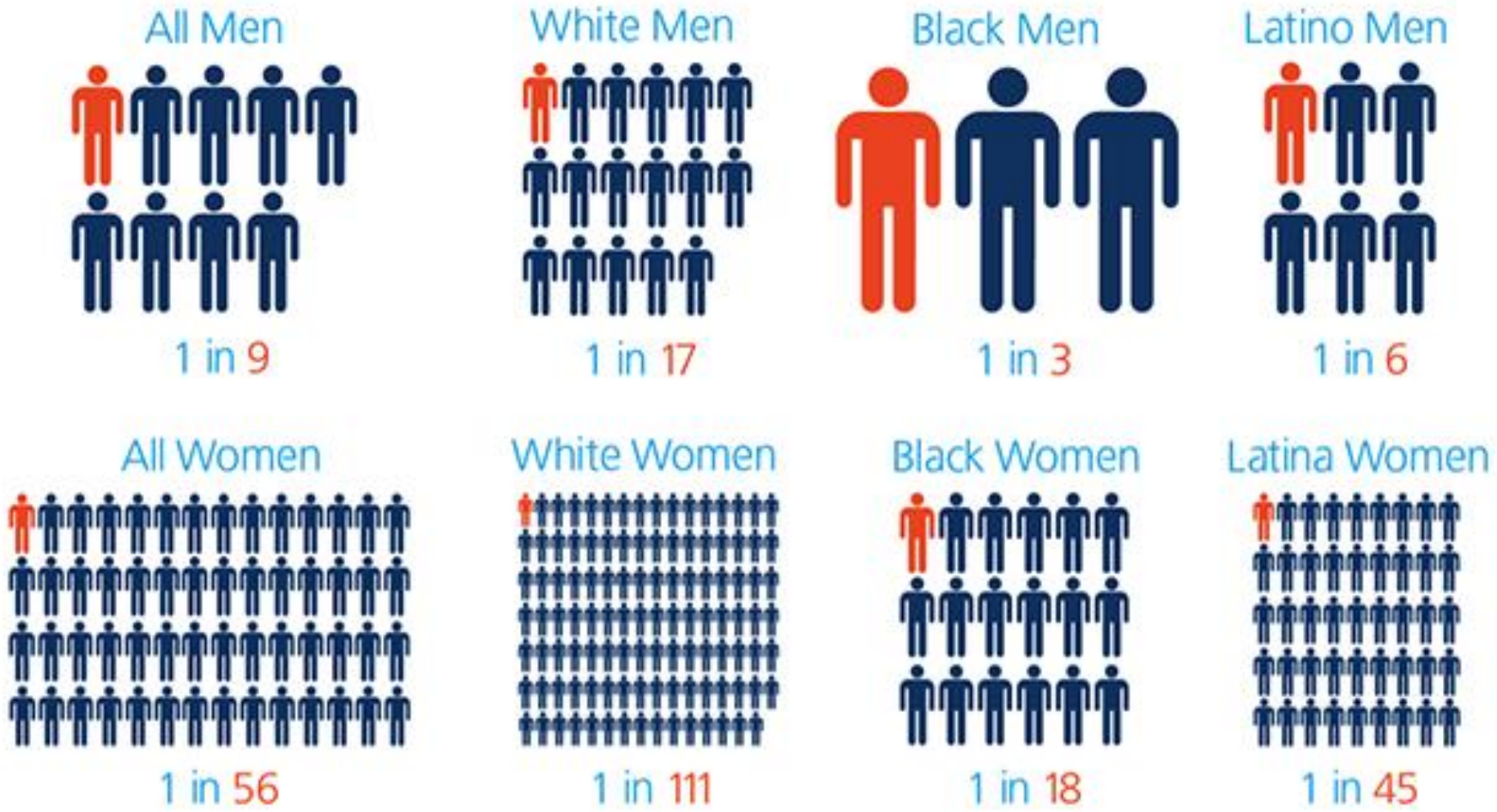
Lifetime Likelihood of Imprisonment



Source: Bonczar, T. (2003). *Prevalence of Imprisonment in the U.S. Population, 1974–2001.* Washington, D.C.: Bureau of Justice Statistics

THE SENTENCING PROJECT

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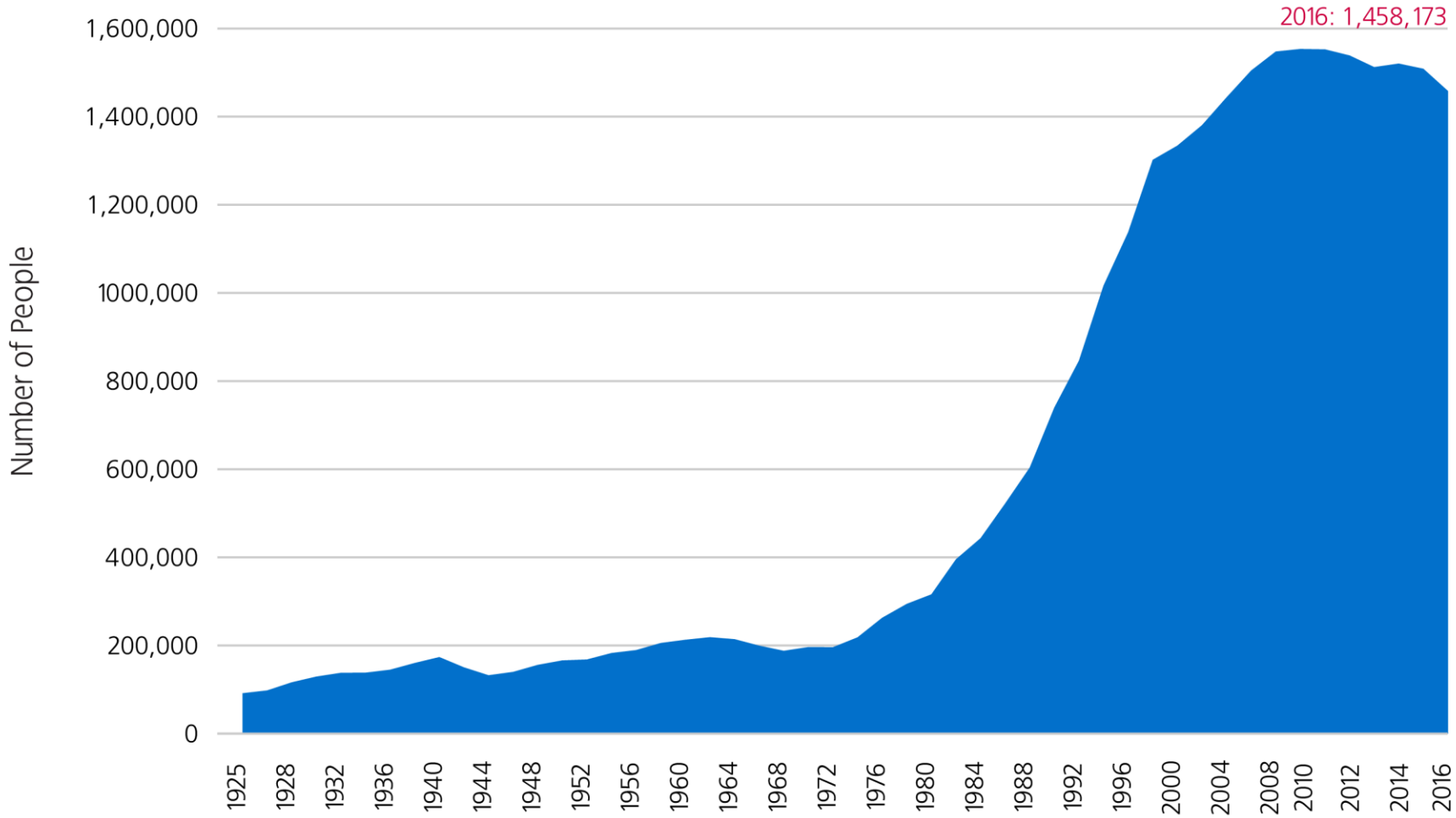
THE SENTENCING PROJECT

U.S. State and Federal Prison Population, 1925-2016



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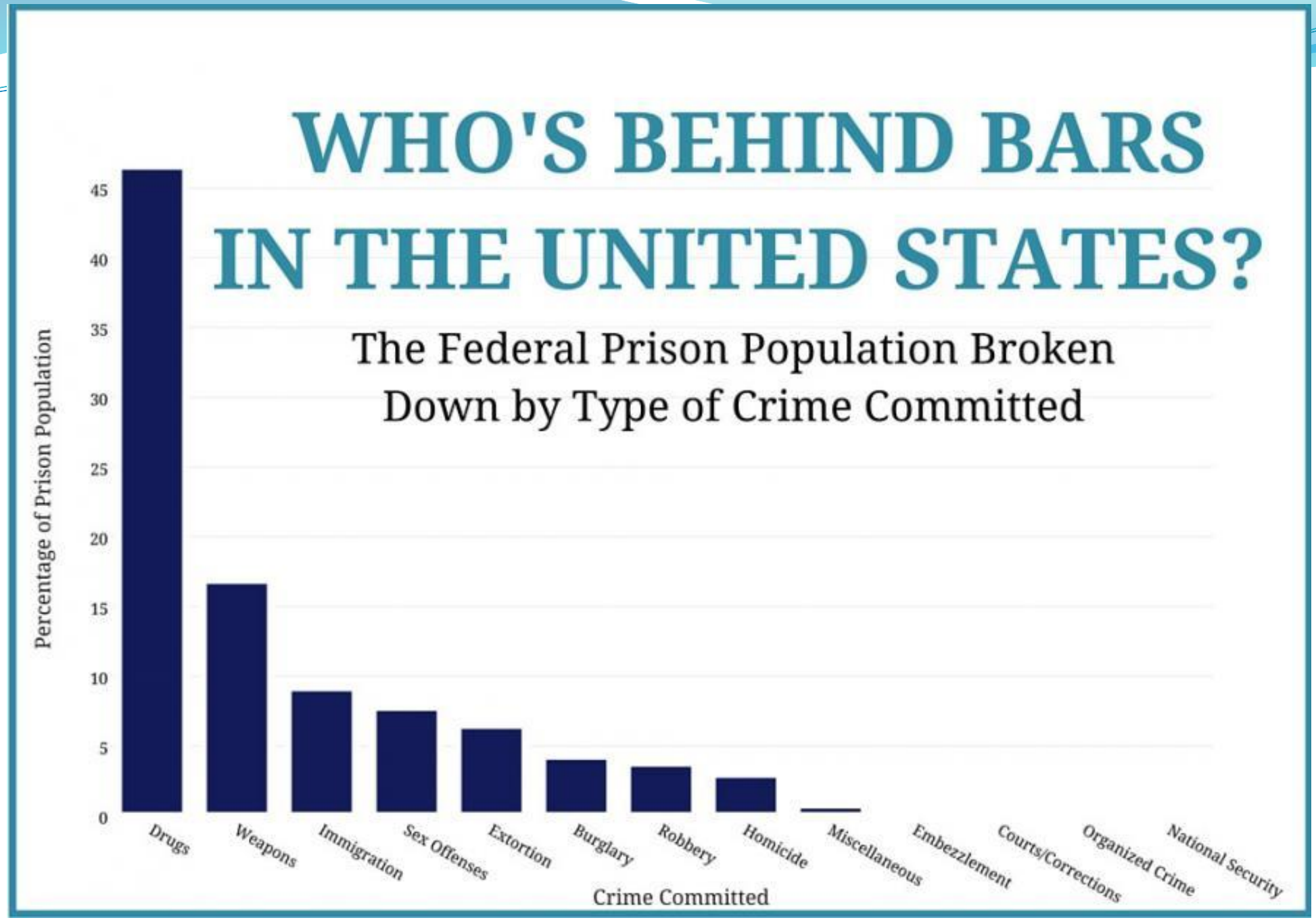
WHO'S BEHIND BARS IN THE UNITED STATES?



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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Release from Prison — A High Risk of Death for Former Inmates

Ingrid A. Binswanger, M.D., Marc F. Stern, M.D., Richard A. Deyo, M.D., Patrick J. Heagerty, Ph.D., Allen Cheadle, Ph.D., Joann G. Elmore, M.D., and Thomas D. Koepsell, M.D.

ABSTRACT

BACKGROUND

The U.S. population of former prison inmates is large and growing. The period immediately after release may be challenging for former inmates and may involve substantial health risks. We studied the risk of death among former inmates soon after their release from Washington State prisons.

METHODS

We conducted a retrospective cohort study of all inmates released from the Washington State Department of Corrections from July 1999 through December 2003. Prison records were linked to the National Death Index. Data for comparison with Washington State residents were obtained from the Wide-ranging OnLine Data for Epidemiologic Research system of the Centers for Disease Control and Prevention. Mortality rates among former inmates were compared with those among other state residents with the use of indirect standardization and adjustment for age, sex, and race.

RESULTS

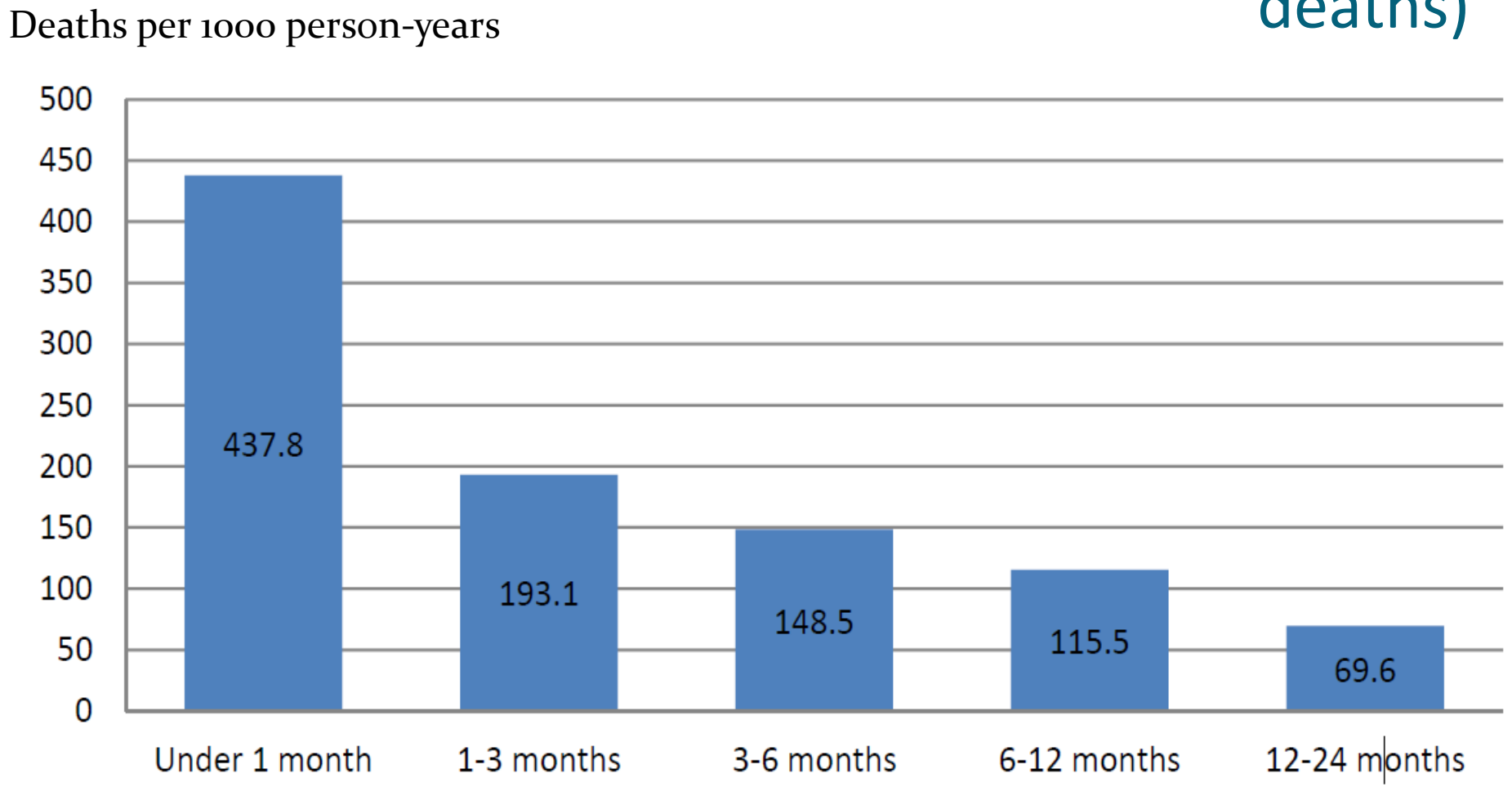
Of 30,237 released inmates, 443 died during a mean follow-up period of 1.9 years. The overall mortality rate was 777 deaths per 100,000 person-years. The adjusted risk of death among former inmates was 3.5 times that among other state residents (95% confidence interval [CI], 3.2 to 3.8). During the first 2 weeks after release, the risk of death among former inmates was 12.7 (95% CI, 9.2 to 17.4) times that among other state residents, with a markedly elevated relative risk of death from drug overdose (129; 95% CI, 89 to 186). The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide.

CONCLUSIONS

Former prison inmates were at high risk for death after release from prison, particularly during the first 2 weeks. Interventions are necessary to reduce the risk of death after release from prison.

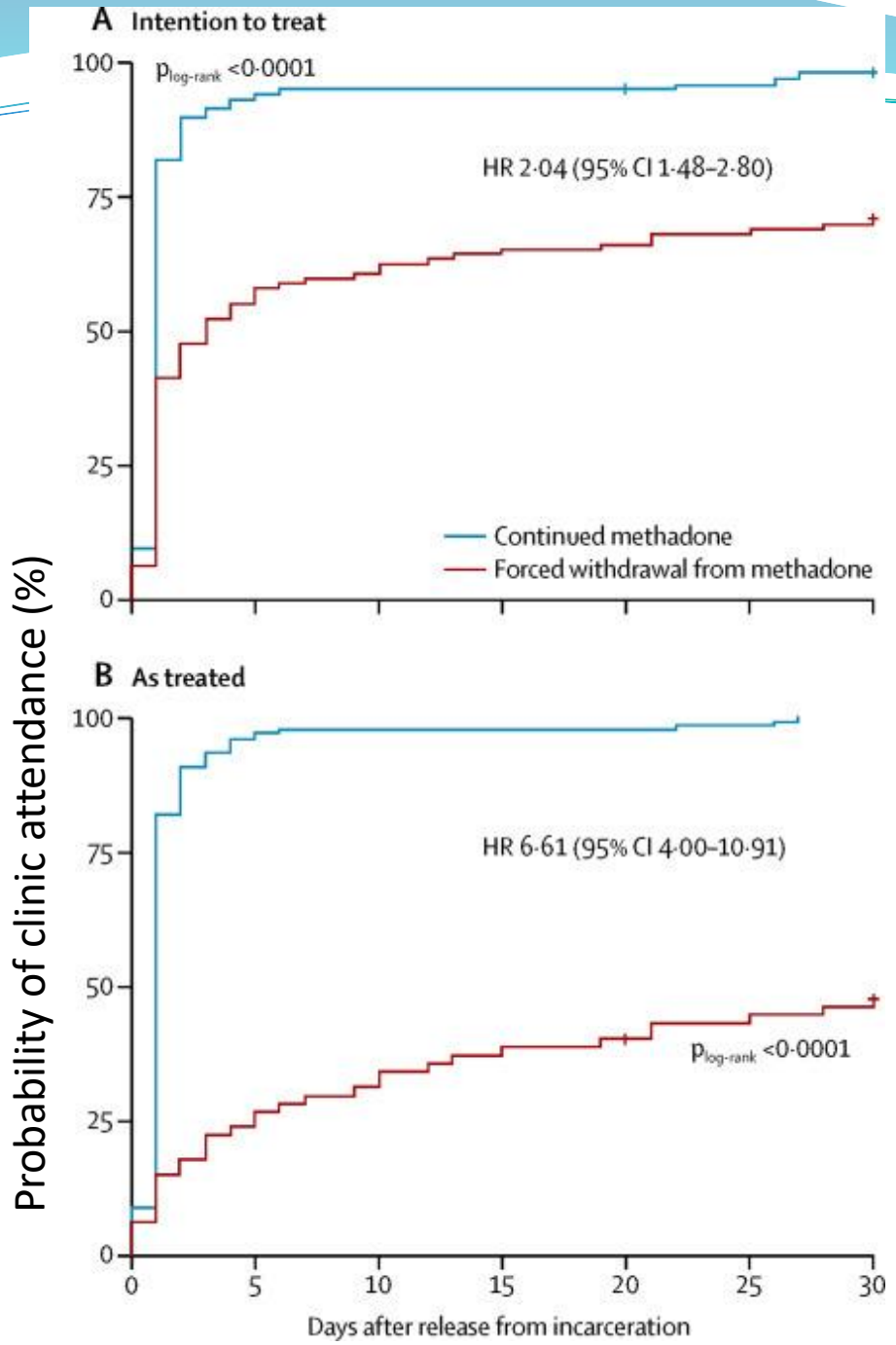
Two weeks after release, the risk of death from an overdose is 129 times that of the community

Opioid Deaths by person-years since being released from a MA state prison. 2013-2014 (121 deaths)



Everyone else (non-former state prison inmates): 15.4 (2071 deaths)

Courtesy of Dr. Thomas Lincoln

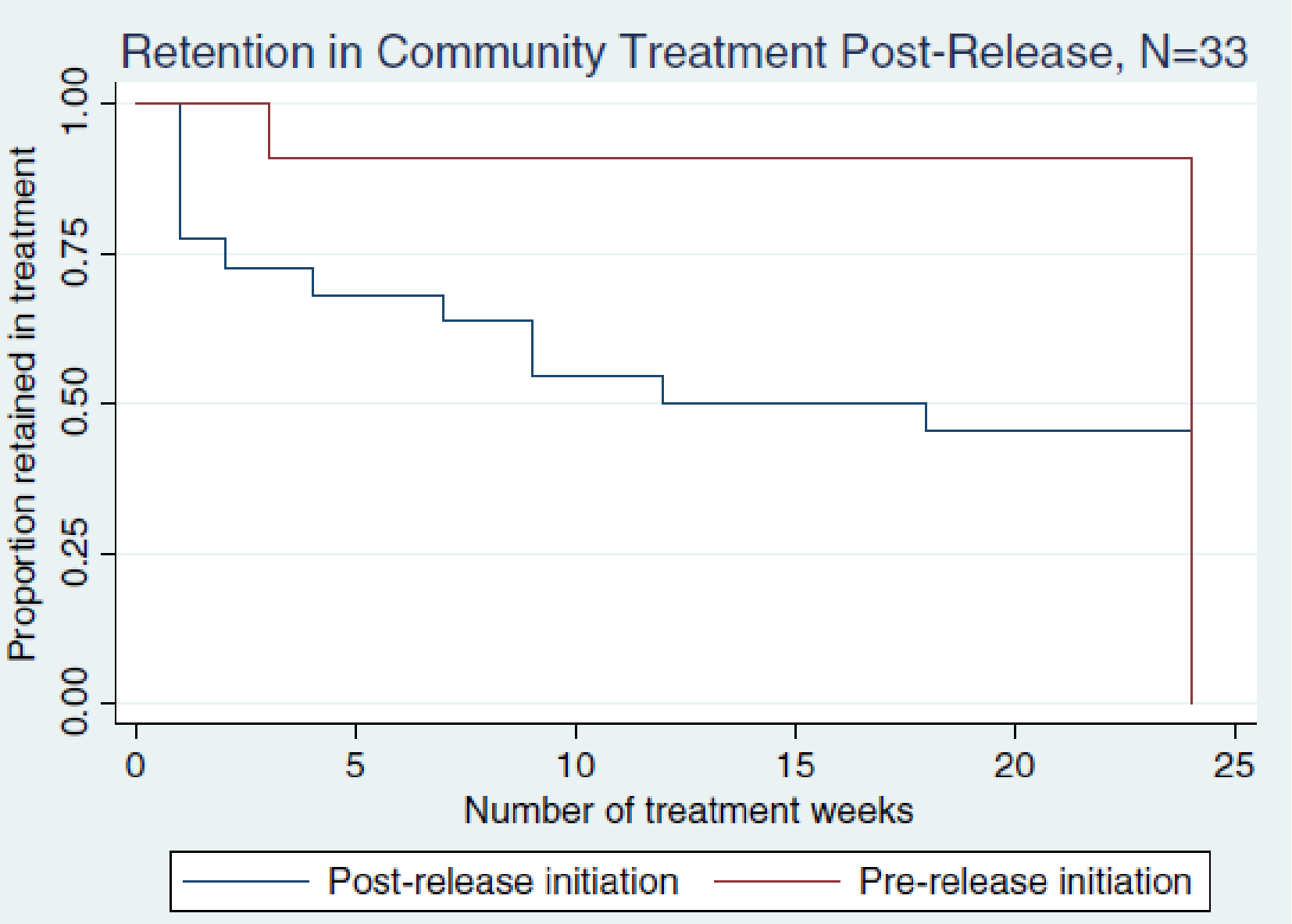


Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial.

JD Rich et al. Lancet 2015.

Figure 2. Probability of attending a methadone clinic in
(A) intention-to-treat and
(B) as-treated populations at 1 month follow-up after release from incarceration.

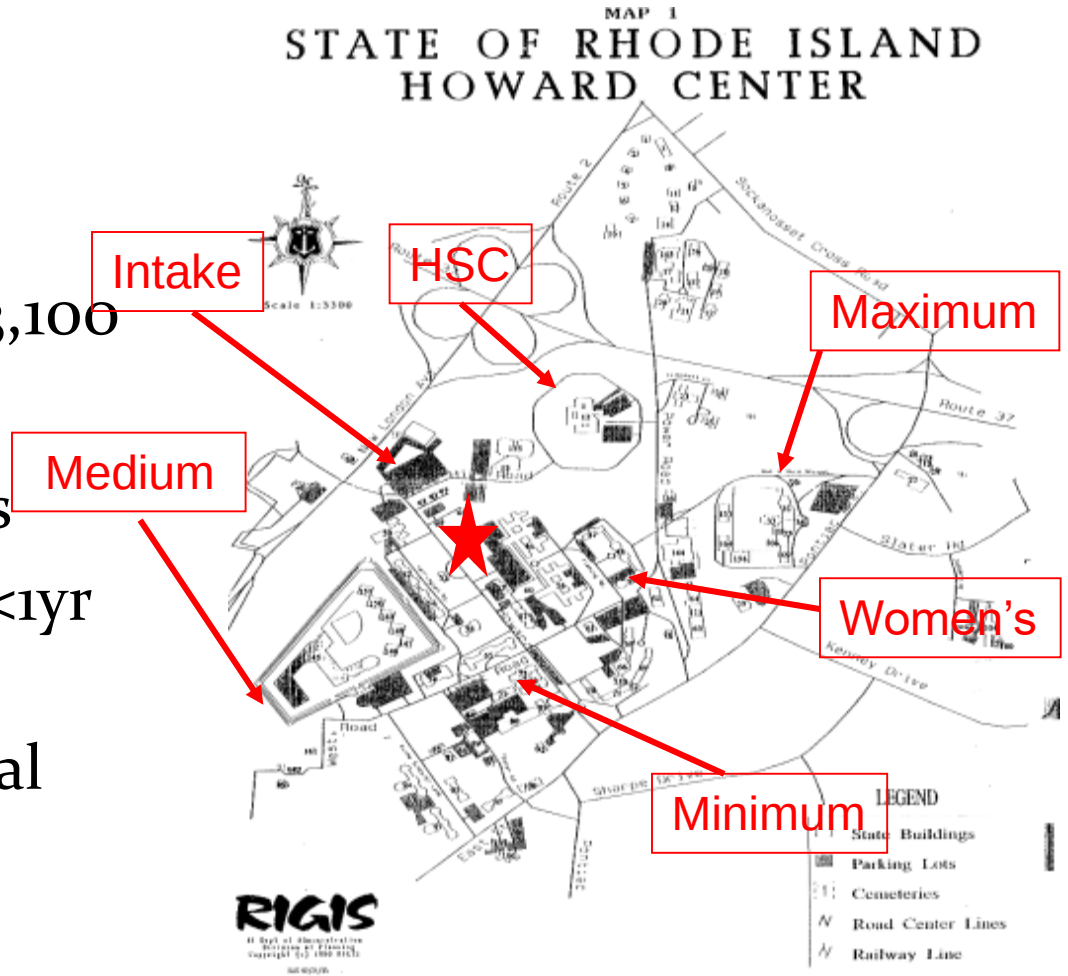
Buprenorphine begun before or after release RIDOC.



Zaller et al. J Subst Ab Treat 2013

RIDOC Overview

- Unified Correctional system
- 6 Facilities
- Average daily census 3,100
- FY 2015
  - 12, 650 commitments
  - Large percentage of <1yr sentence
  - Monthly awaiting trial census 600-700

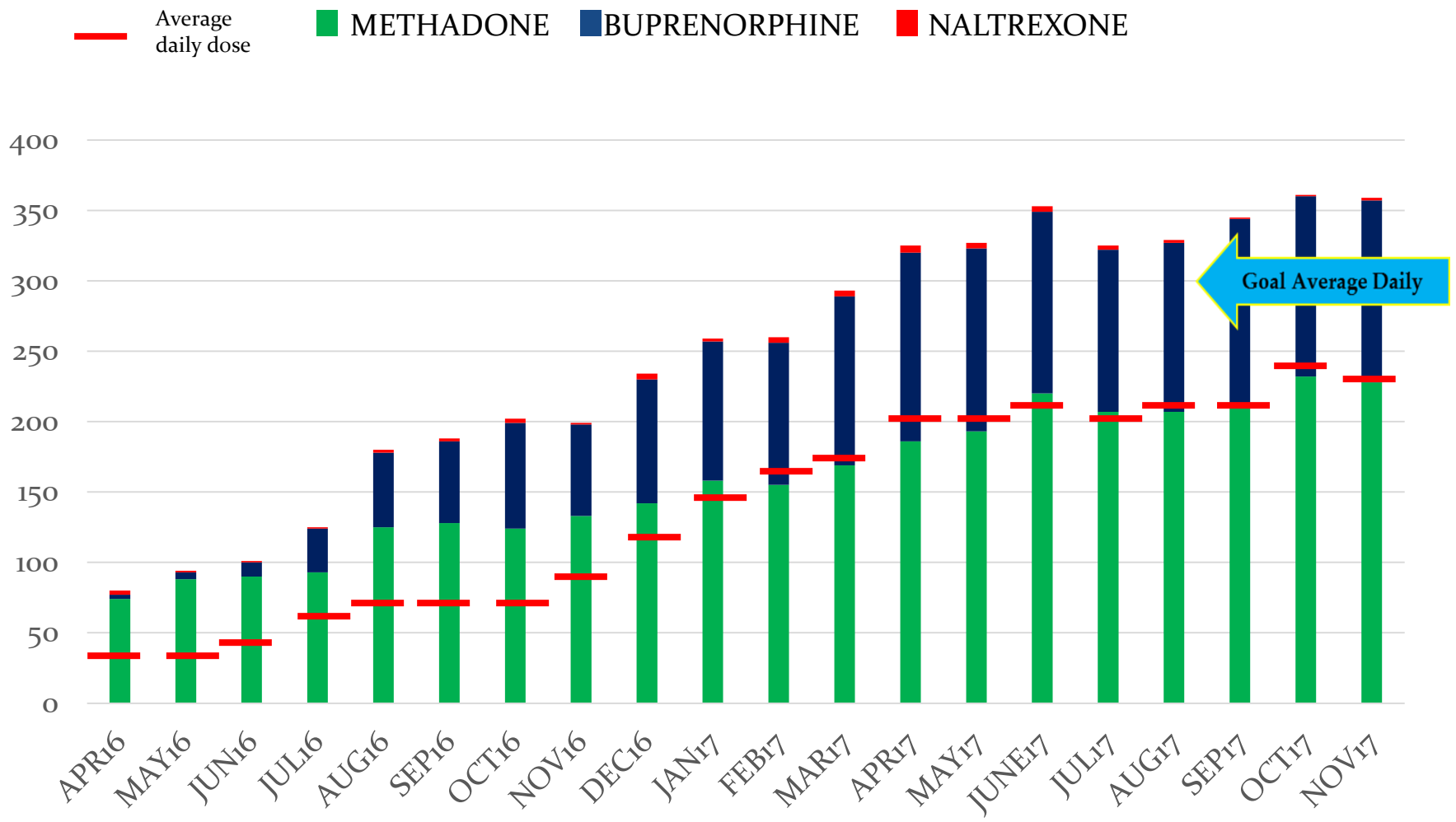


http://www.doc.ri.gov/administration/planning/docs/FY15%20Population%20Report.pdf

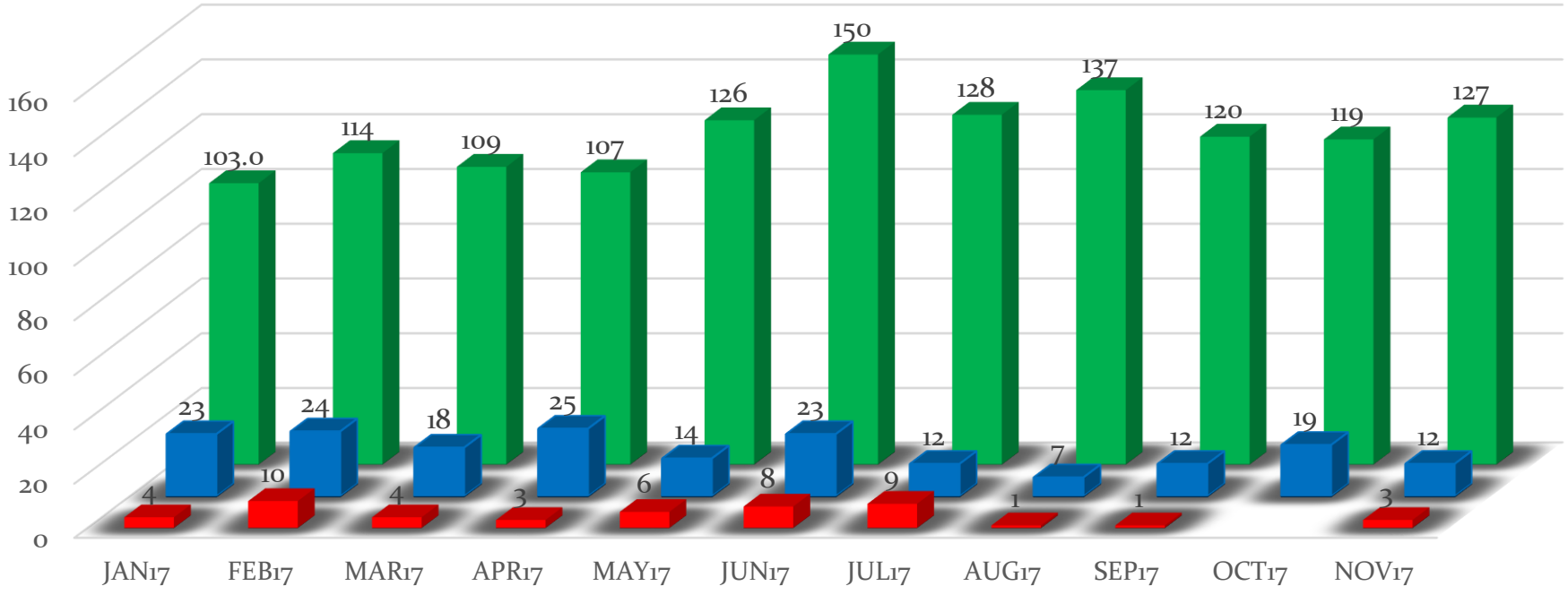
RI DOC MAT

- History
  - Methadone maintenance only for pregnant women
  - Methadone withdrawal for the past 20 years
- Origin
  - Nov 2015 the Task Force developed a strategic plan for the Governor
  - The long term goal is “To reduce opioid overdose deaths by one-third within three years.”
- Program Goals:
  - MAT if appropriate for 3 populations:
    1. Continue MAT for 12 months
    2. Initiate MAT upon commitment
    3. Initiate MAT prior to release

MAT Medication Type



Released to Community per Month



CODAC onsite should eliminate those discharged before receiving MAT

Elective Discontinuation Discharged before receiving MAT Total

MAT After ReleaseN=1339 releases

Disposition	MEDICATION			Total
	METHADONE	NALTREXONE	BUPRENORPHINE	
Continued from community	481	1	258	740 (55%)
Induction at commitment	271	8	216	495 (37%)
Pre-release induction	35	12	57	104 (8%)
Total	787 (59%)	21 (2%)	531 (39%)	1339

MAT Community Follow-up

MAT after Release	Disposition			Total
	Continued	Induction	Pre-release	
No	46 (6.2%)	318 (64.2%)	48 (46.2%)	412 (30.8%)
Yes	694 (93.8%)	177 (35.8%)	56 (53.8%)	927 (69.2%)
Total	740	495	104	1339

- N=74 (5.5%) additional releases received MAT at CODAC post release but were not in BHOLD or PMP.
- Missing people in treatment out of state
- Naltrexone poorly documented

JAMA Psychiatry

- Mortality due to opioid overdose in RI
- January-June 2016 vs. January-June 2017
- Compared opioid overdose mortality general population to individuals with an incarceration in the 12 months prior to death

Decedents: Recent Incarceration	First 6 Months 2016	First 6 Months 2017	Decrease
YES	26	9	17 (65%)
NO	153	148	5 (3%)
TOTAL	179	157	22 (12%)

Relative Risk Reduction= 61%

((9/157)-(26/179))/(26/179)

Challenges / RI Advantages

- Community Vendor
  - Inmates become patients of the community provider upon enrollment
  - Community vendor has 7 sites throughout the state so seamless community transition
- Unified System
  - Unless a patient is transferred out of state we don't need to worry about MAT being stopped if transferred to another facility that does not offer MAT
- One Campus/ Small state
  - Continuity of care through out incarceration
  - No one is more than 15 miles from an MAT provider in the community

QUESTIONS?

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Duke
MARGOLIS CENTER
for Health Policy

Session III—
Opportunities and Barriers to Expand Treatment for Vulnerable Populations

Moderator: Regina LaBelle, Duke-Margolis Center for Health Policy

Panelists:

Marc Fishman, Maryland Treatment Centers

Kaylin Klie, University of Chicago

Kailee Fretland, Indian Health Service

Jennifer Clarke, Rhode Island Department of Corrections

Join the conversation at **#OUDTreatment #EndTheStigma**