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

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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
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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
• 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 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

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental drug overdose</td>
<td>37</td>
</tr>
<tr>
<td>Motor vehicle crash</td>
<td>36</td>
</tr>
<tr>
<td>Suicide</td>
<td>26</td>
</tr>
<tr>
<td>Cardiovascular conditions</td>
<td>22</td>
</tr>
<tr>
<td>Homicide</td>
<td>15</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>12</td>
</tr>
<tr>
<td>Infection</td>
<td>10</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>10</td>
</tr>
<tr>
<td>Neurologic</td>
<td>9</td>
</tr>
<tr>
<td>Cancer</td>
<td>9</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>7</td>
</tr>
<tr>
<td>Amniotic Fluid Embolism</td>
<td>7</td>
</tr>
<tr>
<td>Other non-cardiovascular conditions*</td>
<td>7</td>
</tr>
<tr>
<td>Other**</td>
<td>4</td>
</tr>
</tbody>
</table>

Cardiovascular conditions include:
- Cardiomyopathy (12)
- Other Cardiac Conditions (10)

*Other non-cardiovascular conditions include renal, hematologic and gastrointestinal conditions.
**Data suppressed due to low numbers.

Source: Colorado Death Certificate Data, May 2014
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.
- 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

**Pregnancy Status at Time of Death Among Colorado Maternal Deaths, 2004-2012, N=211**

Count:
- 43 to 365 days after delivery (136)
- Within 42 days of delivery (48)
- Pregnant (26)
- Undetermined (1)

Source: Colorado Birth and Death Certificate Data, May 2014
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%)
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
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
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
ACOG Committee Opinion No 711: Opioid Use and Opioid Use Disorder in Pregnancy; August 2017


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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**
<table>
<thead>
<tr>
<th>Domains of Influence</th>
<th>Levels of Influence</th>
<th>Societal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
<td></td>
<td>Sanitation Immunization Pathogen Exposure Uranium and Coal Mining</td>
</tr>
<tr>
<td>Biological Vulnerability and Mechanisms Metabolic Syndrome</td>
<td>Caregiver-Child Interaction Out-of-Indian Home Adoption Grandparent / Child Rearing Family Microbiome</td>
<td>Community Illness Exposure Exxon Valdez Oil Spill Gold King Mine Waste Water Spill Herd Immunity</td>
</tr>
<tr>
<td><strong>Behavioral</strong></td>
<td></td>
<td>Societal Structure Matrilineal, Patrilineal, &amp; Bilateral Systems of Descent and Jural Authority</td>
</tr>
<tr>
<td>Personal Environment Subsistence Activities</td>
<td>Household Environment HUD Housing Clusters School / Work Environment Boarding School Education</td>
<td>Community Environment Natural Resources Community Resources Gaming Tribal Commercial Enterprise</td>
</tr>
<tr>
<td><strong>Physical/ Built Environment</strong></td>
<td></td>
<td>Societal Norms Hollywood Indian Firewater Myth Societal Structural Discrimination Sports Mascots</td>
</tr>
<tr>
<td>Sociodemographics Per Capita Payments Limited English Cultural Identity Response to Discrimination Historical Trauma</td>
<td>Social Networks Family / Peer Norms Traditional Men’s / Women’s Societies Interpersonal Discrimination Stereotyped Threat Racial Prejudice</td>
<td>Community Norms Progressives and Traditionalists Alcohol Prohibition Local Structural Discrimination Border town Economics</td>
</tr>
<tr>
<td><strong>Sociocultural Environment</strong></td>
<td></td>
<td>Quality of Care Healthcare Policies Reimbursement of Tribal Healing Ceremonies Indian Health Care Reauthorization Act</td>
</tr>
<tr>
<td>Healthcare System</td>
<td>Insurance Coverage Health Literacy Treatment Preferences</td>
<td>Patient-Clinician Relationship Implicit Bias Medical Decision-Making Cultural Construction of Health</td>
</tr>
<tr>
<td><strong>Health Outcomes</strong></td>
<td>Individual Health</td>
<td>Community Health</td>
</tr>
</tbody>
</table>

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

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
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/](http://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/seminar/archive/](https://www.ihs.gov/telebehavioral/seminar/archive/)
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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:

- 5% of the world’s population
- 25% of the world’s prisoners
Note: Prison data based on custody counts. Includes inmates held in privately operated facilities.

WHO'S BEHIND BARS IN THE UNITED STATES?

The Federal Prison Population Broken Down by Type of Crime Committed
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)

Deaths per 1000 person-years

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Deaths per 1000 person-years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 month</td>
<td>437.8</td>
</tr>
<tr>
<td>1-3 months</td>
<td>193.1</td>
</tr>
<tr>
<td>3-6 months</td>
<td>148.5</td>
</tr>
<tr>
<td>6-12 months</td>
<td>115.5</td>
</tr>
<tr>
<td>12-24 months</td>
<td>69.6</td>
</tr>
</tbody>
</table>

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

Courtesy of Dr. Thomas Lincoln
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

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

Average daily dose

- METHADONE
- BUPRENORPHINE
- NALTREXONE

Goal Average Daily
Released to Community per Month

CODAC onsite should eliminate those discharged before receiving MAT

- Elective Discontinuation
- Discharged before receiving MAT
- Total
### MAT After Release N=1339 releases

<table>
<thead>
<tr>
<th>Disposition</th>
<th>MEDICATION</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>METHADONE</td>
<td></td>
</tr>
<tr>
<td>Continued from community</td>
<td>481</td>
<td>740 (55%)</td>
</tr>
<tr>
<td>Induction at commitment</td>
<td>271</td>
<td>495 (37%)</td>
</tr>
<tr>
<td>Pre-release induction</td>
<td>35</td>
<td>104 (8%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>787 (59%)</td>
<td>1339</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NALTREXONE</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Continued from community</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Induction at commitment</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Pre-release induction</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21 (2%)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>BUPRENORPHINE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued from community</td>
<td>258</td>
<td></td>
</tr>
<tr>
<td>Induction at commitment</td>
<td>216</td>
<td></td>
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<tr>
<td>Pre-release induction</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>531 (39%)</td>
<td></td>
</tr>
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</table>
## MAT Community Follow-up

<table>
<thead>
<tr>
<th>MAT after Release</th>
<th>Disposition</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continued</td>
<td>Induction</td>
</tr>
<tr>
<td>No</td>
<td>46 (6.2%)</td>
<td>318 (64.2%)</td>
</tr>
<tr>
<td>Yes</td>
<td>694 (93.8%)</td>
<td>177 (35.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>740</td>
<td>495</td>
</tr>
</tbody>
</table>

- 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
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

<table>
<thead>
<tr>
<th>Decedents: Recent Incarceration</th>
<th>First 6 Months 2016</th>
<th>First 6 Months 2017</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>26</td>
<td>9</td>
<td>17 (65%)</td>
</tr>
<tr>
<td>NO</td>
<td>153</td>
<td>148</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>179</td>
<td>157</td>
<td>22 (12%)</td>
</tr>
</tbody>
</table>

Relative Risk Reduction = 61%

\[
\frac{((9/157)-(26/179))}{(26/179)}
\]
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?

Jennifer.Clarke@DOC.RI.GOV
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