National Network of Perinatal Quality Collaboratives
Thematic Webinar:

**Trauma-Informed Care: Addressing Stigma & Bias**

**Annie Lewis-O’Connor, PhD, NP-BC, MPH, FAAN, DF-IAFN, DF-AFN**
Founder & Director of the C.A.R.E Clinic at Brigham and Women’s Hospital

**AUGUST 4, 2020**
2:00-3:30PM ET
Welcome!

Thank you for joining the call! We will get started shortly.

• You may be **muted upon entry** to the call
• You **DO have the ability** to unmute yourself
• We encourage participants to remain muted in an effort to reduce background noise

• If you are in a room with multiple participants, only one of you will need to connect to audio (see next slide)

This presentation will be recorded.
Terms of Engagement

Our meetings are committed to building a culture of feeling safe, respected and included.

• Throughout the training to keep your video on.
• Mute your microphone when you are not speaking.
• Try to avoid doing other tasks such as checking emails or looking at your phone.
• When you are done speaking state: “I am finished”, “I am done”
• Throughout this training, try and write down three things that you can change
• Ask yourself:
  o WAIT: Why am I talking?
  o WAIST: Why am I still talking?
  o WANT: Why am I not talking?
Connecting to the Audio Conference

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From the audio conference box: Select to “Phone Call” or “Computer Audio”

If using the phone:
- dial the number next to “Dial”
- You will be prompted to enter the “Meeting ID”
- Then you will be prompted to enter the “Participant ID”
Ways to Participate: Chat

After you click the ‘Chat’ button, a sidebar will appear where you can chat to all participants.

At the bottom of the Zoom window, you will see a ‘Chat’ button.

Chat here to everyone!
At the bottom of the window, you will see a ‘Participants’ button.

After you click the ‘Participants’ button, a sidebar will appear where you see ‘non-verbal functions’.

Click here to raise your hand!
Partnering for Improved Birth Outcomes

The Institute for Healthcare Improvement (IHI) Better Maternal Outcomes Initiative and the National Network of Perinatal Quality Collaboratives (NNPQC), coordinated by NICHQ, are partnering to provide participants with a valuable set of webinars on health equity, respectful care and other critical maternal health topics. This partnership recognizes the shared commitment of these two initiatives to improve hospitals and health systems by elevating and spreading evidence-based efforts and examples of improvement from across the country so that families experience better birth outcomes. By bringing all participants together to engage in shared learning, the NNPQC and the Better Maternal Outcomes Initiative will encourage collaboration and innovation among teams with a shared mission, and ultimately accelerate national improvement.
Partnering for Improved Birth Outcomes

The IHI Better Maternal Outcomes Initiative aims to reduce maternal morbidity and mortality by supporting national efforts to implement reliable evidence-based care for women and newborns around the time of birth, and by facilitating locally driven, co-designed rapid improvements in four communities, targeting the interface of health care delivery, the experience of birthers, and community support systems.

The National Network of Perinatal Quality Collaboratives (NNPQC), coordinated by NICHQ, supports the development and enhances the ability of state perinatal quality collaboratives to make measurable improvements in statewide maternal and infant healthcare and health outcomes by providing resources and expertise to nationwide state-based perinatal quality collaboratives (PQCs).
Today’s Speaker: 
Annie Lewis-O’Connor, PhD, NP-BC, MPH, FAAN, DF-IAFN, DF-AFN

Dr. Annie Lewis-O’Connor is a dually Board Certified Pediatric and Women’s Health Nurse Practitioner. She is the Founder and Director of the C.A.R.E Clinic (Caring Approach to Resilience & Empowerment) and is Co-Chair of the Mass General Brigham Trauma-informed Care Initiative. The clinic is committed to providing patient centered and trauma-informed health care to people who have experienced individual, interpersonal and collective trauma. Dr. Lewis-O’Connor addresses violence from four pillars: Research, Policy, Education, and Clinical practice. Dr. Lewis-O’Connor is published in peer-reviewed journals and academic books on the topic of violence against women and children, trauma-informed care, and the effects of trauma, violence and abuse on health. Her current research is focused on measuring Trauma-Informed Care models of care in adult health care settings and exploration of best ‘screening’ (inquiry) methods for trauma, violence and abuse. Currently, Annie is a Clinical Scholar with the Robert Wood Johnson Foundation (2018-2021) focusing on health care leadership using a health equity lens. Her current funding is exploring the return on investment when TIC models are utilized, trauma inquiry and use of trauma-informed care plans. She served as Chair of the National Health Collaborative on Violence and Abuse advancing policy and clinical practice for survivors of violence and abuse. Since 2010 she has served on the Executive Board of Casa Myrna Vasquez, the oldest and longest standing shelter in Mass for women and children. She received her Master’s in Nursing from Simmons College in Boston, a Master’s in Public Health from Boston University and a PhD from Boston College.
Advancing Health Equity and Social Justice:
Using a Trauma-Informed Lens

Annie Lewis-O’Connor PhD, NP, MPH, FAAN
Co-Chair, MGB Trauma-Informed Care Initiative

Summer 2020
Introductions

➢ Welcome! As you join please type the following information into the chat.

Example

➢ **Name:** Annie Lewis-O’Connor

➢ **Role:** Founder & Director C.A.R.E Clinic & Associate Scientist- Division of Women’s Health
Disclosures

I have no financial relationship with a commercial entity producing health-care related products and/or services.
“Advancing Health Equity and Social Justice using a Trauma Informed Lens” is partially funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Massachusetts Department of Public Health, Bureau of Substance Addiction Services, with additional support from the PNQIN Perinatal Opioid Project.
Learning Objectives

➢ Understand the roles of stigma, bias, and trauma-informed care and resilience on disparities in health and birth outcomes specifically:

• Pain management for pregnant or postpartum patients with OUD
• Discharge and prescription practices for obstetric patients
• OUD treatment bias for pre- and post-partum patients
Contributors

- Nomi Levy-Carrick MD, MPhil (Clinical Psychiatrist, BWH)
- Eve Rittenberg MD, MS (Internist, BWH)
- Samara Grossman LICSW, MSW (Social Worker, BWH)
- Joanna Rorie PhD, CNW (Nurse Midwife/ Nurse Coordinator)
- Amy Coe, MSN, FNP (Nurse Practitioner, Bridges to Mom Program)
- Kettie Louis DNP, WHNP (Nurse Practitioner, Boston Medical Center)
- Jeannie Lee BA (Research Assistant II BWH)
- Aria Armstrong BA (Research Intern, BWH)
If today makes you uncomfortable, please feel free to take care of yourself in the way that best suits you.

"Always take care of yourself first"

If you want to learn more or get involved in trauma-informed care, equity and resiliency work let us know!
Participant Poll

Please complete the short poll in Zoom.
Incidences and Prevalence

- 4.6 million women (or 3.8 percent) ages 18 and older have misused prescription drugs in the past year. (ACOG 2017)

- Initial data suggest that recent neonatal abstinence syndrome (NAS) increases have resulted from increased use of prescription opioids rather than illicit drugs. (ACOG 2017)

- Opioid use in pregnancy and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. (ACOG 2017)

- The rate of opioid use during pregnancy is approximately 5.6 per 1000 live births. (Saia 2016)

- A 2012 study found that only 9% of pregnant women in the US who met DSM-IV criteria for SUD received treatment. (Frazer 2019)

ACOG 2017: Opioid Use and Opioid Use Disorder in Pregnancy

## Impact of OUD

### In Massachusetts:

- Approximately 1 in 5 pregnancy-associated deaths (20.6%; n=41) was related to substance use in Massachusetts from 2005 to 2014.

- The rate of SMM increased 179% between 1998 to 2013 (from 57 per 10,000 delivery hospitalizations to 159 per 10,000 delivery hospitalizations).

- 71% of pregnant women enrolled in BSAS treatment program reported use of heroin and 20% report use of other opioids.

- Black women with OUD in pregnancy have 2x the rate of SMM compared to white women in MA.

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Figure Source: [Massachusetts Department of Public Health](https://www.mass.gov/lists/the-2017-massachusetts-state-health-assessment)
Neonatal Abstinence Syndrome: National vs Massachusetts

**National:**
- In 2016, the number of infants diagnosed with NAS was 7 per 1,000 newborn hospitalizations.

**Massachusetts:**
- In 2017, the number of infants diagnosed with NAS was 13.1 per 1,000 live births.

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*2015 values are based on the first three quarters of data using ICD-9-CM coding.*

Source: Pregnancy and Early Life Longitudinal Data System (PELL).
SUDS Across Massachusetts

• Substance Use Disorder (SUD) affects pregnant people across Massachusetts, with variation by region

• Charlton Memorial Hospital in Fall River

• Hospitals with the highest rates of infants diagnosed with NAS:
  – St. Luke’s Hospital in New Bedford
  – Cape Cod Hospital in Hyannis
  – Melrose- Wakefield Hospital in Melrose
  – Berkshire Medical Center in Pittsfield

Massachusetts State Health Assessment (Chapter 2 – Maternal and Child Health)
What is Trauma?

- Adverse Childhood Experiences - ACES
- Social and Behavioral Determinants of Health

- Individual Trauma
  - Racism
  - Homophobia
  - Transphobia
  - Xenophobia
  - Ageism
  - Ableism
  - Sexism
  - Bullying
  - Unconscious Bias
  - Domestic Violence
  - Sexual Violence
  - Human Trafficking

- Interpersonal Trauma
  - Immigration Policies
  - Historical and Structural Traumas
  - Political/Economic trauma
  - Abuse of Power and Control
  - War and combat
  - Medical Trauma
  - Sexual Harassment
  - Micro-aggressions
  - Community Violence
  - Domestic Terrorism
  - Hate crimes

- Collective Trauma
  - Immigration Policies
  - Historical and Structural Traumas
  - Political/Economic trauma
  - Abuse of Power and Control
  - War and combat
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  - Micro-aggressions
  - Community Violence
  - Domestic Terrorism
  - Hate crimes

IMPACT OF
CHILDHOOD TRAUMA

The CDC and Kaiser Permanente surveyed 17,000 of the health plan's members to ask whether they'd had adverse childhood experiences defined as:

**ABUSE**
- Psychological
- Physical
- Sexual

**NEGLECT**
- Emotional
- Physical

**HOUSEHOLD CHALLENGES**
- Family member experiencing:
  - Domestic abuse
  - Mental illness
  - Imprisonment

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**THE STUDY ALSO FOUND**

NEARLY TWO THIRDS of those surveyed experienced at least one event.

The higher the score on ACE survey, the more likely people were to be in poor health:

- Liver disease
- COPD (chronic obstructive pulmonary disease)

Pair of ACEs Tree

The Pair of ACEs

Adverse Childhood Experiences

- Maternal Depression
- Physical & Emotional Neglect
- Emotional & Sexual Abuse
- Divorce
- Substance Abuse
- Mental Illness
- Domestic Violence
- Incarceration
- Homelessness

Adverse Community Environments

- Poverty
- Violence
- Discrimination
- Lack of Opportunity, Economic Mobility & Social Capital
- Community Disruption
- Poor Housing Quality & Affordability

Studies have shown that there is a correlation between a mother’s Adverse Childhood Experiences and her unborn child’s development.

1. Data were derived from a large cohort of pregnant women who were enrolled between March 2005 and May 2009 (N=2,303).

   For each additional ACE:
   - Birth weight by 16.33 grams
   - Gestational age by 0.063 weeks

2. A retrospective cohort study of 311 mother-child dyads and 122 father-child dyads who attended a large pediatric primary care practice.

   For each additional maternal ACE:
   - Increase in the risk for a suspected developmental delay by 18%

References:
2. Parental Adverse Childhood Experiences and Offspring Development at 2 Years of Age Alonzo T. Folger et al. Pediatrics Apr 2018, 141 (4) e20172826; DOI: 10.1542/peds.2017-2826
Health Impact of ACEs on Adults- 2019 MMWR

- 61% report at least 1 ACE
- 16% report 4+ ACEs
- Women, AI/AN, Black, and Other more likely to report 4+ ACEs than Men and Whites

Adjusted Odds Ratio: 4+ vs 0  ACE exposures

Obesity 1.2  Stroke 2.1  Depression 5.3
Diabetes 1.4  Asthma 2.2  COPD 2.8
CHD 1.8  Heavy drinking 1.8  Smoking 3.1

Health Impact of ACEs on Adults (cont.)

From a 2013 nationally representative survey of English (UK) residents aged 18 to 69 (n=3,885):

- 47% of individuals experienced at least 1 of the nine ACEs
- After correcting for socio-demographics, ACE counts predicted all health-harming behaviors

Adjusted Odds Ratio (4+ vs 0):  

<table>
<thead>
<tr>
<th>ACE Exposures</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintended teenage pregnancy</td>
<td>5.86</td>
</tr>
<tr>
<td>Early sexual initiation (&lt;16 years)</td>
<td>4.77</td>
</tr>
<tr>
<td>Heroin or crack cocaine use (lifetime)</td>
<td>10.88</td>
</tr>
<tr>
<td>Violence perpetration</td>
<td>7.71</td>
</tr>
<tr>
<td>Incarceration (lifetime)</td>
<td>11.34</td>
</tr>
</tbody>
</table>

Unconscious Bias & Stigma
Unconscious Bias and Stigma

A tendency or inclination that results in judgment without question.

A shortcut to interact with our world

An automatic response


Acknowledgement and thanks to Lianne Crossette
Unconscious Bias in Medicine

Health Providers with more implicit biases are more likely to have negative interactions with patients.

- Among patients presenting to the BWH ED with HF, Black and Latinx patients were less likely to be admitted to a cardiology service compared to white patients. (2019, Eberly et al JACC)

- Black Americans are undertreated for pain relative to white Americans. (2015, Hoffman et al. PNAS)

- Physicians report that seeing heavier patients was a greater waste of their time. (2001, Hebi and Xu, Int J Obes Metab Disord)

Structural Barriers, Stigma and Bias: Pregnant Women with SUD

• **Fear and Stigma:**
  – Pregnant women of color and with lower socioeconomic status with SUD, are disproportionately surveillanced and may face arrest, prosecution, conviction and/or child removal at higher rates. (Stone 2015)
  – Women have reported that they delayed or avoided prenatal care out of fear of punishment. (Stone 2015)

• **Provider Bias:**
  – A study found that a “nonjudgmental attitude” and lack of stigmatization were important for patients to return and keep follow-up appointments for prenatal care. (Seybold et al, 2014)
  – In a study on nurses’ attitudes toward substance-abusing mothers, regardless of knowledge base and experience of the nurses, 76% felt anger toward the mother. (Seybold et al 2014)

• **Structural Barriers:**
  – Tennessee passed a 2014 legislation that criminalized substance use during pregnancy. (Terplan 2015)
  – 18 states currently define substance use during pregnancy as a form of child abuse. (Terplan 2015)

The Importance of Language

“Care imitates language – that is we tend to relate to people the same way we write and talk about them.”
- Sasser, 1999

• How we speak about our patients has ramifications on how our patients are treated.

• **Avoid labels and pejorative terms:** Dysfunctional, Non-compliant, Resistant, Difficult, Entitled, Demented, Addict, Drug-seeking, Borderline, etc.
Examples

- Drug seeking - Substance Use Disorder; Pain management
- Drug addicted newborn - Neonatal Abstinence Syndrome
- Drug User (pregnant women) – Maternal Substance Use Disorder; Opioid Use Disorder in Pregnancy
- Morbid obesity - BMI is XX
The Big Picture: Structural Racism

VIDEO: Structural Racism Explained

“It’s baked in!”
– Al Richmond, CCPH
We ask patients to embrace and access our health care services despite our knowledge that there can be many inherent challenges –

Perhaps we need to create a system with patients that provides a new and improved way to participate in their health care.

Annie Lewis-O’Connor 2012
Specialized medical appointments can create challenges in care coordination and leave patients burdened with too many medical appointments in addition to their other commitments.
Philosophical Shift

Traditional

What’s wrong with you?
• Deficits
• Expert Mode
• Control
• Gate-keeping
• Dependence
• Prescribed

Trauma-Informed

How has what happened affected you?
• Strengths and Resilience
• Partnership model
• Collaboration and Mutuality
• Empowerment, Voice and Choice
• Patients choose how much to share
• Universal Awareness
Why Consider Trauma in Health Care?

• Trauma is pervasive amongst patients and staff.

• Trauma has significant health and mental health effects.

• Traumatic experiences greatly influence how people access and experience healthcare.

Without considering trauma:

Healthcare services can be re-traumatizing
Treatments may not be effective,
Patients may not be able to engage in care and treatment

“I’m right there in the room, and no one even acknowledges me.”
Recognizing the Health Consequences Caused by Individual, Interpersonal, and Collective Trauma:

How can we shift our models of care in more meaningful ways?
Six principles of trauma-informed care

- Safety: Physical & psychological
- Trustworthiness & transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, Choice
- Cultural, Historical, & Gender Acknowledgment
Birth Equity

VIDEO: https://birthequity.org/
Six principles of trauma-informed care

What principles did you hear regarding this video?

- Safety: Physical & psychological
- Trustworthiness & transparency
- Peer Support
- Collaboration & mutuality
- Empowerment, voice, choice
- Cultural, historical, & gender acknowledgment

www.samhsa.org
One of the main principles of trauma-informed care is to assume, not ask, if a patient has a history of trauma.
How do we minimize re-traumatization?

Be aware of:

- Unconscious bias
- Patient’s heightened emotional state
- Ambiguity
- Distracted or pressured decision making
- Lack of opportunity for feedback

Implement:

- Harm reduction strategies
- Shared decision making
- Individualized plans of care
- Limit distractions/stress
- Be intentionally present
- Allow time for feedback from patients
Stress versus Toxic Stress

Types of stress responses

**POSITIVE**
- A normal and essential part of healthy development
- Examples: getting a vaccine, first day of school

**TOLERABLE**
- Response to a more severe stressor, limited in duration
- Examples: loss of a loved one, a broken bone

**TOXIC**
- Experiencing strong, frequent, and/or prolonged adversity
- Examples: physical or emotional abuse, exposure to violence
Stress versus Toxic Stress

Stress
- Environmental stressors
- Major life events
- Trauma, Abuse

Development of individual susceptibility to stress
- Genes
- Early Life Experiences

Epigenetic changes in brain circuitry and function

Perceived stress
- Vigilance
- Helplessness

Behavioral responses
- Fight or flight
- Personal behavior:
  - Diet, smoking, drinking, exercise, social avoidance

Physiologic responses
- Neural
- Hormonal
- Immune
- Metabolic

Allostasis
The body responds to stressors in order to regain homeostasis

Adaptation

Pathophysiology

McEwen, JAMA Psychiatry 2017
Self-Awareness: The Four C’s

1. **Calm**: Pay attention to how you are feeling. Breathe deeply and calm yourself to model and promote calmness for patient, yourself, and co-workers.

2. **Contain**: Allow patient to maintain safety; don’t emotionally overwhelm the provider or the patient.

3. **Care**: self-compassion, cultural humility, de-stigmatize adverse coping behaviors.

4. **Cope**: emphasize coping skills, promoting positive relationships, interventions that build resiliency.

Trauma Inquiry

Disclosure is NOT the goal; Minimize patient need to retell their story

- Provide a safe environment for people to share as much or as little as they want
- Help patients understand that they have the right NOT to tell their story again, even to providers that ask
- Include education about trauma and its effects
- Balance trauma with resiliency and strengths

Trauma Inquiry

Inquire about impact, ask open-ended questions

• “Has anything happened in your life that you feel has impacted your health and well-being?”

• “How do you feel this has affected you?”

• “Have you had any experiences with health care (or this exam, etc.) that you feel I should know about?”

• “What would be helpful to make you feel safe and comfortable during this visit?”
“What can I do to help you be more comfortable?”

“If you want me to stop and pause, please ask or signal me.”

“Is it OK if I continue with the exam, or would you prefer me to stop?”

Of course I’m listening to your expression of spiritual suffering. Don’t you see me making eye contact, striking an open posture, leaning towards you and nodding empathetically?
Pearls of Warm Handovers

➢ Collaborate *with* patient and *with* other team members

➢ Review plan, contact information, clarity around roles

➢ Use virtual and phone contact to stay connected

➢ Periodic team huddles

➢ Team Collaboration- phone, emails, epic notes
Six Guiding Principles of TIC

1. Safety: Physical & Psychological
   - How and who on your team would inquire about safety? Trauma?
   - How might you associate the effects of trauma on health?

2. Trustworthiness & Transparency
   - How can you build trust and transparency with this patient? What might you say to pt.?

3. Collaboration & Mutuality
   - Level power dynamic - How can you do that?
   - Actively seek to collaborate with other team members, across disciplines. Increase shared decision making - without judgement - how can you do that?

4. Empowerment, Voice, Choice
   - Support the patient in self-management choices (even when you might not agree).
   - Ask permission from patient
   - Acknowledge pt. strengths

5. Peer Support
   - Assess patient for readiness for peer support services? Past experiences with such services?
   - Who will follow-up to assess connection?

6. Cultural, Historical, & Gender Acknowledgment
   - Seek to increase self-awareness of unconscious bias, stigma-
   - Avoid judgement or making assumptions
   - Acknowledge that cultural and historical backgrounds differ - adopt a curious stance
Documentation

- Minimal details/ Need to know
- Transparency and mutuality: Respect patient’s wishes
- Include patient’s strengths
- Establish team communication
Plan of Care

• Include Patient in decision making
• Document Strengths and Resources; Ways of coping without judgement
• What do they want members of their team to know?
• Goals of patient- What will success look like
• Share trauma history (if patient agrees)
  – Do not ask details, rather seek to understand the impact these advent/s have had on the patient’s health
Example Trauma-Informed Plan of Care

• Posted: 12-17-2019 Written with XXXXX

• What the Patient would like you to know:

• Strengths:

• Trauma History
  • XXXX has a significant past history of domestic abuse. She prefers not to be asked details and will ask for help or reach out if she needs to.
  • She is currently safe and has no contact with the ex-husband.

Maternal History: PLEASE DO NOT ASK PATIENT TO REPEAT HER MATERNAL HISTORY G10 P6034.

Detailed history was outlined below

Availability for appointments:
Mondays- she sees XXX I in the Bridge Clinic in the afternoon and wants to keep this time. She can also do am appts on Monday.
Tuesday- before 4pm. (has recovery meetings in evening)
Wednesday- CAN NOT DO APPOINTMENTS this DAY
Thursday- all day is good
Friday- before 1pm

Psychosocial Considerations: Triggers: Coping Skills:

Volunteers of America, Quincy- therapy
Ad Care in Quincy- therapy and groups
Active in NA
DOVE- Quincy- DV Advocacy about past trauma caused by IPV
Baycare Community Service: recovery Coach
Sober mommies- starts in January- graduated
Self-care

- Empathy
- Relaxation
- Support
- Healthy Fitness
- Supervision
- Consultation
- Skills
- Wellness
- Healthy limits
- Meditation
- Knowledge
- Empowerment
- Energy
- Resilience
- Exercise
- Compassion
Resilience: Multifactorial

- Self-Efficacy
- Empowerment
- Role clarity

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Moving the Conversation: Equality to Equity to Liberation

Assumption: Everyone benefits from the same (equal) support

Everyone gets the support they need

Systemic Barriers Removed
In Summary

- Stigma, bias, and trauma-informed care training offers the opportunity for improved engagement with patients with SUD

- Stigma, bias, and trauma-informed care training offers a strategy towards health equity and social justice

- Stigma, bias, and trauma-informed care training can help mitigate vicarious trauma and facilitate staff and provider wellness
General Resources

- WEBINAR: Engaging Women with OUD in the COVID-19 Crisis presented by Mishka Terplan, MD, MPH.
  - View the webinar recording and slides here under the Archived MORE Presentations and Webinars tab!

American Society of Addiction Medicine resources:

- WEBINAR: ASAM National Practice Guideline 2020 Focus Update Webinar - Pregnant Women
  - Date: Tuesday, June 30th 2020
  - Time: 2pm ET/ 1pm CT/ 11am PT
  - Register here!

The American Society of Addiction Medicine is having a webinar that focuses on updated 2020 recommendations to the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder for pregnant women. Many of the risks associated with opioid use disorder are similar for both pregnant and non-pregnant women. However, opioid use disorder carries additional risks for pregnant women and prenatal care for the developing fetus. Treatment of pregnant women with MOUD is associated with substantial improvement in outcomes for both mother and child. This webinar will provide an overview of the new and updated recommendations and in-depth information on treating pregnant women from the ASAM NPG.

- COURSE: ASAM/ACOG's Treatment of Opioid Use Disorder Course for women’s health care professionals
  - Courses are being held in Summer 2020, with more courses coming soon.

Perinatal Opioid Project (POP)

The Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC) and the Massachusetts Perinatal Quality Collaborative (MPQC) are excited to support a statewide quality improvement initiative focused on improving the care of infants and families impacted by perinatal opioid use and neonatal abstinence syndrome. Building upon years of past work by hospitals and organizations throughout the state, this initiative was formally launched in January 2017 and relies on close collaborations with many state partners, including the Department of Public Health, the Bureau of Substance Addiction Services, the Department of Children and Families, Early Intervention, and the Health Policy Commission.

All hospitals that care for mothers or newborns are invited to participate. Please see the drop down menu below to access more information on the various components of our project.

For more information, please contact: Munish Gupta, Ron Ivenson, or Mary Hau斯顿.

Read PNQIN’s Statement on Racial Inequities HERE