

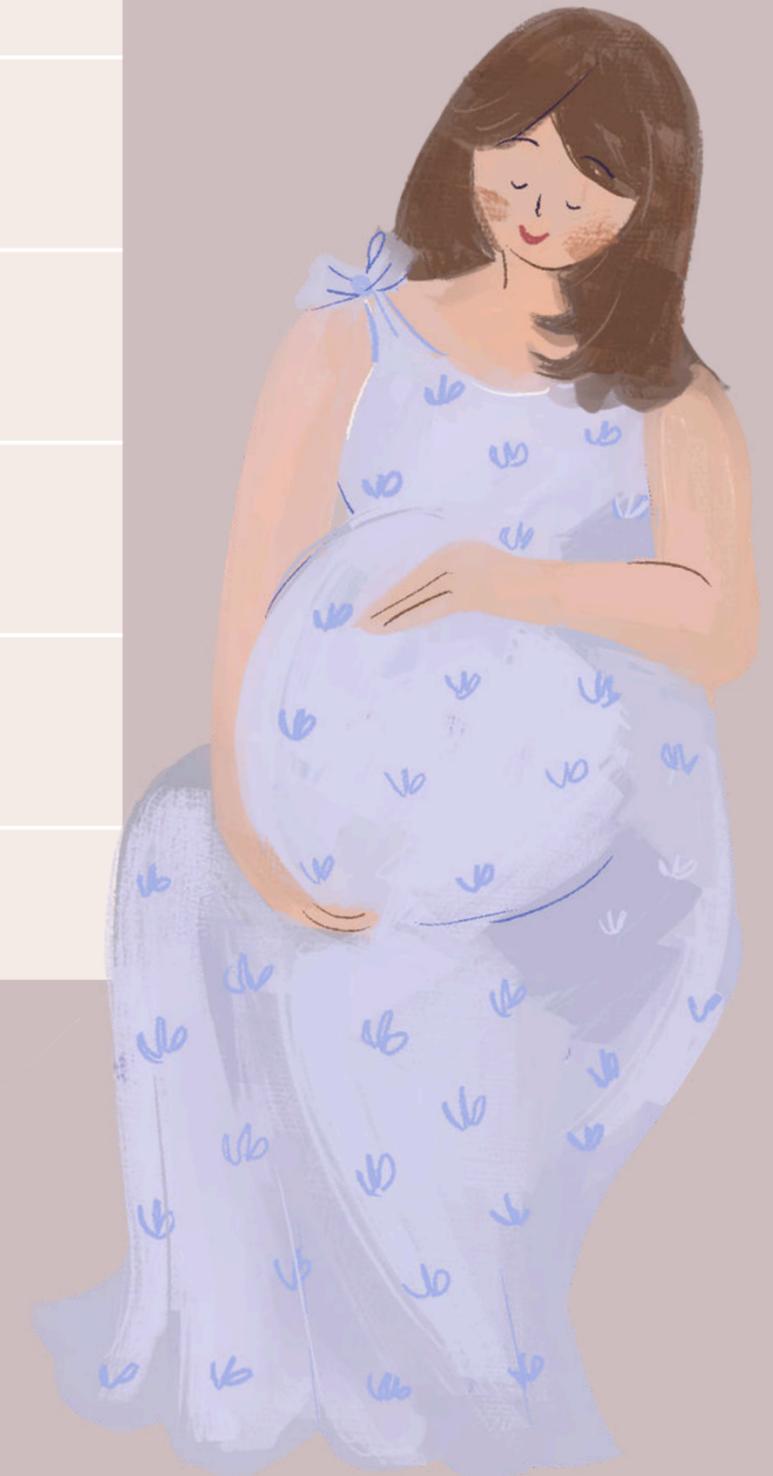
SUPPORTING FAMILIES IMPACTED BY SUD:

A Pilot Project in Region 1



Presented by:

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OVERVIEW

- Advocating for Change - System Level Framing
- Regional Alignment in Action
- Scalable Infrastructure to Support Implementation



**BEHIND EVERY DATA SET IS A PERSON, FAMILY, AND A NEWBORN
WHOSE LIVES ARE SHAPED BY HOW OUR SYSTEMS RESPOND TO
SUBSTANCE USE IN PREGNANCY**

With support from the CDC's ERASE MM funds, the Michigan Mortality and Morbidity Surveillance Program offered a mini award opportunity to Michigan Perinatal Quality Collaboratives that were working on new or existing initiatives aligned to the MMRC priority recommendations.

Region 1 Perinatal Quality Collaborative thanks MI PQC and MMMS Committee for continued support.

04 Co-Occurring Conditions

Trauma & Fear

Up to 80% of women with SUD have a lifetime history of trauma. *SAMSHA 2014* #1 Reason for not seeking prenatal care in birthing people using substances.

Schiff 2022

PTSD

In perinatal SUD populations, rates of PTSD are significantly higher than in the general obstetric population.

PMAD

Untreated perinatal mood disorders increase risk of substance recurrence, disengagement from care, and postpartum instability.

SDOH

Trauma and SUD are deeply intertwined with social determinants — housing instability, poverty, interpersonal violence, and lack of access to care

05

Clinical Foundations of Perinatal Care

Universal Screening

Universal, validated screening is essential for early identification
ACOG Committee Opinion No. 711

EVB Treatment

Evidence Based Treatment is the standard of care – it is the backbone of safe perinatal care

MOUD

Medication for Opioid and Substance Use Disorder is recommended by ACOG, SMFM, AAP, and addiction medicine societies.

NAS & NOWS

NAS & NOWS can occur with in utero exposure and is treatable – including when a mother is appropriately treated with MOUD
Jones et al., NEJM, 2010

PREGNANCY ASSOCIATED MORTALITY

is a broader category that includes any death occurring during pregnancy or within one year postpartum, regardless of whether it was directly related to pregnancy

PREGNANCY ASSOCIATED MORTALITY OCCURENCE

38.7% 1-42 days postpartum

34.0% 43 or more days post partum

74.5%

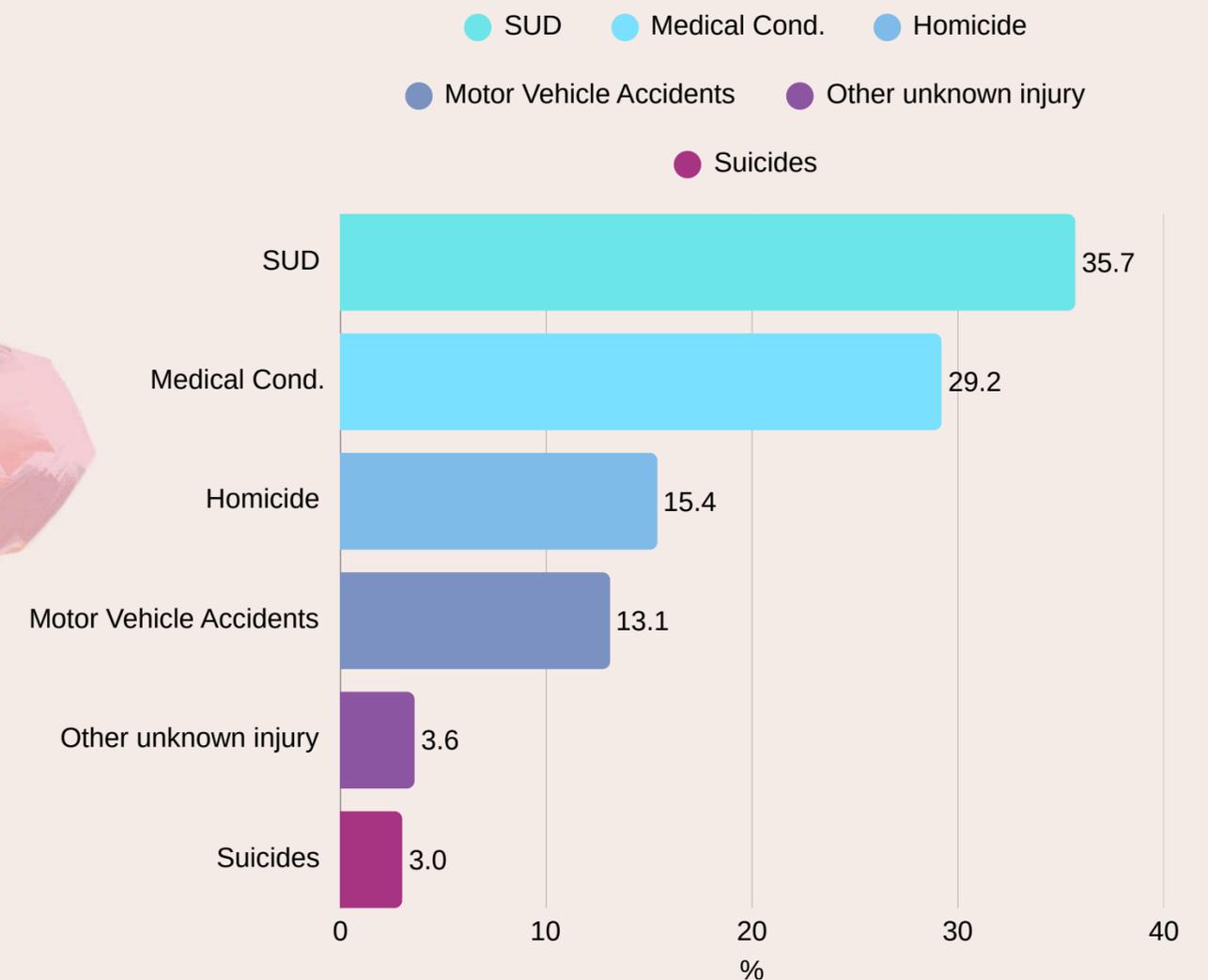
PREVENTABILITY



PREGNANCY ASSOCIATED NOT RELATED MORTALITY

Death of a person while pregnant or within 12mos. of the end of a pregnancy due to a cause unrelated to pregnancy.

Leading Causes of Preg. Associated, Not Related Mortality, 2016-2020



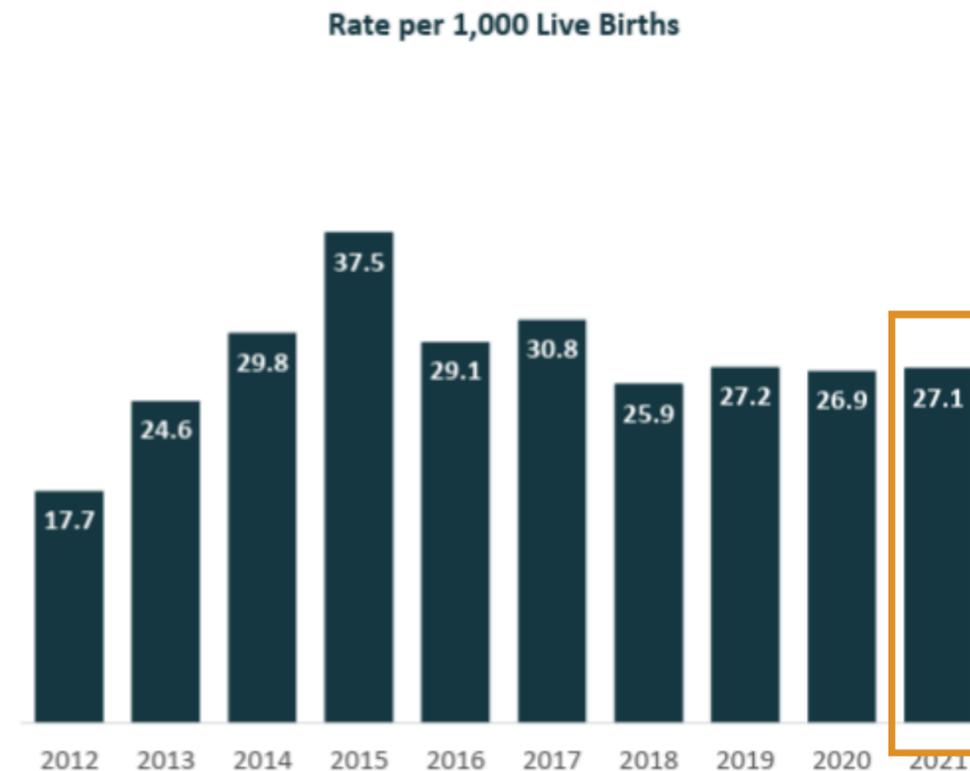
REGION 1

ADVANCING HEALTHY BIRTHS FOR FAMILIES AFFECTED BY SUD

2021

Neonatal Abstinence Syndrome Prosperity Region 1 2012-2021

Year	# Cases	# Births	Rate
2012	50	2,829	17.7
2013	68	2,763	24.6
2014	85	2,856	29.8
2015	102	2,723	37.5
2016	81	2,786	29.1
2017	82	2,665	30.8
2018	69	2,666	25.9
2019	68	2,499	27.2
2020	67	2,489	26.9
2021	70	2,585	27.1



* 2010-2015: 779.5 (drug withdrawal syndrome in newborn) and 2016-current: P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction)

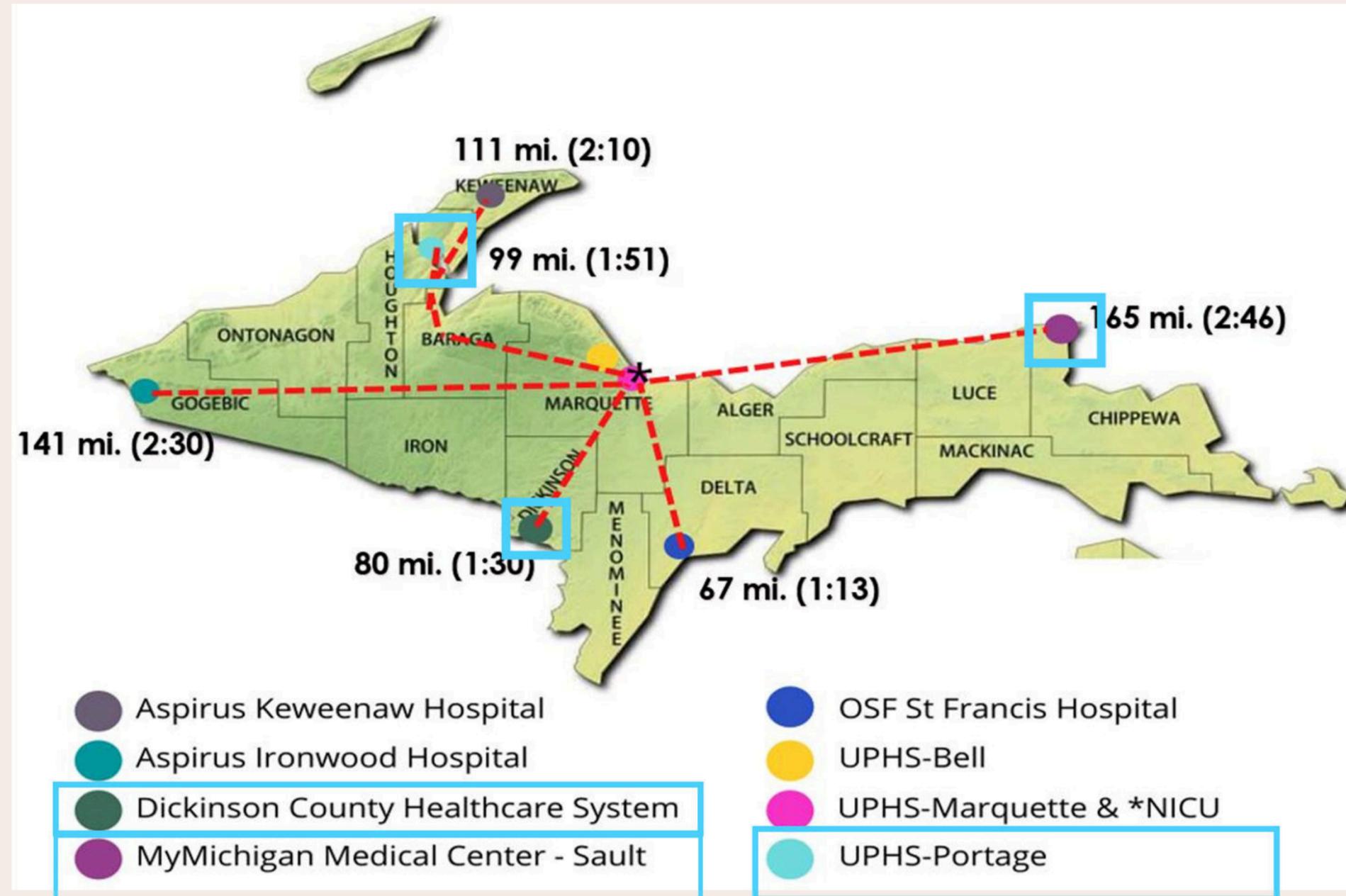
2022

	# NAS Cases	# Live Births	Cases per 1,000 Live Births
Michigan	605	100,880	6.0
Region 1	44	2,181	20.2
Region 2	16	2,597	6.2
Region 3	20	1,577	12.7
Region 4	46	17,799	2.6
Region 5	64	5,304	12.1
Region 6	102	8,260	12.3
Region 7	23	4,542	5.1
Region 8	50	7,696	6.5
Region 9	43	9,031	4.8
Region 10	196	41,893	4.7

REGION 1

ADVANCING HEALTHY BIRTHS FOR FAMILIES AFFECTED BY SUD

- 157 Eligible Between January 2025 and January 2023 (24 mos.)
- Dickinson: 52
- WUP: 32
- Chippewa: 18
- Marquette: 55



SYSTEM LEVEL LESSONS LEARNED

AIM BUNDLE IMPLEMENTATIONS

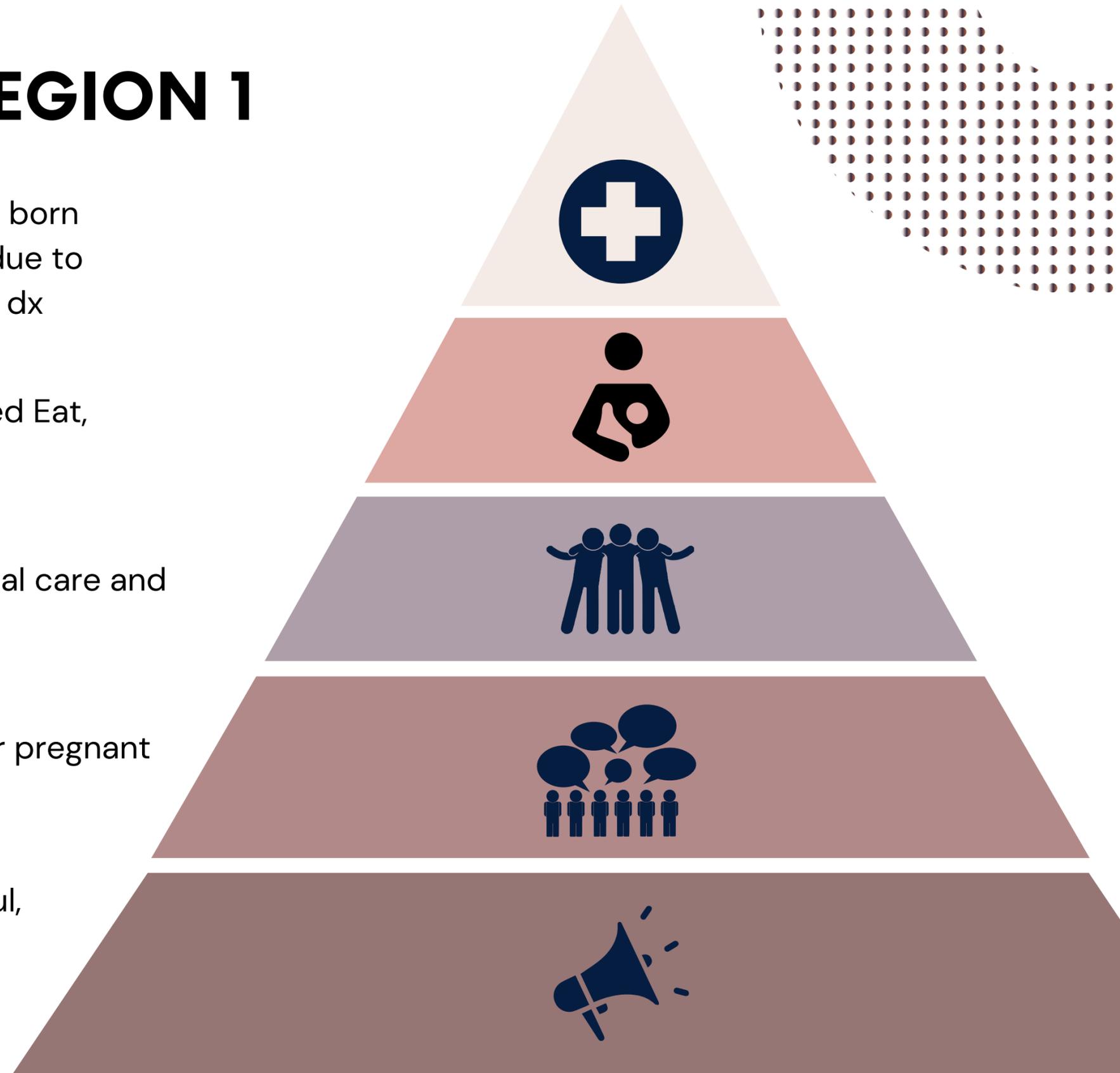
- Clinical Focus
 - Manage an acute physiologic event
 - Standardize recognition & response
- Where Implementation Lives
 - Within hospital workflows
 - Primarily clinical decision-making
- Risk Framing
 - Immediate maternal or neonatal instability
 - Clear escalation pathways
- Success Depends On
 - Timely recognition
 - Protocol adherence
 - Team coordination during an event

AIM CPPPSUD BUNDLE IMPLEMENTATION

- Clinical Focus
 - Manage a chronic condition affecting a dyad
 - Standardize screening, support, and discharge planning
- Where Implementation Lives
 - Spans prenatal, inpatient, and postpartum settings
 - Intersects with clinical, legal, and social systems
- Risk Framing
 - Ongoing risk, not time-limited
 - Includes CAPTA / Plan of Safe Care requirements
- Success Depends On
 - Clear discharge pathways
 - Reliable follow-up supports
 - Consistent decision-making across disciplines

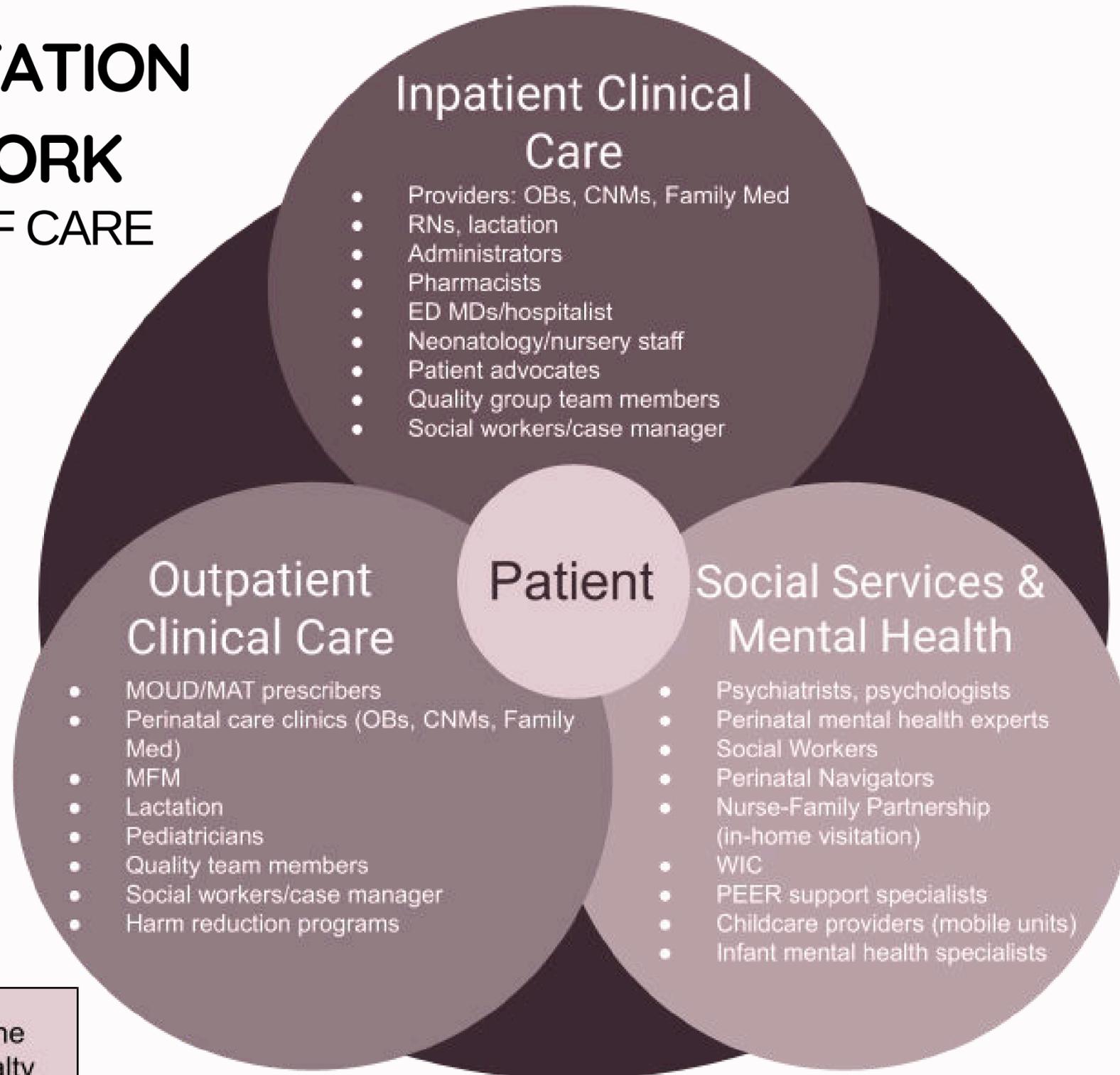
GOALS OF THE PILOT - REGION 1

- 01 Reduced or eliminated NICU stay for infants born maternally exposed to substances in utero due to severity of symptoms of NAS/NOWS related dx
- 02 Increased breastfeeding initiation and applied Eat, Sleep, Console methods
- 03 Increased timeliness of prenatal and postnatal care and continued therapies.
- 04 Increased efficiencies for care transitions for pregnant women and birthing persons
- 05 Advocacy for systems change and respectful, equitable care.



IMPLEMENTATION FRAMEWORK

3 DOMAINS OF CARE



Recruit at least one person per specialty area if possible

Workflows

- Create site-specific clinical care checklists
- Create site-specific inpatient and outpatient referral workflows
- Substance use and mental health case reviews
- Build local partnerships and resources
- Create guidelines to reduce opioid prescribing
- Plan, create and sustain community education around perinatal substance use
- Plan, create and sustain provider education around perinatal substance use
- MOUD workflow (initiation and continuation)
- Naloxone Project/narcan distribution

ALIGNING EVIDENCE BASED PROGRAMS

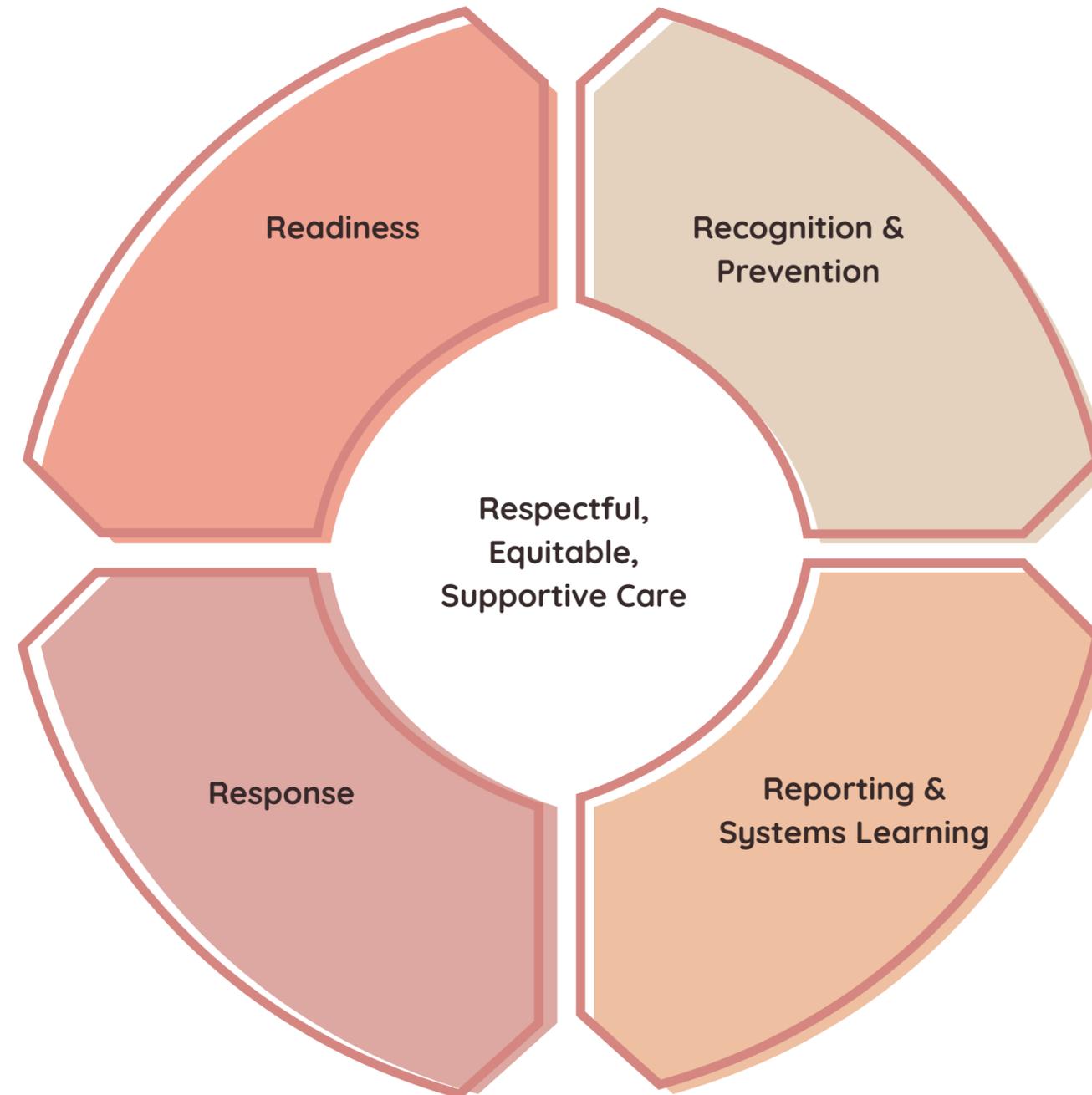
Hospital Led Change

Rooming In - Eat Sleep Console

Family centered, nonpharmacologic approach to treat NAS/NOWS by promoting maternal infant dyad, breastfeeding, function based assessments in the hospital setting immediately postpartum.

U.P. M.O.M.

Rural Health Care Coordination Network Pilot Program utilizing CHWs for integrated care delivery through home visiting models of care.



AIM CPPPSUD

Reduce preventable mortality and morbidity with Naloxone and harm reduction strategies and guided by trauma informed protocols to address biases and stigma related to SUDs.

Perinatal Quality Collaborative

Focused workgroups for care coordination, lived experience, PMAD response, building clinical and non clinical linkages
Stigma reduction and advocacy training bimonthly collaborative meetings



OUTCOMES

ROOMING IN

CARE COORDINATION TO IMPACT ENGAGEMENT

- Lower maternal and infant morbidity associated with opioid use disorder
- Greater continuity of care across the perinatal period
- More equitable, family centered systems of care in rural and frontier settings.
- Responding to regional shifts
- Replication ready framework for integrating AIM safety bundles and Rooming In in other systems

IMPROVED CLINICAL MEASURES

- Baseline:
 - 10/01/2023- 12/31/2023 1 baby transferred out 73 babies born for withdrawal symptoms prior to go live of the rooming in project. Patient stayed 3 days and eat sleep console model was implemented.
- FY 24 -
 - Q1: 2 Hospitals actively participating in Rooming In/ESC model
 - Q2: 0 transfers to NICU - OSF
 - Q3: 0 transfers to NICU - OSF
 - Q4: 3 Hospitals actively participating in Rooming In/ESC model
 - 1 of 2 infants transferred
- Average number of nights spent in NICU >10

OUTCOMES

UP MOM MODEL

CARE COORDINATION TO IMPACT ENGAGEMENT

- Increase access to their health care team
- Increased maintenance of Maternal Infant dyad
- Reduced stressors - mitigating ACEs
- Reductions in aggregate risk scoring
- Reduced health care costs
- Increased compliance with court appointments
- Increased long term housing
- Increased food security
- Increased job security
- Increased ability to navigate social and community services
- Increased sustainability

IMPROVED CLINICAL MEASURES

- **>85%** of enrollees participated in local **home-visiting** programs
- **60% Breastfeeding initiation**
- Breastfeeding **maintenance** (at least 4 months postnatally) climbed **from 8% to >35%**
- By year three, **100%** of enrollees who were not already in long-term recovery were **engaged in SUD treatment.**
- Enrollee **compliance with prenatal** OB/GYN visit recommendations
 - **>91%** for those enrolled prenatally
- **>88%** Enrollee **compliance with postnatal** OB/GYN visit recommendations
- **41%** of enrollees engaged in **tobacco cessation** interventions
- **85%** of enrollees **continuity of pharmacotherapy** treatment at delivery
- The UPMOM rate of avoidable **ED visits < the comparison group** (all pregnant managed care members during the period).
- **Of the 51 infants** that were born to enrollees who enrolled prenatally, **11 were referred to a neonatal intensive care unit** (NICU) for a primary diagnosis of Neonatal Abstinence Syndrome (NAS).

AIM CPPPSUD Bundle Pilot Implementation



Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle

Implementation Resources

Response — Every Event

- Assist pregnant and postpartum people with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive in an intersectional manner and, discuss readiness to start treatment, as well as referral for treatment with warm hand-off and close follow-up.*

Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows.*

Offer comprehensive reproductive life planning discussions and resources.*

Reporting and Systems Learning — Every Unit

Identify and monitor data related to SUD treatment and care outcomes and process metrics for pregnant and postpartum people with disaggregation by race, ethnicity, and payor as able.*

Convene inpatient and outpatient providers and community stakeholders, including those with lived experience in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues.*

Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Engage in open, transparent, and empathetic communication with the pregnant and postpartum people and their identified support person(s) to understand diagnosis, options, and treatment plans.*

Integrate pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, shared decision-making that incorporates the pregnant and postpartum person's values and goals.*

Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals.*

FROM FRAMEWORK TO FUNCTION



- Nursing Champion
- Clinician Champion
- SW or Case Champion
- Data Champion
- Continuity of Care Champion



- Devel. referral algorithms
- EMR integrations
- Hospital Pharmacy Director Alignment (Naloxone)



- Pre/Postnatal Clinical workflows
- Resource mapping tool devel.
- Shared decision making models
- Learning/Training plans



- Multidisciplinary workgroups
- KeyMetrics Build
- Resource Development
- MOU, BAA, DUA, Consents

FROM FRAMEWORK TO FUNCTION



Care for Pregnant and Postpartum
People with Substance Use Disorder
Patient Safety Bundle

Implementation Resources

RESOURCE MAPPING TOOL

SHARED DECISION MAKING MODELS

UPMOM REFERRAL ALGORITHMS

OPERATIONAL TRACKING PLATFORM

EMR INTEGRATIONS

DATA GOVERNANCE - KEYMETRICS

- Localized resource intelligence through dynamic mapping of behavioral health and recovery services
- Standardized decision pathways to support consistent MOUD, naloxone, and postpartum planning conversations
- Formalized cross-continuum referral architecture in collaboration with PQC and UP MOM
- Real-time implementation oversight using an operational tracking platform to support site leads
- Embedded workflow integration within the EMR to prevent parallel processes
- Scalable governance model to support replication across facilities

STANDARDIZED DECISION PATHWAYS

The 5 Ps

SHARED DECISION MAKING MODELS

EMR INTEGRATIONS

Institute for Health and Recovery Integrated Screening Tool

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents Did any of your parents have a problem with alcohol or other drug use?	YES <input type="checkbox"/>			NO <input type="checkbox"/>
Peers Do any of your friends have a problem with alcohol or other drug use?	YES <input type="checkbox"/>			NO <input type="checkbox"/>
Partner Does your partner have a problem with alcohol or other drug use?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		YES <input type="checkbox"/>		NO <input type="checkbox"/>
Emotional Health Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?				YES <input type="checkbox"/> NO <input type="checkbox"/>
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? _____ 2. How many drinks on any given day? _____ 3. How often did you have 4 or more drinks per day in the last month? _____			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Smoking Have you smoked any cigarettes in the past three months?			YES <input type="checkbox"/>	NO <input type="checkbox"/>

Review Risk

Review Domestic Violence Resources

Review Substance Use, Set Healthy Goals

Consider Mental Health Evaluation

Advise for Brief Intervention

	Y	N	NA
Did you State your medical concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Advise to abstain or reduce use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Check patient's reaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Refer for further assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

At Risk Drinking	
Non-Pregnant	Pregnant/ Planning Pregnancy
> 7 drinks / week > 3 drinks / day	Any Use Is Risky Drinking

Date: _____

Language: _____

Race: _____

Ethnicity: _____

For the best health of mothers and babies, we strongly recommend that pregnant women, or those planning to become pregnant, do not use alcohol, illegal drugs or tobacco. Safe levels of usage have not been determined.

2005

STANDARDIZED DECISION PATHWAYS

CPCQC ALCOHOL & SUBSTANCE USE SCREENING QUESTIONNAIRE

SHARED DECISION MAKING MODELS

EMR INTEGRATIONS



Alcohol and Substance Use Screening Questionnaire

In the past 3 months...(please circle the best response to each question).

1. How often did you have a drink containing alcohol?	Never	Monthly or Less	2-3 times a month	2-3 times a week	4+times a week	Any score \geq 1: recommend <u>AUDIT</u>	
	0	1	2	3	4		
2. How many drinks containing alcohol did you have on a typical day when you were drinking?	Never	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7,8 or 9 drinks	10 or more drinks	Any score \geq 1: recommend <u>AUDIT</u>
	0	1	1	2	3	4	
3. How often did you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Any score \geq 1: recommend <u>AUDIT</u>	
	0	1	2	3	4		
4. How often have you used marijuana?	Never	Not Monthly	Monthly	Weekly	Daily or almost daily	Any score \geq 1: recommend <u>CUDIT</u>	
	0	1	2	3	4		
5. How often have you used an illegal drug or a prescription medication for non-medical reasons*?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Any score \geq 1: recommend <u>DAST-10</u>	
	0	1	2	3	4		

STANDARDIZED DECISION PATHWAYS

SUBSTANCE USE DATA COLLECTION SHEET

DEMOGRAPHICS		
1. GA: _____ Weeks _____ Days	2. Date of Delivery: _____ / _____ / _____	3. Birthing Parent Age: _____
4. Patient Specific Circumstances: (select all that apply) <input type="checkbox"/> Out of Hospital Birth <input type="checkbox"/> No or Unknown Prenatal Care <input type="checkbox"/> Left Against Medical Advice (AMA)		
5. Type of Primary Insurance: (select one) <input type="checkbox"/> Medicaid/Medicaid Plans (i.e. Medicaid, CHIP, Medicare, emergency Medicaid, Medicaid plans) <input type="checkbox"/> Private <input type="checkbox"/> Other public insurance (i.e. Tricare, Indian Health Services, other state or federal source) <input type="checkbox"/> Uninsured (i.e. self-pay, not charged for service, or other payor not listed)		
6. Birthing Parent's Self-Reported Race: (select all that apply)		
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino	<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian _____ <input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other _____ _____
7. Birthing Parent's Self-Reported Ethnicity: (select one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Declined		
8. How many live newborns were born to this patient during their admission? _____		
9. Were all newborns born to patient during this admission discharged to either birth parent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
SCREENING		
10. Substances used during pregnancy, prescribed or not prescribed: (check all that apply) <input type="checkbox"/> OPIOIDS (i.e. Heroin, Fentanyl, OxyContin, Vicodin) <input type="checkbox"/> HALLUCINOGENS (i.e. PCP, Psilocybin, LSD, MDMA/Ecstasy) <input type="checkbox"/> DEPRESSANTS (i.e. Alcohol, Barbiturate misuse, Benzodiazepine misuse) <input type="checkbox"/> STIMULANTS (i.e. Methamphetamine, Amphetamine misuse [Adderall], Cocaine) <input type="checkbox"/> MEDICATIONS FOR SUBSTANCE USE DISORDER (i.e. Methadone, Subutex [Buprenorphine], Suboxone [Buprenorphine/Naloxone], Vivitrol [Naltrexone]) <input type="checkbox"/> OTHER (i.e. Cannabis*, other non-prescribed substance, other prescription medication) *Do not fill out this form if the ONLY substance identified is cannabis.		
TREATMENT		
11. Did patient have consultation with social work prior to discharge related to their needs for support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

SHARED DECISION MAKING MODELS

EMR INTEGRATIONS

DATA GOVERNANCE - KEYMETRICS

Complete the form for every patient at birth admission who meets the following criteria:

- Admitted for birth
- ID as using Substances during pregnancy including MOUD
- Do not complete for patients whose only substance use is cannabis.

STANDARDIZED DECISION PATHWAYS

Toxicology Testing Indications BY SuPPoRT Colorado

1. Birthing Parent Toxicology Testing Indications (must obtain consent) Signs and symptoms of intoxication, withdrawal, or altered mental status which could include:
 - a. Unexplained disorientation, psychosis, manic symptoms, ataxia, hallucinations, internal preoccupation, severe psychomotor agitation, confusion, and or somnolence where a toxicology test would dictate medical management.
 - b. There are many conditions that present in a similar fashion to intoxication and/or withdrawal; differentials should be broad and include trauma responses.
2. If desired by the birthing person (e.g., to demonstrate substance use disorder recovery, identify unintended exposure to substances, and/or safety of chest/breastfeeding).
3. If a birthing person desires to chest/breastfeed, toxicology would be indicated if one or more of the following conditions exist:
 - a. Report of substance use or positive urine toxicology test during last trimester of pregnancy.
 - b. Birthing person has an active substance use disorder and is not engaged in treatment. Note:

If birthing person is involved in treatment, it is strongly recommended to consult with providers who have an ongoing relationship with the birthing person to assess the level of engagement with recovery (e.g. prenatal provider, SUD treatment providers, etc).

SHARED DECISION MAKING MODELS

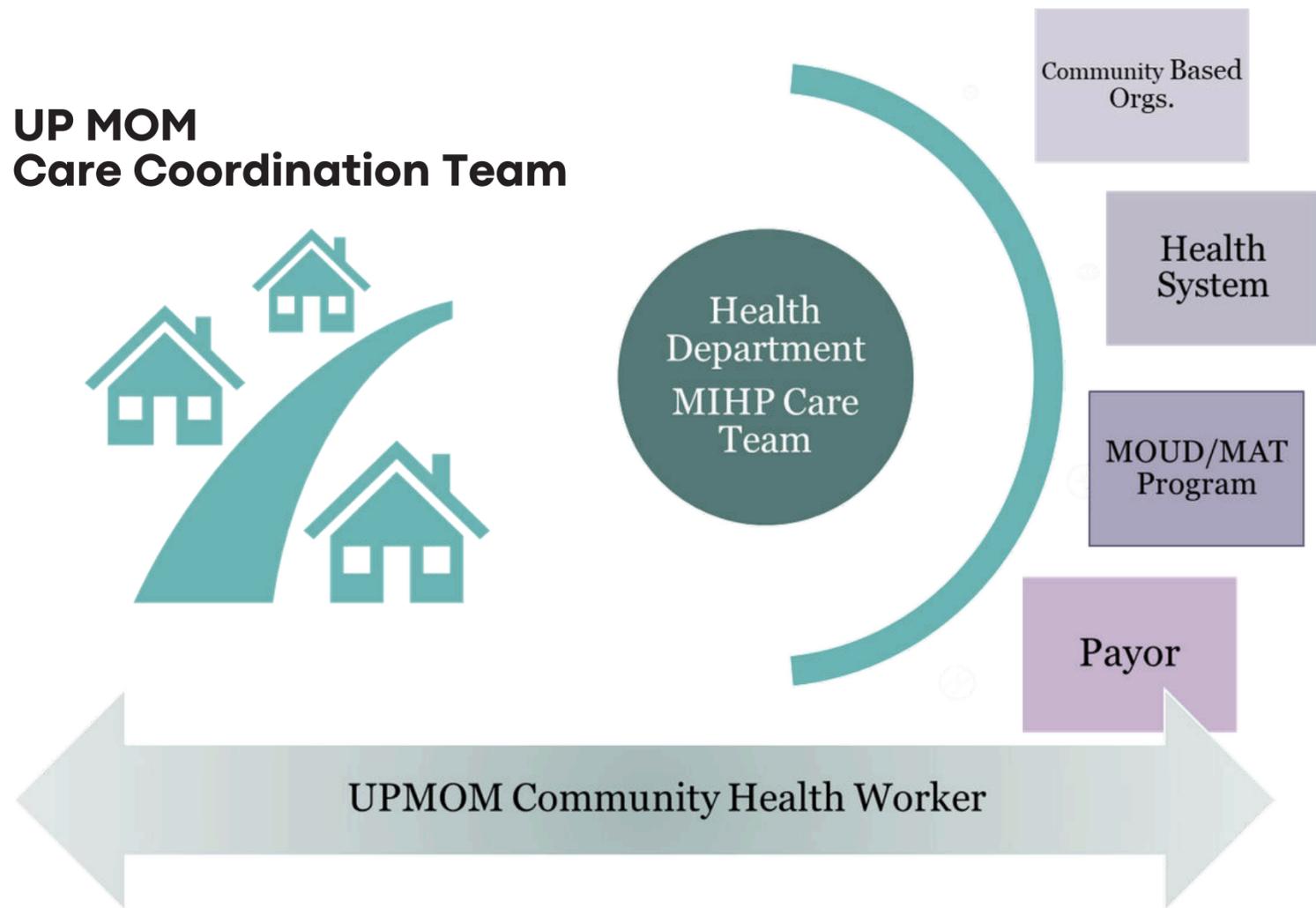


Region 1 Applications

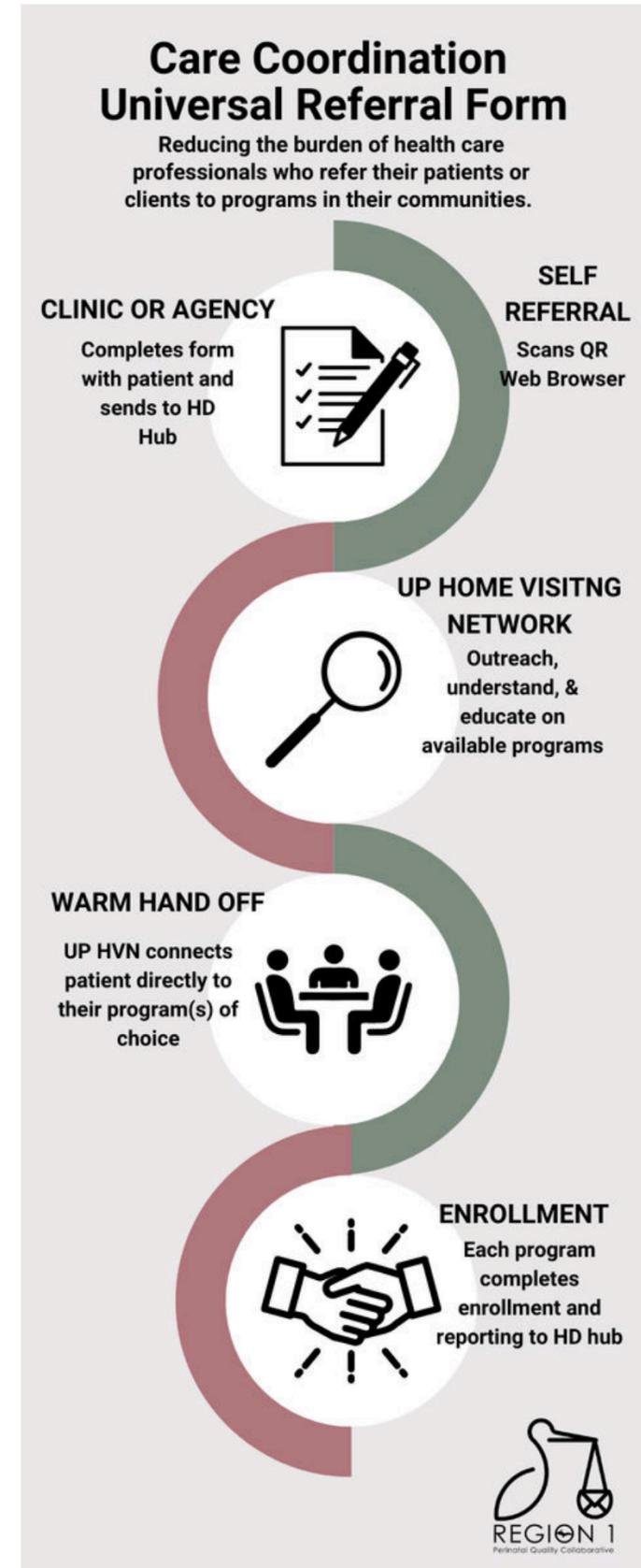
- Clarified distinction between universal verbal screening and toxicology testing
- Developed standardized clinical indications for toxicology to reduce variability
- Centered trauma-informed and bias-aware principles in testing decisions
- Consulted OPEN (Opioid Prescribing Engagement Network), MC3 (Michigan Clinical Consultation & Care), and Addiction Medicine specialists
- Aligned toxicology guidance with evidence-based obstetric and addiction standards
- Reduced subjective decision-making and strengthened equity across sites

LOCALIZED RESOURCE MAPPING AND REFERRAL ALGORITHMS

UP MOM Care Coordination Team



- UPMOM Coordination team - SW, RN, CHW
- Supplement to Home Visiting Program
- No limit to number of visits
- Continues up to 12 months post partum



U.P. Maternal Opioid Misuse Program

THE UP MOM PROGRAM

A service for women and birthing people seeking person centered support through pregnancy and postpartum in managing their Substance Use Disorder.

<p>COORDINATING YOUR CARE</p> <p>Support for Success</p> <p>Providing a Community Health Worker (CHW) to call or text for personal needs, appointments, or assistance.</p>	<p>CONNECTING YOU TO RESOURCES</p> <p>Transportation</p> <p>You and your CHW will work together to get free transportation to your appointments and for other needs.</p>
<p>SUPPORTING YOUR PREGNANCY</p> <p>Housing and In Home Support</p> <p>UP MOM can assist in finding and applying for utility or rent assistance or affordable housing.</p>	<p>CARE FOR YOUR FUTURE</p> <p>Supporting Families</p> <p>Continued support after birth of baby and after the hospital. Additional support available should baby be transferred to the NICU.</p>

INTERESTED?

Support Provided by the UP MOM Team may include:
Diapers | Wipes | Infant Clothing | Phone/Minutes | Breastfeeding Supplies | Groceries | Gas Cards | Formula

Call or text

SUSTAINABILITY PLAN

AIM SAFETY BUNDLE

- **3 UP hospitals are implementing AIM Safety Bundles with support from the Regional PQC**
- Protocols tailored to fit hospital size, staffing, and patient population
- Shared learning sessions facilitate peer exchange and collective problem-solving
- PQC provides facilitation, data support, and technical assistance
- Collaboration across settings: CHWs, home visiting teams, and outpatient providers involved in planning and training
- Focus on equitable implementation across rural and low-volume sites
- Integration into the PQC framework ensures sustainability beyond initial adoption

Region 1 CPPPSUD AIM Initiative: Sustainability Plan

Sustained Improvement Tracking of key process measures:

1. SUD/OD Prenatal and LD Screening documented
2. Medication Assisted Treatment (MAT) Prenatally or by Delivery Discharge
3. Linkage to Behavioral Health Counseling / Recovery Treatment Services Prenatally or by Delivery Discharge
4. Narcan Counseling & Prescription Offered Prenatally or by Delivery Discharge

How will measures be collected? _____

Team member(s) in charge of monthly reporting in KeyMetrics: _____

How often will your QI team meet to review hospital data reports via KeyMetrics and develop a response if compliance on measures are below the goal? Monthly Quarterly Other: _____

Ongoing Education for all providers and nurses

What education tool(s) will you use for ongoing education for all nurses and providers?

- Provider eModule RN eModule Missed Opportunity Review form SBIRT Simulations
 SBIRT/OD Clinical Algorithm OB Toolkit Provider Education Materials RN Workflow Other: _____

How will you incorporate R1 AIM SUD Initiative education and clinical care policies and protocols into ongoing education?

How often will you provide ongoing education? Biannually Annually Other? _____

New Hire Education for all new hires

What education tool(s) will you use for new hires (see above)?

How will you incorporate OB AIM SUD/OD education and clinical care policies and protocols into hospital new hire education?

Sustained System-level Changes

What system-level changes have you put into place to sustain providing optimal care for every patient with OUD?

- LD Admission Huddles Prenatal Care Conference OB AIM Folders OB AIM OUD Order Sets
 Missed Opportunity review with clinical team feedback Validated Screening tool in EMR Other: _____

How will you sustain these efforts, such as how will you ensure that OB AIM Folders are replenished and updated? How will you confirm OUD Admission Huddles are being completed for all patients with OUD?

Community Resources: How often will you update your local map of resources to connect pregnant/postpartum patients to MAT & Behavioral Health/Recovery Treatment Services? Bi-annually Annually

Whose job is it to update the OB AIM folders? _____

Whose job is it to update local map of resources to MAT & Behavioral Health/Recovery Services? _____

Nursing Champion(s): _____ Provider Champion(s): _____

Drafted Date: _____ Quarterly Review Dates: _____

Hospital Name: _____

CIRCLE UP

Comprehensive Integrated Remote Care for Saving Lives

A. Project Goals

1. Expand access to MOUD and mental health care through a virtual recovery platform.
2. Train and support healthcare providers and community health workers (CHWs) to deliver trauma-informed, coordinated care.
3. Develop and evaluate a sustainable model of integrated perinatal recovery care that can be replicated statewide.
4. Engage individuals with lived experience and community stakeholders in program design and improvement.

B. Core Activities

1. Stakeholder Engagement & Program Refinement
2. Pilot Program Implementation
3. Provider and Partner Training
4. Evaluation & Dissemination

CIRCLE UP reduces barriers to care for U.P. birthing persons with OUD/SUDs:

- Geographic isolation
CIRCLE UP provides services in the home community
- Shortage of behavioral health and addiction medicine providers
CIRCLE UP provides access to specialized providers
- Limited care coordination infrastructure
CIRCLE UP incorporates UP MOM services
- Stigmatization in healthcare settings
CIRCLE UP provides compassionate, non-stigmatizing care

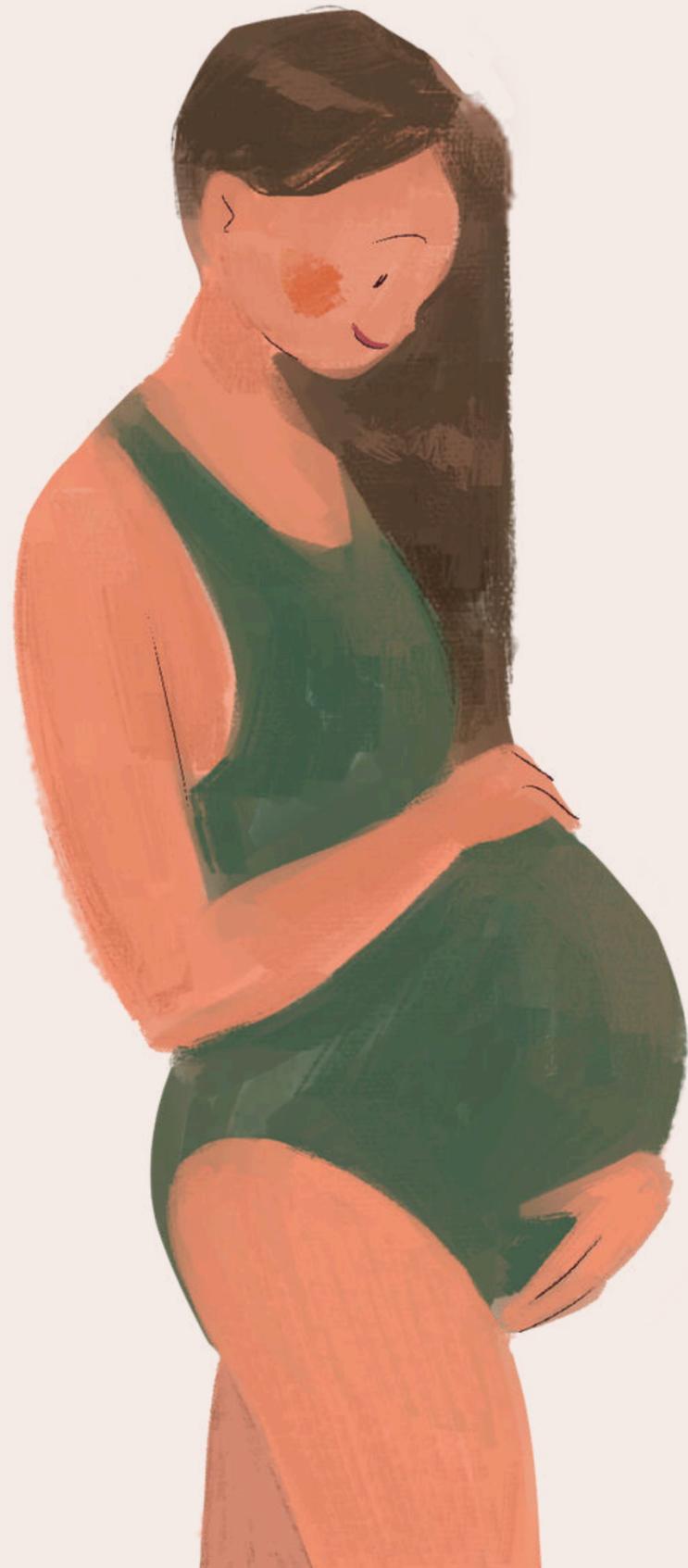


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In partnership with:
University of Michigan Partnering for the Futures Clinic
OBGYN Associates of Marquette
UPMOM

“ALONE WE CAN DO SO LITTLE; TOGETHER WE CAN DO SO MUCH.”
— HELEN KELLER



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