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BEHAVIORAL HEALTH

MOMs +
(Maternal Overdose Matters)
CONNECTION, TREATMENT & COMMUNITY

Treatment & Recovery Training

Agenda

- Connection to purpose
- Treatment and recovery
- MOMs+ introduction: connection, treatment, community
- Steps forward

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Connection to Purpose

Recovery

- Substance use in the perinatal period is common.
- Harm reduction, naloxone, and plans of safe care for families is key.
- When SUD happens, it is treatable.
- Evidence-based treatment is available and extremely successful.
- Recovery is possible.
- Patients (especially parents) that are in recovery are THRIVING.

Why are we not seeing more recovery stories out of our Colorado birthing hospitals?

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Substance Use in Perinatal Period

- Ranges from 6% for illicit substances up to 23% for use of tobacco.
- Alcohol, tobacco, and marijuana are the most commonly used substances followed by stimulants and opioids.
- All substance use comes with risk.
- Special focus on opioids based on the unique risk of overdose and death → a leading cause of maternal death.
- Opioid use disorder (OUD) is a treatable chronic disease state.
    - Several evidence-based medications and treatment options available for our perinatal population.

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Opioid Use and OUD in Perinatal Period

- Opioid use is relatively common in pregnancy, with a worldwide prevalence of 1-2% to as high as 21% in some studies
- Opioid use in pregnancy is associated with a 6-fold increase in maternal obstetric complications and a 74-fold increase in sudden infant death syndrome
- OUD in pregnant patients has increased dramatically in parallel with rates in the general population over the past two decades. The number of pregnant women with an OUD more than quadrupled from 1999 to 2014.
- Of these women, only roughly one-third are on Medications for Opioid Use Disorder (MOUD)

Background: The prevalence of opiate use among pregnant women can range from 1% to 2% to as high as 21%. Heroin crosses the placenta and pregnant, opiate-dependent women experience a six-fold increase in maternal obstetric complications such as low birth weight, toxaemia, third trimester bleeding, malpresentation, puerperal morbidity, fetal distress and meconium aspiration. Neonatal complications include narcotic withdrawal, postnatal growth deficiency, microcephaly, neuro-behavioural problems, increased neonatal mortality and a 74-fold increase in sudden infant death syndrome.

Minozzi S, Amato L, Bellisario C, Ferri M, Davoli M. Maintenance agonist treatments for opiate-dependent pregnant women. Cochrane Database Syst Rev. 2013 Dec 23;(12):CD006318. doi: 10.1002/14651858.CD006318.pub3. Update in: Cochrane Database Syst Rev. 2020 Nov 9;11:CD006318. PMID: 24366859.

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Literature Supports MOUD

Buprenorphine Versus Methadone for Opioid Dependence in Pregnancy

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017 (Replaces Committee Opinion Number 524, May 2012)

Committee on Obstetric Practice
American Society of Addiction Medicine
The Society of Maternal-Fetal Medicine endorses this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD, MPH; Ann E. Borders, MD, MSc, MPH; and the American Society of Addiction Medicine member Mishka Terplan, MD, MPH.

Opioid Use and Opioid Use Disorder in Pregnancy

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Report

smfm.org

Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine

Check for updates

Jeffrey Ecker, MD; Alfred Abuhamad, MD; Washington Hill, MD; Jennifer Bailit, MD; Brian T. Bateman, MD; Vincenzo Berghella, MD; Tiffany Blake-Lamb, MD; Constance Guille, MD; Ruth Landau, MD; Howard Minkoff, MD; Malavika Prabhu, MD; Emily Rosenthal, MD; Mishka Terplan, MD; Tricia E. Wright, MD; Kimberly A. Yonkers, MD

The American College of Obstetricians and Gynecologists supports the value of this clinical document as an educational tool, March 2019.

Recent trends in treatment admissions for prescription opioid abuse during pregnancy

Caitlin E Martin [1], Nyaradzo Longinaker [2], Mishka Terplan [3]

Affiliations + expand

PMID: 25151440 PMCID: PMC4648237 DOI: 10.1016/j.jsat.2014.07.007
Free PMC article

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

A Public Health Response to Opioid Use in Pregnancy

Stephen W. Patrick, MD, MPH, MS, FAAP,[a,b,c,d,e] Davida M. Schiff, MD, FAAP,[f] COMMITTEE ON SUBSTANCE USE AND PREVENTION

Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review and meta-analysis of safety in the mother, fetus and child

Barbara K Zedler [1], Ashley L Mann [1], Mimi M Kim [2], Halle R Amick [1], Andrew R Joyce [1], E Lenn Murrelle [1], Hendrée E Jones [3] [4]

Affiliations + expand

PMID: 27223595 PMCID: PMC5129590 DOI: 10.1111/add.13462

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Harm Reduction for Mom & Baby

The American College of Obstetrics and Gynecologists & The American Society of Addiction Medicine support both methadone and buprenorphine treatment as best practice for OUD during pregnancy.

Treatment with methadone or buprenorphine improves infant outcomes by:

- Stabilizing fetal opioid levels, reducing repeated prenatal withdrawal
- Providing opportunity for treatment of infectious diseases and better prenatal care

Compared to untreated pregnant women, those on MOUD had:

- Lower risks associated with Neonatal Opioid Withdrawal Syndrome (NOWS)
- Greater weight, head circumference and gestational age at birth

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Report

Pregnancy as a window of opportunity for treatment

Pregnancy is a window of opportunity for the treatment of chronic diseases, which includes substance use disorders. During this time, women have access to health insurance and often are motivated toward positive health behaviors in an effort to invest in the health and well-being of their future children.[70] Similar to the treatment of other perinatal chronic diseases (eg, diabetes mellitus, hypertension, connective tissue disease), obstetricians have an opportunity to provide care for substance use disorders during pregnancy that will reduce maternal, obstetric, fetal, and newborn infant morbidity and mortality rates and potentially decrease generational transmission of this chronic condition.[71–74] High-quality, evidence-based treatment interventions during this time have the potential to improve maternal and child health and have far-reaching health benefits for future generations.[75]

SMFM Special Reprot: Substance Use Disorders in Pregnancy: Clincial, Ethical and Research Imperatives fo the Opioid Epidemic Published march 2019

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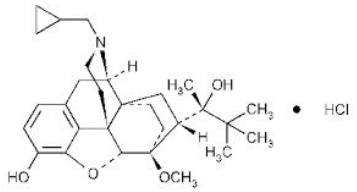
NIDA. 2017, July 1. Treating Opioid Use Disorder During Pregnancy. Retrieved from http://nida.nih.gov/publications/treating-opioid-use-disorder-during-pregnancy on 2023, March 30



MOUD Treatment- Buprenorphine

Mechanism of action: Partial mu agonist that treats opioid dependence and withdrawal to minimize cravings, while having a lower risk for respiratory depression.

Common Dosage Forms for OUD:

- Sublingual (SL) tablets (Subutex®): for use 1-3 times daily
- SL tablets (Zubsolv®) *containing naloxone*: for use 1-3 times daily
- SL/buccal films (Suboxone®) *containing naloxone*: for use 1-3 times daily
- Long-acting depot injection (Sublocade®): for once monthly injection in providers office

Prescribing: Can be prescribed by any provider who is able to prescribe opioids, X-waiver is no longer required. Patients can have filled at any retail pharmacy of choice. Safe to initiate in healthcare facility or at home. It is a schedule III controlled substance.

Risks: Precipitated withdrawal as buprenorphine will replace other opioids on the mu receptor. Therefore, it is recommended to wait up to 36 hours from last use of a non-medical opioid prior to initiating, depending on agent.

Clinical Pearls:

- Naloxone containing products: naloxone poorly absorbed sublingually or buccally
- Naloxone is active if injected or snorted.
- Buprenorphine can prevent overdose if another opioid is taken, as it competitively inhibits at the mu receptor.
- Long half life of 24-36 hours

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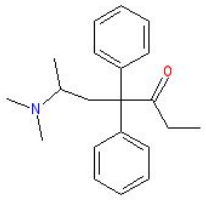
Buprenorphine. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com Accessed 4/3/2023
Buprenorphine and Naloxone. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com Accessed 4/3/2023



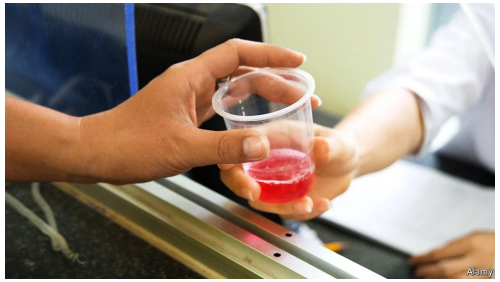
MOUD Treatment- Methadone

Mechanism of Action: Methadone is a full mu agonist used to prevent opioid withdrawal and minimize cravings.

Common Dosage forms for OUD:

- Most commonly dosed as an oral liquid

Prescribing: Methadone is highly regulated in the treatment of OUD. For this indication, it can only be prescribed and dispensed by a government approved Opioid Treatment Program (OTP). It is a schedule II controlled substance.



Risks: QT Prolongation, increased risk of respiratory depression compared to buprenorphine.

Clinical Pearls:

- No waiting period necessary before initiating induction
- Very long half life of up to 60 hours
- More effective than buprenorphine for patients taking high doses of non-medical opioids, or taking potent opioids such as fentanyl
- Patients usually begin by receiving daily doses from an OTP program. Over-time patients work up to having more responsibility and are sent home with supplies lasting up to 30 days.

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Methadone. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com Accessed 4/3/2023

Choice of Medication: Patient-Centered Approach

- Neither medication is superior to the other in all aspects
- Neither medication shows association with birth defects
- Neither medication shows a statistically significant difference in Neonatal Opioid Withdrawal Syndrome (NOWS) risk, when compared to the other

Balance availability, prescribing logistics and risk vs benefit to determine what is best for each individual patient

In studies, buprenorphine was associated with:

- Lower risk of preterm birth
- Less risk of low birth weight
- Lower risk of a decreased head circumference
- No greater harm than methadone
- Greater accessibility and ease of prescribing

In studies, methadone was associated with:

- Reduced pregnancy complications
- Decreased fetal mortality rate
- Better adherence to treatment and prenatal care
- Greater success than buprenorphine with transition from high doses of non-medical opioids
- Dosing challenges in pregnancy due to P450 metabolism

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SMFM Special Reprot: Substance Use Disorders in Pregnancy: Clincial, Ethical and Research Imperatives fo the Opioid Epidemic Published march 2019

Breastfeeding is Safe and Recommended!

Breastfeeding should be encouraged for women who are stable on methadone or buprenorphine, are not using illicit drugs and who have no contraindications.

Breastfeeding in women taking methadone or buprenorphine has been associated with:

- Decreased severity and lower need for pharmacotherapy to treat NOWS
  - Due to small amounts of buprenorphine or methadone secreted into the breastmilk
- Shorter hospital stays for the infant
- Improved attachment between mom and baby
- Increased immunity provided to the infant

Breastfeeding is recommended regardless of the maternal dose of buprenorphine or methadone due to the minimal transfer into breast milk.

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Sachs HC. The transfer of drugs and therapeutics into human breast milk: an update on selected topics. Committee on Drugs. Pediatrics 2013;132:e796–809.

Community Connection

Recovery

- MOUD initiation during a hospital admission or appointment must be able to be continued long term.
- Referral processes have to be seamless; relationships with outpatient community providers must be established and maintained.
    - Provide timely, warm handoffs where the patient has immediate follow up.
- Only when a perinatal patient with OUD can be stably maintained on MOUD is that patient now able to better access the other resources around them that are needed to maintain recovery and care for themselves, their baby, and their family.
- A perinatal patient in new recovery needs as much connection to and support with social, economic, and community services as they do with their healthcare services.
- Peer recovery support specialists, navigators, behavioral health specialists, and social workers are key members of the interdisciplinary team.

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Treatment & Recovery

Healthcare providers

Utilize a trauma-informed approach that incorporates harm reduction and motivational interviewing to optimize the health of the parent-baby dyad.

- Build trust (connection)
- Offer treatment as standard of care
- Community recovery

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Points to Ponder

Are pregnant and parenting patients affected by substance use disorders seeking care at your hospital, clinic, or health system?

If and when they seek care, could it be described as non-judgemental, destigmatized, whole-person care?

How do we go from an attitude of “mandatory reporting” → “mandatory responding”?

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About MOMs+

MOMs+ (Maternal Overdose Matters)

CONNECTION, TREATMENT & COMMUNITY

MOMs+ is a part of CPCQC's IMPACT BH Program, and an extension of the MOMs (Maternal Overdose Matters) Initiative. MOMs+ is focused on helping birthing hospitals statewide provide equitable access to treatment and recovery for perinatal patients with substance use disorders.

Pillars of Care:

1. Connection to the patient, baby, and family
2. Initiation of treatment with medication for opioid use disorder and other SUDs
3. Transition to outpatient recovery with community providers

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COLORADO MOMs INITIATIVE

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Leading Your Community

How can your hospital, clinic, health system, YOU lead the surrounding community in welcoming and providing treatment and perinatal care to pregnant and parenting patients and families affected by substance use?

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