Caring For Women with Opioid Use Disorder: Practical Tips

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Maternal-Fetal Medicine
Disclosures

- No conflicts to report
- Treatments for opioid use disorder in pregnancy are not FDA approved for this indication
OBJECTIVES

• Review current data on opioid use disorder (OUD) in pregnancy
• Discuss new/current resources for OUD in pregnancy
• Identify patient-centered approaches for comprehensive care for opioid-affected pregnancies
• Discuss best practice opioid prescribing to minimize excessive opioid use and limit development of OUD
Terminology

• *Not* interchangeable

• **Addiction**
  • Behavioral syndrome- obtaining drug is motivation
  • No longer accepted as primary medical terminology

• **Dependence**
  • Dependence on drug for normal physiologic function
  • Abstinence = withdrawal

• **Opioid Use Disorder**
  • Medical diagnosis, preferred terminology
Opioid use disorder (OUD)

- Medical condition
- Compulsive opioid use despite adverse consequences
- Withdrawal syndrome with cessation
- Involves dependence on opioids
- Frequent cycles recovery, relapse
The U.S. Opioid Epidemic

- 91 American die each day from opioid overdose
- $75 billion/year health and societal costs
- 2015, heroin deaths surpass gun homicides
- 650,000 opioid prescriptions dispensed daily

cdc.gov; hhs.gov/opioids
The Opioid Epidemic: MN

<table>
<thead>
<tr>
<th>Opioid Overdose Death</th>
<th>Data Year Current</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Opioid Overdose Deaths</td>
<td>2016</td>
<td>395</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nonfatal Overdose</th>
<th>Data Year Current</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonfatal Hospital-Treated Opioid Overdose</td>
<td>2016</td>
<td>2,074</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Prescribing Practices</th>
<th>Data Year Current</th>
<th>Data</th>
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<tbody>
<tr>
<td>Opioid Prescriptions</td>
<td>2016</td>
<td>3,536,939</td>
</tr>
</tbody>
</table>

[https://mn.gov/dhs/opioids/](https://mn.gov/dhs/opioids/)
Total opioid-related deaths in Minnesota since 2005

Heroin and fentanyl abuse resulted in an overall increase in opioid-related deaths in 2016.

*Some death records listed multiple drugs.*

Source: Star Tribune analysis of Minnesota Department of Health data // Graphic by C.J. Sinner, Star Tribune • Get the data

Star Tribune 5.28.17
Trend in Treatment Admissions for Common Drugs in Minnesota, DAANES*

Source: Minnesota’s Drug and Alcohol Abuse Normative Evaluation System (DAANES) * Approximately 48% of total admission episodes indicate alcohol as the primary substance. Other drugs shown are a portion of the overall total, which includes alcohol.

MN.GOV, 2018
Minnesota Women and OUD

Adapted-MN DHS 2018
Minnesota, Pregnancy, and OUD

Adapted - MN DHS 1/29/2018
Pregnancy and OUD

- Conflicting interests
  - Maximize long term maternal recovery
  - Minimize infant complications

- Social context does not promote disclosure
  - Stigma of substance use
  - Inability to understand addiction as a chronic medical disease
  - Criminalization of medical disorder in pregnancy
## Pregnancy and OUD

<table>
<thead>
<tr>
<th>Maternal Complications</th>
<th>Fetal/Neonatal complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection – HIV, Hepatitis B/C, Tb, STIs</td>
<td>Poor fetal growth</td>
</tr>
<tr>
<td>Injury and overdose</td>
<td>Preterm birth (26 vs 11%)</td>
</tr>
<tr>
<td>Death</td>
<td>Infection exposure</td>
</tr>
<tr>
<td></td>
<td>Neonatal abstinence syndrome (NAS)</td>
</tr>
</tbody>
</table>

Dryden 2009, mn.gov
Why treat in pregnancy?

- Prevent opioid withdrawal symptoms
- Prevent complications of nonmedical opioid use (NMU)
- Improved adherence with prenatal care and addiction treatment
- Reduce the risk of obstetric complications

ACOG 2017
## Treatment in pregnancy

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Buprenorphine (Subutex)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Daily observed therapy</td>
<td>• Outpatient prescription</td>
</tr>
<tr>
<td>• Preferred with polysubstance users</td>
<td>• Need withdrawal to start</td>
</tr>
<tr>
<td>• Higher retention 78%</td>
<td>• Increased diversion</td>
</tr>
<tr>
<td>• Higher overdose risk</td>
<td>• Lower retention 58%</td>
</tr>
<tr>
<td>• Equal NAS incidence</td>
<td>• Lower overdose risk</td>
</tr>
<tr>
<td>• Longer NAS treatment</td>
<td>• Equal NAS incidence</td>
</tr>
<tr>
<td>• Safe with breastfeeding</td>
<td>• Shorter NAS treatment</td>
</tr>
<tr>
<td>• Infant safety data</td>
<td>• Safe with breastfeeding</td>
</tr>
<tr>
<td></td>
<td>• Limited infant safety data</td>
</tr>
</tbody>
</table>

Adapted, ACOG Executive Summary, July 2017
Alternative treatment options

- Buprenorphine/naloxone
- Medically assisted withdrawal (MAW)
- Naltrexone
Buprenorphine/naloxone (suboxone)

- Added antagonist - decrease diversion
  - Minimal absorption with correct use
  - Theoretical concern for fetal development
- Preferred with insurance programs
- Use ongoing in OUD in pregnancy programs
- Similar outcomes in small studies

Debalek 2013, Wiegand 2015, SAMHSA 2018
Medically Assisted Withdrawal (MAW)

- Methadone, buprenorphine taper
- Prolonged inpatient/intensive outpatient care
- Any trimester
- 56% - no illicit use at delivery
- Neonatal withdrawal still documented
- No longer term outcomes noted – maternal, infant
- Any trimester

Stewart 2013, SAMSHA 2018
Medically Assisted Withdrawal

• “If a woman does not accept treatment with an opioid agonist or treatment is unavailable”
• Recent studies find NO clear evidence of an association between medically supervised withdrawal and fetal death or preterm delivery”
• Relapse rates 59-90%

ACOG 2017
Naltrexone (Vivitrol)

- Opioid antagonist
- Oral, injectable, implant
- Minimal safety data in pregnancy, breastfeeding
- Implications for post delivery pain management
- SAMHSA – no expert consensus
  - informed consent
  - stable patient

Jones 2018, Stewart 2013, SAMSHA 2018
Naloxone (Narcan)

• Recommended as overdose treatment
• Visibly pregnant
  – Uterus displaced to left
  – Left lateral tilt
• Smallest effective dose
  – 400 mcg every 4 minutes

Blandthorn 2017
Patient-centered care and OUD

- Screening
- Antenatal care
- Labor and delivery
- Postpartum and beyond
Best Practice – Universal Screening

• Universal screening - first prenatal visit
• Nonjudgmental - purpose: healthy mother, healthy baby
• Preferable to inquire privately
• Paper form or provider questioning
• Standardized screening tool higher yield than interview only
### SBIRT

<table>
<thead>
<tr>
<th>Component</th>
<th>Goal</th>
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</thead>
<tbody>
<tr>
<td>Screening</td>
<td>Assess substance use and its severity</td>
</tr>
<tr>
<td>Brief intervention</td>
<td>Increase intrinsic motivation to affect behavioral change (ie, reduce or abstain from use)</td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>Provide those identified as needing more treatment access to specialty care</td>
</tr>
</tbody>
</table>

4 Ps Plus

- **Parents**
  Did either of your parents ever have a problem with alcohol or drugs?

- **Partner**
  Does your partner have a problem with alcohol or drugs?

- **Past**
  Have you ever drunk beer, wine, or liquor?

- **Pregnancy**
  – In the month before you knew you were pregnant, how many *cigarettes* did you smoke?

  – In the month before you knew you were pregnant, how many beers/how much wine/how much liquor did you drink?
Universal Screening

• Overwhelmed providers
• Inadequate training
• Question of clinical utility
• Fear of mandatory reporting - MN
• Uncertainty for referrals
• Inadequate reimbursement

ACOG 2008; Wright et al, 2016
Referral resources

- [www.samhsa.gov/treatment](http://www.samhsa.gov/treatment)
  1-800-662-HELP (24 hr. treatment referral)

- State opioid treatment authority
  - Richard.Moldenhauer@state.mn.us

- Local search – counseling, support groups, sober living

- Minnesota ASAM chapter
Psychosocial support

- Psychosocial Support
  - Interview privately
  - Screen for environmental stressors
  - 50% co-addicted partners/family
  - Social work involvement
  - Perinatal care coordination
  - Consider residential treatment
Mental health and OUD

• High prevalence dual diagnosis
  – Depression, anxiety, PTSD
• Counseling
  – No specific technique
  – Identify triggers for relapse, motivation interviewing, stress reduction education, support groups
• Trauma informed care

Gopman et al. 2014
Tobacco use

- Tobacco use/abuse
- 85-90% pregnant women in MAT smoke cigarettes
  - 16% in all pregnant women
- 20-45% smokers quit spontaneously in pregnancy
  - Almost none in MAT
- Incentive based treatment - effective

Akerman et al., Choo et al., Winklbaur et al
Tobacco use

- Decreased tobacco consumption
- Heavy use (20+ cigarettes per day) vs. lighter use (10 or less per day)
  - Lower birth weight and neonatal length
  - Higher peak neonatal withdrawal scoring
  - Longer duration to peak neonatal withdrawal

Akerman et al., Choo et al., Winklbaur et al
Infectious risks

- Increased infectious disease
  - Up to 60% incidence of hepatitis C
  - HIV, Tb, hepatitis B, syphilis
- Consider repeat screening third trimester
- Avoid operative delivery, fetal scalp monitoring with hepatitis B, C
GI Health

• Constipation
  – Docusate not effective
  – Polyethylene glycol often needed
  – Preventative, not symptomatic treatment
• Don’t forget to ask about it!
Patient-centered care

• Non-judgmental environment
  – Anticipate absences from care
  – Transportation/child care
• Flexibility in scheduling
• Batch care at visits - US, NICU consultation
• Preparation for parenting
  – Separate group for parenting education
  – Pediatrician with NAS experience

Winstock et al. 2008
Patient-centered care

- Management of expectations
  - Compliance with prenatal care
  - Communication with MAT providers
  - Surveillance during pregnancy (ultrasound, urine drug testing)
  - Provider coverage for deliveries and urgent visits
  - Pain management in labor, postpartum
  - Neonatal opiate withdrawal syndrome

Winstock et al. 2008
Provider Communication

• 42 CFR Part 2
  – Confidentiality of SUD patient records
  – Restricts disclosure
SAMPLE CONSENT TO TREATING PROVIDER ENTITY RECIPIENT
42 CFR Part 2 and HIPAA

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure.

A “treating provider relationship” exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

This consent form is for use when a patient wishes to authorize the disclosure of their substance use disorder information to an individual or entity with which the patient has a treating provider relationship.

I, ____________________________________________

[patient’s name]

authorize ________________________________________

[name or general designation of individual or entity making the disclosure]

to disclose ______________________________________

[describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible]

to ____________________________________________

[name of recipient entity, which has a treating provider relationship with the patient]

for the purpose of ____________________________________________

[describe the purpose of the disclosure; as specific as possible]
I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: ___________________________ ___________________________

Signature of Patient
OB practice

- Standard prenatal visits
  - Confirm medication dosing in chart
- Targeted fetal anatomy scan
- Interval fetal growth 28 and 34 weeks
- Antepartum surveillance (BPPs, NSTs) only if:
  - Evidence of poor fetal growth
  - Evidence/suspicion of ongoing illicit use, relapse

Hulse et al 1997
Antenatal consultation

- Social work
- Maternal-fetal medicine/obstetrics
- NICU, pediatrics – NAS
- Anesthesia - non opioid therapy
- Lactation
Labor and Delivery

- Management of expectations prenatally
- Continue on outpatient medication
- Early epidural
- Increased pain medication requirements if cesarean section
  - TAP block, PCA
  - Adequate staff education is key

Meyer et al 2007, 2010
Analgesia

- Scheduled ibuprofen/toradol, acetaminophen
- As needed opioid – start with oral if possible
- Discharge medications
  - Total of 7 days opioids (if required, including inpatient)
  - Taper
  - Consider lock box, input of support person
  - Consider Narcan/naloxone
Postpartum Care

• Breastfeeding
  – Minimal transfer of medication to neonate
  – Limited ability to treat neonatal withdrawal but breastfeeding/skin-to-skin may help
  – Supported by ACOG, AAP, ABA
  – Hepatitis C – avoid with bleeding nipples
  – Contraindications – ongoing illicit use, marijuana, HIV
Postpartum care

• Postpartum dosing
  – Decreased metabolism, volume of distribution
  – Watch for drowsiness
  – Co-ordinate discharge with treatment program
• Prevent relapse
  – Follow up 1-2 weeks, depression screening
• Postpartum contraception
  – Long acting reversible contraception

Avoid misconceptions!

• Continued drug use should not be assumed to reflect a lack of desire to quit using drugs
• Most insurance with limited coverage for substance abuse treatment
• Many can’t afford treatment, there are no spaces available or the programs cannot accommodate childcare/family responsibilities
  – Should this ‘failure’ be counted as grounds for civil commitment?
Harm-reduction

• Strategies, ideas to reduce negative consequences of drug use
  – Naloxone prescription, education
  – Needle exchange
  – Safe injection sites
  – Fentanyl test strips

• Example – prenatal care with ongoing drug use
RESOURCES

• Provider resources
• Patient resources
• Family education
• Personalized to healthcare services
PREGNANCY & OPIOIDS

What families need to know about opioid misuse and treatment during pregnancy

drugfree.org/download/pregnancy-opioids
Opioid Use Disorder and Pregnancy
Taking helpful steps for a healthy pregnancy

Introduction

If you have an opioid use disorder (OUD) and are pregnant, you can take helpful steps now to ensure you have a healthy pregnancy and a healthy baby. During pregnancy, OUD should be treated with medicines, counseling, and recovery support. Good prenatal care is also very important. Ongoing contact between the healthcare professionals treating your OUD and those supporting your pregnancy is very important.

The actions you take or don’t take play a vital role during your pregnancy. Below are some important things to know about OUD and pregnancy, as well as the Do’s and Don’ts for making sure you have a healthy pregnancy and a healthy baby.
Introduction

Opioid use disorder (OUD) is a treatable disease. When OUD is managed with medicines and counseling, you can have a healthy pregnancy and a healthy baby. However, during pregnancy, adjustments to your OUD treatment plan and medicines may be needed.

The actions you take or don’t take play a vital role during your pregnancy. Below are some important things to know about OUD treatment during pregnancy, as well as the Do’s and Don’ts for making sure you receive the best treatment possible.
Introduction

Many pregnant women with an opioid use disorder (OUD) worry about harmful effects of opioids to the fetus. Neonatal abstinence syndrome (NAS) is a group of withdrawal signs that may occur in a newborn who has been exposed to opioids and other substances. NAS signs may include high-pitched and excessive crying, seizures, feeding difficulties, and poor sleeping. **NAS is a treatable condition.**

The actions you take or don’t take play a vital role in your baby’s well-being. Below are some important things to know about what to expect if your baby needs special care after birth, as well as the Do’s and Don’ts for understanding and responding to your baby’s needs.
Good Care for You and Your Baby While Receiving Opioid Use Disorder Treatment
Steps for healthy growth and development

Introduction

If you have an opioid use disorder (OUD), receiving the right medicine along with counseling and recovery support services is important at all stages in your life. From pregnancy to delivery to caring for your baby, addressing your OUD and taking care of yourself is a continuous process. You will be better able to protect and care for your baby with a focus on creating and updating your treatment plan and getting the support you need. In all situations, your commitment to treatment and recovery will go a long way.

After your pregnancy, the actions you take or don’t take matter. Below are some important things to know about OUD and caring for your baby, as well as the Do’s and Don’ts for creating a healthy environment for your family.
Minnesota Opioid Prescribing Guidelines
First edition, 2018
• Acute Pain – 4-7 days after an acute event
Guideline principles

1. Prescribe the lowest effective dose and duration of opioid analgesia when an opioid is indicated for acute pain.
2. Post-acute pain (up to 45 days) – critical time to halt progression to chronic opioid use.
Acute pain discharge prescribing

• Uncomplicated SVD – no opioids
• Complicated SVD – based on in hospital use
• Cesarean section – avg. 20 pills, based on hospital use
• Minimize oxycodone

Bateman 2017
Alternatives to oxycodone

- Most abused, high illicit street value
- 2x as potent as oral morphine
- Most frequently encountered – law enforcement
- Meta-analysis, abuse liability (vs. oral morphine, oral hydrocodone)
  - High subjective attractiveness
  - Increased reinforcing characteristics
  - Increased abuse liability profile
- "Use discouraged" – WI PDMP

Utilizing the PDMP

- Red flags:
  - Inconsistent use vs. prescribed
  - Multiple/overlapping prescriptions
  - Dramatic changes in dose
  - Frequent early refills
  - Concurrent opiate and benzo prescribing
# Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

<table>
<thead>
<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family history of substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Personal history of substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Age between 16—45 years</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>History of preadolescent sexual abuse</strong></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Psychological disease</strong></td>
<td></td>
<td></td>
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<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
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<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Scoring totals</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*drugabuse.gov*
What to do with extra meds?

- Fire safe storage
- DEA National Drug Take-Back Days – April 29, 2017
- Sealable plastic bag with water + dirt, cat litter, coffee grounds
- Away from children
- Out of home for open house, social events etc.

fda.gov
Opioid use disorders in pregnancy

• Opioid use disorders (OUD) is a significant contributor to pregnancy complications in the US
• OUD has well established treatment protocols with many new resources to help
• Patient centered OB care is essential to optimal outcomes
• New opioid prescribing guidelines help establish standard prescribing to reduce new cases
References

References