SUBSTANCE USE TREATMENT AND MATERNITY CARE: INTEGRATING CARE TO IMPROVE ACCESS AND OUTCOMES

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OBJECTIVES

- Discuss lessons learned from Substance-Related Pregnancy Associated Deaths
  - Access to treatment
  - Naloxone
  - Impact of social determinants of health
- Describe integrated care models to improve care for pregnant people with opioid use disorder in New Hampshire
  - Access to medication for opioid use disorder
  - Naloxone initiative
- Explore postpartum challenges
Fatal and nonfatal overdose risk was lowest during pregnancy, highest at 7-12 months postpartum

**Pharmacotherapy reduced overdose risk > 50%**
- Only 64% received pharmacotherapy for OUD during the prenatal year
- Other factors associated with overdose: anxiety, depression, homelessness
CONSEQUENCES OF UNTREATED SUBSTANCE USE

Mother
- Limited prenatal care
- Tobacco, alcohol, other substance use
- Infectious disease
- Pregnancy complications
- Untreated psychiatric needs

Baby
- Poor fetal growth/LBW
- Neonatal abstinence
- Developmental delays
- Adverse childhood events

Prenatal care and substance use treatment transform outcomes
Benefits of MOUD over medically managed withdrawal

- Reduced mortality and morbidity
- Lower relapse rates
- Higher rates of engagement in care

Neonatal abstinence less severe for newborns exposed to MOUD

- 40+ year experience with Methadone
- Buprenorphine equivalent in effectiveness, with decreased duration and severity of NAS

MEDICATIONS FOR OPIOID USE DISORDER (MOUD) DURING PREGNANCY

Methadone

Buprenorphine

(Images: National Institute on Drug Abuse)
BARRIERS TO TREATMENT DURING PREGNANCY AND POSTPARTUM

- Stigma
- Lack of public knowledge about safety and efficacy of MOUD during pregnancy and lactation
- Provider reluctance to treat pregnant people
- Patient reluctance to disclose
- Fear of child protection involvement
- Barriers to accessing or continuing treatment (childcare, transportation, employment)
SPECIAL CONSIDERATIONS FOR INITIATION OF MOUD DURING PREGNANCY

- Buprenorphine monotherapy vs buprenorphine-naloxone?
- Outpatient vs Inpatient?
- Use of adjunctive medications?
- Polysubstance use, benzodiazepines, alcohol
- Tobacco use disorder

CONTINUING MOUD DURING PREGNANCY

- Common side effects should be managed during pregnancy
- Dose adjustment is typical
- Anticipatory guidance
  - Hospital drug testing policies
  - NAS surveillance
  - No correlation between buprenorphine dose and NAS severity
  - Pain management
- What about naltrexone?
- Naloxone
FACILITATING ACCESS TO NALOXONE
WHY NALOXONE?

- Community-administered naloxone saves lives
  - Naloxone “kits” typically include two intranasal applicators
  - Standard education about opioid overdose and naloxone administration is required when dispensing

- Safety during pregnancy and lactation
  
  “Although induced withdrawal may possibly contribute to fetal stress, naloxone should be used in pregnant women in the case of maternal overdose in order to save the woman’s life.”

  -ACOG Committee Opinion #711 (2017)
DEVELOPING A NALOXONE DISTRIBUTION PROGRAM

- **Identify source for naloxone:**
  - Establish relationship with state distribution network
  - Develop collaborative procedures for ordering, delivery, and data collection

- **Develop policies and procedures:**
  - Write clinic/inpatient policy
  - Pharmacy and Therapeutics Committee approval

- **Training and education:**
  - Train providers to dispense naloxone
  - Train nursing staff to provide harm reduction education
  - Develop annual competencies for sustainability

- **Implementation**
  - Launch Screening/identification of patients
  - Integrate naloxone distribution into clinic or inpatient flow

- **Data collection:**
  - Electronic medical record documentation
  - Inventory, ordering, reporting, data collection
NH-AIM recommendation:

**Universal screening for access to naloxone**

- “Opioid overdose is a serious problem in our community. Naloxone can save someone’s life if they overdose. Would you like to talk to someone about getting a naloxone kit?”
Specific Aim: By December 31st, 2021, 75% of postpartum people with an identified substance use condition will receive or be prescribed naloxone by the time of hospital discharge.
DEFINING COMPREHENSIVE CARE
Factors Contributing to Maternal and Infant Outcomes
“Services for pregnant and breastfeeding women with substance use disorders should have a level of comprehensiveness that matches the complexity and multifaceted nature of substance use disorders and their antecedents.”

(World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy 2014)
A CLINICAL PATHWAY FOR PERINATAL OUD

✓ Linkage to care
  ▪ Behavioral Health care
  ▪ Substance use treatment
  ▪ Naloxone

✓ Screening and follow up for infectious disease
  ▪ HIV
  ▪ Hepatitis
  ▪ Sexually transmitted infection

✓ Screen for/address material needs
  ▪ Housing
  ▪ Food insecurity
  ▪ Safety

✓ Anticipatory guidance
  ▪ Infant care/NOWS
  ▪ Hospital policies
  ▪ Plan of Safe Care mandate

✓ Education
  ▪ Breastfeeding benefits
  ▪ Pain management
  ▪ Birth spacing/options

✓ Provide Respectful Care
  ▪ Anti-stigma training for staff

(Krans, et al. Obstet Gynecol 2019;00:1–11)
TRADITIONAL TREATMENT MODEL

SUD Treatment

Prenatal Care

Psychosocial Support

Mental Health Treatment
TWO INTEGRATED CARE MODELS

- **Addiction Treatment Program**
  - OB/Gyn or Primary Care Clinic
  - "Traditional" Integrated Care

- **Behavioral Health**
  - Addiction Treatment Program

- **Perinatal/Women’s Healthcare**
  - "Reverse" Integration

**Key elements**
- Behavioral Health
- Medications for OUD/SUD
- Women’s Health
- Case Manager
- Recovery Support Worker
- Psychiatry
NEW HAMPSHIRE MATERNITY UNIT CLOSURES

Data source: David.Laflamme@unh.edu
Integrated Perinatal Treatment Programs in New Hampshire

Data source: David.Laflamme@unh.edu

<table>
<thead>
<tr>
<th>Perinatal Outcomes</th>
<th>Integrated (n=92)</th>
<th>Non-Integrated (n=132)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm birth, n (%)</td>
<td>10 (11.8%)</td>
<td>33 (26.6%)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Infant days in hospital, m (sd)</td>
<td>6.5 (4.8)</td>
<td>10.7 (16.2)</td>
<td>&lt;0.03</td>
</tr>
<tr>
<td>Admission to the neonatal intensive care (NICU), n (%)</td>
<td>56 (60.9%)</td>
<td>85 (63.9%)</td>
<td>0.64</td>
</tr>
<tr>
<td>Positive meconium/umbilical toxicology, n (%)</td>
<td>27 (29.4%)</td>
<td>46 (34.6%)</td>
<td>0.41</td>
</tr>
<tr>
<td>Positive urine toxicology at delivery, n (%)</td>
<td>33 (35.9%)</td>
<td>99 (74.4%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Pharmacological treatment for neonatal opioid withdrawal (NOWS), n (%)</td>
<td>12 (14.3%)</td>
<td>17 (13.4%)</td>
<td>0.85</td>
</tr>
<tr>
<td>Infant in state custody at discharge, n (%)</td>
<td>9 (10.6%)</td>
<td>15 (12.0%)</td>
<td>0.92</td>
</tr>
<tr>
<td>Tobacco use during pregnancy, n (%)</td>
<td>85 (92.4%)</td>
<td>124 (96.9%)</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Goodman, Saunders, Frew, et al (manuscript in revision)
“I looked into it [treatment], but it was all nothing that I could afford. So I just kept doing what I was doing and getting by, and I got pregnant and I got my insurance and that’s really helped out.”

(Goodman et al. BMC Pregnancy and Childbirth 2020;20:178)
Factors associated with retention in methadone treatment

- Intensive case management
- Methadone dose (>=60 mg/d)

6-month retention rate: 44%

Factors associated with retention in an integrated Family Medicine clinic

- Entry in treatment early during pregnancy
- Pharmacotherapy for depression
- Negative urine toxicology

6 month retention rate: 79.5%

Postpartum Participants Continuing in Dartmouth-Hitchcock Moms in Recovery Program

BARRIERS TO ACHIEVING A TRUE POSTPARTUM “PLAN OF SAFE CARE”

- Reduced Medicaid eligibility for mothers at 60 days post delivery
- Lack of reimbursement for critical services
  - Case management
  - Peer recovery support
  - Community health workers/navigators
- Persistent gaps in continuum of care
  - Access to treatment at level of need
  - Programs accommodating children
  - Woman-centered residential programs
  - Recovery housing options

[Image: Medicaid eligibility thresholds for pregnant women compared to parents, 2021]

RETHINKING POSTPARTUM CARE

✓ Engagement throughout the fourth trimester
  - Short interval follow up (1-2 weeks)
  - Pregnancy spacing/reproductive life plan
  - Emphasis on screening for SDOH needs and linkage to services

✓ Multidisciplinary approach
  - Lactation support
  - Mental health evaluation/treatment
  - Substance use screening/treatment

✓ Affirming cultural knowledge and diverse family structures

✓ Personalized transition to medical home
**Overcoming Barriers**

“I looked into it [treatment], but it was all nothing that I could afford. So I just kept doing what I was doing and getting by and I got pregnant and I got my insurance and that’s really helped out.”

**Internal motivation**

“Just finding out that I was pregnant did give me hope. It made me feel like, wow, I really have – not just for myself, but I have a reason to stop.”

**Self-Efficacy**

“I actually turned it around… I’m not ready to see my parents now that I’m clean… ‘Cause I don’t want them to jeopardize this!”

“You know, people fall and make mistakes. But you can bounce back. ….. it’s not the end of the world to make a mistake, but how you react afterwards and pick yourself up is the important part”
TREATMENT IS MUCH MORE THAN MEDICATION
DISCUSSION

daisy.j.goodman@hitchcock.org
Alliance for Innovation in Maternal Health. https://safehealthcareforeverywoman.org/aim-program


Forray, A, Merry, B, Lin, H et al. Perinatal substance use: A prospective evaluation of abstinence and relapse. Drug and Alcohol Dependence 2015; 150: 147-155


Saiai et al. Caring for pregnant women with opioid use disorder in the USA: expanding and improving treatment. Curr Obstet Gynecol Rep 2016; 5;

Schiff, D, Nielsen, T, Terplan, M et al. Fatal and nonfatal overdose among pregnant and postpartum women in Massachusetts. Obstetrics and Gynecology 2018; 132: 466-74


Wilder, C, Lewis, D, Winhusen, T. Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder. Drug and Alcohol Dependence 2015 149: 225-231

NEW HAMPSHIRE’S PLAN OF SAFE CARE STRATEGY
NEW HAMPSHIRE’S PLAN OF SAFE/SUPPORTIVE CARE (POSC) PROCESS

Baby Born

Is the infant affected by prenatal drug and/or alcohol exposure?

- **NO** A POSC is NOT required by law
- **YES** Notification of Birth*

Notification of Birth*

- **NO** POSC is sent home with mother upon discharge
- **YES** The POSC is sent to DCYF and sent home with mother upon discharge

Develop or update POSC

Inform Health Plan of POSC

Inform Infant’s PCP of POSC

Is a formal report of child abuse or neglect made to DCYF?

It is best practice to begin developing a POSC prenatally and to develop a POSC for all mothers and infants.

*Notification is captured through answering “Prenatal Substance Exposure” questions on the birth worksheet.
Supported Care for Mothers and Infants

July 2019

I. PLAN OF SAFE CARE (POSC)
This POSC, developed collaboratively with the mother and other involved caregivers, reinforces existing supports and coordinates referrals to new services to help infants and families stay safe and connected when they leave the hospital. The POSC must be given to the mother upon discharge and should go to the infant’s primary care provider along with the infant’s other medical records. Providers should encourage the mother to share the POSC with those who do and will provide her services and supports. The POSC includes private health information. For an electronic version of this form, visit: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/.

II. DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Name of Mother</th>
<th>Mother’s Medical Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Father</td>
<td>Infant’s Medical Provider</td>
</tr>
<tr>
<td>Name of Infant</td>
<td>Infant’s Admission Date</td>
</tr>
<tr>
<td>Name of Other Caregiver (if relevant)</td>
<td>Mother’s Admission Date</td>
</tr>
<tr>
<td>Infant’s DOB</td>
<td>Mother’s Discharge Date</td>
</tr>
<tr>
<td>Mother’s Phone Number</td>
<td>Father’s Phone Number</td>
</tr>
<tr>
<td>Mother’s Health Insurance</td>
<td>Other Caregiver’s Phone Number</td>
</tr>
<tr>
<td>Current Address</td>
<td></td>
</tr>
</tbody>
</table>

III. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

IV. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, in recovery)

V. HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Infant</th>
<th>Age</th>
<th>Name</th>
<th>Relationship to Infant</th>
<th>Age</th>
</tr>
</thead>
</table>

VI. EMERGENCY CHILD CARE CONTACT/OFFICE PRIMARY SUPPORTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Infant</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

VII. NOTES/HELP NEEDED (please note date entry)

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NH POSC TEMPLATE

POSC Template (p2)