PREGNANCY AND OPIOID USE DISORDER: PRACTICAL TIPS

CRESTA JONES MD
MATERNAL-FETAL MEDICINE
JONESC@UMN.EDU

DISCLOSURES

- No conflicts to report

OBJECTIVES

- Review the basics of opioid use disorder (OUD) in pregnancy
- Identify how obstetric care may be different when a pregnancy is affected by OUD

POTENTIAL FOR CONFLICTING INTERESTS

THE STIGMA OF DISCLOURE

- Addition as a chronic medical condition
- Substance use disorders in pregnancy
- Criminalization of substance use in pregnancy

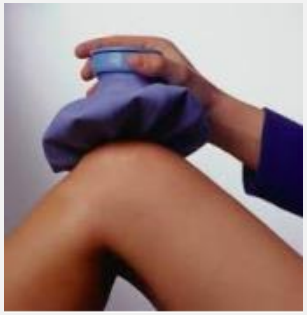
WHY TREAT IN PREGNANCY?

- Prevent opioid withdrawal symptoms
- Prevent complications of nonmedical opioid use
- Improved engagement in care
- Reduce risk of obstetric complications

ACOG 2017

HOW IS PREGNANCY AFFECTED?

INFECTION



INJURY

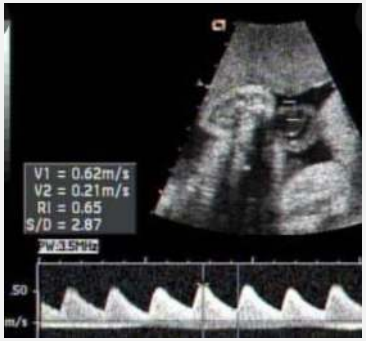
OVERDOSE

PRETERM LABOR, PLACENTAL ABRUPTION

HOW IS FETUS/NEWBORN AFFECTED?

INFECTION

PRETERM BIRTH



GROWTH RESTRICTION

NEONATAL OPIOID WITHDRAWAL

TREATMENT IN PREGNANCY

ACCEPTED

- Methadone
- Buprenorphine
- Buprenorphine/naloxone
- Naloxone (for all!)

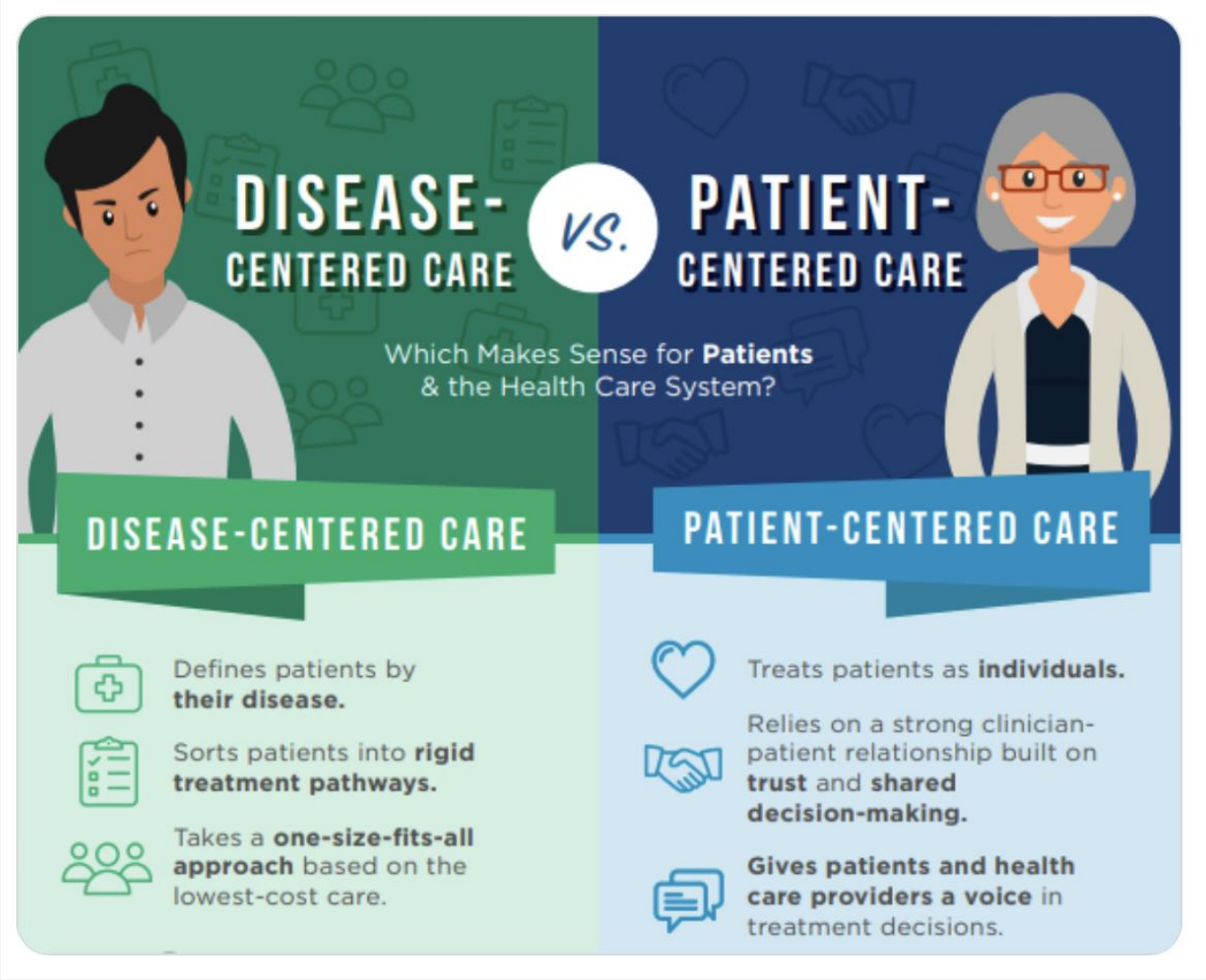
PREGNANCY CONCERNS

- Naltrexone
- Medically assisted withdrawal
- Medication weaning
- Abstinence

PATIENT-CENTERED CARE AND OUD

- ANTENATAL CARE
- LABOR AND DELIVERY
- POSTPARTUM AND BEYOND

PATIENT-CENTERED CARE



allianceforpatientaccess.org

6 elements of patient-centered care

PATIENT-CENTERED CARE

- Non-judgmental environment
  - Anticipate absences from care
  - Transportation/child-care
  - Visitor policy
- Flexibility in scheduling
- Batch care at visits - US, NICU consult
- Preparation for parenting
  - Group for parenting education, online learning
  - Pediatrician with NAS experience

PATIENT-CENTERED CARE

- Management of expectations
  - Goals for care
  - Patient experiences in healthcare system
  - Communication with other providers
  - Surveillance during pregnancy (ultrasound, urine drug testing)
  - Care for delivery, urgent visits
  - Pain management in labor, postpartum
  - Neonatal opioid withdrawal syndrome

HARM REDUCTION

- Harm reduction is person-centered care
- Strategies, ideas to reduce negative consequences
  - Naloxone
  - Sterile syringe exchange
  - Fentanyl test strips
  - No use alone
  - Safe injection sites
- Encourage pregnancy care even if ongoing use
- Discuss contingency plans

PROVIDER COMMUNICATION

Communication is key, but must be compliant!

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

ANTENATAL CARE - PATIENT SUPPORT

Environmental stressors

- ✓ Partner/family with SUD
- ✓ Housing
- ✓ Food access
- ✓ Financial support

ANTENATAL CARE - PATIENT SUPPORT

- Social work
- Perinatal care coordinator
- Peer recovery
- Perinatal mental health
- Residential treatment

ANTENATAL CARE

- Standard prenatal visits
  - Document medication dosing
  - Prescriber contact info
  - Consider UDS
- Targeted fetal anatomy scan
  - Interval growth 28, 34 weeks
- Antepartum surveillance (BPPs, NSTs) 32 weeks ***only if:***
  - Poor fetal growth
  - Non-prescribed use

ANTENATAL CARE - MENTAL HEALTH

- Dual diagnosis
  - Depression, anxiety, PTSD
- Counseling
  - No specific technique
  - Triggers for relapse, motivational interviewing, stress reduction education
- Trauma informed care
- Embed in OB clinic

ANTENATAL CARE – TOBACCO USE

- 85-90% pregnant patients with OUD
- 16% overall pregnancy
- 20-45% smokers quit spontaneously in pregnancy
- Almost none with OUD!

TOBACCO USE TREATMENT

Incentive based treatment – First Breath WI – wwhf.org

Decreased tobacco consumption

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

Akerman et al., Choo et al., Winklbaur et al

ANTENATAL CARE – INFECTIOUS RISKS

- Up to 60% incidence of hepatitis C
- HIV, Tb, hepatitis B, syphilis
- Abscesses, endocarditis, osteomyelitis
- Consider repeat screening third trimester
- Avoid operative delivery, fetal scalp monitoring with hepatitis B, C

Twin Cities Syringe Exchange Calendar:

2022 Hours/Services during COVID-19

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Clinic 555 555 Cedar St, St Paul 651-266-1295		**12pm-430pm** S/W/N/HIV/HCV/VAX/SY/F **Hep A vaccines available**	**12pm-6:30pm** S/W/N/HIV/HCV/VAX/SY/F **Hep A vaccines available**	**12pm-4:30pm** S/W/N/HIV/HCV/VAX/SY/F **Hep A vaccines available**	**12pm-6:30pm** S/W/N/HIV/HCV/VAX/SY/F **Hep A vaccines available**	**12pm-430pm** S/W/N/HIV/HCV/VAX/SY/F **Hep A vaccines available**	
Indigenous Peoples Task Force 1335 E 23rd St Mpls For Syringe Exchange questions call 651-808-3965		**1pm-4pm** S/W/N/HIV/HCV/F	HIV/Hep C/STI testing by apt or walk in. Testing hours: 8:30am-12pm on Tues and Thurs; and Mon, Weds, and Fri 8:30am-4:30pm 612-834-7938	**1pm-4pm** S/W/N/HIV/HCV/F		**1pm-4pm** S/W/N/HIV/HCV/F	
NACC- 1213 Franklin Ave S Mpls In the old Dollar Tree space!		**1130am-2pm** S/W/N/HY/HIV/HCV/VAX/F **Hep A Vaccines Available**					
In 'n' Out-NorthPoint 710 West Broadway Ring doorbell. Call/Text 612-267-0305 or 612-223-3682			**2-5pm** S/W/N/HY/HIV/HCV/F	**2-5pm** S/W/N/HY/HIV/HCV/F	**11am-5pm** S/W/N/HY/HIV/HCV/F	**11am-5pm** S/W/N/HY/HIV/HCV/F	
Rainbow Health-Mainline MCC- All God's Children 3100 Park Ave Mpls 651-359-3459		**2pm-5pm** S/W/HIV/HCV/N/SY/F	**10am-1pm** S/W/HIV/HCV/N'/SY/F		**2pm-5pm** S/W/HIV/HCV/N/SY/F	**10am-1pm** S/W/HIV/HCV/N/SY/F	
Red Door Clinic 525 Portland Avenue Mpls 4th Floor 612.543.5555, press 3 for triage nurse		**9am-4pm** S/W/N/HIV/VAX/F **Hep A vaccines available**		**9am-4pm** S/W/N/HIV/VAX/F **Hep A vaccines available**		**9am-4pm** S/W/N/HIV/VAX/F **Hep A vaccines available**	
Southside Harm Reduction services Mobile team text: 612-615-9725		**Monday-Wednesday 2pm-8pm S/W/N/F** **Text for delivery!** **612.615.9725** See southsideharmreduction.org for map of delivery area **HIV testing available Mondays ONLY 4-7pm**					
Access Points-Valhalla Place BP 2801 Brookdale Drive N Brooklyn Park 763-237-9898		**530am-1pm** S/W/N **Ask at front desk for Access Points**	**530am-1pm** S/W/N **Ask at front desk for Access Points**	**530am-1pm** S/W/N **Ask at front desk for Access Points**	**530am-1pm** S/W/N **Ask at front desk for Access Points**	**530am-1pm** S/W/N **Ask at front desk for Access Points**	

rainbowhealth.org; health.state.mn.us

ANTENATAL CARE – GI HEALTH

- Don’t forget to ask about it!
- Constipation
  - Docusate less effective
  - Polyethylene glycol (Miralax)often needed
  - Preventative, not symptomatic treatment

ANTENATAL CARE – CONSULTATIONS

- Social work
- Maternal-fetal medicine/obstetrics
- Pediatrics
- Anesthesia - non opioid therapy
- Lactation

LABOR AND DELIVERY

- Review expectations beforehand
- Continue outpatient medication
- Buprenorphine continued as prescribed
  - Increased risk of relapse with discontinuation
- Epidural and spinal are effective

Meyer et al 2007, 2010

LABOR AND DELIVERY

- Increased pain surrounding delivery
- *Pearl: Patients require 50% more opioids after Cesarean*
- Post-op pain plan -
  - TAP block
  - PCA/PCEA
  - Adequate staff education is key
  - Enhanced recovery after surgery (ERAS)

Meyer et al 2007, 2010, 2016

DOES PAIN LAST LONGER AFTER CESAREAN?

JONES HE ET AL, AMER JL DRUG ALCO ABUSE 2009

- Pain control after delivery
  - Buprenorphine or methadone vs. no OUD
- Additional opioids used for 1-2 days with rapid decline in use
- Average pain scores were mild and decreased over first 5 days after deliver
- Pain was more intense but did not last longer

POSTPARTUM PAIN MANAGEMENT

- Medication for OUD as prescribed
- Postoperative
  - IV and short acting opioids
  - PCA or PCEA x 24 hours if severe, intractable pain
- Discharge
  - Oral opioid - individualized reduced relapse risk
  - Support person aware of treatment
  - 3-5 days postoperative treatment maximum
  - Lock box
  - Naloxone

POSTPARTUM CARE

- Breastfeeding
  - Minimal transfer of medication
  - Limited ability to treat withdrawal, breastfeeding/skin-to-skin may help
  - ACOG, AAP, ABA support
  - Contraindications
    - Hepatitis C
    - HIV
    - Non-prescribed substance use (cannabis)

POSTPARTUM CARE

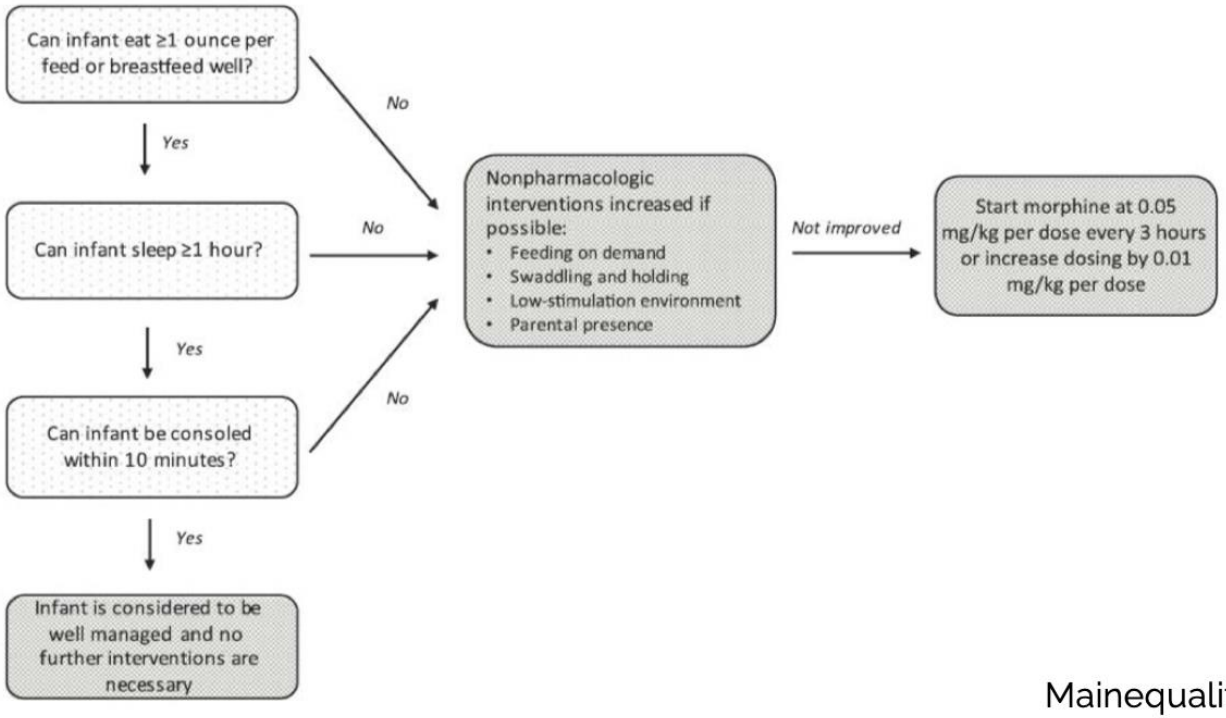
- American Breastfeeding Academy criteria for BF -
  - Compliance with treatment program
  - Consistent prenatal care
  - Negative tox screen at delivery
  - Negative tox screen 30-90 days (not data based)
- Adjusted criteria
  - 50% scheduled visits (2/last month)
  - 4 weeks of no positive tox screen – substantial increase in breastfeeding
  - Substantial increase in breastfeeding

Sala KA et al, 2016

NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

- Constellation of symptoms after cessation of opioid exposure
- 35-70% infants
- No linear association with medication dose/use
- Structured newborn assessments
- Prolonged newborn stay

Eat, Sleep, Console Model



Mainequalitycounts.org

Newborns requiring standard withdrawal medication decreased (46% →27%)

Newborns needing additional medications decreased (13%→ 2%)

CARE AFTER DISCHARGE

- Co-ordinate discharge with treatment program
  - Needs to be planned in prenatal period
  - Bridge prescription or extended stay if weekend, holiday
- Reduce relapse
  - Close follow up - mental health, substance use, OB
  - Postpartum depression screening
  - Ask about cravings/return to use
  - Naloxone prescription
- Transition of care

CARE AFTER DISCHARGE

- 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

OPIOID USE DISORDERS IN PREGNANCY

- Treatment of OUD in pregnancy is very similar to that outside of pregnancy except for medications and dosing changes
- Pregnancy care requires additional support and preparation to optimize outcomes for the pregnant person and the pregnancy
- Long term health remains the goal!