Medication Assisted Treatment for Pregnant Women with Opioid Use Disorder : The MAT4Moms program

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Sobering Statistics

- In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.
- Four in five new heroin users started out misusing prescription painkillers
- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”

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Scope of the Problem in Pregnancy

- **2012 National Survey on Drug Use and Health:**
  - 5.9% of pregnant women use illicit drugs
- **Local numbers- unknown d/t no screening**
  - Approximately 100 NAS babies/year
- **Prenatal substance abuse associated with increased morbidity and mortality for mother, fetus, newborn**
  - Thromboembolic events
  - Infectious disease
  - Perinatal transmission of HIV, hepatitis
  - Preterm birth, placental abruption, IUGR, intrauterine death
  - NAS
  - Child abuse/neglect

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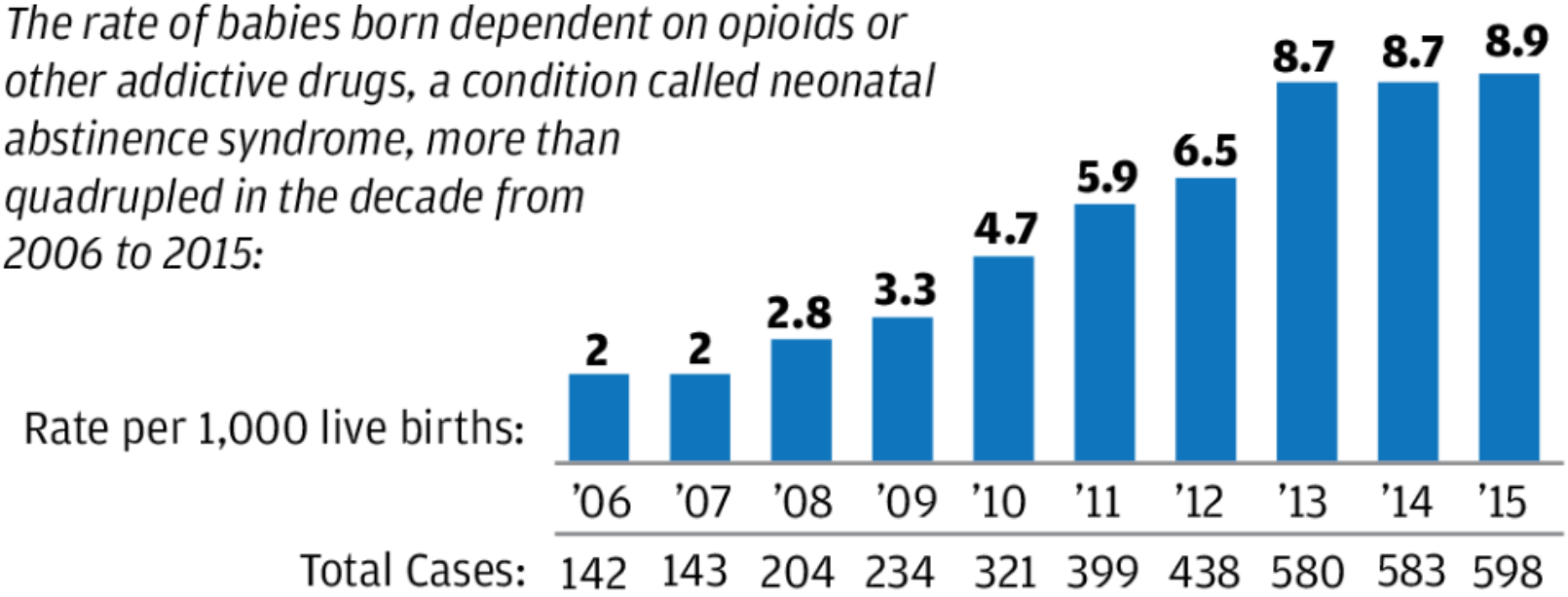
Neonatal abstinence syndrome rising in Wisconsin

The rate of babies born dependent on opioids or other addictive drugs, a condition called neonatal abstinence syndrome, more than quadrupled in the decade from 2006 to 2015:



SOURCE: Wisconsin Department of Health Services

State Journal

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Neonatal Abstinence Syndrome (NAS) Symptoms

- hyperirritability
- excessive crying
- poor sleep
- poor feeding
- diarrhea
- hypertonia tremors
- poor sucking reflex
- seizures

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Barriers To Care

-Lack of trained providers
-In pregnancy specifically, lack of providers who understand both pregnancy and addiction
-Fear of being treated differently
-Stigma of addiction
-Fear of legal ramifications
-Lack of transportation or support
-Inconvenience of methadone clinics

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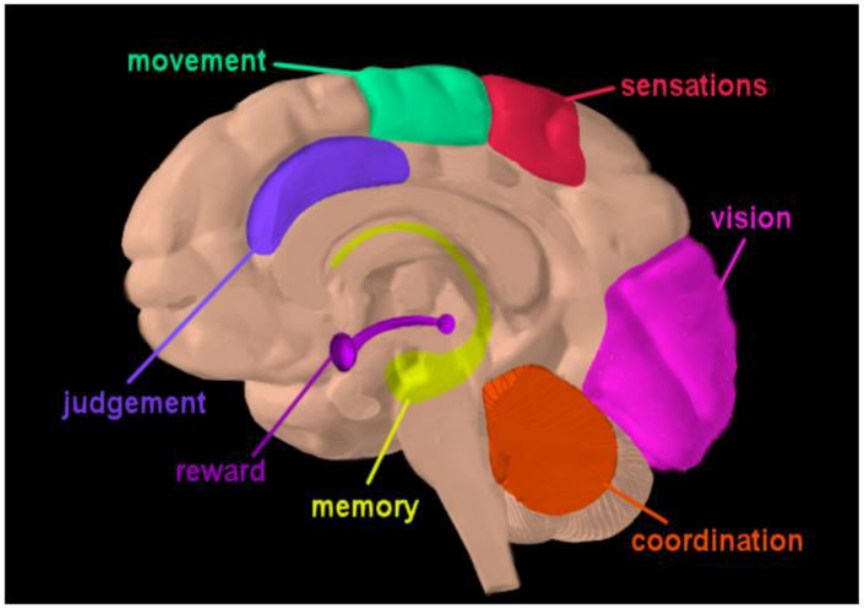
Effect on Brain

Neurological Effects of Opioids

- Desensitizes reward center: decreased pleasure and motivation.
- Increases strength of condition responses: increased cravings.
- Increases stress reactivity: negative emotions when cravings not satiated.
- Weakens executive functions: decision making, inhibitory control, self-regulation.



Volkow, Koob, & McLellan, 2016
www.drugabuse.gov

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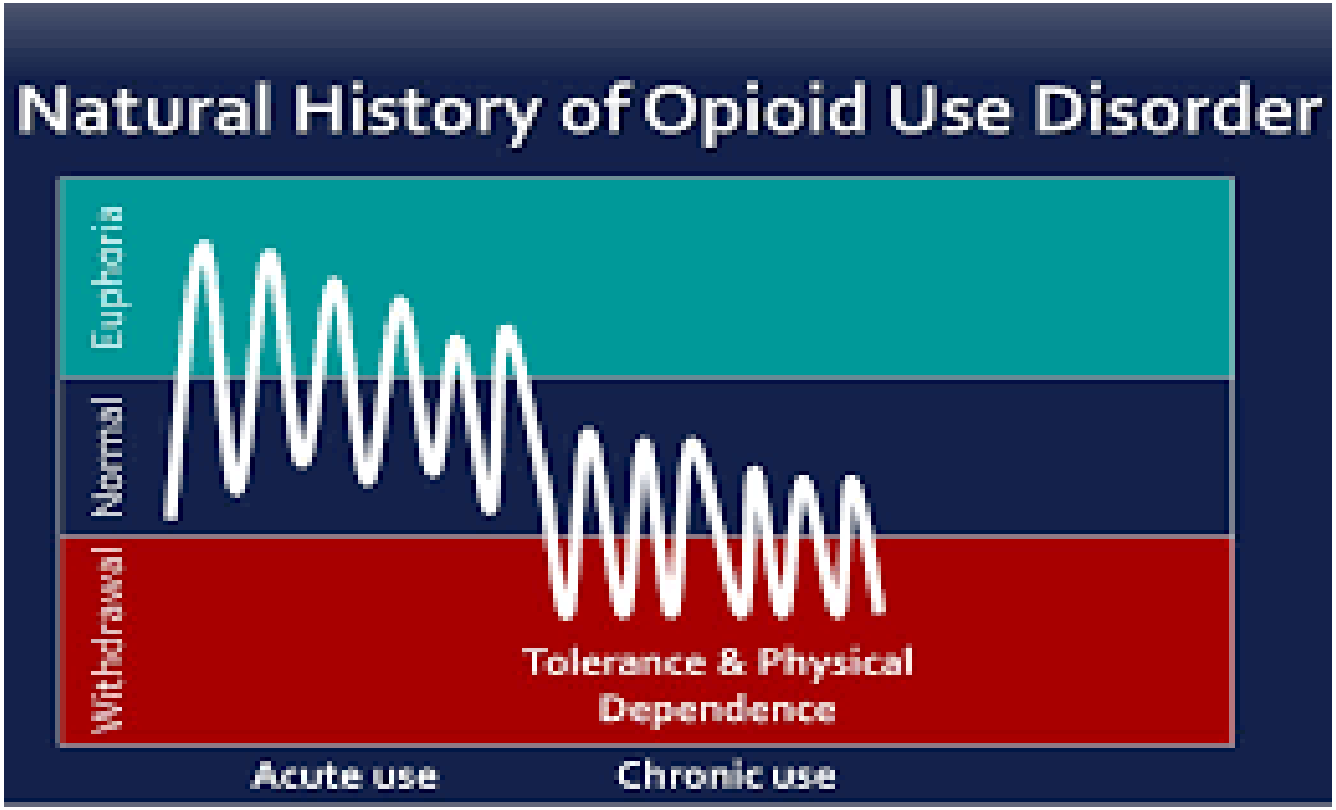
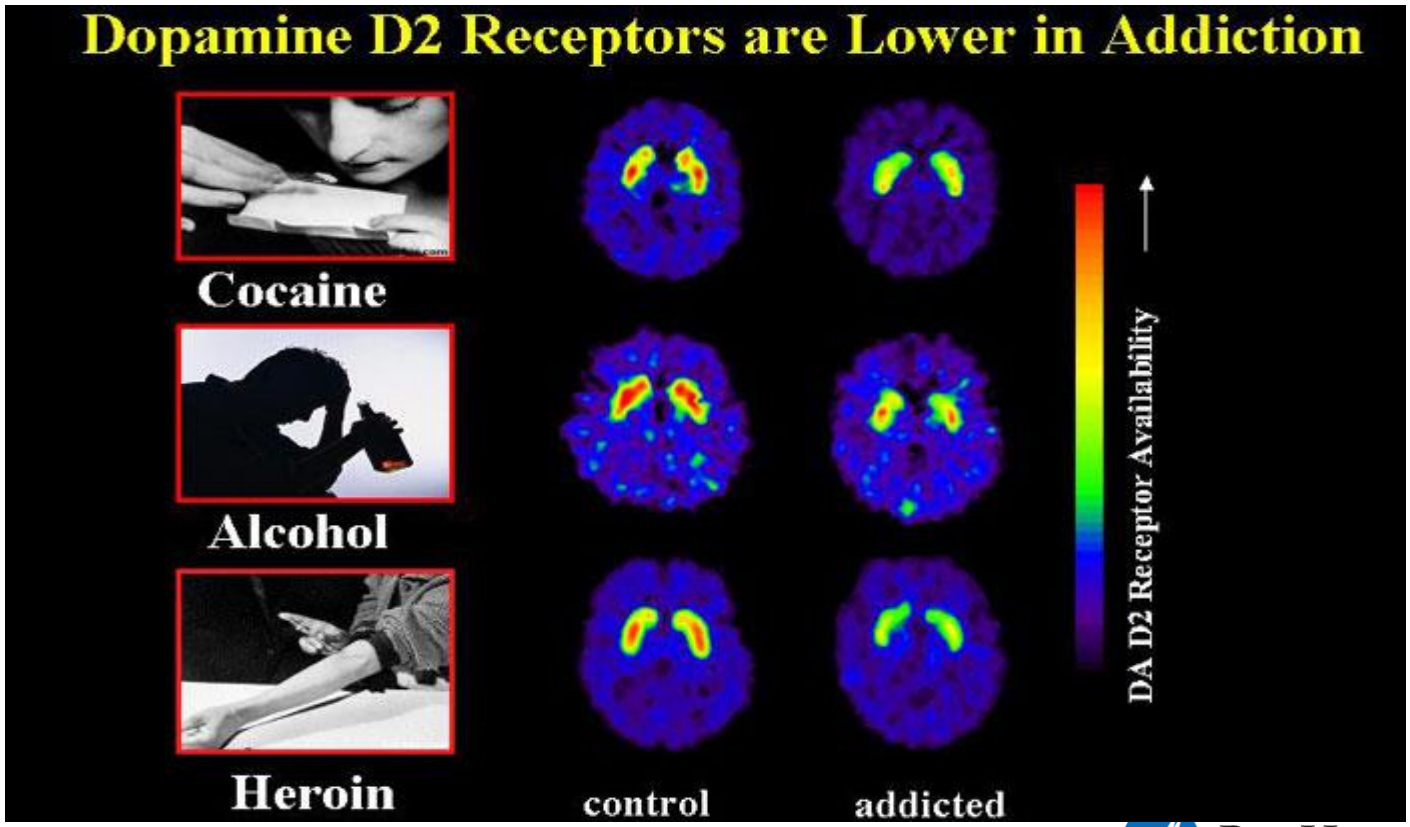

Natural History of Opioid Use Disorder
Euphoria
Normal
Withdrawal
Tolerance & Physical Dependence
Acute use
Chronic use

Substance use affect on brain

- Changes to brain are reversible, but can take years



Condon, T. (2004.)

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Why Use Medication for OUD?

- **Goal is Harm Reduction**
  - 80-90% relapse without medication assisted treatment even after they "detox"
  - Less risk of accidental overdose
  - Increased treatment retention
  - 80% decrease in crime
  - Less HIV/Hep C exposure

Other maternal/fetal benefits of pharmacotherapy for OUD

- Helps remove mother from drug-seeking environment
- Eliminates illegal behavior; prostitution
- Prevents fluctuation of maternal drug
- Reduces maternal mortality and severe morbidity
- Leads to improvement in the mother's nutrition and infant birth weight
- Enhances woman's ability to prepare for the birth
- More likely to retain custody of her children
- Children are monitored more closely when mother is in a treatment program

Detox vs maintenance therapy

- Studies from 1970s demonstrated fetal distress and a 5x increase risk in still birth with antepartum detox
- More recent data shows 2nd trimester detox can be safe for fetus however maternal relapse rates prior to delivery is 70-98%!
- Maintenance therapy in pregnancy

retention in PNC

addiction recovery

in- hospital deliveries

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OUD in Pregnancy (MAT4Moms)

- **We provide a comprehensive program for pregnant and postpartum women**
  - Use Buprenorphine/Naloxone
    - **Induction after 12 hours of abstinence (need to be in mild to moderate withdrawal)**
      - Can be done inpatient or outpatient
    - **Close follow ups (bi-weekly, weekly, monthly)**
  - Individual/small group therapy
  - Social worker to aid with community resources
  - Coordinate care with OB/PAC to limit transportation and increase likelihood of compliance
  - Assists in providing resources for cessation of other substances, including tobacco

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Goals of the Program

- Identify pregnant women with opioid substance use disorder who could benefit from treatment
- Provide treatment in a non-judgmental, supportive environment
- Decrease negative outcomes associated with prenatal substance abuse
- Identify newborns at risk of NAS
- Decrease NICU length of stay
- Provide appropriate support beyond pregnancy
- Train a primary care workforce who will be able to extend the impact of an addictionologist

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Why Family Medicine Doctors?

- Experience with obstetrical care, low and high risk: prenatal care, delivery, postpartum care
- Experience with infant care including NAS babies
- Experience with substance use, addiction
- Provide services inpatient and outpatient
- Used to thinking about care from a whole family perspective
- Coming to FM office decreases stigma for patients

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Program Components

- **Coordinator**
  - Performs intake to make sure patients are appropriate for out program
  - Patient Tracking, Navigator, Communication
- **Behavioral Health**
  - Intake and create BH treatment plan
  - Group and individual counseling
- **MAT Prescribers**
  - FM Faculty and eventually resident doctors
- **Social Work**
  - Link to services and programs. Coordinate with legal system, CPS, insurance. Help obtain baby items.

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OUD in Pregnancy Program

- **How do patients get to the program**
  - Self referral
  - Referral from a community agency
  - Referred by their obstetrical provider or PCP after a positive 4P's screen or other disclosure of opioid use
  - Referred after delivery with baby with NAS
  - De-escalation of care after PHP->IOP->MAT4Moms
  - Can utilize the program for both medication assisted treatment AND behavioral health, or JUST behavioral health (e.g. getting methadone or buprenorphine from outside provider)

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OUD in Pregnancy Program

- **Who qualifies for the program**
  - Women who have opioid use disorder
  - May have other co-existing substance use disorder
  - Interested in treatment
  - Pregnant, Planning to get pregnant, Post-partum (up to 1 year after delivery)
  - Must give permission for us to coordinate care with their obstetrical provider
  - Must have US documentation of viable pregnancy if pregnant

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General Overview

Patient referred or self referred to program

Coordinator makes phone contact same day, sets up intake day within 24-48 hours

Intake day includes extensive assessment by behavioral health and the coordinator

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Intake Day

- **We have same day availability for inductions- outpatient vs inpatient**
- **Tasks of Intake Day**
  - Confirm diagnosis of opioid use disorder
  - Screen for co-existing substance use disorder, mental health issues
  - Complete assessment to confirm appropriate for outpatient therapy
  - Review expectations, rules of the program, sign consents, provide instructions and Rx for medication for induction day

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Induction Day

- Goal is to do most inductions as outpatient
- Start in mild withdrawal (off substance for around 12 hours)
- Serial COWS assessments and medication administration, takes 3-4 hrs
- Home with comfort meds and just enough strips until next appointment
- Follow up by phone next day, in person 1-3 days

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Induction Day

- Can be done inpatient if needed
- Teaching Service would direct therapy
- Patient monitored on L&D

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Follow Up

- **With MAT providers**
  - 1-2 times a week for the first 4 weeks
  - If stable decrease to every 2 weeks
  - Post-partum return to weekly visits
- **With Behavioral health**
  - Treatment plan established at first visit
  - Usually mirrors MAT plan for individual counseling
  - Weekly group
- **With Social Work**
  - Sees patient following intake day, and periodically as needed. Can also make home visits.

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Urine Drug Testing

- **Urine drug testing is done at EVERY MAT visit, and once per day per patient**
  - POCT result available immediately
    - **Temperature measured within 5 minutes**
  - Confirmatory within 48-72 hours
    - **Tests levels of around 100 substances**
    - **Can request additional testing if concern it isn't urine**
    - **Provides actual levels**
    - **Scanned into media**
- **If BH visit only- obtain UDS**

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Other Program Components

- All patients recommended to have a NICU tour/NNP consult
- Patients receive support and counseling on total abstinence (including cigarettes)
- Patients receive education on how they can help decrease their child's likelihood of elevated NAS scores
- Program is notified at delivery, will make visit in hospital and coordinate transition of care around MAT

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Preventing NAS

- **We strongly recommend the following:**
  - Breastfeeding (unless active heroin use, cocaine use, alcohol use)
  - Skin to skin with infant
  - Decreased stimulation in the room (visitors, loud noises)
  - Maternal UDS on admission
- **All babies receive 5 days of monitoring NAS scoring**

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Other Program Components

- Relapse or struggle prompts INCREASE in care
- Only reasons to get kicked out of the program are: diversion, misuse, not using meds
- If we have escalated to MAT/BH visits 5/5 weekdays, would transition to PHP

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Program Leadership & Participation

- Susanne Krasovich, MD- Medical Director
- Maureen Longeway, MD- Director of Education
- Kristen Fox, MD- Director of Advocacy, Addiction Fellow
- Jessica Knipfer, NP, Jenny Gruber, NP- Program Coordinators
- Colleen Allen, MSW- Social Worker, Director of Community Outreach
- Carrie Laux, LCSW, Aaron Grace PsyD- Behavioral Health Providers
- Simon Griesbach, MD, Anna Witt, MD- MAT providers
- Michelle Morgan, MD- Resident liaison
- John Dang, MD, Pat Ginn, MD, Mike Mazzone, MD- additional waiver trained faculty
- Deb Schaber, RN- PHMG-Barstow Clinic Manager
- Megan Anderson- WHSL Leadership
- Olin Yauchler- Director of Behavioral Health
- Subhadeep Barman, MD- Addiction Medicine Advisor
- Randy Kuhlmann, MD- Perinatology Advisor

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Questions?

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