PROUD Program: A Multidisciplinary Approach to Treating PeRinatal Opioid Use Disorder

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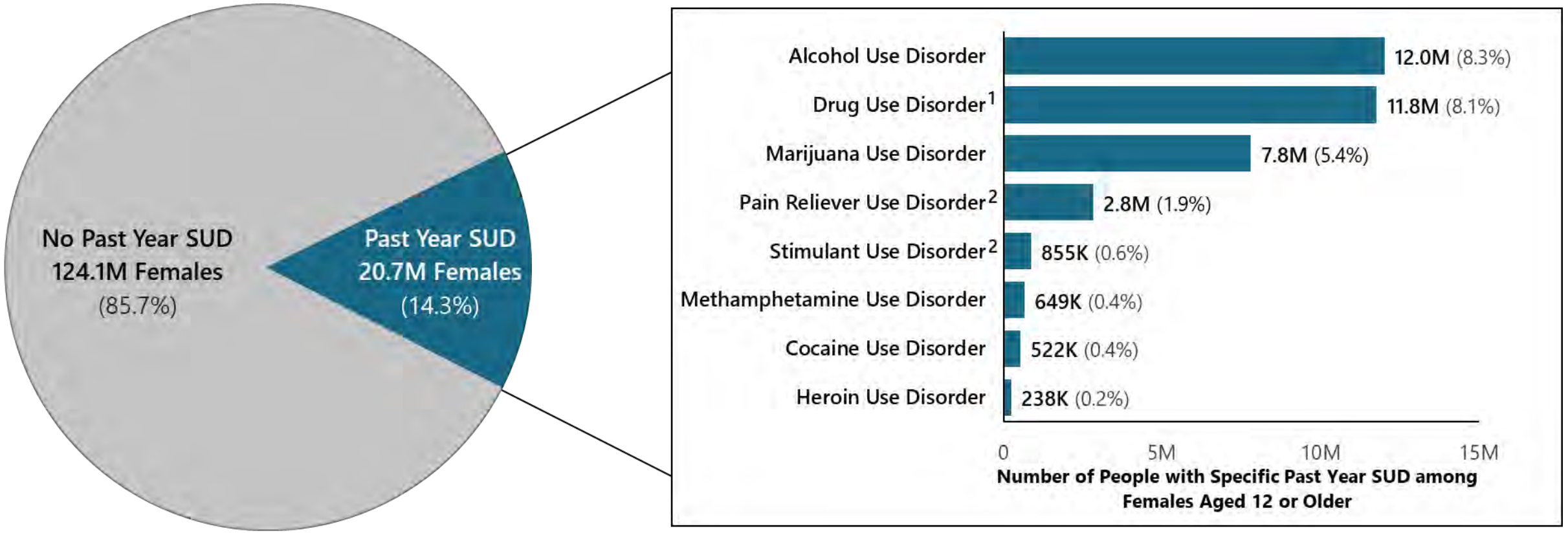
Waukesha County Community Health Partner Summit

11/11/25

Overview

- Perinatal opioid use disorder (OUD) in our Community
- PROUD clinic build and overview of services
- Highlights from the multidisciplinary model and community partnerships
- Outcomes

Past Year Substance Use Disorder (SUD): Among Females Aged 12 or Older

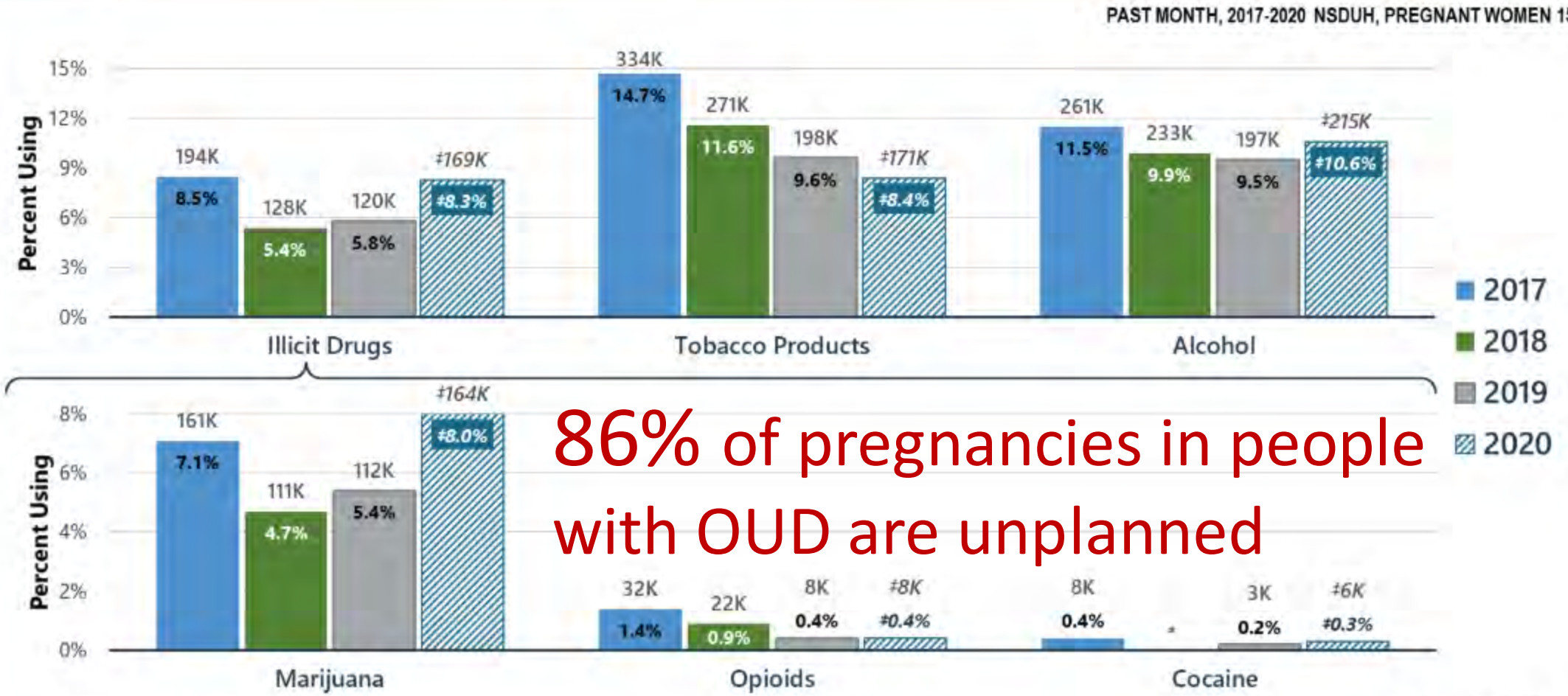


Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

[1] Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

[2] Includes data from all past year users of the specific prescription drug.

Substance Use in Past Month: Among Pregnant Women Aged 15-44



86% of pregnancies in people with OUD are unplanned

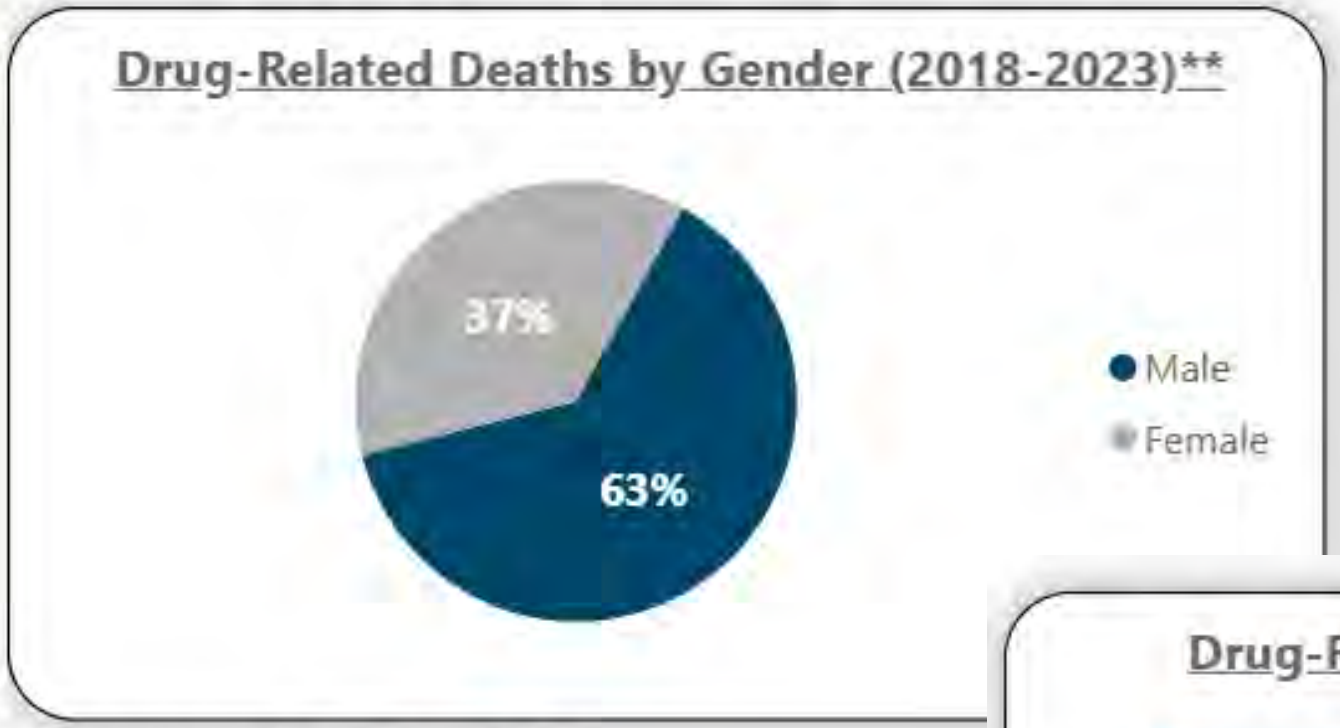
* Estimate not shown due to low precision.

Tobacco products are defined as cigarettes, smokeless tobacco, cigars, and pipe tobacco.

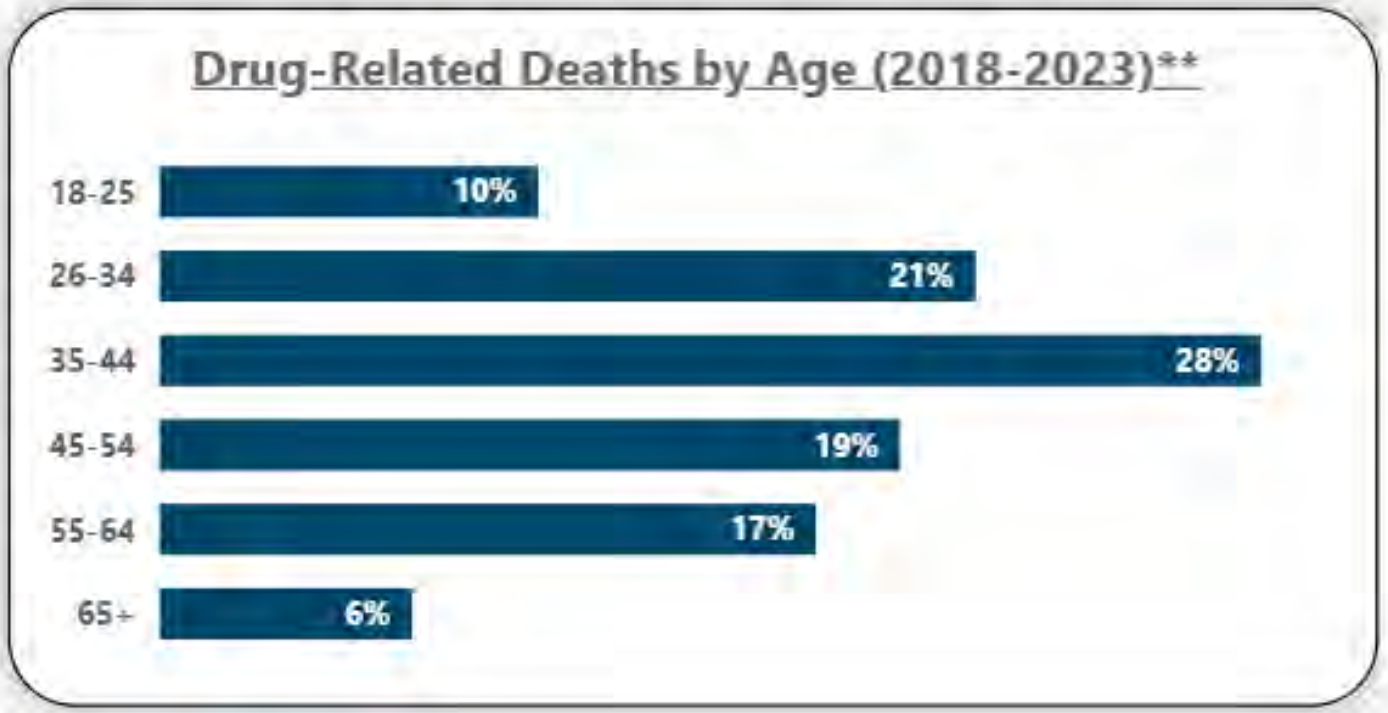
‡ Estimates on the 2020 bars are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

SAMHSA
Substance Abuse and Mental Health Services Administration

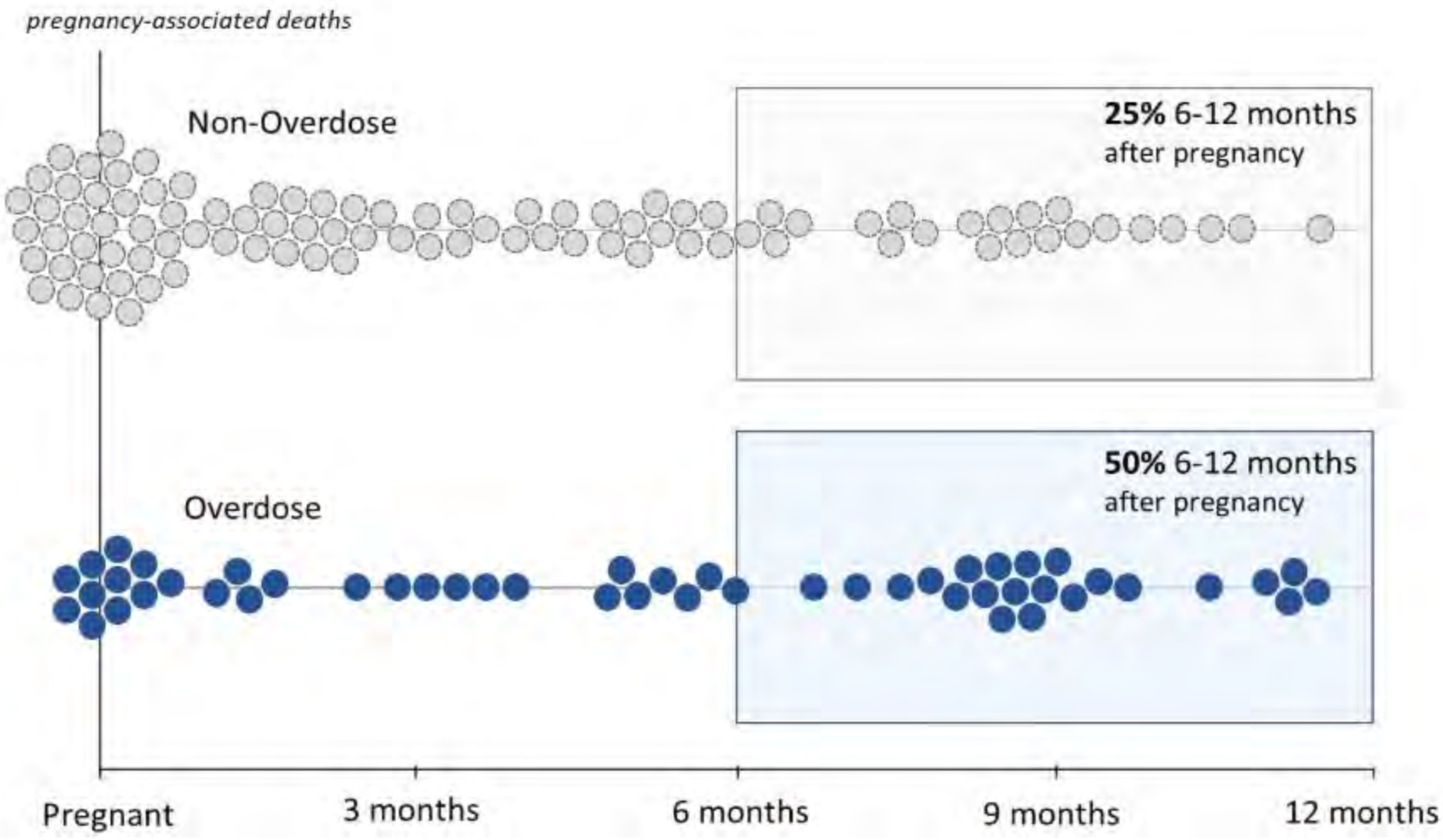
Waukesha County



Source: Waukesha County Examiner's Office.



WI Maternal Mortality Review



52 fatal overdoses 2016-2019

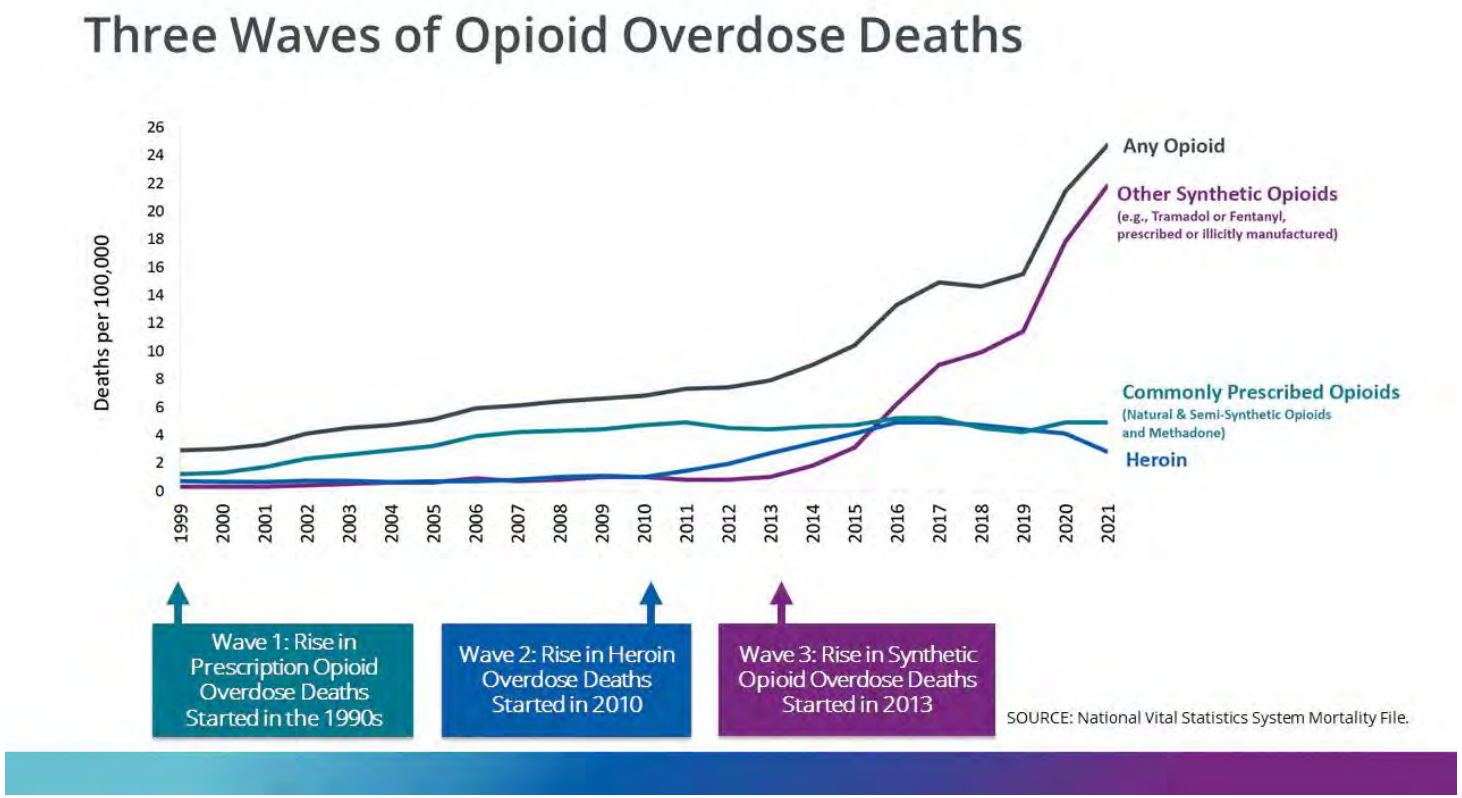
Postpartum is highest risk time

Rise of perinatal OUD

↑131%
OUD related diagnoses at delivery

↑81% increase in drug overdose mortality

↑8x
Incidence of Neonatal Opioid Withdrawal Syndrome (NOWS)



Risks of OUD in pregnancy

↑4.6x death during hospitalization

↑ 2x premature birth or stillbirth

↑ 3.5x cardiac arrest

↑ 2-4x* serious pregnancy complications such as preeclampsia, unplanned C-section, infection

*Note confounding and additive variables (smoking, poverty, poor nutrition, racism, stigma, health equity, etc.)

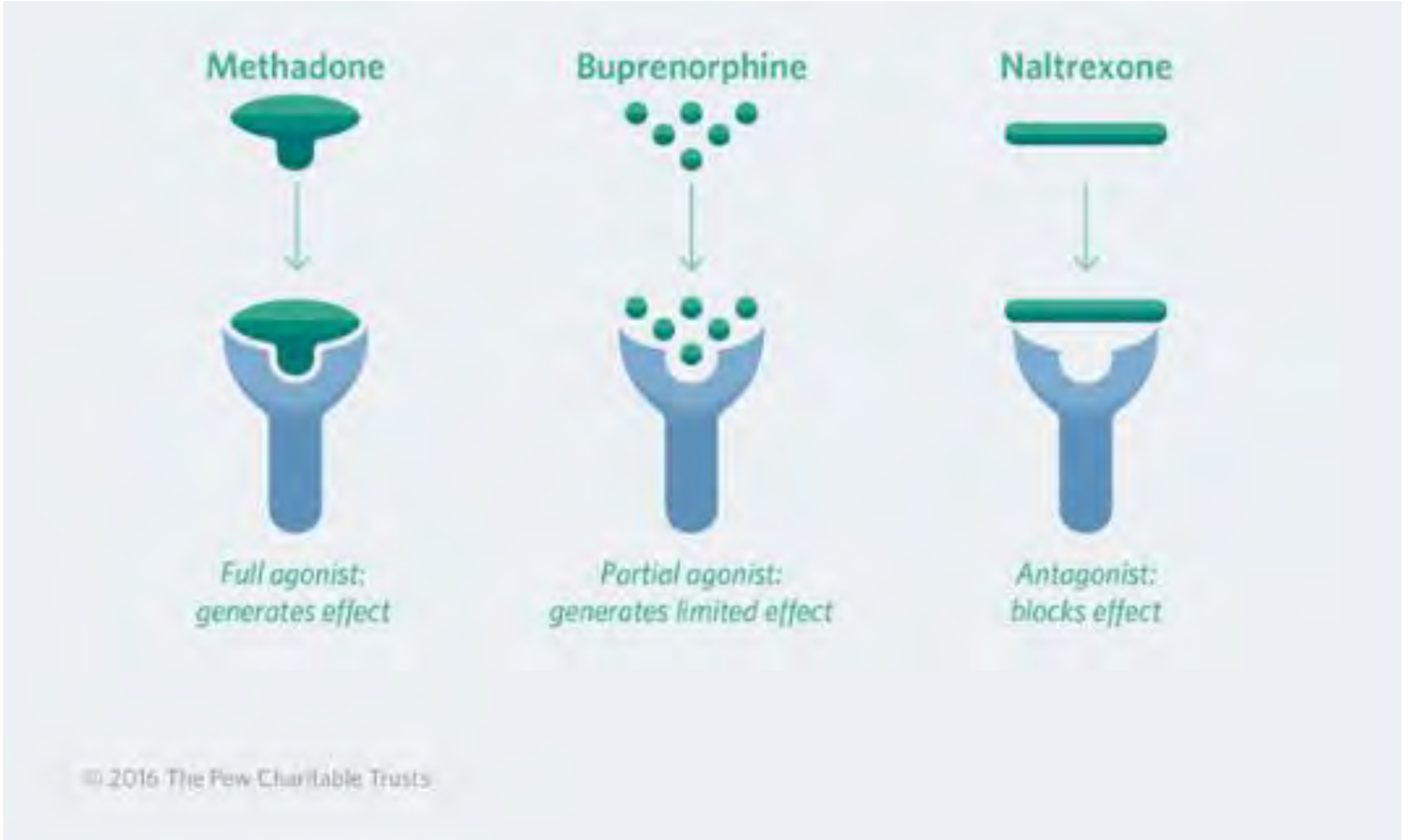
Key points:

- OUD affects people who can become pregnant, right here in our community
- OUD is a major risk factor for morbidity and mortality for both pregnant person and fetus

So, what can be done?

Treating OUD in pregnancy

- Medications (MOUD) are THE standard of care
- Medications are safe, benefits >>>> risks
- Reduce cravings, protect against overdose
- Treatment without medications (e.g. therapy, detox, mutual support) is associated with *higher* rates of:
  - Adverse fetal and maternal outcomes
  - Neonatal opioid withdrawal/abstinence syndrome (NOWS/NAS)
  - Return to substance use
  - Overdose events



Benefits of MOUD in Pregnancy

Maternal

↓ exposure, overdose

↓Pregnancy complications

↓Secondary consequences (e.g. Infections, violence)

↑Mental health treatment

Turning point in recovery for many

Neonatal

↓preterm birth, low birth weight

↓unplanned maternal infant separation

No evidence of significant long term neurodevelopmental harm

Neonatal Opioid Withdrawal Syndrome

- Constellation of symptoms that occur upon cessation of chronic opioid exposure
  - Crying, irritability, tremor, sleep disturbance, feeding difficulties
  - Poor weight gain, dehydration, seizure (rare)
- Stable MOUD is associated with **LOWER** risk of NOWS

Eat. Sleep. Console

- Extended hospital stay for neonate ROOMING in with mother and other caregivers
- Focus on infant function, not just symptoms
  - Eating, sleeping, soothing
  - Weight and hydration
- Mother is the medicine
  - Breastfeeding
  - Soothing
  - Supportive environment
- Escalation of care when necessary

63% less likely to receive medication

>50% reduction in NICU admissions

Discharged **6.7 days earlier**

No difference in adverse outcomes

Medically supervised withdrawal (Detox)

- **NOT RECOMMEND** by any guideline, high failure rate
- Elevated risk of fatal overdose (especially first 4 weeks)
- Significantly increased risk of pregnancy complications compared to MOUD
- Does NOT improve rates of NAS (30-70%) of babies whose mothers were detoxed still had it!)
- Close monitoring if elected after informed consent

Behavioral treatments

- **Behavioral treatments ALONE have NOT shown any benefit**
- No clear evidence to support added benefit when used with MOUD
- Support access if a patient finds it helpful
- DO NOT insist on behavioral treatments to access MOUD!
  - Not evidence based
  - Unnecessary barrier, health equity concerns

Treatment of Comorbidities

- Other substance use disorders (particularly tobacco)
- Psychiatric disease and medications
  - Ensure medications safe in pregnancy (almost all are)!
  - Stopping is RARELY the answer.
  - Review for drug interactions
- Medical conditions
  - HIV, hepatitis, infections
  - Obesity, high blood pressure, diabetes etc.

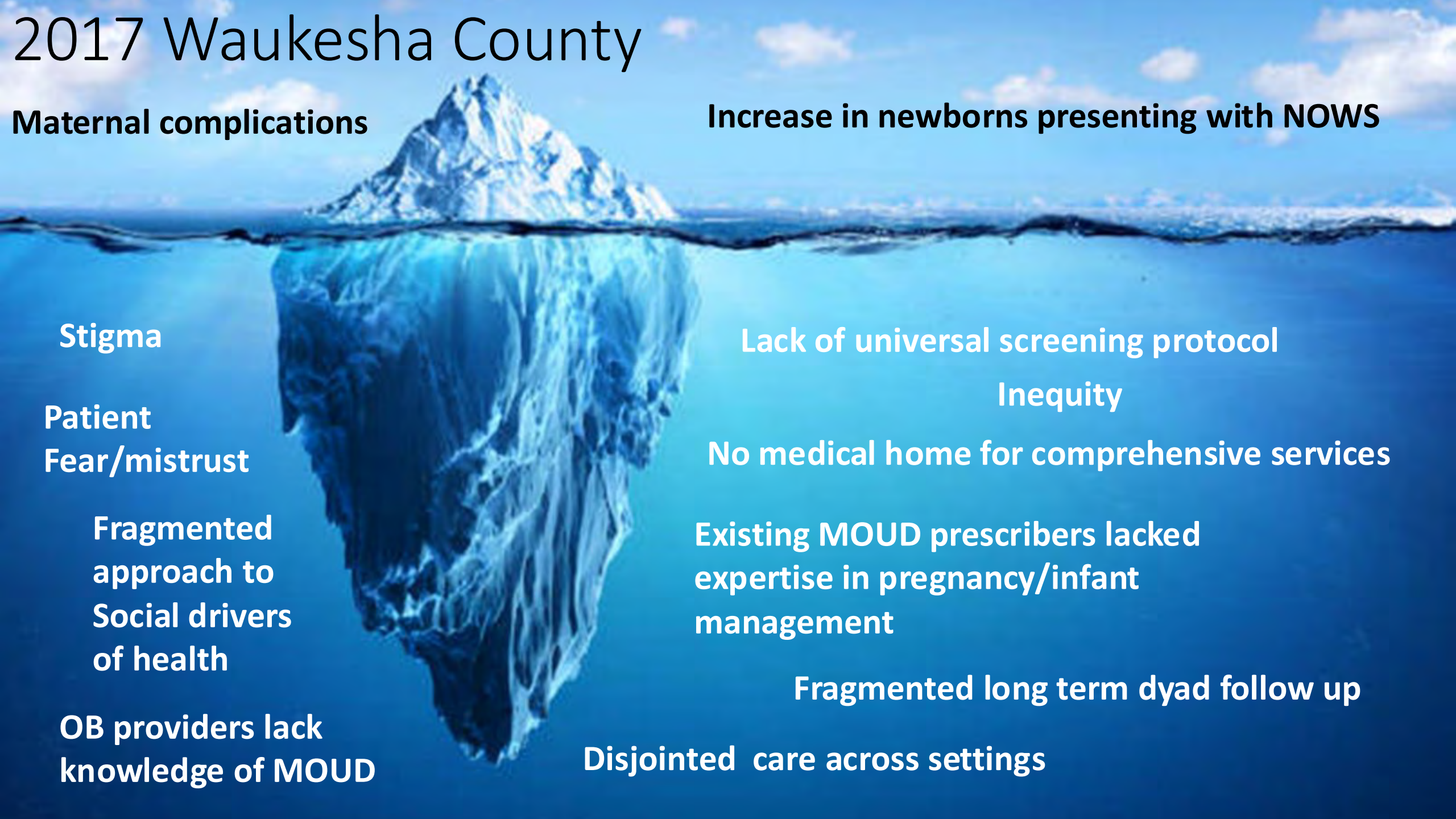
Key Points:

MOUD is the standard of care treatment for perinatal OUD

Numerous positive outcomes for both the pregnant person and fetus/neonate as well as the community

A solution exists…but we were not implementing it

2017 Waukesha County



Maternal complications

Increase in newborns presenting with NOWS

Stigma

Patient Fear/mistrust

Fragmented approach to Social drivers of health

OB providers lack knowledge of MOUD

Lack of universal screening protocol

Inequity

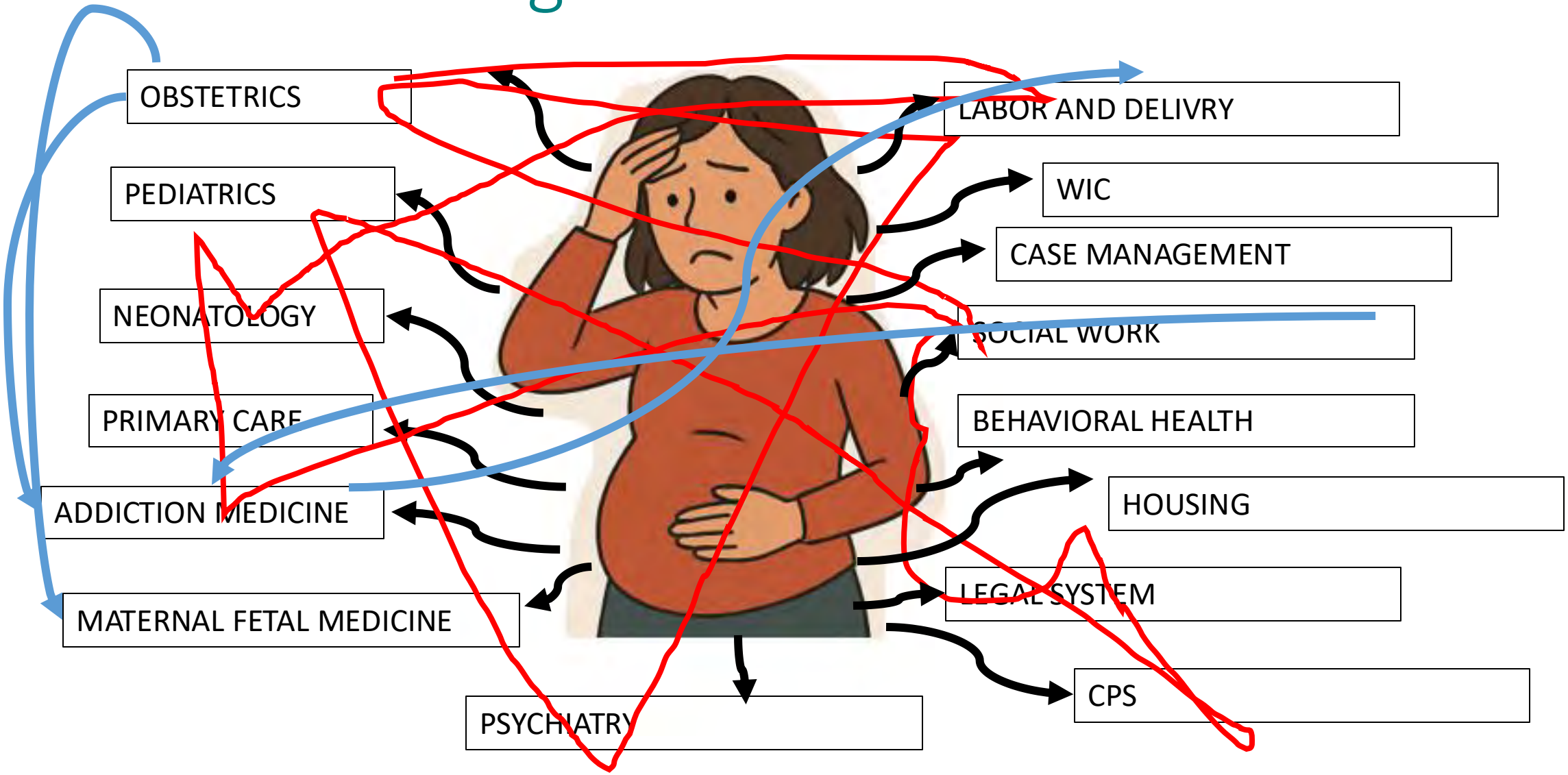
No medical home for comprehensive services

Existing MOUD prescribers lacked expertise in pregnancy/infant management

Fragmented long term dyad follow up

Disjointed care across settings

Challenges with Perinatal OUD



Program Vision

- **Standardize** screening
- **Coordinate** comprehensive services
- **Provide** evidence based OUD treatment
- **Strengthen** culture
- **Improve** dyad outcomes
- **Train** resident physicians

Getting Started

- **Commissioned** core build team
- **Completed** literature review, provider education
- **Built** electronic medical record tools
- **Designed** clinic and panel management workflows
- **Collaborated** across specialties and departments
- **Secured** grant funding

Core services and Program Roles

- Family Physician
- APNP program coordinator/case manager
- OB care by co-located family physician (ideally, may also have outside OB)
- Dedicated, integrated social worker
- Behavioral health when indicated, co-located or referred out

Family Physician

Program Coordinator: Keeping it all running!

Social Worker: Dyad Navigator

Social Worker: Community Advocate

Key Points: A successful program requires

Careful planning with collaboration across the healthcare system and community

Multidisciplinary team

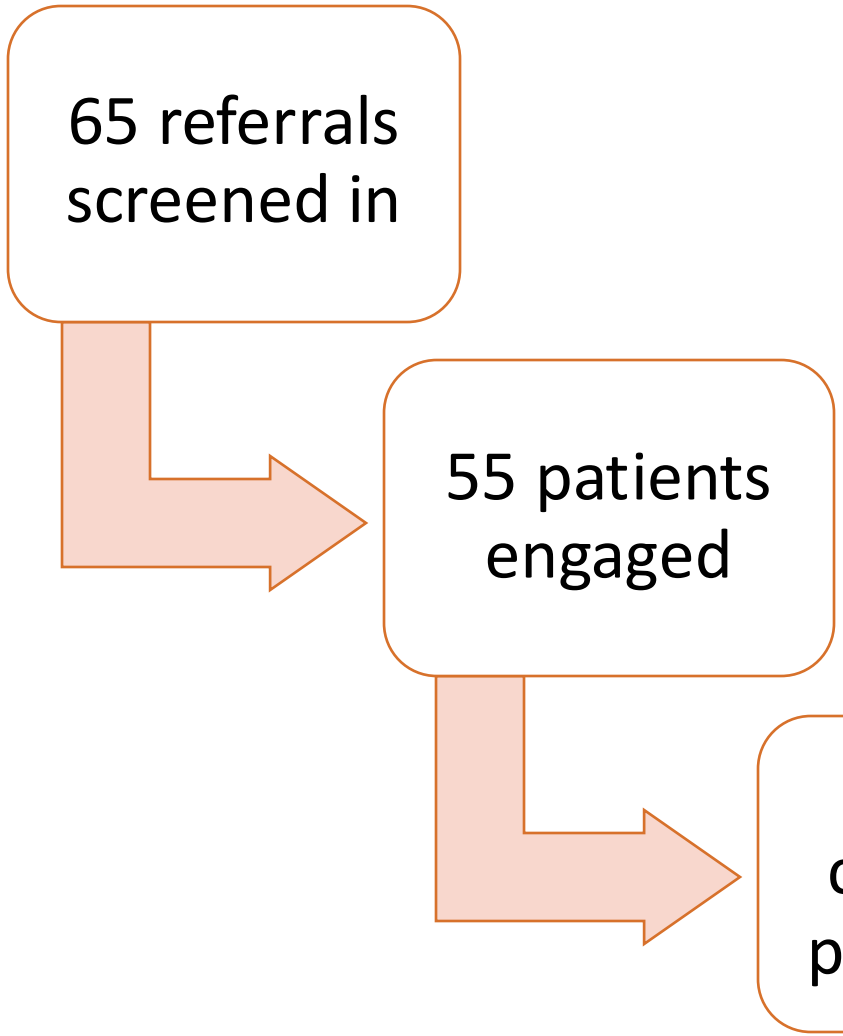
A lot of hard work with a long term vison

Financial Support

So…did it work?

PROUD CLINIC 5 year outcomes

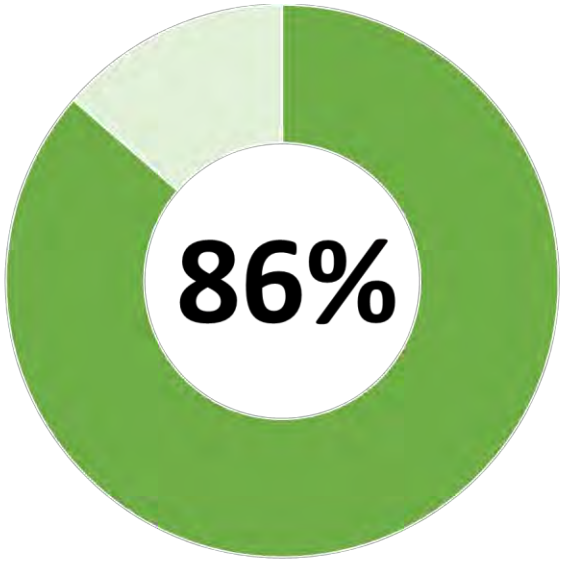
Intensive Case Management



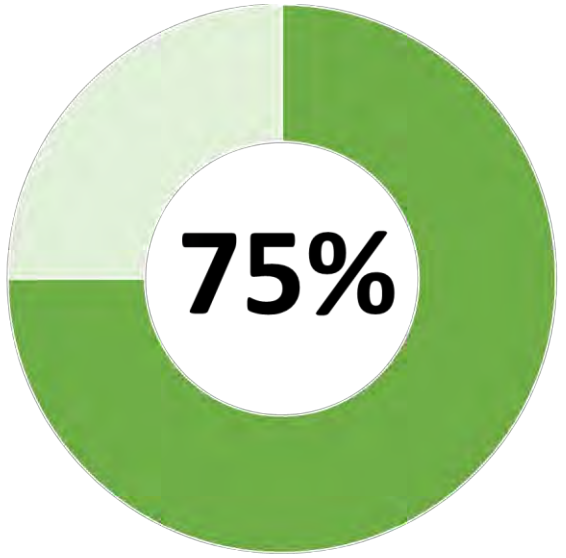
85% engagement rate

81% ≥6 Prenatal visits

Treatment Outcomes



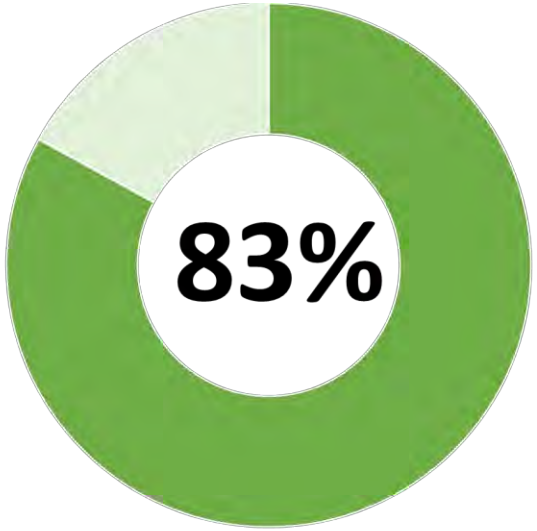
Early remission



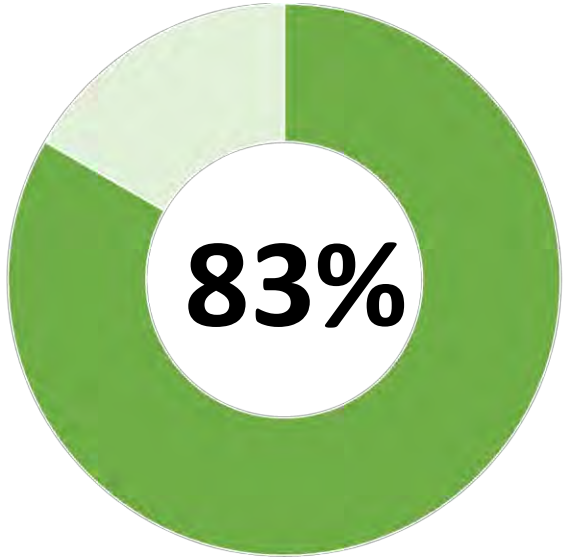
Sustained remission

1 fatal overdose in 7 years

Pregnancy Outcomes



Full term deliveries

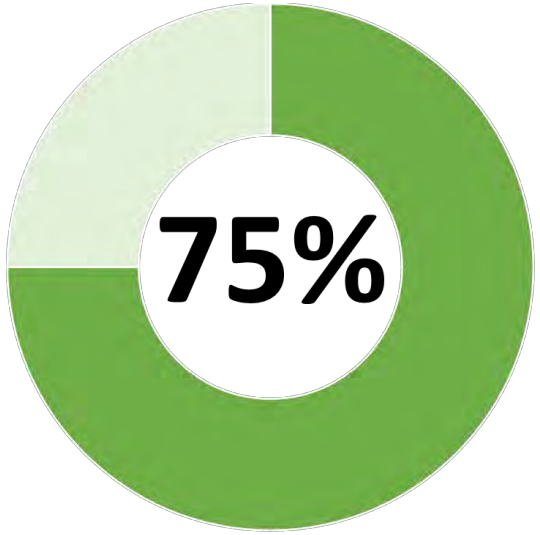


Infants did NOT require NICU for NAS management

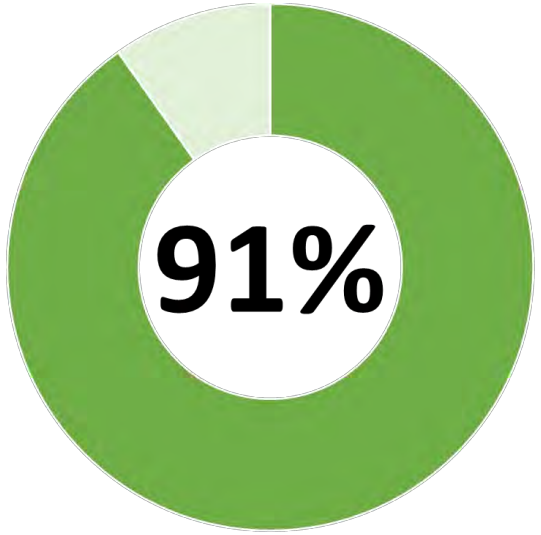
dyads referred postpartum excluded

After implementation of ESC 0 infants required NICU admission for a primary diagnosis of NAS

Long-term Support



Patients not planning another pregnancy chose LARC or sterilization



Patients retained placement of their infants or pre-planned adoption

Lessons learned

- Integrated, multidisciplinary care achieves excellent outcomes
- Family Physicians are uniquely skilled to lead this care
- Intensive case management and SW services are key
- Longitudinal follow up supports healthy dyads and family planning
- Education and advocacy beyond the clinic create broader change
- Residents are eager to learn and continue addiction care

Future Goals

- Developing contingency management
- Growing childcare and transportation resources
- Expanding peer support/doula support
- Improving collaboration with justice involved patients
- Continuing housing advocacy
- Cultivating a community in which all families affected by OUD have access to outstanding care

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