Caring for opioid dependent women in the hospital setting.

GOALS AND OBJECTIVES OF INTERESTED STAKEHOLDERS IN IDENTIFYING AND ADDRESSING NARCOTIC USE IN WOMEN OF REPRODUCTIVE AGE—BEFORE AND DURING AND AFTER THEIR PREGNANCY.

JUNE 3 2016
The Era of Opioid Addiction

Most women currently using drugs are addicted to narcotics. Initial studies (not well designed) reported that opioids and opiates cannot be stopped abruptly, as fetal withdrawal could result in severe fetal distress and fetal death.

Currently, ACOG and ASAM both recommend that opioid dependent women be maintained on legal and readily available opioids to prevent IV use and behaviors associated with drug procurement. Legal maintenance is felt to promote willingness to obtain early and consistent prenatal care.
How does opioid addiction happen?

- Excessive prescribing practices in recent years.
- Excess production by Big Pharma, exceeding amount needed for the legal scripts written.
- Previous easy access from Pill Mills. Closure of Pill Mills greatly reduced access.
- In Volusia and Flagler Counties, addicts who are pregnant have great difficulty obtaining alternatives that are safe, legal and affordable.
- There is one clinic (Daytona Methadone Treatment Center) for East Volusia and Flagler. Single daily dosing is $17 in cash.
Daytona Methadone Treatment Center

$17 every day in cash for methadone

$22 every day for buprenorphine

Must pick up dose daily between 5am and 11am

Dosage in pregnancy quickly increased due to rapid placental excretion—often to amounts exceeding 180 mg each morning.
Opioid misuse during pregnancy is at epidemic levels nationwide.

- High rates of infection, malnutrition, dental caries...
- Premature delivery, seizures, fevers, irritability, inability to nurse....
- Low birth weight, which is an important risk factor for later developmental delay...
- Comprehensive opioid maintenance that includes prenatal care reduces these risks.
- Other alternatives needed if methadone is unavailable or unacceptable to the mother.
Why have we not routinely weaned the mothers to avoid neonatal abstinence syndrome?

Symptoms of withdrawal are painful to mom and fetus.

Recidivism—risk of returning to use after detox

Risk of mom turning to other substances

Risk of withdrawal related damage to fetus

Malpractice risk—weaning is not the standard of care
Community Partnerships at work

In Volusia and Flagler Counties, pregnant women with drug dependency are entering our health system from many directions with unique concerns.

Care for these women must be a multi pronged approach, involving medical providers, addiction specialists and social programs.
Community Partnerships at Work

Standard of care remains maintenance therapy on medically prescribed and monitored opioid.

Currently, our community has no access to subsidized methadone and limited access to buprenorphine.
Project Warm is a long-term residential program for at-risk women, many of whom are pregnant, post partum or parenting young children. To participate, they must be in recovery. At this time WARM cannot accommodate women who are being maintained on methadone or buprenorphine.

Over the last ten years more than 300 women have completed treatment. On average two to three drug-free babies are born each month. 70% of women who enroll at WARM complete the treatment program. Over 250 babies have been born drug-free.
Project WARM at Vince Carter

PROJECT WARM MOVED TO THE VINCE CARTER SANCTUARY
APRIL 1, 2013

THIS INCREASED BEDS FROM 16 TO 52 TO NOW OVER 80 FOR
PREGNANT WOMEN AND WOMEN WITH CHILDREN, WHO WERE
RECOVERING FROM ADDICTION.

SINCE THE MOVE TO VCS, WARM HAS SERVED OVER 190 WOMEN
AND 80 CHILDREN, ANNUALLY.

BETWEEN 16-20 INFANTS ARE BORN DRUG FREE TO RECOVERING
MOTHERS, ANNUALLY AND ABLE TO LEAVE THE HOSPITAL WITH
THEIR MOTHERS.
A multi-provider approach...

- Project WARM is assisting women in recovery to maintain their drug free status during and after the birth of their children.
- If addicted at delivery, moms can then detox.
- Halifax Health NICU treats addicted infants with Neonatal Abstinence Syndrome, so that they may be safely weaned.
- Project WARM is available to moms after delivery, once moms and babies are both in recovery.
Now, Academic and Urban medical centers moving toward detoxification in pregnancy

- University of Tennessee Medical Center
- University of Texas South Western Medical Center
- University of Kentucky Medical Center
- SMA Pine Grove, Daytona Beach
Maternal opiate detoxification during pregnancy significantly improved pregnancy outcome, without putting fetus at risk.

301 opiate addicted pregnant women were detoxed with no fetal death.

These infants avoided NAS care, which is 15-20x more costly than care for an infant born without NAS in the first year.
“It is proven that opiate addiction can cause fetal growth harm as well as addiction and withdrawal. Identifying opiate addicted women, getting them into a program that can first medically withdraw them and then be supported by follow up to further aid a drug free lifestyle is of paramount importance”

Cray Towers, MFM and lead author in study from U Tenn Medical Center March 2016
There exists two major groups in this population:

- Those women who chose detoxification either on their own or with support and can be supported at WARM or in an outpatient setting.
- Infants are born without NAS, and can leave hospital with their moms.
There exists two major groups in this population:

- A larger population of pregnant women exist that cannot participate in WARM, due to ongoing addiction.
- On legal methadone or buprenorphine
- On illicit prescription drugs, heroin +/- other substances
- They may want to be on maintenance therapy in a residential setting or outpatient to stay with legal and safe opioids
Screening of all pregnant women is essential:

- Narcotic use spans all socioeconomic groups
- It is not obvious at a routine prenatal visit
- Opportunities to assist mother in maintenance or recovery are missed without identification and acknowledgment
- If mothers deliver infants that are dependent on methadone or other opioids without knowledge of obstetrician or neonatology team, infants may be discharged prior to NAS symptoms and develop NAS at home with no education or resources for family.
Why do physicians not screen every patient for substance use?

FEAR THAT PATIENTS WILL AVOID PREGNATAL CARE.

CONCERNS OVER LACK OF PROGRAMS TO HANDLE SUBSTANCE USE.

FEAR OF LIABILITY IF PROBLEM IDENTIFIED AND NO TREATMENT OPTIONS OFFERED.

JUDGMENTAL MINDSET “NOT MY PATIENTS”

LACK OF AWARENESS THAT THIS PROBLEM EXISTS.
From Florida Office of the AG Statewide Task Force on Prescription Drug Abuse and Newborns.

- In 2011 1,563 instances of DIAGNOSED NAS—up 3x
- Florida is the epicenter of prescription drug diversion
- Between 2000 and 2009 average hospital charges for newborns with NAS increased from $39,400 to $53,400 per baby.
- These costs are typically paid by Medicaid.
- CURRENTLY HALIFAX NICU HAS 1-3 NAS BABIES ON AVERAGE—EVERY DAY.
Neonatal abstinence syndrome

Irritability, hypertonic
Crying
Tremulousness
Poor feeding
Failure to thrive
Seizures

Treatment:

Opiate agonist therapy with wean (morphine, methadone, tincture of opium)

Most infants remain hospitalized until weaned, 2-6 weeks (occasionally longer)

Treatment severely interferes with maternal-infant bonding, family structure, and creates great feelings of guilt for the parent
Methadone for the treatment of narcotic dependence during pregnancy

Methadone currently remains Standard of Care (How was this standard achieved?)

It does improve compliance with prenatal care (If it can be affordable and available and taken consistently.)

Risks and benefits should be discussed – Risks of fetal exposure and of NAS

Recent studies suggest buprenorphine withdrawal for neonates is less painful and shorter in duration.
Benefits of Maintenance with Opioid Agonist Therapy in Pregnancy

WOW!
I get to give birth
AND change diapers!
Care is a team approach

Obstetrics
Neonatology
Psychiatry
Addiction medicine
Social work
Nursing: obstetrics, neonatology, addiction treatment center
Visiting Nursing
Department of Children and Families (DCF)
Department of Corrections

Ideally, all meet monthly to review the list of due soon, recently delivered, and difficult patients.
Challenges faced by our community

- No available methadone or buprenorphine that is free to addicted women in pregnancy. The DMTC does not address the unique needs of methadone users of reproductive age (contraception) or who are pregnant (placental metabolism and need for split dosing and other counseling).

- Providers are concerned to go against Standard of Care for liability reasons. But obgyns cannot write for methadone and only can write for buprenorphine if they become providers through a specific course. They are reticent to do so.
Challenges faced by our community

- The VCHD ended prenatal care clinics July first.
- In 2008-2009 they serviced 1690 clients—over 50% on the west side of Volusia.
- These women often cannot transition to the private sector due to Medicaid HMO issues, late transfer bias, transportation and other impediments.
- FCHD is at risk of reducing or eliminating prenatal care for the same economic issues.
Challenges faced by caregivers in the hospital setting

Hospitals are faced with caring for NAS babies for days to weeks with huge costs to the community and state.

Caring for women, actively withdrawing is complicated. If the woman is stabilized on methadone or buprenorphine in the hospital, she must find a way to maintain these drugs once discharged. The monthly costs for interventional pain management and medication is ~$450.

Medically supervised weaning of pregnant women while hospitalized is not standard of care and makes no sense if they cannot then go to a residential center.
The next series of slides are liberally lifted from the ACOG/ASAM Buprenorphine Course for OB providers:

- Once certified, providers receive an additional DEA designation and may prescribe buprenorphine.
- References for slides 30 through 42 are available upon request.
Managing Pain during delivery and other procedures

- Patients with active opioid use disorder have less pain tolerance than peers in remission or matched controls.
- Patients with h/o opioid use disorder have less pain tolerance than siblings without an addiction history.
- Patients on opioid maintenance have less pain tolerance than matched controls.
- Which came first—opioid use disorder or less pain tolerance?
Addressing the condition of “Opioid Debt”

- Patients with an opioid use disorder who are physically dependent on OAT must be maintained on a daily equivalence before ANY analgesic effect is realized, with opioids used to treat pain.

- Opioid analgesic requirements are often higher due to increased pain sensitivity and opioid cross tolerance.
Acute pain in patient on methadone

- Methadone maintenance dosed every 24 hours does not confer analgesia beyond 6-8 hours.
- Opioid analgesics will not cause excessive CNS or respiratory depression due to opioid cross tolerance.
- Risk of relapse to active drug use may be higher with inadequate pain management than with the use of opioid analgesics.
Acute pain in patient on Methadone

- Study compared 25 post surgical MMT patients who had received opioid analgesics to 25 MMT patient matched controls.

- After 20 month follow up, no difference in relapse indicators.

Conclusion

- Opioid analgesics may be used safely in MMT patients with acute post surgical pain without compromising addition tx.
Clinical Recommendations for MMT patients

- Continue usual verified methadone dose
- Treat pain aggressively with conventional analgesics, including opioids at higher (1.5x) doses and shorter intervals.
- Avoid using mixed agonist/antagonist opioids (ie stadol) as they will precipitate acute withdrawal.
- Closely monitor use of combined products that contain acetaminophen
Acute pain with Buprenorphine Maintenance Treatment

Options:

- Continue buprenorphine and titrate short acting opioid analgesic
- Stop buprenorphine, use opioid analgesic, then re-induce
- Divide buprenorphine to every 6-8 hours
- Use supplemental buprenorphine
Previous protocols for elective surgery with BMT

- Prior recommendations have suggested that patients need to be off BMT for 5 days prior to surgery and that surgery should be cancelled if patient has not complied.

- This risks disruption of patient’s recovery during a high anxiety preoperative time.

- Is based on theoretical pharmacologic concerns and has not evidence basis.
Boston Medical Center Management Guidelines

- Take last buprenorphine dose in the am of day prior to surgery.
- Hold dose on day of surgery
- Pre procedure, give single dose ER/LA opioid (ie. 15 mg SR morphine)
- Post procedure use standard dosing protocols and watch for decreased pain tolerance and need for higher doses.
- Fentanyl is reasonable given high affinity for mu receptor during surgery and PACU
Boston Medical Center Management Guidelines

- During post op hospitalization, continue to hold buprenorphine
- Use ER/LA opioids like SR Morphine BID for to address baseline requirements and sustained pain control.
- Use IR/SA opioids for breakthrough pain
- Schedule visit with buprenorphine provider within one week of discharge to restart buprenorphine maintenance
MUST IT BE SO COMPLICATED?

- Patients crave consistency.
- Providers in a hospital setting need simplicity.
- It may not be so easy to get patients back into their buprenorphine providers in a timely fashion.
Acute Pain
Buprenorphine Maintenance Case Series

- Five patients underwent 7 major procedures and were maintained on stable doses of SL buprenorphine (from 2 mg -24 mg) for chronic pain and remote addiction.

- Post operative pain was controlled with oral or IV full agonist opioids.
Acute Pain

Buprenorphine Maintenance

Accumulating Research

- Patients maintained on their Buprenorphine before, during and after procedures, responded to additional short acting full agonists.

- RCT comparing PCA with buprenorphine and morphine alone or in combination for post op pain indicated that buprenorphine did not inhibit analgesia provided by morphine.
Acute Pain
Buprenorphine Maintenance
Accumulating Research

- BM patients had similar intrapartum pain and analgesia BUT experience more postpartum pain requiring 47% more opioids following C section.

- Sub-analysis of the MOTHERS study showed not differences in pain management during delivery and postpartum.
Support is needed…

- Policy change that allows providers and centers to explore real options in real time.

- Funding to create sustainable programs that will prevent or treat addiction prior to pregnancy.

- Funding to create sustainable programs that will treat addiction during pregnancy with options that reflect the individual situation. These programs should and could involve maintenance of opioid until delivery with care of the NAS infant, on an in or outpatient basis. They should also include pilot projects to evaluate medically assisted detoxification during pregnancy with residential treatment until several months after the infant is born.

- OUR MOTHERS AND BABIES NEED THESE OPTIONS
Development of Residential treatment for opioid maintained...

- Creating programs within Pine Grove and SMA
- Possibility of SMA creating
  - A residential program for opioid maintained pregnant women
- Development of alternatives to DMTC that accept Medicaid and can work with SMA, prison services and other programs.
Life is a miracle...
Life is Good!!!