Infants and Moms Affected by Perinatal Opioid Use Disorder (OUD)

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Medi-Cal Children’s Health Advisory Panel
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OBJECTIVES

+ Become familiar with epidemiology of OUD during pregnancy and Neonatal Abstinence Syndrome (NAS)
+ Understand components of hospital stay, discharge and aftercare considerations for Mom and Newborn
+ Recognize the variability of “system” approaches to Moms and Babies affected by OUD
+ Embrace opportunities that new paradigms create for Moms, Babies and Families affected by OUD
EPIDEMIOLOGY OF OUD DURING PREGNANCY

- SAMHSA data: > 400,000 infants/year are exposed to EtOH (alcohol) or other illicit/inappropriate drug use during pregnancy
- Rate of pregnant women with OUD increased from 1.5/1000 → 6.5/1000 live births (1999-2014)
- CA prevalence 1.6/1000 live births (6.5/1000 in US)
- Annual rates of increase were lowest in CA and HI (0.1/1000/year) and highest in VT, ME, NM, WV (VT prevalence is 48.6/1000)
Not managing OUD during pregnancy is deleterious

- Abrupt discontinuation of opioids → preterm labor, fetal distress and fetal demise
- Unsupervised withdrawal is not recommended
- Unplanned pregnancies among women with OUD is high

Access to PNC and treatment for women OUD usually results in

- Better utilization of prenatal care and support services
- Fewer preterm, small for gestational age and low birthweight births
- Less relapse during pregnancy

Pregnancy is motivating leading women to seek treatment, shore up protective factors necessary to parent and optimize LT recovery

- Medicaid covers >80% of births to moms with OUD
- Dearth of specific OUD treatment programs for pregnant women
CASE STUDY: KAYLA’S NEWBORN

+ Baby M was born in February 2019
+ Initially ambivalent, Kayla warmed to the idea of being a mom
+ Mom on Buprenorphine, but intermittently taking Alprazolam
+ Total stay was 28 Days
+ Total morphine need was:
  + 50.6 mg total
  + 18.7 mg/day
  + 2.3 mg/dose
+ Infant stayed on 4 different hospital units
+ Kayla felt judged, inadequate and powerless
HOSPITAL BASED CARE (L&D, PP UNIT, NEONATAL ICU/NURSERY)

+ Childbirth + Hospital (labor and delivery, post-partum care and neonatal/nursery units) = chaos

+ Although there have been improvements in recent decades, the post-birth experience (non-medical) of moms and infants is highly variable, and generally siloed

+ Many hospitals don’t have protocols for addressing the needs of OUD moms and exposed infants

+ Historic practices and prejudices influence inpatient and outpatient care
**NEONATAL ABSTINENCE SYNDROME: THE HARD FACTS**

**NAS is a post-birth drug withdrawal syndrome characterized by:**
- Central Nervous System irritability
- Autonomic hyperreactivity
- Gastrointestinal dysfunction

+ CA incidence of NAS has been stable around 1.2/1000 live births
+ The US incidence of NAS increased from 1.5/1000 – 6.0/1000 live births
+ That increase has added ~$1.5B in annual hospital charges
+ NAS data is ALWAYS an undercount of reality
+ NAS is not the only challenge exposed infants face

THE REST OF THE STORY: FOR THE NEWBORNS

+ NAS may not be recognized
  + Early d/c will miss symptoms if no index of suspicion
  + Onset of NAS varies depending on type of opioid and other exposures

+ Having a protocol for identification and management is critical
  + Objective tools for ID and monitoring of NAS
  + Experienced in-hospital caregivers
  + Intervention with mixed modalities
  + Engaging moms/families
  + Meaningful d/c planning

+ Goals
  + Optimize growth and development
  + Minimize negative outcomes
  + Support secure attachment and post-discharge opportunity for health and wellbeing
  + Reduce lengths of stay and treatment*
PEDIATRIC POST DISCHARGE CARE & CONSIDERATIONS

- Stable, experienced recovery program opportunity for mom
- Monitoring health and wellbeing for Baby M
  - Monitoring for additional symptoms
  - Basic health care supervision for infants
- Neuro-developmental monitoring for Baby M
  - Specialty clinic vs. PCP (FQHC, safety net, hospital based)
  - Services and Supports for Baby M and Family (IDEA, HRIF, etc.)
- Protective Factors for Parenting
- Long-term outcomes for exposed infants are mixed
HIGH LEVEL APPROACHES TO OUD DURING PREGNANCY

+ **Criminal Justice:** Criminalizing a chronic illness doesn’t work

+ **Role of the Child Welfare System:** Child Abuse Prevention and Treatment Act (CAPTA) Mandates and the hazards of **Interpretation**

+ **Public Health Model:** Define, ID Risk/Protective Factors, Test Prevention Strategies, Disseminate and Scale

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Miranda L, et al. State with Laws Prosecuting of Pregnant Women for SUD. Published on September, 30, 2015
Prenatal Consultation

Inpatient Observation & NAS Treatment while Rooming In

Appropriate Neurodevelopmental + Primary Care Follow-Up & Support

Source: Family Care Support Services, Women and Infants Hosp, RI

*GLOBAL AIM*
Improve the care of infants with NAS

*AIM*
Decrease the ALOS of infants with NAS by 50%

*BALANCING*
1) Transfers to ICU
2) Seizures
3) 30-day readmissions related to NAS

*Key Drivers*
- Non pharmacologic interventions
- Simplified assessment of infants
- Decreased use of morphine
- Communication between units

*INTERVENTIONS*
- Standardized non pharmacologic care
- Prenatal counseling of parents
- Transfer from WBN to the inpatient unit
- Development of novel approach to assessment
- Rapid morphine weans
- Morphine given as needed
- Empowering messaging to parents
- Spread of change concepts to NICU

HOW DOES ALL OF THIS FIT INTO THE LARGER SYSTEM WORK?
PERINATAL MAT EXPANSION PROJECT – High Level Scope

Outreach
Treatment Access Points
Protocols, Guidelines, Safety Bundles, Toolkits
Expand Treatment Capacity
Distribution of Patient Materials
Learning Collaboratives
Technical Assistance
Resource Library
## Perinatal MAT Expansion Project – High Level Timeline

<table>
<thead>
<tr>
<th>Service Preparation</th>
<th>JAN 2019 – MAR 2019</th>
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<tbody>
<tr>
<td>Co. based services ID</td>
<td>Co. based survey</td>
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<tr>
<td>CMQCC &amp; CPQCC collaboration</td>
<td>Online reference library built</td>
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<tr>
<th>Initial Deployment of Perinatal Services</th>
<th>APR 2019 – DEC 2019</th>
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<tr>
<td>Kick-off meetings held</td>
<td>Perinatal toolkit roll out</td>
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<tr>
<td>Hospital based toolkit roll out</td>
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<tr>
<th>Full Implementation of Perinatal Services</th>
<th>AUG 2019 – SEP 2020</th>
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<tr>
<td>County-wide screening implemented</td>
<td>Expansion to Training Facilities</td>
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<tr>
<td>ID Bright Spots</td>
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<tr>
<th>Expansion of Existing Perinatal Services</th>
<th>NOV 2019 – SEP 2020</th>
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<tr>
<td>Expansion up to 15 Counties</td>
<td>Local experts ID’d</td>
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<tr>
<td>Scaling of service array</td>
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All phases will include work with County specific payers to help build sustainable payment models. Continued interaction with the learning collaboratives will enhance the transition to full implementation.
INITIAL PILOT COUNTIES: TEST, SPREAD AND SCALE

+ NORTHERN COUNTIES
  + Humboldt
  + Lake
  + Mendocino
  + Shasta

+ CENTRAL COUNTIES
  + Sacramento
  + San Joaquin
  + Stanislaus

+ SOUTHERN COUNTIES
  + Orange County
  + San Diego
  + Ventura
Questions?