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

Helen DuPlessis, MD, MPH
Health Management Associates

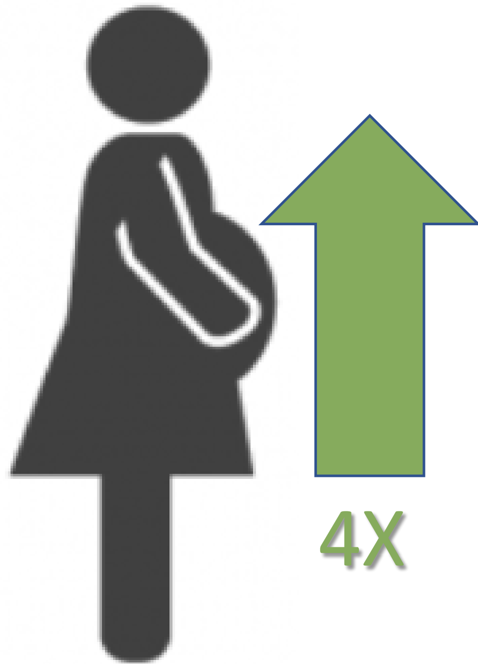
Medi-Cal Children's Health Advisory Panel

April 4, 2019

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

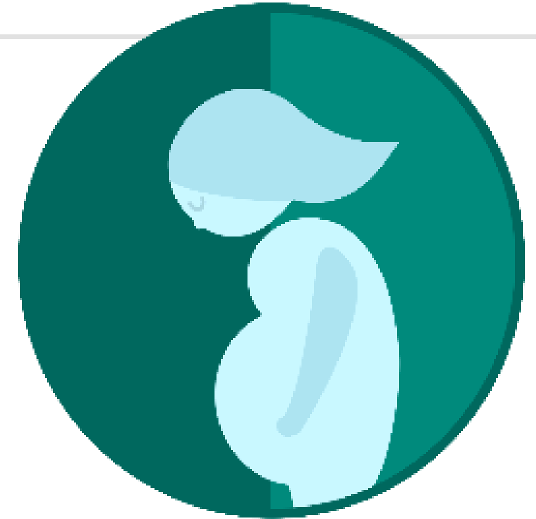


- SAMHSA data: > 400,000 infants/year are exposed to EtOH (alcohol) or other illicit/inappropriate drug use during pregnancy
- Rate of pregnant women with OUD increased from 1.5/1000 → 6.5/1000 live births (1999-2014)
- CA prevalence 1.6/1000 live births (6.5/1000 in US)
- Annual rates of inrease were lowest in CA and HI (0.1/1000/year) and highest in VT, ME, NM, WV (VT prevalence is 48.6/1000)

THE REST OF THE STORY: FOR THE MOMS

- 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

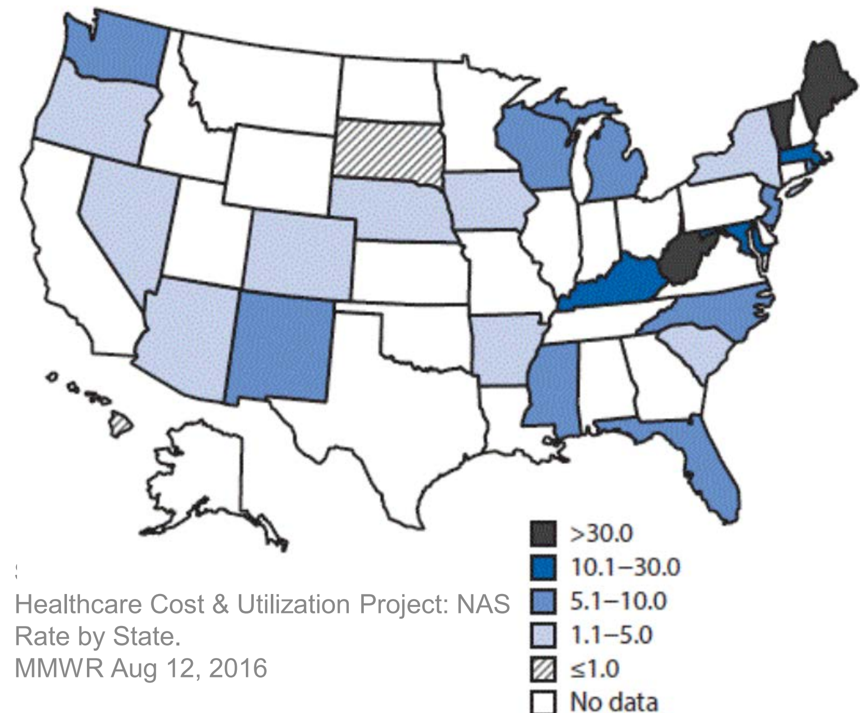
HOSPITAL BASED CARE (L&D, PP UNIT, NEONATAL ICU/NURSERY)

- 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

NAS is a post-birth drug withdrawal syndrome characterized by:

Central Nervous System irritability
Autonomic hyperreactivity
Gastrointestinal dysfunction

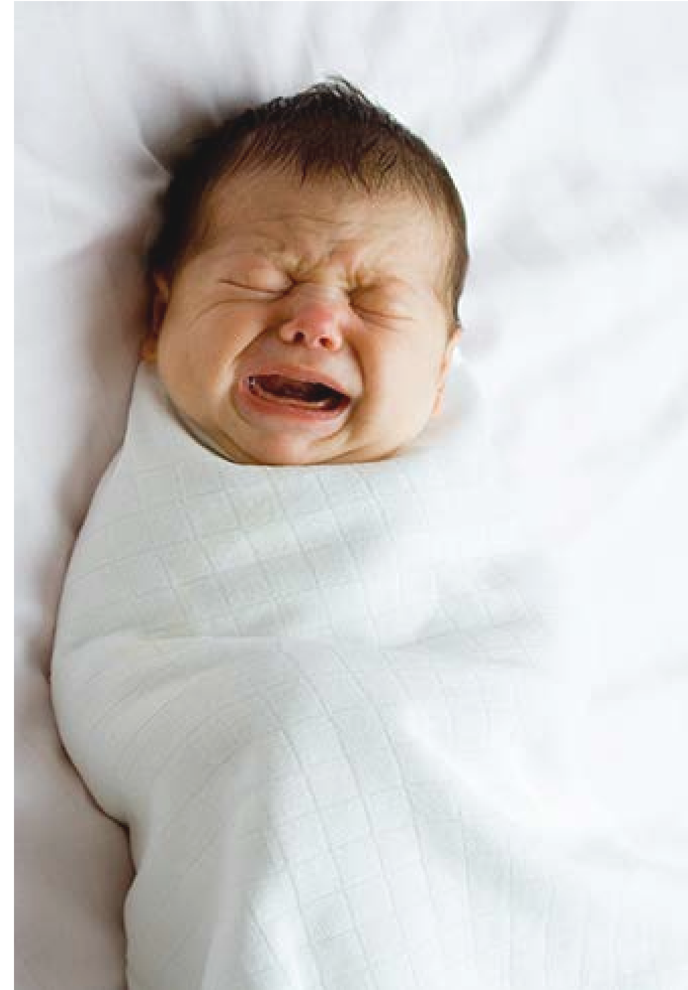
- CA incidence of NAS has been stable around 1.2/1000 live births
- The US incidence of NAS increased from 1.5/1000 – 6.0/1000 live births
- That increase has added ~$1.5B in annual hospital charges
- NAS data is ALWAYS an undercount of reality
- NAS is not the only challenge exposed infants face



Healthcare Cost & Utilization Project: NAS Rate by State.
MMWR Aug 12, 2016

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*

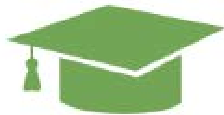


PEDIATRIC POST DISCHARGE CARE & CONSIDERATIONS

Parental Resilience

Social Connections

Concrete Support in Times of Need



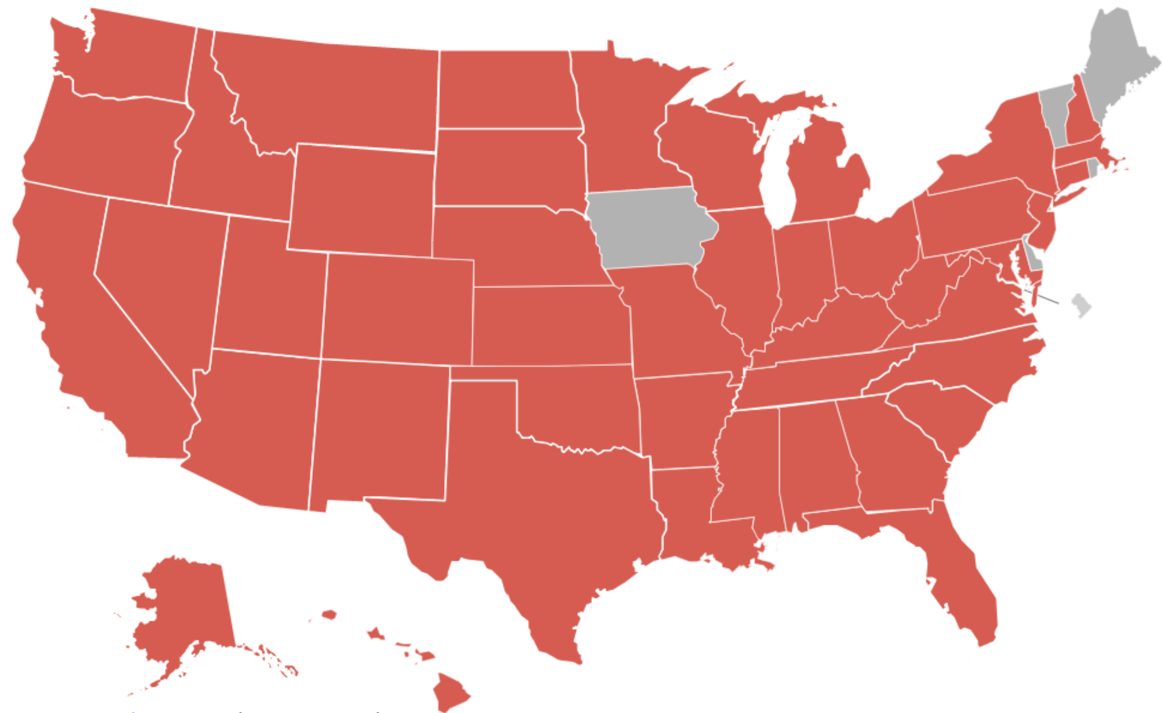
Knowledge of Parenting and Child Development

Social and Emotional Competence of Children

- 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



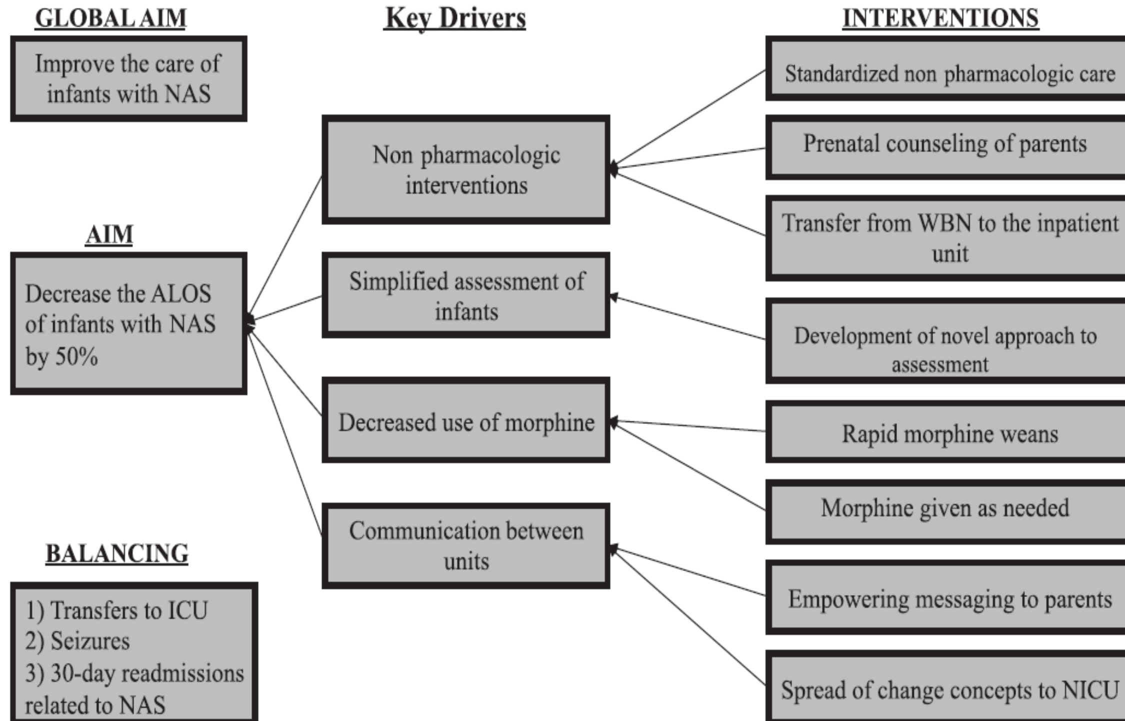
Miranda L, et al. State with Laws Prosecuting of Pregnant Women for SUD. Published on September, 30, 2015

Prenatal Consultation

Inpatient Observation & NAS Treatment while Rooming In

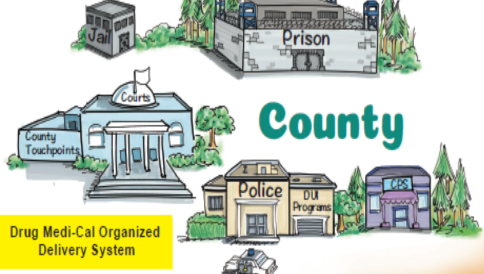
Appropriate Neuro-developmental + Primary Care Follow-Up & Support

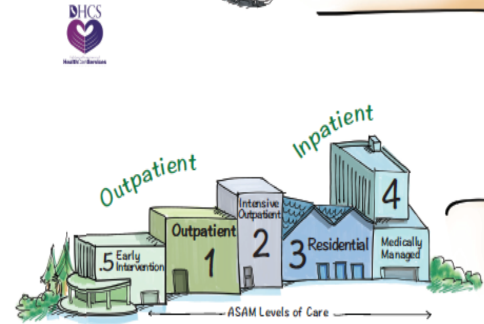
Source: *Family Care Support Services, Women and Infants Hosp, RI*



Source: Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

Department of Health Care Services

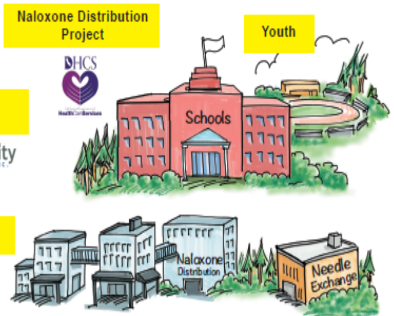




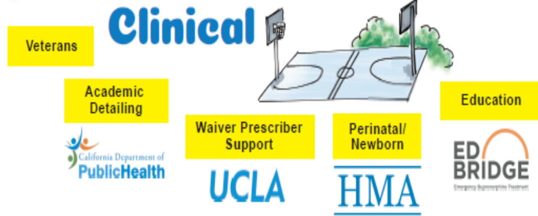
County

SUD Services

Statewide Projects



Prevention



Clinical

Jail — HMA
Juvenile Justice — continuity
County Touchpoints
Drug Medi-Cal Organized Delivery System — DHCS
Outpatient — Inpatient — ASAM Levels of Care — Early Intervention, Outpatient, Intensive Outpatient, Residential, Medically Managed
MAT Supportive Housing
NTP Treatment Capacity
CA Hub & Spoke System
Youth Recovery — YPR
DUI MAT Integration — CADTP
Access Point Transitions
Transitions — HMA
Coalitions — California Opioid Safety Network; Center for Health Leadership & Practice
Tribal MAT — CCUIH
CSAM Mentoring
Fentanyl Outbreak Monitoring
Corrections
MAT Access Point Grants — Sierra Health Foundation
Media Campaign — mediasolutions
MAT Toolkits — Harbage Consulting
24/7 MAT Consultation — UCSF; California Poison Control System
Opioid Safety Initiative — California Health Care Foundation
Database Enhancement — CURES 2.0
Naloxone Distribution Project — DHCS
Youth
CA Conservation Corps — continuity
Drug Take Back — California State Board of Pharmacy
Inpatient — SHOUT
Primary Care Mental Health — CCI
Veterans
Academic Detailing — California Department of Public Health
Waiver Prescriber Support — UCLA
Perinatal/ Newborn — HMA
Education — ED BRIDGE

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

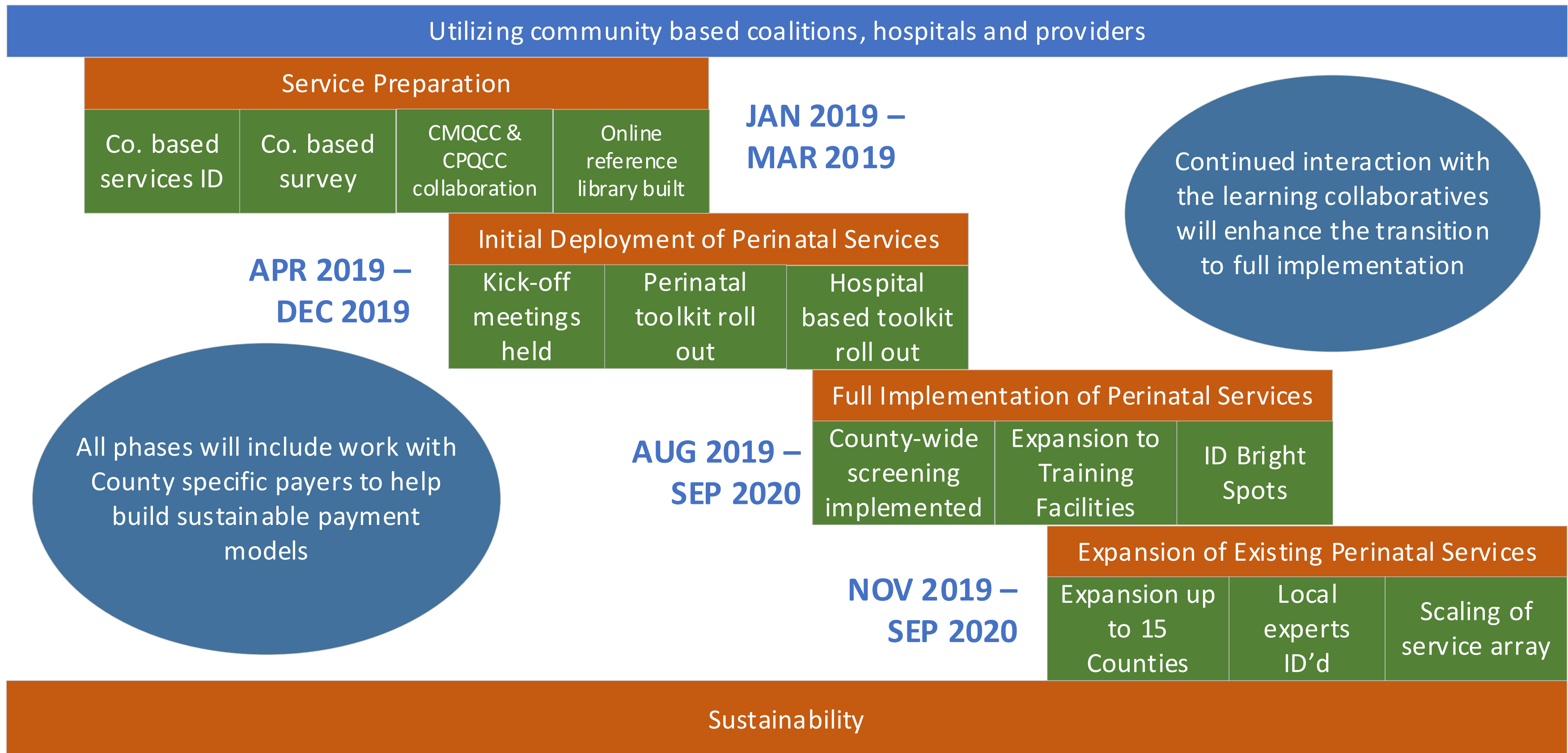
Distribution of Patient Materials

Learning Collaboratives

Technical Assistance

Resource Library

Perinatal MAT Expansion Project – High Level Timeline



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?