Hennepin Healthcare

Navigating Medication Options:

Patient Centered Approaches to Opioid Use Disorder during Pregnancy

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Hennepin Healthcare
Family Medicine & Addiction Medicine
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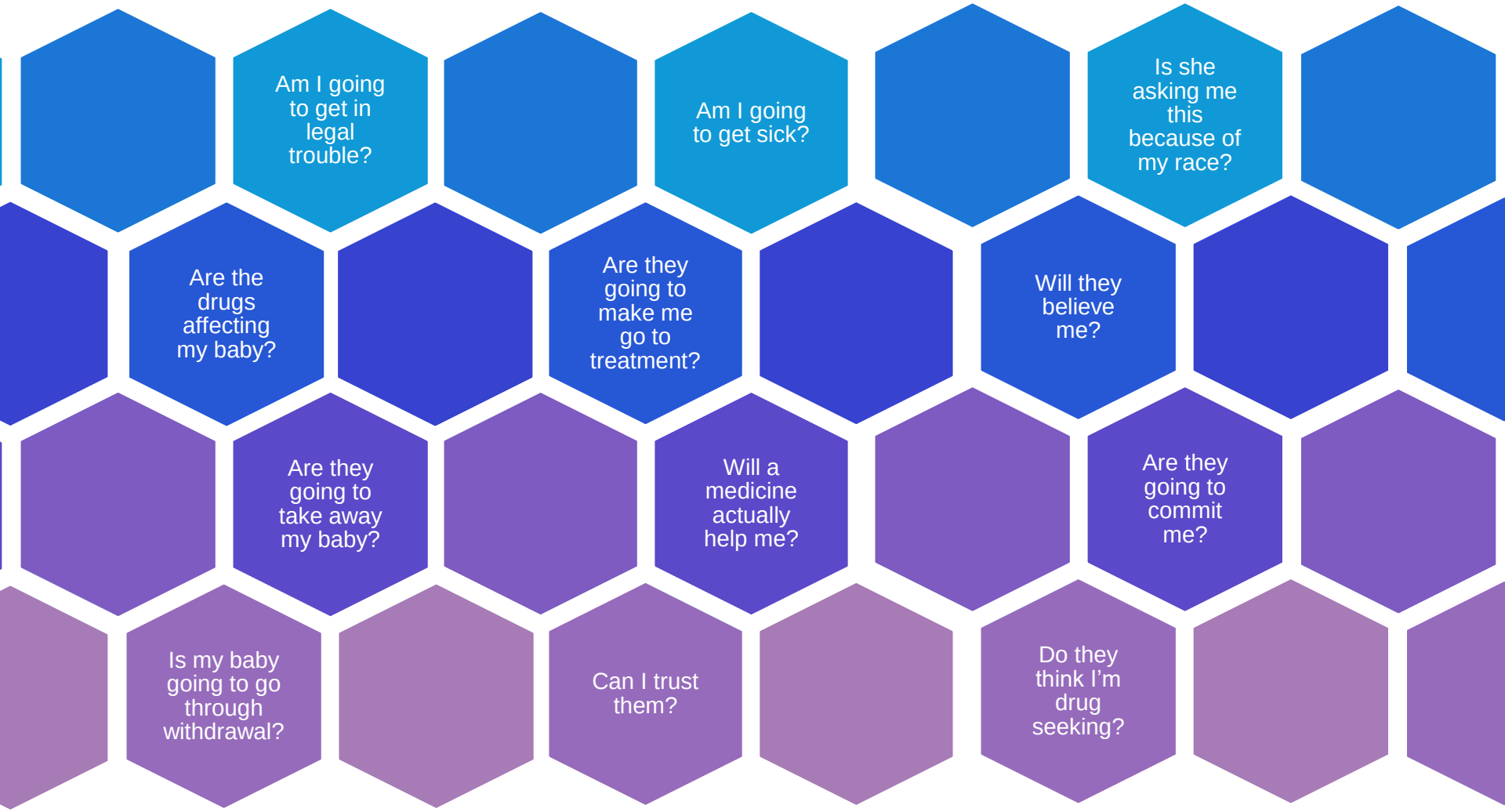
Disclosures

- None

Gratitudes

- Cresta Jones
- Brian Grahan
- Cindy Yang
- Makela Roberts-Virden & Project CHILD team
- Valerie Gustafson
- Gretchen Buchanan
- HCMC Labor & Delivery and Postpartum Teams

So many questions emerge when you are pregnant & using substances



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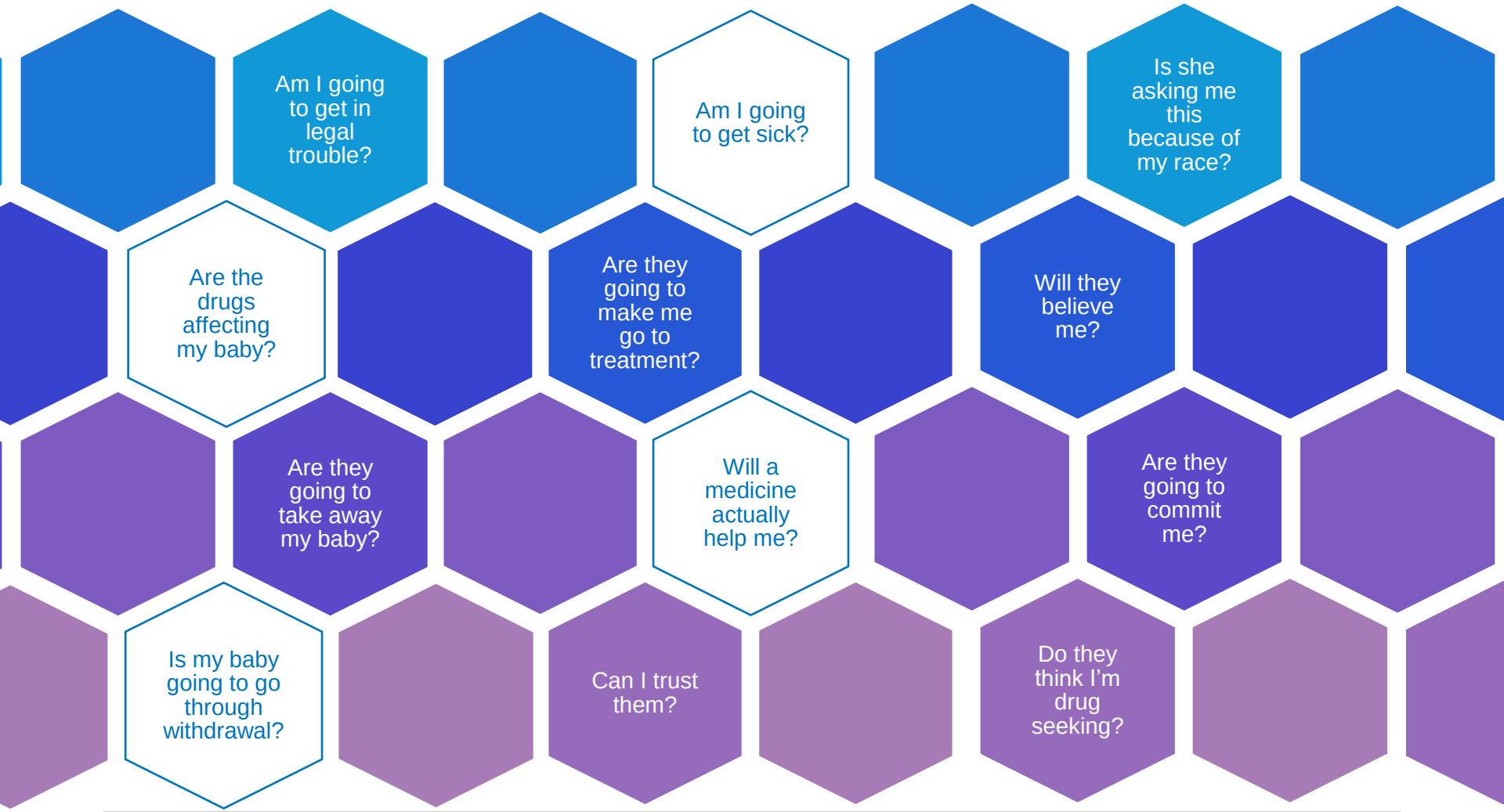


Objectives for today

1. Describe **different medications** for Opioid Use Disorder
2. Consider **risks & benefits** of these options for the pregnant person & the fetus
3. Discuss different ways to **initiate** buprenorphine & methadone
4. Navigate **intrapartum and postpartum pain** for patients on MOUD

Why is this important?

- National maternal drug overdose mortality rates have increased

Pregnant or postpartum Reproductive age

Table. Drug Overdose Mortality Rates Among Pregnant or Postpartum Persons and Those of Reproductive Age From 2017 to 2020[a]

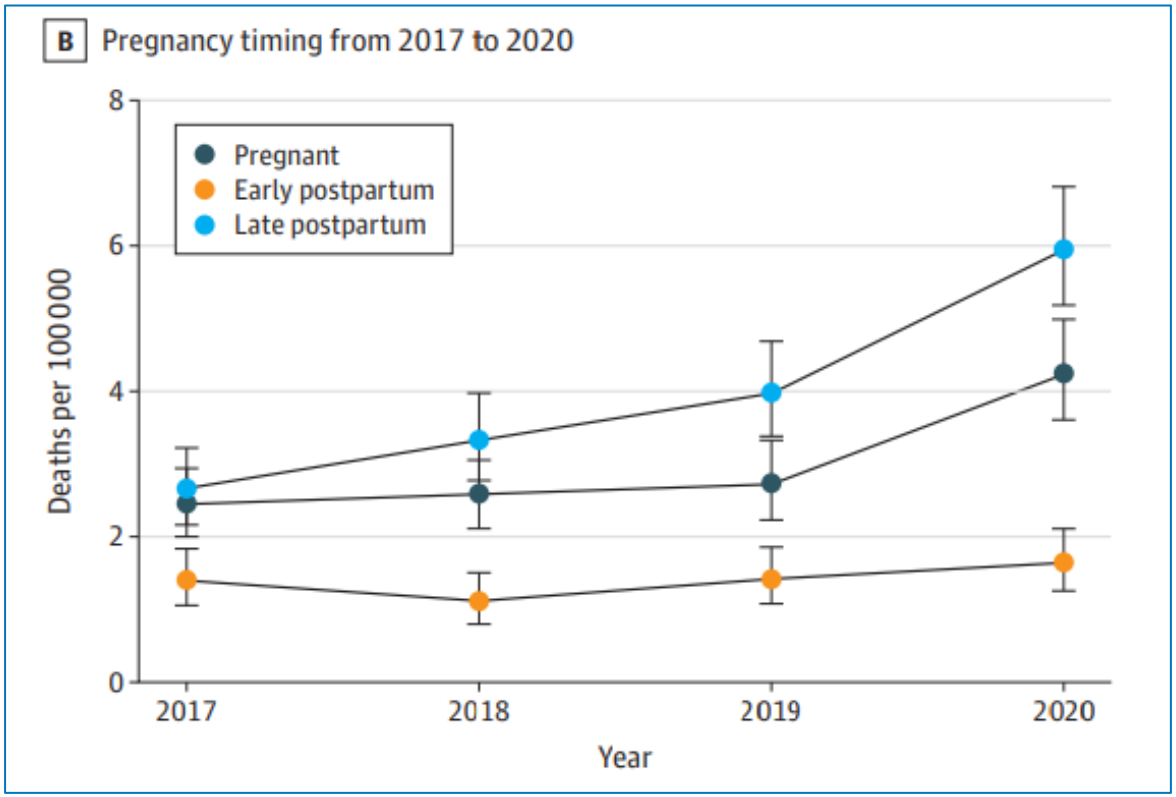
	Pregnant or postpartum			Reproductive age (aged 15-44 y)[b]		
	No. of persons	No. of live births[c]	Drug overdose mortality rate per 100 000 (95% CI)[d]	No. of persons	Population	Drug overdose mortality rate per 100 000 (95% CI)[d]
Year						
2017	252	3 844 260	6.56 (5.78-7.43)	9191	63 958 243	14.37 (14.08-14.67)
2018	266	3 780 401	7.04 (6.23-7.95)	9198	64 171 698	14.33 (14.04-14.63)
2019	304	3 736 144	8.14 (7.26-9.12)	9433	64 325 356	14.66 (14.37-14.96)
2020	427	3 602 653	11.85 (10.77-13.05)	12 756	64 543 832	19.76 (19.42-20.11)
Total	**1249**	**14 963 458**	8.35 (7.89-8.83)	**40 578**	**256 999 129**	15.79 (15.64-15.94)
Absolute change rate (95% CI) [relative change %][e]						
2017-2020			5.30 (3.90-6.7[illegible]) [80.81]			5.39 (4.94-5.8[illegible]) [37.53]
2019-2020			3.72 (2.25-5.20) [45.67]			5.10 (4.65-5.55) [34.77]

80.8% vs 37.5% increase

Bruzelius & Martins, 2022

Why is this important?

- National maternal drug overdose mortality rates have increased particularly for pregnant & late postpartum patients



Bruzelius & Martins, 2022

When starting these conversations

- Start with evidence based statements

Opioids & Fentanyl do NOT cause cognitive or developmental concerns for infants

Most substances impact a baby's growth & can make them come early

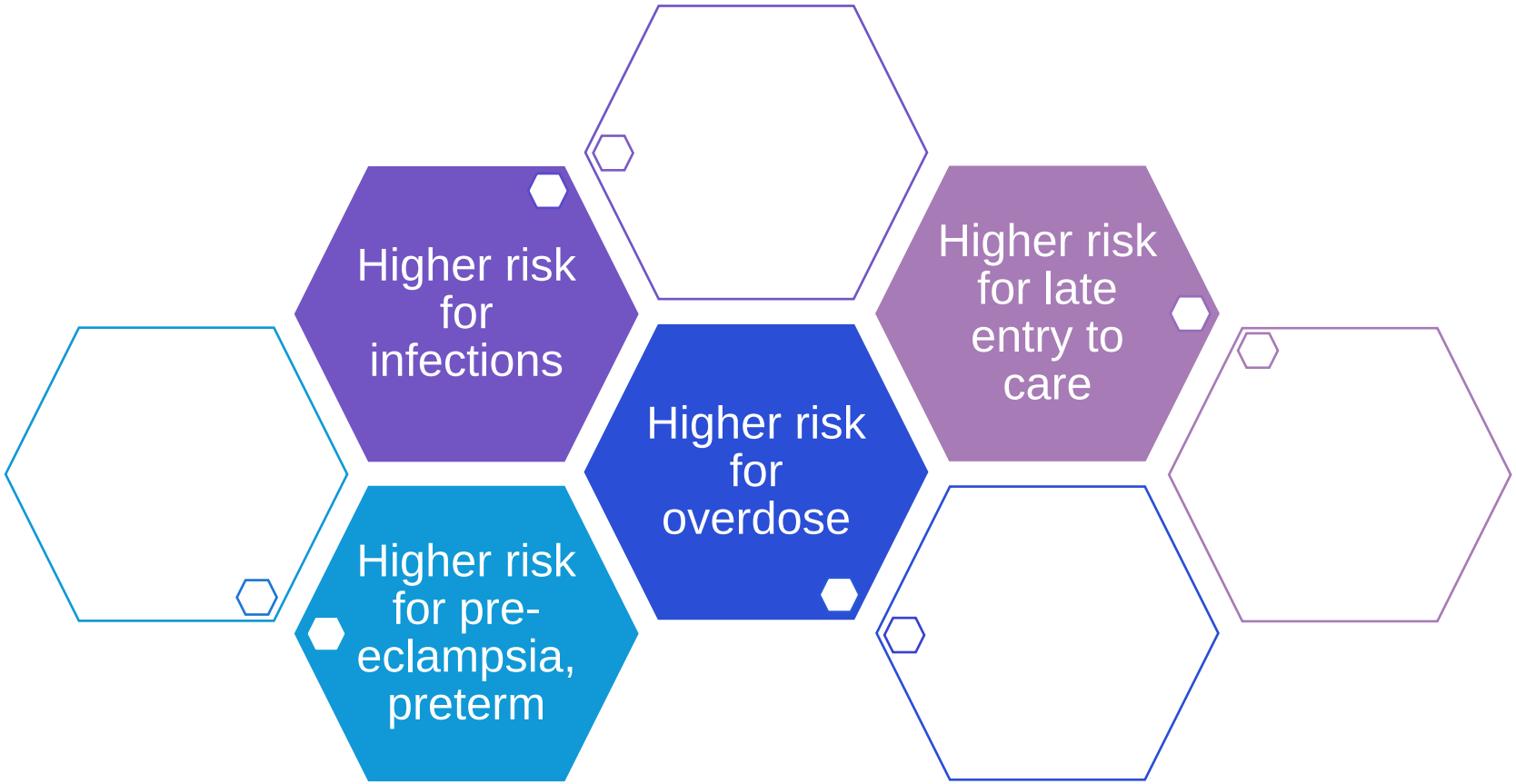
Alcohol, tobacco & cannabis have been associated with cognitive deficits in children

Children exposed to opioids in utero have the same developmental outcomes as children who were not

Babies cannot be born "addicted," but their bodies will have been exposed to opioids, and they will need to transition

Medications for OUD save lives

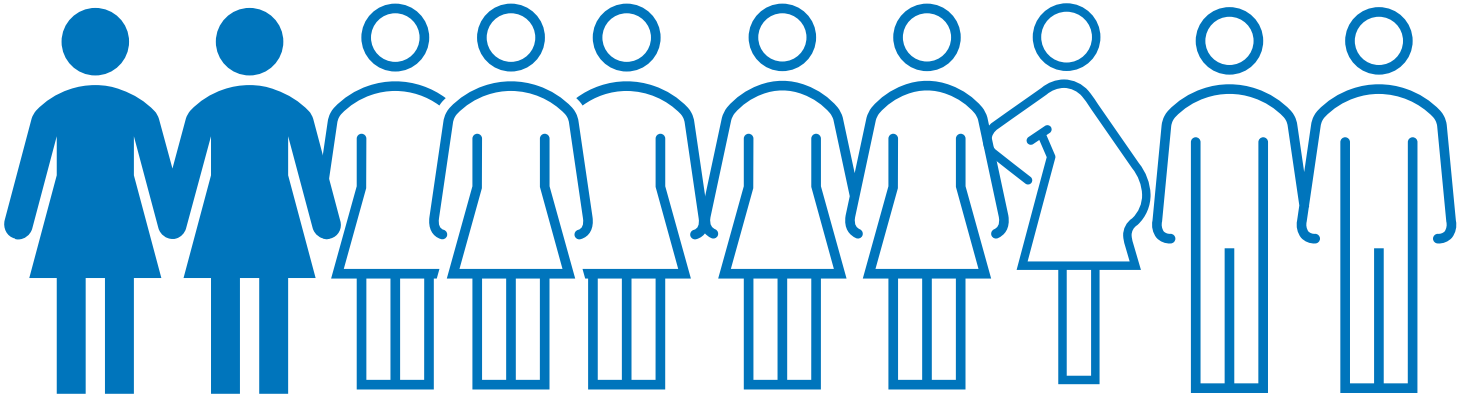
So then why do we worry about opioid use in pregnancy?



Medications for OUD improve ALL of these

Without Medications for OUD

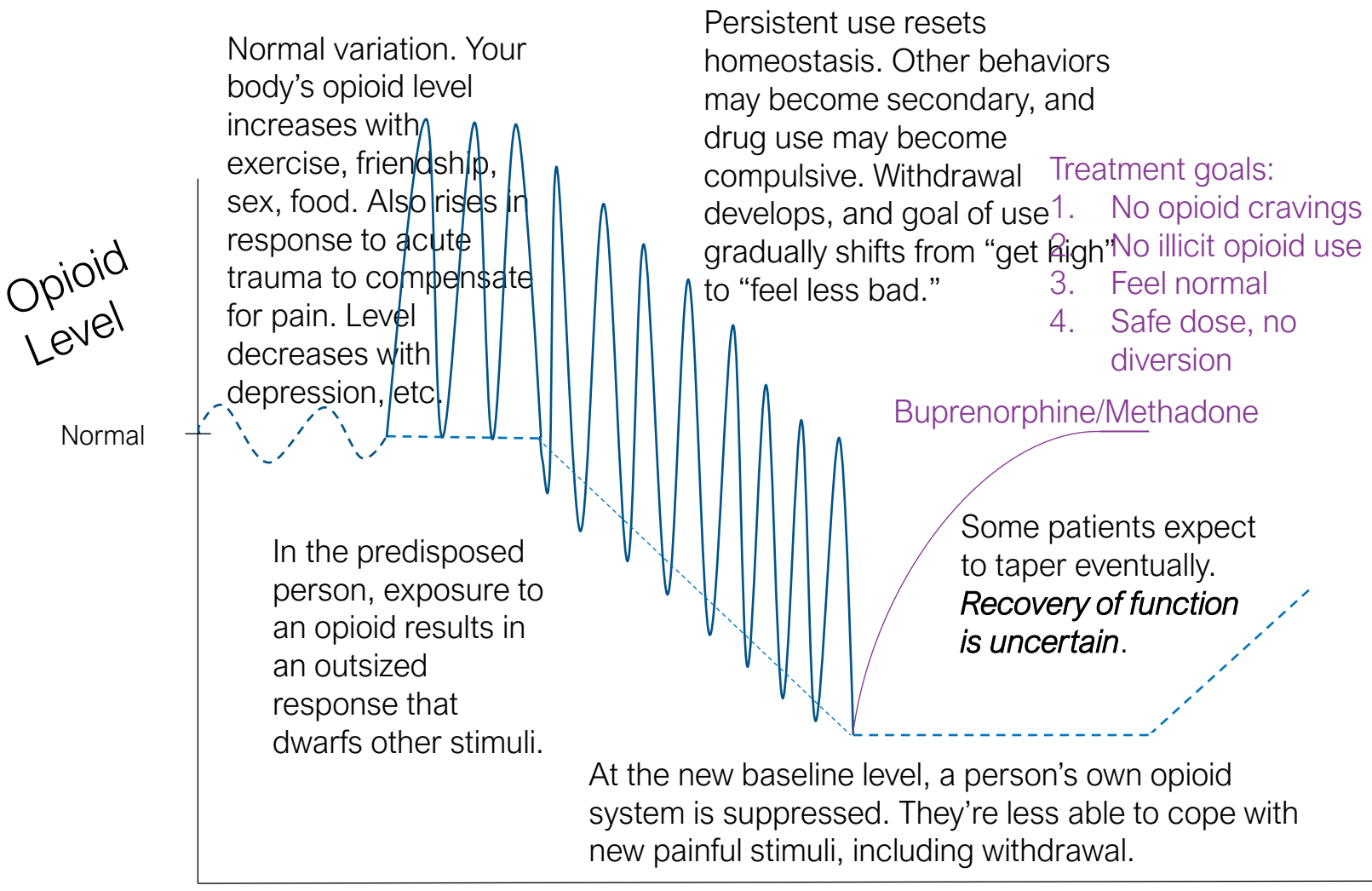
>85% of people return to illicit use



- Lower treatment retention
- Increased risk of overdose
  - Decreased tolerance

- Yet, this may be where your patient is ready to start
- Prenatal care alone improves outcomes for those with OUD!

Impact of Chronic Opioid Use & MOUD



HennepinHealthcare

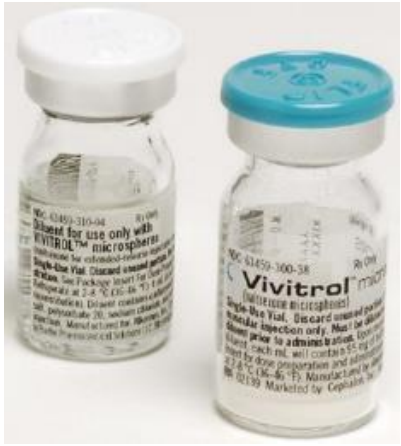
Created by Brian Grahan, MD, PhD on 4/1/18
Hennepin Healthcare Opioid & Addictions Care TeleECHO Group

Medications for Opioid Use Disorder (MOUD)

Methadone

Buprenorphine

Naltrexone



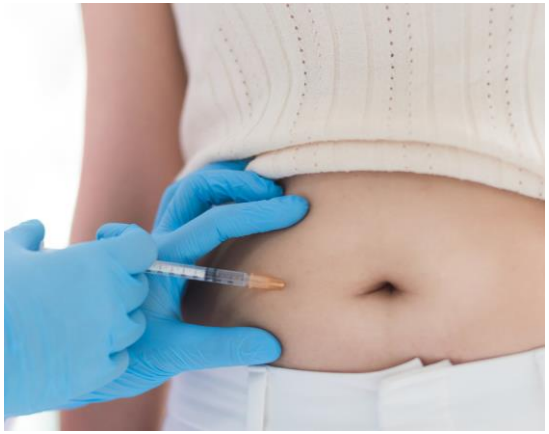
What is Methadone?

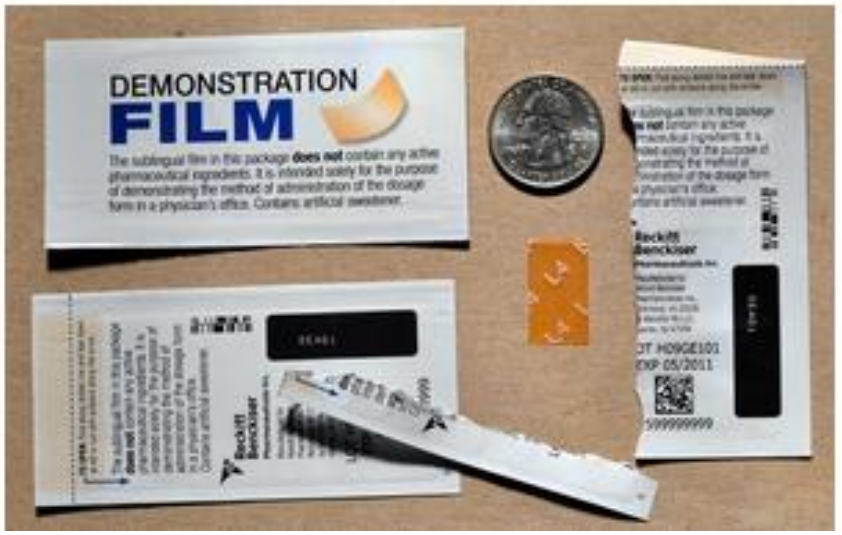
- Full Opioid Agonist & Long Half Life
  - Onset within 30-60 min
  - Half life 18-50 hours
  - 30-60mg relieves acute withdrawal
  - >80mg to extinguish craving and “blockade”
  - Several medication interactions
- Highly Regulated
  - Illegal to prescribe methadone for OUD in general practice
  - Since March 2022 – for institutions that have applied to the DEA, there is a 3-day exception for inpatients as a bridge to an intake appointment at a methadone clinic (21 CFR 1306)

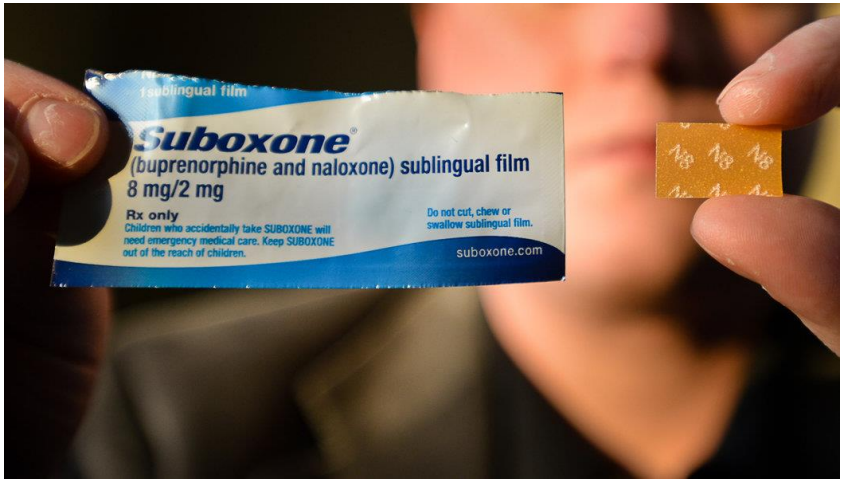
What is Methadone?

- Opioid Treatment Programs (OTPs)
  - "Methadone Clinic"
  - Supervised daily liquid administration
  - Opportunities for "take home" doses (but only after several months)
  - Counseling by Licensed Alcohol & Drug Counselor
  - Urine testing
  - BUT psychiatric, medical services often not provided
- Relationships are important!
  - Connecting patients to a program is critical

What is Buprenorphine?

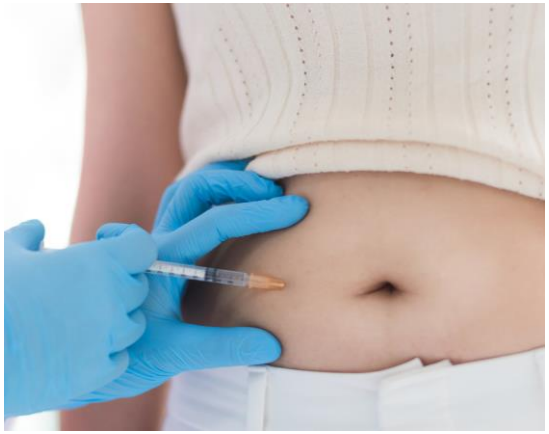


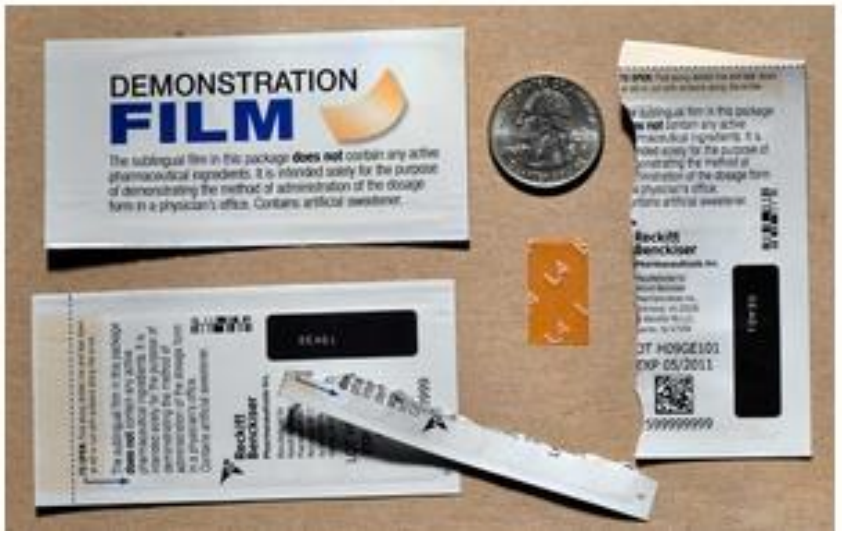


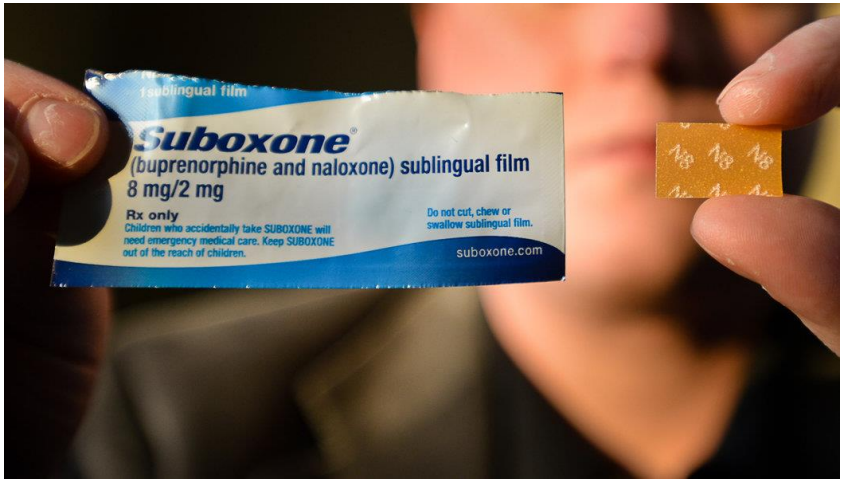


- Partial Opioid Agonist
  - Less respiratory depression
  - Sublingual (poor bioavailability) 8-24 hours
  - Long acting injectables 7- 28 days
  - Goal dose usually 16-24mg/day
- Accessible
  - No X waiver needed to prescribe
  - Any provider with a DEA
  - Allows for split dosing throughout the day

What is Buprenorphine?

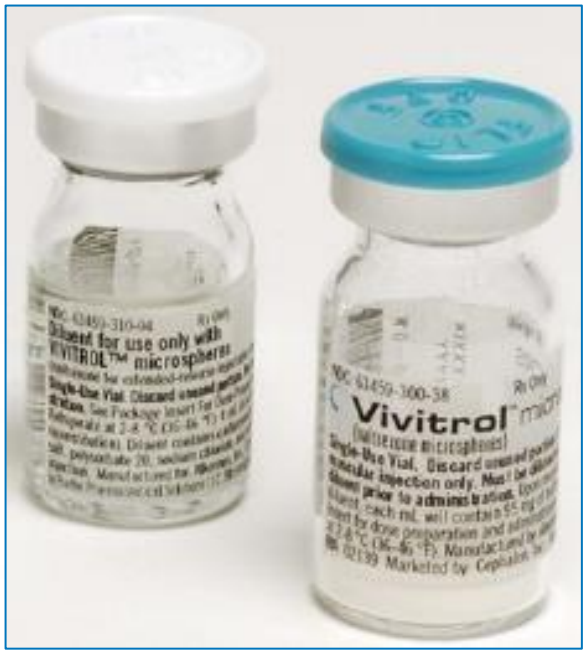






- Suboxone vs Subutex
  - Suboxone = buprenorphine + naloxone
  - Subutex = buprenorphine only
  - In pregnancy, both are very safe & effective
- Precipitated withdrawal
  - It's not the naloxone that does this!
  - Buprenorphine itself bumps off other full opioid agonists
  - Timing of initiation is key
  - Can be a deterrent for patients who have had a bad experience

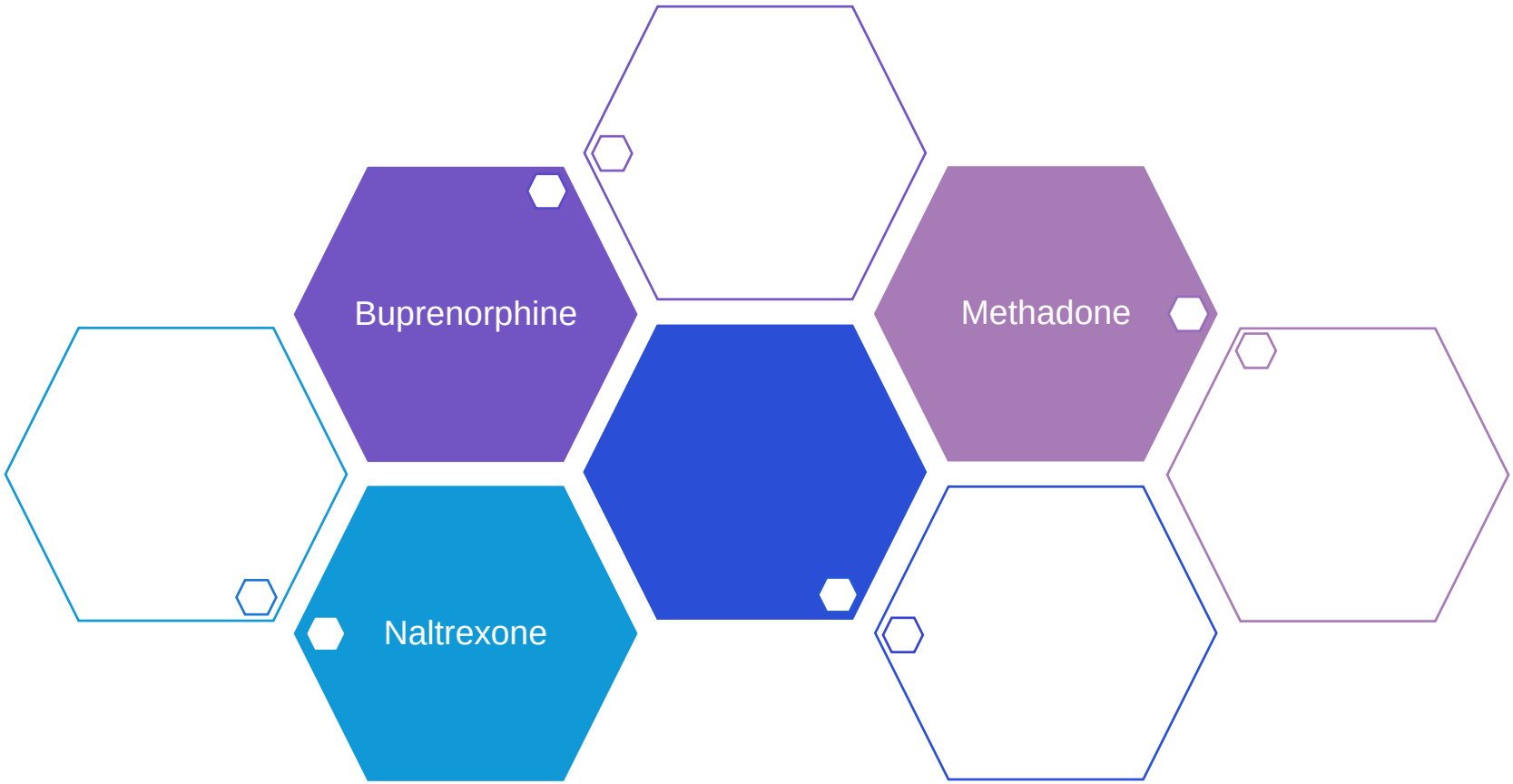
What is Naltrexone?



- Opioid Antagonist
  - Blocks any opioid with no physical dependence
  - Option for unintentional exposures
  - Pill or IM
- Accessible
  - Available in most office settings
  - Effective for alcohol use disorder & opioid use disorder
- Withdrawal Potential
  - For those with opioid tolerance, can cause acute withdrawal
  - Wait 7 days after last use

28% of participants drop out prior to getting naltrexone

Which medication is best for my patient?



Which medication is best for my patient?

Key considerations:

- Patient preference
- Access to care

Summary of outcomes	FAVORS Methadone	FAVORS Buprenorphine	FAVORS Naltrexone
Maternal			
Treatment efficacy	✓	✓	✓
Craving support			
Access to treatment			
Avoids withdrawal for initiation			
Treatment automatically coordinated			
Maternal medical complications			
Long-term outcome			
Neonatal			
Birthweight			
Gestational age			
Breastfeeding			
% requiring NAS treatment			
Severity of NAS symptoms			
Duration of NAS treatment			

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Severity of NAS symptoms		✓	n/a
Duration of NAS treatment		✓	n/a

Fetal Monitoring

- MOUD may affect NST results
- Interpret antenatal testing with caution within 2 hours of a dose

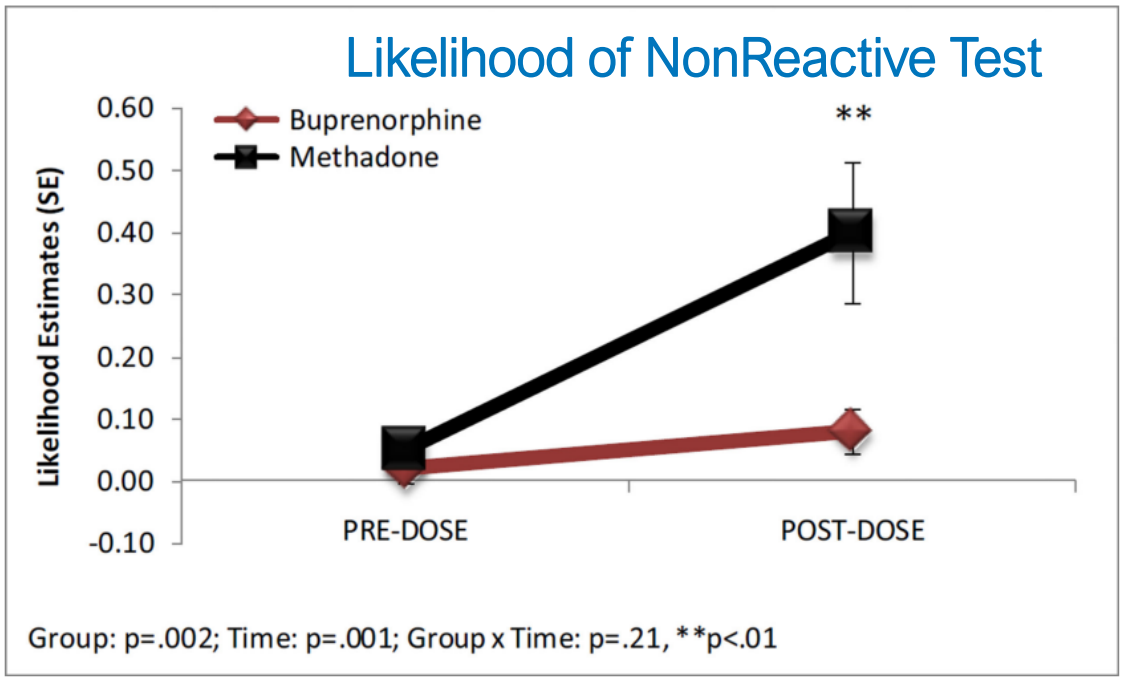


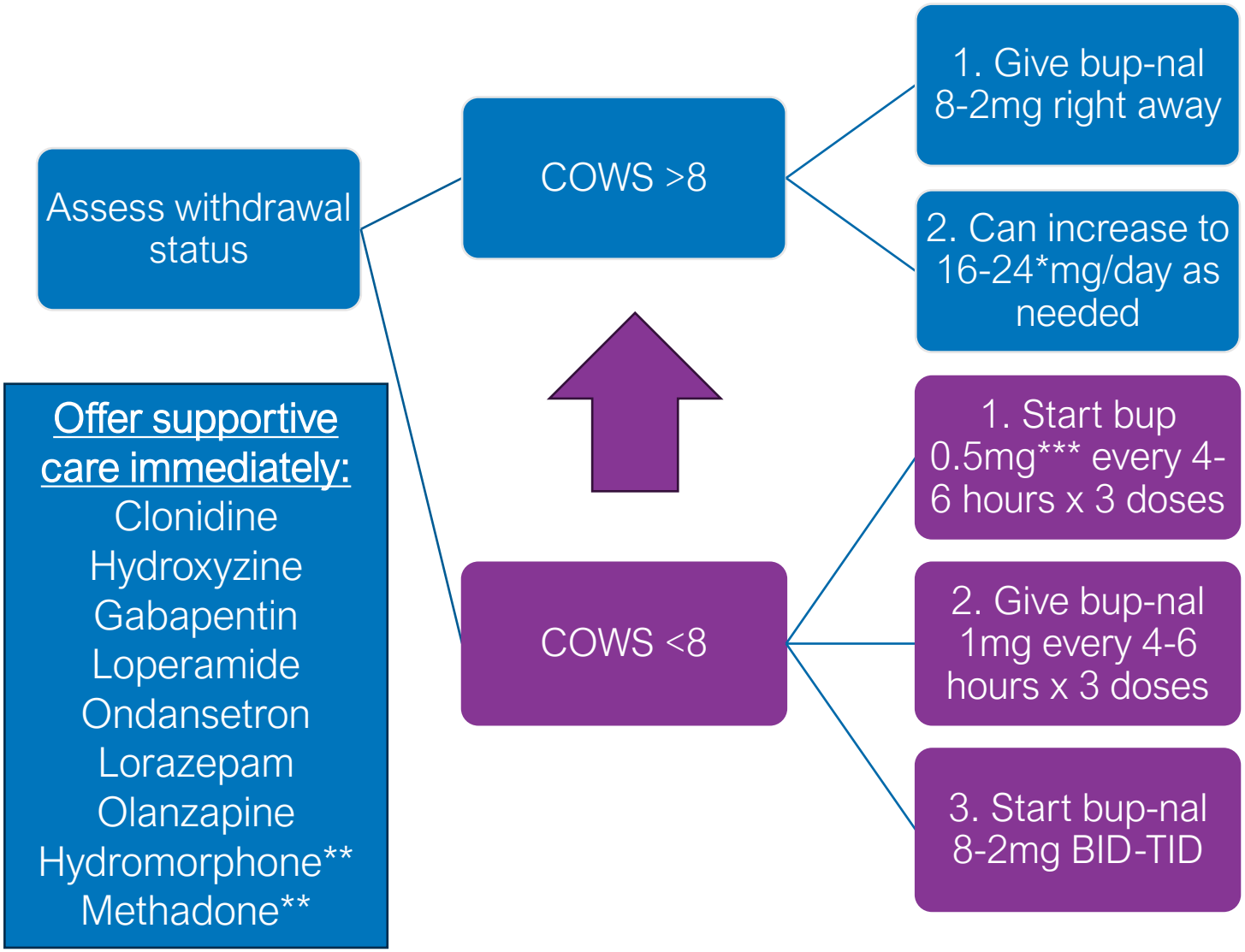
Figure 3.
Likelihood estimates for a non-reactive fetal non-stress test in the pre- and post-dose assessments. ** Pairwise comparison with a Bonferonni correction, $P < 0.01$.

Salisbury 2012

Key Considerations in starting MOUD

- YOU can do this!!
- Is the patient in withdrawal?
  - Makes it hard to weigh medical decisions
  - Very okay to offer options and then decide in the future if patient would like to continue
  - Most important thing is to help them feel better
- Methadone can be given any time, withdrawal or not
  - Monitor 2 hours after dose for sedation
  - Be familiar with methadone clinics for referral
- If COWS >8, give full dose buprenorphine!
  - Low risk at this time for precipitated withdrawal

How to Start Buprenorphine



* At initiation and in 3rd trimester, may need up to 32mg daily to stabilize

**In the urgent treatment of withdrawal & patient centered care, can use full opioid agonists for withdrawal

*** Bup 0.5mg or equivalent! Bup-nal 2-0.5mg FILMs cut in 1/4 OR Belbuca 450mcg buccal

How to Start Methadone

Day 1	Day 2	Day 3	Days 4 (+)
• Give methadone 30mg ASAP • Monitor 2 hours after dose for sedation/ withdrawal • Give additional 10mg if withdrawal persists	• Give total daily dose from Day 1 (40mg) • Monitor 2 hours after dose for sedation/ withdrawal • Give additional 10mg if withdrawal persists	• Give total daily dose from Day 2 (50mg) • Monitor 2 hours after dose for sedation/ withdrawal • Give additional 10mg if withdrawal persists	• Give total daily dose from Day 3 (60mg) • Continue to increase by 5mg every other day • Monitor 2 hours after any dose change

- Then what?
  - Help connect with a Methadone Program (OTP)
  - For participating hospital pharmacies, you can give up to 3 days of liquid methadone as a bridge to methadone clinic appointment
  - Make sure your discharge paperwork clearly states what their last dose of methadone was!

FAQs

- What if my patient is scared that they are going to have precipitated withdrawal?
  - Go slow!
  - Offer lower dose initiation of buprenorphine
  - Connect with the care team for fast response to pt needs
- What if they do have precipitated withdrawal?
  - Give more buprenorphine!
  - 16-32mg more helps flood the opioid receptors
  - Treat their symptoms with other medications
  - Give full opioid agonists (methadone, hydromorphone)
- Does MOUD need to be started in the hospital?
  - After 28-32 weeks gestation for fetal monitoring
  - History of preterm labor or poor cardiovascular capacity

Addressing **Intrapartum** Pain

- Continue MOUD
  - Continue buprenorphine, ideally 16mg or less
  - Continue methadone at full dose
- Increase Full Opioid Agonists
  - If full opioid agonists are indicated, patient may need 1.5-3x usual dosing
  - Adjuvant medications too:
    - Gabapentin
    - Acetaminophen
- Anesthesia
  - Consider transverse abdominus plane anesthetic block

Addressing **Postpartum** Pain

- Continue MOUD
  - Continue buprenorphine, **back to prior to admission dose**
  - Continue methadone at full dose

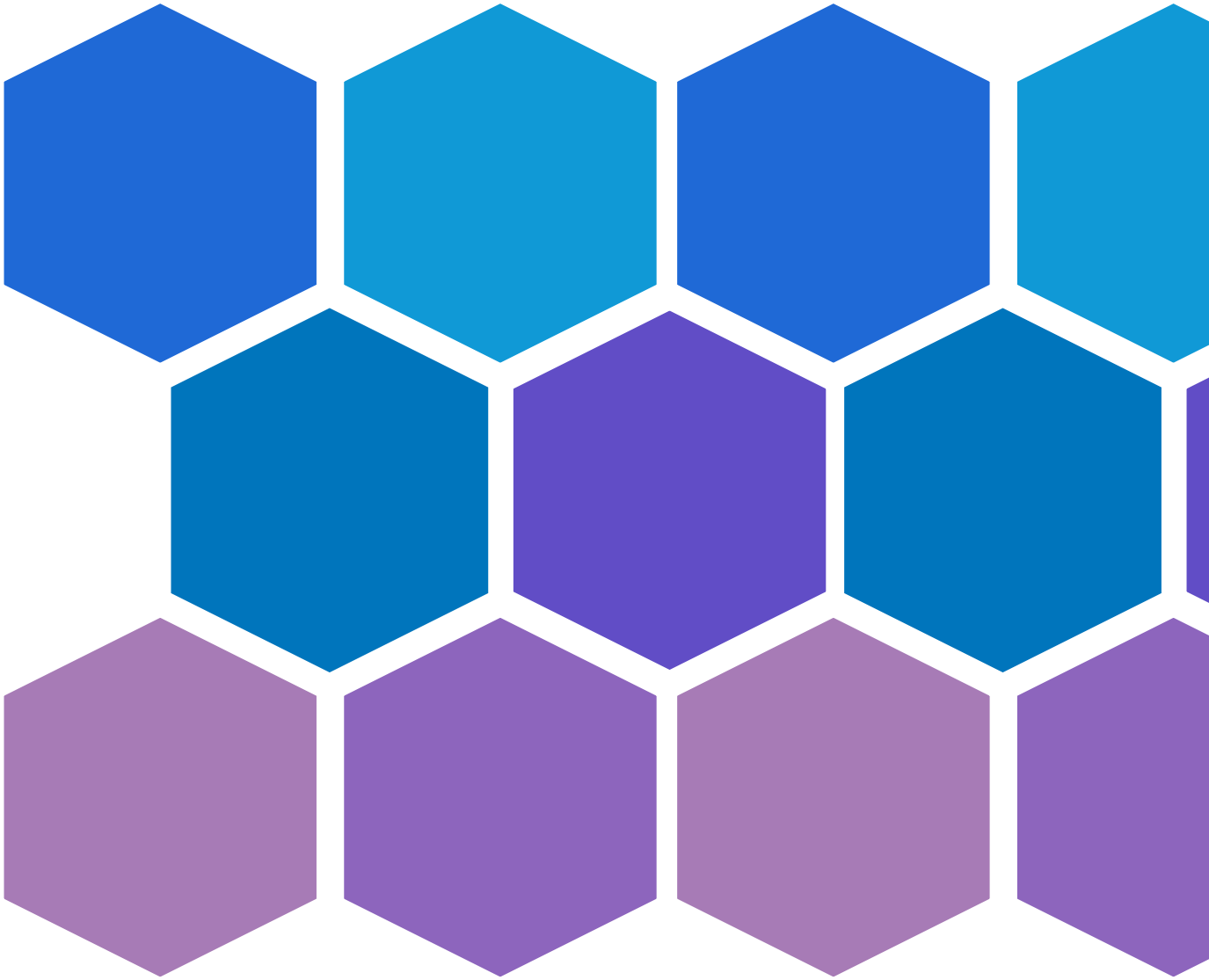
- Continue Full Opioid Agonists
  - May need more frequent & higher dosing
  - Continue **scheduled dosing**
  - Adjuvant medications too:
    - Gabapentin
    - Acetaminophen

- Follow up
  - Ensure everyone is aware of follow up plans to get next dose of MOUD
  - Follow up plan for who will manage post-op or post-procedural pain

In summary

1. Perinatal substance use is risky, but treatable
2. Methadone, buprenorphine and naltrexone are options for pregnant people
3. Buprenorphine can be initiated as low or high dose
4. Perinatal pain management includes continuing MOUD

"I believe you are a great parent"



E-MODULES | Perinatal Substance Use Workforce Development Project

These are free to access, and between 5 – 10 minutes in length. To be viewed, please follow this QR code:

TOPIC	SPEAKER
Prenatal Alcohol Exposure and Fetal Alcohol Spectrum Disorders (FASD)	*Cresta W. Jones, MD, FASAM, FACOG*
Medications for Alcohol Use Disorder (AUD) in Pregnancy	*Kurt Devine, MD, FASAM*
Overview of Medications for Opioid Use Disorder (MOUD) in Pregnancy	*Lauren Graber, MD, MPH*
Perinatal Pain Management for Patients with Opioid Use	*Lauren Graber, MD, MPH*
Medications for Opioid Use Disorder (MOUD): Pharmacology Basics	*Marah Czaja, PA-C*
Prenatal Care for Pregnant People Using Methamphetamine in Pregnancy	*Charles Schauberger, MD, FACOG, DFASAM*
Intrapartum and Postpartum Care for People Using Methamphetamine in Pregnancy	*Charles Schauberger, MD, FACOG, DFASAM*
Breastfeeding and Neonatal and Infant Outcomes in Pregnancies Complicated by Methamphetamine Use	*Charles Schauberger, MD, FACOG, DFASAM*
Marijuana in Pregnancy and Breastfeeding	*Adrienne Richardson, MD*
The 5 Ss: A Conceptual Framework of Perinatal Mental Health	*Katie Thorsness, MD*
Harm Reduction and Perinatal Care	*Kari Rabi, MD*
Lactation and Perinatal Substance Use Disorders	*Meagan Thompson, DNP, APRN, CNM, PMHNP-BC*
Opioid Use Disorder in Pregnancy	*Meagan Thompson, DNP, APRN, CNM, PMHNP-BC*

Perinatal Substance Use ECHO

Join the new series now!

WHEN

(most) 2nd and 4th Wednesdays | 12:15 - 1:15 PM
Next session: November 13th Panel Discussion on The Role of Peer Recovery Doulas

WHAT

Educational sessions, case reviews and discussions of best practices and protocols focused on inpatient perinatal substance use and SUD in the obstetric unit.

WHO SHOULD JOIN

Teams consisting of:

- Labor and delivery/antepartum nurses
- Obstetric care professionals
- Nursing leadership (e.g. charge nurses)
- Unit/Service line administration
- Inpatient social workers
- Doulas

ECHO Minnesota – Perinatal Substance Use
Co-directed by Drs. Cresta Jones & Lauren Graber

Contact:
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Scan QR Code to Register

HennepinHealthcare

Thank you!!

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