Stabilizing the Mother-Infant Dyad for Better Outcomes from OB to FM:

Caring for Patients with Perinatal Opioid Use Disorder through the 4th Trimester

Melinda Ramage, Bayla Ostrach, Blake Fagan, Carol C. Coulson

A 24-year-old woman in her 2nd pregnancy presents for care. Standard screening questions prompt her to disclose illicit use of the opioid buprenorphine, which she obtained in the community to avoid heroin use. Her ultrasound reveals a 32-week gestation; patient is referred to our combined substance use treatment and obstetrics clinic where medically supervised prescription buprenorphine is initiated, as part of medication-assisted treatment for opioid use disorder in pregnancy. She volunteers that she did not seek care sooner due to fear of judgment and apprehension that she will lose her children due to her substance use. Our integrated team of clinical and behavioral health providers, familiar with these intertwined clinical and social dynamics, is briefed. A behavioral health clinician and a neonatal abstinence syndrome educator from the local hospital system see the patient together and discuss the hospital processes that will occur with admission for active labor. The patient continues prenatal care and medication-assisted treatment checks and meets providers from the nearby family health center who can continue medication-assisted treatment after postpartum discharge.

Maintaining the mother-infant dyad, when safe, should be the goal of perinatal substance use treatment. These interactions with multiple clinical and community supports provide opportunities for engagement with both obstetrics and substance use services. Building trusting relationships will assist the patient in the transitions of care common to substance use in pregnancy and ensure continued support through the immediate postpartum months (often called the 4th trimester). Opioid/substance use disorders are present in your waiting room. Are you prepared to screen, intervene, refer, or treat affected patients?

Substance use during pregnancy increased 127% from 1998 through 2011 [1]. Increases have been particularly dramatic in the south, with a 38% increase in opioid use disorder admissions, and national opioid prescription rates that are highest for southern women of reproductive age [2, 3]. This is attributed to disproportionate opioid overprescribing and less access to medication-assisted therapy [2, 4], which is considered the gold standard in pregnancy [5]. While substance use treatment and obstetrics have each been traditionally siloed, effective approaches combine woman-centered, trauma-informed perinatal care. Comprehensive treatment is effective in improving outcomes, reducing maternal and infant morbidity, and maintaining family cohesion [6, 7]. Sadly, due to a paucity of obstetrics and substance use providers, and overall healthcare obstacles, treatment access remains limited in North Carolina [2, 4].

Starting hard conversations is key to successful engagement. Universal screening tools are available [5]. To improve outcomes, include universal screening as part of routine prenatal and postpartum intake. Even brief screening provides opportunities for patients struggling with opioid use disorder (including those who may not match stereotypes) to communicate more openly. In our experience, most patients affected by opioid use disorder disclose use honestly when asked in a non-judgmental fashion.

In some parts of the state, opioid use disorder treatment services are well-developed and include comprehensive perinatal programs. In others, services are more limited. Identify a resource expert within your practice to establish and maintain a list of local prescribers and behavioral health addiction medicine specialists. This is an opportunity to facilitate community engagement while building a multidisciplinary team. Our patient advisory board has been extremely helpful in identifying resources and needs. As a result, our integrated team includes: obstetric buprenorphine prescribers; behavioral health providers; community resources for legal, housing, and inpatient opioid use disorder treatment; perinatal case

management (eg, Community Care of Western North Carolina; HeadStart); and other referrals. We will add transportation, childcare, peer support, and residential services in the future.

Perinatal opioid use disorder is a condition that affects two patients at once, with inextricably linked outcomes. Ensuring superior clinical and social care for the mother through the immediate postpartum period improves short- and long-term health outcomes for both patients. Transition points such as hospitalization for delivery, discharge home with the newborn, and insurance coverage after delivery (which often expires), are stressful for all involved. Unwelcome judgment is common in new environments; early introduction of wraparound services and warm handoffs is paramount. The ability to discuss potential child protective services involvement and provide anticipatory guidance before a baby is born or a newborn is acutely removed is invaluable, as it provides grounding and support in a tense situation. Likewise, partnering with local treatment programs and community agencies that support women in recovery has been integral to providing a perinatal safety net. Our family medicine residency program offers medication-assisted treatment, enabling postpartum patients to have an introduction to their embedded behavioral health and addiction specialist for ongoing care beyond the 4th trimester. Their children can be seen at the same clinic, facilitating further dyadic care and support.

Your perinatal patients need and deserve universal substance use screening, referral, and treatment, but likely lack access. You can probably do more than you think. Even if you can't do it all, resources are available [8]. Meeting patients where they are is a great first step. NCM

Melinda Ramage, FNP-BC, CARN-AP clinical director, Project CARA, Mountain Area Health Education Center, Asheville, North Carolina.
Bayla Ostrach, MA, PhD research scientist, Mountain Area Health Education Center; visiting research scholar-in-residence, University of North Carolina at Asheville, Asheville, North Carolina; assistant professor, Family Medicine, Boston University School of Medicine, Boston, Massachusetts.
Blake Fagan, MD chief education officer, Mountain Area Health Education, Asheville, North Carolina; clinical professor, Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
Carol C. Coulson, MD, FACOG maternal-fetal medicine specialist, Mountain Area Health Education Center, Asheville, North Carolina; clinical professor, Obstetrics and Gynecology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Acknowledgments

Potential conflicts of interest. All authors have no relevant conflicts of interest.

References

1. Maeda A, Bateman BT, Clancy CR, Creanga AA, Leffert LR. Opioid abuse and dependence during pregnancy: temporal trends and obstetrical outcomes. Anesthesiology. 2014;121(6):1158–1165.
2. Hand DJ, Short VL, Abatemarco DJ. Substance use, treatment, and demographic characteristics of pregnant women entering treatment for opioid use disorder differ by United States census region. J Subst Abuse Treat. 2017;76:58–63.
3. Martin CE, Longinaker N, Terplan M. Recent trends in treatment admissions for prescription opioid abuse during pregnancy. J Subst Abuse Treat. 2015;48(1):37–42.
4. Andrilla CHA, Coulthard C, Larson EH. Barriers rural physicians face prescribing buprenorphine for opioid use disorder. Ann Fam Med. 2017;15(4):359–362.
5. American College of Obstetricians and Gynecologists Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy. Washington, DC: American College of Obstetricians and Gynecologists; 2017. https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20180207T2107587226. Accessed February 7, 2018.
6. Saia KA, Jones H, Terplan M. Pregnancy and the Opioid Epidemic. Curr Treat Options Psychiatry. 2017;4(2):184–195.
7. Saia KA, Schiff D, Wachman EM, Mehta P, Vilkins A, Sia M et al. Caring for pregnant women with opioid use disorder in the USA: expanding and improving treatment. Curr Obstet Gynecol Rep. 2016;5(3):257-263.
8. SAMHSA. Screening Brief Intervention Referral to Treatment (tool). SAMHSA; n.d. Available from: https://www.integration.samhsa.gov/clinical-practice/sbirt.

Electronically published May 7, 2018.

Address correspondence to MAHEC OBGYN, Attn: Melinda Ramage, 119 Hendersonville Road, Asheville, NC 28803.

N C Med J. 2018;79(3):164-165.
0029-2559/2018/79306