



WHOLE PERSON-CENTERED CARE FOR PERINATAL OPIOID USE: LESSONS FROM SEATTLE AND BEYOND

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DISCLOSURE

No conflicts of interest





LEARNING OBJECTIVES

- Review substance use disorder in pregnant and parenting people.
- Discuss stigma, trauma-informed care and opportunities for evidence-based and equitable care for birthing parents with opioid use disorder and their families.
- Apply clinical tips tips for compassionate care with medications for opioid use disorder (MOUD).

FENTANYL IN SEATTLE / URBAN AND RURAL WA AREA

- Mode of ingestion:
 - Smoked
 - Swallowed
 - Injected
- 50x more potent than heroin; 100x more potent than morphine
 - small amounts can cause overdoses
- The overdose happens faster than with heroin
- Amount per pill/supply is highly variable
- Counterfeit pills
- Doesn't appear on standard urine drug screens
- Fentanyl powder and rock

M30 pills

These are the most common pills containing fentanyl in our area.



V48 & A215 pills

These pills, although less common, may also contain fentanyl.



Powders

Fentanyl can also be found in white powders.

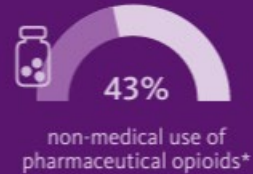
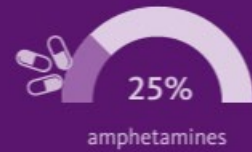
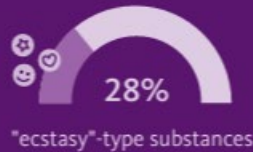
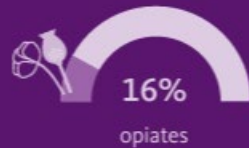


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Public Health
Seattle & King County 

WOMEN REMAIN UNDERREPRESENTED IN TREATMENT – CALL TO ACTION

Women among people who use drugs, 2022



* estimate not global, based on a few countries only

People with drug use disorders, 2022 (in million)

64
million people

↑ 3%
over 5 years, 2018-2022

1 in 11
in treatment



1 in 18 among women
in treatment



1 in 7 among men
in treatment



MYTH # 1: ADDICTION JUST HAPPENS

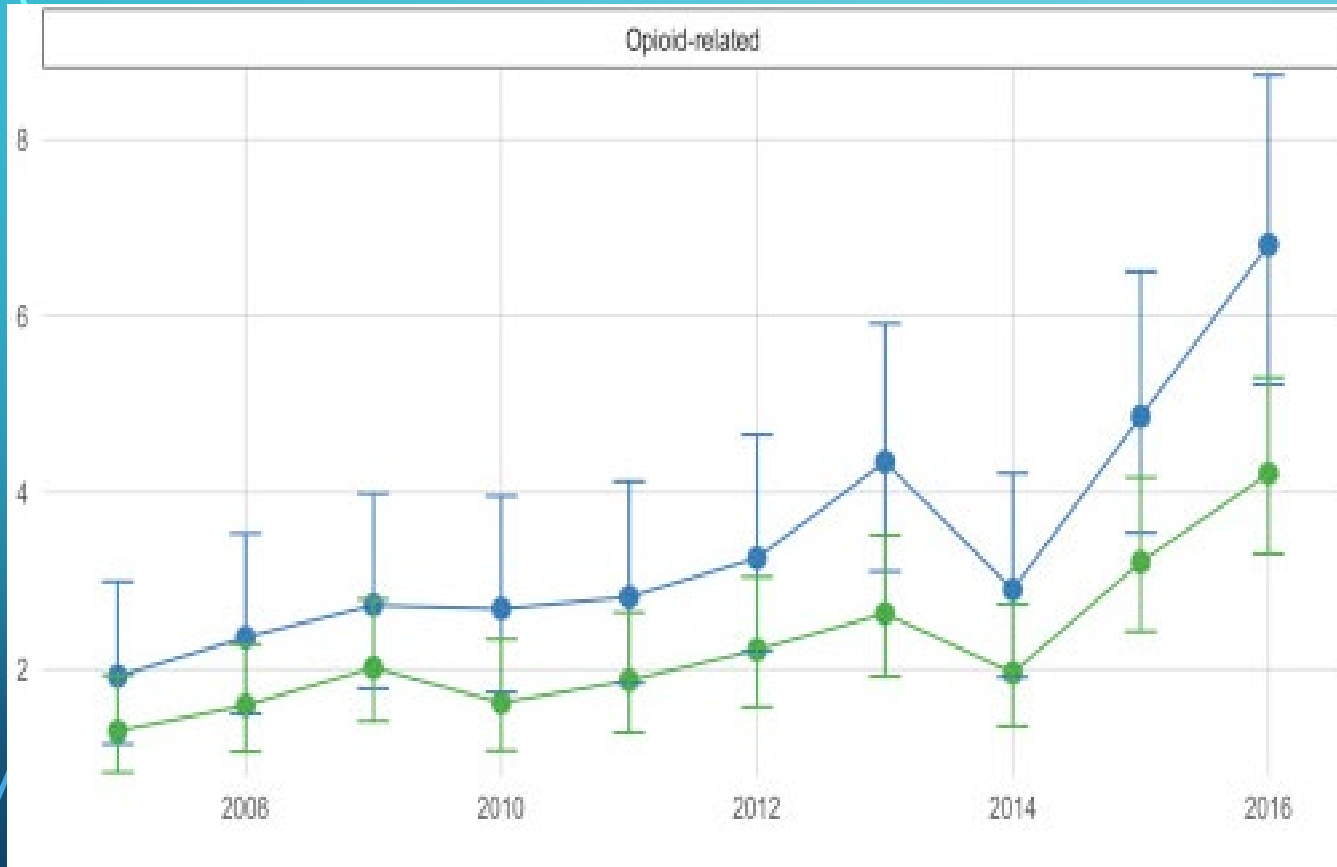
OPIOID PANDEMIC AND WOMEN/BIRTHING PARENTS

- ◆ *1999 – 2015: 850% increase in synthetic opioid-related deaths in women*
- ◆ 1999 to 2010, 400% prescription opioid OD deaths among women increased from 1,287 to 6,631
- ◆ 2010 to 2017, The number of women with opioid-related diagnoses at delivery increased by 131%
- ◆ Increase in incidence of maternal OUD: rates rising from 1.1 per 1000 births in 2000 to 8.2 per 1000 births in 2017

In 2016, the number of women of childbearing age (15–44) who reported past-month illicit opioid use

- 141,000 in 2016 -> 0.1% increase from 2015
- **Medicaid Data 2017-2018 in 39 states::**
 - 2.7% of pregnant or postpartum Medicaid enrollees had clinical documentation of OUD
- NAS: About 6 newborns were diagnosed with NAS for every 1,000 newborn hospital stays in 2020; NAS is now over 2.5 times more common than it was 15 years ago

OUD: INCREASING CAUSE OF MATERNAL MORTALITY



- Opioid Overdose: 10% pregnancy associated deaths
- Rate nearly tripled (1.3 → 4.2)
- WA: 2 in 3 pregnancy-related deaths occurred in the postpartum period
- WA: 4 in 5 of pregnancy-related deaths were preventable
- Among all pregnancy associated deaths, 11–20% were due to opioid-overdose
- [https://www.ajog.org/article/S0002-9378\(18\)30820-2/fulltext](https://www.ajog.org/article/S0002-9378(18)30820-2/fulltext)

Gemmill A, Kiang MV, Alexander MJ. Trends in pregnancy-associated mortality involving opioids in the United States, 2007-2016. Am J Obstet Gynecol. 2019 Jan;220(1):115-116. doi: 10.1016/j.ajog.2018.09.028. Epub 2018 Sep 28. PMID: 30273587.

https://journals.lww.com/greenjournal/Abstract/2020/05001/Opioid_Use_Disorder__A_Poorly_Understood_Cause_of.195.aspx

Mitra, Anjali MD; Brandt, Justin MD; Rosen, Todd MD; Ananth, Cande PhD, MPH; Schuster, Meike DO Opioid Use Disorder: A Poorly Understood Cause of Maternal Mortality in the United States [26E], Obstetrics & Gynecology: May 2020 - Volume 135 - Issue - p 56S

MENTAL HEALTH, SUBSTANCE USE AND MATERNAL MORTALITY

- *1 in 5 birthing parents will experience mental health or substance use problem during pregnancy and postpartum*
 - *75% of birthing parents who screen at-risk for postpartum depression receive no treatment*
 - *90% of birthing parents who screen at-risk for substance use receive no formal treatment*
 - *50% maternal mortality deaths related to suicide and overdose*
- infant hospitalizations and from **13.4 to 17.9 per 1,000** maternal hospitalizations, resulting in a total cost of **\$944 million in 2012**
- Neonatal Opioid Withdrawal Syndrome rates: fivefold increase, from **2.8 per 1000 births in 2004 to 14.1 per 1000 births in 2014**
- Sharp increase in health care spending due to increase in hospital length of stay (**\$1.5-\$2.0 billion 2012-14**)
- The cost of NOT TREATING maternal mental health and substance use conditions is **\$32,000 per birthing parent-infant pair totaling \$14.2 billion nationally**

TRUTH #1: ADDICTION DOES NOT JUST HAPPEN

- Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.
- People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
- Social determinants of health also have an impact on racial and ethnic maternal health disparities.
- Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

→ *It is unethical and cruel to punish women for the chronic illness of substance use disorder.*

→ *It is our responsibility to offer evidence-based treatment*

Adopted by the ASAM Board of Directors September 15, 2019

MYTH #2 ADDICTION IS A CHOICE

Strong relationship between:

- Trauma
- Adverse childhood experiences
- Genetics
- Chronic medical conditions
- Opioid prescriptions
- Lack of social support

And

High-risk behaviors and addiction



WHAT IS TRAUMA

- Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources.
 - Single event or multiple over time (complex, prolonged)
 - Experiences that are shocking, overwhelming such as abuse, neglect, violence, disaster, etc.
 - Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.
- Poor physical and mental health, obsessive behaviors, substance use, social dysfunction

ADVERSE CHILDHOOD EXPERIENCES

- “A comprehensive assessment of children's health should include a careful history of their *past exposure to adverse conditions and maltreatment*. Interventions aimed at reducing these exposures may result in better child health”



<http://www.cdc.gov/ace/index.htm>

Flaherty EG, Thompson R, Litrownik AJ, Zolotor AJ, Dubowitz H, Runyan DK, English DJ, Everson MD. Adverse childhood exposures and reported child health at age 12. *Acad Pediatr*. 2009 May-Jun;9(3):150-6.

TRUTH #2 ADDICTION IS NOT A CHOICE

Individuals > 4 ACEs; certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life

- *2-4 fold increase in poor health, tobacco smoking and sexually transmitted disease*
- *4-12 fold risk for alcohol and other substance use disorders, depression, suicide attempt, high risk behaviors*
- *Strong relationship between ACE, violence , trauma and addiction*

MYTH #3 “ALL I NEED IS DETOX. I DON’T WANT MY BABY BORN ADDICTED”



- Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine rather than withdrawal management or psychosocial treatment alone.
- A medical examination and psychosocial assessment are recommended when evaluating pregnant women for opioid use disorder. However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.
- For pregnant women with an opioid use disorder, pharmacotherapy (Methadone, buprenorphine) is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, ranging from 59% to more than 90%, and poorer outcomes (preterm birth, low birth weight, overdose).

TRUTH #3 ACCESS TO EVIDENCE-BASED TREATMENT NO WRONG DOOR WHOLE PERSON CARE

Opioid detoxification alone is not recommended because:

- Decreased neonatal birth weight
- Decreased prenatal care, poorer obstetrical outcomes
- Illicit drug relapse
- Resumption of high-risk behaviors (IVDU, prostitution, criminal activity)

Relapse poses grave risks, including communicable disease transmission, accidental overdose due to loss of tolerance, obstetric complications, and lack of prenatal care.

Opioid detoxification is a bridge to stabilization with Medication for Opioid Use Disorder (MOUD) (methadone or buprenorphine - standard of care)

Reported success rates 63-82%

FYI same success rates of other chronic disease like asthma and DM

TRUTH #3: Offer Medications for Opioid Use Disorder in Pregnancy and Postpartum

Meet People Where They Are

Choice for MOUD (Methadone, buprenorphine)

Choice for formulation, split Methadone/buprenorphine dose

Warm hand-off and care coordination

Close follow up during pregnancy, postpartum and across the lifespan

Celebrate people for their hard work to get healthy, offer MOUD and unconditional positive regard

METHADONE HIGH DOSE STABILIZATION AND 72 HOUR DISPENSING – “IT WENT VERY WELL”

25 y.o. G2P0010 at 22w4d by 7wk US, admits to ARS for fentanyl use disorder. History of MOUD with Methadone at OTP, using 15-20 “blues” per day on top of Methadone, smoked.

Admits to Addiction Recovery Services, Swedish Medical Center for Methadone stabilization, “I want to quit the blues, I want to be healthy for myself and for my baby”

- Stabilization with ARS high dose Methadone: 130 mg BID
- Offered counseling on methadone 72hr dispensing, harm reduction, OD prevention and takehome Narcan kit.
- Choice to receive 72hr Methadone dispensed, packed in a safely locked medication container.
- Coordinated warm hand-off, tele visits, OTP intake
- Patient was offered the opportunity to have a telehealth follow up visit at the Bridge ARS clinic x 24-48 hrs., medically-shared group zoom visit, ongoing treatment support

“IT WAS A VERY THOUGHTFUL, CONSIDERATE, PRACTICAL AND LIFE CHANGING EXPERIENCE”

72hr Methadone pathway, patient's voice:

- “The last time I used Fentanyl was the day I came to the ARS program”
- “I am grateful to be able to say that I am on a stable dose, taking Methadone twice daily helps me and my unborn son feel healthy”
- “Being able to receive Methadone for 3 days allowed me to come home with a plan set up to give me the peace of mind to be with my family, to receive calls from my doctor and to go to my Methadone clinic to continue care. It went really well: the safety caps, the locked bag, the labels on every syringe, the Narcan kit, the support, all very clear and it helped me feel safe.”
- “I have a much better chance to have a healthy baby now that I have been able to kick off fentanyl”

Improving Child Welfare, Newborn and Maternal Outcomes with the COMPASSION Model

INTRODUCTION

- Opioid use during pregnancy has risen, with a 131% increase in opioid-related diagnoses at delivery from 2010 to 2017.
- Neonatal opioid withdrawal syndrome (NOWS) has also increased, with a 433% increase from 1.5 to 8.0 per 1,000 hospital births from 2004 to 2014.
- Pregnant, postpartum, and parenting individuals with substance use disorder (SUD) and their newborns have unique treatment needs that require a collaborative approach, integrated services, and early intervention to facilitate optimal family wellbeing.
- **Community Of Maternal PArenting Support for Substance Impacted PeOple & Newborns (COMPASSION)** is an innovative model that promotes trauma-informed, respectful care and zero-separation for the family unit during a 5-day, extended stay on the postpartum unit.

METHODS

- Retrospective chart review
- Swedish Medical Center, Seattle, WA
- 44 birthing people/newborn/family units who presented in labor >35 weeks gestation in 2022 and who chose to engage in the COMPASSION stay
- Primary Outcomes:
 - Completion of COMPASSION
 - Child welfare
 - Plan of safety care (POSC), child protective services (CPS) referral, family team decision making (FTDM) meeting, foster placement
 - Secondary Outcomes:
 - Medication for OUD (MOUD) choice and dose
 - Breastfeeding rates
 - Average length of stay (ALOS)
 - NOWS
 - Morphine requirement, NICU admission

RESULTS

Birthing parents on MOUD, n=44	Birthing parents on Methadone BID, n=24	Birthing parents on Buprenorphine, n=20
MOUD Dose	30mg BID – 150mg BID (mean 95mg BID)	4mg BID – 8mg QID (mean 20mg daily)
Mode of delivery, GA	15 SVE (63%), 9 CS (37%), mean GA 37w8d	10 SVE (50%), 10 CS (50%), mean GA 36w3d
Breastfeeding	88%	75%
NOWS	21 (88%) no NOWS 2 (8%) morphine x1 1 (4%) NICU/NOWS	15 (75%) no NOWS 3 (15%) morphine x1 2 (10%) NICU/NOWS
ALOS – birthing parent	5 days, 100% MOUD, warm-hand-off, OD, f/u	5 days, 100% MOUD, warm-hand-off, OD, f/u
ALOS – newborn	8.2 days: 19 (80%) 5 days 2 (16%) 18 days peds/feeding 1 (4%) 30 days NICU	8.2 days: 16 (80%) 5 days 2 (10%) 10 days placement 2 (10%) 32 days NICU
COMPASSION Warm hand-off	98% (23), 2% (1) AMA 100%	100% 100%

Plan of Safety Care / no open CPS case: 12 (50%)

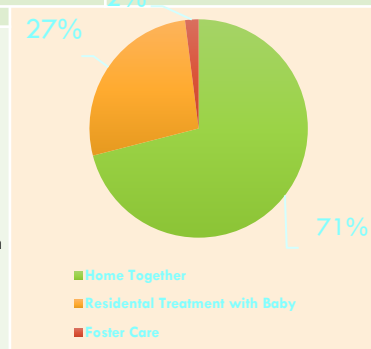
Plan of Safety Care / no open CPS case: 10 (50%)

CPS evaluation: 12 (50%)

CPS evaluation: 10 (50%)

Parent discharge with newborn: 23 (99%)
• 17 (74%) home
• 6 (25%) residential

Parent discharge with newborn: 20 (100%)
• 14 (70%) home
• 6 (30%) residential



CONCLUSION

- The innovative COMPASSION model offers patient-centered and respectful care for the whole family unit while positively impacting child welfare, newborn and maternal outcomes.
- The COMPASSION model offers wrap-around, integrated services with:
 - **Access:** “no wrong door” service
 - **Equity:** embracing patients of all recovery phases, cultures/races, backgrounds
 - **Recovery:** strengthening the lifelong journey while fostering a safe, peaceful and compassionate environment for the birthing parent, newborn and greater family unit
- Further prospective research is needed to evaluate the effectiveness of postdelivery and transitional programs with the goal of facilitating early bonding, promoting positive maternal and neonatal outcomes, and eliminating CPS placement.

AUTHORS & DISCLOSURES

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REFERENCES

American College of Obstetricians and Gynecologists. (2017). Opioid use and opioid use disorder in pregnancy. Committee Opinion 711.
 Hiral, A. H., Ko, J. Y., Owens, P. L., Stocks, C., & Patrick, S. W. (2021). Neonatal abstinence syndrome and maternal opioid-related diagnoses in the US, 2010–2017. JAMA, 325(2), 146–155.
 Patrick, S. W., Barfield, W. D., Poindexter, B. B., Cummings, J., Hand, L., Adams-Chapman, I., ... Walker-Harding, L. (2020). Neonatal opioid withdrawal syndrome. Pediatrics, 146(5), e2020029074.

ACKNOWLEDGEMENT

We are grateful for the courage and resilience of our patients who navigate challenges and disparities to be healthy and to care for their children and loved ones.

WA AND WSAM INITIATIVE

WSAM, WA Legislature, WA HCA:

- *standardize the choice for stabilization with MOUD*
- *standardize the choice for split dose Methadone*
- *and buprenorphine*

- Peer to Peer Support Line:

1833-YesWeCan: 1833-937-9326

WSAM: YesWeCanNW@gmail.com

- Leading the way, Yes, We Can!



TAKE HOME POINTS FOR HEALTH EQUITY GROWTH OPPORTUNITIES

Spokane region – a key leader region to improve perinatal, newborn and family outcomes. Foster “no wrong door”, whole-person care that is trauma-informed, compassionate, racially equitable and evidence-based; group supportive model to empower

- Equity, substance use and mental health wellness
- Support birthing parent’s individual values, autonomy and gender identity
- Trauma-informed communication encourages treatment engagement and breastfeeding
- Comprehensive longitudinal care with MOUD that is compassionate and patient-centered helps with challenges

Meeting needs of vulnerable and disadvantaged people

Community Effort

Birthing Parent/Woman Empowerment

- Together we can make a difference. **Yes, We Can!**

REFERENCES

1. 21 C.F.R. § 1306.07 Administering or dispensing of narcotic drugs. (2023). Accessed from:
2. [https://www.federalregister.gov/documents/2023/08/08/2023-16892/dispensing-of-narcotic-drugs-to-relieve-](https://www.federalregister.gov/documents/2023/08/08/2023-16892/dispensing-of-narcotic-drugs-to-relieve-acute-withdrawal-symptoms-of-opioid-use-disorder)
3. [acute-withdrawal-symptoms-of-opioid-use-disorder.](https://www.federalregister.gov/documents/2023/08/08/2023-16892/dispensing-of-narcotic-drugs-to-relieve-acute-withdrawal-symptoms-of-opioid-use-disorder)
4. Dispensation of narcotic drugs for the purpose of relieving acute withdrawal symptoms from opioid use disorder, Pub. L. 116-215 section 1302 (2020). Accessed from: <https://www.congress.gov/116/plaws/publ215/PLAW-116publ215.pdf>
5. Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. *JAMA Netw Open.* 2023;6(8):e2327488. doi:10.1001/jamanetworkopen.2023.27488.
6. Bowman LA, Berger O, Nesbit S, Stoller K, Buresh M, Stewart R. Operationalizing the new DEA exception: A novel process for dispensing of methadone for opioid use disorder at discharge from acute care settings. *Am J Health Syst Pharm.* 2023 Dec 13:zxad288. doi: 10.1093/ajhp/zxad288. Epub ahead of print. PMID: 38091380.
7. Skogrand E, Sharpe J, Englander H. Dispensing Methadone at Hospital Discharge: One Hospital's Approach to Implementing the "72-hour Rule" Change. *J Addict Med.* 2024 Jan-Feb 01;18(1):71-74. doi: 10.1097/ADM.0000000000001246. Epub 2023 Nov 22. PMID: 37994453; PMCID: PMC10873107

