Supporting Birthing People and Families During COVID; Tools for Buprenorphine and Methadone: Research and Clinical Pearls

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Friday, April 1, 2022
5:00 PM – 6:00 PM

Room: Grand Ballroom West, Second Floor

#ASAMAnnual2022

Disclosure Information (Required)

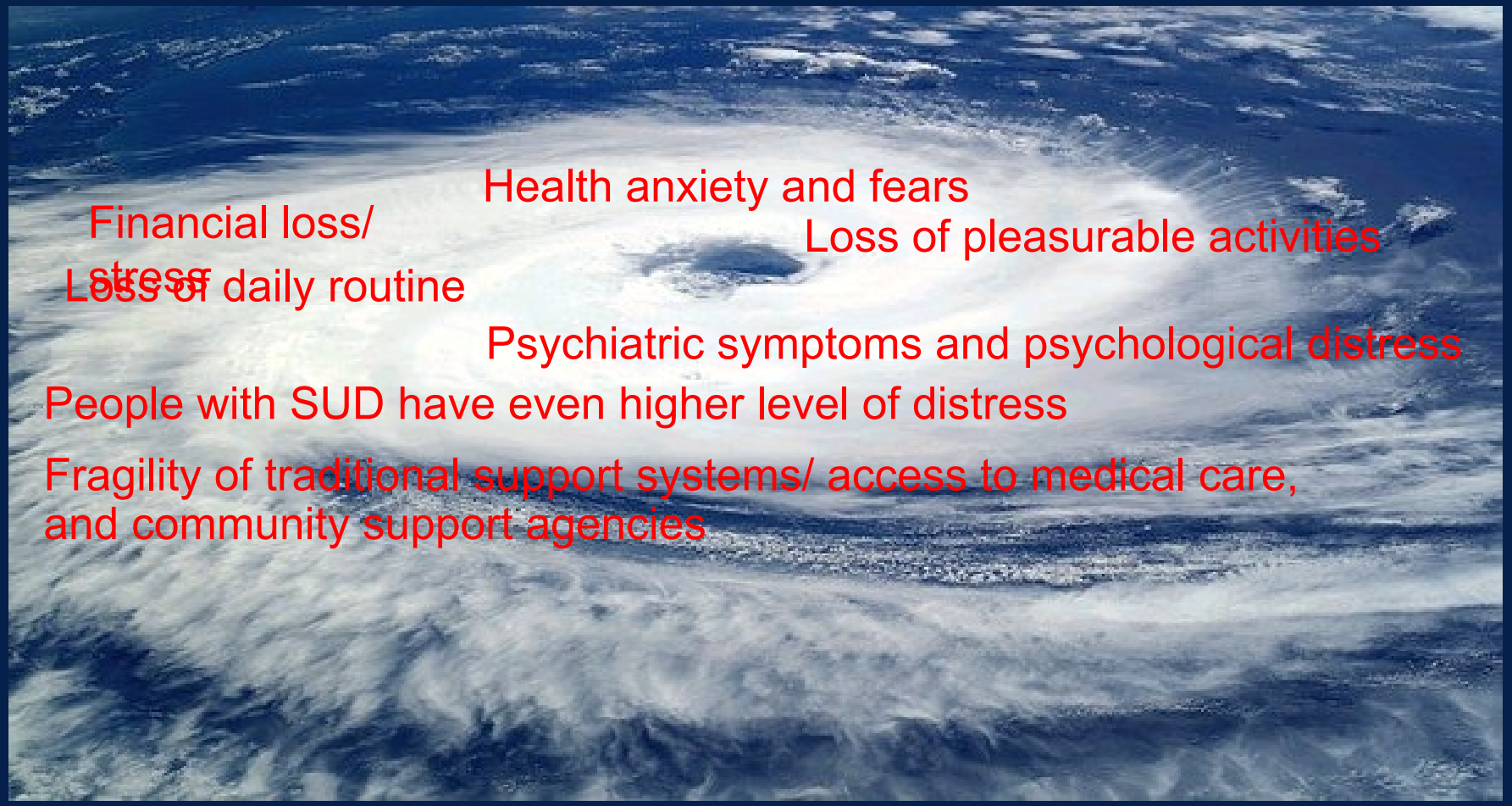
- Presenter 1: Hendree E Jones PhD
  - “No Disclosures”

Learning Objectives

- Name three ways that providers changed their care practices to best provide care to birthing patients with opioid use disorder during the COVID-19 pandemic

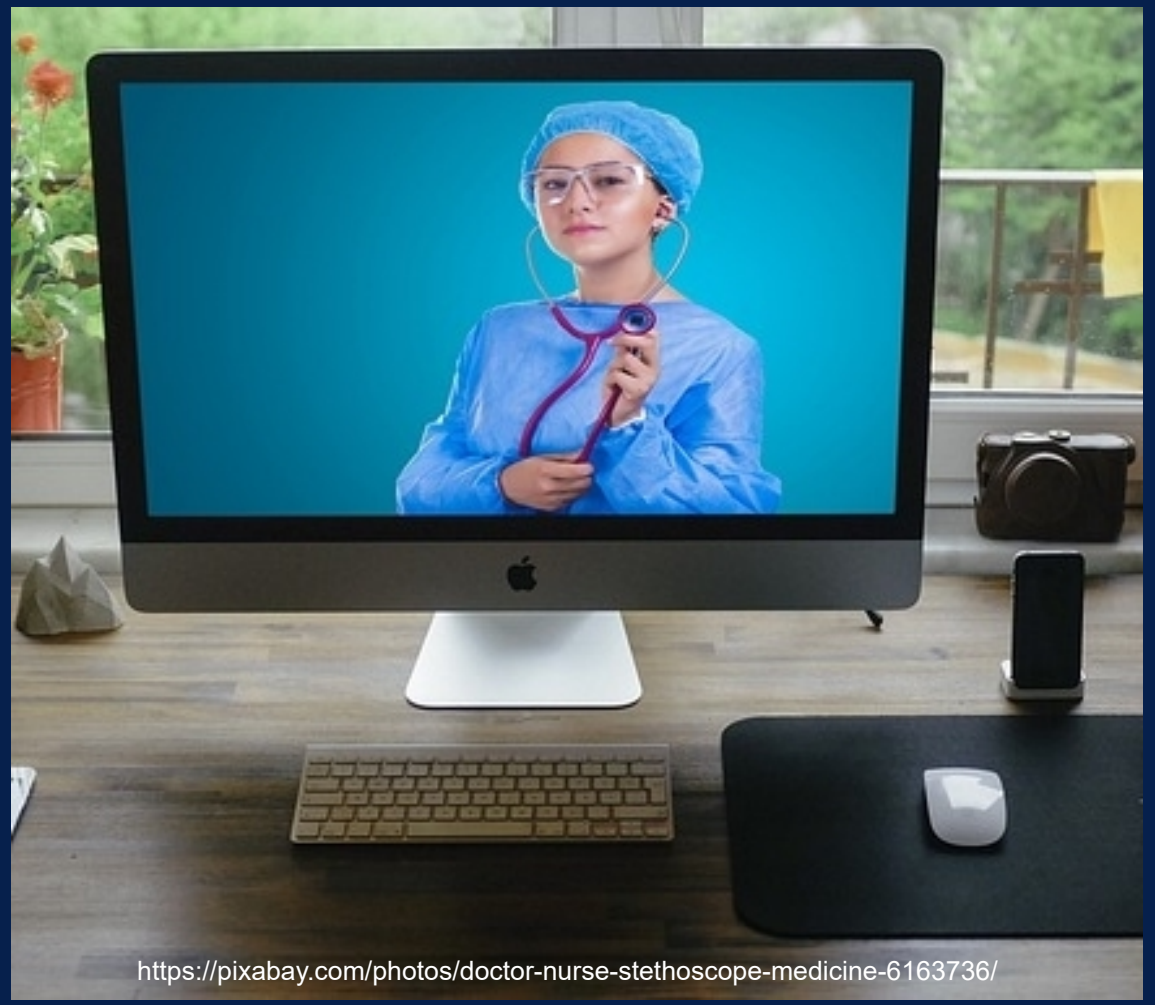
- Identify three ways care improved for birthing patients with opioid use disorder during the COVID-19 pandemic

COVID-19 The Perfect Storm



SUD Treatment Slowed during COVID-19

- WHO declared a pandemic on March 11, 2020
- SUD treatment programs were stopped due to recommendations for physical distancing.
- Those that remained open, substantially reduced their number of admissions or started providing care remotely.
- Many peer-support agencies shut down
- Rapid move to Telehealth



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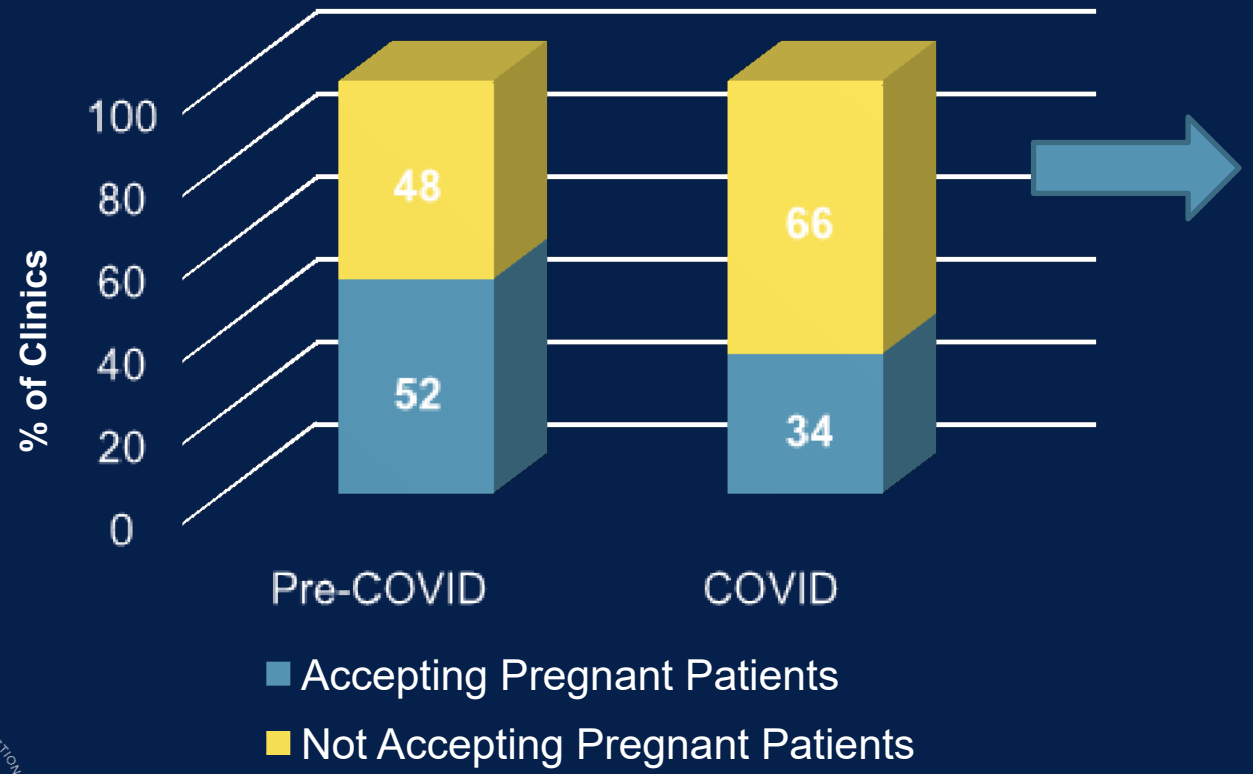
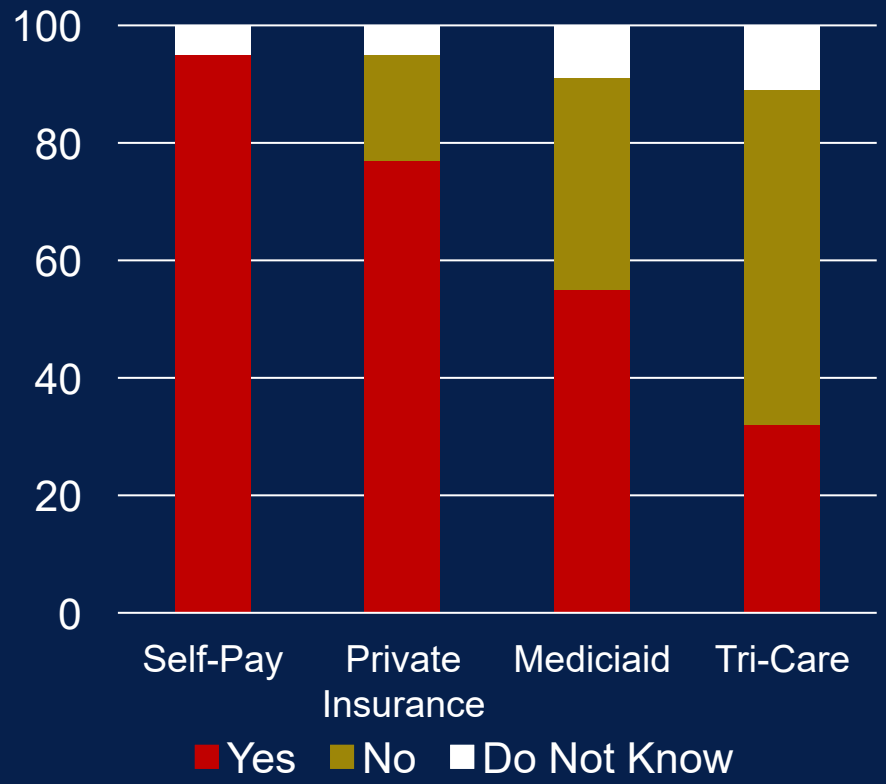
North Carolina: Treatment Access Denied

More Clinics during the COVID-19 Pandemic Deny Pregnant Patients Opioid Use Disorder Medication Treatment (N=128 Clinics)



Types of Payment Clinics Accept from Pregnant Women (n=44 Clinics)



Lensch AC et al., J Addict Med. 2022.16(1):e44-e47

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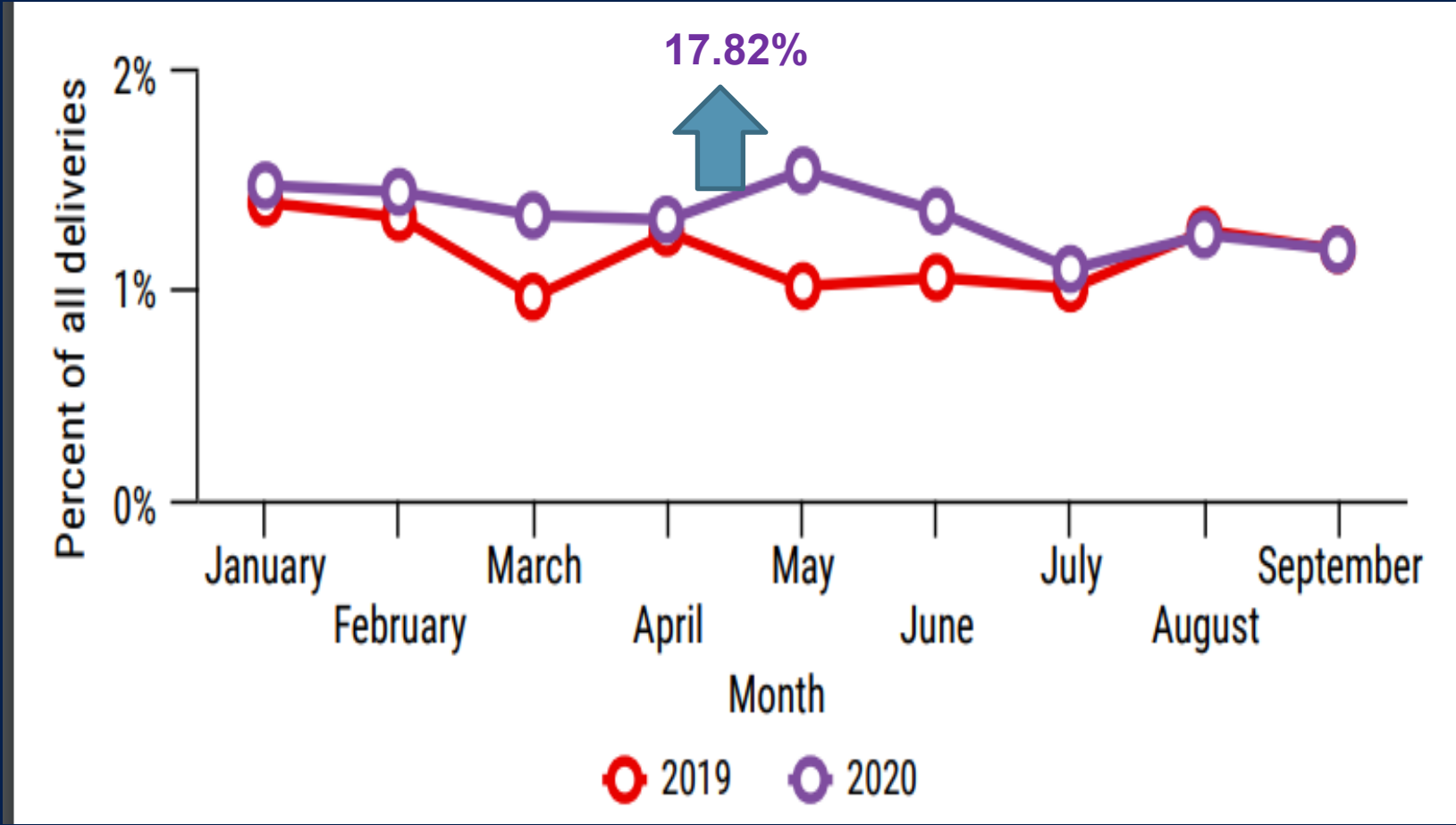
Neonatal Withdrawal Diagnosis Increased



FAIR Health's FH NPIC® dataset of more than 32 billion privately billed medical and dental claim records from more than 60 contributors nationwide.

Buprenorphine History

ELSEVIER

Drug and Alcohol Dependence 63 (2001) 97–103

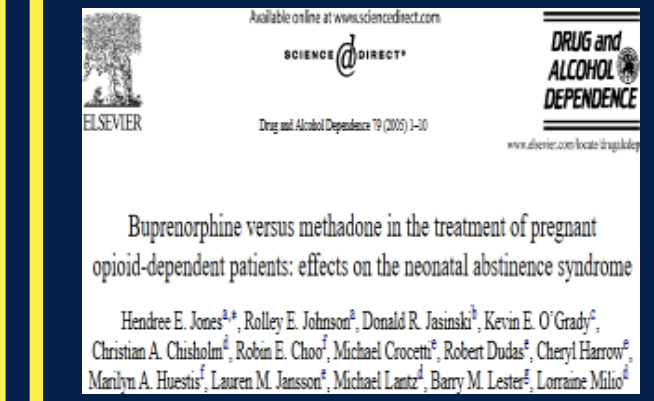
DRUG and ALCOHOL DEPENDENCE

www.elsevier.com/locate/drugalcdep

Short communication

Buprenorphine treatment of pregnant opioid-dependent women: maternal and neonatal outcomes

Rolley E. Johnson [a], Hendrée E. Jones [a,b,*], Donald R. Jasinski [f], Dace S. Svikis [a,b], Nancy A. Haug [a], Lauren M. Jansson [b,d], Wendy B. Kissin [b], Gad Alpan [e], Michael E. Lantz [c], Edward J. Cone [g], Diana G. Wilkins [h], Archie S. Golden [d],



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Drug and Alcohol Dependence 79 (2005) 1–10

DRUG and ALCOHOL DEPENDENCE

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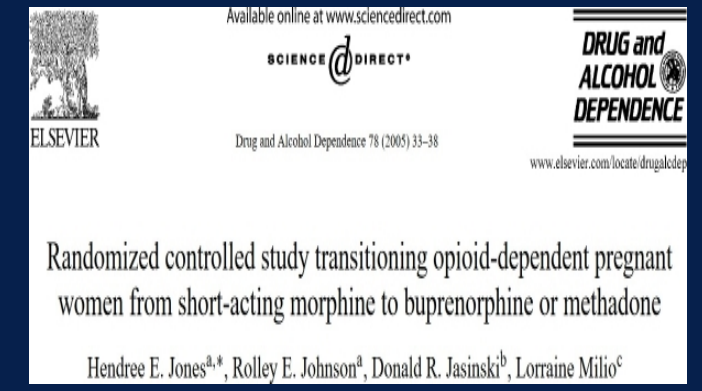
Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: effects on the neonatal abstinence syndrome

Hendree E. Jones[a,*], Rolley E. Johnson[a], Donald R. Jasinski[b], Kevin E. O'Grady[c], Christian A. Chisholm[d], Robin E. Choo[f], Michael Crocetti[e], Robert Dudas[g], Cheryl Harrow[e], Marilyn A. Huestis[f], Lauren M. Jansson[a], Michael Lantz[d], Barry M. Lester[g], Lorraine Milio[d]



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Drug and Alcohol Dependence 78 (2005) 33–38

DRUG and ALCOHOL DEPENDENCE

www.elsevier.com/locate/drugalcdep

Randomized controlled study transitioning opioid-dependent pregnant women from short-acting morphine to buprenorphine or methadone

Hendree E. Jones[a,*], Rolley E. Johnson[a], Donald R. Jasinski[b], Lorraine Milio[c]

The American Journal of Drug and Alcohol Abuse

ISSN: 0095-2990 (Print) 1097-9891 (Online) Journal homepage: https://www.tandfonline.com/loi/ieda20

Management of Acute Postpartum Pain in Patients Maintained on Methadone or Buprenorphine During Pregnancy

Hendree E. Jones, Kevin O'Grady, Jennifer Dahne, Rolley Johnson, Laetitia Lemoine, Lorriane Milio, Alice Ordean & Peter Selby

To cite this article: Hendree E. Jones, Kevin O'Grady, Jennifer Dahne, Rolley Johnson, Laetitia Lemoine, Lorriane Milio, Alice Ordean & Peter Selby (2009) Management of Acute Postpartum Pain in Patients Maintained on Methadone or Buprenorphine During Pregnancy, The American Journal of Drug and Alcohol Abuse, 35:3, 151-156, DOI: 10.1080/00952990902825413

Buprenorphine + Naloxone V. Methadone

Neonatal Outcomes *Primary outcomes*	Methadone (*n*=31)	Buprenorphine + Naloxone (*n*=31)	*p*-Value
Number Treated for NAS	16 (51.6%)	8 (25.1%)	0.01
Amount of Morphine (mg)	5.0 (3.3)	3.4 (1.2)	0.18
Duration of NAS treatment (days)	11.4 (3.4)	10.6 (3.1)	0.88
Peak NAS Score (range 1–25)	10.7 (3.7)	9.0 (4.4)	0.02

Results are given as number (%) or mean (SD)

Wiegand SL, et al., Obstet Gynecol. 2015;125(2):363-368.

Relative Safety and Efficacy of Buprenorphine +Naloxone

The most recent guidelines from the BC Ministry of Health recommended that buprenorphine+naloxone is as safe and effective as buprenorphine monotherapy during pregnancy.

British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions, & Perinatal Services BC. A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement. Published June 1, 2018. Available at: http://www.bccsu.ca/care-guidance-publications/

What about Buprenorphine Dosing?

Pregnancy
1st trimester 4.9 to 17.8 mg/day
2nd trimester 1.1 to 16 mg/day
3rd trimester 0.1 to 34 mg/day

Mean changes in doses during pregnancy ranged from − 12.3 to + 10.5 mg/day

Delivery
2.3 to 34 mg/day

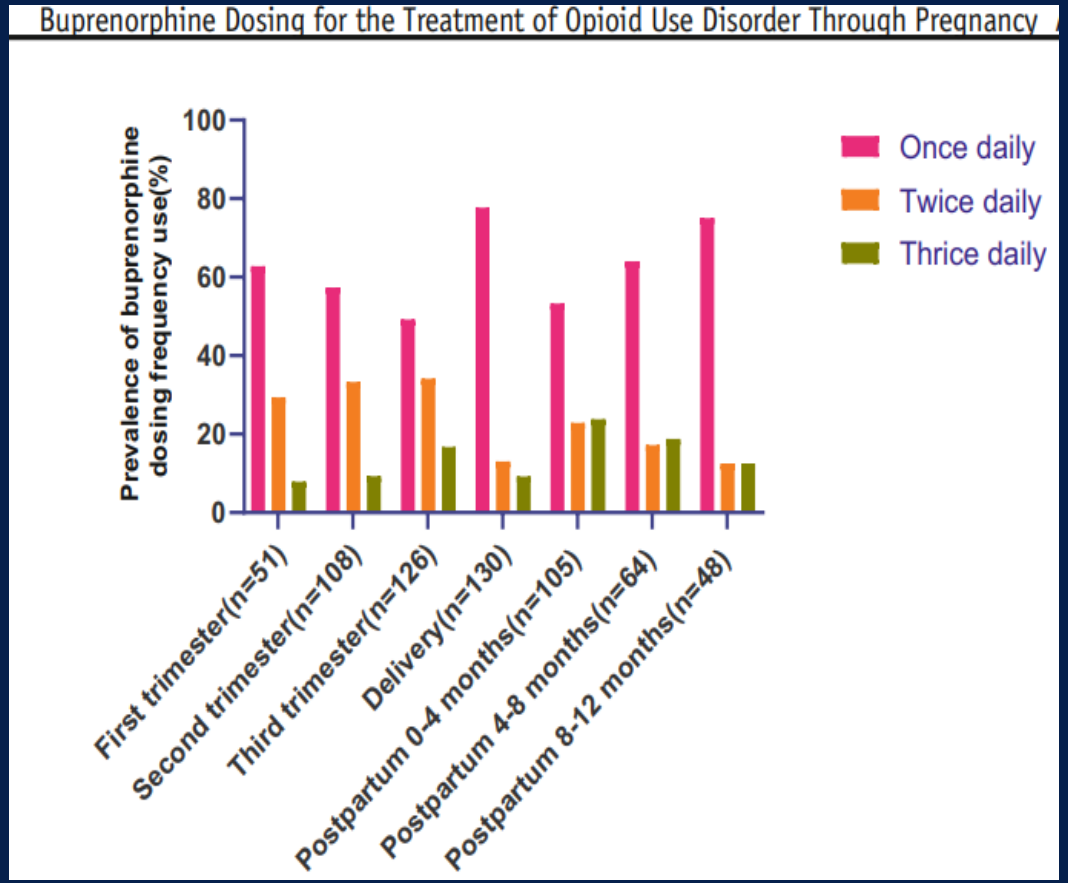
Two studies - higher buprenorphine doses are associated with higher levels of treatment continuation during pregnancy

Martin, C. et al., (2020). Buprenorphine dosing for the treatment of opioid use disorder through pregnancy and postpartum. *Current treatment options in psychiatry*, *7*(3), 375–399.

What about Buprenorphine Dosing?

N=14 participating in the pharmacokinetic study during and after pregnancy

plasma concentrations of buprenorphine were < 1ng/ml (the theoretical concentration required to prevent withdrawal symptoms) for 50–80% of the 12 hour dosing interval while at steady state.



Caritis, S. et al., (2017). American journal of obstetrics and gynecology, 217(4), 459.e1–459.e6.
Martin, C. et al., (2020). Current treatment options in psychiatry, 7(3), 375–399.

Innovation in Treating Pregnant People in OB+SUD Integrated Care

- **Changes**
  - Clinics let patient preference drive modality of de-livery (in-person, phone or virtual)
  - Clinicians conducting visits were in dedicated clinic rooms or in other private settings using hospital-approved equipment.

- **Results**
- COVID-19 hybrid model no-shows rates are lower than pre-COVID-19 in-person model- 10% vs. 34%
- Possible reasons:
  - Not needing transportation or childcare for appointments
  - Avoiding a clinical setting or setting linked to prior substance use
  - Social isolation makes all visits, a purposeful connection for some patients
- Patients seeking inpatient methadone stabilization, dropped from 6 to 1-2 per month

Patton EW et al., Journal of Substance Abuse Treatment 124 (2021) 108273

What We Observed: Telemedicine

- Video visits offer rich insights into patients' lives
- Telemedicine visits may provide a more focused visit format for clinician and patient
- Tele-or video care allows patients with complex competing demands due to their SUD and their pregnancy or parenting to engage in care for both of these health needs more easily, without transportation, childcare, or other logistical concerns.

Patton EW et al., Journal of Substance Abuse Treatment 124 (2021) 108273

Telehealth Advantages

- Reach our patients where they are
- Transportation is no longer a barrier
- Parenting patients are not required to find childcare during appointments
- Reach those who may have missed appointments or who prefer virtual rather than in-person care

https://pixabay.com/illustrations/achievement-across-advantage-703442/

Sadicario JS.. J Subst Abuse Treat. 2021 Mar;122:108200.

Telehealth Advantages

Positive impacts of telemedicine on quality of patient interactions

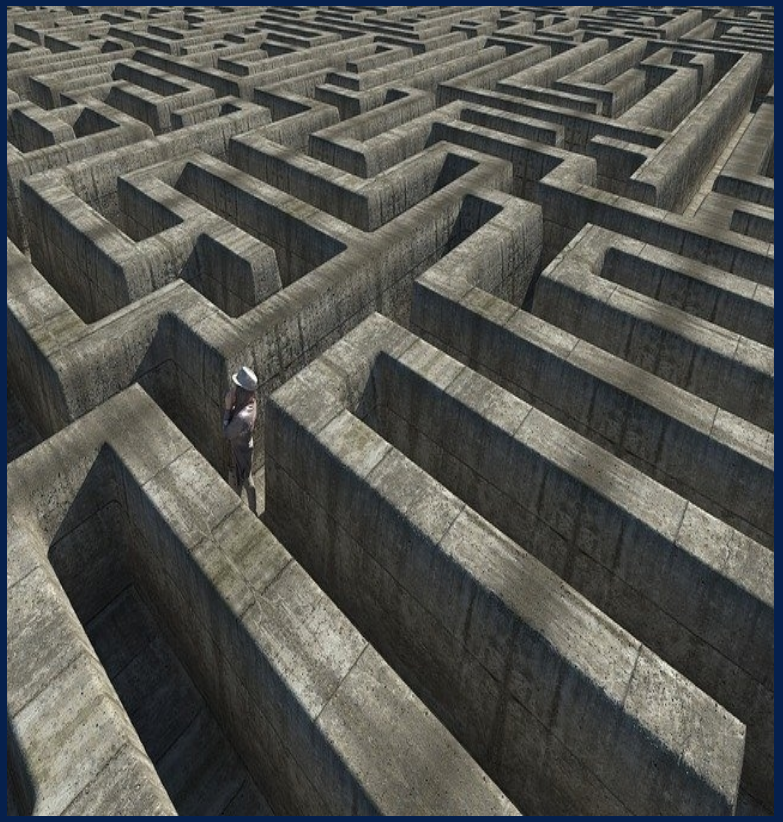
- Shorter visits
- Positive impacts Increased access and convenience
- Reduced anxiety
- Video visits in home can facilitate better emotional connection

https://pixabay.com/photos/telemedicine-doctor-laptop-6166814/

Uscher-Pines L., et al., Journal of Substance Abuse Treatment 118 (2020) 108124

Telehealth Disadvantages

- **Negative impacts of telemedicine on quality of patient interactions**
  - Less structure and accountability
  - Less information to inform clinical decision-making
  - More difficult to connect/establish a connection
  - Technological challenges



https://pixabay.com/photos/labyrinth-freedom-orientation-4300600/

Uscher-Pines L., et al., Journal of Substance Abuse Treatment 118 (2020) 108124

Telehealth Disadvantages

- Patients lack consistent access to resources
- Limits to privately discuss sensitive issues
- Disclosure of suicidal or homicidal ideation in clinic is easier to address than via telehealth
- Domestic violence discussion require appropriate timing and consent from patients
- Remote protocols need increased flexibility- challenging in a busy clinical environment.
- Not being able to perform “warm handoffs” between providers

Sadicario JS.. J Subst Abuse Treat. 2021 Mar;122:108200.

Telehealth Disadvantages

- Addressing unsafe places for patients
- Staff anxiety increased
- Virtual visits may be isolating for providers
- We boosted mutual support among pro-viders

Patton EW et al., Journal of Substance Abuse Treatment 124 (2021) 108273

Pregnancy and the Opioid Crisis: Heightened Effects of COVID-19

- The concerns around interpersonal violence increased and providers used in-person clinic time to develop “safe or code words” with patients to use when they could not speak about topics or were in danger
- Have a safe family member, friend or authority be called for well check visits
- Scarcity of resources
- Increasing discussions and distribution of naloxone

White A, et al., J Addict Med. 2022 Jan-Feb 01;16(1):e2-e4.

Behavioral Health Training Changes

- Shared drive that allows trainees to communicate patient status in a HIPAA protected manner
- Check patient status in real-time via shared documents
- Protocols to operate remotely, including remote peer consultations, supervisions, and integrated clinic meetings to discuss points of education and patient status outside of clinic
- During high-risk situations, trainees can message another team member to alert their clinical supervisor or violence prevention advocates while safety planning to facilitate additional support

Sadicario JS.. J Subst Abuse Treat. 2021 Mar;122:108200.

What The Women Shared

- Isolation is a huge trigger
- Helps to be able to go out and walk, to have a routine
- Having tools to work on education or a job from home helps
- Want providers to know how hard it is to have the same day every day
- Be patient with us and have empathy for us because sometimes we need a break from our kids
- Stop the discrimination against us- last week a non-UNC nurse taking a drug test from me said “if an addict’s lips are moving, then she is lying.” “My test was negative but I felt judged and like I was less than dirt.”

https://pixabay.com/photos/woman-child-face-mask-covid-mask-5716038/

Ways to Reduce Stress: An Attitude of Gratitude

- Meetings start with gratitude
- Email and handwritten notes of thanks
- Calling to check on all team members
- Finding joy in your day
- Sending a though for the day every day as well
- As fun tips for the team to do alone or with their children
- Tokens of thanks given
- Modeling patience, empathy, self-compassion and self-care
- Socially distanced in-person retreats
- Including using similar telephone and video technology for group debriefs and care
- Increased email communication celebrating success

Learning Objectives

- Name three ways that providers changed their care practices to best provide care to birthing patients with opioid use disorder during the COVID-19 pandemic

- Identify three ways care improved for birthing patients with opioid use disorder during the COVID-19 pandemic

Final Takeaways/Summary

- Work to keep flexibilities with telehealth cemented in the system
- Keep flexible access to MOUD
- Provide MOUD dose in a dosing frequency that responds to patient need
- Ensure patient access to hybrid models of care and the infrastructure to support virtual care
- Support each other with gratitude and compassion

Jones HE, et al. Prev Med. 2021 Nov;152(Pt 2):106742.

Contact Info and Questions

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