The UC San Diego Health Culture and Justice Quorum presents the Birth Community Engagement & Symposium Series

Opioid Use During Pregnancy and Lactation: Clinical Care at UCSD & Community Pathways

July 23, 2024

UC San Diego
SCHOOL OF MEDICINE
Department of Obstetrics, Gynecology and Reproductive Sciences

Welcome!

- For tech support needs, please message panelists and hosts; send message to Breanna - Admin
- Please post questions in the **Q&A box**
- Agenda can be found on the right side of slides
- CEU and CME credits will be provided to UCSD faculty and staff. An evaluation form will be shared at the conclusion to request credits.

Agenda

Welcome

10:30 – 10:35: Introductions
Audra Meadows, MD, MPH
Vice Chair, Culture & Justice

Introduction

10:35 – 10:45:
Setting the Stage – Addiction, SUD, OUD
Carla Marienfeld, MD

Clinical Care Pathways

10:45 – 11:00:
Outpatient Care in Pregnancy
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11:15 –11:30:
Neonatal Opioid Withdrawal
Michelle Leff, MD

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McAlister Institute

11:45 –12:00 pm:
HBCD Program

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12:00 – 12:25 Q&A
12:25 – 12:30 Closing

Learning Objectives

1. Provide information on addiction, including the physiological, psychological, and social aspects of Substance Use Disorders (SUD) and Opioid Use Disorders (OUD)

2. Detail the outpatient and inpatient care management strategies for pregnant people with OUD at UC San Diego Health, emphasizing best practices and effective screening and treatment protocols.

3. Describe the withdrawal symptoms associated with opioids and the protocols for managing withdrawal in both mothers and newborns. Explain the symptoms, diagnosis, and management of Neonatal Opioid Withdrawal Syndrome (NOWS), including the impact of maternal opioid use on newborns and lactation.

4. Present the role of community resources, such as the McAlister Institute, in supporting pregnant people with OUD and their families and provide an overview of the Healthy Brain and Child Development (HBCD) program, its objectives, and how it supports mothers and infants affected by opioid use.

5. Discuss Medication-Assisted Treatment (MAT): Explain the use of FDA-approved medications like methadone, buprenorphine, and naltrexone in the treatment of OUD during pregnancy.

6. Explore how implicit biases related to race, ethnicity, gender identity, sexual orientation, age, and socioeconomic status can affect healthcare decisions for pregnant people and families experiencing OUD and SUD. Discuss strategies to mitigate these biases to reduce healthcare disparities and ensure fair and equitable treatment for all patients.

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UC San Diego Health

Setting the Stage – Addiction, Substance Use Disorders, and Opioid Use Disorder

Carla Marienfeld, MD

Medical Director of the UCSD Substance Treatment And Recovery (STAR) Program

HS Clinical Professor of Psychiatry

University of California, San Diego

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What is Addiction?

Part 1: A treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

Part 2: People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Part 3: Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

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American Society of Addiction Medicine – 2019
https://www.asam.org/Quality-Science/definition-of-addiction

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What is Addiction? Part 1

A treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

- Genetic vulnerability
- Brain structure changes with long term use
- Biochemical changes after repeated stimulation of dopamine reward pathways

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What is Addiction? Part 2

People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

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Impaired Control

- Taking the substance in **larger amounts or for longer** than you intend
- **Unable to quit or cut down**
- **Spending a lot of time** getting, using, or recovering from use of the substance
- **Cravings**

Social Problems

- **Problems at work, school, or home** because of substance use
- Interpersonal problems or causing **problems in relationships**
- Giving up **important activities** to use instead

Risky Use

- **Hazardous** use
- **Continuing use, despite** causing/worsening physical/ psychological **problems**

Physical/Pharmacological

- Tolerance
- Withdrawal

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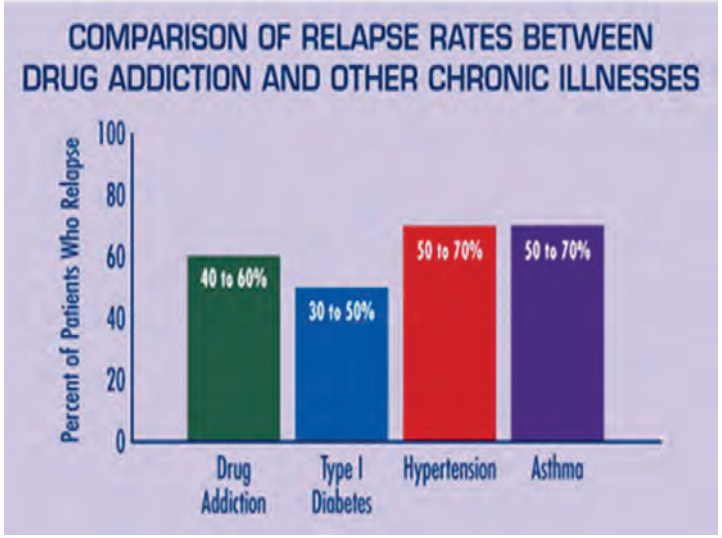
What is Addiction? Part 3

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.



Similarly to diabetes, high blood pressure, asthma…

- Biologically, psychologically, and socially mediated
- Lifestyle and meds both can help
- Symptoms relapse and remit

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Why Treat Substance Use Disorders?

- Be aware of our Implicit Bias
- SUDs common and easily identified
- Effective treatment exists
- Similar outcomes to other chronic diseases
- Rewarding to watch patient's lives improve

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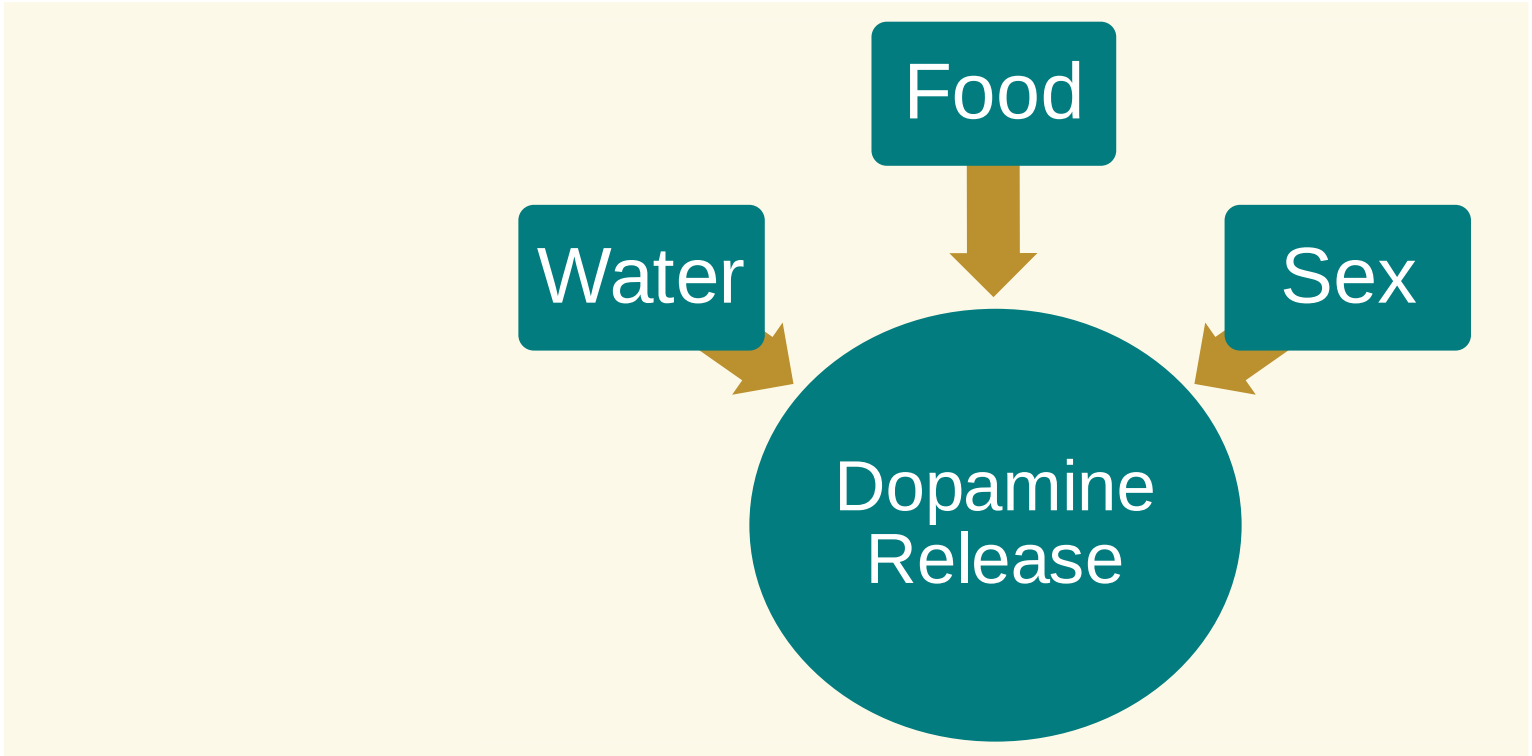
Natural rewards release dopamine



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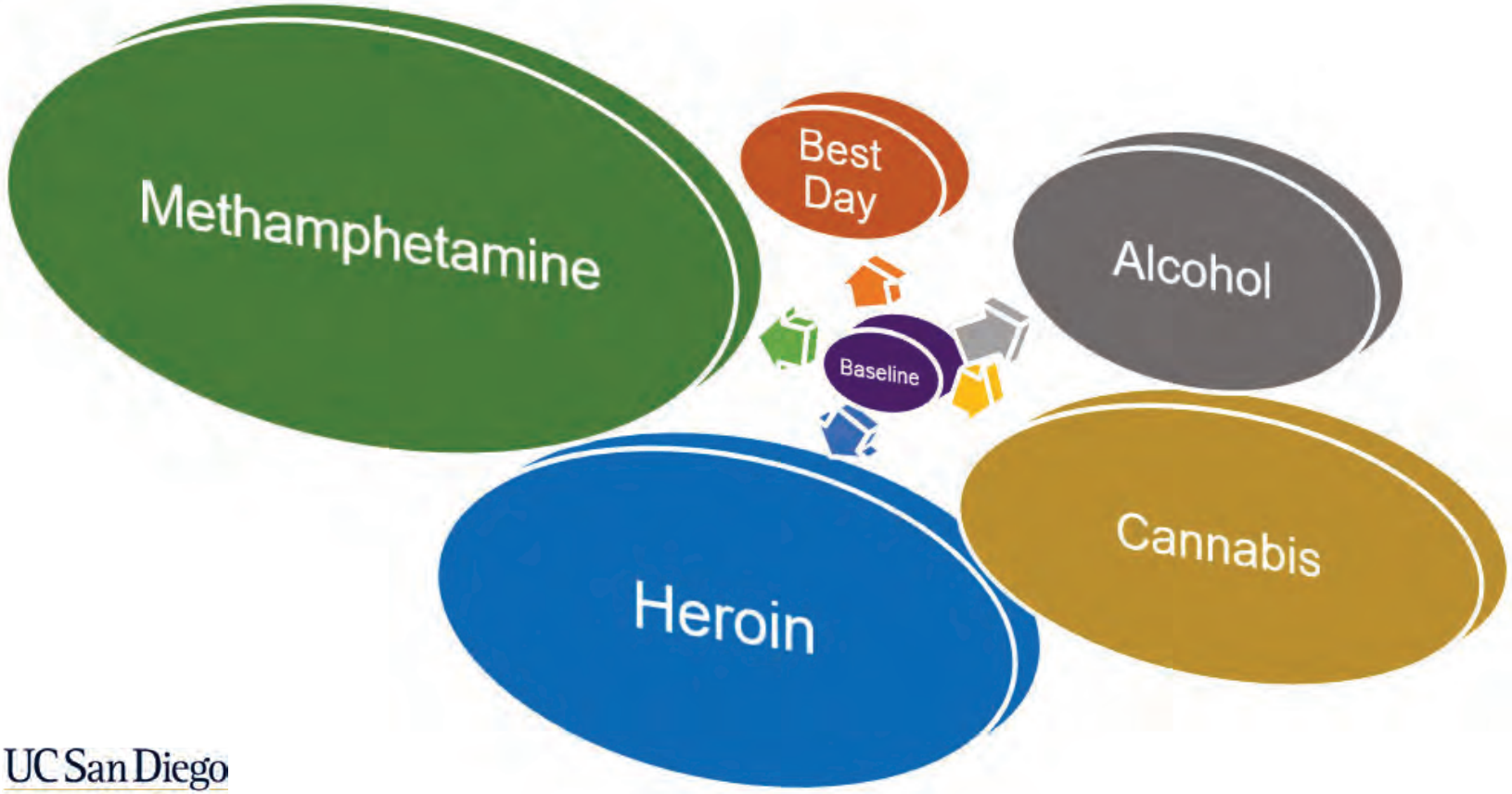
Dopamine Response



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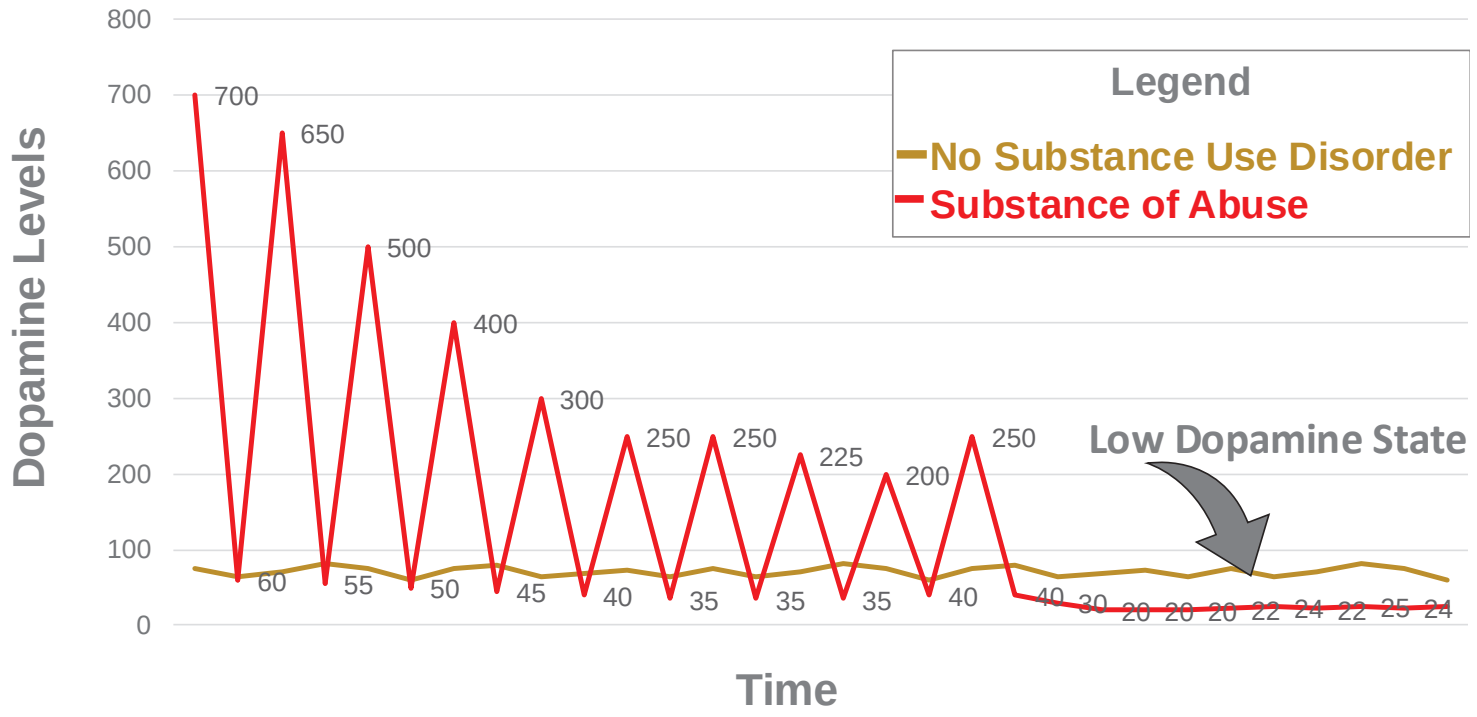
Brain changes with episodes of substance use



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FOUNDATIONAL PRINCIPLES OF HARM REDUCTION

Harm reduction incorporates a **spectrum of strategies** that includes safer use, managed use, abstinence, meeting people who use drugs "where they are," and **addressing conditions of use along with the use itself**. Because harm reduction demands that interventions and policies designed to serve people who use drugs reflect specific individual and community needs, there is **no universal definition or formula for implementing harm reduction**.

- National Harm Reduction Coalition

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Treatment Modalities

- Motivational interviewing
    - Style of treatment interaction to ↑ motivation to change
- Counseling and psychotherapy
    - Group based therapy
        - Psychotherapy provided with peer input / support as part of therapy
    - Cognitive behavioral therapy
        - Relapse Prevention
    - Acceptance and Commitment Therapy (ACT)
    - Community Reinforcement Approach (CRA) with Family Therapy (CRAFT)
- Mutual Help Groups
    - Grew out of Alcoholics Anonymous; free, available
- Medications

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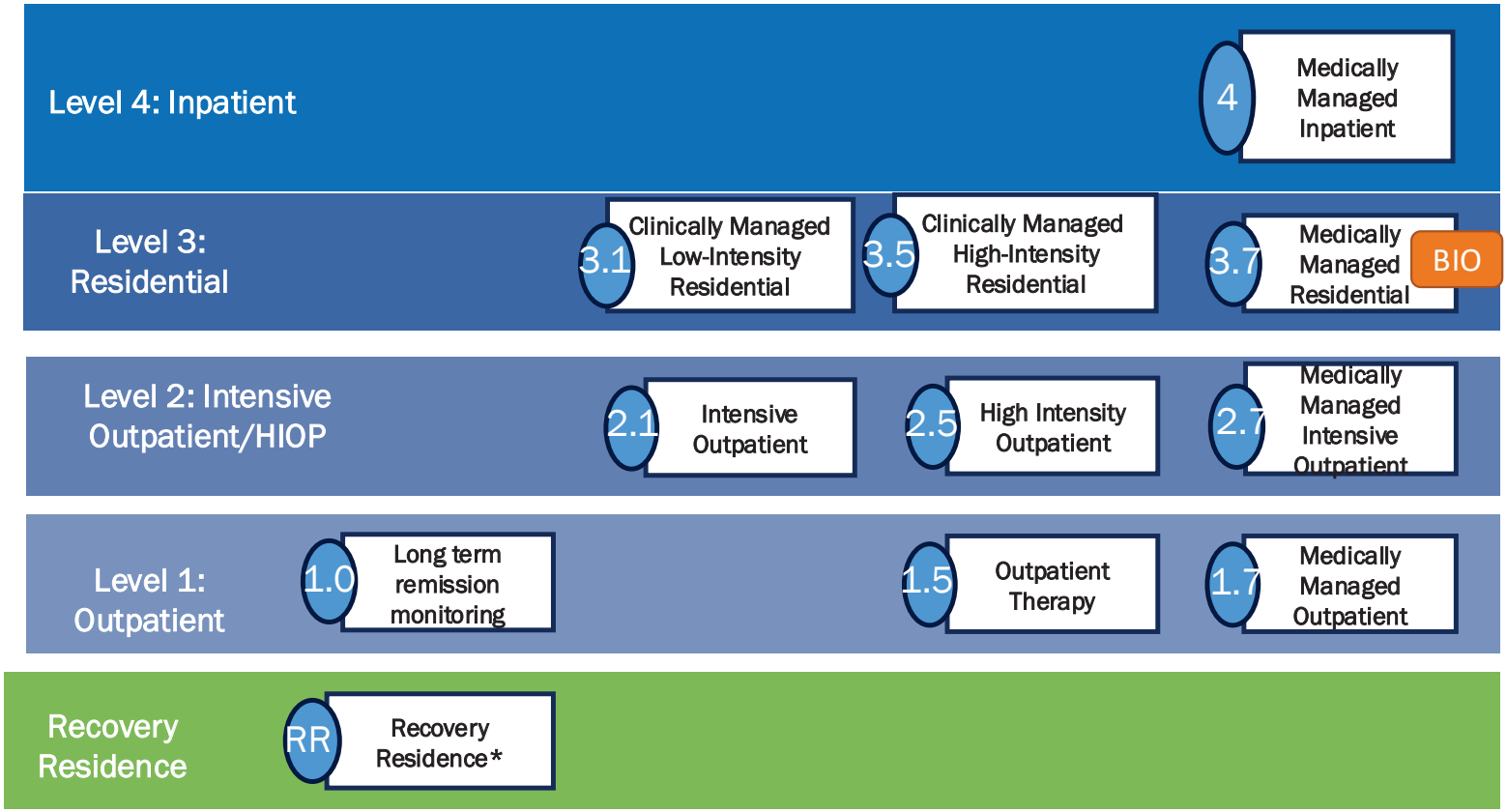
The ASAM Criteria Continuum of Care – Adult



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Co-occurring enhanced care (COE) Standards Defined for x.5, x.7, and Level 4

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Opioid Use Disorder

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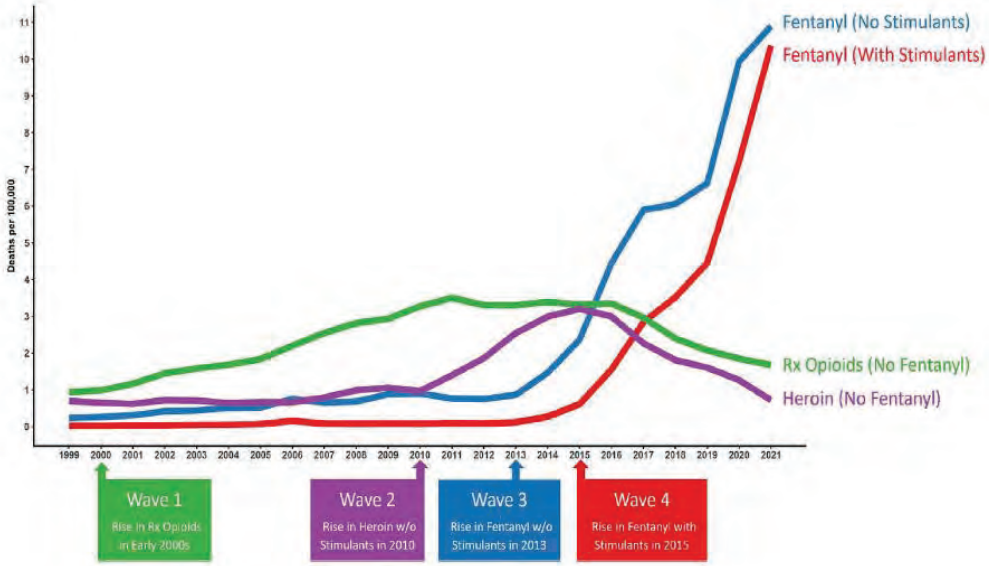
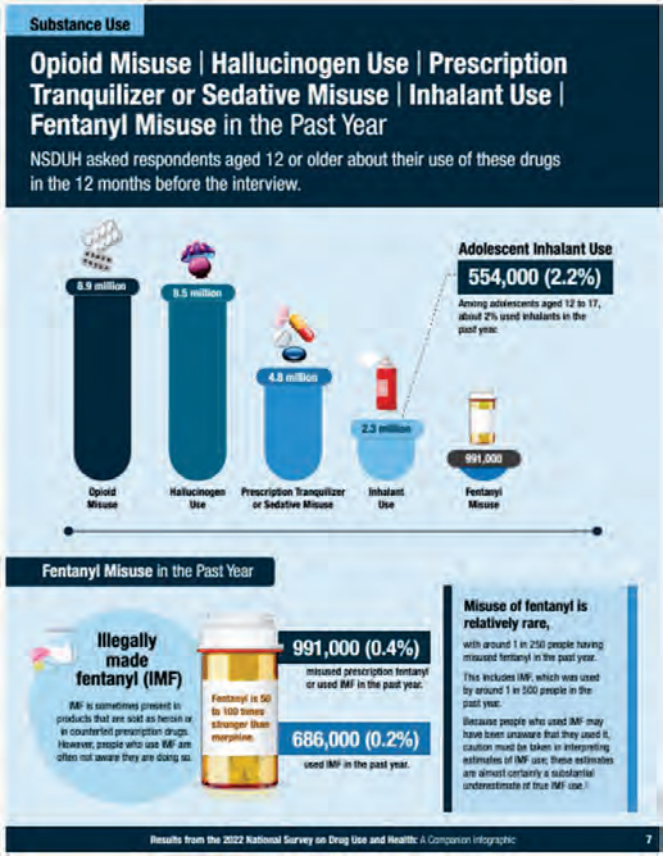
US Overdose Death Rates by Opioid Type, 2000-2021



Addiction, First published: 13 September 2023, DOI: (10.1111/add.16318)



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Source: CDC WONDER. National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

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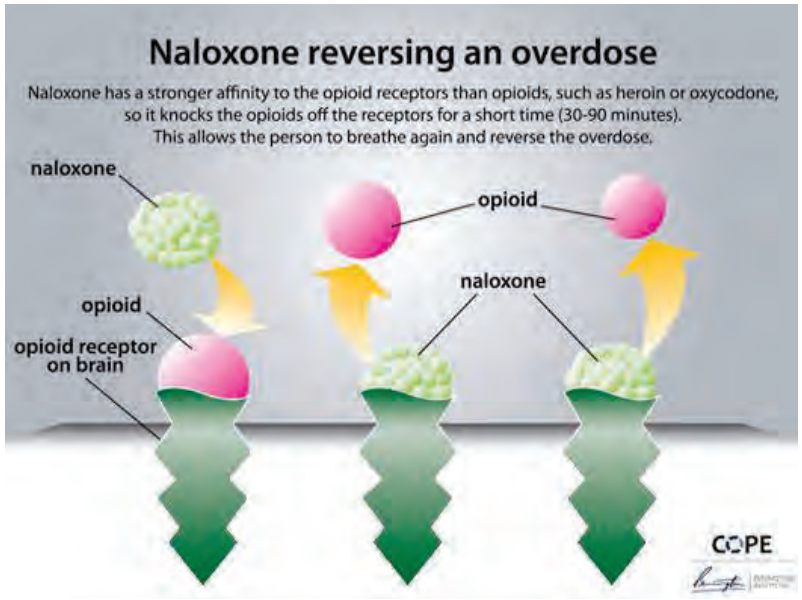
Naloxone

- Naloxone is an opioid receptor antagonist ("blocker")
  - Displaces opioids from the receptors, then binds to and blocks the receptor
- Short acting – 30-90 minutes
  - May need to give more or repeatedly
  - Especially with fentanyl, long-acting, and newer opioids



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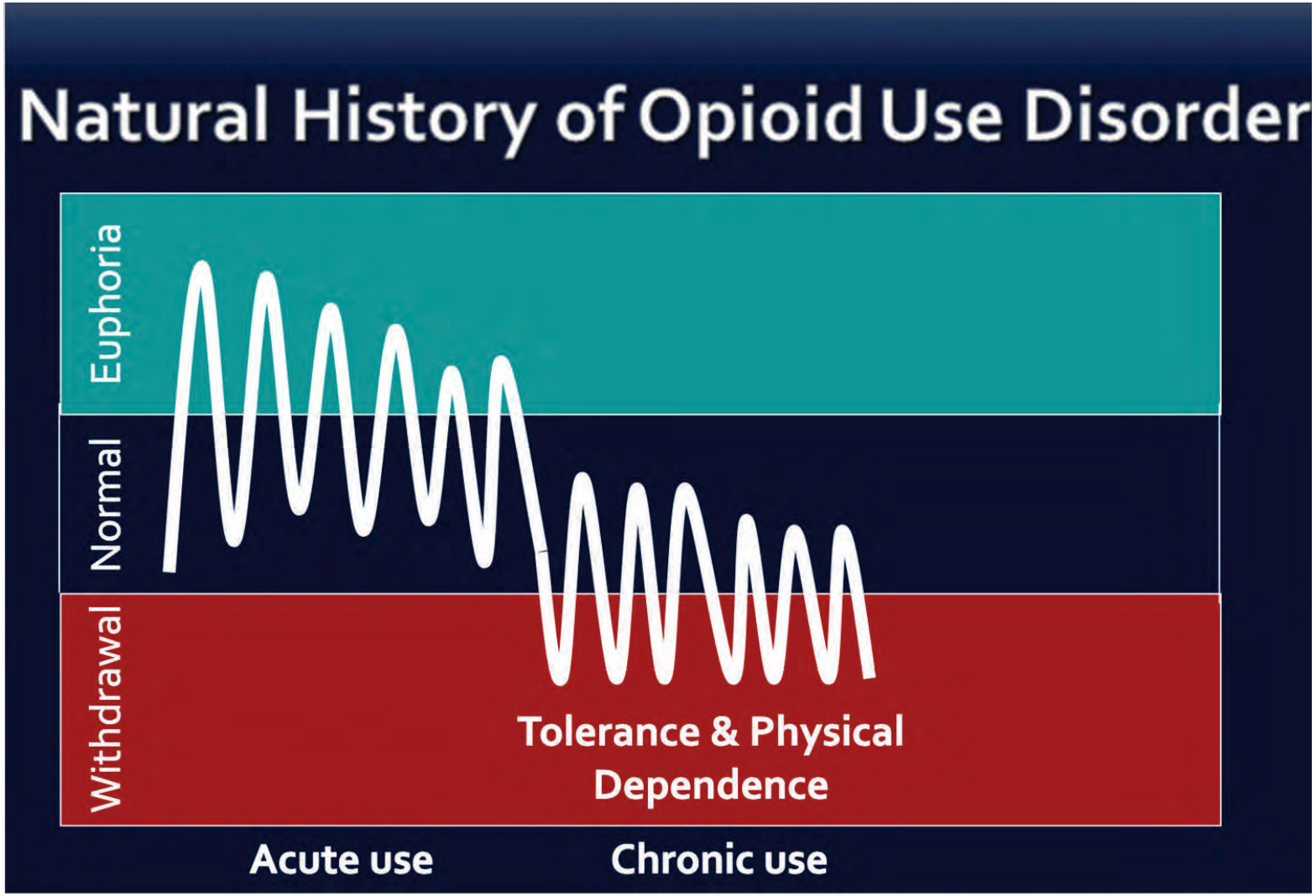

ASAM THE BUPRENORPHINE COURSE
FOR OFFICE-BASED TREATMENT OF OPIOID USE DISORDERS

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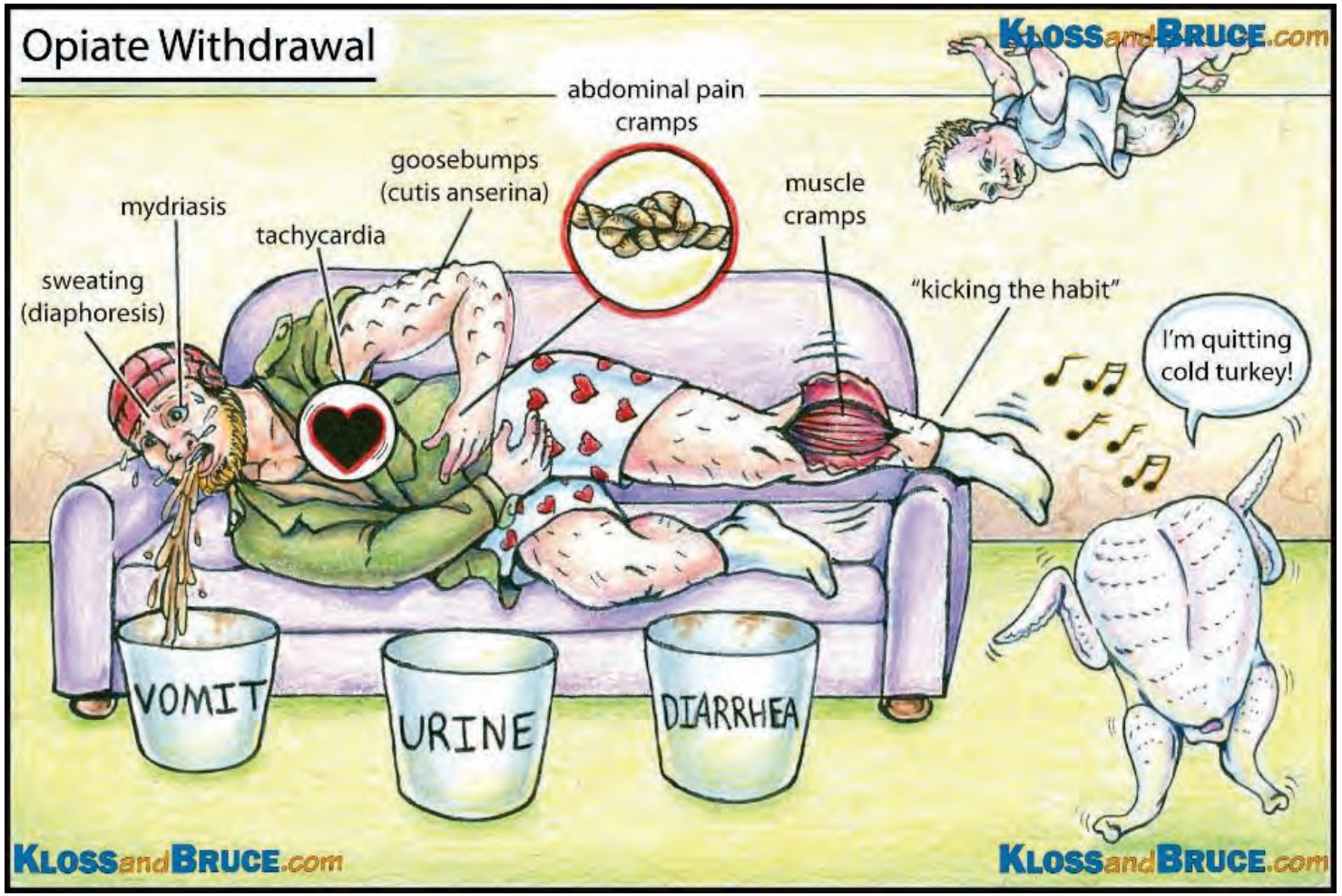

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Just say No

What are we asking of them?

To exert an athletic level of discipline and sustained determination

without much training or experience

in behavioral self-control

that is fully counter to their neurobiological drives

often supported only by fear incentives (loss of work, relationships, or health)

Fear incentives may be effective in the short term in times of crisis, but…

Positive incentives such as

purpose financial security meaningful work relationships

Avoid the natural fatigue of sustaining long-term recovery from substance use disorders

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McKay JR: Making the hard work of recovery more attractive for those with substance use disorders. **Addiction** 2017; 112:751–757

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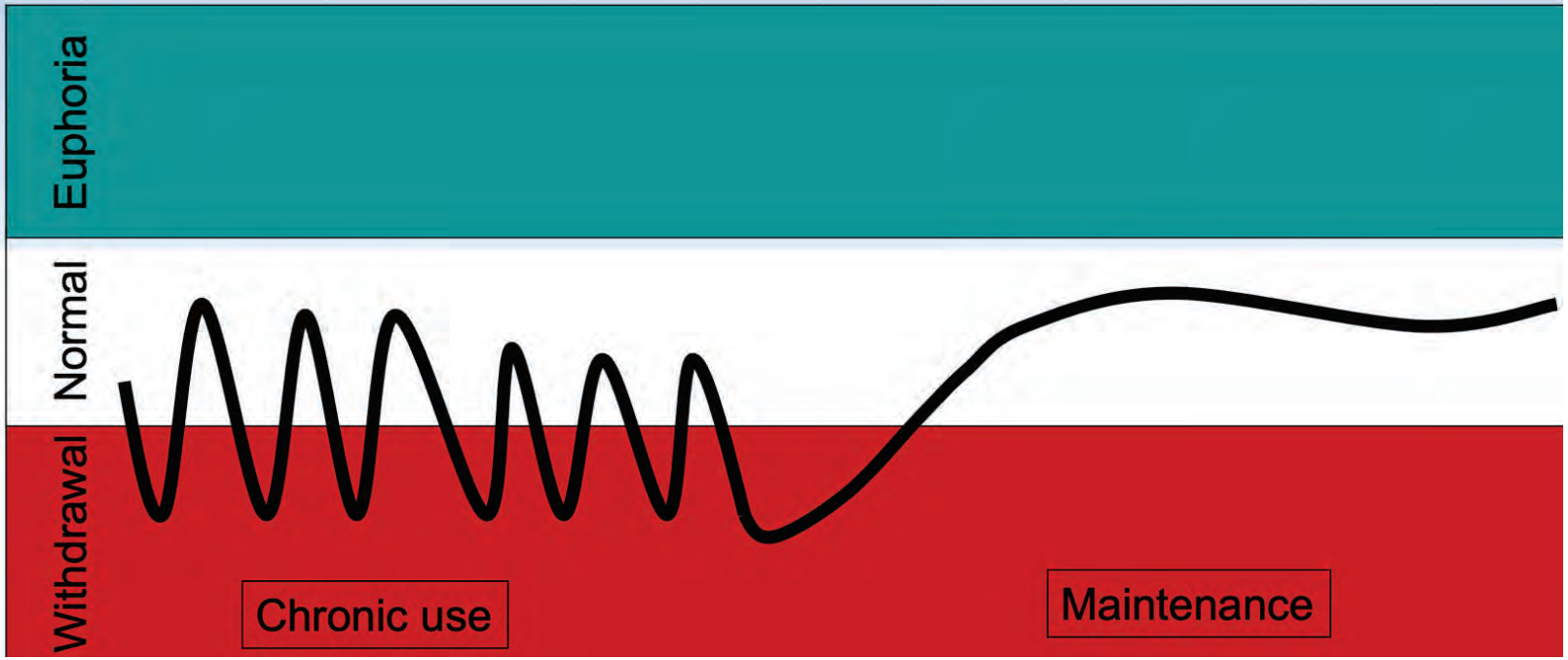
Maintenance Treatment for Opioid Use Disorder



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Why Treat?

- Doing nothing
  - 10% risk of death each year after an overdose
- Treatment
  - 7x decrease in mortality
- Cost Savings

BENEFITS OF MOUD for OUD

+Replaces dopamine

+Helps the person feel normal

+Improves functioning

+Increased retention in treatment

+Decreased cravings

+Decreased opioid use

+Decreased intravenous drug use (IVDU) and complications

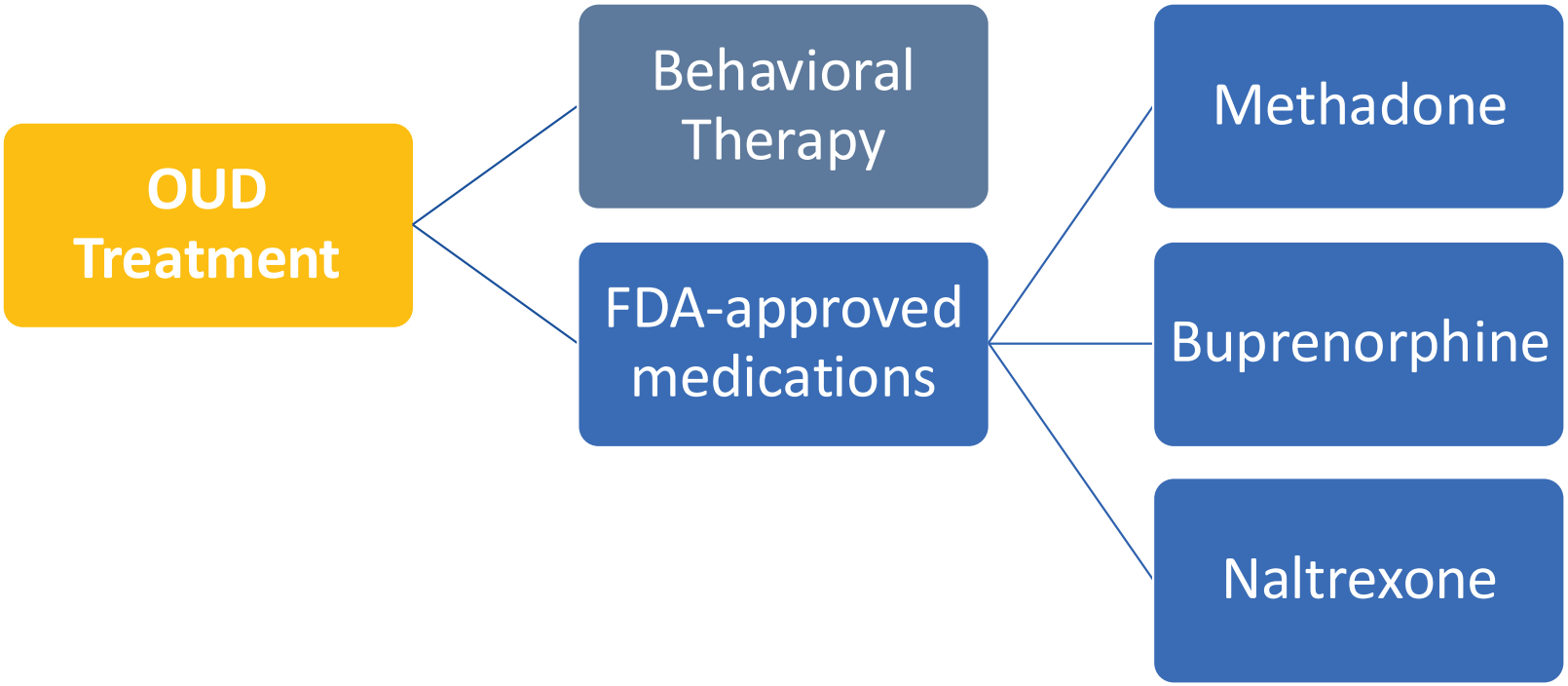
+Decreased overdose

+Decreased mortality

+Decreased criminal behavior

Sources:
The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020
Tsui JI et al., 2014
Metzger DS et al., 1993
Mattick, RP, et al. 2009
Mattick, RP, et al. 2014
Lobmaier, P et al. 2008
Lutgen-Nieves, L. et. al. 2021
Santo, T 2021

OUD Management



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Medications for OUD

SAMHSA = Substance Abuse and Mental Health Services Administration

Methadone

- **Legal for treatment of OUD in 1970/1974**
  - Given in an Opioid Treatment Program (OTP) regulated by SAMHSA

Buprenorphine

- **Legal for Outpatient treatment of OUD in 2000/2002**
  - No longer need 8-hour course for 30 patients or fewer
  - 2016 – PA's and NP's can prescribe

Naltrexone

- **FDA Approved injectable form for OUD in 2010**
  - Can be delivered in any medical facility without extra training

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Thank You!

- The End

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Clinical Care Pathways

Outpatient Care for SUD in Pregnancy

Jerasimos (Jerry) Ballas, MD, MPH
Maternal-Fetal Medicine

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SUD/OUD Referrals to UCSD

- Currently utilizing MAT/MOUD via an established program or with outside provider
  - Primarily Methadone or Buprenorphine
- Current use of illicit substances with varying degree of interest in treatment
  - Most are interested in treatment
- History of punitive outcomes in previous pregnancy

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Barriers to SUD treatment in pregnancy

- Stigma and punitive laws endangering prenatal care
- Inconsistent and inappropriate involvement of CPS
- Provider discomfort in treating pregnant patients with SUD/OUD
- Lack of communication between obstetric providers, other medical teams, including psychiatry, anesthesia, and pediatrics, and social services

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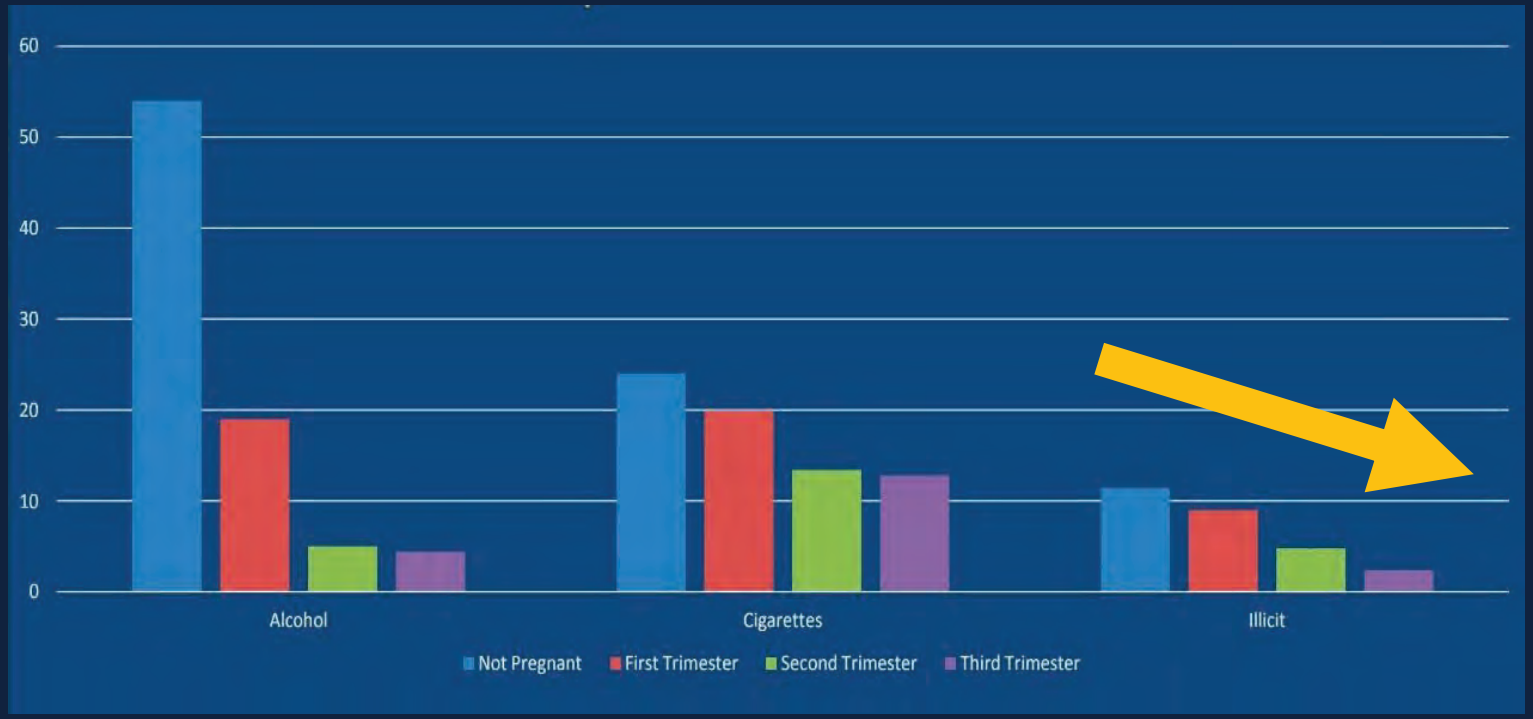
Pregnancy can be a powerful opportunity to change behaviors and start treatment



National Survey Drug Use and Health 2013/2014 Past Month Use Data

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The goal at UCSD is to provide accessible, respectful, evidence-based SUD/OUD treatment for all pregnant individuals, from prenatal care through delivery and the postpartum period.

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Treatment options in Pregnancy

Agonist treatment is the **gold standard**

- Buprenorphine
  - Outpatient prescription, private, less severe NAS/NOW
- Methadone
  - Decades of experience and well-studied; improves prenatal care, reduce fetal mortality, and improve fetal growth
  - Cons: Side effects; intense clinic regimen in addition to prenatal care

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Substance Use Disorder as a disease

YET THE LANGUAGE USED IS OFTEN JUDGMENTAL, ROOTED IN MORALITY, AND FRAMED AS AN INDIVIDUAL'S FAILURE.

Clean & Dirty

Drug Abuser

Addict & Junkie

Relapse / On & Off the Wagon

Hillcrest/MOS patient

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Substance Use Disorder as a disease

- Clean & Dirty
- Drug Abuser
- Addict & Junkie
- Relapse
- On & Off the Wagon
- Hillcrest/MOS patient

- Negative & Positive test results
- Person who uses a substance
- Person with substance use disorder
- Recurrence of use
- Being On or Off therapy
- UCSD patient

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UC San Diego Health

Building a Therapeutic Alliance

- Minimize punitive outcomes with open and honest dialogue
- Respect patient autonomy and preferences
- Shared decision-making
- Informed consent
- Do no harm

https://www.perinatalharmreduction.org/

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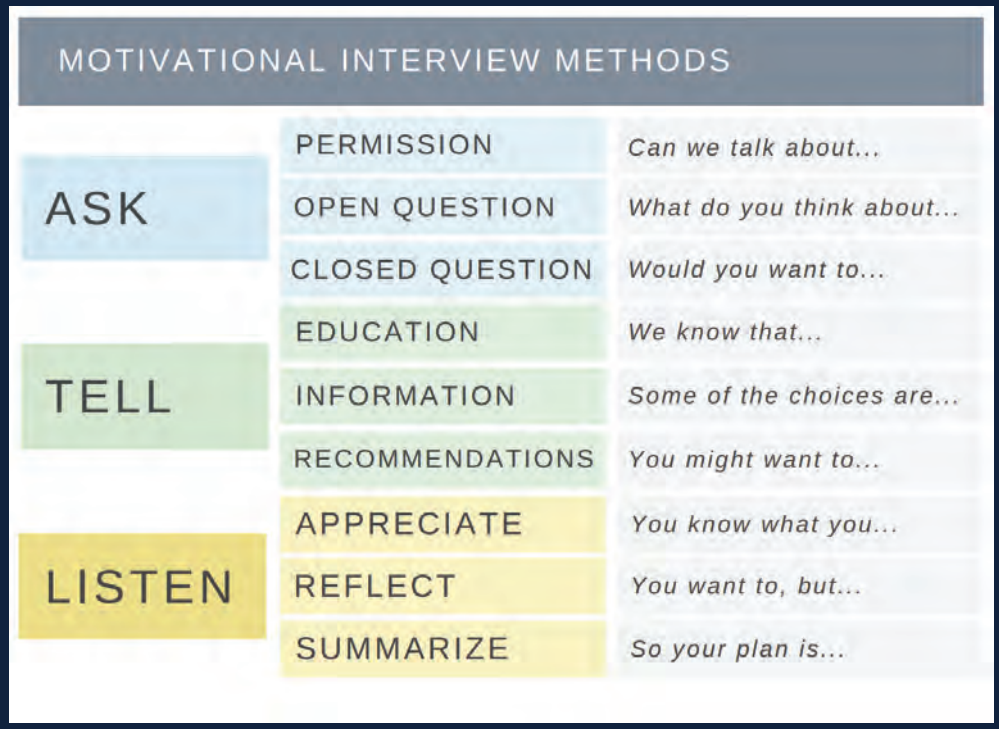
UC San Diego Health

Building a Therapeutic Alliance

- Language **matters**
  - Including body language
- Open-ended questions
- Non-judgmental, non- confrontational
- Motivational interviewing
- **Be aware of your own biases**



https://issuu.com/harmreduction/docs/pregnancy_and_substance_use-_a_harm_2fa242e7fb6684

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Screening for SUD/OUD in pregnancy

- ACOG Committee Opinion #711
  - Screening for substance use should be part of **all** comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant patient.
  - NOT based on "risk factors"
- Examples of screening tools:
  - 4P's
  - NIDA
  - Quick Screen
  - CRAFFT (<26yo)

Box 1. SBIRT: Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use and dependence on alcohol and other substances. The SBIRT model was impelled by an Institute of Medicine (now known as the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) recommendation that called for community-based screening for health risk behaviors, including substance use.

Screening—A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.

Brief Intervention—A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

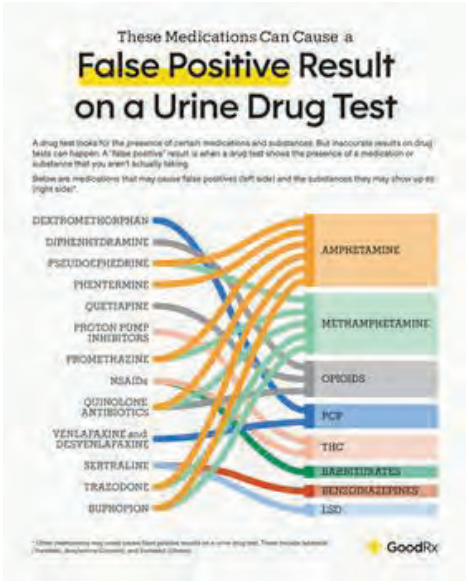
Referral to Treatment—A health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

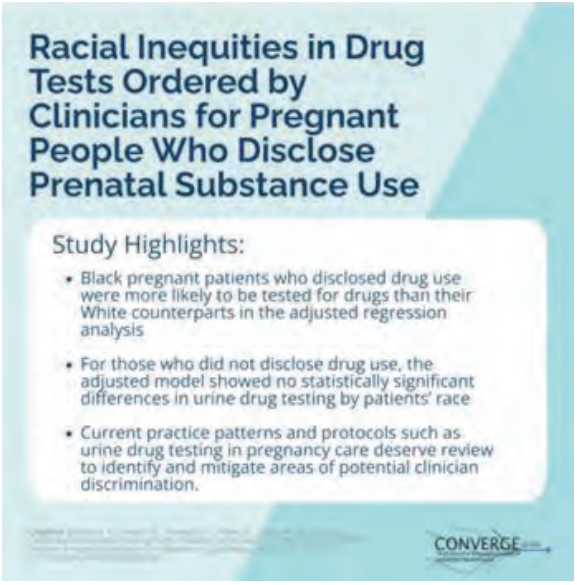
Data from SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment. Available at: http://www.integration.samhsa.gov/clinical-practice/SBIRT. Retrieved March 20, 2017.

Urine Toxicology vs. Evidence Based Screening Tools

- Known racial bias
- Deters from prenatal care
- False positives
- Lack of informed consent
- Criminal persecution

- ACOG recommended universal screening
- Assess for multiple criteria for SUD
- Minimizes stigmatization
- Promotes therapeutic relationships
- By trained clinical staff
- At first prenatal visit





Implementation of SUD Screening

- Lack of screening is a barrier to SUD treatment during pregnancy
- UCSD perinatal clinics and L&D triage areas do not use a validated SUD screening tool
- Our project: 1. Administer tool, 2. Document results to prompt referral, 3. EPIC data extraction to evaluate linkage to care, 4. Interview to assess patient experience with screening
- Outcomes of interest:

Table 3. Validity Indices for the 4P's Plus, NIDA Quick Screen, and SURP-P

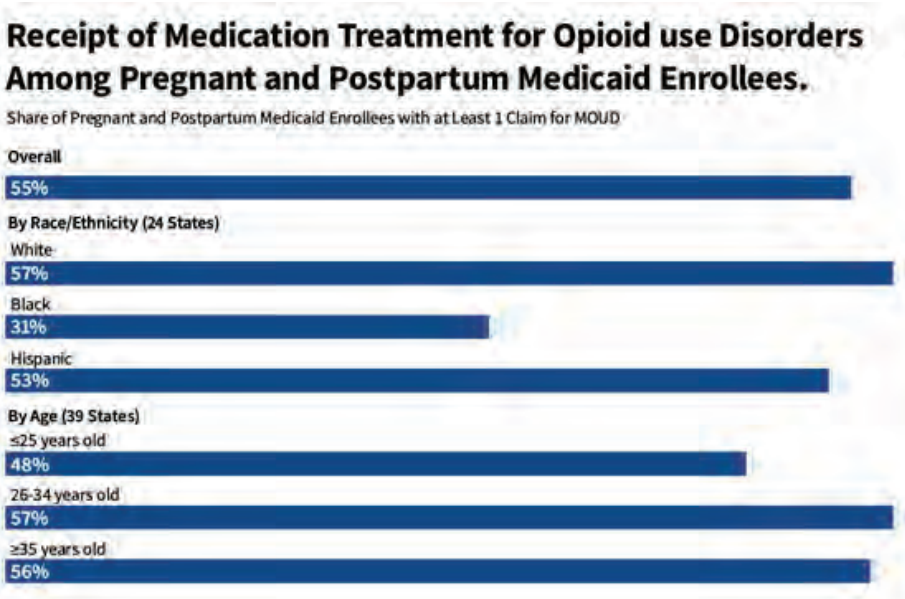
	4 P's Plus	NIDA Quick Screen ASSIST	SURP-P
Sensitivity*	91.2 (85.7–95.1)	83.5 (76.8–89.0)	93.1 (88.0–96.5
Specificity*	28.6 (23.7–33.9)	80.8 (76.0–85.0)	21.0 (16.7–25.9
Positive predictive value*	39.0 (34.0–44.1)	68.4 (61.3–74.9)	37.0 (32.3–41.9
Negative predictive value*	86.7 (78.6–92.5)	90.8 (86.8–93.9)	85.9 (76.2–92.7
Sensitivity†	94.7 (88.5–97.4)	85.4 (76.4–89.5)	95.4 (90.7–98.4
Specificity†	28.7 (23.8–33.6)	76.1 (71.4–80.6)	21.1 (17.3–26.1
Positive predictive value†	32.6 (28.9–38.8)	56.4 (50.1–64.4)	30.6 (27.3–36.5
Negative predictive value†	93.6 (85.7–96.7)	93.5 (88.8–95.2)	92.7 (84.8–97.3
Sensitivity‡	90.2 (84.5–93.8)	79.7 (71.2–84.2)	92.4 (87.6–95.8
Specificity‡	29.6 (24.4–35.2)	82.8 (78.1–87.1)	21.8 (17.4–27.2
Positive predictive value‡	44.1 (39.7–50.0)	74.0 (67.8–80.4)	42.0 (38.0–47.9
Negative predictive value‡	83.0 (73.4–88.9)	86.9 (81.3–89.7)	82.3 (72.1–90.0

Data are % (95% CI).
* Reference standard: hair test results.
† Reference standard: urine test results.
‡ Reference standard: hair and urine test results combined; positive on either urine or hair sample testing.

5Ps questionnaire [23]

1. Did any of your parents have a problem with using alcohol or drugs?
2. Do any of your friends have a problem with drug or alcohol use?
3. Does your partner have a problem with drug or alcohol use?
4. Before you knew you were pregnant, how often did you drink beer, wine, wine coolers or liquor?
5. In the past month, how often did you drink beer, wine, wine coolers or liquor?

Coleman-Cowger, et al Green Journal, May 2019



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What if someone's not ready?

Harm Reduction

- Change route of use
- Sanitized needles / needle exchanges
- Designated drivers or dedicated support person
- Provide contact for safe harbor

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Trauma-Informed Care

Patients have <u>agency</u> when it comes to decision-making, and that agency is derived from a lifetime of experiences.

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

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The 4th trimester is the continuation of the recovery journey

- A significant amount of birthing individuals report some form of trauma from delivery; those with SUD are at higher risk for reporting birth trauma.
- Relapse often occurs in the postpartum period because care becomes disjointed, which jeopardizes breastfeeding, puts new parents at risk for incarceration, separation from newborn, or worse.
- Just like pregnancy can serve as the reason a person presented for care, empathetic and knowledgeable postpartum care can help ensure they maintain therapy beyond delivery.

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Thank you!

Contact me:
jballas@health.ucsd.edu
Office: 619-543-7074

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Mai Hoang, MD, FACOG

Associate Professor, Obstetrics & Gynecology

Division of Hospitalists

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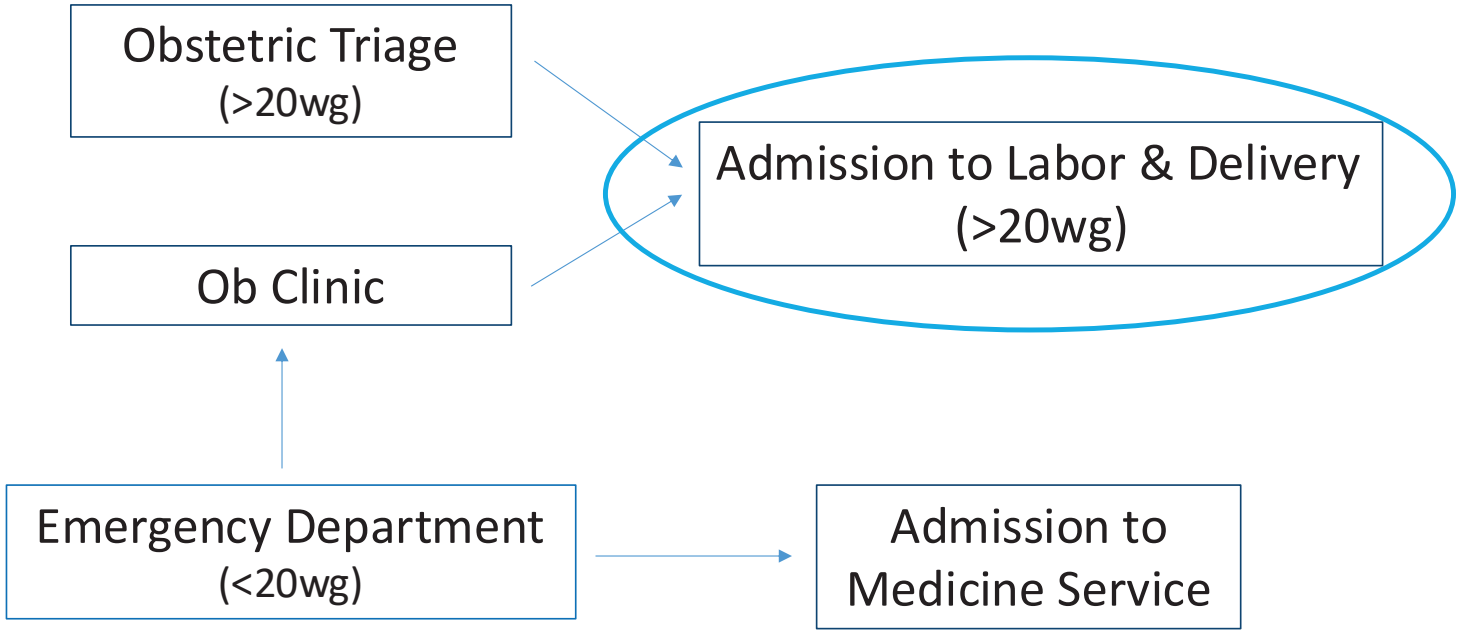
Pathway to Inpatient Admission



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Initiation of Medication for Opioid Use Disorder (MOUD)

- Obtain detail medical history including current symptoms, current and past use and treatment
  - Trauma-informed care focusing
    - OUD as a chronic and relapsing disorder
    - Strengths
    - Parenting goals
- Outline hospitalization course
  - Set expectations
  - Duration of hospital stay

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Treatment Options

- Use shared-decision making

Buprenorphine		Methadone	
Benefits	Risks	Benefits	Risks
More dispensing options	Can precipitate withdrawal	Can start immediately	Daily dispense by a treatment center
Less severe NOWS	Higher risk for diversion	Higher retention in treatment	More drug-drug interactions
Shorter neonatal hospitalization	Less long term data on infant/child effects	More long term data	

- Both improves prenatal care adherence
- Both decreases preterm birth and obstetric complications

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Clinical Opiate Withdrawal Scale (COWS)

- Standardize symptom assessment
- Patient-centered assessments
  - COWS + Patient as the expert of their body

Clinical Opiate Withdrawal Scale (COWS): For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable/anxious that assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints/muscles and is unable to sit still due to pain	**Gooseflesh skin** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

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MOUD Induction Protocol

ADMISSION / DAY 1 – Buprenorphine or buprenorphine-naloxone initiation

First Dose	• Screen for withdrawal: COWS ≥8 or patient reports subjective signs/symptoms • **Administer 8-16 mg buprenorphine** • Consider adjunctive medications to address specific withdrawal symptoms
Within 1 Hour	• Rescreen for withdrawal symptoms: COWS ≥8 or patient continues to report subjective symptoms • **Administer additional 4-8 mg buprenorphine** • Adjunct medications, as needed
Every 1-4 Hours	• Individualize screening intervals based on response to treatment. • **Administer additional 4-8mg buprenorphine based on subjective symptoms or COWS to a maximum daily dose of 32mg***

* Consultation with Maternal-Fetal Medicine recommended prior to escalating dosing beyond 32mg of buprenorphine daily

- Standardize treatment and dosage across all providers

DAY 2 – Buprenorphine or buprenorphine-naloxone initiation

First Dose	• **Administer total dose from first 24 hours** • Depending on amount and patient tolerance/preference, consider splitting dose between AM and PM • Adjunct meds as needed
Every 4-6 Hours	• Rescreen for withdrawal symptoms: COWS ≥8 or patient continues to report subjective symptoms • **Administer additional 4-8 mg buprenorphine*** • Adjunct medications, as needed

* Consultation with Maternal-Fetal Medicine recommended prior to escalating dosing beyond 32mg of buprenorphine daily

DAY 3 / SUBSEQUENT DAYS & DISCHARGE PLANNING

Total Daily Dose	• **Administer total dose from Day 2** • May be given as one daily dose, or split into BID or TID doses • Continue to assess for withdrawal symptoms and add 2-8mg buprenorphine as needed.
Discharge Planning	• A 30-day prescription for total daily buprenorphine AND a separate naloxone prescription should be sent to patient's local pharmacy or UCSD discharge pharmacy and confirmation should be obtained that prescription can be filled. • Patient should be discharged with established appointment to clinic or provider that has experience with prescribing MOUD and resources for managing SUD/OUD. • While an X-Waiver is no longer needed to prescribe MOUD, outpatient provider should be experienced in monitoring for signs and symptoms of cravings and withdrawal and be prepared to continue titrating buprenorphine for remainder of pregnancy.

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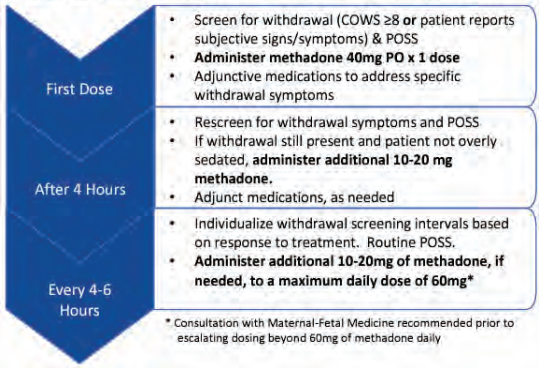
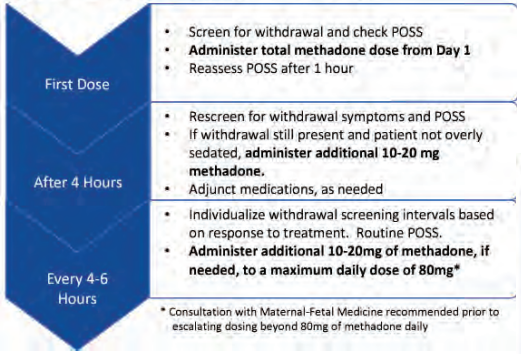
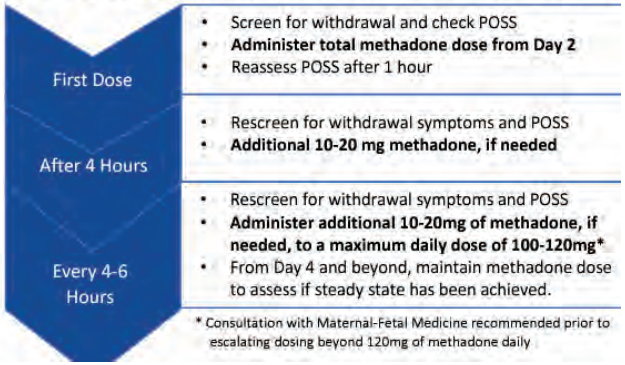
ADMISSION / DAY 1 – Methadone initiation (Maximum dose: 60mg)



DAY 2 – Methadone initiation (Maximum dose: 80mg)



DAY 3 AND SUBSEQUENT DAYS UNTIL DISCHARGE – Methadone initiation (



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ADJUNCTIVE MEDICATIONS:

- **Clonidine 0.1 mg PO q4h** PRN bone pain, autonomic arousal (tachycardia, hyperventilation, flushing)
- **Acetaminophen 650 mg PO q4h** PRN mild to moderate pain, temp >38.5 C (101.3 F), NTE 4 g per 24 hours
- **Diphenhydramine 25 mg PO q4h** (Max 200 mg per 24 hours) or **Hydroxyzine 50 mg PO q6h** PRN anxiety and/or nasal congestion and/or insomnia
- **Diphenhydramine 50 mg PO q4h** PRN severe anxiety and/or nasal congestion and/or insomnia if 25 mg dose is ineffective after 1 hour
- **Guaifenesin (alcohol free) 10 mL PO q4h** PRN cough
- **Aluminum-Magnesium-Simethicone 30 mL PO q4h** PRN dyspepsia
- **Loperamide 4 mg PO** once at first sign of diarrhea
- **Loperamide 2 mg PRN after each loose stool**, NTE 16 mg per 24 hours
- **Ondansetron 4 mg PO q6h** PRN nausea/vomiting, or 4mg IV q6h if unable to tolerate PO intake.

- Patient-centered assessment and treatment

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Medical Care Catch-Up

- Obstetric
  - Obtain missing prenatal labs
  - Perform anatomy or growth ultrasound
  - Fetal monitoring
- Assess and (re)start psychiatric medication

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Intrapartum Care

- Continue the current methadone/ buprenorphine dosage
- Labor pain management: multimodal approach
  - Epidural, nitrous oxide, opioids, pudendal nerve block
  - Doula support, shower, birthing ball

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Postpartum Care

- Continue the current methadone/ buprenorphine dosage
- Optimize pain control and minimize opioid use
  - Non-opioid medications: acetaminophen, ibuprofen, gabapentin, lidocaine patch
  - Anesthetic nerve block after cesarean delivery
  - Acute-pain service: opioids
  - Non-pharmacologic: abdominal binder, heating pads
- Lactation support
- Contraception
- Social support

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Hospital Discharge

- Arrange close clinic follow-up appointment(s)
- Provide adequate medication (up to 30 day supply of buprenorphine or 3 days of methadone)

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Multidisciplinary Collaboration

- Obstetrics/ Perinatology
- Neonatology/ Pediatrics
- Psychiatry
- Anesthesiology
- Nursing
- Social work
- Case management
- Non-medical personnel

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UC San Diego Health

Neonatal Opioid Withdrawal Syndrome

Michelle Leff, MD, IBCLC, NABBLM-C, FAAP

Professor of Pediatrics

Medical Director of Lactation Medicine for UC San Diego Health

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NOWS – Neonatal Opioid Withdrawal Syndrome

- Definition: symptoms in a newly born infant related to the sudden withdrawal of opioids (Opium, heroin, fentanyl, methadone, buprenorphine, prescription pain medications including extended release and short-acting forms)
- Symptoms initially get worse as the substance leaves the body, but then improve
- Symptoms improve if the substance is replaced
- More specific term than Neonatal Abstinence Syndrome (NAS), but often used interchangeably

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NOWS Symptoms

CNS	GI Dysfunction	Autonomic Nervous System
• High-pitched, continuous crying • Decreased sleep • Increased muscle tone/Stiff • Tremors • Hyperactive Moro reflex • Seizures	• Feeding difficulties • Discoordinated suck • Hyperphagia or overactive suck • Vomiting/reflux • Loose or watery stools	• Sweating • Fever • Fast breathing • Nasal stuffiness and flaring • Frequent yawning and sneezing

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NOWS – Contributing Factors

- Opioid type: immediate-release, sustained-release, maintenance
- Timing of last dose before delivery
- Maternal metabolism
- Transfer of drug across the placenta
- Placental metabolism
- Infant metabolism & excretion
- Use of other substances (nicotine, THC, SSRIs, anxiolytics, methamphetamines)

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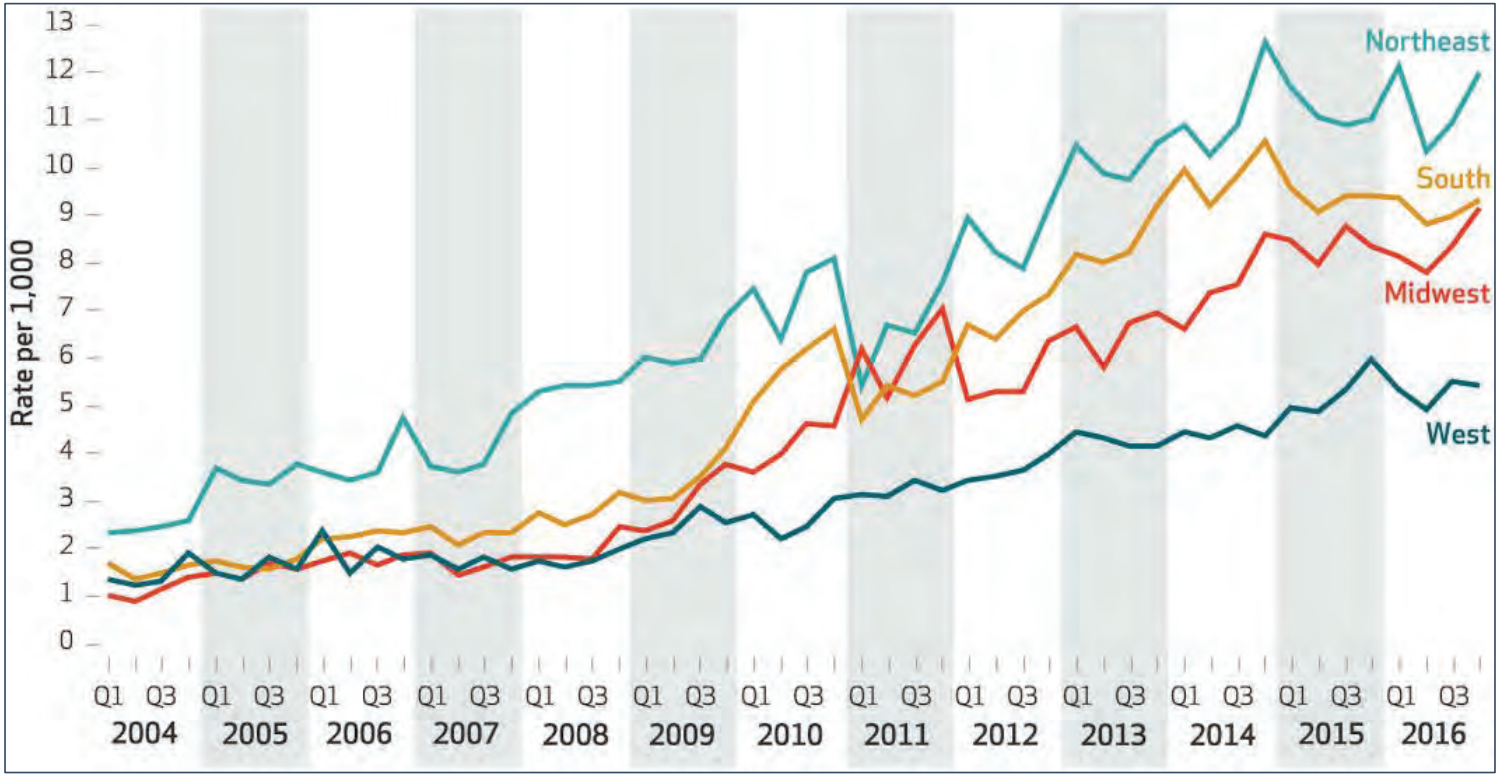
Incidence of NAS in the United States over Time



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Leech et al. Health Aff. 2020:764-767.

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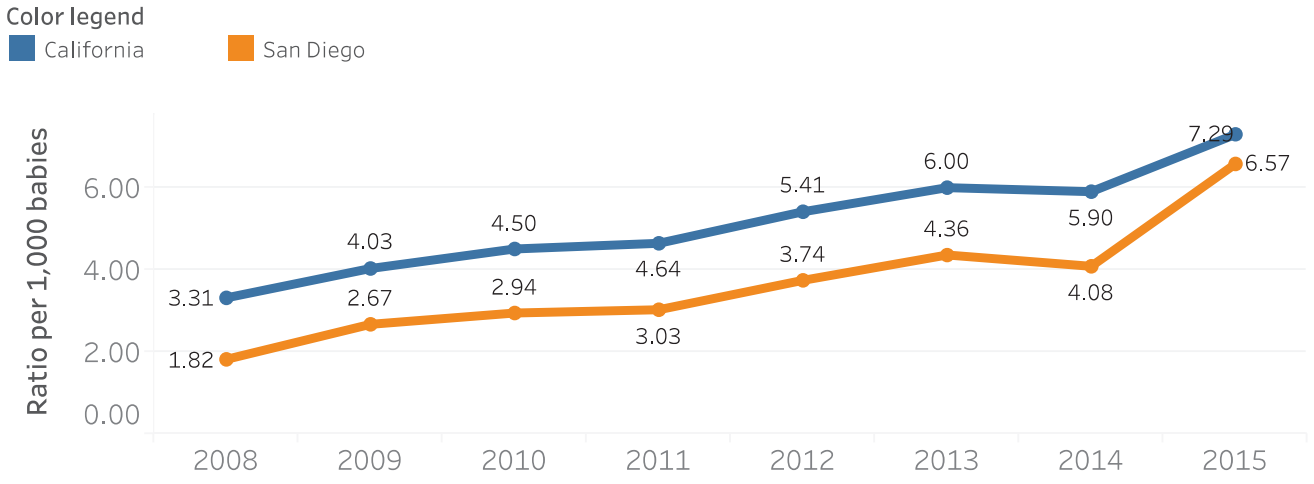
Rates of NAS in California and SD County 2008 - 2015

Newborns affected by drugs

In 2015, 7.29* out of every 1,000 babies born to California parents was affected by drugs transmitted by placenta or breast milk. That ratio has increased since 2008.



*This rate does not include babies affected who were not born in a hospital. Also does not include babies for whom parents reported a ZIP code that couldn't be matched with a California county.

Source: California Office of Statewide Health Planning and Development, California Department of Public Health | Graphic: Leonardo Castaneda, inewsource

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What Can We Do?

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Check internal biases

Attitude adjustments

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Gold Standard:
Optimize Nonpharmacologic Treatments

- Skin-to-Skin
- Breastfeeding
- Soothing Techniques
  - Swaddle
  - Sway or Swing
  - Side or Stomach position
  - Shush
  - Sucking – pacifiers are okay for these patients
- Full stomach – supplement as needed, may need a bottle, OT consult
- Decrease sensory overload: low lights, TV off, quiet voices, cluster care
- Calm parents – good pain control for mom, emotional support
- Prevent diaper rash – early use of barrier cream

Best done in couplet care

UC San Diego Health

Parent Educational Booklet

UC San Diego Health

Soothe and Grow

For newborns at risk for neonatal opioid withdrawal syndrome at UC San Diego Health

What are the symptoms of NOWS?

- Fussiness and crying
- Shaking and jittery movements
- Stiff muscles
- Trouble sleeping
- Feeding problems
- Yawning or sneezing
- Vomiting or diarrhea
- Fast breathing or heart rate
- Seizures (these are rare)

How will I know if my baby is havir newborn fussiness?

All newborn babies can be fussy, but if a baby is not able to eat, sleep or settle down, baby likely is withdrawing. Nurses and doctors are in the hospital 24 hours a day to observe your baby and help decide.

Will my baby need medication for withdrawal?

At UC San Diego Health, approximately 50% of babies at risk for NOWS will need treatment with medication. But when parent and baby stay together, baby is calmer, more likely to get breast milk, and has a smaller chance of needing medication.

GOALS OF NOWS INFANT TREATMENT
To prevent seizures
To allow baby to eat and grow
To allow baby to develop at a normal pace

How Can I Help My Baby?

CALMING MEASURES FOR BABY
Hold baby skin to skin (tummy to tummy) when you are awake – keep baby's head uncovered so you can observe baby's color and feel the breathing. When you are sleepy or asleep baby needs to be in the bassinet.
Feed baby at the breast frequently (there does not need to be any schedule). Supplement as needed to keep baby satisfied.
Swaddle baby
Offer a pacifier after feeding
Soft lights, white noise, and music are calming
Some babies like bathing or a massage or soft touch
When you are sleepy or asleep, baby must be in the bassinet/crib

How do you monitor babies for NOWS?

The nurse will check your baby every three to six hours. We will use standard tools such as ESC and Finnegan to monitor for withdrawal.

Eat, Sleep, Console (ESC) Tool

- Is the baby not able to eat due to NAS?
- Is baby not able to sleep at least one hour due to NAS?
- Is baby unable to be calmed within ten minutes?

If the answer to any of these questions is yes, your baby may need more help or transfer to NICU.

Finnegan Tool

The Finnegan tool assesses more items including vital signs, stools, etc.

Prenatal Consult to Prepare for the Stay

- Length of stay
  - Immediate-release 3 day stay
  - Sustained-releases & buprenorphine 4-7 days
  - Methadone 5-7 days
- What to bring
  - Soothing items: swaddles, pacifiers, white noise, vibration
  - Comfort items for parents: snacks, music, books, clothes
  - MAT for after discharge
- Discuss delivery & feeding plan
- Arrange transportation, support, childcare
- Prepare for maternal pain – drug tolerance
- Awareness of toxicology screens and SW consult

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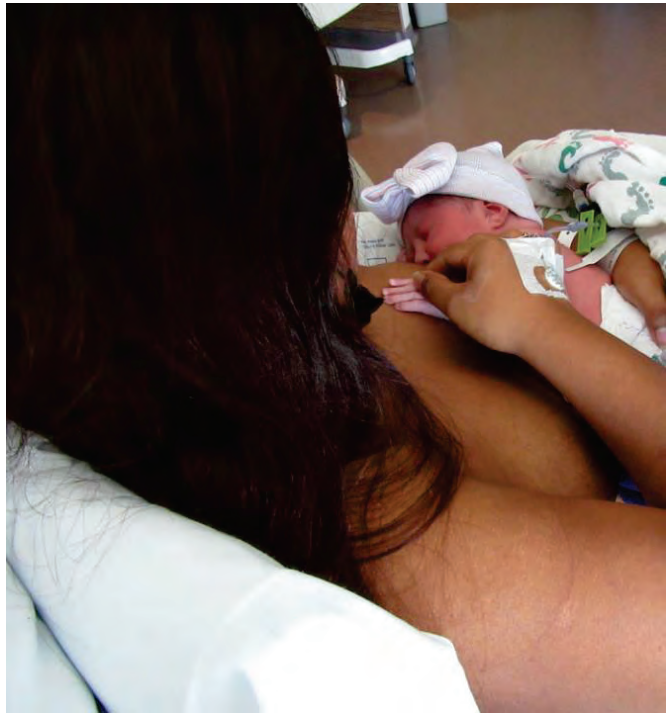
Is Breastfeeding Safe in this Population?

- Studies have shown that infants with NOWS who breastfeed have:
  - Fewer and less severe symptoms
  - Delayed onset of withdrawal
  - Decreased need for medication
  - Shorter hospital stay
- Supported by ABM, ACOG, AAP for parents in recovery



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NOWS & Breastfeeding Guidelines

- Tiny amount of medication in mother's milk
- Breastmilk has so many other benefits
  - Health of baby
  - Health of mom
  - Bonding
- Breastfeeding is part of our treatment for baby
  - Requires parents to be present and engaged
  - Skin to skin contact
  - Being held

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Breastfeeding Cautions

- Mom actively using or relapse in last 30 days – not recommended to breastfeed
- Recovery less than 90 days – have caution
- High doses of opioids that can accumulate in the infant (tramadol and oxycodone) – advice varies, FDA does not recommend
- Use of other substances such as heavy alcohol intake – not recommended

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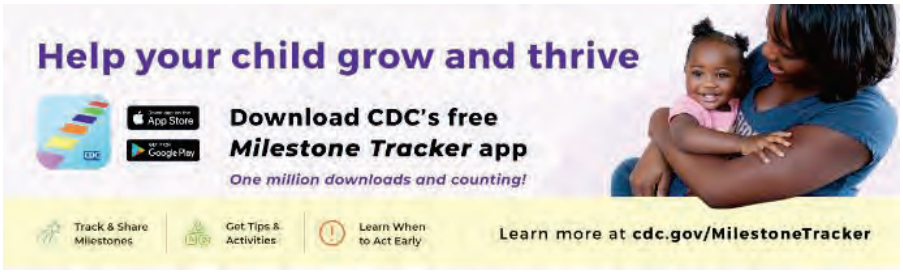
Developmental Outcomes

- Not fully known
- Studies difficult to do
- Confounding variables
- Overall development similar to matched controls but concern for effects on behavior and development
- HEALthy Brain and Child Development (HBCD) Study
- Likely could benefit from support
  - Breastfeeding
  - Parenting support
  - Developmental activities
  - Early Start – California Early Intervention Services



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Community Care Linkages
McAlister Institute

James Dunford, MD
Medical Director
Professor Emeritus, Emergency Medicine
UC San Diego School of Medicine

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McAlister Institute

Founder & CEO

Jeanne McAlister

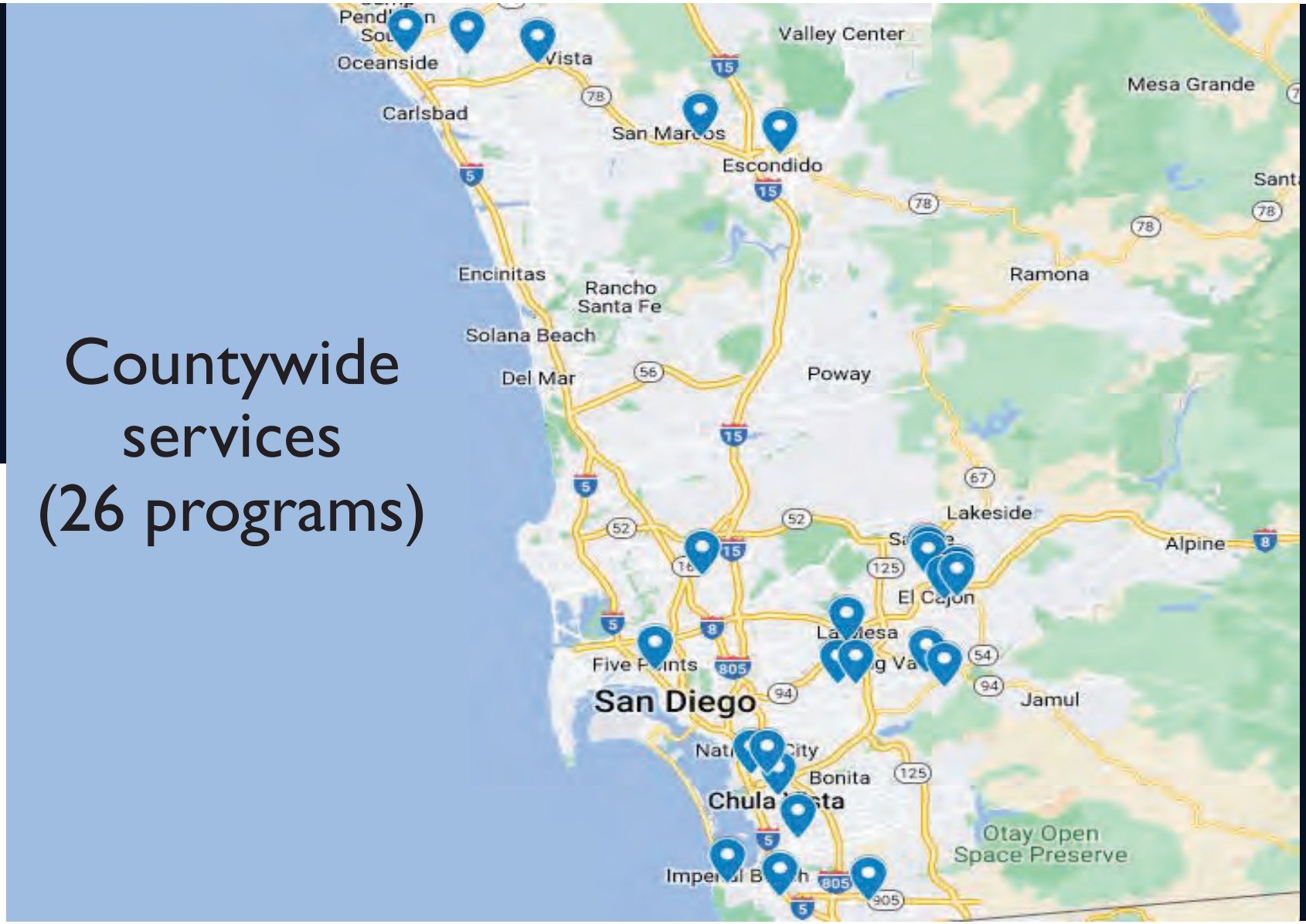
Executive Director

Marisa Varond

COUNTY OF SAN DIEGO
Health and Human Services Agency

LIVE WELL SAN DIEGO

Countywide services (26 programs)



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Continuum of care

Early Intervention

- PC1000 Deferred Entry of Judgment
- Corporate Solutions – school contracts

Outpatient

- Teen Recovery Centers
- Women's Recovery Centers
- Regional Recovery Centers

Withdrawal Management

- Sobering Services at the Recovery and Bridge Center
- Adult Detox
- Kiva Women's Detox

Residential

- Adolescent Group Homes
- Kiva Women and Children's Learning Center
- New Connections

Support

- SAFE Housing for CWS Reunification
- Homeless Outreach and Case Management
- Inclement Weather Vouchers and Supportive Services

Eligibility & ACCESS

- **Medical Necessity**
  DSM SUD Diagnosis
  ASAM Level of Care
- **Target Population**
  Medi-Cal
  200% FPL
  San Diego Resident
- **AOA SUD Program Directory (LINK)**
- **Access and Crisis Line**
  (888) 724-7240
- **Jeanne McAlister, Founder & CEO**
  (619) 987-6393

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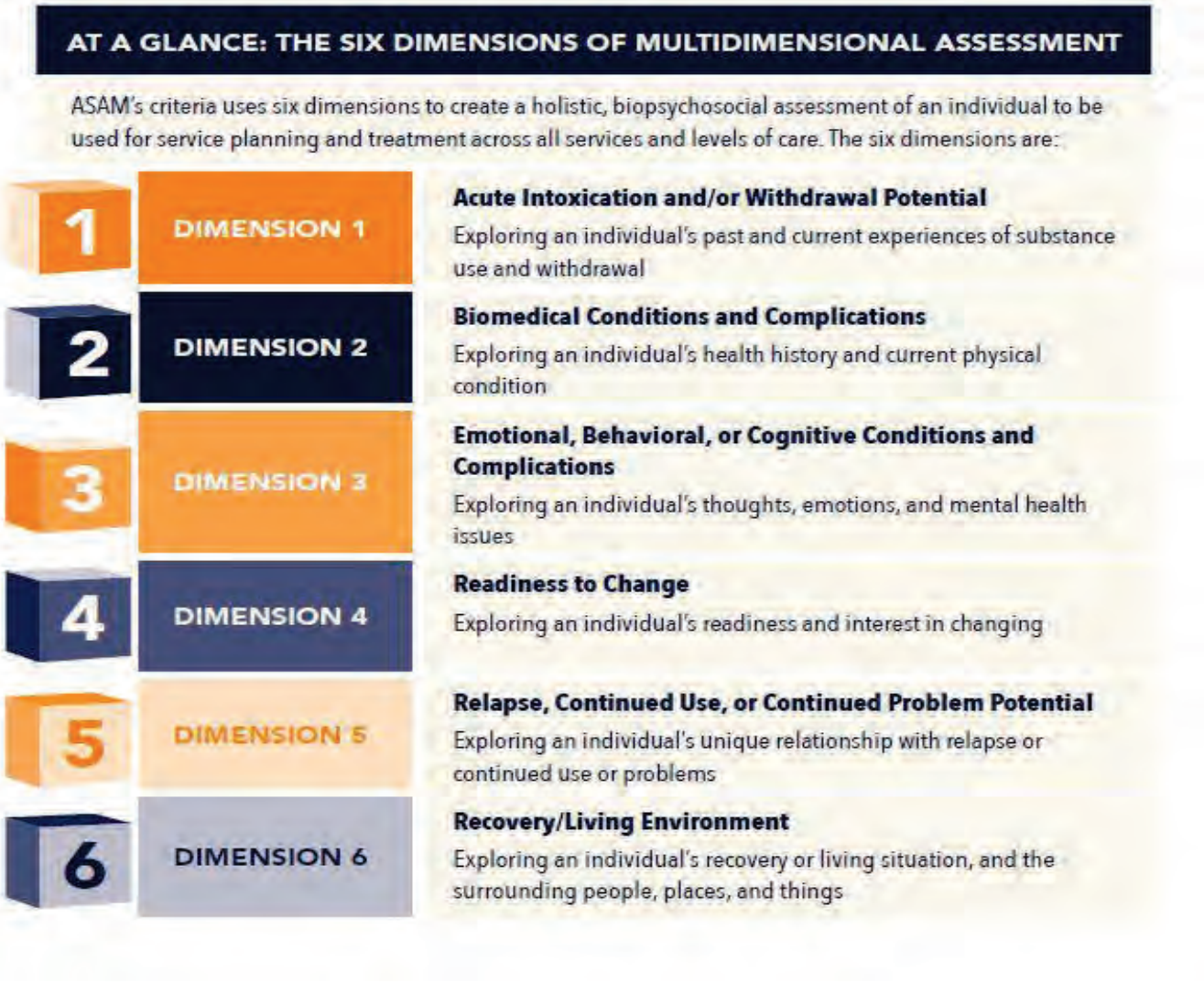
ASAM dimensions define level of care



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Residential programs: Lemon Grove

24 beds Adult Detox (men and women)
9 beds Kiva Detox (women)
60 beds Kiva (women and children)
20 beds New Connections (men)

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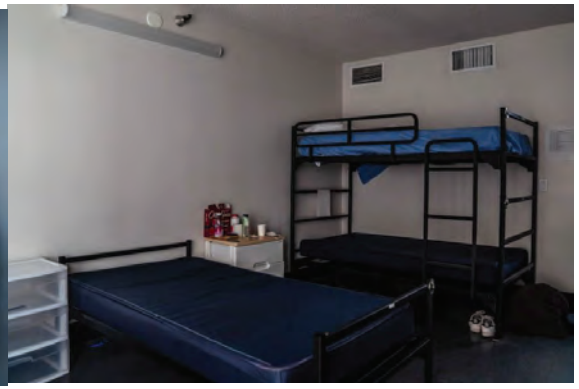
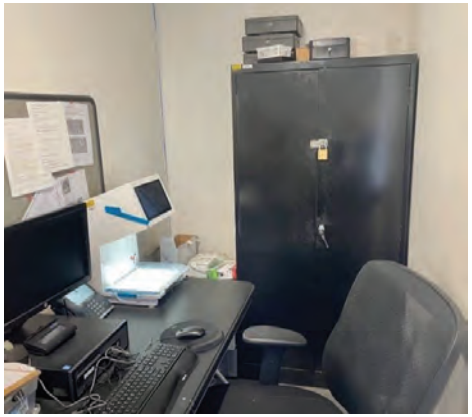
Kiva Detox

- Priorities
  - pregnant
  - homeless
  - injection drug using
- 10 day
- Medical clearance and medication-assisted treatment (MAT) per ED Bridge physicians





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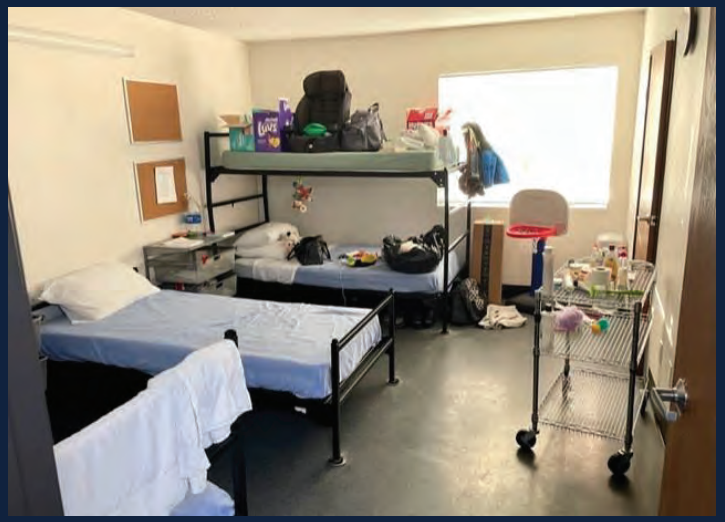
Kiva residential



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Kiva residential

- 60 beds
  - 14 children
- 90 days
- Social model
  - CBT, other evidence-based counseling
- MAT prescribers
  - FQHCs
  - methadone clinics
  - On-site by end-of-year
- Prenatal care typically based upon
  - Assigned Managed Care Provider

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Regional Recovery Centers

- 4 locations
  - ECRRC (El Cajon)
  - SBRRC (Chula Vista)
  - NCRRC (Oceanside, Vista)
  - NIRRC (Escondido)
- Intensity of services based upon ASAM evaluation
- MAT Services on-site soon

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Women's Recovery Centers

- 4 locations
  - SBWRC (National City)
  - NCWRC (Kearny Mesa)
  - NCoWRC (Oceanside)
  - NIWRC (San Marcos)
- MAT Services on-site or via telehealth NP/PA provider
  - Buprenorphine products
  - Naltrexone, Vivitrol
- Childcare
  - Safe place for children
  - Parenting skills training
  - Links to children services

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Services for individuals experiencing homelessness

40% of individuals in our treatment programs report homelessness at admission

Recovery and Bridge Center (safe sobering)

Work for Hope (job training)

Recovery Residences (sober living)

SAFE Housing (women and children)

Inclement Weather Program

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Other Drug Medi-Cal Organized Delivery Service (DMC-ODS) Providers

Acadia/ Comprehensive Treatment Centers	Alpha Project	Amity Foundation	Apex Recovery	CRASH, Inc.	Crossroads Foundation	Deaf Community Services
El Dorado	Episcopal Community Services	Family Health Centers of San Diego	Fellowship Center	House of Metamorphosis, Inc.	Interfaith Community Services	Lifeline Community Services
MAAC Project	McAlister Institute	Neighborhood Housing Association	New Entra Casa Co.	Mission Treatment Center	North County Serenity House / HR360	Optum / Access and Crisis Line
Pathfinders of San Diego	San Diego Freedom Ranch	SOAP MAT	Stepping Stone of San Diego	The Way Back	Tradition One	Turning Point Home of San Diego
	Twelfth Step House/Heartland House	TURN BHS (formerly MHS)	UPAC	Veteran's Village of San Diego	Vista Hill	

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THANK YOU!

McAlister Institute

James Dunford, MD, Medical Director
McAlister Institute
james.dunford@mcalisterinc.org
(619) 988-2558

[McAlister Institute – Substance Abuse Treatment and Education (mcalisterinc.org)]

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UC San Diego Health

Healthy Brain and Child Development (HBCD) Study

HBCD: The largest longitudinal study of early brain and child development in the United States

Dr. Gretchen Bandoli-
Principal Investigator

Ashley Swan-
Clinical Research Supervisor/Project Manager

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Study Overview

The HBCD Study will enroll approximately 7,200 participating families across the United States and follow them from pregnancy through early childhood.

The HBCD study aims to assess how children grow and develop early in life. The research will look at many factors that might influence a child's development. These include exposure to tobacco, alcohol, and other drugs before birth, family members' mental health and stress, the family's social and economic environment, the child's exposure to toxins, and how the parent or caregiver interacts with their child. The overall goal of this study is to better understand how children grow up in various environments.

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HBCD Study Design

TWO CENTRAL QUESTIONS

What are the developmental effects of prenatal opioid and other substance use exposures on children from birth through middle childhood?

What are the "typical" or "normative" developmental trajectories for children from birth through middle childhood?

Q1: EXPOSURES 

 **Q2: DEVELOPMENT**

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10:30 – 10:35: Introductions
Audra Meadows, MD, MPH
Vice Chair, Culture & Justice

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Opioid Use

Self-reported use of prescribed or illicit opioids for 2 or more weeks during pregnancy,

Diagnosis of Neonatal Opioid Withdrawal Syndrome

Positive toxicology for an opioid for research-collected biospecimen.

Alcohol Use

Self-reported use equal to 7 or more standard drinks per week for 2 or more weeks during pregnancy,

Self-reported use equal to 3 or more standard drinks per occasion on 2 or more occasions during pregnancy

Diagnosis of Fetal Alcohol Syndrome

Positive toxicology for alcohol for research-collected biospecimen.

Cannabis Use

Self-reported weekly use of cannabis for 4 or more weeks during pregnancy

Positive toxicology for cannabis for research-collected biospecimen.

Tobacco / Nicotine Use

Self-reported weekly use of tobacco or nicotine products for 4 weeks or more during pregnancy

Positive toxicology for nicotine for research-collected biospecimen.

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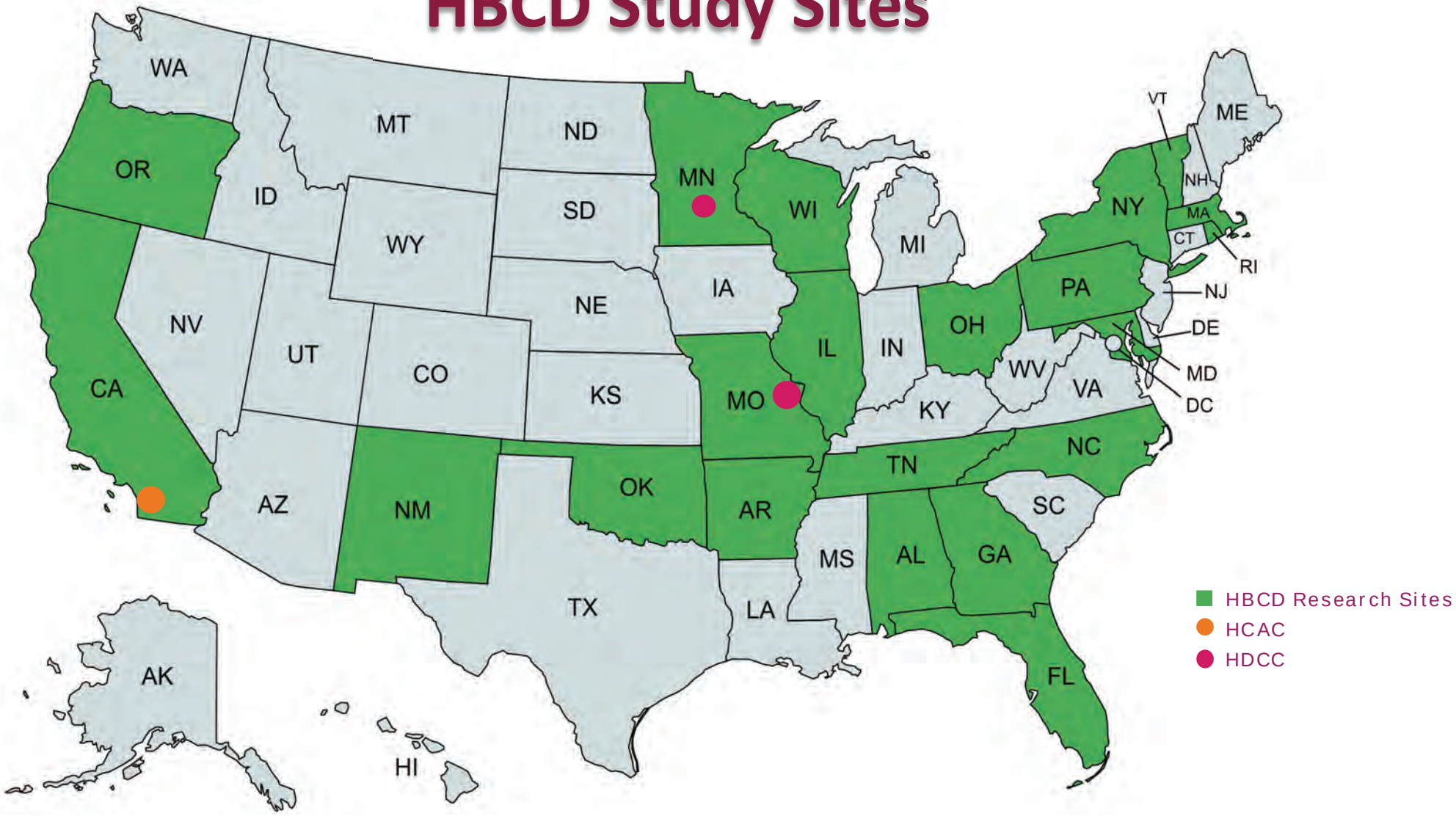
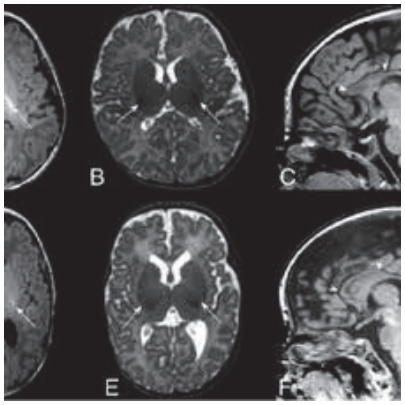
When will study activities be taking place?

- You will be asked to participate once during pregnancy and then across several visits during the first 10 years of your child's life
- The schedule for the first five years includes:

Remote assessments will take place at visits **5** (10-17 months), **7** (16-50 months), and **8** (36-60 months).

HBCD Study Sites



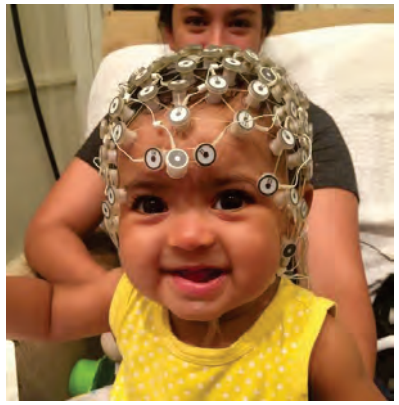


MRI

Structural MRI T1/T2
Diffusion MRI
MR Spectroscopy

EEG

Baseline
Auditory Oddball
Visual Evoked Potentials
Response to Faces



Behavioral, Observational, and Cognitive Assessments

Wearable Biosensors

Biospecimens

Questionnaires, EHR review

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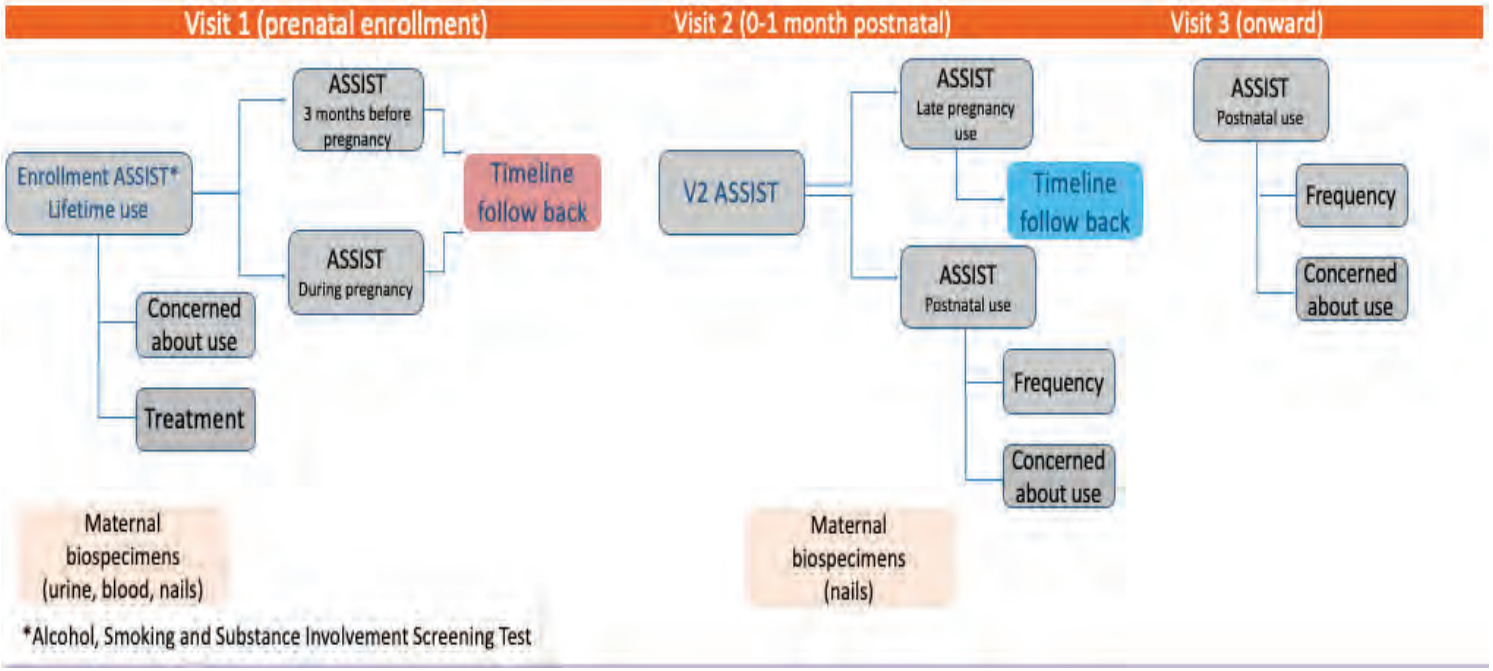

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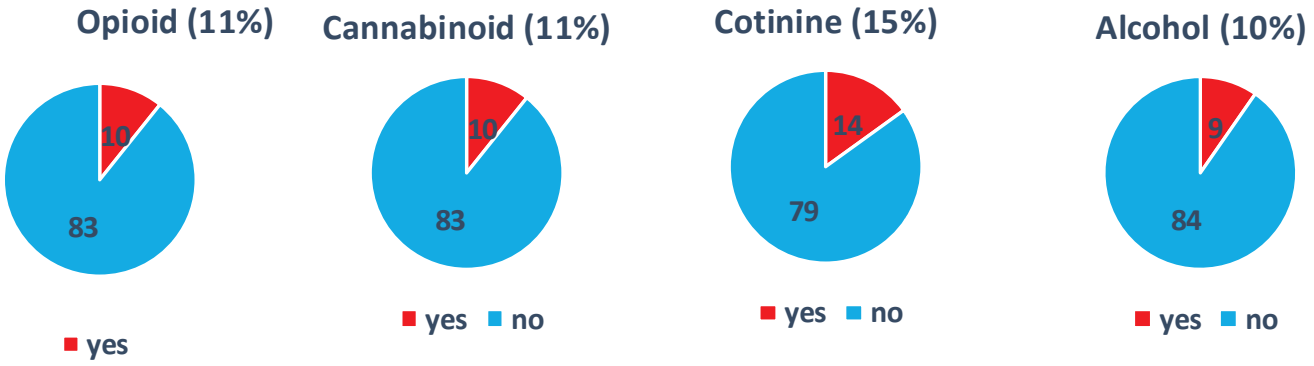
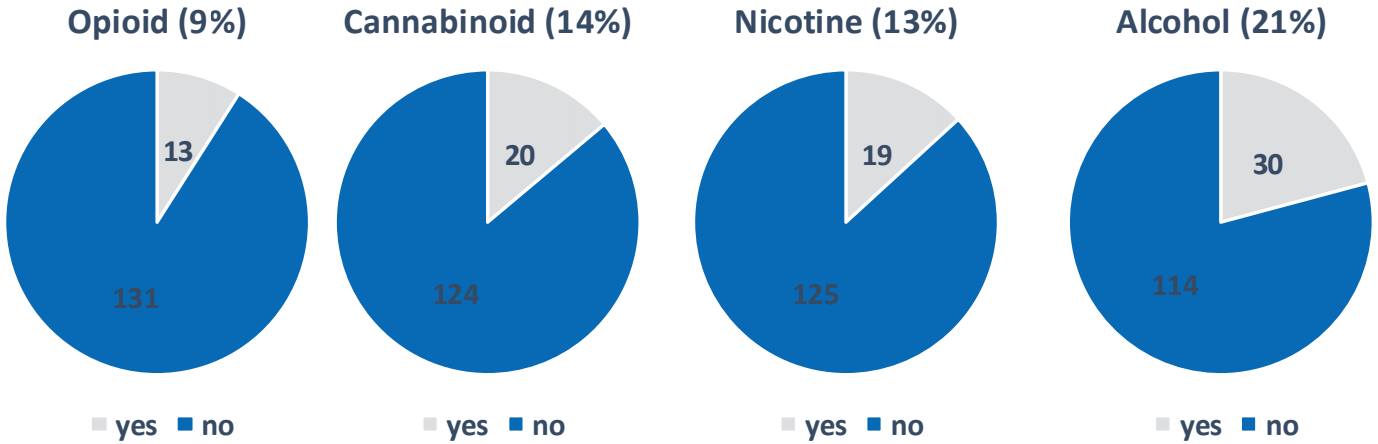
UDS/blood spots



Self report



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Equitable Participation

- DEI: The HBCD consortium has developed a DEI committee that reviews all study materials to make sure that there are no intrinsic biases in the developed questions as well as to provide suggested changes to materials if a bias is identified.
- Each site has a Community Advisory Board that consists of community stakeholders with significant experience in different areas of the study that help to review different processes within the study and are a critical resource to provide knowledge of participant experiences
- Each site has a study navigator to help walk the participant through each visit
- Each site has developed resource guides unique to the community they are in

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Data availability

- Cumulative, curated data from HBCD will be publicly available through application and a data use agreement.
- Raw data from Assist and TLFB, as well as summary measures will be released.
- Biospecimen assays (continuous confirmatory results and categorical (positive/negative) results will be released.
- First data release anticipated late 2024.
- More information on study: https://hbcdstudy.org

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Gretchen Bandoli, PhD
Pediatrics

Sheila Gahagan, MD
Pediatrics

Anders Dale, PhD
Neuroscience

Tim Brown, PhD
Neuroscience

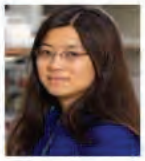
Natacha Akshoomoff, PhD
Psychiatry

Christina Chambers, PhD
Pediatrics

Carla Marienfeld, MD
Psychiatry

Audra Meadows, MD
OB-GYN

Camille Nebeker, EdD
HWSPH



Louise Laurent, MD PhD
OG&RS

Michelle Leff, MD
Pediatrics

Jerry Ballas, MD OG&RS

Natalie Laub, MD
Pediatrics

Marni Jacobs, PhD
OG&RS

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UC San Diego Health

Florencia Anunziata
Postdoctoral Researcher

Lucia Ferrer
Research Associate

Nathalie Marquez-Larrondo
Research Associate

Josselin Martinez
Research Associate

Lilliana Osuna
Clinical Research Coordinator Assistant

Abigail Sanchez
Research Associate

Ashley Swan
Project Manager/Clinical Research Supervisor

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Question and Answer

Please post questions in the Q&A Box!

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Upcoming Events

- National Breastfeeding Month – August
- Black Breastfeeding Week – Aug 25 – 31
- Newborn Screening Month – August
- Midwifery Week Grand Rounds – October 9

UC San Diego
School of Medicine

THANK YOU FOR ATTENDING!