Maine Quality Counts presents…

Provider Lunch & Learn: Pain Management Series

Introducing the Snuggle ME Recommendations: Care of Pregnant Women with Perinatal Substance Use with a Focus on Pain Management

April 2, 2013 (12N - 1PM)

Jacqueline Blackstone, DO
Maternal Fetal Medicine, Maine Medical Center

Kelley Bowden, MS, RN
Perinatal Nurse Educator for the State of Maine

Don’t forget to dial in to hear the audio!
866.740.1260, Access Code: 6223374
Who We Are

Maine Quality Counts (QC) is a regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality throughout Maine.
Our Mission

QC is transforming health and health care in Maine by **leading, collaborating** and **aligning** improvement efforts.

- Maine Patient Centered Medical Home Pilot
- Community Care Teams
- Aligning Forces for Quality (AF4Q)
- Behavioral Health Integration
- Quality Counts for Kids / First STEPS Initiative
QC Learning Community Webinars

• Monthly webinars:
  – Provider Lunch & Learn: 1st Tues/mo – 12N
  – QC 2013 Triple Aim Series: 3rd Thurs/mo – 12N
  – QC Brown Bag Forum: 4th Tues/mo – 12N

• Next Provider Lunch & Learn:
  – Tues, May 7 at 12N
Important Webinar Notes

• To minimize background noise, all lines will be muted
  • To unmute your line, press *7
  • To mute your line, press *6

• To ask questions or share comments, use one of two ways:
  1. Raise Your Hand button (press *7 to unmute your line)
  2. Type in chat box on the lower left-hand side of the screen

• Please state your name and organization before asking your question or sharing your comment
Jacqueline Blackstone, DO, is one of the three board certified Maternal-Fetal Medicine specialists working at Maine Medical Center serving the State of Maine and part of New Hampshire. She has a particular interest in hospital-based obstetrics and the prenatal management of pregnancies complicated by maternal and fetal medical and problems as well as chronic pain and drug addiction. Her practice is primarily made up of the underserved, whose social and psychological issues contribute to their special needs. She has presented at national and local meetings and was the Chairman of the Department of Obstetrics and Gynecology at the University of New England for 15 years.

Kelley Bowden, MS, RN, is the Perinatal Outreach Nurse Educator for the State of Maine. After graduating from the University of Southern Maine with her Bachelor’s degree in nursing, she joined the Maine Medical Center NICU staff. Kelley then went on to earn a certificate from Georgetown University as a Neonatal Nurse Practitioner. After working in the NICU for 18 years, she left to become a chart abstractor for the Maine Birth Defects Program and assumed the outreach position in 2004. Kelley completed her master’s degree in nursing at USM in 2005. In her current role, she serves as a resource and consultant for birthing hospitals, community based health care organizations, and health care providers on topics related to perinatal care. Kelley presents locally and nationally and has publications in Pediatrics, Advances in Neonatal Nursing, and on the National Guideline Clearinghouse website.
The Snuggle ME Project:

Embracing Drug Affected Babies and their Families in the First Year of Life

To Improve Medical Care and Outcomes in Maine

April 2, 2013

Working in conjunction with the Maine Chapter of the AAP, Maine CDC, Maine Child Abuse Action Network and OCFS who have formed a statewide group- meeting quarterly since Oct. 2010
Agenda

- Describe why addressing perinatal substance use is important for providers who care for pregnant women
- Outline what is in the new Snuggle ME Recommendations
- Discuss Pain Management of the Opioid Addicted Pregnant Women - Jacquelyn Blackstone, D.O, MMC MFM
- Briefly Describe Newborn Care Recommendations
How Do We:

- Identify newborns affected by perinatal substance use sooner and do a better job of screening during pregnancy?
- Better coordinate prenatal care, addiction treatment, and newborn care?
- Ensure early intervention through Child Development Services and other supports?
- Bring together other groups and medical providers working on this issue throughout the state?
Why is this a Crisis?
Rising Numbers of Newborns Statewide Affected by Perinatal Substance Use

Maine DHHS
Division of Child Welfare
Overall Goals for Snuggle ME

- Improve care and coordination for families
- Outline recommendations for prenatal, labor, and postpartum care of pregnant women with substance abuse issues
- Identify Screening Tools and Treatment Services Available- including 4P+
Overall Goals for Snuggle ME

- Review newborn care policies including newly updated AAP Guidelines from 2012 around NAS, medication management and breastfeeding
- Develop standardized patient education
- Develop Referral form for DHHS, Child Development Service, Public Health Nursing, Primary Care
Participants:

- MMC
- CMMC
- EMMC
- MaineGeneral
- Penobscot Bay Medical Center
- Franklin Memorial
- Mayo Regional
- Maine CDC, OSA, WIC, Lactation Consultants
- Maine Chapter of the AAP
- Maine ACOG
Snuggle ME Care Recommendations

- Screening for Substance Use in Pregnancy
- Checklist for Care
- Chapters on:
  - Antepartum Care by Trimester
  - Intrapartum Care
  - Postpartum Care
  - Newborn Care
  - 2 Family Educational Materials: Trifold and Longer Family Packet
  - Resource Lists for Providers
Introducing the Snuggle ME Recommendations

Pain Management of the Opioid Addicted Pregnant Women

Jacquelyn Blackstone, D.O.
Maine Medical Center
Portland, Maine
Buprenorphine vs. Methadone

- Buprenorphine is a relatively new drug
- Induction with buprenorphine requires the mother (and fetus) to experience some withdrawal symptoms, so that many physicians feel that the induction should only be done in a hospital setting where the patient can be observed and treated as she is started on the new regimen
Buprenorphine vs. Methadone

- Usually the patient is given a month’s supply to take home leading to more diversion, overuse.
- It has the advantage of availability without requiring daily (potentially long and difficult) trips to and from the clinic.
Buprenorphine vs. Methadone

- A randomized trial shows buprenorphine-treated pregnancies to have:
  - bigger and older neonates
  - less neonatal abstinence severity and treatment
  - shorter neonatal length of stay

Mother Study, Jones, NEJM 2010
# Medical Complications Associated with Opioid Dependence in Women

<table>
<thead>
<tr>
<th>Medical Complication</th>
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<tbody>
<tr>
<td>Anemia</td>
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<tr>
<td>Bacteremia/Septicemia</td>
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<tr>
<td>Bacterial vaginosis</td>
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<tr>
<td>Cellulitis</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>UTIs</td>
</tr>
<tr>
<td>STD’s – Chlamydia, gonorrhea, herpes, HIV, syphilis, Trichomonas vaginatis</td>
</tr>
<tr>
<td>Hepatitis B&amp;C</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Dental Abscesses</td>
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<tr>
<td>UTIs</td>
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<tr>
<td>Group B Strep</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Phlebitis</td>
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<tr>
<td>Endocarditis</td>
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<td>Dual psychological diagnosis</td>
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</table>
Patients already being treated who become pregnant may find that the dose that has been therapeutic in the past is no longer adequate to prevent withdrawal or reduce the craving for illicit drug use.
Buprenorphine and Methadone Maintenance

- Increased blood volume, increased maternal clearance (↑GFR), rapid elimination and decreased GI absorption all result in lower plasma levels of the chosen drug
Buprenorphine and Methadone Maintenance

- Changes in the way methadone is metabolized by the liver, and excreted in the urine may require increased oral doses or split doses, particularly in the third trimester.

- A split dose can be used to avoid increasing the dosage.
Detoxification from Methadone

- Not generally recommended during pregnancy
- If performed, should be done between the fourteenth and thirty second weeks of pregnancy due to the risk of spontaneous abortion in the first trimester and the risk of neonatal death or preterm labor in the third trimester
Detoxification in Pregnancy

- Most authorities still advocate continued methadone treatment throughout pregnancy in opiate addicts

Kallenback, Berghella, and Finnegan, 1998
Detoxification in Pregnancy

- Two influential reports describe a stillbirth following acute narcotic withdrawal at term.
- Zuspan, et al. describe a case report of increased amniotic fluid epinephrine levels in a woman undergoing methadone detoxification in pregnancy.

Rementeria and Nunag, 1973
Zuspan, et al. 1975
Detoxification from Methadone

- Medical monitoring is recommended whenever methadone detoxification is attempted during pregnancy.
- Just as abrupt withdrawal from methadone during pregnancy may precipitate preterm labor or fetal death, so can the acute withdrawal caused by the use of Narcan or other narcotic antagonists.
Pain Management

- Women maintained on methadone should have pain management in labor discussed thoroughly during their antepartum visits.
- These patients are at high risk for receiving inadequate pain control in labor.
- Addressing the issue prior to labor should help allay anxiety.
A common misconception includes the belief that methadone itself will provide pain relief, or that if a narcotic is given the methadone dose should be lowered.

These patients should receive their usual scheduled dose of methadone in the intrapartum setting to avoid withdrawal symptoms.
Intrapartum Pain Management

- Additional analgesia will be needed for this patient population often in higher than usual doses due to tolerance
- Unusual complaints of pain should not be viewed as “drug seeking behavior”, but should be anticipated due to chronic narcotic use
Intrapartum Pain Management

- Epidural anesthesia is usually most effective and safe.
- Some patients may fear using opioids will lead to a loss of control and fear of re-addiction.
- They can be reassured that the methadone will block the euphoric effects of opioid analgesia though it will still provide pain relief.
Intrapartum Pain Management

- Narcotics that are opioid agonists such as: morphine, meperidine or fentanyl should be offered at more frequent intervals and higher doses as dictated by patient response.

- Meyer et al. found that methadone maintained patients had increased post partum pain and required up to 70% more oxycodone equivalents after c-section delivery.

Women who have had vaginal deliveries may not be adequately treated with the usual acetaminophen and NSAIDS.

May need to add a short-acting opioid such as oxycodone.
Post partum mothers can be observed for signs of intoxication such as drowsiness, decreased respirations, hypotension and rarely, coma. In this setting the daily methadone dose may be decreased, delayed or held until symptoms resolve.
Buprenorphine and Methadone Maintenance – Postpartum

- Cesarean section patients may need a PCEA (Patient Controlled Epidural Anesthesia) or 24 hours for intractable pain along with their maintenance medicines
Pain Management and Buprenorphine

- Due to the strong affinity buprenorphine has for mu pain receptors there has been controversy about discontinuing buprenorphine before delivery.
- This is not recommended as it creates the potential for term withdrawal which we have tried to avoid throughout pregnancy.
Acute Pain Management in the Opioid Addicted Patient

- Opioid agonist therapy provides little, if any, analgesia for acute pain
- Fears that opioid analgesia will cause addiction relapse or respiratory and CNS depression are unfounded
- Clinicians should not allow concerns about being manipulated to cloud good clinical assessment or judgment about the patient’s need for pain medication
Newborn Recommendations
Newborn Issues in the Hospital

- Each nursery should have a policy for screening mothers, plan for testing, evaluation and treatment of infants at risk for withdrawal (AAP, 2012)
- Newborns should be observed for 5-7 days
- Eating: Weight gain and Breastfeeding Issues
- Sleeping: Periods of restful sleep
- Safety
- Bonding: Ability to interact with family

**Neonatal Drug Withdrawal**
Mark L. Hudak, Rosemarie C. Tan, THE COMMITTEE ON DRUGS and THE COMMITTEE ON FETUS AND NEWBORN
*Pediatrics*; originally published online January 30, 2012; DOI: 10.1542/peds.2011-3212
Buprenorphine and Methadone Maintenance – Postpartum

- Mothers need to be warned that the infant going through Neonatal Abstinence Screening (NAS), can be very difficult to soothe.

- Positive parenting behaviors need to be taught and reinforced to help these patients deal with their frustrations while caring for these babies and the guilt engendered both by their anger and frustration and the knowledge that their own addiction caused the infants condition.
Buprenorphine and Methadone Maintenance – Breastfeeding

- When maternal blood-borne disease and illicit drug use are not ongoing, there are no contraindications to breastfeeding.
- Some practitioners have limited breastfeeding to those moms on low doses of Methadone.
- This has shown no benefit either to neonate or mother.
- There is some evidence to support that presence of methadone in breast milk may reduce the severity of withdrawal symptoms.
Breastfeeding

- AAP: Not with cocaine, amphetamines, marijuana
- AAP: Yes with mother stable in a treatment program
  - promotes bonding
  - nutritional benefits

- Medications and Mothers’ Milk
- Drugs in Pregnancy and Lactation
Who Can Help?

- Maine Families
- Public Health Nursing
  - 1-877-763-0438
- The Women’s Project
  - 1-800-611-1588 (South)
  - 1-800-611-1779 (North)
- Child Development Services
- Child Protective Services
- Text4baby.org
Contact Information

Kelley Bowden, MS, RN
Perinatal Outreach Nurse Educator
Maine Medical Center
22 Bramhall Street
Portland, ME 04102
Phone: 207-662-2696 or 207-662-2167
Fax: 207-662-4598

Maine Medical Partners Women’s Health
Division of Maternal-Fetal Medicine
887 Congress Street, Suite 200
Portland, ME 04102
Phone: 207-771-5549
Fax: 207-771-7834