Staying Afloat: Keeping Moms Connected to Opioid and Substance Abuse Services

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Overdose Deaths - Women of Childbearing Age


Produced by the Kentucky Injury Prevention and Research Center (KIPRC), as bona fide agent for the Kentucky Department for Public Health, January 2017. Data sources: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Deaths Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-10.htm on Jan 17, 2018. Data are provisional and subject to change.
Kentucky Overdose Deaths in Women of Childbearing Age


Deaths were counted under each relevant category. Produced by the Kentucky Injury Prevention and Research Center (KIPRC), a Johns Hopkins Center for the Department of Public Health, January 2017. Data sources: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015; CDC WONDER Online Database, released December, 2017. Data from the Multiple Cause of Death File, 1999-2015, as compiled from data provided by the I7 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at https://wonder.cdc.gov/mcdp

NAS Hospitalizations of Kentucky Newborns

Produced by the Kentucky Injury Prevention and Research Center, May 2016. Kentucky Inpatient Hospitalization Claims Files, Frankfort, KY, [2000-2015]; Cabinet for Health and Family Services, Office of Health Policy. Data for 2010-2015 are provisional; therefore these results are subject to change. NAS Case Definition: Any mention of ICD9CM diagnosis code 779.5 AND any mention of ICD10 code V30-V39 AND patient’s year of birth matches the reporting year. Medicaid data provided by the Department for Medicaid Services and include claims with a diagnosis code of V30-V39 AND Z38.
Summary of Differences in Woman with SUD

- Higher rates of other trauma history
- Higher rates of other conditions such as Depression, Anxiety and PTSD
- Shorter time between first use and physical consequences of misuse of substances
- More likely to begin use with sexual partner
- More likely to use shared needles
- More likely to enter treatment via referral from medical setting
MAT- PDOA SMART Initiative Sites

Community Mental Health Centers

- Identification of Woman Prenatally
- Coordinated Care Model
  - High quality prenatal care
  - Medication Assisted Therapy (Buprenorphine and Methadone)
- SUD Services
  - Residential
  - Intensive Outpatient
  - Individual
  - Peer Support
  - SUD Case Management
- Nurse Care Coordinator Function
- Hospital, Pediatric and Neonatology involvement
- Post-delivery, mother and infant follow-up
WHO 2014 Guidelines

• “Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification. Opioid maintenance treatment in this context refers to either methadone maintenance treatment or buprenorphine maintenance treatment.”

SMART: Additional Services

• Housing
• Transportation
• Job Training and Supportive Employment
• Child Care
• Parent Child Dyadic Therapy with older Children
MAT-PDOA Functional Outcomes

- Illicit drug use decreased 61% to 18%
- Arrears decreased from 16% to 1%
- Employment increased 12% to 42%
- Inadequate housing decreased 21% to 7.2%

MAT-PDOA NAS (NOW) Outcomes

- 176 mothers served during project period
- 70 births total – 41 w/ mother receiving MAT services

Births w/ Mother is Receiving MAT services
- 63% NAS Diagnosed
- 37% No NAS Diagnosed

NICU Services
- 71% NICU Svc. Rqd.
- 29% No NICU Svc. Rqd

7.46 Average length of hospital stay for all substance exposed infants
Barrier to Implementation

• Lack of Screening/Testing for SUD in prenatal care settings
• Initial Barriers to acceptance of Medication Assisted Therapy
  – Abstinence only SUD treatment culture (more acute in rural setting)
• Historical lack of integration between healthcare and SUD services
• Lack of information sharing infrastructure (EMR’s)
• Stigma regarding SUD/MAT in hospital labor and delivery settings

Barriers to Implementation

• Rural Issues
  – FQHC provided all OB services resisted caring for woman on MAT
  – Lack of full continuum of SUD Services (over reliance on Residential)
  – Transportation an acute problem for non-residential

• Urban Issues
  – Multiple OB providers and challenges coordinating
  – High Risk OB’s agreed to provide MAT and prenatal care but this made post delivery MAT challenging
  – Tertiary Care setting leads to referrals from broader geographic areas which exacerbates transportation issues
Notable Lessons

• Baby’s have fathers, and often fathers have SUD as well
• Training and changing culture regarding acceptance of MAT is not accomplished and maintained with intensive one time stakeholder engagement and training
• Child Welfare workers must be trained to recognize what quality treatment and recovery looks like
• Judges are a critical variable and must become aware that women who are compliant with treatment and on MAT can be in Recovery and care for their children
• Peer support is crucial all during the treatment cycle and post-partum

Policy Considerations

• Encourage use of Prescription Drug Monitoring Systems (PDMPs) to identify those on prescription opioids
• Increase routine drug testing as part of prenatal care
• Create an NAS registry with mandated reporting
• Reduce administrative burden on MAT prescribers
  – Preauthorization requirements
  – Consider Case Rates
  – Bundled Payments
  – Health Homes
• Insure that Peer Support and Case Management are part of State Medicaid Plan
Policy Considerations

• Allowing women to bring other children to residential SUD program is critical (remove regulatory or licensure barriers)
• Utilize policy levers to standardize NAS (NOW) treatment
• Avoid creation of additional NICU Beds or Residential NAS (NOW) treatment that do not address mothers SUD
• Create integrated health data sets to drive policy and target information (collect baseline utilization data)

Policy Considerations

• Need for short term, non hospital, residential MAT induction program
• Decrease barriers to hepatitis C treatment in the population (preauthorization requirements)
• Transitional housing is critical
• Promote telehealth linkages
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