ACCEPT
Addiction & **C**o-morbid **C**onditions: **E**nhancing **P**revention & **T**herapeutics

Agenda

Webex link to join from PC, Mac, iOS or Android**:**

Meeting number/Access code: 120 276 9209

Password: 12345

Link: https://uwmadison.webex.com/uwmadison/j.php?MTID=m6dfbe50f3c56cb4719e74b72b73ef916

Join by phone: +1-415-655-0001

For attendance, purposes please text the following code: MONFOB to 608-260-7097

Session Date: Friday August 21, 2020

Didactic Topic and Presenter:
Opioid Use Disorder in the Perinatal Patient

Christine L. Wichman, DO –
Medical Director, The Periscope Project
Director, Women's Mental Health
Professor of Psychiatry & Behavioral Medicine and Obstetric & Gynecology
Medical College of Wisconsin

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
  - Presenter: Jacquelyn Adams, MD
- 1 PM: Didactic Presentation
  - Presenter: Christine L. Wichman, DO
- 1:15 PM End of Session

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2020 Universal Activity Number (UAN) JA0000358-9999-20-005-L04-P

2021 Universal Activity Number (UAN)

2022 Universal Activity Number (UAN)

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN–MADISON
School of Medicine and Public Health
School of Nursing
School of Pharmacy

Project ECHO
University of Wisconsin

ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2020-2022
Opioid Use Disorder in the Perinatal Patient
Friday August 21, 2020
Didactic Presenter: Christine L. Wichman, DO
Case Presenter: Jacquelyn Adams, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Implement appropriate opioid prescribing and monitoring practices.
2. Effectively participate in office-based, collaborative management of substance use disorders.
3. Consistently provide in overdose prevention education to appropriate patients.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine, and contributions of different members of the healthcare team to the management of substance use disorders.

Policy on Disclosure
It is the policy of the University of Wisconsin-Madison ICEP that the faculty, authors, planners, and other persons who may influence content of this CE activity disclose all relevant financial relationships with commercial interests* in order to allow CE staff to identify and resolve any potential conflicts of interest. Faculty must also disclose any planned discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). For this educational activity, all conflicts of interest have been resolved and detailed disclosures are listed below.

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Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?	COI completion date
Randall Brown, RSS Chair	No relevant financial relationships to disclose	Yes	4/8/2020
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No	4/8/2020
Kathleen Maher, RSS Coordinator	No relevant financial relationships to disclose	No	4/18/2020
Nada Rashid, RSS Coordinator	No relevant financial relationships to disclose	No	7/1/2020
Ritu Bhatnagar, Planner	No relevant financial relationships to disclose	Yes	4/15/2020
Richard Crawford, Planner	No relevant financial relationships to disclose	No	4/9/2020
Paul Hutson, Planner	No relevant financial relationships to disclose	No	4/9/2020
Susan Mindock, Planner	No relevant financial relationships to disclose	No	4/6/2020
Lindsey Peterson, Planner	No relevant financial relationships to disclose	No	4/6/202

Alyssa Tllhou, Planner	No relevant financial relationships to disclose	No	4/13/2020
Sheila Weix, Planner	No relevant financial relationships to disclose	No	4/6/2020
Christine L. Wichman, Speaker	No relevant financial relationships to disclose	No	7/16/2020
Jacquelyn Adams, Speaker	No relevant financial relationships to disclose	No	8/13/2020

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ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1. Date: Friday, August 21 2020
2. Presenter Name: Jacquelyn Adams, MD
3. Presenter Organization: Maternal Fetal Medicine, University of Wisconsin School of Medicine and Public Health
4. ECHO ID: 9324
5. Have you presented this patient during this teleECHO clinic before? ☐ Yes ☒ No

6. Please state your main question for this case: How can we optimize pain management/outcomes for women on medication assisted treatment at the time of delivery?

Patient Demographic Information:

7. Age: 31 yo
8. Sex: Female
9. Gravida 2 Para 1001
10. Education/Literacy: High school diploma
11. Income source: Currently unemployed
12. Social Factors/History: Patient has a history of domestic violence with a previous partner as well as trauma history in childhood

13. **Substance Use History: History of opioid use disorder beginning at age 25. She was initially given pain medication following a Cesarean delivery. She had issues with wound healing as well as a chronic pain history from a previous motor vehicle accident at age 21. She began using heroin at age 27 when she was no longer able to receive pain medications and was in a turbulent relationship with a significant other that also used heroin. Patient was motivated to enter a recovery program at age 29 when she lost custody of her child. She was stable in an MAT program until one year ago when she switched to Vivitrol.**

14. **Consequences of Substance Use:**
    - Social/occupational/educational: **Patient has been unable to maintain employment due to substance use and chronic pain. She has lost custody of her previous child.**

- Physical (including evidence of tolerance/withdrawal): **Patient currently well maintained on injectable naltrexone. She had previously tried both methadone and buprenorphine-naloxone. She was highly motivated due to her loss of custody, and was able to successfully transition to naltrexone one year ago.**

15. <u>Interventions that have been tried:</u> Patient currently well maintained on Naltrexone. She had previously tried both methadone and buprenorphine-naloxone. She was highly motivated due to her loss of custody, and was able to successfully transition to injectable naltrexone one year ago.

16.

Current Addiction and Mental Health-related Medications:	Medical/Behavioral Health Diagnosis:
• Escitalopram 20mg daily • Naltrexone 380mg IM every 4 weeks	• Depression • Anxiety • PTSD

17.

Patient Strengths/protective factors:	Risk factors:
• Motivated to gain custody of this child • Relationship with sister	• Adverse childhood events • Co-existing mental health diagnoses

18. <u>Labs (as indicated), include summary of urine testing or last urine drug screen results:</u>
Most recent urine drug screen negative for all except THC

19. <u>Patient Goals/Motivations for Treatment:</u>

Goal is to maintain custody of her baby

"I want to be able to parent my child"

"I don't want to go back onto buprenorphine due to risks to me and my baby"

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20. **Proposed Diagnoses:**
Opioid use disorder
Major depressive disorder
Generalized anxiety disorder
Post traumatic stress disorder

21. **Proposed Treatment Plan:**

Initial Plan:

Continue naltrexone injections during pregnancy

Transition to oral naltrexone at 32 weeks

Change to plan:

Patient presented with preterm labor at 27 weeks.

She received steroids for fetal lung maturity and tocolytics.

Multi-disciplinary conference held STAT to discuss options for pain control if vaginal delivery versus Cesarean delivery given recent Vivitrol injection.

By initialing here __JHA__ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations

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9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Opioid Use Disorder in the Perinatal Patient

Christina L. Wichman, DO

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Overview

- Identify risks of opioid use in pregnancy to fetus and neonate
- Describe potential treatment options for opioid use disorder in the perinatal patient
- Describe The Periscope Project as a resource for you

CNN Health » Food | Fitness | Wellness | Parenting | Live Longer — Live TV — U.S. Edition +

Drug overdose deaths skyrocketed among women

By Jacqueline Howard, CNN
Updated 3:17 PM ET, Thu January 10, 2019

Science News *from research organizations*

Opioids: Leading cause of pregnancy-related death in new Utah moms

CNN INVESTIGATES

Dangerous jail births, miscarriages, and stillborn babies blamed on the same billion dollar company

By Blake Ellis and Melanie Hicken, CNN
Updated 7:14 PM ET, Tue May 7, 2019

For Addicted Women, the Year After Childbirth Is the Deadliest

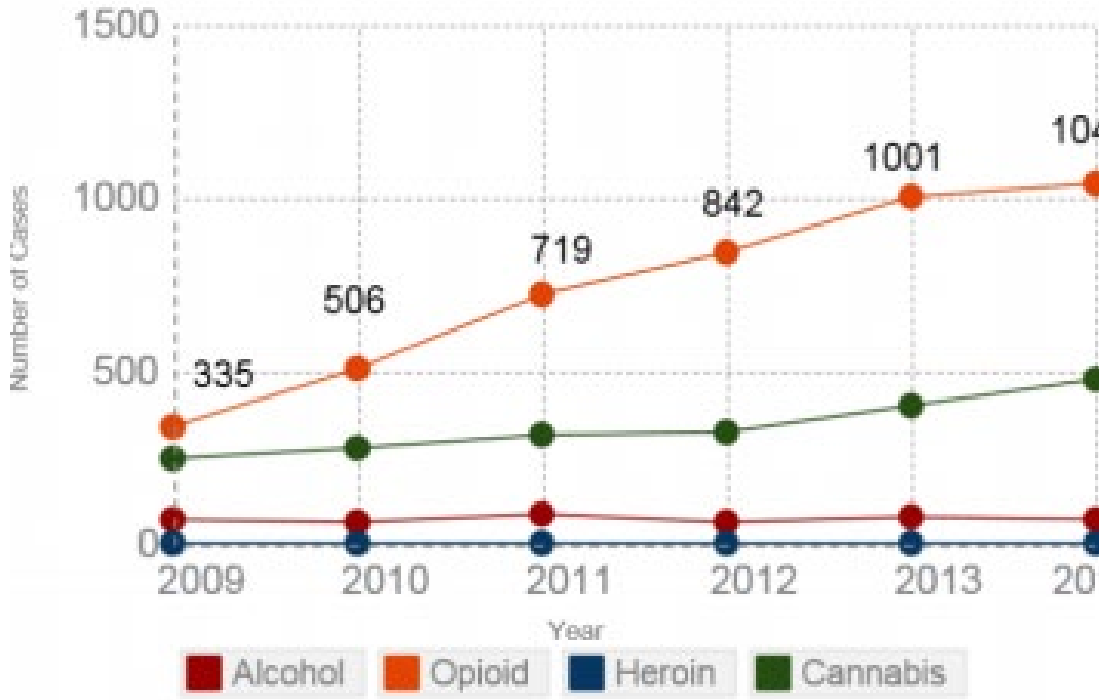
STATELINE ARTICLE August 14, 2018 By: Christine Vestal Topics: Health Read time: 5 min

Project ECHO University of Wisconsin

Substance Use During Pregnancy is Under-Diagnosed!

- Pregnancy is a motivator for cessation
- Persistence of substance abuse during pregnancy may represent a particularly refractory and high risk subpopulation
- Higher levels of use prior to pregnancy correlate with continued use during pregnancy
- Most women return to pre-pregnancy rates of smoking and alcohol abuse within 6-12 months postpartum

Maternal Substance Use Identified During Delivery Hospital Stay in Wisconsin 2009-2014



Increasing use of opioids and cannabis noted in pregnant women at time of delivery

Opioid Use in Women of Childbearing Age

90% of female opioid users in the US are of childbearing age

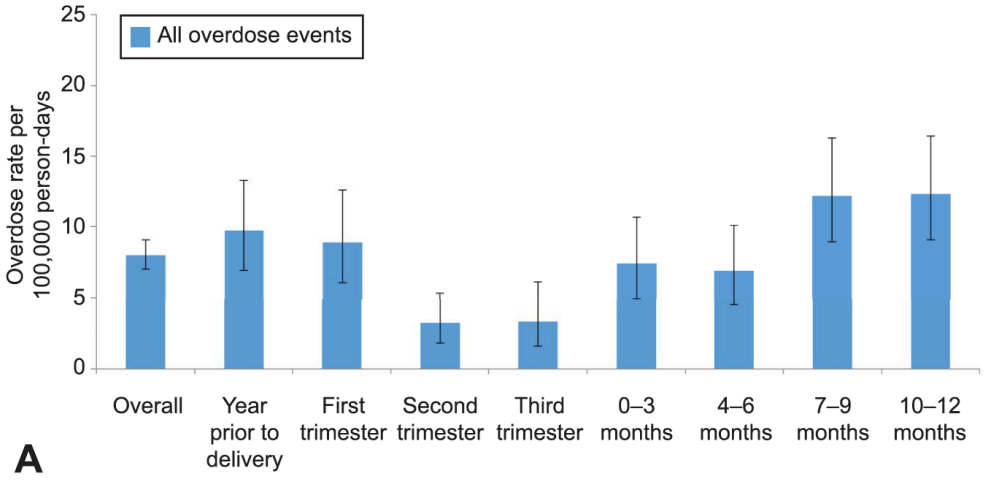
- Most women who chronically used opioids pre-conception used pattern of use into pregnancy
- 5.63 in 1000 births: delivering mothers defined as dependent on or using opioids antenatally
- High costs associated with maternal and neonatal care
- Especially neonatal abstinence syndrome (NAS)

Drugs in Pregnancy: *Review*

Opioid Detoxification During Pregnancy

A Systematic Review

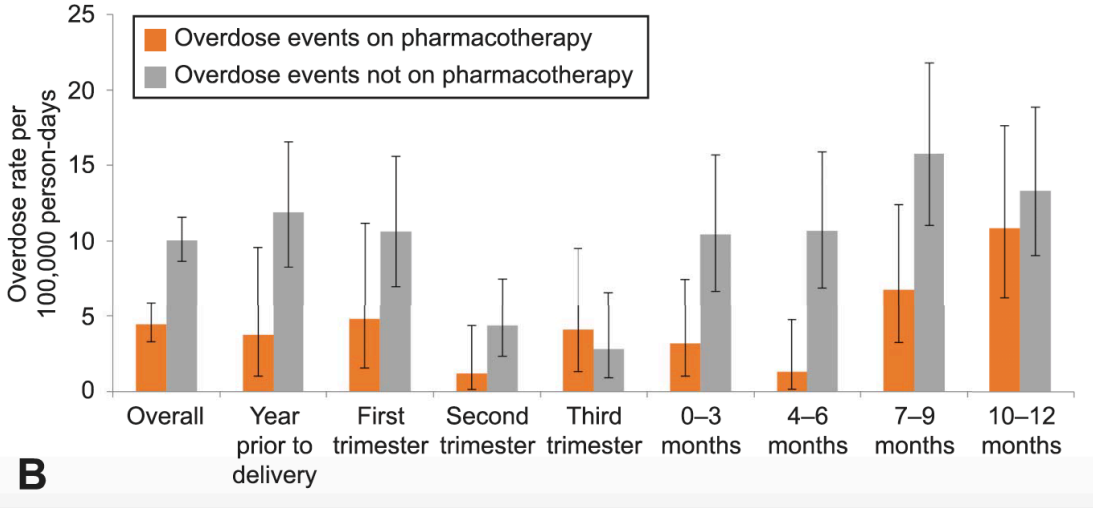
Mishka Terplan, MD, MPH, Hollis J. Laird, MPH, Dennis J. Hand, PhD, Tricia E. Wright, MD, MS, Ashish Premkumar, MD, Caitlin E. Martin, MD, MPH, Marjorie C. Meyer, MD, Hendrée E. Jones, PhD, and Elizabeth E. Krans, MD, MSc



Opioids: *Original Research*

Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Davida M. Schiff, MD, MSc, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Bernson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MSc, and Thomas Land, PhD



Project ECHO University of Wisconsin

ACOG Committee Opinion Summary

- Recommends universal screening at first prenatal visit with a validated verbal screening tool
- If a woman screens positive, recommends brief intervention (i.e. motivational interviewing) and referral for treatment
- Highlights the importance of recognizing comorbid psychiatric illness

TABLE 5 The CRAFFT questions

Two or more "Yes" answers suggest high risk of a serious substance-use problem or a substance-use disorder.

4 P's for Substance Abuse

1. Have you ever used drugs or alcohol during **P**regnancy?
2. Have you had a problem with drugs or alcohol in the **P**ast?
3. Does your **P**artner have a problem with drugs or alcohol?
4. Do you consider one of your **P**arents to be an addict or alcoholic?

Ewing H. Medical Director, Born Free Project. Contra Casta County, 111 Allen Street, Martinez, CA 94553. Phone: (510) 646-1165.

T Have you ever gotten into **Trouble** while using drugs or alcohol?

Abbreviation: CRAFFT, Car, Relax, Alone, Forget, Friends, Trouble.
Knight JR, et al.[23]

Risks of Opioid Use in Pregnancy

OBSTETRICAL

- NOT teratogenic
- Associated with:
  - Pre-eclampsia
  - Intrauterine growth restriction
  - Placental insufficiency/abruption
  - PPROM
  - IUFD/stillbirth
  - Postpartum hemorrhage
- Risks related to peaks/troughs and intermittent withdrawal
- Lifestyle factors associated with use/relapse, such as poor prenatal care and poor nutrition

FETAL

- Associated with:
  - Postnatal grown deficiency
  - Microcephaly
  - Neurobehavioral problems
  - Neonatal abstinence syndrome (NAS)
  - Sudden infant death syndrome
- All increase neonatal morbidity and mortality
- Can prolong hospital stay for newborn

Neonatal Abstinence Syndrome

Occurs in 50-80% of neonates with in utero exposure to opioids (illicit and prescribed)

- Constellation of symptoms:
  - CNS and autonomic irritability
  - GI distress, feeding issues
  - Respiratory symptoms
  - Typical onset 1-72 hours
  - Nonspecific scales
  - Treatment with morphine or phenobarbital
  - Can be fatal

Opioid Use and Pregnancy Outcomes

Birth and Neonatal Outcomes Following Opioid Use in Pregnancy: A Danish Population-Based Study

Mette Nørgaard, Malene Schou Nielsson and Uffe Heide-Jørgensen
Department of Clinical Epidemiology, Institute of Clinical Medicine, Aarhus University Hospital, Aarhus, Denmark.

Supplementary Issue: Harm to Others from Substance Use and Abuse

	UNEXPOSED		ANY EXPOSURE		BUPRENORPHINE ALONE		METHADONE ALONE		SELF-REPORTED HEROIN USE ONLY		OTHER COMBINATIONS	
	N	%	N	%	N	%	N	%	N	%	N	%
Overall	949,615	100.0	557	100.0	167	100.0	197	100.0	28	100.0	165	100.0

TYPE OF OPIOID	PRETERM BIRTH	VERY PRETERM BIRTH	LOW BIRTH WEIGHT*	SMALL FOR GESTATIONAL AGE	LOW APGAR SCORE	CONGENITAL MALFORMATIONS
Any opioid use	2.8 (2.3–3.4)	1.8 (0.7–4.4)	4.3 (3.0–6.1)	2.7 (1.8–4.1)	0.7 (0.2–2.3)	2.0 (1.5–2.6)
Buprenorphine	2.4 (1.6–3.5)	2.4 (0.6–9.7)	0.9 (0.2–3.6)	1.4 (0.4–4.2)	–	2.0 (1.2–3.2)
Methadone	3.5 (2.6–4.7)	2.9 (0.8–10.1)	6.3 (3.8–10.5)	2.0 (0.9–4.3)	2.1 (0.7–6.6)	2.4 (1.6–3.7)
Self-reported heroin use	1.3 (0.4–4.5)	–	2.7 (0.4–17.7)	6.1 (2.1–17.8)	–	0.9 (0.1–5.7)
Combinations	2.7 (1.8–3.8)	–	5.9 (3.4–10.2)	4.5 (2.6–7.8)	–	1.6 (0.9–2.8)

Note: *Restricted to infants born at term.

Treatment

- **Standard of care is opiate substitution**
- Prevent complications of illicit opioid use and opioid withdrawal
- Encourage prenatal care
- Reduce criminal activity
- Harm reduction
- **Tapering MAT does NOT reduce risk of NAS AND increases risk of relapse**
- Behavioral treatment is **crucial**
- Detoxification/withdrawal is **controversial and LEAST preferred treatment option**
- **VERY high risk of relapse** after discontinuation of opioids

Methadone Maintenance Treatment During Pregnancy

MATERNAL CONSIDERATIONS	FETAL/NEONATAL CONSIDERATIONS
Improved OB care	Decreased heart rate and heart rate variability
Increased fetal growth	Slower breathing and fetal movements on BPP
Decreased risk of HIV	Neonatal Abstinence Syndrome
Decreased risk of preeclampsia	Respiratory distress
Longer treatment retention	
Fewer relapses	
Increased volume of distribution	
May warrant dose increases in 3rd trimester	
Split dosing should be considered	

MINOZZI ET AL. COCHRANE DATABASE SYST REV 2008; 2:CD006318

Buprenorphine

- Partial mu agonist and kappa antagonist
- Half life 24-60 hours (shorter for analgesic effects)
- Diminished risk of overdose/respiratory depression
- Office based treatment (vs clinic setting)
- Decreased sedation
- Consideration of split dosing in pregnancy

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure

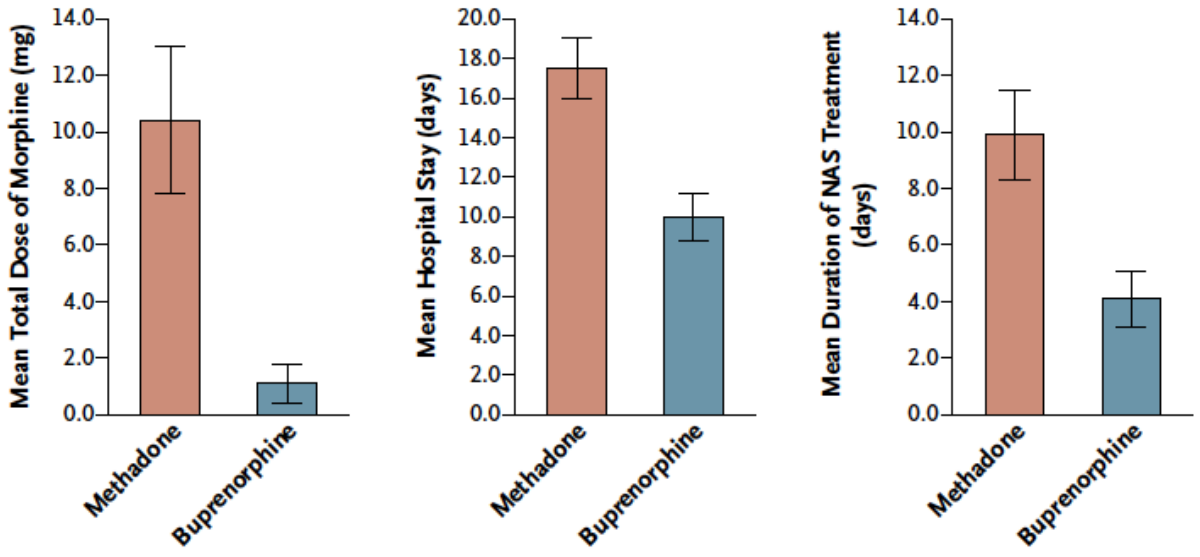


Figure 2. **Mean Neonatal Morphine Dose, Length of Neonatal Hospital Stay, and Duration of Treatment for Neonatal Abstinence Syndrome.**

Buprenorphine vs. Methadone

MATERNAL CONSIDERATIONS

- No apparent difference for:
  - Maternal weight gain
  - Cesarean section
  - Abnormal presentation
  - Use of analgesia
  - Positive drug screen
  - Medical complications at delivery

NEONATAL CONSIDERATIONS

- Buprenorphine exposed infants:
  - Less motor suppression
  - Lower incidence of non-reactive Non Stress Tests
  - HOWEVER, clinical significance of these findings not clear
- NAS
  - Compared to methadone:
    - Similar incidence
    - Shorter duration of symptoms
    - Lower mean morphine requirement
    - Shorter hospital stay

Jones HE. Neaonatal Abstinence Syndrome after Methadone or Buprenorphine Expsoure. NEIJM 2010; 363: 2320-2331

Naltrexone

- Reversible opiate antagonist
- Competes with exogenous and possibly endogenous opioids
- Utilized in patients who wish to eliminate opioid use entirely; must wait at least 7-10 days from last dose of opioids in order to avoid withdrawal symptoms
- Decreases reactivity to drug-conditioned cues and opioid cravings, potentially reducing the risk for relapse and any associated complications
- Does not have abuse potential
- Limited data with use in pregnancy, although growing data
- Thought to be option for women if already have successful opioid detoxification or have been maintained on naltrexone at time of conception

	Naltrexone (*n* = 68)	Methadone (*n* = 199)	Buprenorphine (*n* = 124)	Control (*n* = 569)
Stillbirth	1.5 (1)	0.5 (1)	1.6 (2)	0.9 (5)
Neonatal (0–28 days)	0.0 (0)	2.0* (4)	0.0 (0)	0.2 (1)
Perinatal mortality	1.5 (1)	2.5 (5)	1.6 (2)	1.1 (6)

* $p < 0.05$ (compared with non-exposed neonates; no adjustment has been made for multiple comparisons)

	Naltrexone (*n* = 68)	Methadone (*n* = 199)	Buprenorphine (*n* = 124)	Control[a] (*n* = 569)	Rates in WA 2005–2009 [21]
Rate of infants with abnormalities in the following areas[b]					
Nervous system	0.0	1.5	0.0	0.5	0.5
Congenital anomaly of eye	0.0	0.0	0.0	0.0	0.8
Congenital anomaly of ear, face and neck	0.0	0.0	0.0	0.2	0.4
Cardiovascular defect	1.5	2.5	0.0	1.1	1.1
Respiratory system defect	0.0	0.5	0.0	0.2	0.1
Gastrointestinal defect	1.5	2.0	3.2*	0.5	0.6
Urogenital defect	5.9*	2.0	1.6	1.6	1.6
Musculoskeletal defect	0.0	3.5*	0.8	0.7	1.4
Congenital abnormalities of integument	0.0	0.0	0.0	0.4	0.3
Chromosomal defect	0.0	1.0	0.0	0.0	0.1
Other	0.0	3.5*	0.0	0.7	
Infants with a birth abnormality	8.8	10.6**	4.8	4.4	
Infants with a major abnormality[c]	7.4	8.5*	4.8	3.9	

WA Western Australia

* $p < 0.05$, ** $p < 0.01$ (compared with non-exposed controls; no adjustment has been made for multiple comparisons)

[b]Infants may have had one or more abnormality in the same area; however, multiple abnormalities in the same area have only been counted as a single incidence. Infants may have had one or more abnormality in different areas and these would have been counted in each area

[c]Major anomalies are those that create a significant medical problem for the patient and/or require specific surgical or medical management

Kelty E and Hulse G. Drugs 2017 July; 77(11): 1211–1219

	Naltrexone	Methadone	Buprenorphine	Control
Number of infants	68	199	124	569
Gender (% male)	47.1	58.3	55.7	50.4
Birth weight ± SD (g)	3137.1 ± 629.4	2884.1 ± 658.8*	3035.8 ± 594.5	3378.0 ± 560.1*
Birth weight <10th percentile for gestational age (%)	13.2	23.6	17.7	6.0*
Birth weight <2500 g (%)	11.8	23.1	12.1	4.6
Body length ± SD (cm)	48.8 ± 3.6	47.4 ± 4.1**	48.3 ± 3.7	50.0 ± 3.0*
Head circumference ± SD (cm)	33.9 ± 2.5	33.1 ± 2.7*	33.6 ± 3.0	34.5 ± 2.0
Apgar 1 min ± SD	7.9 ± 1.8	7.9 ± 1.7	8.0 ± 1.9	8.3 ± 1.3
Apgar 5 min ± SD	8.8 ± 1.5	8.8 ± 1.2	8.8 ± 1.4	9.0 ± 1.0
Percentage of Apgar score <7 at 5 min	5.9	5.0	4.0	1.1
Estimated gestation ± SD	38.0 ± 2.5	37.7 ± 3.0	38.1 ± 2.6	38.7 ± 2.0
Rate <37 weeks gestation (%)	16.2	19.6	10.5	7.6
Rate <32 weeks gestation (%)	1.5	3.0	1.6	1.1
Time to establish unassisted regular breathing[a] [min (range)]	1.3 (1–14)	1.3 (1–7)	1.2 (1–15)	1.1 (1–5)
Resuscitation required[b,c] (%)	41.8	42.9	44.3	29.1
Threatened abortion <20 weeks[d] (%)	0.0	2.0	3.2	4.2
Threatened pre-term labor <37 weeks (%)	5.9	4.0	1.6	3.3
Fetal distress (%)	25.0	21.6	27.4	13.2**
Length of stay [days (range)][b]	5.5 (0–28)	11.3 (0–68)***	8.0 (0–49)*	4.3 (0–93)***
Special care [days (range)][b]	2.5 (0–28)	8.1 (0–68)	4.7 (0–49)	0.5 (0–93)**
Admitted with NAS diagnosis[b,e] (%)	7.5	51.5***	41.8***	0.2***
Admitted with IRDS diagnosis[b,e] (%)	1.5	6.6	1.6	1.4

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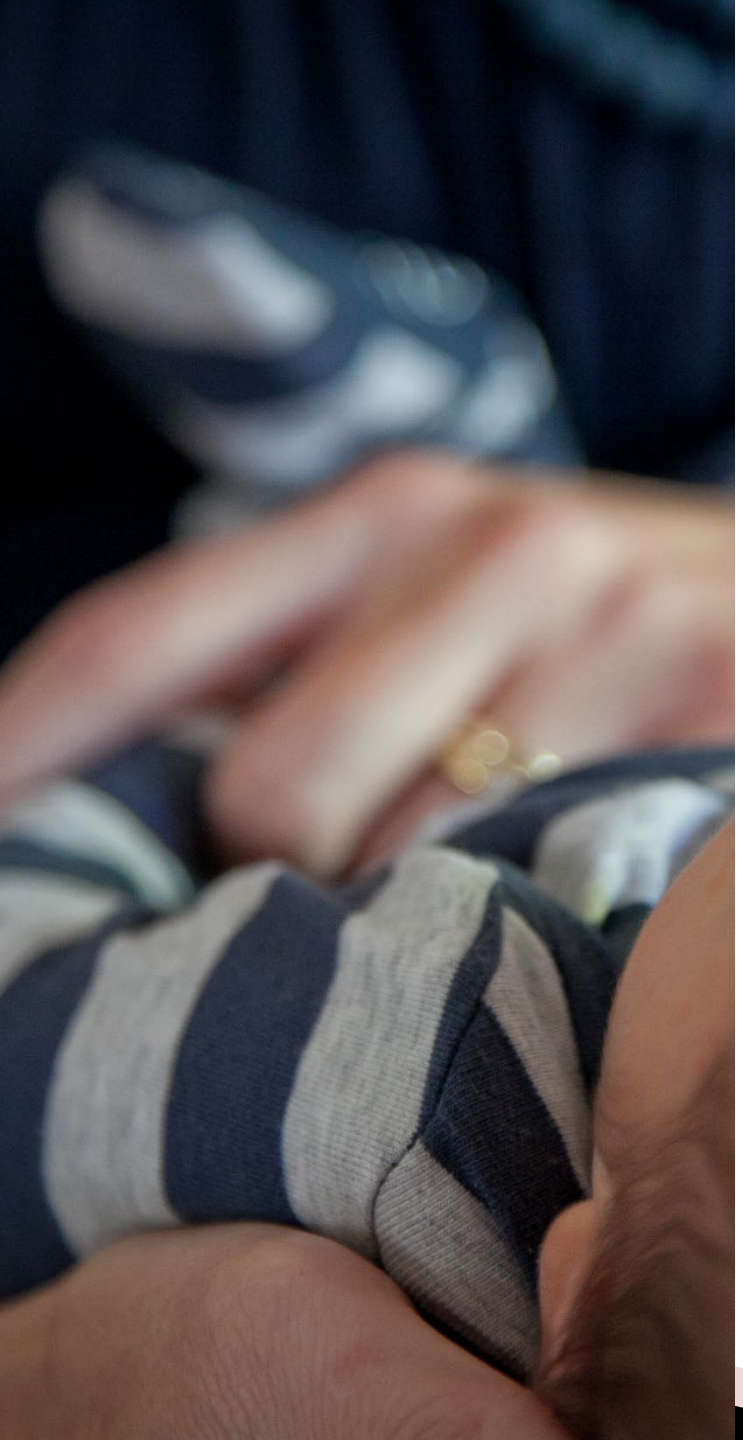
Kelty E and Hulse G. Drugs 2017 July; 77(11): 1211–1219



Breastfeeding

- ASAM recommends breast-feeding for mothers using methadone or buprenorphine
- Present in low levels in breast milk
- Breastfeeding important treatment of NAS
- Soothing effects
- Skin-to-skin contact
- Women who are interested and able to breastfeed, should be encouraged to do so

Intrapartum Management

- Awareness is key!
- Continue MAT: MAT is NOT analgesia!
- More analgesia during labor than non opioid-dependent patients
  - Giving opioids does not ”cause relapse.”
  - Withholding opioids/pain management is more likely to cause relapse
  - Buprenorphine
    - Mu receptors tightly bound
    - Higher doses may be required for adequate analgesia
- Neuraxial anesthesia is appropriate as needed
- Avoid opioid antagonists (butorphanol, nalbuphine, pentazocine) which can precipitate withdrawal
- Pediatric staff should be available

Document and Collaborate

- **Document:**
  - ✓ Diagnosis, current symptom burden, period of stability, risk of relapse
  - ✓ Non-pharmacological management/treatment options
  - ✓ Pharmacological management options: why choosing one medication over another?
  - ✓ Specific risks of psychotropic exposure to developing fetus/breastfeeding infant dependent on gestational age
  - ✓ Educational resources provided to patient
  - ✓ How you collaborated with providers (OB, MFM, methadone clinic, buprenorphine prescriber, etc.)
  - ✓ Review of PDMP

Collaborate! Discuss!
Pick up the phone and talk to other providers!

THE PERISCOPE PROJECT

PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

A free resource **for health care providers and professional** caring for perinatal women who are struggling with mental health or substance use disorders

	Real time provider to perinatal psychiatrist teleconsultations
	Education presentations and downloadable toolkit
	Information on available community resources

Provider to Provider Consultation

877-296-9049 | theperiscopeproject@mcw.edu

Monday– Friday from 8am to 4pm CST, excluding holidays

Provider is connected with a perinatal psychiatrist within 30 minutes

- E-mails returned within one business day

When to Call

- Psycho-pharmacology or substance use treatment
  - Preconception, during pregnancy, or while breastfeeding
- Diagnostic clarification, screening tools and follow up recommendations
- How to discuss mental health with pregnant & postpartum patients
- General questions on behavioral health during perinatal period

Community Resources

Access through Triage Coordinator

Types of resources

- Psychotherapy providers
- AODA treatment centers
- Peer to peer and community support groups
- Perinatal Psychiatrists

Will provide

- Resource name and description, location, and best way to establish with resource

How it Works

Triage

- Provider contacts Periscope and speaks to triage
  - Less than 5 minutes

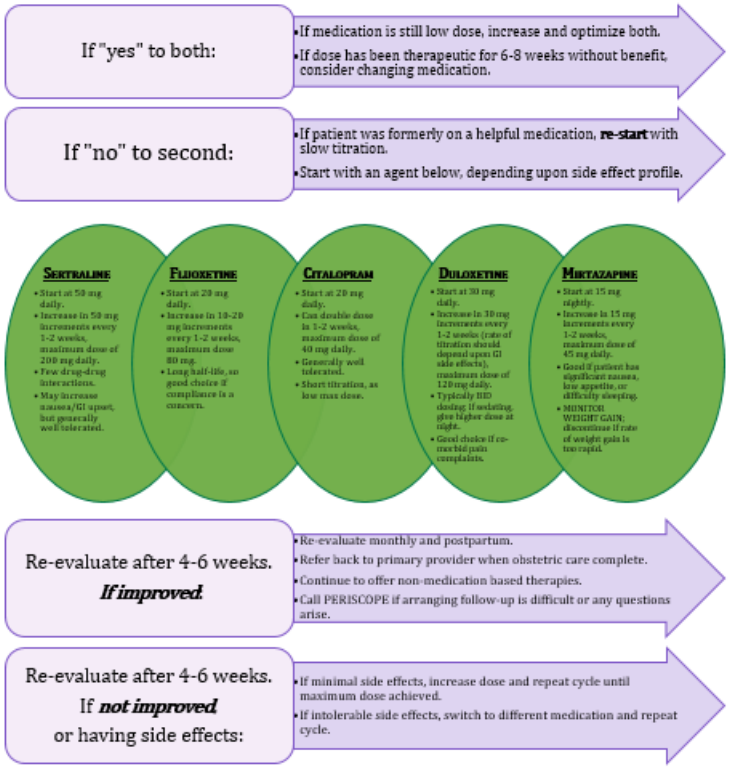
Provider to Perinatal Psychiatrist Consultation

- Perinatal psychiatrist returns providers call
  - Average return call time: **6 minutes**, mode: **2 minutes**
- Two providers have case base discussion
  - Average 8-10 minute conversation

Provider Discusses with Patient

- Provider discusses treatment options with their patient
- Typically patients remain in the care of the inquiring provider

Provider Education & Tools



Online | www.the-periscope-project.org

Provider Toolkit

- Free downloadable PDFs
- Evaluation guides, screening tools, treatment algorithms

Modules

- Ex. Antidepressant Use in Pregnancy, Perinatal Psychiatric Disorders, Psychotropic Medication Use in Breast-feeding, Screening and Follow Up, Conversation Starters

In-Person

Didactic & Grand Round presentations upon request

Conclusions

- Neonatal abstinence syndrome occurs in 50-80% of neonates with in utero exposure to opioids
- The standard of care for treatment of OUD in pregnant women is opiate substitution (methadone or buprenorphine)
- ASAM recommends breast-feeding for mothers using methadone or buprenorphine
- Utilize The Periscope Project and ACCEPT for support caring for perinatal patients struggling with SUD

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

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Thank you! Questions?

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