A New Standard of Care for Maternal Addiction Treatment

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Thursday, June 16, 2016
2:15-2:45pm ET
EVERY 25 MINUTES…

• Shrill, high pitched cry
• Irritability
• Hypertonicity
• Tremors
• Short sleep cycles
• Apnea
• Stuffy nose
• Diarrhea
• Vomiting
• Sweating
• Fever
• Sneezing
Act I: A National Epidemic
OPIOID EPIDEMIC = NAS EPIDEMIC

- $1.5 billion in healthcare expenditures
- 80% paid by Medicaid
- 5 fold increase from 2000-2012
- Up to 50% of total NICU annual hospital days
NAS PREVENTION AND “TRIPLE AIM” STRATEGIES

- Better care for individuals & families
- Reducing per capita costs
- Better health for populations
BETTER CARE FOR MATERNAL SUBSTANCE USE

- Improved opioid prescribing practices
- Screening
- Integrated care
- Coordinated treatment among all levels of care
BETTER HEALTH FOR POPULATIONS

• Improving access to effective substance abuse treatment
• Maternity medical home models
• Targeted services and outreach for high risk populations
REDUCING COSTS

• Inpatient/outpatient care coordination
• ~ $93,000 per infant charges for NAS hospitalization
• 2x more likely to be readmitted within 30 days of birth
Act II: Treatment with the Current Standard of Care
FOR OVER 40 YEARS...
QUALITY OF CARE?

Integrated care?
- No prenatal care
- No mental health treatment
- Ongoing domestic violence

Addiction Treatment?
- Continued polysubstance abuse
- Partner using drugs

Population health?
- 5 babies in 10 years of methadone maintenance, all born with NAS
# PHARMACOLOGY & BIRTH OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine</th>
<th>Methadone</th>
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<tbody>
<tr>
<td><strong>Cost</strong></td>
<td>Covered by insurance</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>Registered outpatient providers</td>
<td>Methadone clinic only</td>
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<tr>
<td><strong>Treatment</strong></td>
<td>Multiple options</td>
<td>limited</td>
</tr>
<tr>
<td><strong>Associated NAS Rates</strong></td>
<td>10%</td>
<td>90%</td>
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<tr>
<td><strong>In utero</strong></td>
<td>Reactive NST with more FHR accelerations, ↑ BPP</td>
<td>Non-reactive NST, ↓ BPP score</td>
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<td><strong>Preterm Delivery</strong></td>
<td>10%</td>
<td>30%</td>
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HOW CAN WE OPTIMIZE SUBSTANCE ABUSE TREATMENT IN PREGNANCY?
Act III: A New Standard of Care
Maternal Addiction Treatment (MAT) at Memorial Regional Hospital
A MAT “TRACER”

**ER Admission**
- Outreach
- Initial OB Work-up
- Initiate SW Involvement

**Inpatient Induction**
- Average 7 days
- Psychiatric stabilization
- Setting up outpatient resources & support

**Outpatient Stabilization**
- 14-21 days for detox
- Supportive housing
- Intensive Outpatient Program
- DBT based skills/Trauma
- Coordination with outpatient OB/GYN
TRIPLE AIM ACHIEVED THROUGH COLLABORATION

- Emergency department, inpatient & outpatient
- OB, Psychiatry, Pharmacy, Nursing, Social Work, Peer Support, Administration
- Residential treatment programs, OB clinics, child welfare, smoking cessation, Medicaid
MAT PROGRAM SUCCESS AT 1 YEAR

- Multidisciplinary clinical guidelines, order set
- Evidence based approach (COWS, DBT)
- 34 women treated
- 21 births, 16 born drug free
- 68% moms still drug-free at follow up
CHALLENGES

• Staying cost-effective
• Managing maternal & fetal comorbidity (Hep C, thyroid, cardiac)
• Developing a simple entry point for patients in a complex hospital system
• Treating polysubstance abuse
• Smoking cessation
• Staff education
• Recovery support for partners
• Widening the net to neonatal, pediatrics
RESULTS: IMPROVED HEALTH OF INDIVIDUALS & FAMILIES ACROSS THE LIFE COURSE
WHAT STRATEGIES MAY WORK FOR YOUR HOSPITAL?
QUESTIONS?

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REFERENCES


