

OPIOID USE DISORDER IN PREGNANCY

Actionable Strategies to Improve
Management & Outcomes in New York State

NOVEMBER 2017

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
I. INTRODUCTION & BACKGROUND	2
II. OPIOID ADDICTION IN PREGNANCY SUMMIT	4
A. RECOMMENDATION 1	
B. RECOMMENDATION 2	
C. RECOMMENDATION 3	
D. RECOMMENDATION 4	
III. FUTURE STEPS AND CONCLUSION	12
IV. ACKNOWLEDGEMENTS	12
V. REFERENCES	13
VI. APPENDIX A: SUMMIT PARTICIPANTS	15
VII. APPENDIX B: SPEAKER BIOS	16

EXECUTIVE SUMMARY

The opioid epidemic is increasingly becoming one of the most important and influential public health issues of the 21st century. The American Congress of Obstetricians and Gynecologists (ACOG), District II has made examining and addressing opioid use disorder in pregnant women a priority in New York State (NYS). More than 19,300 New Yorkers were admitted to the hospital for opioid abuse treatment in 2013, and from 2005-2014, admissions for heroin treatment among upstate NY residents increased by 115%.¹ As the member organization for over 4,000 women's health care providers in NYS, ACOG District II is committed to ensuring women across the state receive high quality care and support, including pregnant women struggling with opioid addiction.

ACOG District II, with support from the New York State Health Foundation (NYSHealth), has embarked on an initiative to educate women's health care providers about the comprehensive management of pregnant women with opioid use disorder. The goal of this initiative is to increase education and awareness on evidence-based guidelines for the care of pregnant women with opioid use disorder (OUD). As a byproduct of this work, ACOG District II aims to strengthen safety nets for pregnant women by working in concert with various state and local governments, including the New York State Office of Alcohol and Substance Abuse Services (OASAS), New York State Department of Health (NYSDOH), and community-based organizations, seeking clinical practice and public policy changes that increase and sustain access to addiction services.

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.

A statewide educational summit was held in Syracuse, New York to provide multidisciplinary stakeholders with an opportunity to network and learn from their colleagues and develop key recommendations and solutions to improve management of opioid use disorder in pregnancy. This white paper is a summary of the key public health, policy and clinical recommendations that our expert participants developed.

This white paper aims to provide communities with actionable strategies to effectively manage opioid use disorder in pregnancy thereby improving outcomes for women and infants throughout New York State.

SUMMARY OF KEY RECOMMENDATIONS

1. Change perceptions of opioid use disorder through the use of a common language
2. Develop and offer multifaceted education and implementation tools to better assist women's health care providers in caring for pregnant women with opioid use disorder
3. Create better engagement and communication among providers within the continuum of care and across service areas, including the justice system
4. Enhance patient and family engagement

The material outlined in this white paper is an example only and is not meant to be prescriptive. ACOG accepts no liability for the content or for the consequences of any actions taken on the basis of the information provided.

The language used in this paper is derived from the terms used in the referenced source material and in dialogue from the summit. Herein, the terms "opioid addiction," "opioid abuse," "use of opioids," and "disease" are all used when referencing "opioid use disorder."

I. INTRODUCTION & BACKGROUND

THE EFFECT OF THE OPIOID EPIDEMIC ON WOMEN

The United States opioid epidemic has been on the rise with a significant increase in overdoses and deaths in recent years, many of which are due to opioids such as oxycodone and hydrocodone that are commonly prescribed to treat chronic pain or pain following surgery or injury. In fact, every three minutes, a woman shows up at an emergency room because of prescription drug misuse or abuse.² In New York State a leading cause of pregnancy associated death is injury related to substance abuse.³

Cesarean deliveries are the most common inpatient surgery in the United States with 1.3 million procedures performed each year, according to researchers. But, there is little data on how much medicine patients actually need to manage their pain. To that end, how many pills are prescribed varies from provider to provider. The path needed to address this national crisis is complex and multifaceted. Studies conclude that more attention is needed to limit the amount of leftover drugs that could wind up in the wrong hands.⁴

From 1992-2012, the overall proportion of pregnant admissions in the US remained stable at 4%; however, admissions of pregnant women reporting prescription opioid abuse increased substantially from 2% to 28%.⁵ Furthermore, a Centers for Disease Control and Prevention (CDC) report noted that nearly 48,000 women died of prescription painkiller overdoses between 1999 and 2010 representing an increase of more than 400% since 1999 compared to a 265% increase among men.⁶

Before prescribing opioids, ob-gyns and other women's health care providers should ensure that opioids are appropriately indicated; discuss the risks and benefits of opioid use and review treatment goals; take a thorough history of substance use; and, review the [Prescription Drug Monitoring Program](#) to determine whether patients have received prior opioid prescriptions.⁷

UNIVERSAL SCREENING

Pregnancy provides an important opportunity to identify and treat women with opioid use disorder. Early universal screening, brief intervention (such as engaging the patient in short conversations, providing feedback and advice), and referral for treatment of pregnant women with opioid use disorder improves maternal and infant outcomes. Therefore, it is essential that screening be universal and part of comprehensive obstetric care and completed at the first prenatal visit in partnership with the pregnant woman. Routine screening should rely on validated screening tools such as questionnaires like 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).⁸

TREATMENT OPTIONS DURING PREGNANCY

Treating pregnant women poses unique challenges for health care providers, many of whom may not have substantial knowledge or experience with providing care to pregnant women using opioids. Treatment must be gender-specific, multidisciplinary, and comprehensive in nature and continued through the continuum of care, ideally from preconception to the postpartum period, including the formative childhood development stage. Regardless of experience, knowledge, or personal belief, ob-gyns have an ethical responsibility to treat patients with addiction with dignity and respect.⁹ It is important for physicians to understand that pregnant women with opioid addiction are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, and/or exhibit signs of withdrawal or intoxication.¹⁰ Once a woman is identified with opioid use disorder, the patient and physician should work together to find the best possible treatment course.

For pregnant women with opioid use disorder, ACOG recommends opioid pharmacotherapy which is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates and can lead to worse outcomes. More research is needed to determine the safety, efficacy, and long-term outcomes of medically supervised withdrawal.¹¹

I. INTRODUCTION & BACKGROUND

Medication-assisted treatment (MAT) with methadone or buprenorphine is recommended to prevent complications from continued opioid use and narcotic withdrawal; to encourage prenatal care and drug treatment; to reduce criminal activity; and, to avoid risks to the patient of associating with a drug culture.¹² This treatment is believed to have little long-term postnatal developmental impact compared to the impact associated with illicit drug use.¹³

Neonatal Abstinence Syndrome (NAS) is an expected and treatable condition that can occur after prenatal exposure to opioids, including MAT, and characterized by hyperactivity of the central and autonomic nervous systems.¹⁴ It is important to realize that different populations of women can give birth to an infant with NAS: women with chronic pain maintained on medication; women who misuse prescribed medications; women in recovery from opioid addiction and maintained on methadone or buprenorphine (ie, MAT); women who are actively abusing or dependent on heroin, and women who misuse non-prescribed medication.¹⁵ Treatment options vary, but may include an extended hospital stay.

Methadone has long been the standard of care for MAT during pregnancy but buprenorphine is also considered an effective treatment option. While mothers treated with buprenorphine have been shown to drop out of treatment more frequently, their infants had shorter hospital stays and treatment times for NAS.¹⁶ Furthermore, combining MAT and prenatal care reduces the risk of obstetric complications and leads to better outcomes for the mother and her fetus. A multidisciplinary approach to care is integral for optimal health outcomes.¹⁷

It is important to note that breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.¹⁸

PROVIDER KNOWLEDGE AND TRAINING

ACOG District II's opioid task force, consisting of medical experts from various specialties, created a knowledge, attitude, and practice survey that was disseminated to ob-gyns across New York State. In analyzing the data, preliminary results gathered are as follows:

- 62% of respondents felt there was not adequate training and resources in their area/region to appropriately manage opioid addicted pregnant and postpartum women
- 91% of respondents were not trained to prescribe buprenorphine and the majority of those not trained had no plans to become trained in the next several months
- Respondents had limited comfort level with managing/treating pregnant women with addiction and withdrawal
- There was a lack of awareness regarding current state regulatory requirements when receiving a positive drug test

The data highlights the need for ACOG District II and other partners to offer additional education and resources to the provider community to compassionately care for pregnant women with opioid use disorder.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

OVERVIEW

ACOG District II's Opioid Addiction in Pregnancy Summit on April 27, 2017 brought together a multidisciplinary group of health care providers to identify challenges and propose solutions to support women and families struggling with addiction during pregnancy.

The panel discussion opened with a keynote from Lieutenant Governor Kathy Hochul who highlighted the opioid epidemic in New York and emphasized the new resources the state has committed to the opioid crisis. The medical director of OASAS, Dr. Charles Morgan, shared key resources, including the OASAS Treatment Availability Dashboard, where providers can search for a listing of available treatment beds at OASAS-certified substance use disorder treatment facilities, including facility location and contact information. A multidisciplinary panel of experts then presented in a "rapid fire" opening session about management approaches and treatment practices for women using opioids and identified key challenges for the summit participants to discuss. Each of the panelists care for women at various stages of pregnancy and interact with pregnant women using opioids. The presentations provided attendees with the perspective necessary to facilitate a rigorous discussion of key management challenges.

Following the presentations, multidisciplinary groups were formed to address key challenges using a framework of questions provided to them. The charge of each group was to propose solutions to an assigned challenge. See *Appendix A* for a full list of participants and *Appendix B* for speaker bios.

KEY RECOMMENDATIONS AND ACTIONABLE STRATEGIES

Following the discussion of challenges, each team proposed solutions to address the barriers and issues relative to the management of opioid use disorder in pregnancy. With several of the proposed solutions being applicable across multiple challenges, it became apparent that the proposed solutions could be analyzed through the lens of four key recommendations, each with its own actionable strategies. Using the work performed by summit participants, the key recommendations and actionable strategies are summarized hereafter. Actionable strategies are identified in two main categories:

- 1) Health Care Provider Strategies** — tailored towards key health care stakeholders such as ACOG, hospital leadership, women's health care providers, clinicians and obstetric teams. Health care providers and hospital systems may need to conduct internal assessments to determine how to tailor the recommendations to meet their own communities' needs.
- 2) Public Health and Policy Strategies** — geared towards public health organizations, including NYSDOH, OASAS, county health departments, and patient advocacy groups. Stakeholders can discuss improvement opportunities to coordinate and implement each strategy to achieve the proposed recommendations.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 1: CHANGE PERCEPTIONS OF OPIOID USE DISORDER THROUGH THE USE OF A COMMON LANGUAGE

The stigma associated with opioid use disorder, and substance use in general, stems from significant biases apparent within the health care system. Stigma can isolate patients and can discourage them from seeking necessary care to treat their substance use disorder.¹⁹ Using supportive and compassionate language is one way to effectively promote empathy, dignity and respect throughout the health care system.

HEALTH CARE PROVIDER STRATEGIES

- Implement universal screening as part of comprehensive obstetric care and performed at the first prenatal visit.
 - Routine screening should rely on validated screening tools such as questionnaires like 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).²⁰
- Strive to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients. For example, replace “drug abuser” with “person with a substance use disorder” and “in recovery” rather than being “clean.”²¹
- Develop tools to educate multidisciplinary teams of providers on the use of non-judgmental and harm-reduction focused language and learn how to acknowledge and change implicit biases of providers. Engage all staff in training, including clinical, administrative, and all other office personnel.

DISCUSSION TAKEAWAY

Given the severity of the epidemic, it is time to address the barrier of stigmatization, both of patients and health care providers who manage them.

Tools are needed to educate providers on the use of harm reduction language.

PUBLIC HEALTH AND POLICY STRATEGIES

- Reframe opioid use disorder as a chronic disease rather than an inherent personal flaw. Develop a community-based strategy through media campaigns, public service announcements, and community outreach to shift how the public perceives addiction.
- Develop educational materials/videos for patients suffering from addiction that promote self-worth and integrity that can be used in provider offices.
- Recognize buprenorphine prescribers with a specific credential (eg, gold star) who are admired and respected by colleagues, insurers, and the public to reduce stigma for those who treat this vulnerable population.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 2: DEVELOP AND OFFER MULTI-FACETED EDUCATION AND IMPLEMENTATION TOOLS TO BETTER ASSIST WOMEN'S HEALTH CARE PROVIDERS IN CARING FOR PREGNANT WOMEN WITH SUBSTANCE USE DISORDER

Obstetric care providers have a unique opportunity to make a substantive impact on the lives of opioid dependent women and their infants by providing a medical home for patients during pregnancy, facilitating care coordination among providers, and delivering comprehensive prenatal and postpartum care.²²

While there has been an increase in programs available (eg, [American Society of Addiction Medicine \(ASAM\)](#)/[ACOG](#), [Providers' Clinical Support System](#), or [NYSDOH AIDS Institute Office of Drug User Health](#)) to train obstetric care providers on prescribing and dispensing buprenorphine, even once trained, there are still many barriers. Barriers include lack of clinical mentorship programs, lack of knowledge of reimbursement policies, and concerns on how to incorporate the management and treatment of this vulnerable patient population into their current office flow. Moreover, lack of accessible training and tools for providers on effective management of women with opioid use disorder in pregnancy has limited providers willingness to treat this population.

DISCUSSION TAKEAWAY

There are significant obstacles for providers in identifying, treating, and managing opioid use disorder in pregnant patients.

Providers need more accessible education, implementation tools, and mentorship to be successful.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 2

HEALTH CARE PROVIDER STRATEGIES

Buprenorphine Training:

- Designate clinical support mentors for providers following completion of buprenorphine training. Mentors can assist newly trained prescribers and those in training with clinical questions, billing/coding, and other guidance. Mentors can also provide periodic follow-up to trainees to address barriers and challenges.
- Offer on-site implementation training to providers who complete a buprenorphine training course to provide “real life” guidance on incorporating this education into their current patient workflow.

Education on Opioid Use Disorder Management:

- Create “Opioid Use Disorder Management” educational materials or a toolkit to increase provider knowledge base on the science of addiction, specific treatment options, and management of acute withdrawal (eg, [COWS scale](#)).
- Educate providers on how to incorporate standard screening tools into practice utilizing ACOG’s and ASAM recommendations on screening and intervention (eg, [Screening Brief Interventions and Referral to Treatment-SBIRT](#)).
- Create a continuing medical education (CME) course for practicing providers on the management of opioid use disorder in pregnancy as an additional option for the [New York State mandatory prescriber training](#) program.
- Enhance medical school and residency training program curricula on opioid management and treatment during pregnancy (eg, [SAMHSA Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders](#)).
- Develop grand rounds curriculum to enhance awareness.

Opioid Prescribing:

- Educate providers on strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacological (eg, exercise, physical therapy, behavioral approaches), and non-opioid pharmacologic treatments.

PUBLIC HEALTH AND POLICY STRATEGIES

- Create a statewide hotline (similar to New York State HIV/AIDS Hotlines) for providers who need assistance in administering buprenorphine medication (eg, broad dosage guidance, billing, etc.). Providers can also use this hotline for connecting with a mentor or sign up to become one themselves.
- Develop an online repository of educational materials, videos, and webinars in collaboration with OASAS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and ASAM that is tailored toward NYS providers.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 3: CREATE BETTER ENGAGEMENT AND COMMUNICATION AMONG PROVIDERS WITHIN THE CONTINUUM OF CARE AND ACROSS SERVICE AREAS, INCLUDING THE JUSTICE SYSTEM

The management and treatment of substance use disorder in pregnancy is a challenging and complex process that requires involvement and investment from a multidisciplinary team of health care providers. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families suffering from opioid use disorder.²³

One of the critical components of effective care across the continuum is ensuring that providers are aware of the various resources available to women and families facing addiction (eg, [AMCHP WHEN Program](#), [Safe Babies Court Teams: Zero to Three](#), [NYS OASAS Treatment Services](#)).

Furthermore, special attention should be focused on care for opioid addicted pregnant women with experience in the justice system. Care is inconsistent and women may face significant barriers in accessing the needed services that are most beneficial to their health — before, during, and after being incarcerated. With 70% of women in state prisons being substance users prior to incarceration, more focused attention on their health care needs is essential.²⁴

DISCUSSION TAKEAWAY

Patients and providers are often unaware of what community and regional resources are available.

Case management services are not abundant, and case managers can be challenged by working with jails that have their own policies and procedures — some of which may be contraindicated for pregnant women with SUD.

Communities are encouraged to create local task forces across service areas to break down barriers specific to their region and ensure all women receive the appropriate care.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 3

HEALTH CARE PROVIDER STRATEGIES

- Identify provider champions who can promote education and encourage other providers and systems to become engaged.
- Identify a facilitator to train new staff, determine gaps in services, and bring teams together through hospital-based quality improvement programs (eg, The joint project between ACOG District II and New York State Perinatal Quality Collaborative (NYSPQC), [SAMHSA Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders](#)).
- Develop patient-specific care plans to enhance communication among treating providers that detail prenatal, labor and delivery, postpartum and newborn care as well as a plan of safe care after hospital discharge.
 - Representatives from all care disciplines who interact with the patient should be engaged in development of the plan, including obstetrics, pediatrics, neonatology, patient advocates, behavioral health, social worker/case managers, anesthesiology, and addiction specialists.
 - Identify a case manager to oversee transition of the patient.
 - Hold regular meetings to review cases and coordinate care management.
- Educate emergency medicine physicians about the unique care plans for opioid use disorder in pregnant women and create protocols/processes for caring for this population when presenting to the emergency department (ie, care management/coordination through the development of algorithms/visual aids).
- Educate all providers of the importance of universal screening and be aware of the resources available (eg, [NYS OASAS Treatment Services](#)).

PUBLIC HEALTH AND POLICY STRATEGIES

- Create a task force or coalition locally, convened by a hospital or local health department, to facilitate understanding of barriers and challenges and enhance communication and collaboration.
 - Hold roundtable discussions regularly
 - Utilizing Regional Health Information Organizations (RHIOs), and in compliance with applicable laws,* require certain elements of the patient's health record, including social and psychological information, to be transferred from one service area to another.
- Educate local jails and help ensure that their policies facilitate access to medication-assisted treatment for pregnant women with opioid use disorder.
- Contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment among women of reproductive age to mitigate the risk of unplanned pregnancy.²⁵
 - Ensure women have access to contraception in jails to avoid unintended pregnancy.
- Alleviate limitations of current Electronic Health Record (EHR) technology posing barriers to adequate universal screening for substance abuse.

* The [substance abuse confidentiality regulations for Health Information Exchanges \(HIEs\)](#) may be perceived as a barrier to the electronic exchange of health information. However, it is possible to electronically exchange drug and alcohol treatment information while also meeting the requirements of Part 2 of the consent requirement.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 4: ENHANCE PATIENT AND FAMILY ENGAGEMENT

Women's health care providers have a responsibility to provide patient-centered compassionate care, educate others regarding the chronic disease of addiction and its effect on pregnancy, and promote social and legal change that enhances autonomy and clinical outcomes for both the mother and her child.²⁶

Engaging couples or family members early in treatment and recovery can help address questions and concerns, alter interactions within the family and improve communication. Treatment can be provided with the individual family member or in multiple family groups, both of which provide a supportive environment to share common experiences and concerns.²⁷

DISCUSSION TAKEAWAY

Including the patient and her family when developing a care plan is vital.

Finding ways to create healthy patient-provider connections can be achieved through a patient and family engagement bundle.

II. OPIOID ADDICTION IN PREGNANCY SUMMIT

RECOMMENDATION 4

HEALTH CARE PROVIDER STRATEGIES

- Engage the patient and her family early on in the process and care plan.
- Allow a woman to describe her family dynamic and define who she would like to engage in the process.
- Create a patient and family engagement bundle for providers to assist in engaging the patient and managing their expectations such as:
 - Am I hurting my baby
 - Is MAT safe for my baby
 - What is the role of child protective services (CPS) and what requires a notification to CPS
 - Will my baby be taken away
 - What is NAS and its long-term effects
 - What will treatment look like
- Utilize motivational interviewing techniques and communicate positive stories of people with substance use disorders to engage the patient in her care (eg, [Enhancing Motivation For Change in Substance Abuse Treatment](#)).
- Provide written information for the patient and her family that addresses her key concerns.
- Hold a specific prenatal consultation visit to educate the patient and her family on the care of the baby following delivery, including discussion of:
 - What will happen to baby in the NICU
 - Can I breastfeed my baby
 - The NAS scoring system tool
 - Child protective services role

PUBLIC HEALTH AND POLICY STRATEGIES

- Develop provider education on the current Child Abuse Prevention and Treatment Act (CAPTA) requirements and the changes in the Comprehensive Addiction and Recovery Act (CARA) legislation related to the full continuum of care from primary prevention to recovery support, including significant changes to expand access to addiction treatment services and overdose reversal medications.
- Create opportunities for support resources such as peer mentors, family navigator programs, and group therapy centering programs. For example, a few hospitals have implemented [CenteringPregnancy®](#) programs specific to opioid use disorder. Peer navigator programs such as the [OASAS Certified Recovery Peer Advocates \(CRPA\)](#) also exist. This program is for those individuals who hold an OASAS-approved certification as a peer advocate. The [Center for Court Innovation Patient Navigator](#) program (a Women's Health Education Navigation (WHEN) network partner) is another similar program. These programs work with patients one-on-one to identify health care and social service needs, and link clients to other organizations and services.

III. FUTURE STEPS AND CONCLUSION

The summit identified practice gaps and generated a set of recommendations that revealed where actionable strategies can be applied. As a result, ACOG District II has identified top priority areas to maximize adoption and uptake of best practices for the management and treatment of opioid use disorder in pregnancy.

As mentioned in the key recommendations, it is important for all health care stakeholders to be included when developing and disseminating educational materials. Utilizing a multidisciplinary expert task force, ACOG District II's opioid initiative will proceed with the creation of an educational toolkit for providers based on the ACOG National bundle on obstetric care for women with opioid use disorder. The toolkit will emphasize management of opioid use disorder in pregnancy, universal screening, treatment options, and coding and billing guidance.

ACOG District II is excited about pursuing our partnership with the NYSDOH New York State Perinatal Quality Collaborative (NYSPQC) to align efforts to participate in the Alliance for Innovation on Maternal Health (AIM) collaborative on maternal opioid use disorder. NYS will be one of several AIM states committed to improving maternal health outcomes in the United States. ACOG District II and the NYSPQC will select hospitals to pilot the collaborative's interventions before rolling them out statewide.

Future programs should also incorporate the critical role contraceptives play, especially information on long-acting reversible contraception (LARC), as the ability for a woman to plan when to become pregnant significantly benefits her health as well as the health of her future children.

Pregnant women with opioid use disorder require careful attention and optimal care from a multidisciplinary team of providers knowledgeable about the unique circumstances of pregnancy and addiction. The challenges and strategies outlined in this white paper only scratch the surface of the problem and require the commitment of health care providers, public health professionals, policymakers, the public, and patients to advocate on behalf of women battling opioid use disorder in pregnancy in NYS. As the educational and scientific resource on women's health care, ACOG District II encourages organizations and policy makers to utilize ACOG as a resource and to partner and work together to effectively support women and families.

IV. ACKNOWLEDGEMENTS

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VI. APPENDIX A: LIST OF SUMMIT PARTICIPANTS

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VII. APPENDIX B: SPEAKER BIOS

Lieutenant Governor Kathy Hochul, as the highest ranking female elected official in New York State and a former Congresswoman, has been, and continues to be, a fierce advocate for women and families across the state. In addition to serving as the President of the New York State Senate, Lt. Gov. Hochul serves as the Chair of the New York State Heroin and Opioid Abuse Task Force. As chair, she has convened several outreach sessions across New York State to hear from experts and community members in search of answers to the heroin crisis and to develop a comprehensive strategy for New York. Lt. Gov. Kathy Hochul also chairs the Regional Economic Development Councils and New York State's Women's Suffrage 100th Anniversary Commemoration Commission, and Co-Chairs the Community College Councils. The Lt. Gov. has traveled the state many times over to meet with elected officials, business leaders, and residents alike to discuss issues that are important to her, the Governor, and the people of New York.

Charles W. Morgan, MD, DFASAM, FAAFP, DABAM serves as Medical Director of the New York State Office of Alcoholism and Substance Abuse Services. Dr. Morgan is a Distinguished Fellow of the American Society of Addiction Medicine and also of the American Academy of Family Physicians, and has worked in the field of Addiction Medicine for over three decades. He did his graduate work in Human Genetics at Cornell University, and his residency work in Internal Medicine in Rochester, NY, and Anesthesiology at the University of Pennsylvania. Following that he completed fellowships in both Regional and Obstetric Anesthesia at the University of Pennsylvania and in Addiction Medicine at Willingway Hospital in Statesboro, Georgia. Dr. Morgan has lectured extensively and served on expert panels and committees on local, regional and national levels. He has taught residents, fellows, physicians, nurse practitioners, physicians' assistants, counselors and other professionals throughout his career from across the country and other parts of the world, and has been recognized by the American Academy of Family Physicians for his teaching. Dr. Morgan's expertise includes all levels of care including outpatient treatment, inpatient rehabilitation and

detoxification, and extended care, as well as all modalities of treatment including medication supported recovery and recovery without using medications. Dr. Morgan has published various written materials on addiction and anesthesiology and serves as a reviewer for the Journal of Groups in Addiction and Recovery.

Leah Kaufman, MD, FACOG is the Residency Program Director and Vice Chair of the Department of Obstetrics and Gynecology at the SUNY Upstate Medical University in Syracuse, NY. She attended medical school in Syracuse before completing residency at the Long Island Jewish Medical Center where she was previously the Residency Program Director. When that program merged to form the Hofstra School of Medicine Program, she served as program director before returning to Syracuse. Dr. Kaufman has a long history of service to ACOG, serving on many district and national committees including the Committee on Scientific Program, the CREOG Education Committee of which she is Vice Chair, and the District II Advisory Council where she recently served as legislative chair and currently serves on the Executive Committee as secretary. In her role as legislative chair and clinically as a general ob-gyn, Dr. Kaufman has advocated for increased access and education surrounding the care and resources for women and children affected by the opioid addiction crisis.

David Garry, DO, FACOG is currently the Maternal Fetal Medicine Division Director at Stony Brook Medicine for the Department of Obstetrics, Gynecology and Reproductive Medicine. Dr. Garry works with ACOG as an FASD Champion in the effort to reduce alcohol exposed pregnancies. He has served as an ACOG advisor for "Women and Alcohol" through media interviews and blogs. In District II, Dr. Garry helped produce, "Think-Don't Drink," an FASD handbook for providers. Over the past year, Dr. Garry has set up and established a Maternal Opioid Management program at Stony Brook for the care of women with opioid addiction during pregnancy. He also works with local organizations in Suffolk County to manage pregnant and postpartum women to improve outcomes of pregnancy.

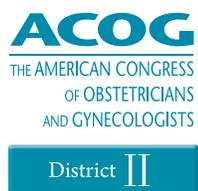
VII. APPENDIX B: SPEAKER BIOS

Michelle Bode, MD, MPH is the Medical Director of Clinical Informatics at Crouse Hospital in Syracuse, NY. Dr. Bode is also an attending neonatologist with the Neonatal Associates of Central New York. Certified by the American Board of Pediatrics in both Pediatrics and Neonatal-Perinatal Medicine, Dr. Bode is a leading expert on Neonatal Abstinence Syndrome. As such, Dr. Bode has given several presentations and speeches on the topic of NAS and other neonatal issues.

Paul Updike, MD is Medical Director of the Chemical Dependency Program and the St. Vincent's Health Clinic at Sisters Hospital in Buffalo, NY. Board certified in Internal Medicine, Dr. Updike is also certified in Addiction Medicine and Pain Management. Through his work as Medical Director, Dr. Updike provides medical supervision for the Pathways Methadone Maintenance Program, has developed and directed team standards for monitoring patient treatment plans, and instituted Suboxone treatment which dramatically increased their capacity to treat opiate dependency. He is a frequent lecturer in the Western New York area on the topics of pain treatment and addiction medicine. Dr. Updike has also been involved in various initiatives to improve pain management skills of primary care physicians, increase access to treatment for opiate use disorder, and provide mentoring and education to primary care physicians on pain management and addiction.

Sarah Reckess, Esq. is the Director of the Center for Court Innovation's Syracuse office. Sarah oversees the development and implementation of problem-solving justice initiatives in Syracuse and Upstate New York. She oversees the Patient Navigator Programs in Syracuse and Buffalo, NY that provide one-on-one case management services to court-involved women who are pregnant or parenting an infant. She has planned and implemented a number of court-based programs that reduce recidivism, empower communities, and support justice system reform, including a juvenile diversion court for 16-17yos charged as adults, an employment services program for noncustodial parents who cannot pay their child support payments, an ESL court program for drug court participants, and a neighborhood-based restorative justice program that diverts cases from the Onondaga County justice system. She is a SAMHSA-certified Trauma-Informed Care Trainer and is also a facilitator for Community-Police Dialogues in the city of Syracuse in collaboration with the Syracuse Police Department. Sarah holds a J.D. with a concentration in Family Law and Social Policy from Syracuse University College of Law.

Kim Hober, MSSW, LMSW is a Senior Social Worker at the University of Rochester Medical Center where she provides assessment and treatment for obstetrical and gynecological patients. As a social worker, she collaborates with other teams, providers, and agencies to ensure patients receive proper treatment and often provides crisis intervention, treatment planning, and case management for ob-gyn and pediatric patients. Throughout her career in social work, Ms. Hober has worked with pediatric and obstetric patients in various capacities, including with high-risk patients struggling with addiction and newborns in the NICU. She has also provided education to pediatric and ob-gyn fellows, residents, and nurses regarding psychological issues in pregnancy and medically complex newborns.



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