Missouri State Medical Association
House of Delegates

Resolution # 23
(A-24)

Introduced by: Vikita Patel, Alexis Pheng, Nu Ellie Bui, Feng Ming Li, Reeya Patel, Kansas City University College of Osteopathic Medicine

Subject: Opioid Use Disorders During Pregnancy

Referred to:

WHEREAS, the opioid use disorder (OUD) epidemic is an increasing burden in the United States and has been declared a public health emergency[1,2]; and,

WHEREAS, opioid agonist pharmacotherapy is the standard of care treatment for pregnant individuals with OUD, surpassing medically supervised withdrawal (i.e., detoxification) in efficacy and risk reduction[3]; and,

WHEREAS, the American College of Obstetricians and Gynecologists (ACOG), Substance Abuse and Mental Health Services Association (SAMHSA), and World Health Organization (WHO) underscores the effectiveness and safety of agonists such as methadone and buprenorphine in managing OUD during pregnancy rather than detoxification, with proven benefits for maternal and fetal health[1,3,4]; and,

WHEREAS, the use of opioid maintenance therapy improves adherence to standard prenatal care and is shown to decrease the risk of preterm birth, low birth weight, and NICU admissions[5,6]; and,

WHEREAS, our AMA has a policy supporting brief interventions and early comprehensive treatment for pregnant individuals with OUD, and supports legislation and efforts for expansion and improved access to evidence-based treatment for substance use disorders during pregnancy[7]; and,

WHEREAS, our AMA has a policy encouraging the crucial support for establishing and increasing availability of specialized treatment programs for drug-addicted pregnant and breastfeeding women whenever possible, specifically with the provision of physician-led, evidence-based care that offers supportive services for rehabilitation[8]; and,

WHEREAS, despite the clear benefits of medication-assisted treatment, significant barriers such as stigma, lack of education, mistrust of physicians, and legal constraints hinder access for pregnant individuals, particularly in rural and medically underserved areas[9]; and,

WHEREAS, women who use substances that *do* receive prenatal care experience more positive birth outcomes and have greater opportunities for other health promoting interventions than women who do not receive care[10]; and,

WHEREAS, despite the recent elimination of the X waiver requirement to prescribe buprenorphine, increasing buprenorphine knowledge among providers is vital for encouraging patients to seek treatment and decreasing stigma surrounding OUD[11]; and,

WHEREAS, provider inexperience is a barrier to treatment, as less than half of the already few buprenorphine providers are willing to prescribe treatment due to the general lack of knowledge in utilizing opioid agonist treatment in pregnant patients[12]; and,

WHEREAS, our AMA has policies encouraging physicians to increase their knowledge on the effects of substance use during pregnancy and breastfeeding through continued medical education opportunities and routine inquiry about substance use in the course of providing prenatal care[8,13]; and,

WHEREAS, research has shown that clinics in Missouri with opioid treatment programs are predominantly located in urban areas[14]; and,

WHEREAS, states with more rural populations and medically underserved areas dispensed the most opioids per person in the last 10 years, but did not provide as much access to rehabilitation[11]; and,

WHEREAS, high risk rural populations such as American Indians experience significant barriers to accessing care for OUD during pregnancy[15]; therefore, be it,

RESOLVED, that our MSMA supports the expansion of access to evidence-based treatments, particularly buprenorphine, for pregnant individuals with opioid use disorder, with a specific focus on underserved areas and high risk populations; and, be it further,

RESOLVED, that our MSMA advocates for improved medical education on the knowledge and management of opioid use disorders during pregnancy and the perinatal period aimed at reducing stigma and misinformation among healthcare professionals, ensuring compassionate and effective care; and, be it further,

RESOLVED, that our MSMA advocates for equitable access to comprehensive prenatal care and addiction treatment services for pregnant individuals with opioid use disorder.

Fiscal Note: **None**

Current Policy:

References:

1. American College of Obstetricians and Gynecologists. Opioid Use and Opioid Use Disorder in Pregnancy. Acog.org. Published August 2017. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
2. Becerra X. Renewal of Determination that a Public Health Emergency Exists as a Result of the Continued Consequences of the Opioid Crisis. aspr.hhs.gov. https://aspr.hhs.gov/legal/PHE/Pages/Opioid-22Dec2022.aspx
3. Amatetti S, Stedt E, Young NK, et al. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016
4. World Health Organisation. Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy. www.who.int. Published 2014. https://www.who.int/publications/i/item/9789241548731
5. Ly V, Persad MD, Herrera K, Garry D, Garretto D. Does Opioid Maintenance Therapy Decrease the Risk of Neonatal Withdrawal in Mothers with Opioid Use Disorder? [28N]. *Obstetrics & Gynecology*. 2018;131 Suppl 1:159S. doi:10.1097/01.AOG.0000533124.64418.cf
6. Roberts T, Frederiksen B, Saunders H, Salganicoff A. Opioid Use Disorder and Treatment Among Pregnant and Postpartum Medicaid Enrollees. KFF. Accessed March 14, 2024. https://www.kff.org/medicaid/issue-brief/opioid-use-disorder-and-treatment-among-pregnant-and-postpartum-medicaid-enrollees/

7. Policy Finder. AMA. Substance Use Disorders During Pregnancy H-420.950. policysearch.ama-assn.org. Published 2023. https://policysearch.ama-assn.org/policyfinder/detail/pregnancy?uri=%2FAMADoc%2FHOD.xml-H-420.950.xml
8. Policy Finder. AMA. Perinatal Addiction - Issues in Care and Prevention H-420.962. policysearch.ama-assn.org. Published 2019. https://policysearch.ama-assn.org/policyfinder/detail/substance%20use%20and%20pregnancy?uri=%2FAMADoc%2FHOD.xml-0-3705.xml
9. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder, Mancher M, Leshner AI, eds. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); March 30, 2019.
10. Stone R. Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care. *Health & Justice*. 2015;3(1). doi:https://doi.org/10.1186/s40352-015-0015-5
11. Nahian A, Shepherd JG. Analysis of Opioid Poisoning in Medically Underserved Rural Areas: An Evaluation of International Statistical Classification of Diseases Codes from the State of South Dakota. *J Addict Res Ther.* 2022;13(11):496.
12. Connolly B, Paulson L. Missouri Initiative Combines Treatment for Opioid Use Disorder and Prenatal Care. pew.org. Published July 12, 2021. Accessed March 14, 2024. https://www.pewtrusts.org/en/research-and-analysis/articles/2021/07/12/missouri-initiative-combines-treatment-for-opioid-use-disorder-and-prenatal-care
13. Policy Finder. AMA. Infant Victims of Substance Abuse H-420.971. policysearch.ama-assn.org. Published 2019. Accessed March 14, 2024. https://policysearch.ama-assn.org/policyfinder/detail/pregnancy%20substance%20use?uri=%2FAMADoc%2FHOD.xml-0-3714.xml
14. Bedrick BS, O'Donnell C, Marx CM, et al. Barriers to Accessing Opioid Agonist Therapy in Pregnancy. *Am J Obstet Gynecol MFM.* 2020;2(4):100225. doi:10.1016/j.ajogmf.2020.100225
15. Kelley AT, Smid MC, Baylis JD, et al. Treatment Access for Opioid Use Disorder in Pregnancy Among Rural and American Indian Communities. *J Subst Abuse Treat*. 2022;136:108685. doi:10.1016/j.jsat.2021.108685

RELEVANT AMA POLICY

H-420.950 Substance Use Disorders During Pregnancy
Our AMA will:
(1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;
(2) oppose any efforts to imply that a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse;
(3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;
(4) oppose the filing of a child protective services report or the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation;
(5) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected; and
(6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, or diagnosis of a substance use disorder.
[Res. 209, A-18; Modified: Res. 520, A-19; Modified: Res. 505, A-23]

H-420.962 Perinatal Addiction - Issues in Care and Prevention
Our AMA:
(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug

and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
[CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

H-420.971 Infant Victims of Substance Abuse
It is the policy of the AMA:
(1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders on children.
[Res. 101, A-90; Reaffirmation A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]