Current Commentary

The Comprehensive Addiction and Recovery Act

Opioid Use Disorder and Midwifery Practice

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The federal response to the opioid use disorder crisis has included a mobilization of resources to encourage office-based pharmacotherapy with buprenorphine, an effort culminating in the 2016 Comprehensive Addiction and Recovery Act, signed into law as Public Law 114-198. The Comprehensive Addiction and Recovery Act was designed to increase access to treatment with special emphasis on services for pregnant women and follow-up for infants affected by prenatal substance exposure. In this effort, the Comprehensive Addiction and Recovery Act laudably expands eligibility for obtaining a waiver to prescribe buprenorphine to nurse practitioners and physician assistants. However, certified nurse–midwives and certified midwives, who care for a significant proportion of pregnant and postpartum women and attend a significant proportion of births in the United States, were not included in the Comprehensive Addiction and Recovery Act legislation. In this commentary, we argue that an "all-hands" approach to providing office-based medication-assisted treatment for opioid use disorder is essential to improving access to treatment. Introduced in the House of Representatives in September 2017, the Addiction Treatment Access Improvement Act (H.R. 3692) would allow midwives to apply for the federal waiver to prescribe buprenorphine and is supported by the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives. We support this change and encourage the U.S. Congress to act quickly to allow midwives to prescribe medication-assisted treatment for pregnant women with opioid use disorder.

(Obstet Gynecol 2018;131:542–4)
DOI: 10.1097/AOG.0000000000002493

The current opioid crisis has had an unprecedented effect on patients, communities, and the U.S. health care system, demanding a systematic and coordinated response. The crisis has had a particular effect on women of childbearing age. Prescription opioid overdose deaths, which have risen steadily in the United States over the past decade and a half, have increased more among women than among men: 400% vs 237% between 1999 and 2010.[1] Heroin use among women increased 100% between 2002 and 2013, a rate of increase roughly twice that of men.[2] Disturbingly, the vast majority of emergency department visits related to prescription opioid use by women occur for women of childbearing age between 25 and 44 years old.[3] Among admissions for pregnant women into substance use disorder treatment nationally, almost one fourth are for prescription opioid use and an additional one fourth are for heroin.[2] The rise in opioid use disorders in pregnant women is also reflected in increasing numbers of opioid-exposed newborns. National estimates for the prevalence of neonatal abstinence syndrome resulting from withdrawal from in utero opioid exposure have risen from 7 cases per 1,000 neonatal admissions to more than 30

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This article was written while Dr. Murphy was employed at the Patient-Centered Outcomes Research Institute (PCORI). The opinions presented in this article are solely the responsibility of the authors and do not necessarily represent the views of PCORI, its Board of Governors or Methodology Committee, nor of any of the other institutions referenced.

Each author has indicated that she has met the journal's requirements for authorship.

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Financial Disclosure
The authors did not report any potential conflicts of interest.

ISSN: 0029-7844/18

per 1,000 births, primarily to women on Medicaid. Many of these neonates are cared for in neonatal intensive care; in 2015, 27 per 1,000 neonatal intensive care admissions in the United States were for neonatal abstinence syndrome.[4]

BACKGROUND

In response, the federal government mobilized resources to encourage office-based opioid use disorder treatment, an effort that culminated in the recent (2016) Comprehensive Addiction and Recovery Act, signed into law as Public Law 114-198. The Comprehensive Addiction and Recovery Act was designed to increase access to pharmacotherapy with buprenorphine for opioid use disorders with special emphasis on services for pregnant women and follow-up for neonates affected by prenatal substance exposure. In this effort, the Comprehensive Addiction and Recovery Act laudably expanded eligibility for obtaining a waiver to prescribe buprenorphine to nurse practitioners and physician assistants. However, in an oversight, certified nurse–midwives and certified midwives were not included in the Comprehensive Addiction and Recovery Act legislation.

As a result of the complexity of challenges faced by pregnant women with or at risk for opioid use disorders, rapid initiation and maintenance of pharmacotherapy with methadone or buprenorphine coupled with behavioral counseling is the recommended standard of care during the antepartum period. Timely access to care is critical to facilitate entry into treatment, increase engagement in prenatal care, and avoid loss to follow-up. Because methadone requires daily observed dosing in a federally licensed methadone program, buprenorphine is increasingly favored for prenatal use because it can be prescribed in an office setting by primary care providers.[5]

Buprenorphine is a partial μ-agonist, κ receptor antagonist medication used widely in treatment of opioid use disorder. It is safe and effective during pregnancy and preferred over methadone because of its improved safety profile for neonates. Federal regulations of opioid treatment programs require that pregnant women be given priority access to treatment, and pregnant women need not fully meet *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* criteria for opioid use disorder to initiate pharmacotherapy.[6] Medication-assisted treatment for opioid use disorder is optimized using an integrated approach that facilitates coordination between substance use disorder treatment providers and maternity care providers. Such integrated programs demonstrate improved outcomes such as better adherence to treatment, resulting in decreased preterm birth, and improved birth weight.[7] However, there is a significant gap between the need for and availability of woman-centered comprehensive treatment services, mirroring the gap between need for and receipt of opioid use disorder treatment in the general population.[8] Therefore, health care providers with routine contact with pregnant women can provide urgently needed opioid use disorder treatment in integrated pregnancy and substance misuse care settings.

As providers of primary maternity care, midwives provide prenatal care and attend a large proportion of births in areas disproportionately affected by the nation's opioid crisis. Midwifery, as practiced by certified nurse–midwives and certified midwives, encompasses a range of essential health care services for women from adolescence through menopause, including pregnancy and postpartum care, but also primary care, gynecology, and family planning services. These services are provided in outpatient clinics, private offices, community and public health systems, homes, hospitals, and birth centers. According to the American College of Nurse-Midwives (ACNM), certified nurse–midwives and certified midwives attended 332,107 births, or 8.3% of total U.S. births in 2014.[9] Predominantly rural states such as New Hampshire, Maine, Vermont, and West Virginia have high rates of perinatal opioid use disorder and also have relatively high rates of midwife-attended births, ranging from 12% in West Virginia to 21% in Vermont.[10] Furthermore, midwives have traditionally cared for medically underserved populations, including rural women. Forty-four percent of births attended by certified nurse–midwives and certified midwives during the period from 1990 to 2012 were to women insured by Medicaid.[11] Given the significant numbers of pregnant women they care for, midwives need to be part of the nation's system of detecting and treating opioid misuse in pregnancy.

In fact, midwives are already providing a large share of primary maternity care for this vulnerable population of pregnant and parenting women.[12] A recent (July 2017) national pilot survey of certified nurse–midwives and certified midwives conducted by the ACNM demonstrated that more than half of respondents care for women with opioid use disorder at least monthly (personal communication, S. Estes, 2017). The exclusion of certified nurse–midwives and certified midwives as office-based buprenorphine prescribers under the Comprehensive Addiction and Recovery Act legislation is therefore an unfortunate omission in an otherwise admirable piece of legislation. Working with physician colleagues, certified

nurse–midwives and certified midwives are uniquely positioned to provide high-quality, integrated services for pregnant women with opioid use disorders as full members of multidisciplinary treatment teams. It is therefore urgent to remove barriers that prevent midwives from being able to adequately treat pregnant women with opioid use disorders.

DISCUSSION

Licensure and scope of practice for midwives vary by state. In some states, nurse–midwives are licensed as advanced practice registered nurses with independent prescribing authority for scheduled drugs. In others, midwifery practice is restricted by requiring formal collaborative agreements with physicians and by limitations on prescribing authority.[10] Given the diversity of practice environments for certified nurse–midwives and certified midwives in the United States, the exclusion of midwives as a named clinician group from the Comprehensive Addiction and Recovery Act makes it likely that those who practice in states with unclear status as nurse practitioners will not be able to prescribe buprenorphine. Thus, we support legislation introduced September 2017 in the House of Representatives by Representatives Lujan (Democrat, New Mexico) and Tonko (Democrat, New York), the Addiction Treatment Access Improvement Act (H.R. 3692), that permits certified nurse–midwives and certified midwives to prescribe buprenorphine if they are practicing in states where they already have the authority to prescribe schedule III medications. In addition, the legislation would make permanent the authorization that allows nonphysician providers to treat patients with buprenorphine. Importantly, this bill is supported by the ACNM and the American College of Obstetricians and Gynecologists (https://tonko.house.gov/news/documentsingle.aspx?DocumentID=663). We strongly urge the U.S. Congress to pass this crucial "fix" to the Comprehensive Addiction and Recovery Act during the current legislative session.

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