Example Best Practice Recommendations for Prenatal/ Intrapartum/ Postpartum Care Complicated by Substance Use Disorders

The following checklist reflects recommendations in the 2018 *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*, available from the Substance Use and Mental Health Services Administrations at: https://store.samhsa.gov/product/SMA18-5054. Providers are encouraged to download and consult the Clinical Guidance document for a more complete discussion of the topics included below.

ANTEPARTUM CARE

1. **Screening for substance use in pregnancy**

   All pregnant patients should be screened for drug and alcohol use at the first prenatal visit and subsequently, including patients for whom substance use has already been identified as a concern (World Health Organization [WHO], 2014, Substance Use and Mental Health Services Administration [SAMHSA], 2018). Screening should be done with empathy, using a validated screening instrument (American College of Obstetricians and Gynecologists [ACOG], 2012), and positive screens should be followed up with brief intervention to determine use patterns, motivation, and level of need for substance use treatment services.

   All healthcare professionals providing maternity care should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist patients to obtain further evaluation and/or treatment (ACOG, 2015a; Wright, 2016; Reddy, 2016). Providers caring for women with opioid use disorders (OUD) are referred to Factsheet 1 (p17) of the 2018 SAMHSA guidelines https://store.samhsa.gov/product/SMA18-5054 for a review of supporting evidence for this approach.

2. **Initial encounter after disclosure of probable substance use disorder (SUD), alcohol use disorder (AUD) and/or opioid use disorder (OUD)**

   If patient is already in treatment for SUD/OUD, obtain written consent for two-way exchange of information with treatment provider for the purpose of care coordination (SAMHSA, 2018).

   Education/discussion/referral: Discuss level of care and choice of treatment mode for substance use/opioid use disorder

   - Counsel that the recommended management of alcohol use disorder (AUD) during pregnancy is complete abstinence from alcohol, explore options with the pregnant woman, and arrange appropriate referrals as needed

- Counsel that the recommended management of marijuana use during pregnancy is abstinence, and explore options with the woman
  - Assess withdrawal risk according to guidelines (below: facilitating treatment for OUD/facilitating treatment for AUD). Consultation with internal medicine is strongly recommended if risk for alcohol withdrawal is suspected.
- Counsel that the recommended treatment for opioid use disorders during pregnancy is medication assisted treatment with buprenorphine or methadone, explore options with the patient, and arrange appropriate referrals. Discussion should include the following key points:
  - Methadone has been used during pregnancy since the 1970s and is the accepted standard of care, but that buprenorphine has been shown to be a safe and effective alternative (ACOG, 2012)
  - Detoxification from opioids is associated with a high risk of relapse and is therefore not the recommended choice during pregnancy (Jones, 2014)
  - Provide information about neonatal opioid withdrawal syndrome (NAS/NOWS), practice policies regarding antepartum drug testing, maternal and neonatal in-patient drug testing, birth hospital policies, including institutional policy about breastfeeding in the context of a substance use history
- Determine the appropriate level of care based on substances used, use history, available resources, and patient preferences, and facilitate an appropriate referral
- Provide information about federal and state laws regarding mandated reporting of women using substances during pregnancy including the requirement for a Plan of Safe Care at the time of discharge

- Provide education about risks of polysubstance use during pregnancy
  - Counsel regarding the risks of tobacco exposure and offered strategies to help with cessation (ACOG, 2015b) – strongly encourage smoking cessation
  - Provide education about the risks associated with alcohol and specific types of drug use, including marijuana
  - Counsel regarding prevention of hepatitis and HIV
  - Counsel about and offer a prescription for a Naloxone rescue kit (Narcan)

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Comprehensive Assessment

- Refer to Social worker, Care Management, and/or appropriate services if available
  - If not available, screen for food and housing insecurity at minimum
  - Use of a validated screening tools is recommended (examples include PRAPARE or the Hunger Vital Signs)
- Screen for comorbid psychiatric conditions using validated screening tool (**Section 10**)
  - If positive, treat and/or refer to Behavioral Health
- Screen for intimate partner violence using validated screening tool (**Section 11**)
  - If positive, refer to domestic violence advocacy service
- Obtain complete medical history
- Obtain substance use history to help identify an appropriate treatment plan, including type, amount, duration, and time of last use (SAMHSA, 2018).
- Consult Prescription Drug Monitoring database for the appropriate state (SAMHSA, 2018).
- Obtain consent for urine toxicology to determine nature of prenatal exposure (SAMHSA, 2018), including alcohol metabolites.
  - The 2018 SAMHSA *Clinical Guidance* includes the following recommendations regarding consent for urine toxicology testing:

    > The pregnant woman should be asked to provide informed consent for urine, blood, or saliva screenings for substance use. Although oral informed consent is used in many labor-and-delivery clinics, as signed paper or electronic form is pregerred. The healthcare professional should review with the pregnant woman the risks and limitations of each type of test and the need for confirmatory testing for any positive results…. (SAMHSA, 2018, p. 18)

Orders

- Labs: Women with IV use history are often difficult to draw. This should be discussed in advance with the patient, and if possible, an experienced technician should be available. Drawing in the OB clinic may make the procedure more acceptable to patients. Women initiating treatment may be under physiologic stress and may not be well hydrated. Core labs include:
  - HIV
  - HBsAg, anti-HBcore, HBsAb: (to verify absence of disease and immunity)
  - HCV antibody: if + draw HCV PCR and genotype
  - Hepatic Function (LFTs) and serum creatinine

- Consider gama-glutamyl transferase (GGT) if active alcohol use is suspected (https://www.mayomedicallaboratories.com/test-catalog/Clinical+and+Interpretive/8677)
- Consider testing for tuberculosis if history of incarceration, other risk factors, or symptomatic
- Obtain consent for urine drug test with confirmation

- Avoid ondansetron (Zofran) for women treated with methadone, to avoid increasing risk for prolonged QTc interval
- Naloxone Rx and instructions should be offered to all patients with opioid use disorders
- Obtain baseline ECG for patients on methadone if dose >= 100 mg/day
- Ask about and initiate prophylaxis when indicated for patients with history of deep vein thrombosis. All will need postpartum enoxaparin or warfarin. Some women will need antepartum medication. Consult or refer to Maternal Fetal Medicine or hematology.
- Recommend immunization for hepatitis B if HBsAg, anti-HBcore, HBsAb all negative

Medical referrals/ care coordination

- Referral to substance use treatment: when possible, telephone call/warm handoff to appropriate treatment provider. Give phone number of treatment provider to patient
  - Obtain federally compliant written consent for release of medical information (CFR42 pt2) to allow communication between maternity care and substance use treatment providers
- Ensure patient has appropriate follow up for identified psychiatric needs unless this will be provided by treatment program (section 12)
- Schedule short interval follow up with maternity care provider of choice
- Refer for Cardiology consultation if history of pericarditis
- Refer patient with HIV to infectious disease specialist
- Refer patient with HCV/HBV to infectious disease or gastroenterology/hepatology
  - Ensure notification of pediatric provider for infants exposed to HIV, HCV, HBV
- Refer to dentist: for patients without dental coverage, provide dental education and assist in enrolling in free dental services as available

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3. Ongoing Assessment

- **Document treatment coordination using toolkit chart template/handoff tool**
- Reassess for and treat opioid side effects (constipation/nausea)
- Repeat screening for changes in social needs
- Ask about cravings, non-prescribed drug, and alcohol use at every visit
- Provide tobacco cessation counseling and offer treatment at every visit for patients who smoke – strongly encourage smoking cessation
- Review prescription drug monitoring program (PMP) records and document in patient chart

4. Third trimester

- Verify medication/dose and treatment status with treatment provider and record on checklist

Additional orders

- U/S for fetal growth at 32 weeks; repeat study at 36 weeks if clinical suspicion for growth restriction (Reddy, 2017)
- Repeat Labs:
  - Urine toxicology with confirmation (**consent required**)
  - HIV if previously negative
  - HCVab, if previously negative
  - HCV viral load if HCVab previously positive AND viral load negative
  - HBsAg if previously negative
  - Syphilis if risk for recent infection (SAMHSA, 2018)
  - Urine GC/CT/Trichomonas if risk for recent infection (SAMHSA, 2018)

Education and discussion

- Delivery plan:
  - Ask about status of family support for treatment. If needed, offer assistance talking with family/partner about plan of care. Address concerns about privacy and hospital policies
  - Discuss management of neonatal opioid withdrawal after birth. Prepare for 4-7 days of hospitalization recommended for neonate for NAS/NOWS observation, address need for

longer stay if pharmacologic treatment for NAS/NOWS is required. For summary guidance for prenatal patient education on NAS/NOWs see Factsheet 7 (p. 53) of SAMHSA's 2018 *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*: https://store.samhsa.gov/product/SMA18-5054

- Discuss possibility of infant transfer to a tertiary care center if community hospital not able to medically manage newborn needing treatment for NAS/NOWS
- Arrange hospital tour/meeting with pediatric staff and nursing
- Advise to bring medication to hospital with her for safety and verification

Newborn care

- Provide education regarding safety and recommendations for breastfeeding for women who are HIV negative and not using illicit drugs
- Provide safe sleep/safe newborn care education
- Help identify pediatric provider of choice
- Emphasize importance of regular pediatric follow up after discharge

Pain management

- Review pain management options during labor, including non-pharmacologic measures; epidural/spinal anesthesia and short-acting opioid analgesics (SAMHSA, 2018);
- Consider Anesthesia consultation (SAMHSA, 2018)

Hospital policies

- Hospital policy re: NAS/NOWS assessment and management, especially non-pharmacologic measures such as rooming-in if available
- Breastfeeding policy and support services
- Hospital policies re: maternal and newborn toxicology testing (meconium or umbilical cord segment)
- Federal, state and hospital policies regarding mandated reporting and Plan of Safe Care

Care Coordination

- Review requirements specific to Plan of Safe Care
- Assist patient identify pediatric provider to discuss NAS management and neonatal follow up
- Ensure patient has seen Social worker/care management at least once during pregnancy

- Recommend and refer to home visiting services if accepted
- Repeat screening for food and housing insecurity
- Remind patient on buprenorphine to bring medication with her for safe storage and dose verification
- Verify dose with methadone prescriber

Contraceptive counseling

- Discuss intention regarding repeat pregnancy and preference for pregnancy spacing
- Explore contraceptive preferences: offer post-placental IUD insertion if available at institution, or etonogetrel implant or medroxyprogesterone injection prior to discharge or 2-6 weeks postpartum (SAMHSA, 2018)
- If tubal ligation is desired, ensure consent is signed at appropriate interval to comply with applicable federal requirements

INTRAPARTUM CARE

Maternity care providers should be aware of the particular issues of concern to women with substance use disorders at the time of delivery. Women should be offered information and reassurance about adequate pain management, IV access, management of neonatal abstinence syndrome, and state and hospital policies regarding mandated reporting. Caregivers should be guided by awareness that both childbirth and hospitalization are potentially re-traumatizing for women with trauma history.

- General
  - Address concerns about pain management promptly and ensure timely re-assessment
  - Provide continuity of care providers whenever possible
  - Maintain strict confidentiality during any discussion of NAS/substance use disorder
  - Promote transparency about Child Protective Service involvement
- Screen for illicit drug and alcohol use
  - Consider interview-based or electronic self-screening using validated instrument (see NNEPQIN guideline)
  - Urine drug test with confirmation (consent required)
- Standard admission orders:
  - Confirm MAT medication/dose; maintain dose/frequency throughout hospitalization
  - Nicotine replacement if needed

- Labs: Repeat HIV/HCV antibody if not obtained in third trimester
- Obtain verbal or written consent for urine toxicology
- Notify attending pediatric provider
- Refer to Social worker/care management to discuss mandated reporting
- Lactation consultation if available
- Anesthesia consultation

- Pain management:
  - A shared decision making approach is essential as many women experience anxiety about adequate pain management, or fear treatment with opioids will challenge recovery
  - **Nalbuphine and butorphanol are contraindicated** for patients with opioid dependence as they can precipitate withdrawal
  - Epidural/spinal analgesia is recommended and most effective for labor pain. Solutions with higher concentrations of local anesthetic and less reliance on short acting opioid may be more effective due to cross tolerance (Reddy et al, 2017)
  - Fentanyl IV, titrated to effect, may be used for analgesia if patient declines epidural
  - Non-pharmacologic methods should be optimized with/without pharmacologic agents
  - Maintenance medication does not treat pain (SAMHSA, 2018)
  - Cross-tolerance [methadone] and partial blockade [buprenorphine] can increase dose needed for effective analgesia; a multimodal approach is therefore most effective
    - 50% higher dose may be needed for oral agonists to achieve adequate postoperative pain relief (Meyer, 2010; Jones, 2014)
  - Consider PCA or epidural for post-operative pain if oral medication is not adequate
  - Avoid acetaminophen in patients with hepatic damage.
  - Anticipate that IV access may be difficult, consider PICC or central line if unable to achieve
  - If history of deep vein thrombosis, initiate anticoagulation postpartum as indicated (see above)

Discharge plan

- Work with patient and multidisciplinary team to complete a Plan of Safe Care as required by institutional and state policies (Section 13)

- If treatment of postoperative pain with opioids is required at discharge, prescribe only the quantity likely to be used, maximizing NSAIDs and nonpharmacologic measures (Reddy, et al, 2017).
- Copy medication administration record to give patient *and* fax to treatment provider
- Ensure plan for postpartum MAT is in place (if applicable) and patient has transportation to next scheduled treatment appointment
- Monitor women on methadone for increased somnolence, and contact treatment provider if dose decrease seems indicated. Risk for sedation is highest several hours after dosing, increasing risk for infant falls especially in the early postpartum period when women are frequently sleep deprived. This should be discussed with the woman's treatment provider. Additional guidance regarding adjusting pharmacotherapy can be found in Factsheet 14 (p. 113) of *Clinical Guidance for Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018): https://store.samhsa.gov/product/SMA18-5054
- Explore pregnancy intention, desired pregnancy spacing, and contraceptive preference. Offer post-placental long acting reversible contraception (LARC) if available at institution, or etonogestrel implant or medroxyprogesterone injection prior to discharge.
- Schedule for postpartum visits at 1-2 and 6 weeks prior to discharge, verify contact numbers for communication about these appointments
- Refer to public health nursing or other home visiting services, coordinate with pediatric follow up schedule

POSTPARTUM CARE

- Consider scheduling at 1-2 and 6 weeks postpartum to screen for depression, encourage family planning, and monitor for relapse
  - Screen for onset of postpartum depression at each postpartum visit
  - Refer/treat as needed
- Repeat intimate partner violence screening at 6 weeks and any time concern exists
- Provide breastfeeding support as needed

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- Ask about pregnancy intention, provide contraception as needed/desired
- Reinforce smoking cessation to prevent relapse; or continue cessation counseling if still smoking – strongly encourage smoking cessation
- Reinforce safe infant care practices, including safe sleep
- Communicate with treatment provider at 6 weeks to ensure patient has continuing care. Providers of maternity care should consider continuing supportive services for longer than 6 weeks post-delivery, to avoid loss of continuity for a woman (SAMHSA, 2018).
- Assess resource needs at each visit and coordinate with case worker/social service providers
- Assist patient to follow up on referrals to public health nursing and other services
- Assist patient to schedule follow up for infectious disease management (HCV/HBV/HIV)
- Facilitate transition to a recovery-friendly primary care practice if not already established
- The postpartum period is one in which women are particularly vulnerable to relapse to opioids, other drugs, or alcohol. Collaboration between prenatal care providers, pediatricians, mental health and substance use treatment providers as outlined in the 2016 SAMHSA recommendations: *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders* (2016) can facilitate early identification of the need for additional support. Members of a woman's healthcare team should request her written consent to communicate with each other to coordinate care (SAMHSA, 2016; see also SAMHSA, 2018, Factsheet 16 [p. 119-122]).