

Example Checklist for Providers for Prenatal/ Intrapartum/ Postpartum Care of Pregnant Women with Substance Use Disorders

ANTEPARTUM CARE

1. Screening for substance use in pregnancy:

- Screen all women for drug and alcohol use at the first prenatal visit and subsequently using a validated screening instrument
- Provide brief intervention for positive screens to determine a woman's use pattern, motivation, and level of need for substance use treatment services.
- Acknowledge prevalence of trauma history among women with substance use disorders.

2. Initial encounter after disclosure of probable opioid use disorder (OUD):

Education/discussion/referral

- Discuss level of care and choice of treatment mode for opioid use disorder
 - Advise women that the recommended treatment for opioid use disorders during pregnancy is medication assisted treatment with buprenorphine or methadone.
 - Counsel women that medical detoxification is associated with a high risk of relapse and is not the recommended choice during pregnancy
 - Appropriate level of care should be determined based on substances used, use history, available resources, and the woman's preferences, and an appropriate referral should be facilitated
 - Provide information about neonatal abstinence syndrome (NAS), practice policies regarding antepartum drug testing, maternal and neonatal inpatient drug testing, birth hospital policies, including policy about breastfeeding in the context of substance use history
 - Provide information about federal and state laws regarding mandated reporting of women using substances during pregnancy including requirement for Plan of Safe Care
- Provide education about risks of substance use during pregnancy
 - Counsel regarding the risks of tobacco exposure and offered strategies to help with 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 and provide prescription for a Naloxone rescue kit

Additional needs assessment (may defer until follow up visit):

- Refer to Social worker, Care Management, and/or appropriate services if available
 - If not available, screen or coordinate using security team

- Screen for comorbid psychiatric conditions and when positive, treat and/ or refer
- Screen for intimate partner violence and if indicated, refer to domestic violence advocacy service

Orders:

- Labs: *Women with IV use history are often difficult to draw. This should be discussed with the patient, and if possible, an experienced technician should be available.*
 - HIV
 - HBsAg, anti HBcore, HBsAb
 - HCV antibody: if + draw HCV PCR and genotype
 - LFTs
 - Consider testing for TB if history of incarceration, other risk factors, or symptomatic
 - Consider urine drug test with confirmation (consent required)
- Other:
 - Avoid ondansetron (Zofran) for women treated with methadone due to increased risk for prolonged QT interval
 - Naloxone Rx and instructions should be provided for patients with opioid use disorder
 - Baseline ECG for patients on methadone
- Ask about and initiate prophylaxis when indicated for patient with history of DVT. All will need postpartum enoxaparin or warfarin. Some women will need antepartum medication. Contact or refer to Maternal Fetal Medicine or to hematology.
- Recommend immunization for hepatitis B if HBsAg, anti HBcore, HBsAb all negative

Medical referrals/ care coordination

- Refer to substance use treatment: when possible, telephone handoff to appropriate treatment provider
 - Obtain federally compliant written consent for release of medical information (CFR42 pt2) to allow communication between maternity care and substance use treatment providers
 - Query Prescription Monitoring Program for state
- Encourage/arrange individual therapy for identified psychiatric needs if not provided by treatment program
- 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
- Coordinate care with pediatric provider for infants exposed to HIV, HCV, HBV
- Refer to dentist if needed

Ongoing:

- Document plan using template/handoff tool
- Communicate with treatment provider every trimester

- Reassess for and treat side effects of buprenorphine/methadone (constipation/nausea) periodically

Third trimester:

- Verify medication/dose and treatment status with treatment provider *[Appendix 2]*
- Draft Plan of Safe Care with patient and provider team

Additional orders

- U/S for fetal growth at 32 weeks; repeat study at 36 weeks if clinical suspicion for growth restriction or additional risk factors such as poor weight gain and/or heavy tobacco use.
- Repeat Labs at 36 weeks: Urine toxicology with confirmation (consent required)
 - HIV if previously negative
 - HCV if previously negative
 - HBsAg if previously negative
 - STI screen: GC/CT/Trich, syphilis

Education and discussion

- Birth plan:
 - Prepare for prolonged LOS: at minimum 4-5 days recommended for NAS observation
 - Discuss possibility of transfer of infant if community hospital not able to medically manage newborn needing treatment for NAS
 - Hospital tour/meeting with nursing staff if possible
 - Review hospital pharmacy policy- medication verification/formulary issues
- Discuss pain management during labor
 - Arrange Anesthesia consultation if acceptable to patient
- Additional education/Review:
 - NAS assessment and management
 - Breastfeeding
 - Hospital policy re: maternal and newborn toxicology testing (meconium, cord blood)
 - Review Federal, state and hospital policies regarding mandated reporting

Postpartum planning

- Explore contraceptive preferences: offer post-placental LARC if available at birth hospital or Nexplanon prior to discharge vs. 2 weeks postpartum.
- If tubal ligation is desired, ensure consent is signed at appropriate time
- Discuss choice of pediatric provider: consider antepartum consultation to discuss NAS management
- Recommend and support choice regarding breastfeeding if substance free, provide materials
- Ensure social service referrals are made and documented on Plan of Safe Care
- Remind patient on buprenorphine to bring medication with her for safe storage and dose verification

INTRAPARTUM

Maternity care providers should be aware of the particular issues of concern to women with substance use disorders at the time of delivery.

- General
 - Address concerns about pain management promptly
 - 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
 - Urine drug test with confirmation
- Standard admission orders:
 - Confirm MAT medication/dose and continue throughout hospitalization
 - 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:
 - Key points: A shared decision making approach is essential as many women experience anxiety about 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 is recommended and most effective for labor pain
 - Fentanyl IV may be used for analgesia if patient declines epidural
 - Non pharmacologic methods should be used with/without pharmacologic agents
 - Maintenance medication does not treat pain; and hyperalgesia is associated with OUD.
 - 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
 - Consider PCA or epidural for post operative pain if oral analgesia not adequate
 - Anticipate that IV access may be difficult, consider PICC or central line if unable to achieve
 - If history of VT, initiate anticoagulation postpartum as indicated see above)
- Discharge plan:
 - Work with patient and multidisciplinary team to complete Plan of Safe Care
 - Copy medication administration record to give patient *and* fax to treatment provider
 - Ensure postpartum MAT plan is in place and patient has transportation to treatment for next scheduled appointment

- Monitor women on methadone for increased somnolence and contact treatment provider if dose decrease seems indicated
- All women on MAT should have a follow up appointment with OB or psychiatric provider to screen for depression by 2 weeks postpartum
- Discuss desire for contraception: if needed, consider Depo provera or Nexplanon prior to discharge
- Schedule for postpartum visits at 1, 2, 4 and 6 weeks
- Refer to public health nursing and other services

POSTPARTUM

- Schedule at 1, 2, 4, and 6 weeks postpartum to monitor for depression and relapse
 - Screen for onset of postpartum depression at each visit
 - Refer/treat as needed
 - Communicate results to MAT provider
- Ask about pregnancy intention, provide contraception as needed
- Communicate with treatment provider to ensure patient has continued care
- Assess needs and coordinate with case worker/social service
- Follow up regarding referrals to public health nursing and other services
- Assist patient to schedule follow up for infectious disease management (HCV/HBV/HIV)
- Facilitate transition to primary care provider if not provided at maternity care site