ILPQC Mothers and Newborns affected by Opioids Initiative

Slide set by: ACOG District II Opioid Use Disorder in Pregnancy Bundle – Part 1

Readiness, Recognition and Prevention

April 2018

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

NYS HEALTH FOUNDATION
Improving the state of New York's health

IL PQC Illinois Perinatal Quality Collaborative

This education has been made possible through funding from the New York State Health Foundation (NYSHealth).

Disclaimers: The following material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or consequences of any actions taken on the basis of the information provided.

- This education is not exclusive to maternal opioid use disorder (OUD). The management approaches outlined within may also be effective in helping women with other substance use disorders.
- Each clinical setting must take into account the resources available within its own institution and community. Practices and institutions are strongly encouraged to review their existing policies and procedures for OUD in pregnancy management and modify them if necessary to maximize safe patient care.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Opioid Use Disorder in Pregnancy Bundle

Purpose

- Offer multi-faceted education and implementation tools to better assist women's health care providers in caring for pregnant women with OUD
- Encourage better communication and engagement among providers across all of the services within the continuum of care, including the justice system
- Enhance the communication of OUD through the use of a common language
- Enhance patient and family engagement through education, common language; understand treatment and process

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Created by ACOG District II in 2018

Opioid Use Disorder in Pregnancy: Know the Basics

First Steps

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Physical Opioid Dependence

"Physical dependence is the physiological adaptation of the body to the presence of an opioid. It is defined by the development of withdrawal symptoms when opioids are discontinued, when the dose is reduced abruptly or when an antagonist (eg, naloxone) or an agonist-antagonist (eg, pentazocine) is administered."

Source: O'Brien CP. Drug addiction and drug abuse. In: *Goodman and Gilman's The pharmacological basis of therapeutics. 9th edition*.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Opioid Addiction

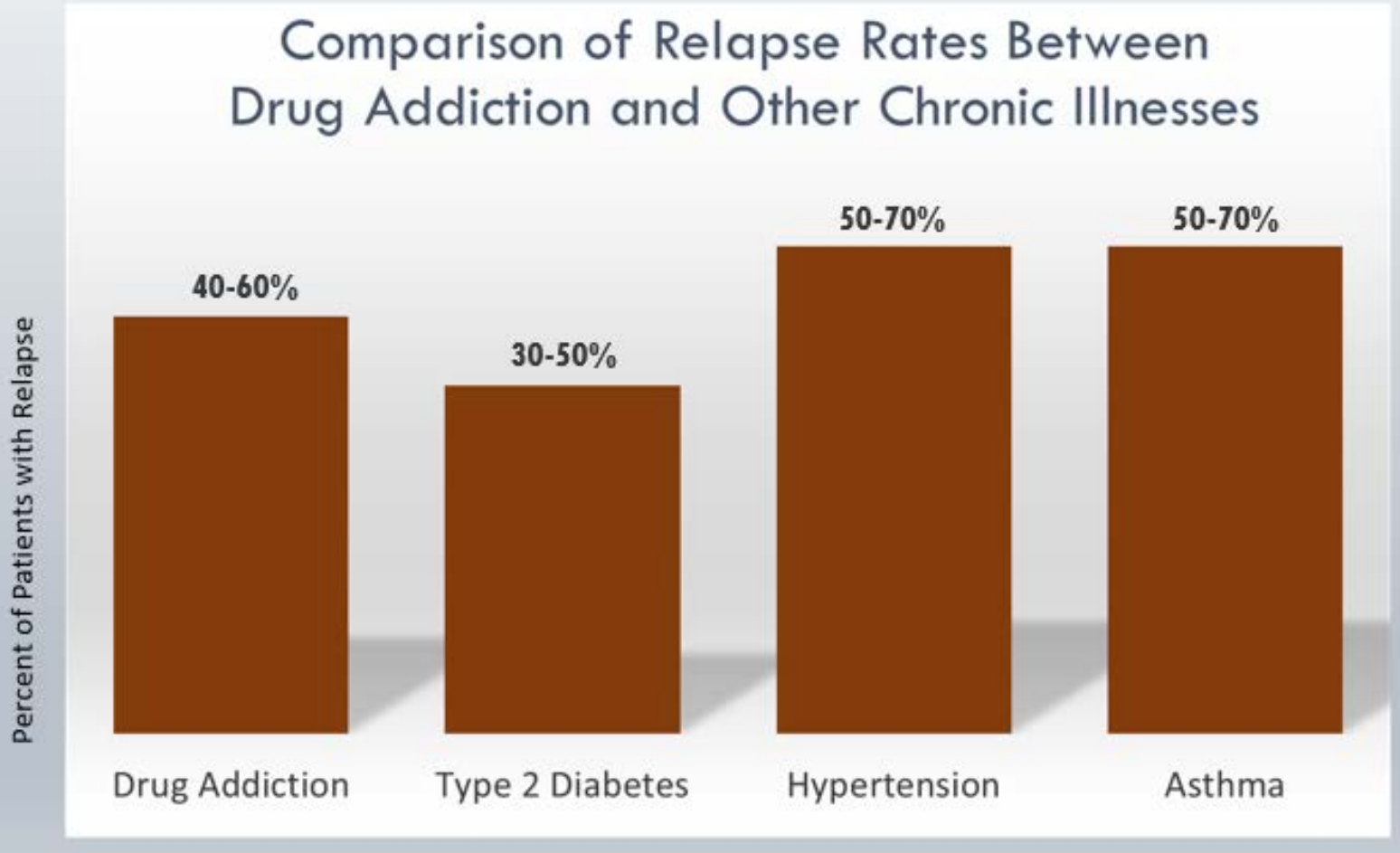
- Primary **chronic disease** of brain reward, motivation, memory and related circuitry.
  - Dysfunction in these circuits leads to psychological, social, and spiritual manifestations.
- Reflected in an individual pathologically pursuing reward and/or relief by opioid use and other behaviors.
- Like other **chronic diseases**, addiction often involves cycles of relapse and remission.
- Without treatment, addiction is progressive and can result in disability or death.

Source: ASAM Public Policy Statement on **Treatment for Alcohol and Other Drug Addiction**, Adopted: May 01, 1980, Revised: January 01, 2010 https://www.asam.org/resources/definition-of-addiction

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Addiction and Other Chronic Conditions



Source: JAMA 284: 1689-1695, 2000

JAMA, 284:1689-1695, 2000

Substance Use Disorders (SUDs)

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.

- Alcohol Use Disorder (AUD)
- Opioid Use Disorder (OUD)
- Stimulant Use Disorder
- Hallucinogen Use Disorder (HUD)
- Tobacco Use Disorder
- Cannabis Use Disorder

Source: SAMHSA; https://www.samhsa.gov/disorders/substance-use

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Opioid Use Disorder (OUD)

Opioid use disorder is a chronic, treatable brain disease that can be managed successfully by combining medications with comprehensive care and recovery support, which enables those with OUD to regain control of their health and their lives.

In 2014, an estimated 1.9 million people had an OUD related to prescription pain relievers and an estimated 586,000 had an OUD related to heroin use.

Sources: SAMHSA; https://www.samhsa.gov/disorders/substance-use
ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711. ACOG Committee Opinion on Obstetric Practice & the American Society of Addiction Medicine. Replace Opinion No. 524, May 2012. Published August 2017.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

DSM-V Diagnostic Criteria: OUD & SUD

A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6 or more is severe.

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision. Source: APA 2013

It Can Happen to Anyone

https://youtu.be/Pet6ugDj8CY

https://youtu.be/DbeVhMye9NQ

https://youtu.be/6NBNKvYSWPo

https://youtu.be/KtZLIoQglys

ACOG District II

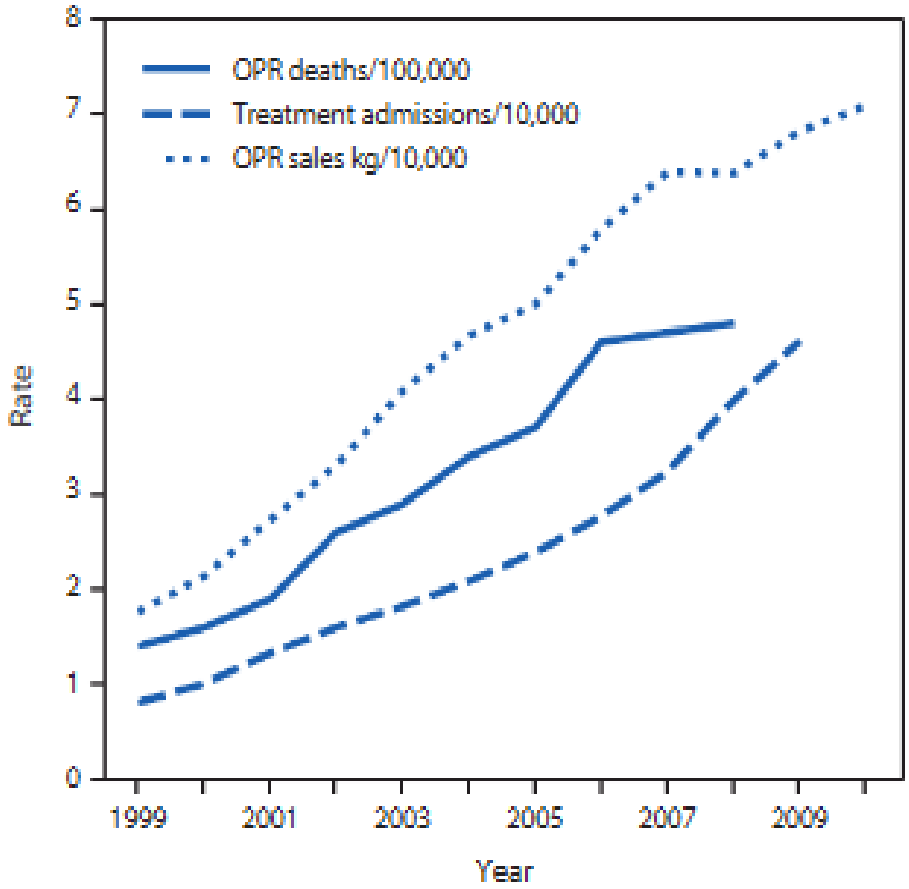
MANAGING OPIOID USE DISORDER IN PREGNANCY

Prescribing Practices

In 2012, providers wrote 259 million prescriptions for opioids

- More than enough for every American adult to have a bottle of pills
- 20% of those with a pain-related diagnosis, acute or chronic, receive an opioid prescription
- Opioid prescriptions:
  - » Have a place in pain management when used appropriately
  - » Can lead to OUD

FIGURE 2. Rates* of opioid pain reliever (OPR) overdose death, OPR treatment admissions, and kilograms of OPR sold — United States, 1999–2010



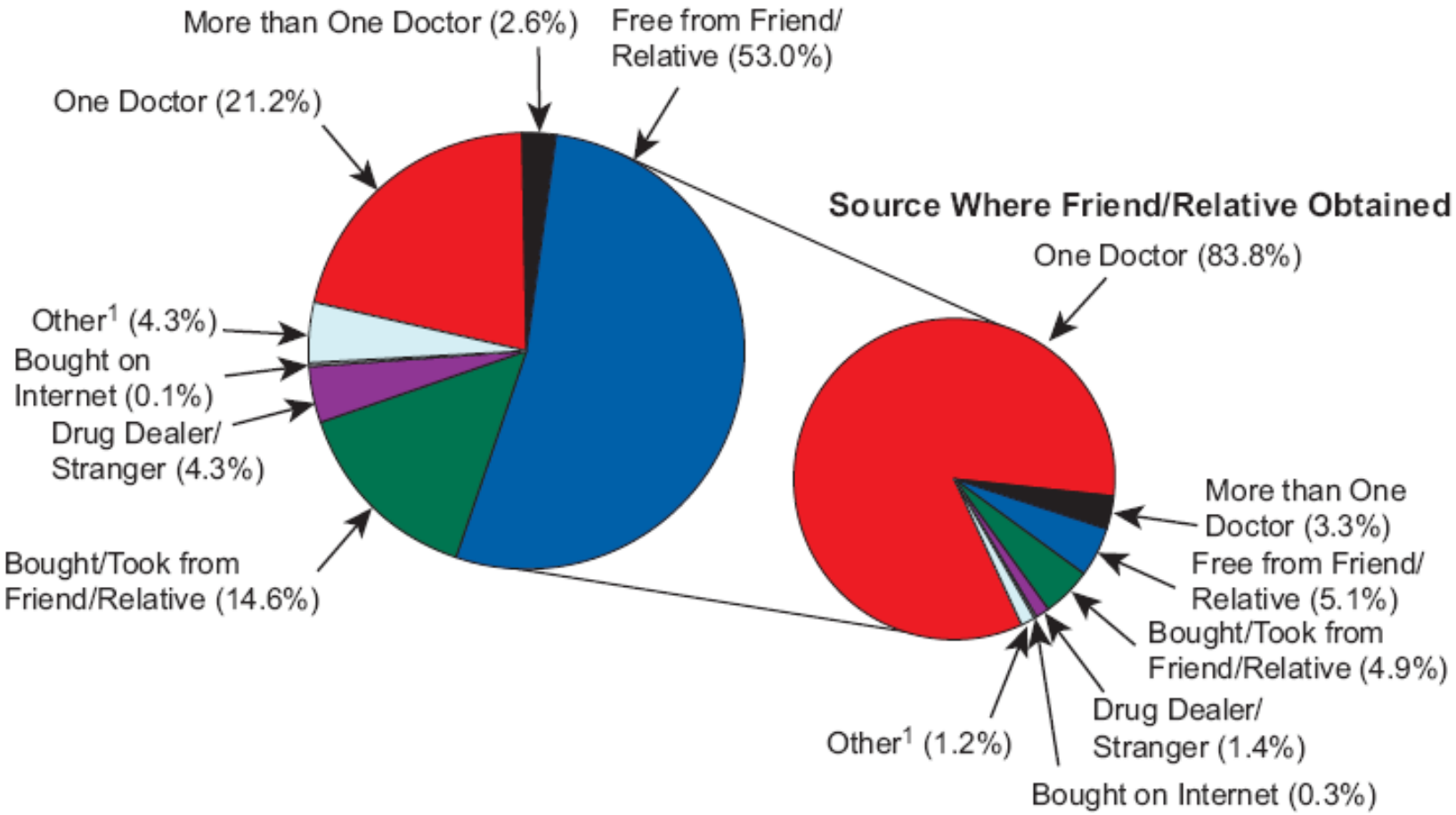
* Age-adjusted rates per 100,000 population for OPR deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

Source: https://www.cdc.gov/vitalsigns/opioid-prescribing/
https://www.researchgate.net/publication/278354874_Vital_Signs_Overdoses_of_Prescription_Opioid_Pain_Relievers-United_States_1999-2008_Reprinted_from_MMWR_vol_60_pg_1487-1492_2011

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013

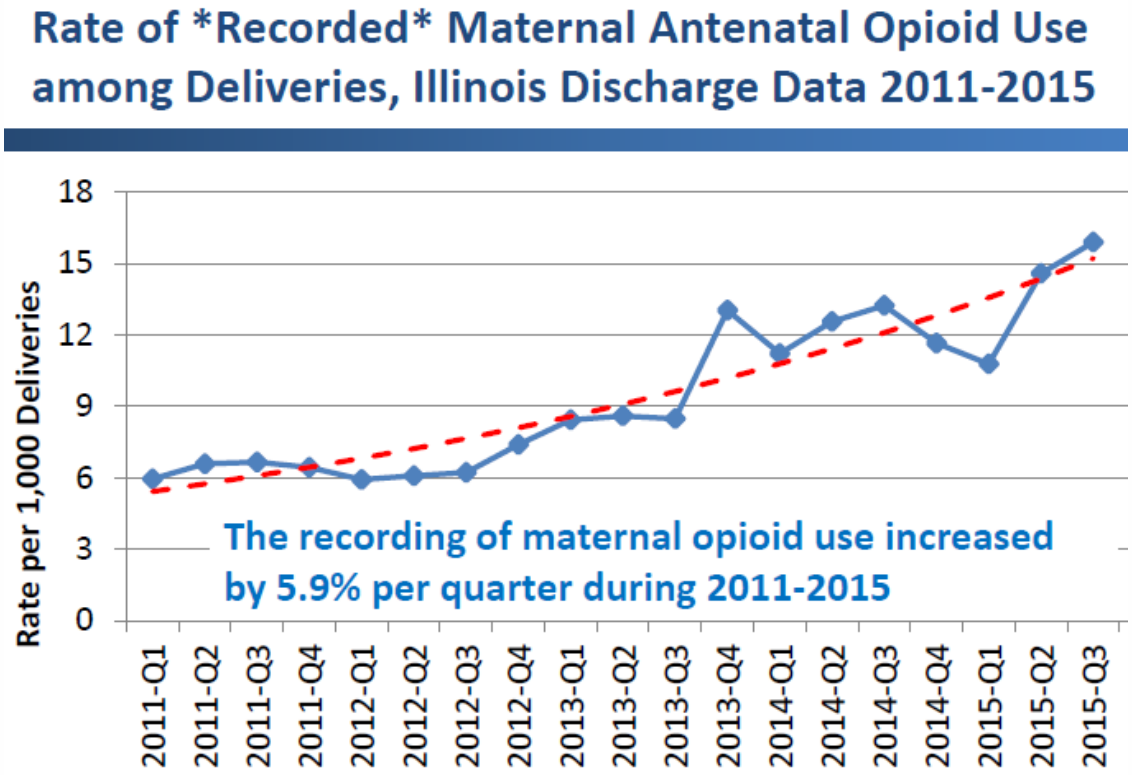


[1]The Other category includes the sources "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."

Note: The percentages do not add to 100 percent due to rounding.

Source: SAMHSA 2013; https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-47a

Increase in Mothers affected by Opioids in Illinois



Pregnancy is a window of opportunity to identify women with OUD and link to treatment as well as begin to develop a plan for optimizing her baby's care

Screening vs. Testing

Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases and may add to stereotyping and stigma. → **Therefore, it is essential that screening be universal with a validated verbal tool.**

A positive biochemical drug test result is not in itself diagnostic of OUD or its severity.

- Urine drug testing only assesses for current or recent substance use; therefore, a negative test does not rule out sporadic substance use. Also, urine toxicology testing may not detect many substances, including some synthetic opioids, some benzodiazepines, and designer drugs.

Source: ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711. ACOG Committee Opinion on Obstetric Practice & the American Society of Addiction Medicine. Replace Opinion No. 524, May 2012. Published August 2017.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Urine Toxicology

Urine drug testing has been used to detect or confirm suspected opioid use, but should be preformed only with the patient's consent and in compliance with state laws. Pregnant women should be informed of the potential ramifications of a positive test result, including any mandatory reporting requirements.

Limitations of urine toxicology:

- Typically does not test for alcohol or tobacco use
- Potential for false positive and false negative results
- Increases risk for possible child welfare involvement
- Test results do not assess parenting capabilities
- Often applied selectively
- Lab cut-off points for sensitivity

Sources: ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711.
Tenore, P. L. (2010). Advanced Urine Toxicology Testing. Journal of Addictive Diseases, 29(4), 436-448.
Roberts, S. C., Zahnd, E., Sufrin, C., & Armstrong, M. A. (2014). Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use? A California case study. Journal of Perinatology, 35(2).

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

ACOG Screening Guidance

Assess all pregnant women for SUDs.

- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.
- Early **universal screening, brief intervention** (such as engaging the patient in a short conversation, providing feedback and advice), and **referral for treatment (SBIRT)** of pregnant women with OUD improve maternal and infant outcomes and should be incorporated into the maternity care setting. (*see appendix, slides 64-69 for screening tools)*

Who can perform SBIRT?

Physicians, nurse practitioners, licensed midwives, physician assistants, nurses, health or substance use counselors, prevention specialists, and other health or behavioral health staff.

Source: ACOG. Opioid Use and Opioid Use Disorder in Pregnancy. Opinion No. 711. ACOG Committee Opinion on Obstetric Practice & the American Society of Addiction Medicine. Replace Opinion No. 524, May 2012. Published August 2017.
New York State OASAS, https://www.oasas.ny.gov/admed/sbirt/index.cfm

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

ACOG Patient Safety Bundle

Obstetric Care for Women with Opioid Use Disorder

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Care for Women with Opioid Use Disorder

READINESS

Every patient/family

- Provide education to promote understanding of opioid use disorder (OUD) as a chronic disease.
  - Emphasize that substance use disorders (SUDs) are chronic medical conditions, treatment is available, family and peer support is necessary and recovery is possible.
  - Emphasize that opioid pharmacotherapy (i.e. methadone, buprenorphine) and behavioral therapy are effective treatments for OUD.
- Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.
  - Awareness of the signs and symptoms of NAS
  - Interventions to decrease NAS severity (e.g. breastfeeding, smoking cessation)
- Engage appropriate partners (i.e. social workers, case managers) to assist patients and families in the development of a "plan of safe care" for mom and baby.

Every clinical setting/health system

- Provide staff-wide (clinical and non-clinical staff) education on SUDs.
  - Emphasize that SUDs are chronic medical conditions that can be treated.
  - Emphasize that stigma, bias and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
  - Provide training regarding trauma-informed care.
- Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substance use during pregnancy.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

- Know federal (Child Abuse Prevention Treatment Act - CAPTA), state and county reporting guidelines for substance-exposed infants.
  - Understand "Plan of Safe Care" requirements.
- Know state, legal and regulatory requirements for SUD care.
- Identify local SUD treatment facilities that provide women-centered care.
  - Ensure that OUD treatment programs meet patient and family resource needs (i.e. wrap-around services such as housing, child care, transportation and home visitation).
  - Ensure that drug and alcohol counseling and/or behavioral health services are provided.
- Investigate partnerships with other providers (i.e. social work, addiction treatment, behavioral health) and state public health agencies to assist in bundle implementation.

RECOGNITION & PREVENTION

Every provider/clinical setting

- Assess all pregnant women for SUDs.
  - Utilize validated screening tools to identify drug and alcohol use.
  - Incorporate a screening, brief intervention and referral to treatment (SBIRT) approach in the maternity care setting.
  - Ensure screening for polysubstance use among women with OUD.
- Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities.
  - Ensure the ability to screen for infectious disease (e.g. HIV, Hepatitis and sexually transmitted infections (STIs)).
  - Ensure the ability to screen for psychiatric disorders, physical and sexual violence.
  - Provide resources and interventions for smoking cessation.
- Match treatment response to each woman's stage of recovery and/or readiness to change.

PATIENT SAFETY BUNDLE

Obstetric Care for Women with Opioid Use Disorder

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

READINESS
(Every Patient / Family)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Readiness

- Stigma/bias/discrimination
- Chronic disease
- Treatment
- Education
- Family/patient engagement
- Care coordination
- Multidisciplinary care coordination
- Antenatal, intrapartum, postpartum planning
- Pain control
- Know guidelines and statutes
- Know best resources

Enhance Patient & Family Engagement

Provide education to promote understanding of OUD as a chronic disease.

- Engage the patient, her partner, family, or other support (if she desires) early in the process and care plan.
- Encourage the patient to describe the dynamics of her support network and identify who she would like to participate in her care.
- Create a bundle (toolkit) to assist with patient and family engagement and to help manage the patient's expectations such as:
  - Am I hurting my baby?
  - Is Medication-assisted treatment (MAT) safe for my baby?
  - Will my baby be taken away from me if I am using? Are there issues with specific drugs?
  - Breastfeeding recommendations – refer to ACOG guidelines
  - What is Neonatal Abstinence Syndrome (NAS) and what are the long-term effects of NAS? (*see appendix, slide 72 for NAS resources*)
  - What is the role of child protective services (CPS) and what requires a notification or a report to CPS? (*see appendix, slide 81 - CAPTA flowchart*)

Enhance Patient & Family Engagement

- Utilize motivational interviewing techniques, include trauma-informed care, and communicate positive stories of people with OUD to engage the patient in her care (*see appendix, slide 74 for SAMHSA resource*)
- Provide written information for the patient and her family that addresses her key concerns (assess patient health literacy to improve comprehension)
- Schedule a prenatal consultation with a neonatologist, NNP, MFM, or social worker to provide the patient facts about what happens at the particular institution or with the NICU to educate the patient and her family on the care of the baby following delivery, including discussion of:
  - Neonatal Assessment
  - Breastfeeding recommendations
  - The NAS scoring system tool – empower patient by reviewing components of assessment systems, discuss the limitations of the tool and strategies for engaging mother in the process

Reduce Stigma

Change perceptions of OUD through the use of a common language and emphasize that SUDs are chronic medical conditions that can be treated.

- Stigma, bias, and discrimination negatively impact pregnant women with OUD and their ability to receive high quality care.
- 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” or “in recovery” rather than being “clean.”
- 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.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Source: Drug Policy Alliance

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Words Matter

X Don't Use Dehumanizing, demeaning, demoralizing, language, such as:	✓ Use People-first language that confers respect, such as:
Addict	*When speaking generally, say: person who uses drugs. When talking about a specific issue, say: person who has a problematic relationship with drugs.* *When referring to the newborn, they are not born addicted rather they have prenatal substance exposure*
Get clean, Clean drug test	Stay away from this term, which implies that a person was previously "dirty." *Instead say: a person who formerly used drugs. When possible, ask the person directly how they refer to themselves and their journey. If referring to a test, say: test was negative, test was not positive for substance*
Crazy vs. "normal"	Avoid using terms that refer to mental illness – unless that's truly what's being discussed. *Instead: celebrate difference and diversity of experiences and approaches.*

Source: Drug Policy Alliancehttp://www.drugpolicy.org/sites/default/files/documents/Drug-Use-Glossary-for-Elected-Officials.pdf

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Words Matter

X Don't Use	✓ Use
Dehumanizing, demeaning, demoralizing, language, such as:	People-first language that confers respect, such as:
Junkie, Crackhead, Zombie, Tweaker	Do not use dehumanizing terms for people who use various substances – that contributes to the othering, stigmatizing, and discrimination of people who have needs. *Instead say: person who uses injection drugs/crack cocaine/synthetic cannabinoids, if in fact it's necessary to specify.*
"Those" people	Don't use "othering" language that draws false distinctions among people. *Instead: use inclusive language and describe the group or individual using people –first language.*
Crack baby	This label is not scientifically supported and leads to damaging stereotyping. Poverty - not drugs - was found to pose a much higher danger to children's outcomes. *Instead say: prenatal exposure to a controlled substance.*

Source: Drug Policy Alliancehttp://www.drugpolicy.org/sites/default/files/documents/Drug-Use-Glossary-for-Elected-Officials.pdf

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Neonatal Abstinence Syndrome (NAS)

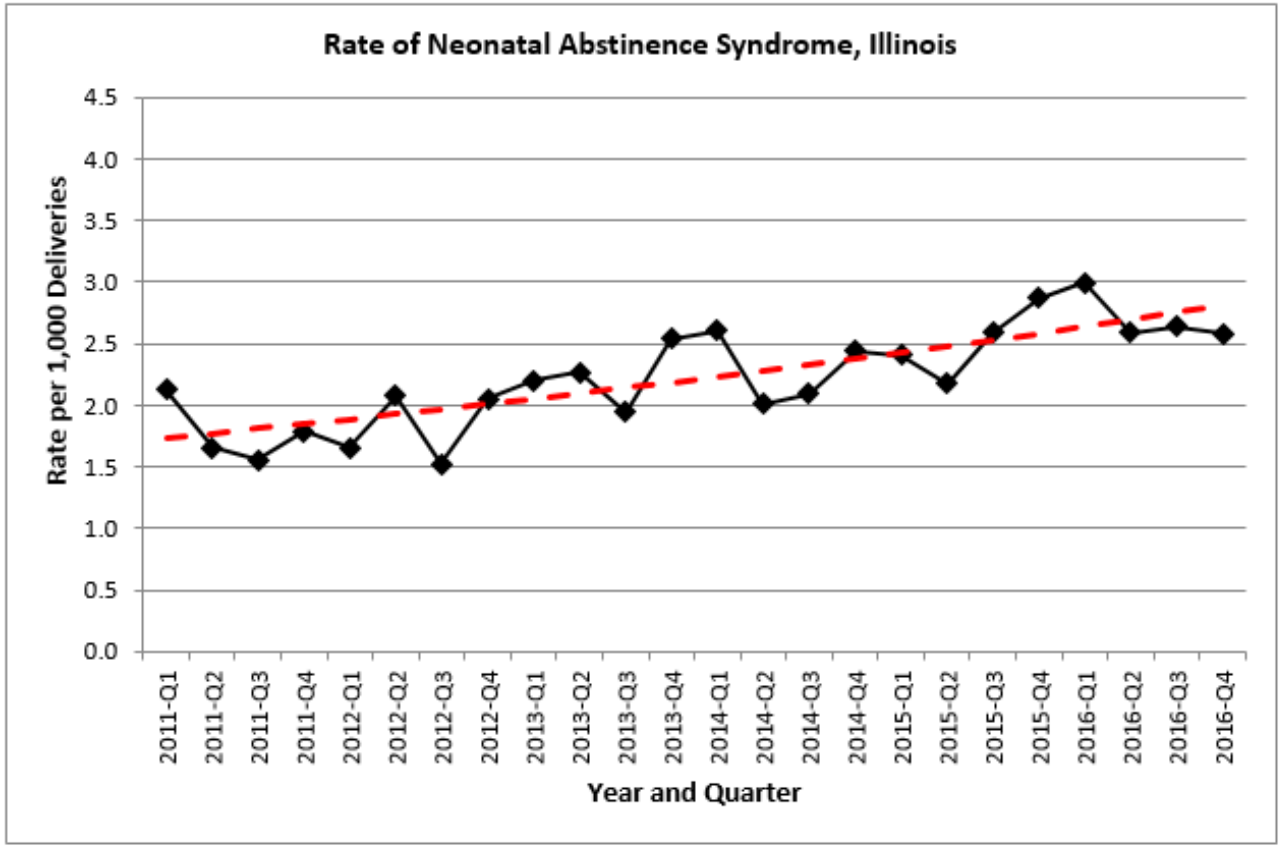
Provide education regarding neonatal abstinence syndrome (NAS) and newborn care.

- Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome (NAS), a drug withdrawal syndrome that opioid-exposed neonates may experience shortly after birth.
  - Engage patients early on in care and offer a consultation with MFM or pediatrics in their third trimester
  - Ensure awareness of the signs and symptoms of NAS
- Include interventions to decrease NAS severity (eg, maternal-infant bonding and breastfeeding, and smoking cessation)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Increase in Neonatal Abstinence Syndrome



Average increase was 2.1% per quarter over the full time period. ($p<0.001$)

NAS: Signs to Watch For

- Increased muscle tone "tightness"
- Poor eating or vomiting. Often, babies look like they want to eat, but they are not able to suck and swallow at the same time
- High pitched or long periods of crying or fussiness
- Trouble sleeping. Without enough sleep, they are not able to eat properly.
- Tremors or shaking
- Diarrhea. This may cause the baby to lose weight.
- Fever or sweating
- Frequent yawning or sneezing
- Difficulty breathing because of a stuffy nose, fast breathing, or forgetting to breathe
- Breakdown of skin on face or knees because of rubbing on the linen
- Possible seizures

**Use a modified NAS scoring system (eg, Finnegan's)*

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Source: Catholic Health Women Care NAS Pamphlet

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Plan of Safe Care

Develop a network of providers (eg, social workers, case managers, legal services if available) to assist patients and families in the development of a "plan of safe care" for mom and baby *(see appendix, slide 75 for plan of safe care resources)*.

- 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 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.
  - Identify a case manager to oversee transition of the patient.
  - Hold regular meetings to review cases and coordinate care management.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Plan of Safe Care

Understand "Plan of Safe Care" requirements.

- Child Abuse Prevention and Treatment Act (CAPTA) *(see appendix, slide 81 for resources)*
- Talk with mom to ensure she has thought about safe care for herself and her baby after delivery
  - Ensure access and referral to support in the community for breastfeeding, postpartum care (including depression screening and family planning), and social services following release from health care providers
- Address the health and substance use disorder treatment needs of the baby and family
- Ensure mom has a plan for continuity of care post-delivery – a safe house to care for her baby, MAT, crib, car seat, etc.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

READINESS
(Every Outpatient Clinical Setting/Health System)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Professional Education

Provide staff-wide (clinical and non-clinical staff) education on SUDs.

- Recognize that pregnancy is a great window of opportunity to identify and treat women with OUD and improve maternal and infant outcomes
- What is OUD and who is affected (universal terminology and definitions for common language)?
- Offer strategies to engage the patient and how to overcome barriers
- What medications are appropriate during pregnancy?
- Medication-assisted treatment (MAT): methadone vs. buprenorphine (ie, Subutex/Suboxone) regimens – and accept patients who are NOT willing to take the treatment
    - Interactions with other medications may synergize opioids

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Professional Education

- Ensure providers and the obstetric team are educated on safe opioid prescribing practices
- Harm reduction interventions/programs (eg, naloxone distribution and syringe exchanges) for patients
- Appropriate levels of treatment maintained throughout the delivery
- Collaborate with the pediatric provider in the solution and in developing a newborn management plan
- Identify community resources with which to partner (eg, agencies that treat SUD, domestic violence shelters, WIC, home visiting agencies, etc.)

Practice Approach

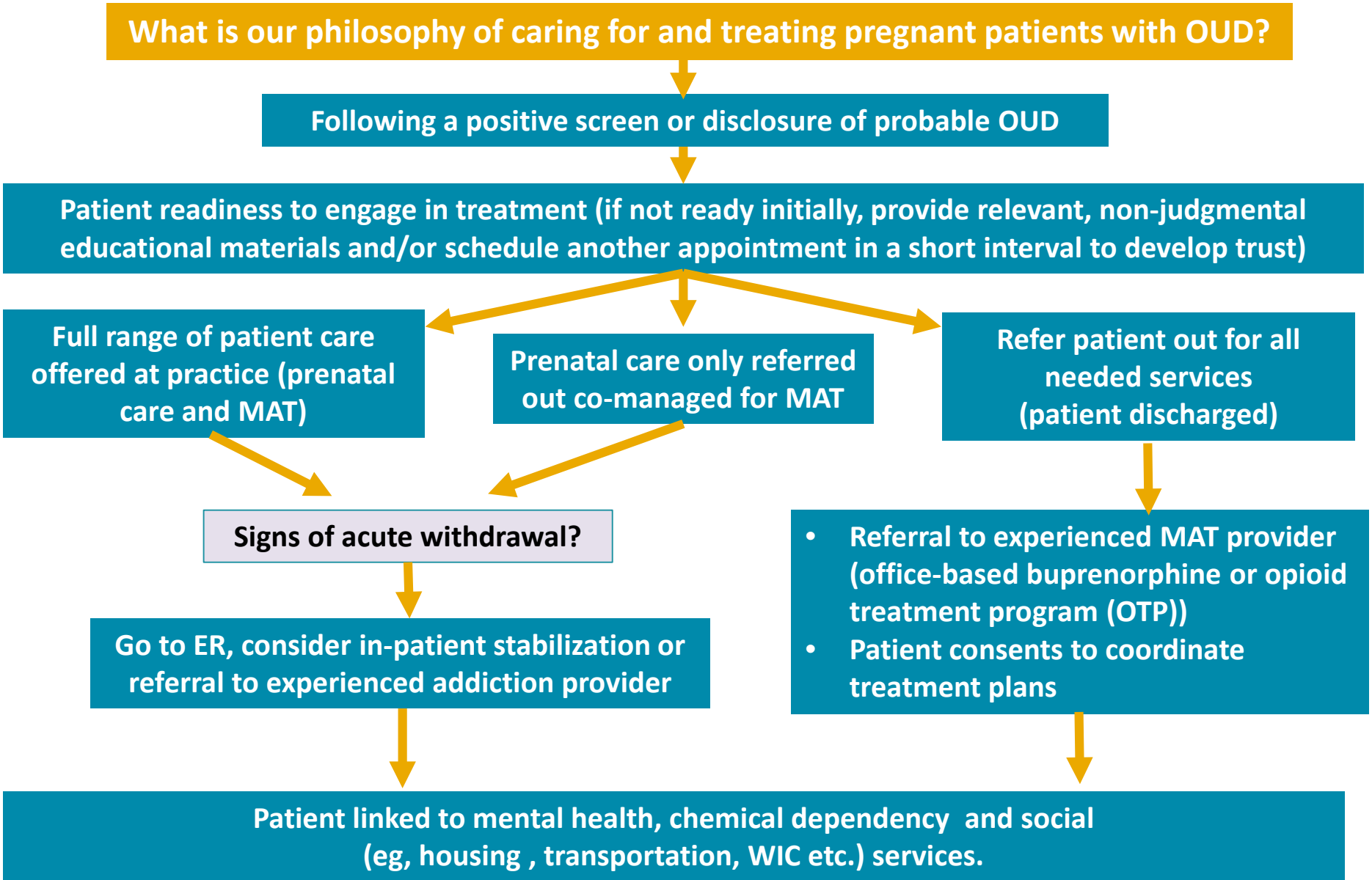
Practices should **clearly define** the approach to screening and testing pregnant patients for opioid use based on what best aligns with their resources, expertise, and capacity.

- An important first step all practices should initiate is mapping of local resources such as identifying available treatment centers for pregnant women and locating buprenorphine prescribing providers.
  - Educate **ALL** staff on the practice approach and why you are screening, explain the reasons (eg, identify patients early on for care, next steps, NICU stay, etc.)
  - Explain to staff why withdrawing a mom while pregnant is not optimal

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Practice Approach Algorithm



Practice Education: Patient Encounters

- Ensure office staff are knowledgeable about patient education, MAT, available opioid treatment programs and the potential impact on the fetus (*see appendix, slide 70 for resources)*
    - This may include coordinating a meet and greet with a pediatrician and ensuring an appointment is scheduled prior to delivery, connecting the patient to community-based services (eg, mental health services).

- Discuss the importance of trauma-informed care and an environment of open communication *(see appendix, slide 76 for trauma-informed care resource)*

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Trauma-Informed Care

Provide training regarding trauma-informed care to your staff.

**It is important that the staff who use motivational interviewing, recognize trauma-informed care as an element in the tapestry of a woman's life.*

- Understand the neurobiology of trauma
- Recognize the signs and symptoms of trauma in patients and families
- Screen for physical and sexual violence (eg, use ACES screening 10 question as a guide (*see appendix, slide 76 for example)*
- Coordinate care with behavioral health/psychiatric care teams
- Prevent re-traumatization
- Seek someone in the community to educate your staff on trauma- informed care, read articles and books, and recognize cues to help where staff need to go with questions.

    - Attend trainings provided by crisis centers/universities

Becoming a MAT Provider

Buprenorphine Waiver Training:

- To prescribe or dispense buprenorphine, physicians must **qualify** and apply for a waiver under the **Drug Addiction Treatment Act of 2000 (DATA 2000)**.
- **Physicians:** The DATA 2000 specifies training is necessary for physicians to obtain a waiver to engage in office-based treatment of opioid use disorders using drugs approved by the FDA on Schedules III, IV, and V.
- **Nurse Practitioners and Physician Assistants:** In July 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law. CARA authorizes **qualified** NPs and PAs to become waivered to prescribe buprenorphine in office-based settings for patients with Opioid Use Disorder (OUD) for a five-year period expiring in October 2021. ASAM, AANP, and AAPA are authorized by statute to provide this training.

**** For alternatives to becoming a licensed treatment provider**, go to www.buprenorphine.samhsa.gov. Click on "Data Physician Locator" under the "General" category. This will bring you to a listing of qualified physicians, which you can search by city, county or zip code.*

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Methadone vs. Buprenorphine in Pregnancy

Methadone	Buprenorphine
• May have better treatment retention • No risk of precipitating withdrawal (with initiation of therapy) • Treatment initiation may be easier	• May have less severe NAS • Fewer drug interactions • Ability to be treated on an outpatient basis and does not require daily visits • Reduced risk of overdose during induction

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Pain Management Strategies: Practice-Based

Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

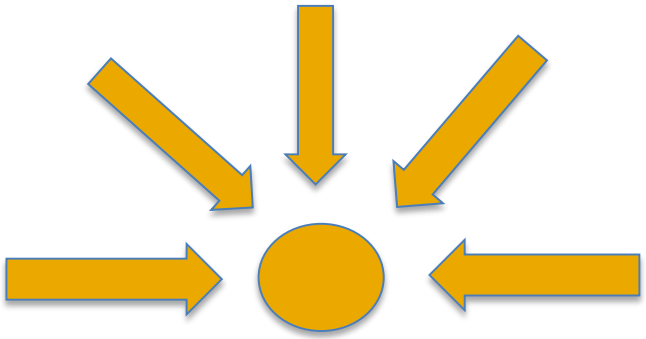
- Educate providers on strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacological, and non-opioid pharmacologic treatments.
  - Confirm dose of methadone or buprenorphine with women's health care provider and with ISTOP/PMP.
- Ensure awareness of dosage needs throughout the phases of pregnancy including addressing pain medication with patients and appropriate hospital staff at delivery.

  - If the patient is in prolonged labor, she may need to use her maintenance therapy medications during labor.

Establish Care Coordination

Establish specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers *(see appendix, slides 78-80).*

- Help women's health care providers obtain resources to become buprenorphine trained.
- Ensure pediatricians in the community are equipped with patient education about NAS and provide education about OUD.
- Educate emergency medicine physicians about the unique care plans for OUD in pregnant women and create protocols/processes for caring for this population when presenting to the ED (eg, care management/coordination through the development of algorithms/visual aids).
- Every hospital should standardize their discharge education and dosing for opioids (7 day supply limit).



Identify provider champions who can promote education and encourage other providers and systems to become engaged.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Establish Care Coordination

Ensure that OUD treatment programs meet patient and family resource needs (eg, wrap-around services such as housing, child care, transportation and home visitation).

- Identify a facilitator to train new staff, determine gaps in services, and bring teams together through hospital-based quality improvement programs.
- Seek out community health worker networks in your region

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Practice Education: Federal & State Guidelines

Know federal (Child Abuse Prevention Treatment Act – CAPTA), state and county reporting guidelines for substance-exposed infants.

(*see appendix, slide 81 CAPTA notification*)

- Know what the delivering hospital policy is regarding testing, contacting Child Protective Services (CPS), and the expected length of stay
- Know state, legal and regulatory requirements for SUD care

For example:

- Pregnant women have priority (SABG Block Grant Requirements)
- Treatment providers must ensure timely access to treatment services for pregnant women
- Providers of treatment services must establish a policy to offer admission preference to substance abusers who inject drugs intravenously or are pregnant

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

RECOGNITION
(Every Provider/Clinical Setting)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Recognition

- Assess ALL
- SBIRT
- Polysubstance use
- Co-morbidities
- Psychiatric disorders
- Intimate Partner Violence (IPV)
- Smoking
- Readiness to change

Screening

Screen and evaluate all pregnant women with OUD for commonly occurring co-morbidities including psychiatric disorders, and physical and sexual violence. Ensure the ability to screen for infectious disease (eg, HIV, hepatitis and sexually transmitted infections (STIs)).

Ensure screening for polysubstance use among women with OUD. Provide resources and interventions for smoking cessation.

- ALL women seen in the office, in-patient or emergency/urgent care should be screened for drug, alcohol and all forms of nicotine use utilizing a selected SBIRT tool (*refer back to slide 15-16 screening vs. testing as well as appendix, slides 64-67 for specific screening tools*)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

OUD Screening Tools

Utilize validated screening tools to identify drug and alcohol use.

- Routine screening should rely on validated screening tools, such as questionnaires like the 4Ps, Audit-C, NIDA Quick Screen, and CRAFFT (for women 26 years or younger)
  - All practices should use a screening tool that is non-judgmental, open-ended and implemented by their practice (*see appendix, slides 64-67*)
  - Patients may be more receptive to provider questioning while others may prefer a self-assessment on paper.
  - Screening is recommended at the first encounter. Elements can be added to the EMR under the flowsheet and flagged as a reminder to ask about substance use again in the third trimester.
  - In hospital screening – H&P should document what screening tool was used and that it was performed with the patient alone (away from family). Training should emphasize documentation that is non judgmental
    not allowing for statements like “non-contributory”.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Brief Intervention

- Patients who screen positive for OUD in pregnancy should receive a brief intervention. This intervention should use principles of motivational interviewing to affect behavioral change (*see appendix, slide 74*)

- Effective brief intervention includes 3 steps:
  1. **Offer feedback**
  2. **Listen and understand** the patient's motivation (eg, "I hear that you use x to deal with stress of life at home")
  3. **Explore other options** to address patient's motivation for substance use (eg, "Are there other ways to deal with stress in a more healthy way?")

Note: providing written handouts to ALL women can reach those who are afraid to disclose use, but who may be at risk and need treatment

Source: The role of screening, brief intervention, and referral to treatment in the perinatal period. American Journal of Obstetrics & Gynecology, Special Report. November 2016

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Referral to Treatment

Match treatment response to each woman's stage of recovery and/or readiness to change.

- Work with behavioral health/case managers in-office (*if available*) to assist with the intervention component of SBIRT
- Make referrals as needed that facilitate access to treatment and related services for women who need these services
  - Make connections with treatment providers to build relationships
  - Communicate with MAT providers at least once a month
- Ensure support for women's health care providers starting buprenorphine waiver training or newly trained

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

READINESS
(Every Inpatient Clinical Setting/Health System)

- **Understanding Your Hospital Approach/Philosophy**

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Regional Perinatal Center (RPC) & Hospital Education

- Engage community resources - ensure that all agencies are involved in the community – create resource guides, etc.
- All hospital teams should be trained in trauma-informed care, substance use disorders, opioid use disorder, safe care plan, etc. (*see appendix for examples*).
- Facilitate discussions with childbirth educator, obstetric provider (ob-gyn or licensed midwife), pediatric provider or neonatologist, anesthesiologist, and social worker to establish a plan and clarity of approach to care.
- Understand the hospital policy/approach for evaluating newborns for substance exposure at the time of delivery.
- The ob-gyn provider should know the basic discharge criteria for the at risk newborn.

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Hospital Approach

- Ensure all health care providers involved in the care of the woman have an understanding of the federal reporting requirements of CAPTA/CARA. Provide education where needed.

- Nursing
- Social Worker
- Women's Health Care Provider including ob-gyn, midwife, hospitalist, resident, medical and nursing students
- Anesthesiologists
- Neonatologists
- Behavioral Health Specialists
- Emergency Department

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Pain Management: General

Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.

- Each hospital is encouraged to develop guidelines for management of patients with OUD.
- Patients with OUD may experience more pain (increased sensitivity) and require higher doses of opioids (tolerance).
- As appropriate, maximize non-pharmacologic therapies (eg, PT) and non-opioid pharmacologic treatments (eg, NSAIDS). Avoid mixed agonist-antagonists.
- Share 'withdrawal" order set for pregnancy patients (include anesthesia, pharmacy, OBs, and neonatologists/pediatricians) (*see slide 78 for sample order set*)

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Pain Management

Medical Care

Evaluation and management avoiding bias from patient's history of OUD and/or pregnancy.

1. Women with OUD are as (or more) susceptible to medical conditions
2. Pregnancy may alter the presentation of common medical conditions
3. Pregnancy is not a contraindication to appropriate evaluation or opioid pain management

Medication-assisted treatment (MAT)

Assess engagement in treatment

Tx: Yes. Verify MAT dose/frequency. Avoid changes unless medically necessary and in consult with MAT provider.

Tx: No. Assess willingness to engage in treatment and refer

Prenatal care

Assess for prenatal care

PNC: Yes. Update provider

PNC: No. Refer for prenatal care

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Pain Management: Intrapartum

- Intrapartum analgesia needs are the same as for any other woman
  - It should not be assumed that MAT is sufficient for intrapartum analgesia
- Methadone or buprenorphine should be continued throughout labor
  - Buprenorphine should not be temporarily stopped in anticipation of delivery
  - MAT should not be used/adjusted for intrapartum analgesia
- IV access may be more difficult
- Neuraxial anesthesia is safe
  - The incidence of hypotension may be increased in the presence of some co-morbid health conditions (eg, liver disease)
- Avoid mixed agonist-antagonists

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Pain Management: Postpartum

Reassure the patient that their pain will be addressed.
Medications for MAT should not be assumed to cover postpartum pain or adjusted/interrupted for pain management.

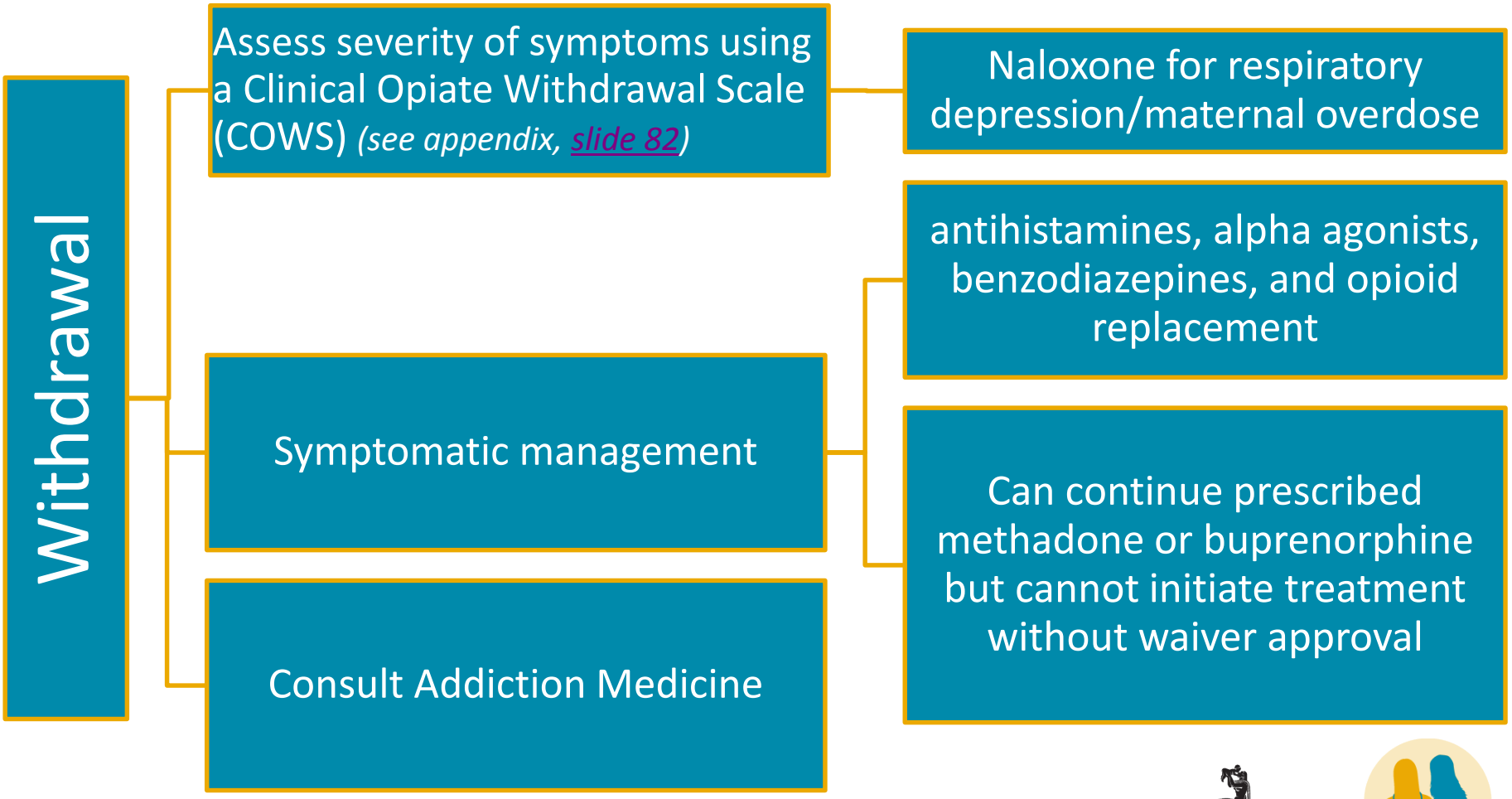
- **Vaginal delivery:** Non-opioid analgesics are often adequate
- **Cesarean delivery:** Patients often experience more pain and require higher than average opioid doses
- It is impossible to predict a patient's pain level or opioid need
- Maximize nonpharmacological (eg, heat) and non-opioid pain management (eg, TAB block, Toradol); double concentration patient-controlled analgesia (PCA)
  - Consider scheduled, rather than PRN, medications
- Avoid agonist/antagonists and full antagonists.

Breastfeeding should be encouraged for women who are on a stable dose of methadone or buprenorphine, interested, and have no other contraindications

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Withdrawal/Overdose



ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Treatment Services

Identify local SUD treatment facilities that provide women-centered care.

Ensure that drug and alcohol counseling and/or behavioral health services are provided.

- Create better engagement and communication among providers within the continuum of care and across service areas, including the justice system, as needed
- Educate all providers of the importance of universal screening and have resources available for those screening positive
- Utilize tools to connect patients to treatment

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Conclusion

- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman.
- It is vital to use language that helps reduce stigma, accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.
- Specific prenatal, intrapartum and postpartum clinical pathways for women with OUD that incorporate care coordination among multiple providers should be established.
- Various resources exist, including those listed in the attached appendix

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Special thanks to ACOG District II Opioid Use Disorder in Pregnancy Task Force & Key Partners

Leah Kaufman, MD FACOG Co-Chair
David Garry, DO, FACOG Co-Chair
Cynthia Abraham, MD, FACOG
Michelle Bode, MD, MPH
Erin Bortel, MSW
Sharon Chesna, MPA
Michele Calvo, MPH
Kathleen Dermady, DNP, LM, CNM, NP
Darcy Dreyer
Christie Finch
Aimee Gomlak, FACHE
Dede Hill
Lyla Hunt
Julia Hunter, MD, MPH, FASAM
Solita Jones, MS
Marilyn Kacica, MD, MPH
Melissa Kubenik, MD, FACOG
Nicholas Kulbida, MD, FACOG
Helena LaDue, LMSW, CASAC
Kristen Lawless, MS
Lauren Miller, MD, MPH
Maria Morris-Groves, MSEd
Debby O'Brien
James Scott, MD, FACOG
Neil Seligman, MD, MS, FACOG
Maggie Taylor, PhD
Darlene Walker, RN, FNP
Bridget Walsh
Ellie Ward

- *Alliance for Innovation on Maternal Health (AIM)*
- *HANYS' Statewide Opioid Addiction Prevention and Management Collaborative*
- *NYSDOH AIDs Institute, Office of Drug User Health*
- *NYSDOH's New York State Perinatal Quality Collaborative (NYSPQC)*
- *NYS Office of Alcoholism and Substance Abuse Services (OASAS)*

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Contact

- Email info@ilpqc.org
- Visit us at www.ilpqc.org

THANKS TO OUR SPONSORS

Illinois Department of Public Health
Center for Disease Control and Prevention
Illinois Department of Human Services

APPENDIX

The resources provided in this section are for informational purposes only. The exclusion of a resource, program or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change without advance notice

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Resources: Screening Tools

4 Ps*

Parents: Did any of your parents have a problem with alcohol or other drug use?
Partner: Does your partner have a problem with alcohol or drug use?
Past: in the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
Present: In the past month, have you drank any alcohol or used other drugs?
Scoring: Any "yes" should trigger further questions

CRAFFT – Substance Abuse Screen for Adolescents & Young Adults

C Have you ever ridden in a **CAR** driven by someone (including self) who was high or had been using alcohol or drugs?
R Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
A Do you ever use alcohol or drugs while you are by yourself or **ALONE**?
F Do you ever **FORGET** things you did while using alcohol or drugs?
F Do your **FAMILY** or friends ever tell you that you should cut down on your drinking our drug use?
T Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?
Scoring: Two or more positive items indicates the need for further assessment

Source: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Resources: Screening Tools

STEP 1 – Ask the NIDA *Quick Screen* Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For *each* substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Source: https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf

Resources: Screening Tools

Quick Screen Question: In the past year, how often have you used the foll
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day
Tobacco Products
Prescription Drugs for Non-Medical Reasons
Illegal Drugs

- If the patient says **"NO"** for all drugs in the Quick Sc **complete.**
- If patient says **"Yes"** to **one or more days of heavy** Please see NIAAA website "How to Help Patients W http://pubs.niaaa.nih.gov/publications/Practitioner information to advise, assess, assist, and arrange he use disorders.
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco users to quit. For more information on sm Smokers Quit: A Guide for Clinicians" http://www.a guidelines-recommendations/tobacco/clinicians/ref
- If the patient says **"Yes"** to **use of illegal drugs or pr** proceed to **Question 1** of the NIDA-Modified ASSIST

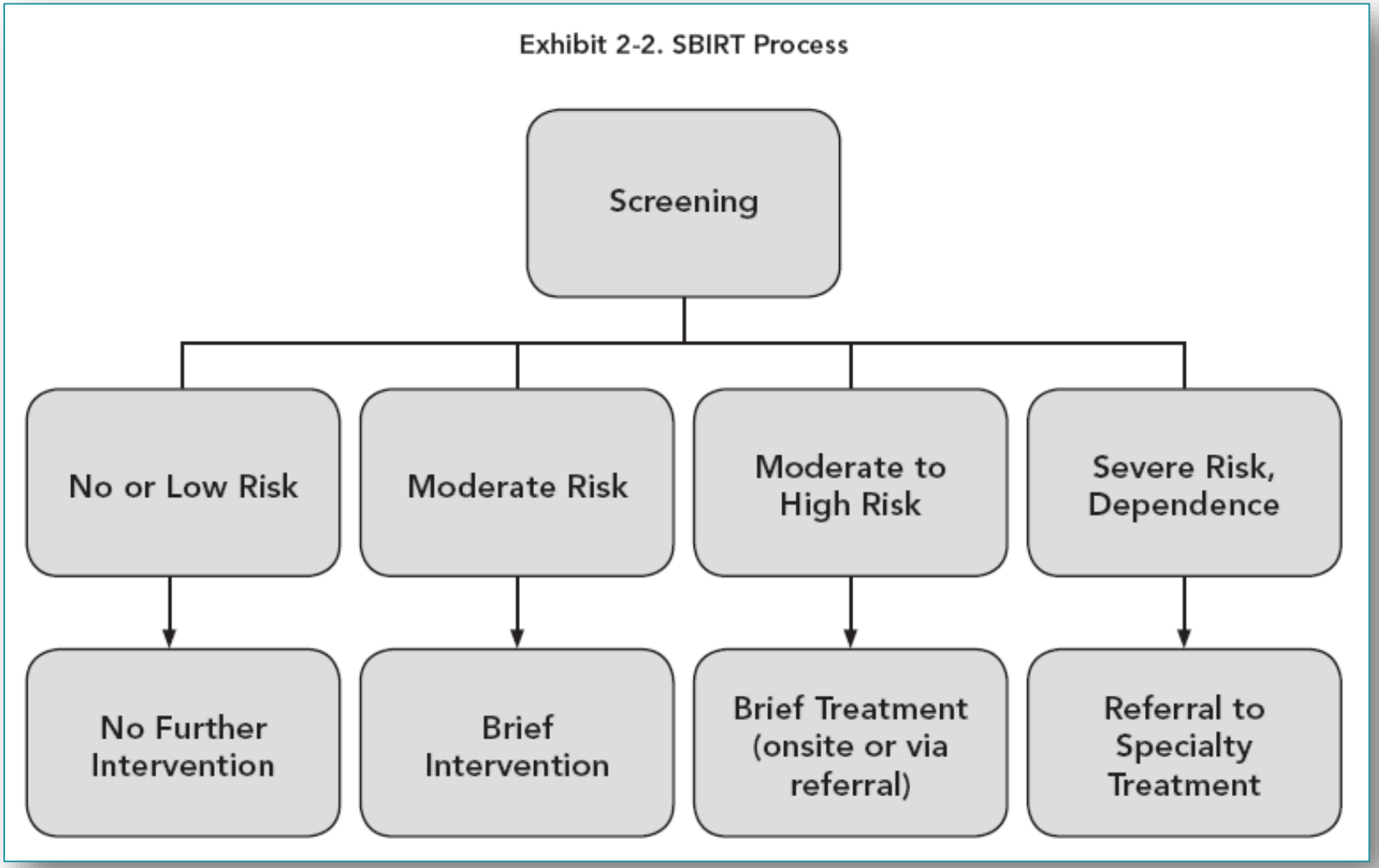
STEP 2 – Ask about any *lifetime* drug use (Question 1)

Instructions: Now ask the patient about any **lifetime** drug use. This form may be completed by your patient or any health care professional in your office. Screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed.

Q1. In your *LIFETIME*, which of the following substances have you ever used?	**Yes**	**No**
a. **Cannabis** (marijuana, pot, grass, hash, etc.)		
b. **Cocaine** (coke, crack, etc.)		
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. **Methamphetamine** (speed, crystal meth, ice, etc.)		
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.)		
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. **Street opioids** (heroin, opium, etc.)		
i. **Prescription opioids** (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) • Please record **nonmedical use only**: *Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.*		
j. **Other – specify:**		

Source: https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf

Resources: Screening Tools



Source: https://www.integration.samhsa.gov/sbirt/TAP33.pdf

Resources: Reimbursement for SBIRT

Payer	Code	Description
Commercial Insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min
Commercial Insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min
Medicare	G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year. No coinsurance; no deductible for patient http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf

Source: https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf

Resources: Reimbursement for SBIRT

Medicare	G0443	Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient http://www.cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249
Medicaid	H0049	Alcohol and/or drug screening (code not widely used)
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)

Source: https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf

Resources: Patient Education

Risks of continued SUD in Pregnancy:
https://www.marchofdimes.org/pregnancy/street-drugs-and-pregnancy.aspx

Benefits of Medication-assisted treatment (MAT) in pregnancy with methadone and buprenorphine:
https://store.samhsa.gov/shin/content//SMA14-4124/SMA14-4124.pdf

Safety of the newborn, developing a plan of safe care for mother and newborn:
https://ncsacw.samhsa.gov/files/CAPTA_SEI_Statutory_Summary.pdf

https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Neonatal Abstinence Syndrome: What You Need to Know:
http://www.nnepqin.org/wp-content/uploads/2017/08/ToolkitOUD_5_2_NAS_Parent_Education_Guide.pdf

Breast feeding - ABM Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2989871/pdf/bfm.2009.9987.pdf

Resources: Patient Education

HEALTH ACTION SHEET

Are you taking any of these prescription painkillers?

These are prescription painkillers called opioids and some of their brand names. If you take an opioid during pregnancy, it can cause serious problems for your baby.

- Buprenorphine (Belbuca®, Buprenex®, Butrans®, Probuphine®)
- Codeine
- Fentanyl (Actiq®, Duragesic®, Sublimaze®)
- Hydrocodone (Lorcet®, Lortab®, Norco®, Vicodin®)
- Hydromophone (Dalaudid®, Exalgo®)
- Meperidine (Demerol®)
- Methadone (Dolophine®, Methadose®)
- Morphine (Astramorph®, Avinza®, Duramorph®, Roxanol®)
- Oxycodone (OxyContin®, Percodan®, Percocet®)
- Oxymorphone (Opana®)
- Tramadol (ConZip®, Ryzolt®, Ultram®)

The illegal drug heroin is an opioid. Fentanyl and other prescription opioids also are being made and sold illegally.

Your provider may prescribe an opioid for you if you've been injured or had surgery. Opioids can be dangerous and addictive. They can cause problems for a baby in the early weeks of pregnancy, even before you know you're pregnant.

If you take opioids during pregnancy, your baby can be exposed to them in the womb and go through withdrawal after birth. This is called neonatal abstinence syndrome or NAS. Even if you use an opioid exactly like your provider says to, it still may cause NAS in your baby.

If you're pregnant and using opioids:

- Don't start or stop taking any opioid until you talk to your health care provider. Starting or stopping certain medicines can be harmful to you and your baby. Quitting suddenly (called cold turkey) can cause severe problems for your baby, including death.
- Tell your prenatal care provider about any opioid or other medicine you take, even if it's prescribed by another health care provider.
- If you go to a provider who prescribes you an opioid, make sure she knows you're pregnant.
- Ask your provider about other kinds of painkillers you can take instead of opioids.

If you're not pregnant and you're using opioids:

- Use effective birth control until you've stopped taking the opioid.
- Talk to your provider about taking a safer pain medicine.

Watch a video about prescription medicine at: marchofdimes.org/prescriptionmeds

march of dimes
A FIGHTING CHANCE FOR EVERY BABY

PREGNANCY:

Methadone and Buprenorphine

Some women are surprised to learn they got pregnant while using heroin, Oxycontin, Percocet or other pain medications that can be misused (known as opioid drugs). You, along with family and friends, may worry about your drug use and if it could affect your baby.

Some women may want to "detox" as a way to stop using heroin or pain medicines. Unfortunately, studies have shown that 8 out of 10 women return to drug use by a month after "detox." Therefore, most doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.

HOW SAFE IS IT TO TAKE METHADONE OR BUPRENORPHINE (SUBUTEX®) DURING PREGNANCY?

- In the right doses, both methadone and buprenorphine stop withdrawal, reduce craving, and block effects of other opioids.
- Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
- Based on many years of research studies, neither medicine has been associated with birth defects.
- Babies born to women who are addicted to heroin or prescription opioids can have temporary withdrawal or abstinence symptoms in the baby (Neonatal Abstinence Syndrome or NAS). These withdrawal symptoms (NAS) also can occur in babies whose mothers take methadone or buprenorphine
- Talk with your doctor about the benefits versus the risks of medication treatment along with the risks of not taking medication treatment.

IS METHADONE OR BUPRENORPHINE A BETTER MEDICATION FOR ME IN PREGNANCY?

- A pregnant woman and her doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
- If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

HOW CAN I GET STARTED ON METHADONE OR BUPRENORPHINE?

- Depending where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
- Methadone may only be given out by specialized clinics while buprenorphine may also be available from your primary care physician or obstetrician if they have received special training.
- Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

WHAT IS THE BEST DOSE OF METHADONE OR BUPRENORPHINE DURING AND AFTER PREGNANCY?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

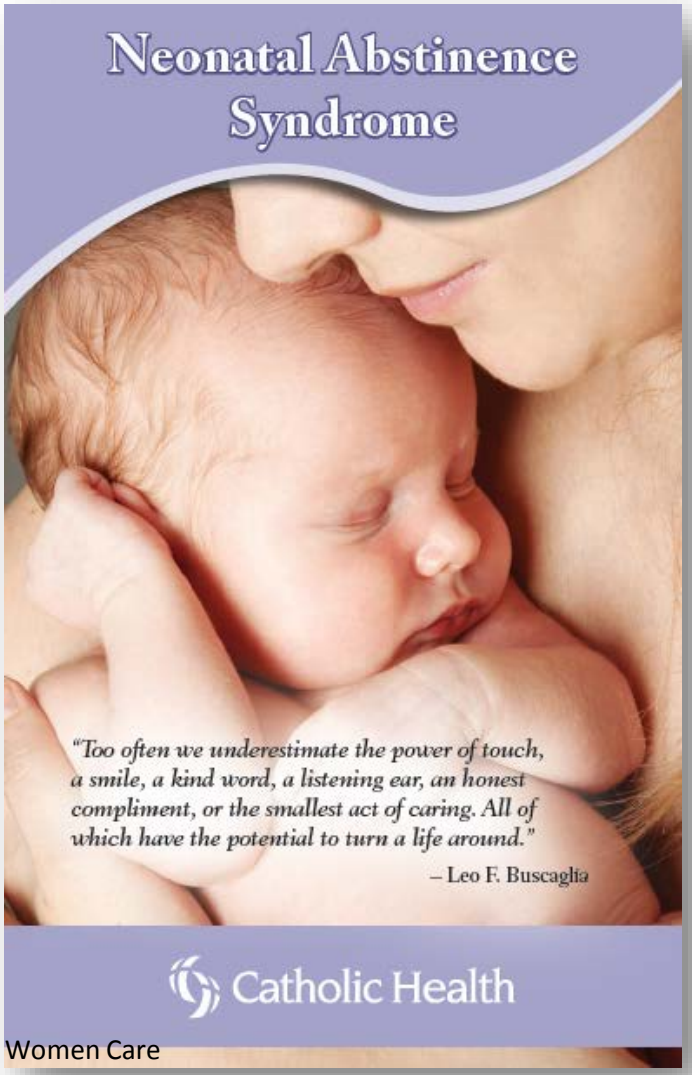
- The "right" dose will prevent withdrawal symptoms without making you too tired.
- The right dose depends on how your body processes the medications.
- In pregnancy, you process these medications more quickly, especially in the last several months and this affects what dose you need.
- The dose of methadone usually needs to increase with pregnancy – especially in the third trimester and you may need to take methadone more than once a day.
- There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.
- The dose does not seem to determine how much NAS a baby will have.
- After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause sedation. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. *For further information, please see brochure Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine.*

Sources: https://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx
https://pcss-o.org/wp-content/uploads/2015/10/WAGBrochure-Opioid-Pregnancy_Final.pdf

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Resources: Patient Education



Sources: Catholic Health Women Care
National Perinatal Association

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Resources: Provider Tools – NAS Scoring

EXAMPLE

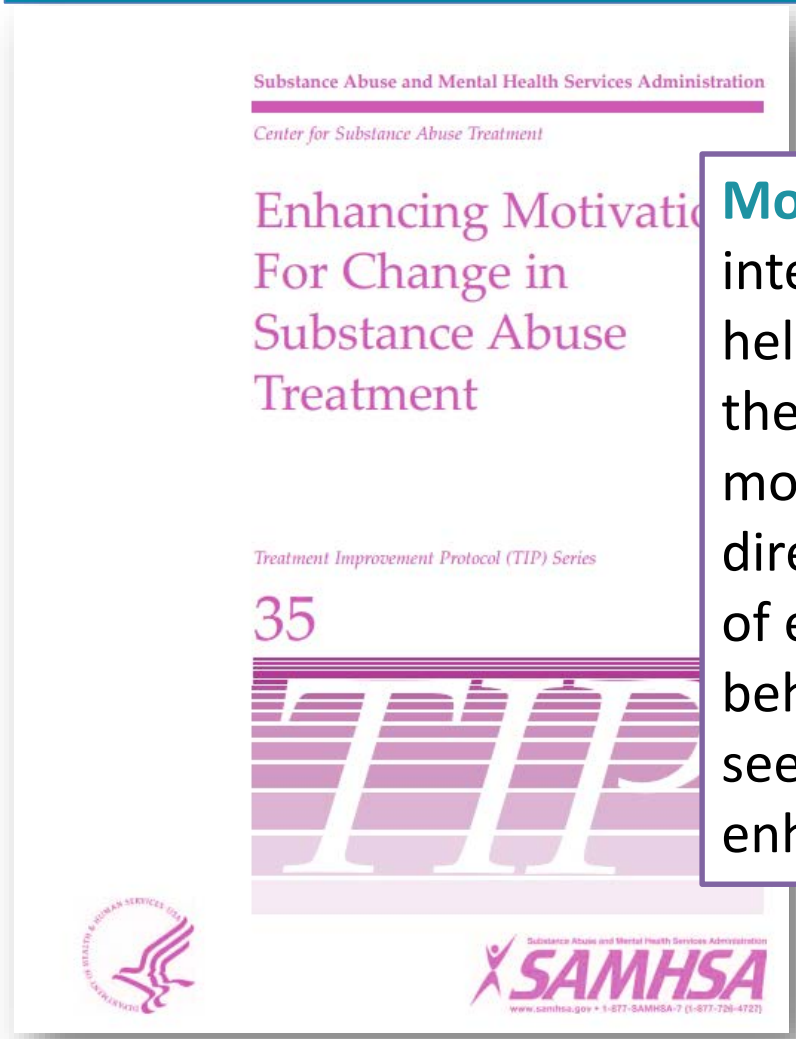
SYSTEMS	SIGNS AND SYMPTOMS	SCORE	AM 2	4	6	8	10	12	PM 2	4	6	8	10	12	DAILY WT.
CENTRAL NERVOUS SYSTEM DISTURBANCES	High Pitched Cry Continuous High Pitched Cry	2 3													
	Sleeps < 1 Hour After Feeding Sleeps < 2 Hours After Feeding	3 2													
	Hyperactive Moro Reflex Markedly Hyperactive Moro Reflex	2 3													
	Mild Tremors Disturbed Moderate Severe Tremors Disturbed	2 3													
	Mild Tremors Undisturbed Moderate Severe Tremors Undisturbed	1 2													
	Increased Muscle Tone	2													
	Excoriation (specify area): _____	1													
	Myoclonic Jerks	3													
	Generalized Convulsions	3													
METABOLIC VASOMOTOR/ RESPIRATORY DISTURBANCES	Sweating	1													
	Fever < 101°F (39.3°C) Fever > 101°F (39.3°C)	1 2													
	Frequent Yawning (> 3-4 times/interval)	1													
	Mottling	1													
	Nasal Stuffiness	1													
	Sneezing (> 3-4 times/interval)	1													
	Nasal Flaring	2													
	Respiratory Rate > 60/min Respiration Rate > 60/min with Retractions	1 2													
GASTROINTESTINAL DISTURBANCES	Excessive Sucking	1													
	Poor Feeding	2													
	Regurgitation Projectile Vomiting	2 3													
	Loose Stools Watery Stools	2 3													
SUMMARY	TOTAL SCORE														
	SCORER'S INITIALS														
	STATUS OF THERAPY														

Adapted from Finnegan L. Neonatal abstinence syndrome: assessment and pharmacotherapy. Neonatal Therapy: An update, F. F. Rubaltelli and B. Granti, editors. Elsevier Science Publishers B. V. (Biomedical Division). 1986: 122-146

ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Resources: Provider Tools – Motivational Interviewing



Motivational Interviewing: Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. While conducting a motivational interview, the clinician is directive yet client centered, with a clear goal of eliciting self-motivational statements and behavioral change from the client, and seeking to create client discrepancy to enhance motivation for positive change.

Source: https://store.samhsa.gov/shin/content//SMA13-4212/SMA13-4212.pdf

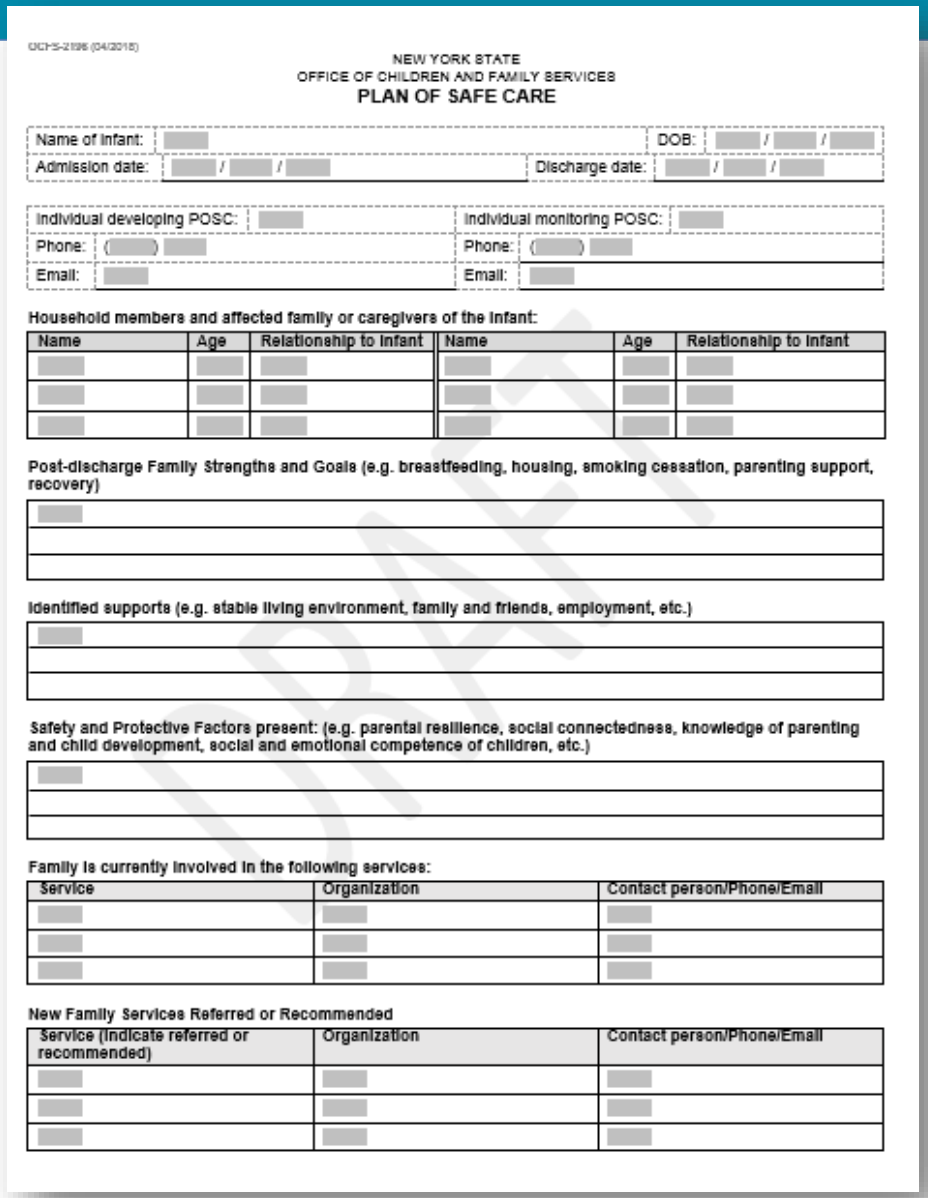
ACOG District II

MANAGING OPIOID USE DISORDER IN PREGNANCY

Resources Providers: Plan of Safe Care

EXAMPLE

Final Coming Soon



OCFS-2196 (04/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

PLAN OF SAFE CARE

Name of Infant:		DOB:	/ /
Admission date:	/ /	Discharge date:	/ /

Individual developing POSC:		Individual monitoring POSC:	
Phone:	( )	Phone:	( )
Email:		Email:	

Household members and affected family or caregivers of the infant:

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

Post-discharge Family Strengths and Goals (e.g. breastfeeding, housing, smoking cessation, parenting support, recovery)

Identified supports (e.g. stable living environment, family and friends, employment, etc.)

Safety and Protective Factors present: (e.g. parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children, etc.)

Family is currently involved in the following services:

Service	Organization	Contact person/Phone/Email

New Family Services Referred or Recommended

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email

DRAFT

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Resources: Provider Tools – Trauma Informed Care

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

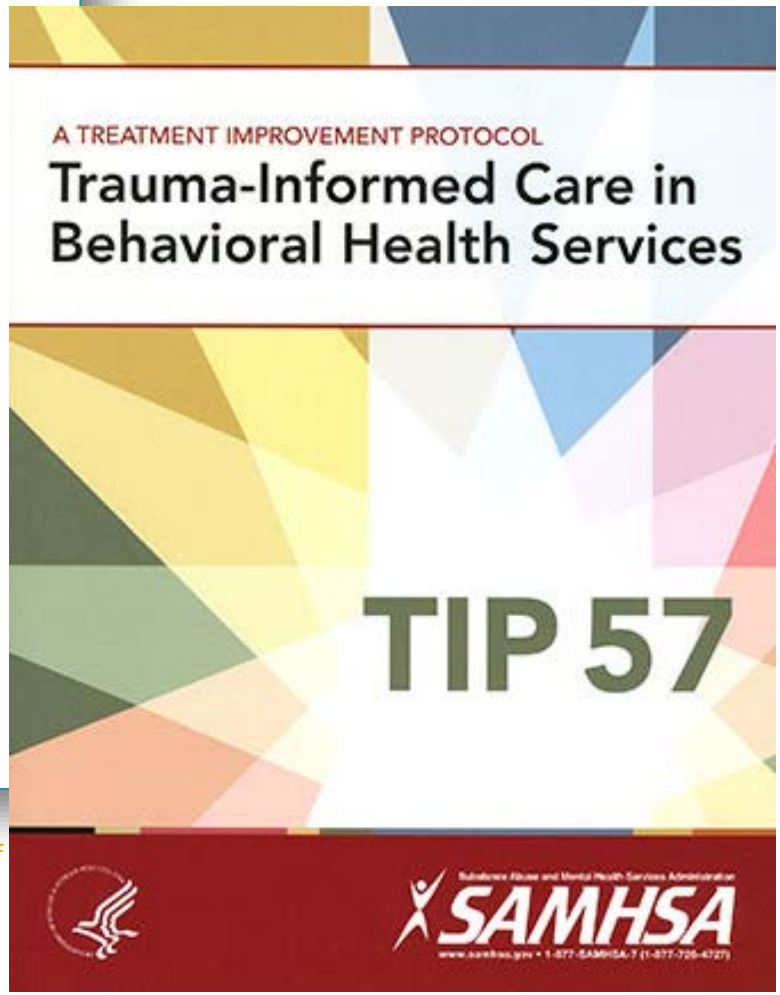
1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

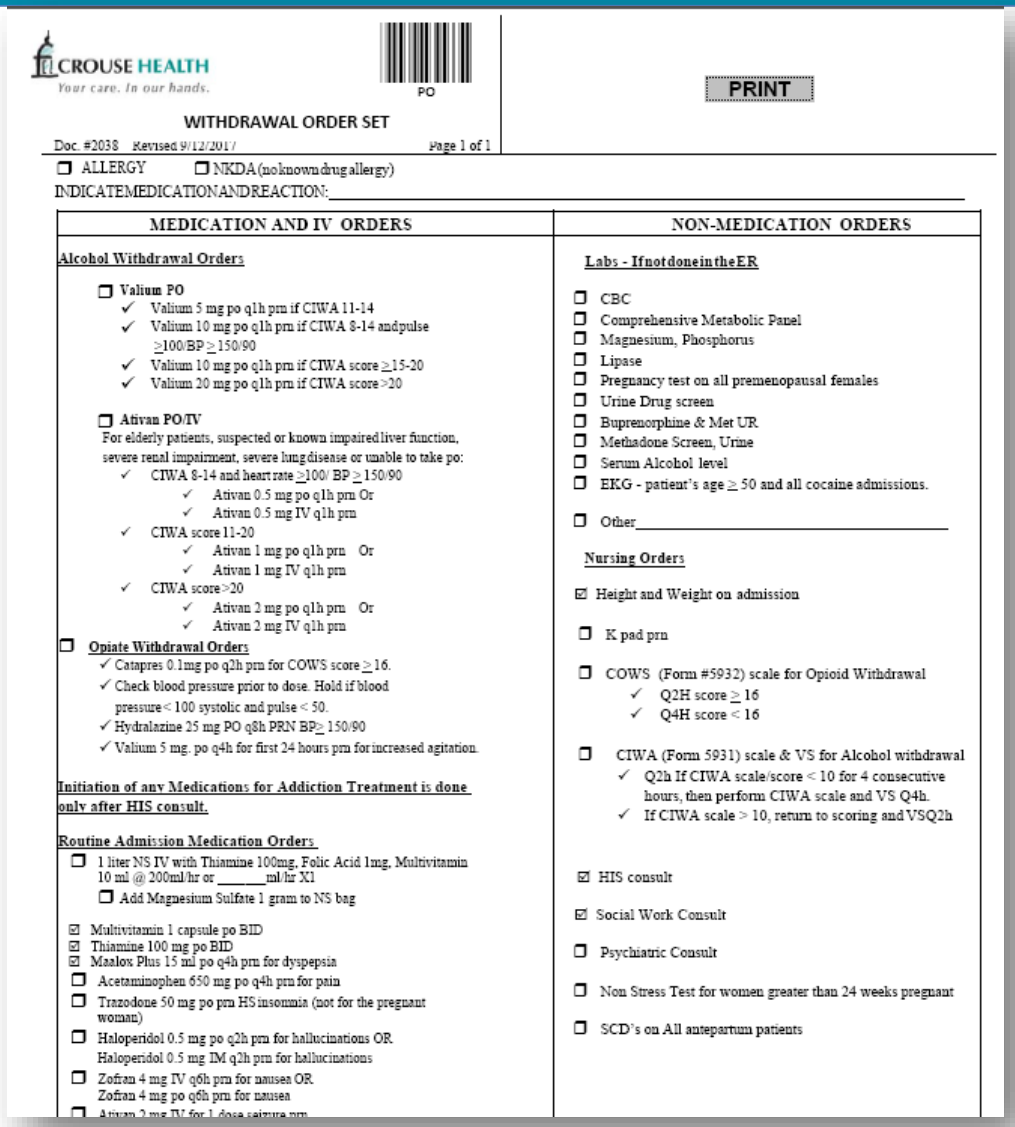
5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____



Source: https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Resources: Provider Tools – Withdrawal Order Set

EXAMPLE



CROUSE HEALTH
Your care. In our hands.

PO

PRINT

WITHDRAWAL ORDER SET

Doc. #2038 Revised 9/12/2017 Page 1 of 1

☐ ALLERGY ☐ NKDA (no known drug allergy)

INDICATE MEDICATION AND REACTION: _____

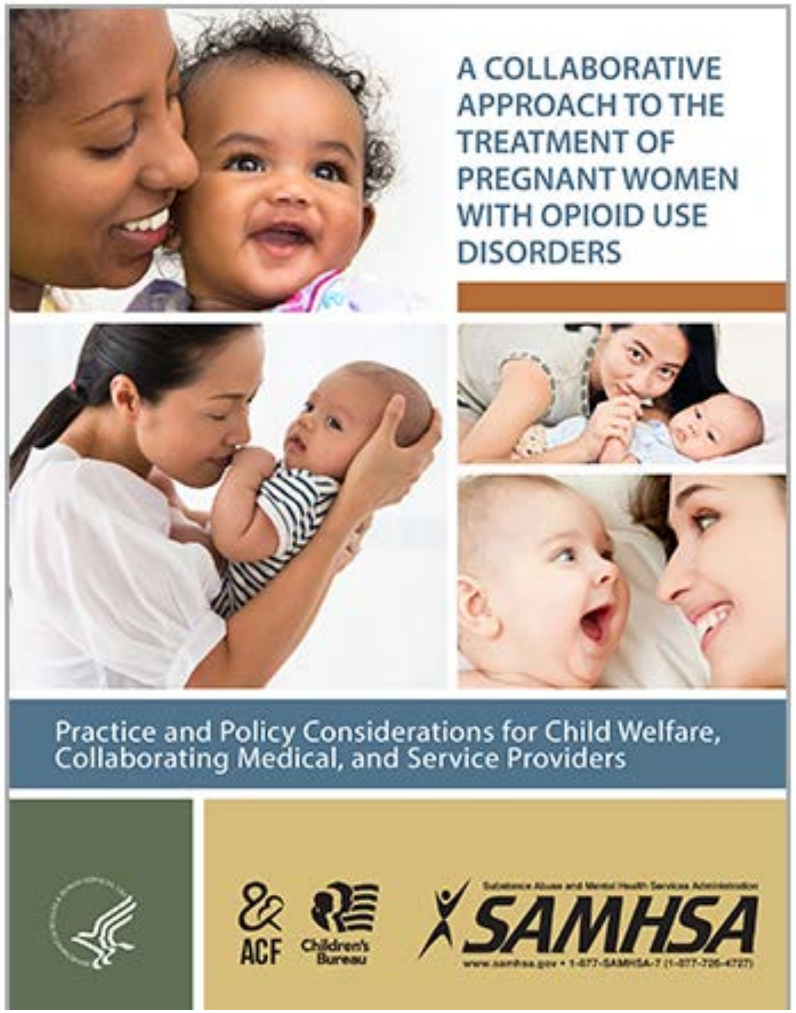
MEDICATION AND IV ORDERS	NON-MEDICATION ORDERS
Alcohol Withdrawal Orders ☐ **Valium PO** ✓ Valium 5 mg po q1h prn if CIWA 11-14 ✓ Valium 10 mg po q1h prn if CIWA 8-14 and pulse ≥100/BP ≥ 150/90 ✓ Valium 10 mg po q1h prn if CIWA score ≥15-20 ✓ Valium 20 mg po q1h prn if CIWA score >20 ☐ **Ativan PO/IV** For elderly patients, suspected or known impaired liver function, severe renal impairment, severe lung disease or unable to take po: ✓ CIWA 8-14 and heart rate ≥100/ BP ≥ 150/90 ✓ Ativan 0.5 mg po q1h prn Or ✓ Ativan 0.5 mg IV q1h prn ✓ CIWA score 11-20 ✓ Ativan 1 mg po q1h prn Or ✓ Ativan 1 mg IV q1h prn ✓ CIWA score >20 ✓ Ativan 2 mg po q1h prn Or ✓ Ativan 2 mg IV q1h prn ☐ **Opiate Withdrawal Orders** ✓ Catapres 0.1mg po q2h prn for COWS score ≥ 16. ✓ Check blood pressure prior to dose. Hold if blood pressure < 100 systolic and pulse < 50. ✓ Hydralazine 25 mg PO q8h PRN BP≥ 150/90 ✓ Valium 5 mg. po q4h for first 24 hours prn for increased agitation. **Initiation of any Medications for Addiction Treatment is done only after HIS consult.** **Routine Admission Medication Orders** ☐ 1 liter NS IV with Thiamine 100mg, Folic Acid 1mg, Multivitamin 10 ml @ 200ml/hr or _____ml/hr X1 ☐ Add Magnesium Sulfate 1 gram to NS bag ☑ Multivitamin 1 capsule po BID ☑ Thiamine 100 mg po BID ☑ Maalox Plus 15 ml po q4h prn for dyspepsia ☐ Acetaminophen 650 mg po q4h prn for pain ☐ Trazodone 50 mg po prn HS insomnia (not for the pregnant woman) ☐ Haloperidol 0.5 mg po q2h prn for hallucinations OR Haloperidol 0.5 mg IM q2h prn for hallucinations ☐ Zofran 4 mg IV q6h prn for nausea OR Zofran 4 mg po q6h prn for nausea ☐ Ativan 2 mg IV for 1 dose seizure prn	**Labs - If not done in the ER** ☐ CBC ☐ Comprehensive Metabolic Panel ☐ Magnesium, Phosphorus ☐ Lipase ☐ Pregnancy test on all premenopausal females ☐ Urine Drug screen ☐ Buprenorphine & Met UR ☐ Methadone Screen, Urine ☐ Serum Alcohol level ☐ EKG - patient's age ≥ 50 and all cocaine admissions. ☐ Other _____ **Nursing Orders** ☑ Height and Weight on admission ☐ K pad prn ☐ COWS (Form #5932) scale for Opioid Withdrawal ✓ Q2H score ≥ 16 ✓ Q4H score < 16 ☐ CIWA (Form 5931) scale & VS for Alcohol withdrawal ✓ Q2h If CIWA scale/score < 10 for 4 consecutive hours, then perform CIWA scale and VS Q4h. ✓ If CIWA scale > 10, return to scoring and VSQ2h ☑ HIS consult ☑ Social Work Consult ☐ Psychiatric Consult ☐ Non Stress Test for women greater than 24 weeks pregnant ☐ SCD's on All antepartum patients

Source: Crouse Health Withdrawal Order Set

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Resources: Provider Tools – Collaborative Approach



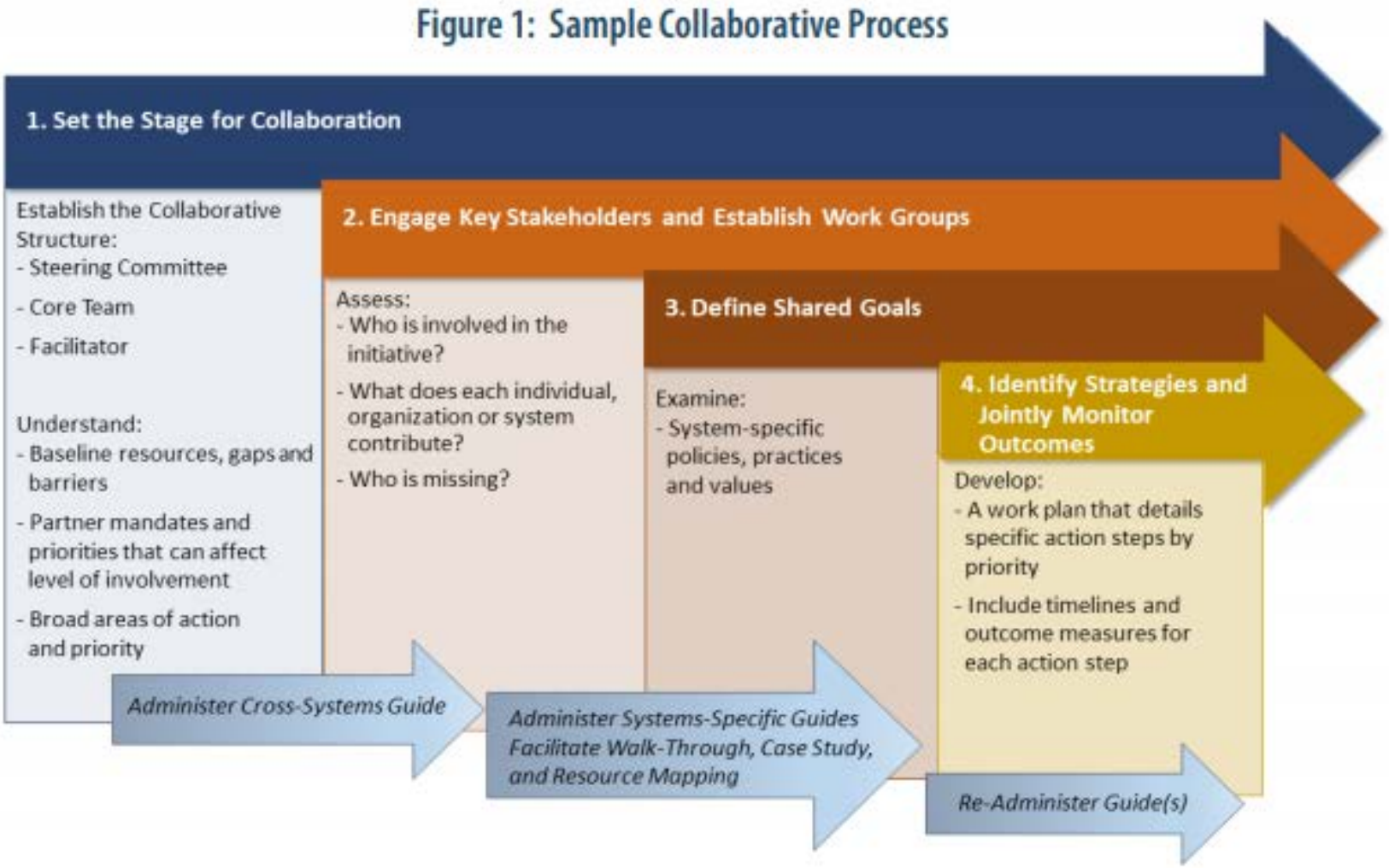
Compared to efforts by individual agencies and systems, collaboration across multiple agencies and systems, coupled with strong leadership and consistent communication, offers a more effective approach, a more efficient way of doing business, and ultimately leads to better outcomes.

Source: https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

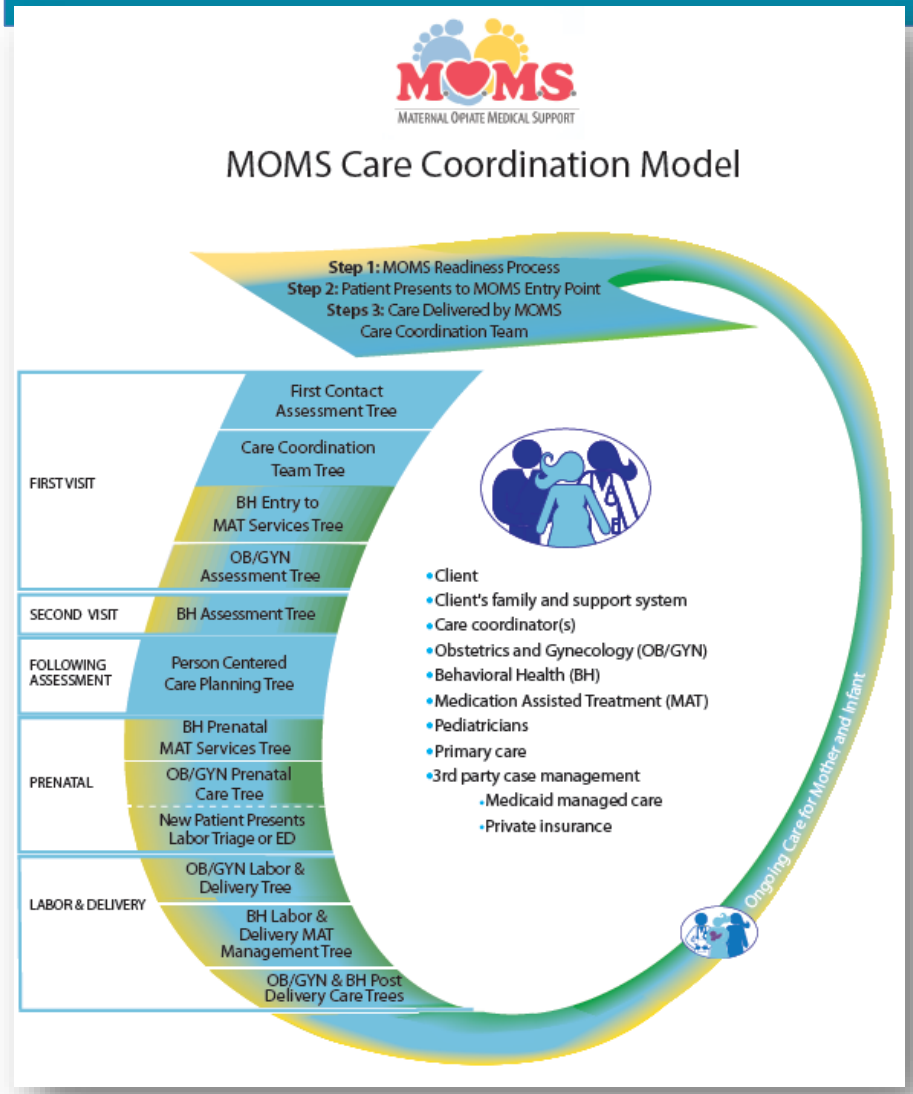
Created by ACOG District II in 2018

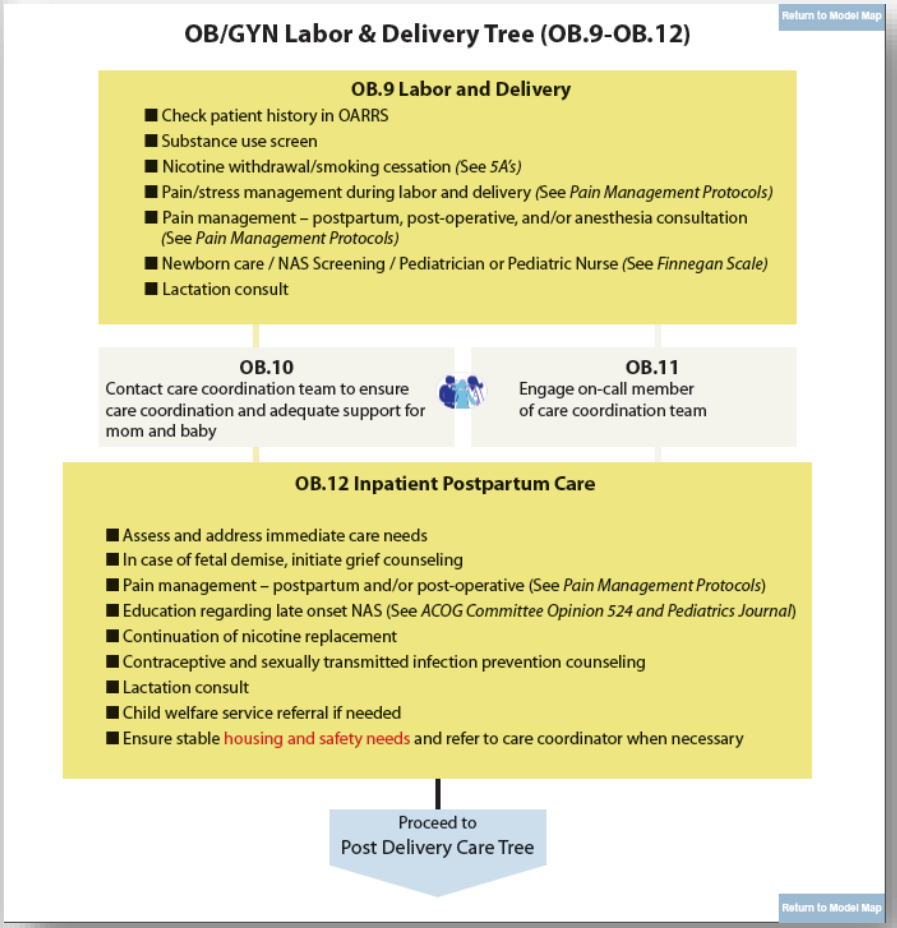
Resources: Provider Tools



Source: https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978

Resources: Provider





Source: http://momsohio.org/healthcare-providers/decision-trees/decisiontree-attributes/MOMS-Decision-Tree_F3_12-8-15.pdf

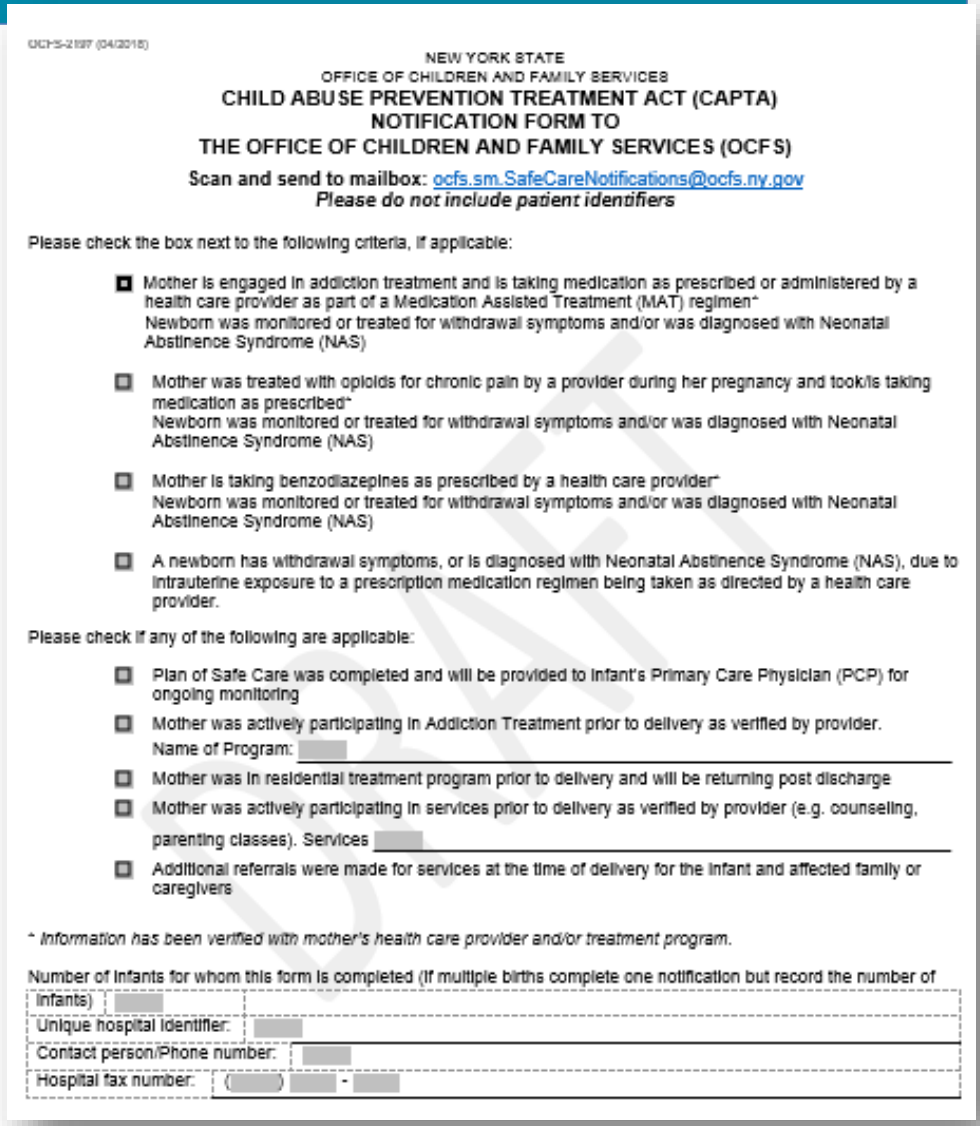
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Resources: Provider Tools – CAPTA Notification

EXAMPLE

Final Coming Soon



OCFS-2197 (04/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD ABUSE PREVENTION TREATMENT ACT (CAPTA)
NOTIFICATION FORM TO
THE OFFICE OF CHILDREN AND FAMILY SERVICES (OCFS)

Scan and send to mailbox: ocfs.sm.SafeCareNotifications@ocfs.ny.gov
Please do not include patient identifiers

Please check the box next to the following criteria, if applicable:

- ☐ Mother is engaged in addiction treatment and is taking medication as prescribed or administered by a health care provider as part of a Medication Assisted Treatment (MAT) regimen*
  Newborn was monitored or treated for withdrawal symptoms and/or was diagnosed with Neonatal Abstinence Syndrome (NAS)
- ☐ Mother was treated with opioids for chronic pain by a provider during her pregnancy and took/is taking medication as prescribed*
  Newborn was monitored or treated for withdrawal symptoms and/or was diagnosed with Neonatal Abstinence Syndrome (NAS)
- ☐ Mother is taking benzodiazepines as prescribed by a health care provider*
  Newborn was monitored or treated for withdrawal symptoms and/or was diagnosed with Neonatal Abstinence Syndrome (NAS)
- ☐ A newborn has withdrawal symptoms, or is diagnosed with Neonatal Abstinence Syndrome (NAS), due to intrauterine exposure to a prescription medication regimen being taken as directed by a health care provider.

Please check if any of the following are applicable:

- ☐ Plan of Safe Care was completed and will be provided to infant's Primary Care Physician (PCP) for ongoing monitoring
- ☐ Mother was actively participating in Addiction Treatment prior to delivery as verified by provider.
  Name of Program: _____
- ☐ Mother was in residential treatment program prior to delivery and will be returning post discharge
- ☐ Mother was actively participating in services prior to delivery as verified by provider (e.g. counseling, parenting classes). Services _____
- ☐ Additional referrals were made for services at the time of delivery for the infant and affected family or caregivers

** Information has been verified with mother's health care provider and/or treatment program.*

Number of infants for whom this form is completed (if multiple births complete one notification but record the number of infants) _____

Unique hospital identifier: _____

Contact person/Phone number: _____

Hospital fax number: (___) ___ - ____

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

Created by ACOG District II in 2018

Clinical Opiate Withdrawal Scale (COWS)

Patient's Name:_____ Date and Time ____/____/____:_____

EXAMPLE

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute

Source: https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Additional Resources

ACOG Maternal Opioid Bundle
http://safehealthcareforeverywoman.org/patient-safety-bundles/obstetric-care-for-women-with-opioid-use-disorder/
ACOG Maternal Opioid Bundle Resource Listing
http://safehealthcareforeverywoman.org/wp-content/uploads/2017/08/Obstetric-Care-for-Women-with-Opioid-Use-Disorder-Bundle_Resource-Listing.pdf
Buprenorphine Waiver Training Resources

- https://elearning.asam.org/products/the-asam-buprenorphine-course-acog march-3-2017
- https://pcssnow.org/clinical-coaching/
- https://pcssnow.org/resources/

Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants
https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf
HANYS Opioid Addiction Prevention & Management Collaborative
https://www.hanys.org/quality/collaboratives_and_learning_networks/opioids/
Medications for OUD
https://store.samhsa.gov/shin/content/SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf
SBIRT

- http://bigsbirteducation.webs.com/addictionwebinars.htm
- https://www.integration.samhsa.gov/clinical-practice/sbirt#why
- http://www.sbirtoregon.org/

The Alcohol Use Disorders Identification Test (AUDIT)
https://www.integration.samhsa.gov/clinical-practice/sbirt/AUDIT_Manual,_2.pdf