Opioid Use Disorder During Pregnancy

TOOLKIT

GREAT MOMs

MICHIGAN OPIOID COLLABORATIVE

Opioid Use Disorder During Pregnancy

Background

Substance Use Disorder (SUD) is a growing problem for people who are pregnant in the state of Michigan. According to the Michigan Prescription Drug and Opioid Task Force *Report of Findings and Recommendations for Action:*

- The rate of heroin use among women has doubled in the past 10 years.
- Increase in heroin use has led to a significant increase in the number of children being born with neonatal abstinence syndrome (NAS).
- In 2012, 21,732 babies born in the United States suffered from NAS. This is a five-fold increase from 2000.
- The average hospital costs for an infant born with NAS is $66,700 compared to $3,500 for an infant born without NAS.

Definitions

OBOT — outpatient based opioid treatment
NAS — neo-natal abstinence syndrome
NOWS — neo-natal opioid withdrawal syndrome
MAT — Medication for Addiction Treatment
MOUD — Medication for Opioid Use Disorder
Qualified practice setting — must provide professional coverage for patient emergencies during hours when the practice is closed, provide access to case management services, accept third-party payment for health service costs, utilize health information technology and be registered by their state prescription drug monitoring program where operational.
DATA 2000 — The Drug Treatment Act of 2000
CARA 2.0 Act of 2018 — Comprehensive Addiction and Recovery Act
SUPPORT Act 2018 — Expanded Waiver 2000 to include Certified Nurse Specialists, Certified Nurse Anesthetist and Certified Nurse Midwives as a qualified practitioner in becoming waivered.
42 CFR Part 2 — Confidentiality of Substance Use Disorder Patient Record

Screening

Candidates for treatment:

- Must have a DSM-5 diagnosis of Mild, Moderate or Severe Opioid Use Disorder
- Must be pregnant
- Must agree with the goals of treatment:
    - Prevention/reduction of withdrawal symptoms and cravings for opioids
    - Addressing any psychiatric problems through consultation with community resources
    - Follow through with necessary referrals and treatment
    - Restoration of normal physiological functions that may have been disrupted by substance use and improvement in quality of life
- Is able to come to visits during office hours of operations
- Must be able to be treated in an office-based setting safely without harm to self or others
- Willing to address use of other harmful and/or illicit substances

Brief Screening Options

5 P's of Prenatal Substance Abuse Screen for Alcohol and Drugs
Accuracy of five self-report screening instruments for substance use in pregnancy
Accuracy of Three Screening Tools for Prenatal Substance Use
Comparison and validation of screening tools for substance use in pregancy: a cross-sectional study conducted in Maryland prenatal clinics

Diagnosis

Opioid Use Disorder in the DSM-5 (ICD-10:F11.XX).
IT MATTRs Opioid Use Disorder Criteria diagnosis tool

Diagnostic severity: 2-3 symptoms = Mild, 4-5 symptoms = Moderate, 6+ = Severe

In order to be diagnosed with OUD, a person must meet at least two of the following criteria:

1. Continuing to use opioids, despite the use of the drug causing relationship or social problems
2. Craving opioids
3. Failing to carry out important roles at home, work, or school because of opioid use
4. Giving up or reducing other activities because of opioid use
5. Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway
6. Spending a lot of time seeking, obtaining, taking, or recovering from the effects of opioid drugs
7. Taking more opioid drugs than intended
8. Wanting or trying to control opioid drug use without success
9. Using opioids even when it is physically unsafe
10. Tolerance for opioids and
11. Withdrawal symptoms when opioids are not taken
    Note: tolerance and withdrawal alone do not meet criteria for an OUD, but must have at least one additional criterion besides those two.)

Withdrawal Symptoms

- Agitation
- Muscle aches
- Restlessness
- Anxiety
- Increased tearing
- Runny nose
- Excessive sweating
- Inability to sleep
- Yawning often

Late-stage symptoms include:

- Diarrhea
- Abdominal cramping
- Nausea and vomiting
- Skin goose bumps
- Dilated pupils
- Rapid heatbeat
- High blood pressure

Withdrawal Management

Includes supportive care as well as medication to manage symptoms and prevent complications (ondansetron 4-8 mg, dicyclomine, acetaminophen and loperamide). Ibuprofen is contraindicated in pregnancy. Consider fetal assessment if a pregnant patient is in withdrawal.

Treatment for Opioid Use Disorder in People Who are Pregnant

- Treatment for Opioid Use Disorder Before, During, and After Pregnancy
- ACOG Committee Opinion Opioid Use Disorder in Pregnancy

Additional Resources

- Michigan Opioid Collaborative
- Medication for Opioid Use Disorder (MOUD) Overview
- American Society of Addiction Medicine (ASAM)
- Providers Clinical Support System (PCSS)
- American College of Obstetrics and Gynecologists (ACOG)
- American Academy of Pediatrics (AAP)
- ACOG Frequently Asked Questions
- IT MATTRs based at University of Colorado Anschutz Medical School
- Project RESPECT
- OBAT Clinical Decision-Making Algorithms
- OBAT Physician Resources
- SAMHSA Opioid Use Disorder and Pregnancy: Taking helpful steps for a healthy pregnancy
- CDC Pregnancy and Opioid Pain Medications
- SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
- CDC Treatment for Opioid Use Disorder Before, During and After Pregnancy
- SAMHSA Treating Opioid Use Disorder During Pregnancy: Getting the help and support you need from your healthcare professionals
- SAMHSA TIP 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families
- Opioid Use Disorder and Pregnancy
- SAMHSA Medications to Treat Opioid Use Disorder During Pregnancy
- Oregon Pregnancy and Opioids Workgroup Recommendations
- AIM Opioid Collaborative: Cross Collaborative Chart
- IT MATTRs MAT Resources Toolkit
- MDHHS Opioid Start Talking form

Resources for Patients

- Local Community Mental Health agency
- Peer Recovery Specialists in their area (contact local CMH agency to find local peer services)
- OBAT Patient and Family Resources
- Naloxone by Mail
- March of Dimes

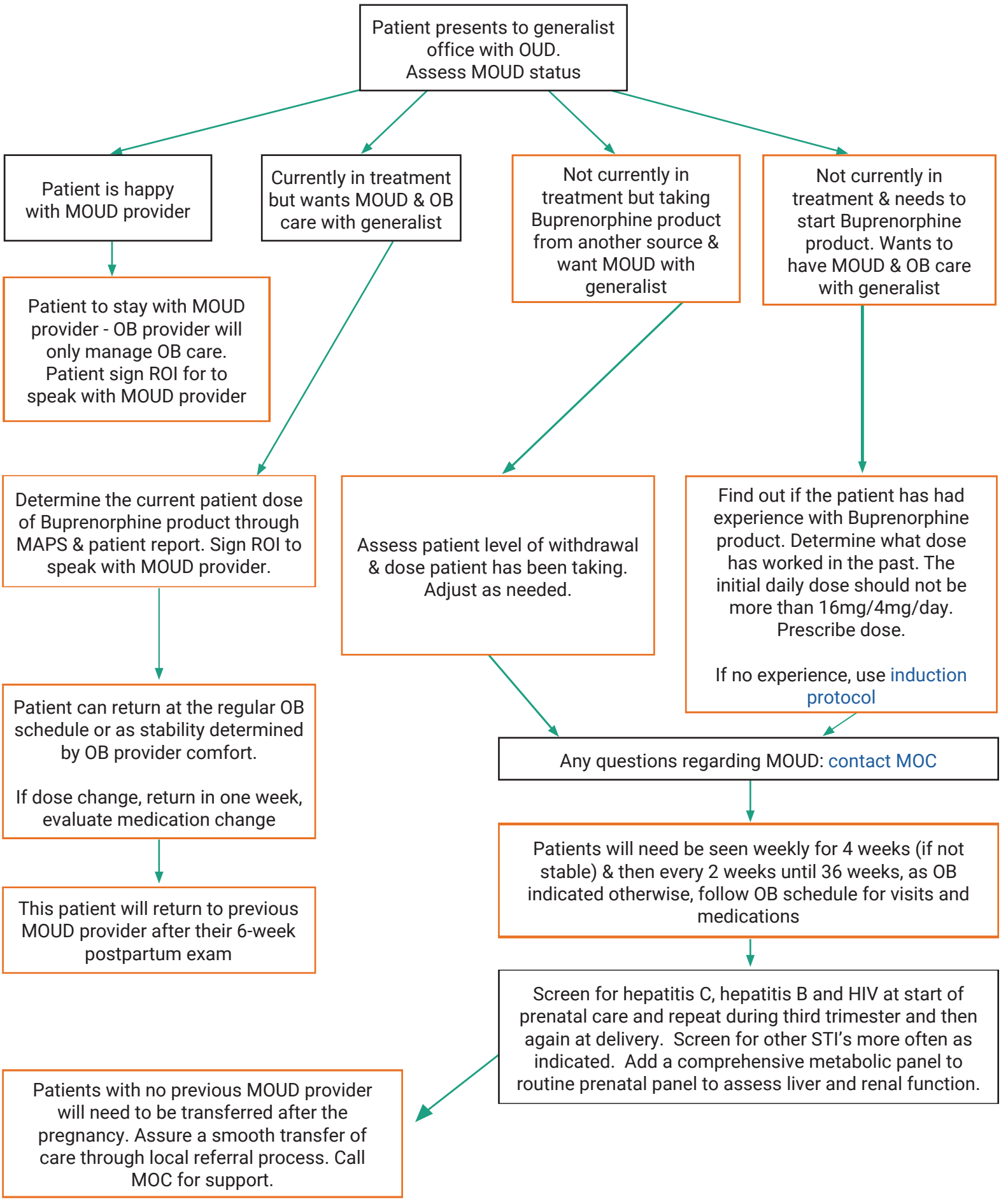
Checklists

Buprenorphine New Start Checklist and Flowsheet for Generalist OBGYN/APP

1. Follow flowsheet that is located below this checklist
2. "Opioid Start Talking" form to be filled out, signed and scanned into the medical record
3. If required by your office or entity, obtain signatures on appropriate consent forms (ROI) and must specify the people who can be given information on SUD treatment.
4. Obtain consent and do Point of Care urine drug screen
    - If consistent with use no confirmation testing is needed
    - If inconsistent, discuss with patient.
        - If patient endorses erroneous screening results, send for confirmation.
        - If patient endorses results are accurate, there is no need for confirmatory testing.
5. Do PMDP/MAPS review in EMR (with each new prescription)
6. Michigan Opioid Collaborative can be called for support if needed:
    - Contact Us - Michigan Opioid Collaborative
    - Resouces - Michigan Opioid Collaborative
    - Contact the behavioral health consultant (BHC) assigned to your region (can be found on MOC's website)
    - 734-763-9500, moc-administration@umich.edu
7. One (1) week supply of medication
    - Start max dose — 8 mg film - 4 mg (1/2 strip) every 6 hours prn for max 16 mg per day
    - Dispense max one week supply (14 films)
8. Weekly follow up for at least initial first 4 weeks as determined by provider.
9. Referral to behavioral health services (not required for treatment but highly encouraged). BHC in your region can help connect you with resources if needed for this.
10. Tobacco and Cannabis cessation support if needed with counseling of increased Neonatal Abstinence Syndrome risk
    - Referral if appropriate (encourage that patient meet with NICU or Nursery provider)
    - Medications if appropriate (nicotine replacement, Wellbutrin, Chantix).
11. Medication support:
    - Narcan/Naloxone prescription for all patients if they do not already have
    - Immodium, Zofran, Bentyl, Clonidine, Colace on individual basis — short term prescriptions for withdrawal during induction.
12. Charting (examples included in toolkit)
    - buprenorphine-naloxone New Start
    - buprenorphine-naloxone OB Follow Up
    - buprenorphine-naloxone Postpartum Follow Up
13. Patient education
    - "Home Induction with Buprenorphine" - attach to patient instructions in EMR and print copy to review and fill out with patient.
    - Neonatal Abstinence Syndrome information to be given to and reviewed with patient
    - Highly encourage enrollment in childbirth education and lactation education
    - Ensure patient education and ability to secure medication — provide lock box resources
    - Discuss delivery options (Induction,vaginal birth, cesarean) and pain control

14. Referral — per your systems policies and procedures coordinate any additional care the patient and/or baby may need/experience due to being treated for OUD during their pregnancy. Be sure to educate the patient on these so they are aware.
15. Postpartum planning
    - Confirm return to prior MOUD Provider or refer to new MOUD provider
    - Local MOUD provider options — check with the BHC in your region for options
    - Connect patient with lactation support/services
    - Offer immediate postpartum contraception
    - Close follow up for behavioral disorders/pp mood disorder
16. Code and bill for additional time/management
    - *** minutes of face-to-face counseling, medical decision making, chart review, and charting in addition to OB visit (total time of visit *** minutes) done for above medical issues.
17. Ideally at least 2-3 providers in an office are participating to decrease risk of care interruption

Buprenorphine New Start Flowsheet



Sample GREAT MOMs Model of Care Birth Plan

General Overview:
This pregnant person is on medication assisted treatment for an opioid use disorder. There are some unique and important considerations for their care during labor and delivery and in the immediate postpartum period.

The partial blockade by buprenorphine can increase the dose of pain medication needed for effective analgesia.

Maintenance medication, in this case buprenorphine, does not treat pain. Hyperalgesia, a worsening of pain perception due to opioids, is associated with their use. **Continuation of their maintenance medication is imperative.**

Nalbuphine and butorphanol are contraindicated for patients on buprenorphine as they can precipitate withdrawal. If they are inadvertently given, fentanyl IVP should be administered until withdrawal symptoms abate.

IV access may be difficult, consider consult to IV access team and, if needed, PICC or central line. In general we recommend avoiding central line placement in laboring people if at all possible.

Review newborn testing recommendations with patients privately.

Plan SVD:

Continue buprenorphine at prescribed doses (this information can be found in the electronic health record, out-patient record or by accessing MAPS). NOTE: While the patient is admitted to the hospital, a provider may legally order buprenorphine to maintain a patient's outpatient dose during their hospitalization. Documentation of this Federal regulation is available at: https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm

An epidural with low dose local anesthetic + fentanyl in standard dosing is recommended in labor, this should be offered as early as possible.

May give NSAIDs (eg. Motrin 800mg Q8hrs ATC) post vaginal delivery. Recommend giving in scheduled dosing, NOT PRN.

If with a significant tear or other significant pain, consider opioid analgesia at 1.5-2x increased opioid dose and more frequent intervals than non-opioid tolerant patients. Avoid discharging patient with a prescription for oral opioid pain medication.

Backup C-section:

Continue buprenorphine at prescribed doses (this information can be found in the electronic health record, outpatient record or by accessing MAPS).

We recommend either spinal or epidural duramorph unless there is a patient-specific contra-indication.

Backup C-setion (continued):

Scheduled 30mg IV ketorolac Q6 until scheduled PO ibuprofen can be started +/- prn dilaudid if needed for breakthrough.

PCA dilaudid will most likely be needed if the patient does not receive neuraxial duramorph. TAP blocks can also be considered in these cases if the patient has not already received a prohibitively large dose of local anesthetic through an epidural catheter.

Transition to oral pain medication as soon as possible. Anticipate scheduled dosing of 1.5-2 times increased opioid dose and more frequent intervals than non-opioid tolerant patients.

Do not write for more than #20 doses of oral opioid pain medication and verify that patient knows to call their OB and/or MOUD program for post-partum pain management.

General Discharge Instructions:

Patient should have an appointment with their OB/MOUD program made for 2 weeks postpartum for addiction follow up.

Please remind the patient that it is their responsibility to contact their MOUD provider for a refill during regular clinic hours if needed on discharge.

Remind patient to bring their prescription bottle to the follow up appointment, even if they have used all of the medication.

Language Acknowledgment

We recognize there is non-inclusive language in this toolkit. Much of the material in this toolkit is sited work. To maintain the integrity of this evidence-based work, we are not at liberty to edit wording to be inclusive of all. However, we ask you to use people first language as you learn from and apply this material in your practice (i.e., pregnant people (instead of pregnant women) or birth parent, (instead of mother, etc.)