# Opioid Use Disorder Clinical Pathway

| Antepartum Care (Outpatient) |
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| Upon entry into care and identification of substance use in pregnancy (Snuggle ME Checklists) |
| ☐ Assess for signs and symptoms of acute withdrawal (Ohio MOMS F.1-F.9)<br>• Early: agitation, anxiety, muscle aches, increased tearing, insomnia, runny nose, sweating, yawning<br>• Late: abdominal cramping, diarrhea, dilated pupils, goose flesh, nausea, vomiting<br>☐ Refer immediately to one of the following for treatment and/or stabilization depending on acuity:<br>• Emergency Room<br>• Obstetric ER/Triage<br>• Inpatient treatment center |
| ☐ Screen for co-morbid psychiatric conditions<br>• If positive refer to Behavioral Health, unless this will be provided by treatment program |
| ☐ Screen for co-morbid domestic violence<br>• If positive refer to domestic violence advocacy service |
| ☐ Complete a detailed medical, surgical, obstetric, and prenatal history |
| ☐ Provide a thorough physical examination |
| ☐ Assess for other immediate psychosocial needs |
| ☐ Obtain recommended lab testing in addition to routine prenatal labs (NNEPQIN checklist)<br>• HIV<br>• HepBsAg, anti-HBcore, HBsAb<br>o Consider immunization as indicated<br>• HCV antibody<br>o If positive draw HCV PCR, LFTs<br>• Serum creatinine<br>• Consider gamma-glutamyl transferase (GGT) if active alcohol use suspected<br>• Assess risk factors for tuberculosis and screen if indicated<br>• Urine toxicology with woman's consent.<br>o Synthetic opioids (e.g., buprenorphine, fentanyl, oxycodone) may not be detected with standard drug test and may require more specific testing. Consult with individual lab<br>• Baseline EKG before starting methadone |
| ☐ Perform dating ultrasound upon entry to care |

- ☐ Determine appropriate level of care and arrange referrals to treatment when indicated and accepted by woman (Wright el al, Figure 1)
  - Assess Risk (Ohio MOMS F.1-F.9)
  - Refer for medically supervised inpatient detox if alcohol or benzo dependent
  - If psychiatric or medical instability, refer for appropriate emergency psychiatric or medical care services.
- ☐ Give the woman information re. treatment provider/center contact (SAMHSA treatment directory)
- ☐ If woman is currently in a treatment program:
  - Obtain appropriate CFR42 Part 2 consent to communicate with treatment provider (Legal Action Center sample consents)
  - Coordinate care with mental health/treatment provider or center
  - Women receiving treatment for chronic pain should have drug agreement in place with treatment provider
- ☐ Provide a "warm" handoff to treatment provider whenever possible
- ☐ Counsel woman on recommended substance use management, risks to pregnancy, fetus, infant and explore treatment options (NNEPQIN toolkit)
  - Recommended treatment for OUD during pregnancy is MAT with buprenorphine or methadone; explore options and arrange appropriate referrals.
  - Recommended management of alcohol use during pregnancy is complete abstinence; explore options and arrange appropriate referrals as needed.
  - Recommended management of marijuana use during pregnancy is abstinence; explore options.
- ☐ Counsel woman regarding risks of tobacco use and offer smoking cessation strategies
- ☐ Counsel woman on maternal/fetal/neonatal risks of polysubstance use (SAMHSA Factsheet #6)
- ☐ Check the woman's record in state Prescription Monitoring Program
- ☐ Be aware of pharmacologic interactions with Buprenorphine/Methadone (McCance-Katz et al, Table 2)
- ☐ Discuss Narcan rescue and offer prescription (Narcan toolkit)
- ☐ Assess need for bowel regimen for constipation
- ☐ Assess need for anti-emetics and antacids for hyperemesis/reflux
  - Note: avoid Zofran for women on methadone to avoid prolonged QTc interval
- ☐ Consultation and Referral considerations may include, but are not limited to:
  - Social Work
  - Case Management
  - Maternal Fetal Medicine if medically complex

- Cardiology with prior history of pericarditis
- Infectious Disease if HIV positive
- Infectious Disease or Gastroenterology if HCV/HVB
- Dental
- Dietary

☐ Schedule short interval follow up for prenatal care

## Follow-Up Care

☐ Reassess and treat for opioid side effects

☐ Assess for changes in psychosocial and medical needs

☐ Ask about cravings, on-prescribed drug and alcohol use at every visit

☐ Provide continued tobacco cessation counseling and treatment for patient who smokes

☐ Periodically review PDMP for patient prescription history

☐ Repeat urine toxicology with consent when indicated

☐ More specific tests may need to be ordered to identify methadone, buprenorphine, fentanyl, other synthetics or alcohol metabolites. Consult individual lab for guidance.

☐ Document treatment coordination

## Second and Third Trimester Care

☐ Schedule and/or provide second trimester anatomy scan

☐ Schedule and/or provide third trimester growth scan
- Monitor growth with serial assessments as indicated

☐ Antenatal testing only if clinically indicated; e.g., IUGR. (Reddy et al, Box 1)
- If antenatal testing performed, reduce false positive NST and/or BPP by performing at least 4-6 hours after last treatment dose

☐ Repeat HIV, HCV, RPR, GC/CT in third trimester
- Repeat HBsAg if initial testing negative

☐ Verify and update MAT medication/dose/status with treatment provider/center prior to birth
- Advise woman to bring buprenorphine to hospital admission for safe storage and dose verification

☐ Discuss pain management options for labor and birth and assist woman in development of plan
- Consider Anesthesiology consult for the woman with high anxiety, difficult IV access, or other co-existing medical issues pertinent to anesthesia

- ☐ Educate woman and support persons importance maternal participation in newborn care/safety, NAS/NOWS, breastfeeding
  - Maternal participation in newborn care (Mommies Toolkit)
    - Options for Rooming in
    - Maternal participation in Eat, Sleep, Console (ESC tool)
    - Encourage skin to skin and breastfeeding (SAMHSA factsheet #11)
- ☐ Provide Patient/family education to include:
  - Hospital policies (SAMHSA Factsheet #7)
    - NAS/NOWS assessment/management/length of stay
    - Breastfeeding
    - Maternal/newborn toxicology and reporting requirements
  - Signs and symptoms of potential pregnancy complications
    - Preterm labor
    - Preterm premature rupture of membranes
  - Importance of prenatal care
  - Plan for fetal surveillance
  - NAS/NOWS assessment/management/length of stay
  - Maternal/newborn toxicology and reporting
  - Parenting classes
- ☐ Consider prenatal consult appointment with pediatrician/neonatologist at delivering institution
- ☐ If delivering hospital is unable to care for infant with NAS/NOWS, discuss antenatal transfer of care versus neonatal transfer after delivery if treatment necessary
- ☐ Provide contraceptive counseling (SAMHSA Factsheet #7)
  - If tubal ligation desired, sign federally required consent for Medicaid patients
  - Offer post-placental IUD insertion or implant prior to discharge, if available at institution.

## General Considerations of Methadone MAT in Pregnancy

- ☐ For women on methadone MAT prior to pregnancy, continue current dosing.
  - May need increased dose in 3rd trimester to increase plasma volume.
- ☐ Patient/family education (MAT in pregnancy patient education)
  - Risk and benefits of methadone treatment in pregnancy
  - Daily visit requirement at treatment center
  - Insurance coverage and/or cost
  - Incidence of NAS 50-66%
  - Possible effects of newborn head circumference and white matter tracts
  - Conflicting long-term studies on outcomes in children exposed in utero
- ☐ Initiation of methadone:

- Start at 10-20 mg and titrate to eliminate withdrawal symptoms without producing intoxication.

## General Considerations of Buprenorphine MAT in Pregnancy

*If on suboxone prior to pregnancy, can consider continuing suboxone during pregnancy*

- ☐ In order to maintain plasma concentrations above 1ng/mL to prevent withdrawal symptoms, consider frequent dosing (3-4 times per day) (Caritis, S.N. et al)

- ☐ Patient/family education
  - Risk and benefits of buprenorphine treatment in pregnancy
  - Insurance coverage and/or cost
  - Higher dropout rate than methadone (33% v. 18%) (MOTHER trial)
  - Higher relapse rate
  - Limited providers with prescription training and authority
  - Use with caution with antiretrovirals, antiseizure, dexamethasone, and SSRI medications

- ☐ Initiation of buprenorphine:
  - Note: Little data on appropriate way to initiate dosing during pregnancy
  - Must be in moderate withdrawal
  - Must be at least 12 hours since last dose of short-acting opioid
  - Start with 2-4 mg and titrate for relief of withdrawal symptoms

- ☐ Consider possible "graduation" to monthly prescription as indicated

# Inpatient Obstetric Care

## If Initial Contact is in Obstetric ED/Triage or L&D

- ☐ Refer to above "Upon entry into care and identification of substance use in pregnancy"

- ☐ Ohio Moms OB.5-OB.8

- ☐ NNEPQIN checklist

- ☐ Initiate clinical pathway for acute opiate withdrawal or elective induction to MAT
  - ASAM buprenorphine course
    - ASAM Induction Protocol
    - ASAM Sample Inpatient Nursing Protocol
  - Miami Valley Protocol example

- ☐ Consider acute withdrawal in DDX of woman with intractable, nausea, vomiting, or abdominal pain

- ☐ Assess for signs and symptoms of placental abruption

## Admission for Labor and Birth

- ☐ When possible, confirm MAT medication and dose with addiction provider
  - Note: Inpatient provider may legally prescribe buprenorphine and methadone to maintain the woman's treatment dose during hospitalization

- ☐ Continue buprenorphine/methadone at usual dosing (SAMHSA Factsheet #8)
  - Consider dividing total daily dose into every 6-8 hour dosing for maximal analgesic effects (ACOG Committee Opinion 711)
- ☐ Prescribe nicotine replacement as indicated
- ☐ Labs
  - Routine labs for labor and birth
  - Repeat HIV/Hepatitis screening if not repeated in third trimester
  - Urine drug test with consent
- ☐ Notify pediatric provider of admission for delivery and determine need for neonatal team at birth
- ☐ Consults
  - Neonatology consult if not previously done
  - Social work/Care management
  - Anesthesiology
  - Lactation
  - If illicit substance use first disclosed at time of birth, consider consultation with addiction specialist or phone consultation with addiction specialist/center, or MFM.
- ☐ Offer immediate postpartum long-acting contraception as provided by facility (ACOG Committee Opinion #670)
- ☐ Involve the woman, social work, and pediatrics/neonatology to establish a Plan of Safe Care. (ACOG District II Slides 31-32)

**Peripartum Pain Management (Ohio MOMS Pain Management Protocol)**

- ☐ General Considerations: (Zhou Pain Management Presentation)
  - Maintenance medication does not treat pain
  - Women using MAT or with history of long term opioid exposure may require higher and more frequent dosing of narcotic medications for intrapartum and postpartum pain
    - Opioid dependent women have increased sensitivity to painful stimuli (hyperalgesia)
    - Opioids dependent women experience tolerance to opioid treatment for analgesia
    - Higher doses of full opioid agonists will be required to displace buprenorphine and provide analgesia
- ☐ Pharmacologic interactions
  - **Avoid partial agonist/antagonists in treating pain (i.e., nalbuphine or butorphanol)**
- ☐ Neuraxial analgesia is preferred for cesarean birth or other procedures
  - If general anesthesia is necessary, be aware of increased risk of airway compromise or drug interactions with concomitant use of stimulants

## Intrapartum (Executive Summary on Opioid Use in Pregnancy Box 2)

- ☐ Educate L&D and postpartum staff on opioid pharmacology and appropriate pain control

- ☐ Provide continuous labor support during active labor
  - 1:1 staffing
  - Consider Doula services if available

- ☐ Avoid fetal scalp electrodes in women with HIV or HCV

- ☐ Recommend early labor neuraxial anesthesia with continuous dosing to provide pain relief for labor and birth
  - Epidural analgesia using opioids (e.g. fentanyl) in usual labor doses may not be effective in opioid dependent patients.
  - May be necessary to use higher doses of local anesthetics or nonopioid adjuvants such as clonidine
  - If neuraxial anesthesia is not feasible or available, consider the following:
    - Nitrous oxide
    - Short acting opioids
    - **Do not use nalbuphine or butorphanol for analgesia or pruritis as these can precipitate withdrawal**
      - **If withdrawal inadvertently precipitated, withdrawal symptoms can be reversed with full agonists or for those in treatment with buprenorphine a 2-4 mg dose (confirm with current ASAM buprenorphine recommendations/ course slides)**

## Postpartum Care (Reddy et al)

- ☐ Vaginal birth pain management
  - Consider scheduled doses of NSAIDs and acetaminophen rather than prn dosing
    - Avoid acetaminophen with evidence of liver impairment

- ☐ Cesarean birth pain management may include the following:
  - Intrathecal or epidural opioids for postpartum pain control
    - May not be fully effective requiring other options
      - Higher concentrations of local anesthetics or non-opioid adjuvants (e.g., clonidine) in epidural solutions
      - Consider PCA for additional coverage if needed but use PCA by demand only and patient monitored carefully for respiratory depression
  - Intraoperative ketorolac when appropriate
  - Scheduled Nonsteroidal anti-inflammatory drugs and acetaminophen
    - Avoid acetaminophen with evidence of liver impairment
  - Alternative pain management includes gabapentin, transversus abdominis plane (TAP) blocks, and IV Tylenol but further data needed

- ☐ When opioids used for complicated vaginal or cesarean birth:
  - Monitor closely for over sedation.

- If somnolent, decrease pain medication dose or consult the addiction treatment provider to adjust dose of MAT
- Provide close follow-up
- Prescribe limited quantities
- Taper rapidly transitioning for non-opioid options
- Consider avoiding triggering opioids with "high likeability" (e.g., oxycodone) and instead use oral morphine or hydrocodone.

## Postpartum Support

- ☐ If the woman desires to breast feed, provide lactation consultation and breast feeding support (SAMHSA Factsheet #11)
- ☐ Provide patient and family education to include:
  - Caring for NAS babies (Stronger Together video)
  - Signs and symptoms of newborn withdrawal
  - Comfort care measures
  - Maternal care needs
  - Signs and symptoms of postpartum depression
  - When to notify a provider (obstetric and newborn)
- ☐ If on methadone, monitor for increased somnolence and contact treatment provider if dose decrease appears necessary.

## Discharge Planning (SAMHSA factsheet #15)

- ☐ Avoid postpartum discontinuation of treatment due to increased relapse rates for SUD after delivery
- ☐ Coordinate hospital discharge with addiction treatment provider/center and release planned so treatment can continue after discharge without interruption
- ☐ Provide contraception counseling and determine contraception plan
  - Offer option to receive postpartum LARC if not already provided
- ☐ Develop Plan of Safe Care
  - Engage woman, care coordination, and pediatric/neonatal team to define plan of safe care.
- ☐ Determine discharge pain management plan
  - Maximize NSAIDs and nonpharmacologic measures
  - If opioids are required at discharge, prescribe only the quantity likely to be used
- ☐ Ensure that plan for postpartum MAT is in place
- ☐ Schedule for more frequent postpartum visits with first postpartum visit within 1-2 weeks.
- ☐ Safe storage of medications

| Postpartum care (Outpatient) |
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| Close postpartum follow-up with frequent visits |
| ☐ Rescreen and brief intervention for return to substance use (SAMHSA Factsheet #16) |
| ☐ Provide postpartum depression screening |
| ☐ Monitor for relapse |
| ☐ Screen for intimate partner violence at 6 weeks and whenever indicated |
| ☐ Provide smoking cessation reinforcement or continued cessation counseling as indicated. |
| ☐ Consider providing support services for longer than the traditional 6-week postpartum period |
| ☐ Assess resource needs at each visit and coordinate with case worker/social service providers |
| ☐ Assist the woman in scheduling appointments for infectious disease management as indicated |
| ☐ Facilitate transition for recovery-friendly primary care provider if not previously established |
| ☐ If breast feeding, provide support |
| ☐ Provide contraception and counsel on birth spacing if immediate postpartum LARC not used |

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