# Opioid Use Disorder Clinical Pathway

## Antepartum Care (Outpatient)

### 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)*
  - Early: agitation, anxiety, muscle aches, increased tearing, insomnia, runny nose, sweating, yawning
  - Late: abdominal cramping, diarrhea, dilated pupils, goose flesh, nausea, vomiting

- **Refer immediately to one of the following for treatment and/or stabilization depending on acuity:**
  - Emergency Room
  - Obstetric ER/Triage
  - Inpatient treatment center

- **Screen for co-morbid psychiatric conditions**
  - If positive refer to Behavioral Health, unless this will be provided by treatment program

- **Screen for co-morbid domestic violence**
  - 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** *(NNEPQIIN checklist)*
  - HIV
  - HepBsAg, anti-HBcore, HBsAb
    - Consider immunization as indicated
  - HCV antibody
    - If positive draw HCV PCR, LFTs
  - Serum creatinine
  - Consider gamma-glutamyl transferase (GGT) if active alcohol use suspected
  - Assess risk factors for tuberculosis and screen if indicated
  - Urine toxicology with woman’s consent.
    - 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
  - 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 breastfeed, provide lactation consultation and breastfeeding 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)

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
References

- Klaman SL, Isaacs K, et al. Treating women who are pregnant and parenting for opioid use disorder and the concurrent care of their infants and children: Literature review to support national guidance. J Addict Med 2017;11(3);178-190. doi: 10.1097/ADM.0000000000000308
- Krans EE, Patrick SW. Opioid use disorder in pregnancy. Obstet Gynecol 2016;128:4-10d


