

Opioid Use Disorder During Pregnancy

TOOLKIT



GREAT MOMs

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 waived.

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 pregnancy: 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 heartbeat
- 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](#)
- [Opioid Use and 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

Generalist OBGYN/CNM Process for Starting Buprenorphine Prescribing in Pregnancy

1. Ideally at least 2-3 providers in an office are participating to decrease risk of care interruption
2. Consider signing up for a training course through ASAM:
 - [Waiver Qualifying Training \(asam.org\)](https://www.asam.org/education/continuing-education/waiver-qualifying-training)
3. Once waiver training completed through ASAM, follow MOC guide to applying for Waiver
 - [Resources - Michigan Opioid Collaborative](#)
4. [Connect with](#) the Michigan Opioid Collaborative (MOC) Behavioral Health Consultant (BHC) in your region.

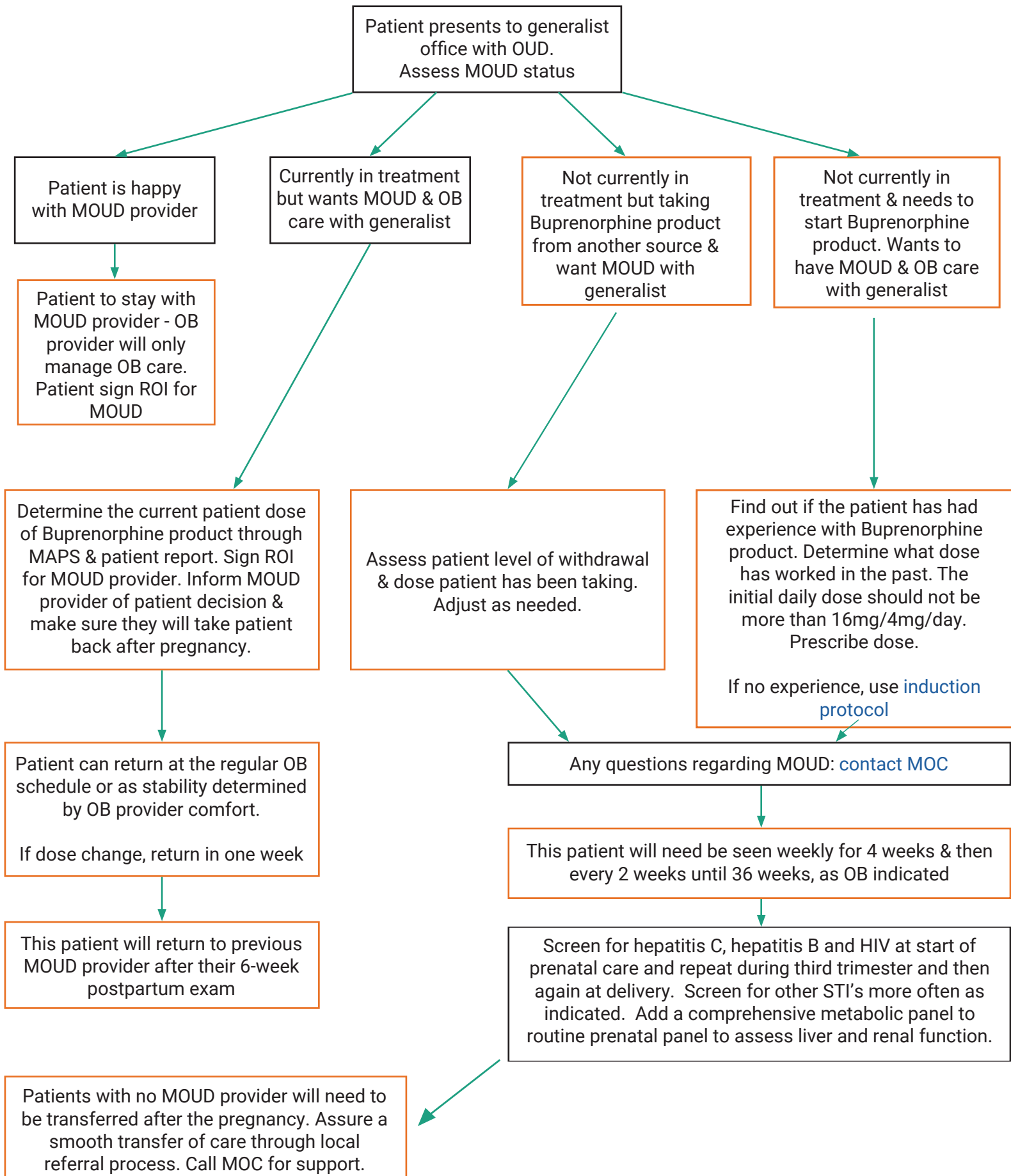
Checklists

Buprenorphine New Start Checklist and Flowsheet for Generalist OBGYN/CNM

1. Follow [flowsheet](#) that is located below this checklist
2. “[Opioid Start Talking](#)” form to filled out by patient, signed and scanned into the medical record
3. If required by your office or entity, obtain signatures on appropriate consent forms.
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 (This may be required by your electronic health record: For electronic prescription need to add in section for “Notes to Pharmacy”: Type in...NADEAN then your DEA-X number)
 - 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
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
 - 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 prescriptions¹².
12. Charting
 - buprenorphine-naloxone New Start: .msbsuboxonenewstartob
 - buprenorphine-naloxone OB follow up: .msbsuboxoneobfollowup
 - buprenorphine-naloxone postpartum follow up: .msbsuboxonepostpartum¹³.
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 Syndrom Packet 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

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.

Buprenorphine New Start Flowsheet



Home Induction with Buprenorphine

These instructions will help guide you through the process of starting on a buprenorphine product at home. (Suboxone®, Zubzolv®, Subutex®, Bunavail®, or buprenorphine-naloxone)

Stop the use of illicit opioids and pain pills (heroin, hydrocodone, etc.) prior to starting buprenorphine/naloxone induction to avoid risk of precipitated withdrawal.

- You should stop using typically 12-24 hours prior to starting medication.
- Methadone: should be a minimum of 24 hours prior to beginning buprenorphine containing products, depending on dose of methadone being taken.

Before starting medication, ensure you have 5 of the following withdrawal symptoms:

Yawning	Unable to sit still
Sweating	Nauseous
Running nose	Feel like vomiting
Goose bumps	Muscles twitch
Shakes	Cramps in your stomach
Hot flashes	Feel like using
Bones and muscles ache	Enlarged pupils

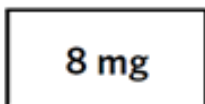
Things NOT TO DO with Buprenorphine

- DON'T use buprenorphine when you are high – it will make you dope sick!
- DON'T use buprenorphine with alcohol – this combination is **not safe**.
- DON'T use buprenorphine with benzos (like Xanax® [“sticks”], Klonopin®, Valium®, Ativan®) unless you have discussed with your buprenorphine provider.
- DON'T use buprenorphine if you are taking pain killers until you talk with your doctor.
- DON'T use buprenorphine if you are taking more than 60 mg of methadone.
- DON'T swallow buprenorphine – it gets into your body by melting under your tongue.
- DON'T lose your buprenorphine – it cannot be refilled early.

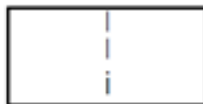
Before taking first dose of buprenorphine, take a drink of water. You will only want to start with 4 mg of buprenorphine.

This is one half of an 8 mg sublingual film strip.

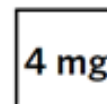
1. Start with full film.



2. Cut film in half.



3. This is your first dose.



Place 4 mg of buprenorphine under your tongue.



Then let the medication dissolve. The medication is orange flavored and has a bitter aftertaste.

- Do not eat or drink (this includes gum) for 15 minutes after taking the medication.
- No acidic drinks (examples: coffee, soda pop, grapefruit juice or orange juice) before or after taking the medication.
- It is okay to rub a small, strong mint (example: the small Altoids®) on your tongue to help with the flavor before putting the buprenorphine in your mouth. Be sure it is a small mint that does not make you produce a lot of saliva.

After 1 hour, how are you feeling?

- **Feel better?** Good, the medication is working. Don't take anymore until 6-12 hours later.
- **How are you feeling?** If you begin having withdrawal symptoms later in the day, take the other half of the strip 4 mg. If you don't have withdrawal symptoms don't take more until the next day.

Still feeling withdrawal symptoms after 1 hour?

- If you still have feelings of withdrawal symptoms, put the remaining 4 mg strip under your tongue.
- Then wait 6-12 hours if you still feel withdrawal symptoms take another 4 mg. If you feel better don't take any more until the next day.
- **Don't take more than 16 mg in 24 hours, unless the prescriber authorizes it.**

How much was taken?

	Time	Dose
Day 1	_____ a.m./p.m.	_____ mg
	_____ a.m./p.m.	_____ mg
	_____ a.m./p.m.	_____ mg
Day 2	_____ a.m./p.m.	_____ mg
	_____ a.m./p.m.	_____ mg
	_____ a.m./p.m.	_____ mg

My next appointment:

Date: _____ **Time:** _____ **Office number:** _____

You may have also been prescribed medications to help treat withdrawal symptoms. These may include:

- Imodium® (loperamide) – for diarrhea
- Bentyl® (dicyclomine) – for stomach cramping
- Zofran® (ondansetron) – for nausea
- Clonidine for general withdrawal symptoms including sweats and anxiety

This handout does not take the place of a discussion with your doctor. Discuss any question or concerns you may have with your doctor.

Sample Charting First OB Assessment

Persons name is a ***AGE@ ***G?P?@ at @GA? with an EDD@ They present for evaluation of the potential for a substance use disorder affecting their pregnancy.

They are being considered for appropriateness for continued treatment with buprenorphine.

Start Time: ***

End Time: ***

In terms of their history of substance use, the patient reports that their current situation is as follows:

Drug Use History:

What have you used in the past?

What are you currently using at this time?

Injection Drug Use:

Have you ever injected a substance with a needle?

Have you ever shared needles?

Have you ever belonged to the needle exchange program?

Last HIV: ***

Last Hepatitis C: ***

Overdoses:

Have you ever overdosed?

Number of lifetime overdoses? ***

Have you ever been hospitalized due to an overdose?

Was naloxone administered?

Recovery History:

What was the longest period of time that you have been in recovery? ***

When was this? ***

What helped you to be successful? ***

What barriers did you encounter? ***

Addiction Treatment History:

Have you ever had any addiction treatment?

If yes, how many times to each type:

Are you currently participating in any form of addiction treatment?

Do you attend meetings?

If so, how many meetings each week? times per week

Do you have a sponsor?

Do you have a history of any other addictive behaviors?

Criminal History:

Have you ever been incarcerated?

What is the longest period of time you spent in jail or prison? ***

Are you on probation?

Are you on parole?

Are you facing any potential jail time?

Do you have any outstanding legal issues?

Mental Health History:

Have you ever been diagnosed with any mental health conditions?

Where do you see your psychiatrist, psychologist or counselor? ***

What is this individual's name? ***

How often do you see them? ***

How many times have you seen this person in the last six months? ***

Are you currently taking any medications for this/these problem(s)?

If yes, what medications are you taking? ***

Have you ever taken any medication for a mental health condition?

If yes, what medications did you take? ***

Will you sign consent to release information so that we can communicate with your psychiatrist, psychologist or counselor about your treatment plan?

Have you ever been hospitalized for mental health issues?

Have you ever attempted to end your life or to hurt yourself?

Do you currently have thoughts about hurting yourself or ending your life?

Do you currently have a plan for how you would hurt yourself or end your life?

Do you have the means to carry out your plan?

Have you ever attempted or thought about homicide?

Employment:

Are you currently employed?

If yes, what do you do for work? ***

Are you working full or part time?

What days of the week do you work and how many hours per day do you work? ***

Social Support:

What is your relationship status?

Do you live with your partner/significant other?

Does your partner have a history of substance use?

Is your partner/significant other currently in treatment?

What kind of treatment are they in?

How satisfied are you with the support you get from your partner/significant other?

Family History:

Do any other family members have a history of substance use?

Housing:

Have you spent one or more weeks on the street or in a shelter in the last three months?

What type of place are you living in now?

Who do you live with at this time?

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 Acknowledgement

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.)