Clinical Algorithm for Treating Obstetric Patients with Opioid Use Disorder (OUD)

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Provide Universal Substance Use Disorder (SUD)/OUD* Screening with validated tool

Patient Screen Positive

Yes

No

Routine Care and follow-up

Screening / Assessment

1. Assess patient for signs and symptoms of drug withdrawal.
2. Screen for:
   - Mental health disorders (Depression, anxiety, PTSD***).
   - Intimate Partner Violence.
   - Infectious disease (HIV, Hepatitis and Sexually Transmitted Diseases).
3. Inform Neo/ped/social/MFM/Anesthesia services.

Intervention

1. Provide **brief intervention** by asking, advising, assessing willingness, assist to quit, and arrange follow-up (SBIRT** Counseling).
2. Assess willingness to start treatment for OUD.
3. Educate regarding risks of continued opioid/drug use to mother and fetus, Neonatal Opioid Withdrawal Syndrome, resources for smoking/vaping cessation, if appropriate.
4. Increase awareness about Naloxone and provide prescription to prevent opioid overdose.
5. Initiate social work support.
6. Initiate behavioral treatment support.
7. Plan for pain management during labor and postpartum.
8. Review **H**elping **O**pioid **P**atients **E**xcel (H.O.P.E.) folder materials with patient.

Continuity of Care

1. Stabilize patient.
2. Coordinate care, follow-up and discharge.
3. Document OUD in EMR.
4. Bill for SBIRT:
   <30 min G0396
   ≥ 30 min G0397

*SUD/OUD: Substance or opioid use disorder
**SBIRT: Screening, Brief Intervention and Referral to Treatment
*** PTSD: Post-traumatic stress disorder

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Patient Sticker

Obstetric Care for Women with Opioid Use Disorder (OUD) Nursing Workflow

When an obstetric patient screens positive for Opioid Use Disorder (OUD) during a Labor and Delivery admission, a Helping Opioid use disorder Patients Excel (H.O.P.E.) Folder should be obtained by the patient's nurse. The folder should have clinical resources on the left hand side: (1) *Clinical Algorithm* for Treating Obstetric Patients with Opioid Use Disorder (OUD), (2) *Prenatal consultation guidelines*, and (3) An *OUD nursing workflow*. P*atient education material* is on the right hand side to provide the patient information on OUD / Neonatal Opioid Withdrawal Syndrome (NOWS)/and various resources. The L&D nurse should hand-off and review this form with the postpartum nurse.

The patient's nurse should work with the rest of the obstetric clinical team to make sure the OUD Clinical Algorithm, OUD Consultation Guidelines are completed prior to discharge and schedule a postpartum follow-up as early as two weeks. Drug-induced death is the leading cause of pregnancy-associated death in Utah* and occurs primarily in the late postpartum period.

Labor and Delivery

	Labor and delivery and Intrapartum Care	Comments/Notes
	Use universal screening tools to identify substance use in pregnancy, and identify the patient risk, if low risk and screening is negative, provide brief intervention, discuss risk reduction.	
	Inform OB with a positive OUD screen, and provide OB the *Clinical Algorithm* for Treating Obstetric Patients with Opioid Use Disorder (OUD) and OUD Prenatal Consultation Guidelines to complete. As a reminder, these items need to be completed for every OUD patient during the hospital admission.	
	Consider acute withdrawal in differential diagnosis of a woman with intractable nausea, vomiting, or abdominal pain	
	Assess fetal well-being and signs and symptoms of placental abruption.	
	Confirm all appropriate lab tests are ordered.	
	Initiate clinical pathway for acute opiate withdrawal or elective induction to MAT	
	If on treatment, continue buprenorphine/ methadone continue at patient dosing Consider dividing the total daily dose into every 6–8-hour dosing for maximal analgesic effects (ACOG committee opinion #711 Opioid Use and Opioid Use Disorder in Pregnancy) https://bit.ly/ACOGOUD	
	Consults: • Neonatology/or pediatrician consult (if not previously completed) • Social work • Anesthesiology • Lactation • If illicit substance use first disclosed at the time of birth, consider a consultation with an addiction specialist or phone consultation with an addiction specialist/center or MFM	
	Ensure the patient has received the OUD/NOWS/NAS education materials in the H.O.P.E. folder and review materials with the patient and document.	

	Confirm the provider has the Naloxone guide https://naloxone.utah.gov/prescribers from the H.O.P.E. folder (to assist with Naloxone counseling/prescription as a risk reduction strategy for all patients who use opioids regularly).	
	Offer immediate postpartum long-acting contraception (LARC) as provided by facility. (ACOG Committee opinion #670) https://bit.ly/ACOGLARC	
	Handoff H.O.P.E. folder and nursing workflow to postpartum nurse and review completed tasks.	
Postpartum Care		
	Review OUD patient education material (found in the H.O.P.E. folder) with the patient/family and confirm understanding of the important role of mom/family in the care of opioid exposed newborns, including breastfeeding, skin to skin, and rooming-in. Provide education on safe sleep. Document education provided.	
	Work with neonatology / pediatric team to engage and support mom/family providing non-pharmacologic care as appropriate: breastfeeding, skin to skin, rooming-in, eat-sleep-console.	
	Work with pain team management for vaginal/ Cesarean birth management	
	Confirm patient's Medication Assisted Treatment (MAT) plan with the clinical team and patient's understanding of next steps for MAT follow-up as indicated. Document appropriately.	
	Confirm Behavioral Health/Recovery Treatment Program appointment made before discharge for close postpartum follow-up.	
	Confirm Naloxone counseling, and a prescription has been provided before discharge. If possible, encourage having the prescription filled before discharge. Document counseling/prescription received.	
	Confirm Hepatitis C screening completed and results provided to the patient, follow up plan established by OB for all positive screens.	
	Confirm patient has an early postpartum follow-up visit with OB for 1-2 weeks postpartum scheduled before hospital discharge.	
	Ensure the OB clinical team is in communication with neonatology/pediatrics to confirm a coordinated discharge plan checklist has been completed for the newborn and make sure the patient/family is engaged in and understands the discharge plan process.	
	Remind all care team members that reducing stigma and treating patients with empathy and compassion improves outcomes for moms with OUD.	

References

*Smid MC, Stone NM, Baksh L, Debbink MP, Einerson BD, Varner MW, Gordon AJ, Clark EAS. Pregnancy-Associated Death in Utah: Contribution of Drug-Induced Deaths. Obstet Gynecol. 2019 Jun;133(6):1131-1140. doi: 10.1097/AOG.0000000000003279. PMID: 31135726; PMCID: PMC6548332.

Special thank you to the Illinois Perinatal Quality Collaborative for developing this resource.

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Opioid Use Disorder Prenatal Consultation Guidelines

PREPARING FOR A HEALTHY PREGNANCY AND BIRTH

- ❒ Provide patients who screen for Opioid Use Disorder/Substance Use Disorder with **H**elping **O**pioid use disorder **P**atients **E**xcel (H.O.P.E.) Resource Folders.
- ❒ Discuss the need for continued maternal compliance with treatment for opioid use disorder
- ❒ Discuss limiting tobacco and marijuana exposure
- ❒ Discuss impact of maternal outpatient medications (including mental health medications like SSRIs)

REVIEWING NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

- ❒ Discuss the signs and symptoms of Neonatal Opioid Withdrawal Syndrome
- ❒ Discuss duration of NOWS symptoms

DESCRIBING EXPECTATIONS AFTER BABY IS BORN

- ❒ Discuss location of care in your hospital for infants with NOWS
- ❒ Discuss the need for 4-7 days of inpatient monitoring for infants who do not require pharmacotherapy
- ❒ Review possible NOWS assessment methodologies at your hospital
- ❒ Discuss approach to toxicology testing of the infants
- ❒ Describe the benefits of the mother to stay in the hospital until baby is discharged (if hospital is able to provide a place for mother)
    - o Address barriers to staying with baby
- ❒ Discuss arrangements to be present during the hospitalization including speaking to residential treatment programs, methadone guest dosing near the hospital, childcare preparations, and transportation considerations
- ❒ Review need for a support person to assist the mother during the hospitalization
- ❒ Discuss anticipated length of hospitalization and criteria for discharge
- ❒ Discuss need for at least 48 hours of inpatient monitoring after stopping NOWS medications for infants who require pharmacotherapy
- ❒ Review maternal Hepatitis C status, and if positive, discuss with mother potential impact on baby (8-15% transmission rate) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4164177/

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TREATING NOWS

- ❒ Review non-pharmacologic care as the key to treatment of NOWS
  - o Moms are the best treatment!
- ❒ Discuss the approach to non-pharmacologic care
  - o Feeding on demand
  - o Swaddling
  - o Holding, cuddling, or gently rocking
  - o Non-nutritive sucking
  - o Rooming-in
  - o Breastfeeding or pumping milk as appropriate
  - o Keep lights, noise, visitors to a minimum
  - o Skin-to-skin
  - o Gently handling baby
  - o Avoid waking baby
- ❒ Discuss the possibility of needing medication to treat symptoms

BREASTFEEDING

- ❒ Review benefits of breastfeeding and breast milk in the context of NOWS
- ❒ Review possible need for supplementation or higher calorie formula
- ❒ Review breastfeeding contraindications
- ❒ Review breastfeeding if the mother has Hepatitis C infection (HCV)
  - o AAP 2015 Redbook recommendations regarding breastfeeding: "Maternal HCV infection is not a contraindication to breastfeeding. Mothers who are HCV positive and choose to breastfeed should consider abstaining if their nipples are cracked or bleeding."

DISCHARGE EXPECTATIONS

- ❒ Provide patient/family with Naloxone or Naloxone prescription
- ❒ Discuss the plan of safe care
- ❒ Discuss need for inpatient monitoring for 4-7 days if no pharmacologic treatment needed
- ❒ Discuss discharge approximately 48 hours after stopping pharmacologic treatment and possible length of time in the hospital
- ❒ Discuss need for baby optimal weight gain
- ❒ Discuss need for close follow-up with the baby's pediatrician
- ❒ Discuss need and timing for Hepatitis C monitoring in the infant if the mother has HCV infection
  - o HCV antibody testing at 18 months
  - o HCV RNA-PCR could be obtained at 2-4 months if earlier concerns

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