Mother & Baby Substance Exposure Toolkit

Best Practice No. 11

A part of the California Medication Assisted Treatment Expansion Project

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Implement an inpatient treatment protocol for pregnant women with opioid use disorder

Best Practice No. 11

Labor and Delivery and Treatment

Overview

While the ideal timing for initiation of medication assisted treatment (MAT) would be early in the pregnancy, implementation of an inpatient protocol for evidence-based evaluation, treatment, and discharge of pregnant patients with opioid use disorder (OUD) is the next best opportunity to address the chronic disease of OUD and improve long term outcomes for the pregnant woman and her affected infant.

Why we are recommending this best practice

The patient with OUD who presents to labor and delivery in labor also presents with a unique opportunity to initiate treatment for opioid use. While the provider and nursing staff may initially find such a patient challenging, they can introduce life-changing therapy at this distinct moment. Providers often feel uncomfortable prescribing MAT for various reasons, many of which are common misperceptions, including:

- Myth: Inpatient providers believe they cannot treat OUD because they do not have a waiver to prescribe MAT ("X waiver").
    - ***Fact: federal law allows providers without an X waiver to administer or dispense (but not prescribe) buprenorphine on an inpatient basis for up to 72 hours. This law is known as the "three-day rule" and provides for effective treatment of acute withdrawal in the emergency department or inpatient setting.***

- Myth: There may be possible deleterious fetal effect.
    - ***Fact: MAT, particularly buprenorphine, is the gold standard for treatment of OUD and is safe during pregnancy. Split dosing or even higher overall dosing may be required during pregnancy. On the other hand, withdrawal is associated with high rates of relapse and poor outcomes for both mother and infant.***

- Myth: Neonatal abstinence syndrome (NAS) will be more severe, especially with the higher doses of buprenorphine needed during pregnancy.
    - ***Fact: Buprenorphine reduces NAS severity and the dose is not correlated with NAS severity.***

A clear, informed protocol that providers can leverage for safe management of OUD in pregnant women will increase provider comfort in caring for these patients and optimizing

health outcomes for patients and their newborns.

It is important to recognize that not all areas of the country have access to the same resources for MAT, especially for women who are pregnant. In rural and/or underserved areas, there may be access to only one type of treatment and/or treatment setting, and each group implementing this toolkit should become familiar with the treatment options available in their community. These settings may be integrated into primary care or OB/GYN offices (e.g., office-based outpatient treatment), stand-alone outpatient treatment programs, residential treatment programs, opioid treatment programs (“methadone clinics"), emergency departments, hospital labor and delivery units, or within the general hospital setting. Each of these locations has its own unique strengths and challenges. Referral protocols should be built by individual locations to reflect assessment of the severity of OUD matched with the ASAM level of care resources that are available in the local community with the goal of providing access to treatment for women during their pregnancy and after delivery.

Outpatient Services
Not all women may require or accept inpatient induction of MAT. If a woman presenting for care declines inpatient or emergency department induction, ensure that the institution has referral processes in place to directly connect the patient with outpatient services, such as office-based outpatient treatment or an opioid treatment program, and provide a warm handoff.

Strategies for Implementation

- Utilize a multidisciplinary team, ideally with obstetricians, midwives, psychiatrists, nurses, anesthesiologists, addiction and pain medicine specialists, pharmacists, and social workers to create a facility-specific protocol that addresses the following:
    - Evaluation of patients for OUD with a non-judgmental, trauma-informed approach (please see the Resources section of this Best Practice: Sample Evaluation of Opioid Use Disorder in Pregnancy Checklist).
    - Shared decision making for OUD treatment, emphasizing the risks of OUD in pregnancy and options for MAT, as well as the risks of supervised withdrawal (Please see the Resources section of this Best Practice: Considerations for, Treatment of Opioid Use Disorder in Pregnancy).
    - Development and utilization of a treatment algorithm for inpatient MAT initiation for both buprenorphine and methadone, including adjunctive therapies to optimize MAT induction (please see the Resources section of this Best Practice: Sample Inpatient Medication-Assisted Treatment Induction Algorithms and the Buprenorphine Quick Start in Pregnancy Algorithm).
    - Development and utilization of a treatment algorithm for outpatient buprenorphine induction. If capacity for close follow up with provider(s) comfortable with outpatient induction of buprenorphine in pregnancy is available, develop guidelines for which patients can consider outpatient induction of MAT and develop a protocol for outpatient buprenorphine induction (please see the Resources section of this Best Practice: Sample Outpatient Buprenorphine Induction Algorithm). Consider partnering with local residential treatment facilities and withdrawal management (detoxification) centers.

- Development of a Plan of Safe Care to ensure pregnant patients with OUD are

discharged with appropriate transition to outpatient care with a focus on coordination of MAT (e.g., handoffs to methadone treatment programs and buprenorphine prescribing providers) and harm reduction. The “Transitions” section of this toolkit includes multiple best practices that will support development efforts in these areas (**See Best Practice #29**).

- Educate physicians, nurses, and other care team members on OUD in pregnancy, strategies for caring for patients with OUD, and implementation of developed protocols.
    - Create awareness of OUD in Pregnancy through various mediums to educate hospital staff about OUD in pregnancy (e.g., emails, physical bulletin boards, staff meetings) and mitigate stigma, bias and discrimination toward patients with OUD.
    - Create opportunities for the workforce to learn about trauma-informed care in the inpatient setting (**See Best Practice #7**).
    - Train providers on OUD treatment protocols for pregnancy and encourage them to obtain a waiver to prescribe buprenorphine.

- Train nurses on OUD treatment protocols and the use of the Clinical Opiate Withdrawal Scale and the Ramsay Sedation Scale (refer to the Resources section of this Best Practice) in the care of patients taking buprenorphine and methadone (refer to the Resources section of this Best Practice: Considerations for Administration of Buprenorphine and Methadone).

- Create process metrics to regularly evaluate the implementation of the facility-based protocols.
    - Define target metrics for OUD treatment. Develop facility-specific metrics to track implementation and effectiveness of OUD treatment protocols (e.g., development of a dashboard if enough volume vs. audit of OUD cases if a few cases) and assess for disparities in treatment (e.g., examine outcomes by race, preferred language).
    - Delineate role(s) for assessment and improvement of OUD treatment. Designate either an individual or a team to take accountability for ongoing facility-level assessment and improvement of OUD treatment in pregnancy to ensure access and health equity.

Kayla

When building an inpatient treatment protocol, consider increasing the total daily dose as we well as dividing the patient's MAT doses to help with acute pain control. For example, if Kayla is taking 24 mg of buprenorphine as an outpatient and has acute pain from her delivery, one may consider increasing her total daily dose to 32 mg but providing it in 8 mg doses every 6 hours. Build a basal/bolus pain control protocol into your admission order sets. Both buprenorphine and methadone can be divided into 6-8-hour dosing regimens to allow for better basal pain control. While it is clear that methadone maintenance therapy usually necessitates increases in the baseline daily methadone dose during pregnancy, especially during the third trimester to account for changes in pharmacokinetics, there is emerging evidence of a similar need to increase the daily dosage of buprenorphine during pregnancy. These recommendations are useful for pain management during the intrapartum and immediate post-partum period, after which a return to pre-labor dosing is appropriate.

Reference: Alford DP, Compton P, Samet JH. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. Annals of internal medicine. 2006;144(2):127-134.

Deep Dive

For acute pain requiring bolus control, consider using a moderate affinity μ-opioid agonist such as morphine IV at 4-6 milligrams or a strong affinity μ-opioid agonist such as fentanyl IV 100 micrograms. Evidence shows that total opioid requirements is less when MAT is continued as a basal pain medication.

Reference: Macintyre PE, Russell RA, Usher KA, Gaughwin M, Huxtable CA. Pain relief and opioid requirements in the first 24 hours after surgery in patients taking buprenorphine and methadone opioid substitution therapy. Anaesthesia and intensive care. 2013;41(2):222-230.

Resources

1. COWS: A clinical opioid withdrawal scale designed to monitor signs of opioid withdrawal.
2. Ramsay Sedation Scale: Designed for use in critically ill adults that has broad applicability in evaluation of the range between agitation and over sedation in response to sedatives and analgesics.
3. Considerations for Administration of Buprenorphine and Methadone.
4. Considerations for Treatment of Opioid Use Disorder in Pregnancy.
5. Sample Evaluation of Opioid Use Disorder (OUD) in Pregnancy Checklist.
6. Sample Inpatient Medication-Assisted Treatment Induction Algorithms.

7. Sample Outpatient Buprenorphine Induction Algorithm.
8. NNEPQIN Opioid Use Disorder Clinical Pathway.
9. ED Bridge. Buprenorphine Quick Start in Pregnancy Algorithm.

References

1. ACOG committee opinion no 711: opioid use and opioid use disorder in pregnancy. Obstet Gynecol. 2017; 130(2): e81-94. doi: 10.1097/AOG.0000000000002235.
2. Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy. World Health Organization. https://www.who.int/substance_abuse/publications/pregnancy_guidelines/e Published March 21, 2014. Accessed December 19, 2019.
3. The ASAM National Practice Guideline . American Society of Addiction Medicine . https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf. Accessed December 19, 2019.
4. Jones HE, Martin PR, Heil SH, et al. Treatment of opioid-dependent pregnant women: clinical and research issues. J Subst Abuse Treat. 2008; 35(3): 245-259. doi:10.1016/j.jsat.2007.10.007.
5. Buprenorphine QuickStart in Pregnancy Algorithm. ED Bridge. https://static1.squarespace.com/static/5c412ab755b02cec3b4ed998/t/5d6d85 +9-1-2019.pdf. Accessed December 19, 2019.
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7. Macintyre PE, Russell RA, Usher KA, Gaughwin M, Huxtable CA. Pain relief and opioid requirements in the first 24 hours after surgery in patients taking buprenorphine and methadone opioid substitution therapy. Anaesth Intensive Care. 2013; 41(2): 222-230. doi: 10.1177/0310057X1304100212.

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Dr. Stockton is Board Certified in both Family Medicine and Addiction Medicine. Candy’s passion is providing patient-centered care to pregnant and parenting women with addiction as well as addressing the upstream causes of addiction in her community. She is Chief Medical Officer at the Humboldt IPA, and is a practicing physician at their Priority Care Center. In her role at the IPA, she oversees the developing School Based Health Center Program and is the clinical champion for the Humboldt RISE Project (a county-wide Perinatal Substance Use Disorder project) and Humboldt County’s Jail MAT program. She serves as a consultant for the implementation of the Hub and Spoke project in Northern California and for California’s Opioid Response Network, based out of UCLA.

Holly Smith

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Holly Smith is a certified nurse-midwife with 20 years experience in diverse practice settings. She is the project manager for the CMQCC/CPQCC Mother and Baby Substance Exposure Initiative. Previous to this role, she was a the lead editor for the CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans, and a clinical lead for the CMQCC Collaborative to Support Vaginal Birth and Reduce Primary Cesareans, a large-scale quality improvement project with over 90 California hospitals. Her primary role as clinical lead focused on assisting southern California hospitals with the implementation of evidence-based practices to reduce cesarean. She is a hospital coach and steering committee member for the American College of Nurse-Midwives' Reducing Primary Cesareans Project, and expert consultant on various national and state quality improvement and health policy initiatives. Additonally she chairs the Health Policy Committee of the California affiliate of the American College of Nurse-Midwives and is a health policy consultant to the California Nurse-Midwives Foundation.

Martha Tesfalul

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Dr. Martha Tesfalul is currently a Maternal-Fetal Medicine Fellow at at the University of California, San Francisco. Having served as the Quality Improvement (QI) Chief in her final year of residency, she has a professional interest in health systems strengthening and health equity. She has received local, regional and national recognition for her efforts in clinical care, education, and research including awards from the Pacific Coast Obstetrical and Gynecological Society and the Foundation for the Society for Maternal-Fetal Medicine. In addition to her commitment to improving the care of pregnant patients in California, Dr. Tesfalul engages in QI-focused research in in the East African country Eritrea.

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Dr. Khan is an Addiction Medicine specialist and Chief of Addiction Medicine consult-liason service and outpatient specialty clinic at Ventura County Medical Center. He is the medical director of Prototypes Southern California which has hundreds of residential treatment beds as well as medical-withdrawal (detox) beds throughout Southern California. Dr. Khan is the Medical Director of the Ventura County Backpack medicine group, and Primary Care Hepatitis C Eradication Project. His niche is managing SUD in pregnancy and is a national speaker on this topic.