ASSESSMENT AND MANAGEMENT OF

Opioid Use in Pregnancy

2019 Update

This care process model (CPM) was developed by the Neonatal Abstinence Syndrome (NAS) workgroup, a subgroup of the Women and Newborns Clinical Program at Intermountain Healthcare. Recommendations are based on national guidelines and regional standards of care. The CPM is intended to provide guidance and resources to help obstetric providers identify and manage opioid use in their patients. It outlines a practical approach that is appropriate for most patients but should be adapted to meet the needs of individual patients.

Why Focus ON OPIOID USE IN PREGNANCY?

- **The rate of opioid use and abuse is high and rising.**[MAN] Opioids are currently the main driver of drug overdose deaths in the U.S. These drugs were involved in 47,600 overdose-related deaths in 2017 (68% of all drug overdose deaths).[CDC1] For each drug overdose that results in death, there are multiple other nonfatal overdoses, each of which comes with its own emotional and economic toll.[CDC2]
- **Opioid use may be particularly problematic for women.** Some experts believe that women become dependent on prescription pain medication more quickly than men. This is especially concerning given studies showing that, compared to men, women are more likely to have chronic pain, are more likely to be given prescription pain medication, are given higher doses, and use prescription pain medication for longer periods of time.[CDC3]
- **Utah is a hot spot for opioid use and abuse.** In 2015, providers in Utah wrote 2.2 million opioid pain reliever prescriptions, more than 3% higher than the national average.[NIDA1] In 2017, Utah ranked third highest among all states in prescription opioid-involved death rates—10.8/100,000 people. That year, more than 26 Utahns died each month from prescription opioid overdose.[CDC1]
- **Data show a significant impact.** In the U.S., nearly 90% of women with a substance use disorder are of reproductive age.[KUC] As opioid use has grown locally and nationally, Intermountain data suggest that chronic use of opioids among pregnant women has resulted in an increased length of stay (LOS) for newborns. The long-term effects of opioid exposure on the developing fetus are not well understood.

WHAT'S INSIDE?

MEASUREMENT & GOALS

Intermountain measures two clinical practices to improve care for women who use opioids and to improve outcomes for babies, including:

1. Screening for substance use in pregnancy.
2. Prescriptions for opioid use at postpartum discharge.

Indicates an Intermountain measure

Key Points

- **Screen and educate every pregnant patient.**[ACOG] Abuse is common and often overlooked, even by patients.
- **Recognize that withdrawal is not a medical emergency, even in a pregnant woman.** Contact the provider who prescribed opioids for the patient and attempt to coordinate management of opioid use, utilizing behavioral health personnel whenever possible and appropriate.
- **Follow up and refer for counseling and treatment as needed.** Treatment for substance abuse during pregnancy can be more effective than at other times in a woman's life.[VER] Women who receive treatment early in their pregnancy can achieve the same health outcomes as pregnant women who do not use substances.[GOL]
- **Prescribe wisely.** If prescribing opioids at postpartum discharge, give the minimum appropriate amount. See specific guidelines on page 3.

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ALGORITHM 1: SCREENING

SCREEN at each encounter
(or at least once per trimester during pregnancy ACOG)

ADMINISTER *NIDA Quick Screen* tool (a)

ASK about:

- **Alcohol use:** ≥ 4 standard drinks a day
- **Tobacco use** (including e-cigarettes)
- **Prescription medication use** for non-medical reasons
- **Prescription medication use** in amounts greater than prescribed, for reasons other than prescribed, or that weren't prescribed to patient
- **Illegal (illicit) drug use** (street or recreational drugs)

EDUCATE patient

- **ASK** patient what they understand about effects of drugs, alcohol, and tobacco use during pregnancy (see *Substance Use During Pregnancy* fact sheet).
- **ENSURE** patient understands prescription medications can be misused, just like "street" drugs (see *Opioid Pain Medicine in Pregnancy* fact sheet).

CHECK DOPL Controlled Substance Database (dopl.utah.gov) and medical records for patients with admitted / suspected substance abuse*

→ If opioid use confirmed, **MANAGE** per algorithm 2 on page 3

***Note:** Multiple visits / providers in the medical record could signify a red flag.

ALGORITHM NOTE

(a) *NIDA Quick Screen* tool

See the *Substance Use Disorder* CPM for the *Intermountain-Modified NIDA Quick Screen* tool. This screening approach reduces subjectivity, discomfort, and bias, and is far more effective than guessing. For the *Intermountain-Modified NIDA Quick Screen*, any positive response signals a positive result (see table below).[GOL, VER] To identify patients who take prescription pain medication, consider asking this additional screening question: "When you have pain, what do you do for it?" In some cases, signs and symptoms will suggest abuse, even when screening is negative.

Intermountain-Modified National Institute on Drug Abuse (NIDA) Quick Screen [NIDA2]

In the past year, how often have you used the following?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
Alcohol: • For men, ≥ 5 standard drinks* a day • For women, ≥ 4 standard drinks a day					
Tobacco products (including e-cigarettes)					
Prescription medications for non-medical reasons					
Prescription medications in amounts greater than prescribed, for reasons other than prescribed, or that weren't prescribed to you					
Illegal drugs (illicit, street drugs)					

* Definition of a "standard drink":

- Beer or cooler (5 % alcohol): 12 oz
- Malt liquor (7 % alcohol): 8–9 oz
- Table wine (12 % alcohol): 5 oz
- Hard liquor (40 % alcohol): 1.5 oz

ALGORITHM 2: MANAGEMENT

Patient with confirmed opioid use

Opioid use managed by physician?

yes

COORDINATE care with prescribing physician **(a)**

no

ASSUME prescribing role; **ESTABLISH** "rules of engagement" (see *Medication Management Agreement: Opioids*) **(a)**

PROVIDE special care during pregnancy: PERFORM ALL 3

1 - COORDINATE care, and REFER as needed

- **COORDINATE** care with prescribing physician, maternal provider, and/or counselor.
- **SCHEDULE** more frequent prenatal visits.
- **REFER** for further screening and counseling or treatment (see *Substance Use Disorder* CPM).
- **MONITOR** antenatal course closely, with attention to the possibility of poor fetal growth and preterm birth.
- **ADDRESS** possible comorbid conditions, such as tobacco and alcohol use, mental illness diagnosis, hepatitis C, HIV infection, STDs, tuberculosis, etc.

2 - WEAN off opioid use, OR PRESCRIBE transition or maintanance medication ACOG, JON1, JON2

- **If short-acting prescription opioid use** (e.g., oxycodone, hydrocodone) **and motivated to stop or decrease use:**
  - **ATTEMPT** to wean off on an outpatient basis.
  - **DECREASE** dose 10% to 15% weekly.
  - **ENGAGE** patient in ongoing substance use disorder treatment per the *Substance Use Disorder* CPM.
- **If methadone or buprenorphine use: CONTINUE** therapy on outpatient basis throughout pregnancy.
- **For all other patients using opioids, carefully TRANSITION to buprenorphine** (preferred agent for use in pregnancy; however, in some cases, methadone may be used). **(b)**

3 - PLAN for postnatal issues

ANTICIPATE the possibility of:

- Neonatal abstinence syndrome (NAS) and need for special care for newborn; **COORDINATE** with pediatric provider.
- Poor fetal growth and preterm birth (see *Preterm Birth* CPM).

PRESCRIBE thoughtfully at postpartum discharge

IF vaginal birth:

- **CONSIDER** NSAIDs (preferred).
- **LIMIT** use of opioids to patients with more severe pain; no more than 10 pills and no refills.

IF cesarean birth:

- **CONSIDER** NSAIDs (preferred).
- **LIMIT** use of opioids for pain up to 7 days, post-op only; no more than 20 pills at discharge and no refills.

ALGORITHM NOTES

(a) Physician management

ENSURE that a physician is actively managing the patient's opioid use. Either:

- **COMMUNICATE with the prescribing physician to coordinate care.** This provider needs to continue to manage in consultation with you, the OB provider. Reassure the prescribing physician that a pregnant woman can be weaned safely from opioid use. A more standard option is to transition the patient to a maintenance medication (buprenorphine or methadone) that minimizes the perinatal risks. Offer to assist the prescribing physician with this process.

OR

- **ESTABLISH "rules of engagement" with the patient** if you assume a prescribing role. Access the *Medication Management Agreement: Opioids* among the provider resources described on page 4.

(b) Transitioning to buprenorphine

- **CONTACT** a psychiatrist for help identifying a physician credentialed to prescribe buprenorphine for opioid use disorder. (Note that there is no single, reliable list of buprenorphine providers in Utah; many credentialed doctors choose not to appear on official lists, and about half of those on the Substance Abuse and Mental Health Services Administration [SAMHSA] list are not accepting new patients.)
- **ADMIT** for medical observation, and manage with help from a clinician experienced in buprenorphine use. Generally, the patient will begin on Subutex and be managed per their withdrawal symptoms as assessed by the Clinical Opiate Withdrawal Scale (COWS) or other.
- At time of discharge, **ENSURE** that the patient continues with or is referred to a credentialed physician for management throughout pregnancy.

COMMUNICATION IN SHARED DECISION-MAKING

Conversational techniques that foster effective communication with patients and families include the following:

- **Open-ended questions** that don't require a yes/no answer. Example: *"What concerns or questions do you have about this plan?"*
- **Reflecting back the speaker's feelings and perspectives.** Example: *"It sounds like the idea of working hard on lifestyle change appeals to you."*
- **Paraphrasing key statements and giving a general summary based on those statements.** Condensing key statements and giving a summary of the situation can clarify content, show you've understood the patient's perspective, and help the patient and family focus on the broader perspective rather than being mired in the details. Example: *"From what you've said, it sounds like you'd like to…"*
- **Asking for teach-back.** Ask patients to repeat key points (information about benefits and risks, etc.) in their own words. Example: *"Can you explain back to me the pros and cons of this plan?"*

RESOURCES

Provider resources

Access intermountainphysician.org/clinicalprograms and select the "Neonatal Abstinence Syndrome" or "Substance Use Disorder" clinical topic from the A–Z list on the right side of the screen. Look for:

- This CPM and other related CPMs and guidelines
- Clinical forms
- Patient education

Quick links to documents and sites of particular relevance:

- *Assessment and Management of Substance Use Disorder* (SUD) CPM
- *Opioid Use in the Lactating Mother* CPM
- *Medication Management Agreement: Opioids*
- Substance Abuse and Mental Health Services Administration (SAMHSA) website to locate providers (www findtreatment.samhsa.gov)

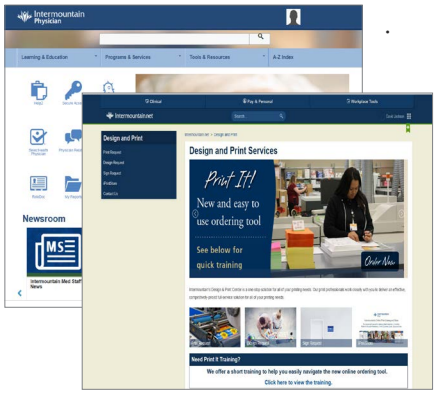
Intermountain-approved patient education materials

The following Intermountain-approved patient education resources can be accessed and ordered online (available in both English and Spanish).

- *Substance Use During Pregnancy*, for use with all pregnant patients
- *Opioid Pain Medication in Pregnancy*, for patients using opioids or considering use during pregnancy
- *Newborn Withdrawal*, for parents and caregivers with neonates in withdrawal

Intermountain education materials are designed to support your efforts to educate and engage patients and families. They complement and reinforce interventions by providing a means for patients to reflect and learn in another mode and at their own pace. To access these materials:

- **In iCentra,** search for Intermountain items in the patient education module.
- **Log in to** Intermountainphysician.org, and search for the patient education library under A–Z. Then, search item number and title in the appropriate area.
- **Use Intermountain's** Design & Print Center for one-stop access and ordering for all Intermountain-approved education.



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CDC1 Centers for Disease Control and Prevention. Drug and Opioid-Involved Overdose Deaths—United States, 2013–2017. *MMWR.* 2019;67:1419-1427.

CDC2 Centers for Disease Control and Prevention, Enhanced State Opioid Overdose Surveillance (ESOOS) Program. Nonfatal Drug Overdoses. https://www.cdc.gov/drugoverdose/data/nonfatal.html. Accessed May 9, 2019.

CDC3 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. Policy Impact: Prescription Painkiller Overdoses. https://www.cdc.gov/drugoverdose/. Accessed November 5, 2014.

GOL Goler NC, Armstrong MA, Taillac CJ, Osejo VM. Substance abuse treatment linked with prenatal visits improves perinatal outcomes: A new standard. *J Perinatol.* 2008;28(9):597-603.

JON1 Jones HE, Kaltenbach K, Heil SH, et al. Neonatal abstinence syndrome after methadone or buprenorphine exposure. *N Engl J Med.* 2010;242:3230.

JON2 Jones HE, Heil SH, Baewert A, et al. Buprenorphine treatment of opioid-dependent pregnant women: A comprehensive review. *Addiction.* 2012;107(Suppl 1):5-27.

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NIDA1 Utah Opioid Summary. National Institute on Drug Abuse. https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/utah-opioid-summary. Revised February 2018. Accessed July 16, 2018.

NIDA2 NIDA Quick Screen V1.0. National Institute on Drug Abuse. http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf. Accessed July 16, 2018.

VER Vermont Child Health Improvement Program (VCHIP). Screening for Substance Abuse during Pregnancy. http://www.med.uvm.edu/vchip/Downloads/ICON%20-%20SCREENING_FOR_PREGNANCY_SUBABUSE.pdf. Burlington, VT: March of Dimes; 2009. Accessed November 5, 2014.

This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Robert Andres, MD, Maternal Fetal Medicine, Intermountain Healthcare (Robert.Andres@imail.org).

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