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.** 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). 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.

- **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.

- **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. 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.

- **Data show a significant impact.** In the U.S., nearly 90% of women with a substance use disorder are of reproductive age. 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.

### Key Points

- **Screen and educate every pregnant patient.** 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. Women who receive treatment early in their pregnancy can achieve the same health outcomes as pregnant women who do not use substances.

- **Prescribe wisely.** If prescribing opioids at postpartum discharge, give the minimum appropriate amount. See specific guidelines on page 3.
ALGORITHM 1: SCREENING

SCREEN at each encounter (or at least once per trimester during pregnancy AC0G)
**ALGORITHM 2: MANAGEMENT**

Patient with confirmed opioid use

- **yes** Opioid use managed by physician?
  - COORDINATE care with prescribing physician (a)
  - 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 maintenance 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](http://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](http://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.
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).

REFERENCES


