ACOG District II
Opioid Use Disorder (OUD) in Pregnancy
Bundle - Part 2

Response & Reporting

ACOG District II
Opioid Use Disorder (OUD) in Pregnancy
Bundle - Part 2

Response & Reporting

This education has been made possible through funding from the New York State Health Foundation (NYSHealth).
Disclaimer: The following material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or consequences of any actions taken on the basis of the information provided.

- This education is not exclusive to maternal opioid use disorder (OUD). The management approaches outlined within may also be effective in helping women with other substance use disorders (SUDs).

- Each provider should take into account the available institutional and community resources when providing and coordinating care.
  - Practices and institutions are strongly encouraged to review their existing policies and procedures for OUD in pregnancy management and modify them if necessary to maximize safe patient care.
Purpose

• Offer multi-faceted education and implementation tools to better assist women’s health care (WHC) providers in caring for pregnant women with OUD

• Encourage better communication and engagement among providers across all services within the continuum of care, including the justice system

• Improve patient outcomes through use of destigmatized language

• Enhance patient and family engagement
Obstetric Care for Women with Opioid Use Disorder

RESPONSE
Every provider and/or provider setting should:
- Ensure that all patients with OUD are enrolled in a woman-centered OUD treatment program.
- Establish communication with OUD treatment providers and obtain consents for sharing patient information.
- Assist in linking to local resources (e.g., peer navigators, harm reduction programs, anonymous/call center) that support recovery.
- Incorporate family planning, breastfeeding, pain management and infant care counseling, and education and resources into prenatal, intrapartum, and postpartum clinical pathways.
- Provide breastfeeding and lactation support for all breastfeeding women and children.
- Provide immediate postpartum contraceptive options (e.g., long acting reversible contraception [LARC]) prior to hospital discharge.
- Ensure coordination among providers during pregnancy, postpartum, and the inter-conception period.
- Provide referrals to providers (e.g., social workers, psychiatry, and infectious disease) for identified co-morbid conditions.
- Identify a lead provider responsible for care coordination, specify the duration of coordination and assure a "warm handoff" with any change in the lead provider.
- Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff (i.e., inpatient maternal care staff, social services) and child welfare services.
- Engage child welfare services in developing safe care protocols tailored to the patient and family's OUD treatment and resource needs.
- Ensure priority access to quality home visiting services for families affected by SUDs.

Reporting & Systems Learning
Every clinical setting should:
- Develop mechanisms to collect data and monitor process and outcome metrics to ensure high quality healthcare delivery for women with SUDs.
- Develop a data dashboard to monitor process and outcome measures (e.g., number of pregnant women in OUD treatment at specified intervals).
- Create multidisciplinary case review teams to evaluate patient, provider and system-level issues.
- Develop and disseminate education and learning opportunities for providers and staff regarding SUDs.
- Identify ways to connect non-medical and community stakeholders with clinical providers and health systems to share outcomes and identify ways to improve systems of care.
- Engage child welfare services, public health agencies, court systems and law enforcement to assist with data collection, identify existing problems and help drive initiatives.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Bundle Part 1: Readiness, Recognition & Prevention

- Stigma/bias/discrimination
- Chronic disease
- Treatment
- Education
- Family/patient engagement
- Multidisciplinary care coordination
- Antenatal, intrapartum, postpartum planning
- Pain control
- Guidelines and statutes
- Best resources
- Universal screening
- SBIRT

- Polysubstance use
- Co-occurring disorders
- Intimate partner violence (IPV)
- Smoking
- Readiness to change
Bundle Part 2: Response & Reporting

- Communication and care coordination
- Service linkages
- Woman-centered treatment options
- “Warm handoffs” across the continuum
- Pregnancy, postpartum, inter-conception care
- Pain management support
- Breastfeeding support
- Postpartum contraception
- Infant care and child welfare tips
- Safe care protocols
- Home visiting options
RESPONSE
(Provider/Clinical Setting/Health System)
MAPPING LOCAL RESOURCES, WOMEN-CENTERED CARE, CARE COORDINATION, PARTNER INVOLVEMENT, TREATMENT & RECOVERY SUPPORT
Mapping Local Resources

Identify a lead provider (eg, ob-gyn, nurse manager, other clinical champion) within your practice responsible for care coordination, specify the duration of coordination and assure a “warm handoff”* with any change in the lead provider.

- A process for mapping of local resources should be developed and updated regularly at the community level
  - Determine screening and treatment services available within your geographic area for OUD & SUDs (see appendix, slides 61-62 for NYS OASAS dashboard)
- Many county health departments offer wraparound services like WIC or mental health treatment (see appendix, slide 63 for county/WIC program resources)

*A warm handoff is a transfer of care between members of the health care team, typically occurring in the presence of the patient (see appendix, slide 64 for more)
Mapping Local Resources

Assist in linkage to local resources that support recovery (eg, peer navigator programs, narcotics anonymous (NA), support groups).

- Create opportunities for support resources such as peer advocates, recovery coaches, family support navigators, and group centering programs
  - Examples:
    - Group prenatal care specific to OUD *(see appendix, slide 65 for Centering details)*
    - Peer navigator programs: NYS OASAS also has Peer Engagement Specialists who can help connect to services
    - The Center for Court Innovation Patient Navigator program (a WHEN Network partner)
    - Consider co-locating services
Woman-Centered Care

• Women face many challenges as they engage in care, including lack of access to gender-specific care, limited child care availability at treatment facilities, lack of access to providers with obstetric and addiction medicine experience, increased social stigma, and fear of criminal or child welfare consequences.

• Studies have found that women in programs that offer services tailored to their unique needs have higher retention rates (or lower dropout rates), show reductions in substance use, and report fewer barriers to care.

• Treatment services for postpartum women should be comprehensive and include medical services, family and child related treatment services, comprehensive and coordinated case management, and mental health services.

Ensure that ALL patients with OUD are enrolled in a woman-centered OUD treatment program, establish communication with OUD treatment providers, and obtain consents for sharing patient information.

- Women-centered treatment programs that address gender issues, provide child care, individual and group therapy, trauma informed care and family planning interventions should be prioritized (see appendix, slide 66 for further defining women-centered/family-centered treatment).

*Note: Federal rules protect the privacy and confidentiality of OUD treatment records (see appendix, slides 67-70 for sample consent forms and 42 CFR regs.)*
Care Coordination & Information Sharing

Ensure coordination among providers during pregnancy, postpartum and the inter-conception period. Develop a communication strategy to facilitate coordination among the obstetric provider, OUD treatment provider, health system clinical staff (eg, inpatient maternity staff, social services) and child welfare services and other service areas (ie, Emergency Department - see slide 15 for more).

- Communication and information-sharing through regular (ie, monthly) team meetings is essential to ensure the effectiveness of a care coordination model. A formal Memorandum of Understanding (MOU) and/or information-sharing agreement would be necessary for the appropriate exchange of information (see slide 85 for the Children and Recovering Mothers (CHARM) Collaborative- best practice model of a multidisciplinary group of agencies serving women and families with OUD in Vermont).

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Care Coordination: Hospital Based

- Encourage a patient tour (if available) of the maternity care unit.
- Consider prenatal neonatal consultation, if available, to discuss immediate neonatal care and to educate families on the expected assessment, possible outcomes, and management of infants at risk for neonatal exposure.
- Discuss with patient and her family the hospital screening instrument used for monitoring for signs of fetal withdrawal (eg., Eat Sleep Console (ESC) vs. Modified Finnegan or other).
- Introduce the concept of plan of safe care. Promote transparency about CPS, ensure the appropriate expectation about social work and CPS involvement are discussed with the patient and care team.

*Note: Ob-gyn providers are encouraged to know their hospital procedures/policies regarding a call or notification to CPS*

Source: [https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs](https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs)
Care Coordination: Referrals

Provide referrals to providers (e.g. social work, mental health agencies, psychiatry, and infectious disease) for identified co-morbid conditions.

• When assessing a patient, if all services needed are not available at current facility, staff are responsible for ensuring patients receive the appropriate level of care at other facilities. Follow-up with the cooperating facility to ensure the patient receives proper care is also essential.

• WHC providers are strongly encouraged to partner with local community mental health/SUD providers.

• Some ER/urgent care facilities or other specialties may benefit from established protocols or processes for caring for this population when presenting to the emergency department (see appendix, slide 71 for a sample ED algorithm)

Note: Many hospitals have health homes that work with patients with multiple chronic conditions and may be a good start for coordination (see appendix, slide 72 for eligibility criteria).

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Partner Involvement in Treatment Considerations

In deciding whether or not to involve a woman’s partner in treatment, primary consideration should be given to her safety and to the partner’s willingness to participate. Patient preference in engaging partner is also essential.

The following important issues should determine participation and level of treatment involvement and to establish an appropriate treatment plan:

- History of violence
- History of substance use in the relationship
- Partner’s history of substance use
- Accessibility
- History of mental illness
- Relationship support of the partner
- Commitment to relationship
Treatment & Recovery Support

Treatment and recovery support may include:

- Safe housing
- Behavioral health counseling
- Intimate partner violence (IPV) support
- Child care
- Transportation
- Parenting support
- Opportunities to connect with other women in recovery

*Note: Providers should communicate with the hospital social worker or discharge planner to coordinate treatment and recovery support*
WITHDRAWAL
Withdrawal: Terminology

• Opioid withdrawal symptoms:
  o Abnormal physical or psychological features that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence. Common withdrawal symptoms include sweating, vomiting, anxiety, insomnia, and muscle pain

• Detoxification/tapering/medically supervised withdrawal
  o Gradual reduction in the dose of methadone or buprenorphine (reducing withdrawal symptoms) with the goal of completely discontinuing maintenance

Sources: https://www.medicinenet.com/script/main/art.asp?articlekey=9974

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Withdrawal: Risks

- Opioid detoxification/medically supervised withdrawal during pregnancy is **NOT** recommended.
  - Low rate of completion (9-100%)
  - High rate of relapse (0-100%)
  - Limited data on maternal and neonatal outcomes
  - Does not avoid all cases of NAS
  - Increased risk of morbidity (HIV, hepatitis) as well as CPS involvement and involvement in the justice system
  - Lower tolerance and risk of overdose
  - Increased mortality

Medication-assisted treatment (MAT) with methadone or buprenorphine is the recommended treatment during pregnancy.

Source: https://www.ajog.org/article/S0002-9378(16)00477-4/pdf
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
ACOG District II, 2019
Withdrawal: Risks

• Older evidence
  o Myth and misconception about the risks of fetal demise have persisted since case reports by Rementeria and Zuspan in the 1970s.

• Current evidence
  o Systematic review of 15 studies
    • Fetal demise:
      – Detoxification group: 1.24% (14/1,126)
      – Comparison group: 1.95% (17/871)
      – Fetal demise not different
  • Need for intense behavioral health monitoring

Medically supervised withdrawal during pregnancy is **NOT** recommended.

Medication-assisted treatment (MAT) with methadone or buprenorphine is the recommended treatment during pregnancy.

Management of acute withdrawal symptoms

- Recognize the symptoms (Clinical Opioid Withdrawal Scale) (see appendix, slide 73 for example)
- Identify treatment readiness:
  - Follow-up with MAT provider if patient already in treatment
  - SBIRT for those not in treatment
  - Consider initiating MAT for those who are willing to start treatment
- Use of additional non-opioid adjunctive medications

Minimally, develop a system to follow-up with patients who decline MAT.
Provider Tools – Withdrawal Order Set

Featured highlights may include:

- Notifications
- Assessment
- Medication and IV orders
- Withdrawal orders
- Ancillary medications
- Non-medication orders (ie, labs)
- Nursing orders

Source: Crouse Health Withdrawal Order Set

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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In-Patient Initiation of MAT

- Each obstetric unit should develop guidelines for initiation of MAT for pregnant women with OUD in conjunction with experts in addiction medicine and that align with the resources available within their region.
- A non-waivered provider can continue buprenorphine or methadone when a patient is admitted to the hospital or initiate treatment of acute withdrawal.
  - Within 3 days of initiation, prescribing provider should successfully transfer the patient to a licensed or waivered provider for ongoing treatment (see DEA, “three-day rule” for more details or slide 70 in appendix).

*See ACOG District II Readiness Bundle for guidance on “Methadone vs. Buprenorphine” pros/cons (see slide 41)

Sources:
https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/legislation-regulations-guidelines/special
https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4527170/
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Initiation of MAT with Buprenorphine

Patient dependent on opioids

Stop opioid use & assess readiness for treatment

Withdrawal symptoms present 12-24 hours after last dose?

No  Yes

Reevaluate  Administer buprenorphine 2 mg to 4 mg and observe

Withdrawal symptoms relieved?

No  Yes

Repeat dosing  Day 1 dosing established

Withdrawal symptoms relieved?

No  Yes

Manage withdrawal symptomatically  Day 1 dosing established

Return next day for repeat induction of buprenorphine attempt

Source: Modified from SAMHSA Tip 40 guidance
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Initiation/Stabilization of MAT

• Inpatient/outpatient options will need to be individualized for each patient.
• Accessing the most clinically appropriate level of care for OUD services is essential in providing safe and effective treatment.
  • Assessment of the individuals presenting issues, history of use, medical history, mental health, family/social and housing status all need to be considered for the appropriate level of care.
  • NYS OASAS Treatment LOCADTR 3.0 (Level of Care for Alcohol and Drug Treatment Referral) is available to guide decision making regarding appropriate level of care for each patient. [https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm](https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm)
• Treatment for acute withdrawal will also depend on other co-factors.
PAIN MANAGEMENT: INTRAPARTUM & POSTPARTUM
Pain Management

Medical Care

Evaluation and management avoiding bias from patient’s history of OUD and/or pregnancy.

1. Women with OUD are as (or more) susceptible to medical conditions
2. Pregnancy may alter the presentation of common medical conditions
3. Pregnancy is not a contraindication to appropriate evaluation or opioid pain management

Tx: Yes. Verify MAT dose/frequency. Avoid changes unless medically necessary and in consult with MAT provider.

Tx: No. Assess willingness to engage in treatment and refer

Prenatal care

Assess for prenatal care

PNC: Yes. Update provider

PNC: No. Refer for prenatal care

Medication-assisted treatment (MAT)

Assess engagement in treatment

EXAMPLE

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https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Pain Management: Intrapartum

- OB Team (anesthesia, nursing, OB providers)
  - Address patient fear about pain management offering clear explanations and reassurance (discussion reduces anxiety and may reduce doses needed)
- Epidural is primary analgesia for opiate dependent women
  - Early anesthesia evaluation may benefit from referral antepartum depending on history (PTSD issues affecting labor)
  - Nalbuphine (Nubaine) and butorphanol (Stadol) may precipitate withdrawal and contraindicated for those on methadone or buprenorphine
    - Opioid agonist - antagonist (can precipitate withdrawal)
  - Neuraxial (epidural and intrathecal) opioids
    - Dosing adjustment due to increased tolerance typically needed
  - “Natural” pain management (eg, acupuncture, TENS, etc.)
  - Nitrous oxide provides benefit in early labor (consider baseline consciousness of each individual patient when deciding on nitrous oxide as a labor analgesic option)
  - Doula – may be helpful with coexisting anxiety

Source: Gunderson & Stimmel, 2004
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Pain Management: Intrapartum

- Intrapartum analgesia needs are the same or higher as for any other woman
  - MAT is NOT sufficient for intrapartum analgesia
  - Women receiving methadone or buprenorphine should have the same options for intrapartum analgesia as any other patient
- Methadone or buprenorphine should be continued throughout labor
  - Methadone or Buprenorphine should not be temporarily stopped in anticipation of delivery
- Neuraxial anesthesia is safe and preferred
  - The incidence of hypotension may be increased in the presence of some co-morbid health conditions (eg, liver disease)
- IV access may be more difficult
- Avoid mixed agonist-antagonists
Postpartum Pain Management Recommendations

- Opioid prescribing for postpartum pain could lead to misuse/dependence if not managed/used appropriately.
  - Use of non-opioid strategies should be maximized
  - When opioids are needed, safe prescribing strategies should be used

**Key principles among the CDC prescribing guidelines** *(see appendix, slide 74 for the CDC opioid prescribing recommendations)*:

1. **Non-opioid therapy is preferred**
2. If opioids are used, the lowest possible effective dose should be prescribed to reduce the risks of OUD and overdose
3. Providers should exercise caution when prescribing opioids and should monitor all patients closely. Three days of treatment or less will often be sufficient; more than 7 days will rarely be required.

Pain Management: Postpartum

- It is **impossible** to predict a patient’s pain level or opioid need
  - Reassure the patient that her pain will be addressed
- Medications for MAT should not be assumed to cover postpartum pain or adjusted/interrupted for pain management.
- **Vaginal delivery:** Non-opioid analgesics are often adequate
- **Cesarean delivery:** Patients often experience more pain and require higher than average opioid doses
- Maximize nonpharmacological (eg, heat) and non-opioid pain management (eg, TAP block, Toradol); double concentration patient-controlled analgesia (PCA)
  - Consider scheduled, rather than PRN, medications
- Avoid agonist/antagonists and full antagonists (full agonists may need to be used for pain control if the above fail. The next slide refers to their use)

**Breastfeeding should be encouraged for women who are on a stable dose of methadone or buprenorphine, interested, and have no other contraindications.**
Pain Management: Postpartum

• Pain can interfere with a woman’s ability to care for herself and her infant. Nonpharmacologic and pharmacologic therapies are an important component of postpartum care.

• Women with cesarean birth; pain control can be challenging
  o Require 70% more opiates for pain management
    • Do not withhold
    • Limit length of dosing
  o Success with alternatives
    • Acetaminophen
    • Ibuprofen

• Women with vaginal birth:
  o Early ambulation
  o NSAIDS, acetaminophen
  o Sitz bath, anesthetic spray if perineal pain

Source: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Postpartum-Pain-Management
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
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Pain Management: Postpartum

• Anesthesia
  o Transversus abdominis plane block (TAP)
    • Ultrasound guided regional anesthetic technique that blocks T6-L1 nerve roots and provides analgesia for lower abdominal procedures
    • Reduce postoperative opioid consumption and opioid-related side effects
    • Improved postoperative pain control and patient satisfaction
  o Patient controlled analgesia (PCA) pump / PCEA (epidural)
    • Shown to be effective – use up to 24 hours post-op
    • Autonomy for patient
    • Anesthesiology / pain management team

Note: Pain therapy should be individualized based on the patient’s condition
Think about collaborating with anesthesia team w/ use of TAP block
Pain Management: Postpartum

- Breast Engorgement/Uterine Contractions:
  - Nonpharmacological treatments
  - Ice pack for perineal pain
  - In breastfeeding women, frequent breastfeeding to avoid engorgement, application of breastmilk to nipples, good latching, avoid trauma

- Perineal/Laceration Pain:
  - Ice pack cool packs applied briefly oral analgesics
  - Topical cream; astringents for hemorrhoid pain
Pain Management: Postpartum

- Postpartum uterine cramping/after pains:
  - Application of heating pad, k-pad, early ambulation
  - NSAIDS more effective than acetaminophen (possibly associated with elevated BP).
  - Scheduled medications for pain relief may provide better control of pain and improved patient satisfaction than traditional PRN (as needed) dosing
  - Data on opioid use inconclusive, use short-acting low dose to improve maternal mobility
  - Stepwise dosing combinations of NSAIDS, low dose opiate, to higher opiate dose then back to lower dose when pain controlled

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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Enhanced Recovery After Surgery (ERAS)

• Multimodal approach to recovery including, nutrition, hydration, etc. emphasizing non-opioid analgesia as first line therapy is safe and effective for vaginal and cesarean deliveries to optimize patient experience, perioperative care, and surgical outcomes.

• Uses evidence-based elements of care during pre-, intra-, and postop experiences to decrease physiologic stress and organ dysfunction so that patients recover more quickly with fewer complications.

• Fundamentals of ERAS pathways will continue to evolve as evidence changes over time.

Source: ACOG CREOG Education & ACOG CO ERAS
https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co750.pdf?dmc=1&ts=20181002T1724332764

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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## Reduction of Prescribing

<table>
<thead>
<tr>
<th>Outcome</th>
<th>30 or Fewer Tablets (n=237)</th>
<th>31-40 Tablets (n=299)</th>
<th>More Than 40 Tablets (n=69)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied or very satisfied with pain relief</td>
<td>200 (84.4)</td>
<td>252 (84.3)</td>
<td>56 (81.2)</td>
<td>.501</td>
</tr>
<tr>
<td>Patient’s perception of opioid quantity dispensed</td>
<td></td>
<td></td>
<td></td>
<td>.032</td>
</tr>
<tr>
<td>Too little</td>
<td>35 (14.8)</td>
<td>29 (9.7)</td>
<td>6 (8.7)</td>
<td></td>
</tr>
<tr>
<td>Just right</td>
<td>134 (56.5)</td>
<td>179 (59.9)</td>
<td>33 (47.8)</td>
<td></td>
</tr>
<tr>
<td>Too much</td>
<td>49 (20.7)</td>
<td>62 (20.7)</td>
<td>25 (36.2)</td>
<td></td>
</tr>
<tr>
<td>Experienced an opioid-related side effect</td>
<td>111 (46.8)</td>
<td>185 (61.9)</td>
<td>49 (71.0)</td>
<td>.001</td>
</tr>
<tr>
<td>Required a refill of opioid</td>
<td>14 (5.9)</td>
<td>15 (5.0)</td>
<td>4 (5.8)</td>
<td>.873</td>
</tr>
<tr>
<td>Pain score at week 1*</td>
<td>4 (3-5)</td>
<td>4 (2-5)</td>
<td>4 (2-5)</td>
<td>.034</td>
</tr>
<tr>
<td>Pain score at week 2*</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>.630</td>
</tr>
<tr>
<td>No. of tablets consumed</td>
<td>15 (5-24)</td>
<td>20 (10-32)</td>
<td>32 (14-50)</td>
<td>.001</td>
</tr>
</tbody>
</table>

Data are n (%) or median (interquartile range) unless otherwise specified.

* Pain score (0-10).


- Over prescribing opioids may lead to patients consuming greater amounts of opioids which may predispose patients to higher consumption without improved pain control.
- WHC providers can play an important role in decreasing the supply of opioid medication by adopting more judicious prescribing patterns and by counseling women about the importance of safe leftover medication disposal.
CASE STUDY
Case Study

- 30 year old; G3 P2002

**Medical History**
- Hx. polysubstance and heroin use
- Hx. of depression and mood disorders
- Hx. of traumatic birth experience wanted cesarean delivery
- Previous Hx. of MAT with buprenorphine
- Currently on MAT with counseling, trying to wean herself

**Prenatal History**
- Entered care at 21 weeks gestation through Perinatal Center
- OB care transfer into Centering Pregnancy Special Care

**Social History**
- No longer with father of the baby as support, patient’s mother lives in area, both children live with patient’s mother
- Patient has limited support system
- Not working, some college education
Case Study

Inadequate pain management in previous labor now described as a “traumatic birth”

Problem

- Demand for primary cesarean delivery at initial visit
- Patient described staff as treating her as an “addict,” noting “they did not believe me when I said my epidural was not working”
- 3rd anesthesiologist evaluated the epidural to be not infusing in the patient. Patient stated: “they never believed what I was saying”

Management plan

- Acknowledge experience and describe actionable strategies that include thorough understanding of pain management options in labor
- Work with MAT treatment provider
- Refer patient for anesthesia consult in 3rd trimester
- Patient decided to attempt vaginal birth after anesthesia consult
Case Study

Patient’s Perinatal Course through Centering Pregnancy

- Entered labor spontaneously at 38.6 weeks 5 cm on admission, del girl 3156 gm
- Attended all visits, bonding with other group members
- Baby home day 4 without additional interventions

- Came back to PNC reported baby only stayed 2 additional days and she stayed with her
- Felt empowered and much more prepared, felt the staff had read her chart and understood her concerns
- Expressed that she was able to discuss her concerns with nursing, less defensive
- Grateful that she had opportunity to explore issues of NAS, scoring system, and treatment, expressed guilt that her baby had to go through this
- Expressed relief that she did not have to leave baby in NICU

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

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POSTPARTUM PLANNING
Postpartum Risks & Challenges

- Women with OUD are at an elevated risk of relapse during the postpartum period

- Unique challenges postpartum include:
  - Lack of specialized and prioritized treatment
  - Loss of pregnancy-related Medicaid coverage
  - Stigma of having a substance-exposed infant
  - Postpartum depression, hormonal changes

Components of Postpartum Care

Mood & emotional well-being

- Screen for postpartum depression and anxiety with a validated instrument
- Provide local resources for mentoring and support
- Screen for tobacco use; counsel regarding relapse risk in postpartum period
- Screen for SUD and refer as indicated
- Follow-up on preexisting mental health disorders, confirm attendance at mental health related appointments, and titrate medications as appropriate for the postpartum period

Source: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20181031T1342465133

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Components of Postpartum Care

Infant Care & feeding

• Assess comfort & confidence w/ caring for newborn, including:
  o Feeding, childcare strategy, pediatric medical home, safe sleep, caregivers are immunized

• Assess comfort & confidence w/ breastfeeding, including:
  o Breastfeeding-associated pain
  o Logistics of and legal rights of milk expression if returning to work/school
  o Return to fertility while lactating
  o Address maternal concerns regarding hormonal contraception and breastfeeding within context of each women’s desire to breastfeed and her risk of unplanned pregnancy

Source: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20181031T1342465133

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
Postpartum Planning

• Postpartum planning begins in the antepartum period. Discuss benefits of breastfeeding and maternal infant bonding early on.

• Address concerns about pain management promptly. Women with OUD need additional support and planning for pain management postpartum.

• It is recommended that ALL women have contact with their ob-gyn or other WHC provider within the first 3 weeks postpartum. Make an appointment before the delivery if possible (eg, in the 4th trimester).

• Provide postpartum psychosocial support services, including referral to treatment and relapse prevention programs.

• Communicate with treatment provider to ensure patient has continued care including adjusting dosage as needed.

Breastfeeding

Provide breastfeeding and lactation support for all postpartum women on pharmacotherapy.

Breastfeeding helps calm and soothe the baby and increases maternal bonding and overall improves the course of withdrawal.

*Breastfeeding is not contraindicated* and should be encouraged for women on MAT who are not using illicit drugs, and who have no other contraindications, such as HIV infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.

Breastfeeding is the standard of care.

Postpartum Contraception

Provide immediate postpartum contraceptive options (eg, long acting reversible contraception-LARC) prior to hospital discharge.

- Contraceptive counseling and access to contraceptive services should be a routine part of OUD treatment among women of reproductive age to mitigate the risk of unplanned pregnancy.
  - Within the first year postpartum, at least 70% of pregnancies are unintended
  - Between 40–57% of women report having unprotected intercourse before the routine 3-6 week postpartum visit
- The rate of unintended pregnancy among women with OUD is extremely high
  - Nearly 9 of every 10 pregnant opioid-dependent women reports that the current pregnancy was unintended.
  - Studies show that opioid and other substance dependent women are less likely to use a contraceptive method, and those who do tend to use less effective methods, such as condoms.
- Ensure women have access to contraception in jails to avoid unintended pregnancy.

Sources:
https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric Practice/co670.pdf?dmc=1&ts=20180808T1855382581
Engage child welfare services in developing safe care protocols tailored to the patient and family’s OUD treatment and resource needs.

- Ensure social service referrals are made and documented on Plan of Safe Care; connect and work with social worker and/or associated birth hospital to coordinate a plan of safe care if not already established by ob-gyn or MAT provider/addiction specialist.
- Work with patient and multidisciplinary team to complete Plan of Safe Care (see appendix, *slides 76-77*) if not already established.
- Confirm a postpartum MAT plan is in place and patient has transportation to treatment for her next scheduled appointment.
- Ensure hospital compliance with the New York State Caregiver Advise, Record, and Enable (CARE) Act (see appendix, *slide 78* for more details).
Home Visiting

Ensure priority access to quality home visiting services for families affected by OUD.

Develop relationships with local home visiting programs to ensure priority access, as well as to ensure HV programs are reinforcing and sharing the same evidence-based, best practice information as the patients WHC provider (see appendix, slide 79 for resources).

- Individuals simultaneously enrolled in recovery programs and home visiting programs often report scheduling conflicts due to requirements of both programs. Programs should collaborate and schedule creatively to better accommodate the needs of their clients.
Encourage Data Collection and Information Sharing

- Partnering with home visiting and OUD (MAT) programs to address opioid addiction necessitates some level of data and information sharing. Metrics related to addiction, overdose, and their effects on child health and welfare can help organizations better assess community needs. Thus, allowing home visiting programs to deliver targeted, informed care to the families they serve.

As previously noted: communication and information-sharing through regular (ie, monthly) team meetings is essential to ensure the effectiveness of a care coordination model. A formal MOU and/or information-sharing agreement signed by the patient and all those who care for the patient (and her infant) would be necessary for the appropriate exchange of information.
REPORTING
(Every clinical setting/health system)
Reporting

- Develop mechanisms to collect data and monitor process and outcome metrics to ensure high quality healthcare for women with SUDs.
  - Develop a data dashboard to monitor process/outcome measures (ie, number of pregnant women in OUD treatment at specified intervals)
- Create multidisciplinary case review teams to evaluate patient, provider and system-level issues.
- Develop continuing education/learning opportunities regarding SUDs
- Identify ways to connect community stakeholders with clinical providers and health systems to share outcomes and identify ways to improve systems of care
  - Engage child welfare services, public health agencies, court systems and law enforcement to assist with data collection, identify existing problems and help drive initiatives

Source: https://safehealthcareforeverywoman.org/aim-resources-2/
Outcome Measures (O)
O1: Severe Maternal Morbidity
O2: Severe Maternal Morbidity (excluding transfusion codes)
O3: Pregnancy Associated Opioid Deaths
O4: Average Length of Stay for Newborns with NAS

Process Measures (P)
P1: Percent of Women with OUD during Pregnancy who Receive MAT or Behavioral Health Treatment
P2: Percent of OEN Receiving Mother’s Milk at Newborn Discharge
P3: Percent of OEN who Go Home to Biological Mother
P4: Universal Screening at Prenatal Care Sites

Structure Measures (S)
S1: Universal Screening on L&D
S2: General Pain Management Practices
S3: OUD Pain Management Guidelines

Source: https://safehealthcareforeverywoman.org/aim-resources-2/
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
State Surveillance (SS) Measures
SS1: Percent of Newborns Diagnosed as Affected by Maternal Use of Opioids
SS2: Percent of Newborns Diagnosed with NAS

New York State (NYS) Measures
NYS1: Percent of Women who are Verbally Screened for Substance Use with a Screening Tool on Admission to L&D
NYS2: Percent of Women with OUD at Time of Delivery
NYS3: Percent of Women with a Referral to MAT or Other Treatment for Opioid Use
Conclusion

- For all women, before prescribing opioids, ensure opioids are appropriately indicated; discuss risks and benefits of use; review treatment goals; rule out history of substance use and review ISTOP/PMP to determine whether patients have receive prior opioid prescriptions
- Patients with OUD, a shared decision making approach is essential as many women experience anxiety about pain management, or fear treatment with opioids will challenge recovery during labor and postpartum
- Patients with OUD, pain medication requirements may be higher as a result of tolerance
- For chronic pain, avoid or minimize use of opioids. Review alternative therapies such as nonpharmacologic approaches (eg, exercise, meditation techniques, physical therapy, behavioral therapy), and non-opioid pharmacologic treatments (eg, short term acetaminophen therapy or NSAIDs < 28 weeks)

Note: Some screening tools used to “rule out” SUDs including alcohol and tobacco use include AUDIT or DAST and those that predict nonmedical prescription opioid use, such as the SOAPP-R

ACOG District II Opioid Use Disorder in Pregnancy
Task Force & Key Partners

<table>
<thead>
<tr>
<th>Chair/Co-Chair</th>
<th>Name</th>
<th>Title/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Chair</td>
<td>Leah Kaufman, MD FACOG</td>
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<tr>
<td>Co-Chair</td>
<td>David Garry, DO, FACOG</td>
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<tr>
<td></td>
<td>Cynthia Abraham, MD, FACOG</td>
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<td></td>
<td>Michelle Bode, MD, MPH</td>
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<td>Erin Bortel, MSW</td>
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<td>Sharon Chesna, MPA</td>
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<td>Michele Calvo, MPH</td>
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<td>Kathleen Dermady, DNP, LM, CNM, NP</td>
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<td>Darcy Dreyer</td>
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<td>Christie Finch</td>
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<td>Aimee Gomlak, FACHE</td>
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<td>Dede Hill</td>
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<td>Julia Hunter, MD, MPH, FASAM</td>
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<td>Kristen Lawless, MS</td>
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<td>Melissa Kubenik, MD, FACOG</td>
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<td>Maria Morris-Groves, MSEd</td>
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<td>Debby O’Brien</td>
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<td>James Scott, MD, FACOG</td>
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<td>Neil Seligman, MD, MS, FACOG</td>
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<td>Kari Siddiqui</td>
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<td>Maggie Taylor, PhD</td>
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<td>Darlene Walker, RN, FNP</td>
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<td>Bridget Walsh</td>
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<td>Ellie Ward</td>
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<td>Anar Yukhayev</td>
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<td>Ifthath Abbasi Hoskins – Chair</td>
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<td>Christa Christakis, MPP – Executive Director</td>
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<tr>
<td></td>
<td>Kelly Gilchrist – Manager, Medical Education</td>
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</tbody>
</table>

- **Alliance for Innovation on Maternal Health (AIM)**
- **NYSDOH’s New York State Perinatal Quality Collaborative (NYSPQC)**
- **NYS Office of Alcoholism and Substance Abuse Services (OASAS)**
- **NYSDOH AIDS Institute, Office of Drug User Health**
- **HANYS’ Statewide Opioid Addiction Prevention and Management Collaborative**

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
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Albany, NY 12203  
(518) 436-3461  
[www.acogny.org](http://www.acogny.org)

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ACOG District II, 2019
APPENDIX

The resources provided in this section are for informational purposes only. The exclusion of a resource, program or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change without advance notice.
Resources: NYS OASAS Provider Directory

Office of Alcoholism and Substance Abuse Services

OASAS Provider Directory Search

Provider Type
- Prevention Providers
- Treatment Providers
- Providers of Clinical Screening and Assessment Services for the Impaired Driving Offender

Provider Location
- Statewide Search
- County: Albany
- Region: Central
- City: [Blank]
- ZIP: [Blank] 5 Miles

Provider Details
- Provider Name: [Blank]
- Program Type: All Program Types

Submit

Sources: https://apps.oasas.ny.gov/reports_doc/TreatmentDirectory.pdf
https://oasas.ny.gov/providerDirectory/index.cfm
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
ACOG District II, 2019
## New York State Office of Alcoholism and Substance Abuse Services

### Provider Directory

**County Name**: Albany

<table>
<thead>
<tr>
<th>Program Type - Service</th>
<th>Provider Name</th>
<th>Contact Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Services - Med Sup Withdrawal-Outpatient</td>
<td>St. Peter’s Hospital City of Albany</td>
<td>315 S Manning Blvd, Albany, NY 12208</td>
<td>(518) 263-1603</td>
<td>9306G053157</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Program Type - Service</th>
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<th>Provider NoPRU</th>
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</thead>
<tbody>
<tr>
<td>Crisis Services - Medical Managed Detoxification</td>
<td>St. Peter’s Hospital City of Albany</td>
<td>315 S Manning Blvd, Albany, NY 12208</td>
<td>(518) 263-1303</td>
<td>9306G050227</td>
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</table>

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<th>Contact Phone</th>
<th>Provider NoPRU</th>
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</thead>
<tbody>
<tr>
<td>Gambling - Gambling Outpatient</td>
<td>Capital Counseling</td>
<td>660 Warren Street, Albany, NY 12208</td>
<td>(518) 462-6531</td>
<td>3834G050234</td>
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</table>

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Inpatient Treatment Services - Inpatient Rehabilitation</td>
<td>St. Peter’s Hospital City of Albany</td>
<td>3 MercyCare Ln, Glens Falls, NY 12804</td>
<td>(518) 452-6745</td>
<td>9306G051039</td>
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<th>Contact Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Treatment - Medical Maintenance</td>
<td>Whitney M Young Jr Health Center, Inc.</td>
<td>10 DeWitt St, Albany, NY 12207</td>
<td>(518) 466-4771</td>
<td>3520G052011</td>
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<thead>
<tr>
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<th>Provider Name</th>
<th>Contact Address</th>
<th>Contact Phone</th>
<th>Provider NoPRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Treatment - Methadone Clinic</td>
<td>PROMESA, Inc.</td>
<td>176 Central Ave, Albany, NY 12206</td>
<td>(518) 726-5659</td>
<td>0016G052795</td>
</tr>
</tbody>
</table>

**Sources:**


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**ACOG District II, 2019**
NYS County Health Department Websites
https://www.health.ny.gov/contact/contact_information/

NYS Department of Health WIC Program Resources
https://www.health.ny.gov/prevention/nutrition/wic/
## Resources: Warm Handoff

### AHRQ Warm Handoff Guides


<table>
<thead>
<tr>
<th>Material</th>
<th>Uses</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm Handoffs: A Guide for Clinicians [PDF, 129 KB]</td>
<td>Inform clinicians about warm handoffs.</td>
<td>Handout that defines a warm handoff and explains how to do a warm handoff and why it is important.</td>
</tr>
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</table>

### For Practice Staff

<table>
<thead>
<tr>
<th>Material</th>
<th>Uses</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm Handoffs: A Guide for Staff [PDF, 134 KB]</td>
<td>Inform practice staff about warm handoffs.</td>
<td>Handout that defines a warm handoff and explains how to do a warm handoff and why it is important.</td>
</tr>
<tr>
<td>• Checklist: Conducting a Warm Handoff – full [PDF, 86 KB]</td>
<td>Assist practice staff in conducting a warm handoff to the clinician after roaming a patient.</td>
<td>Brief checklist that can be used as a communication tool when conducting a warm handoff to the clinician. It is meant to be used as a job aid by staff who are already familiar with the process. This aid may be customized for practice-specific needs.</td>
</tr>
<tr>
<td>• Checklist: Conducting a Warm Handoff – pocket [PDF, 61 KB]</td>
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</tbody>
</table>
Resources: Centering Programs

- Provide comprehensive patient-centered care, improving outcomes for mothers and newborns
- Promote breastfeeding, infant safety and other choices that improve newborn outcomes
- Enhance patient satisfaction, providing a powerful and enriched perinatal and birthing experience in the presence of a high-risk pregnancy

**Multidisciplinary Team**

- Psychiatric care, mental health and trauma based care, stress reduction
- Social services and community health outreach
- Nutrition
- Pediatric nurse educators – infant massage
- NICU meeting with neonatologist
- OCHD Healthy Families Doula program
- Maternal Fetal Medicine/Obstetrician
- Midwife CNM/CM
- Addiction medicine and services
- Neonatologist/Pediatrician
- Dental
- Gastroenterology
- Infectious Disease

Source: [https://www.centeringhealthcare.org/what-we-do/centering-pregnancy](https://www.centeringhealthcare.org/what-we-do/centering-pregnancy)
## Table 1. Family-Based Services Continuum for Women with Substance Use Disorders

<table>
<thead>
<tr>
<th>Level</th>
<th>What</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Women’s Treatment With Family Involvement</td>
<td>Services are provided to women including pregnant women and women with or without children. Individual is the focus of intervention. Services are offered in context of family relationships. Women may have limited family education, counseling, or visitation.</td>
<td>Improves outcomes for women compared with programs without family context. Allows women whose children have been removed to meet court requirements. Improves birth outcomes over programs without family context.</td>
</tr>
<tr>
<td>2</td>
<td>Women’s Treatment With Children Present</td>
<td>Women are at center of treatment but have children with them. Program provides for child care and basic needs but no service plan for children. Children’s presence is primarily to support women’s participation in treatment.</td>
<td>Allows for visitation. Allows for parent/child attachments to continue. Provides for safety of children. Having children helps motivate mothers toward recovery. Increased reunification.</td>
</tr>
<tr>
<td>3</td>
<td>Women’s and Children’s Services</td>
<td>Women bring children to treatment. Women and each child have case plans and receive services. Parenting support and parenting skills provided. Some children and other family members may be excluded.</td>
<td>Improved treatment retention/outcomes for women. Early screening/intervention for developmental delays. Increased reunification. Improved child outcomes. Improved parenting &amp; family functioning.</td>
</tr>
<tr>
<td>4</td>
<td>Family Services</td>
<td>Programs provide women’s and children’s services with some other family members’ services to support women’s recovery. Women and children have case plans, but fathers and other family members do not.</td>
<td>Improved treatment retention/outcomes for women. Further improved child outcomes. Limited improved outcomes for other family members. Further improvements in parenting &amp; family functioning.</td>
</tr>
<tr>
<td>5</td>
<td>Family-Centered Treatment</td>
<td>Women, children, fathers, and other family members all participate and all have case plans. Family unit is supported in communication and decision-making.</td>
<td>Family transformation (improved parenting and increased family functioning). Improved treatment retention/outcomes for women. Improved outcomes for all family members. Increased percentage of families remaining intact. Further improved child outcomes.</td>
</tr>
</tbody>
</table>

As more members of the family are present and able to access services, the potential for improved short- and long-term outcomes for all members involved increases.

<table>
<thead>
<tr>
<th>Fathers</th>
<th>Fathres and their children receiving services.</th>
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</thead>
<tbody>
<tr>
<td>Men’s treatment with some family groups and family issues addressed in treatment.</td>
<td>Fathers and their children with some other family member services to support the fathers’ recovery.</td>
</tr>
<tr>
<td>Fathers and their children with them but no therapeutic services or case plans for children.</td>
<td>Whole family services with male who abuses substances as center of family.</td>
</tr>
</tbody>
</table>
Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was first promulgated in 1975 to address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings such as administrative or criminal hearings related to the patient.

Part 2 is intended to ensure that a patient receiving treatment for a SUD in a Part 2 program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce or employment. Each institution may develop their own forms, but must include information as stated in the regulations.

To help stakeholders understand their rights and obligations under Part 2, the Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have released two fact sheets illustrating how Part 2 might apply in various settings.

Resources: Sample Consent Forms

PCSS Document Detailing 42 CFR & Sample Consent

Sample Treatment Agreements:
https://www.asam.org/docs/default-source/advocacy/sample-treatment-agreement30fa159472bc604ca5b7ff000030b21a.pdf?sfvrsn=bd4675c2_0

Children and Recovering Mothers (CHARM) Collaborative
SUMMARY:
The final rule makes changes to the Substance Abuse and Mental Health Services Administration's (SAMHSA) regulations governing the **Confidentiality of Substance Use Disorder Patient Records**. These changes are intended to better align the regulations with advances in the U.S. health care delivery system while retaining important privacy protections for individuals seeking treatment for substance use disorders.

The final rule addresses the prohibition on re-disclosure notice by including an option for an abbreviated notice. This final rule also addresses the circumstances under which lawful holders and their legal representatives, contractors, and subcontractors may use and disclose patient identifying information for purposes of payment, health care operations, and audits and evaluations.

*Effective date:* This final rule is effective February 2, 2018.

SAMHSA’s TIP 63: Medications for OUD

New York State Law: Methadone Induction
Article 33, Section 3351 of the New York State Controlled Substances Act
https://www.health.ny.gov/professionals/narcotic/laws_and_regulations/

State Policies on Substance Use During Pregnancy
https://www.guttmacher.org/print/state-policy/explore/substance-use-during-pregnancy
Resources: Emergency Dept. Triage Algorithm

Emergency Department Triage for Pregnant Women with Opioid Use Disorder (OUD)

Pregnant Patient w/ OUD Evaluated in the Emergency Department
- Standard exam and vital signs- current medication(s) and/or diagnoses

Patient indicates she has pain
- Assess patient for the cause of pain (do not assume patient is seeking meds to “get high”)
- Determine if patient is in MAT (contact MAT provider if possible). If suspicion of opioid use/misuse, encourage staff to review the PDMP/STOP to determine whether the patient has received prior opioid prescriptions

Signs a patient may be opioid seeking:
- Frequent visits to different EDs with complaints of pain
- Opioid scripts from multiple providers

- Assess for substance use and conduct a thorough substance use screen as soon as possible (4 P’s, Audit C, NIDA Quick screen)
  - If positive screen → Urine toxicology testing
  - Evaluate for polysubstance use

Assess for acute withdrawal or risk of withdrawal from opioids
*Signs and symptoms of withdrawal: achiness, anxiety, increased sensitivity to pain, irritability, restlessness, sweating, GI upset, tremor (See COWS)*

- Pain management/medical care appropriate to the complaint should be without bias for the patient’s history of OUD/pregnancy

Verify patient's obstetrical care provider, contact them if possible and address any outstanding obstetrical needs

Pregnant patients who are opioid-agonist maintained, type and dose of medication must be verified from prescribing provider

Once verified, the patient’s daily dose and number of doses per day of the medication should not be changed unless medically necessary (if in treatment)

For non-laboring pregnant patients not enrolled for prenatal care, obstetrical referral is indicated

- Assess for engagement in treatment and refer to/or update treatment provider
- Confidently provide local drug treatment center contact information to the patient

Refer to appropriate level of care (eg, Ob-Gyn, MAT provider, Behavioral Health, Social Worker etc.)

This material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or consequences of any actions taken on the basis of the information provided.
Resources: Health Home Services

Medicaid Health Homes
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Health Home Services
• Comprehensive care management
• Care coordination
• Health promotion
• Comprehensive transitional care/follow-up
• Patient & family support
• Referral to community & social support services
Clinical Opioid Withdrawal Scale (COWS)

Assessment of Withdrawal
Clinical Opiate Withdrawal Scale (COWS)

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<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tr>
<td>5-12: mild</td>
<td></td>
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<tr>
<td>13-24: moderate</td>
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</tr>
<tr>
<td>25-36: moderately severe</td>
<td></td>
</tr>
<tr>
<td>More than 36: severe withdrawal</td>
<td></td>
</tr>
</tbody>
</table>

**Reason for this assessment:**

**Patient’s Name:** __________________________

**Date and Time ___/___/___:**

<table>
<thead>
<tr>
<th><strong>Resting Pulse Rate:</strong></th>
<th><strong>GI Upset:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pulse rate 80 or below</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>3 vomiting or diarrhea</td>
</tr>
</tbody>
</table>

**Sweating:** over past 1/2 hour not accounted for by room temperature or patient activity.

| 0 no report of chills or flushing | 0 no tremor                     |
| 1 subjective report of chills or flushing | 1 tremor can be felt, but not observed |
| 2 flushed or observable moistness on face | 2 slight tremor observable |
| 3 beads of sweat on brow or face | 4 gross tremor or muscle twitching |
| 4 sweat streaming off face      |                                |

**Restlessness Observation during assessment**

| 0 able to sit still           | **Yawning Observation during assessment** |
| 1 reports difficulty sitting still, but is able to do so | 0 no yawning |
| 3 frequent shifting or extraneous movements of legs/arms | 1 yawning once or twice during assessment |
| 5 unable to sit still for more than a few seconds | 2 yawning three or more times during assessment |

*See ACOG District II Readiness Bundle for more guidance on withdrawal*


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
Resources: Prescribing & Dosing

ASAM National Practice Guideline

General Overview of Acute Pain Management for Patients on MAT:
Managing Acute & Chronic Pain with Opioid Analgesics in Patients on Medication Assisted Treatment (MAT)
https://pcssnow.org/education-training/training-courses/12-managing-acute-chronic-pain-opioid-analgesics-patients-medication-assisted-treatment-mat/

Management of Postoperative Pain: A Clinical Practice Guideline From the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council

Medicaid Pharmacy Program: Treatment of substance use disorder and the use of opioids/non-opioids
https://health.ny.gov/health_care/medicaid/program/opioid_management/

New York State Department of Health reference chart, "Medicaid Non-Opioid Alternative Treatment Options"
https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf

The challenge of perioperative pain management in opioid-tolerant patients

The CDC Guidelines for Prescribing Opioids
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

VA’s Opioid Decision Taper Tool for other adjunctive medications
Resources Providers: Plan of Safe Care

- If the patient is in treatment, SUD/MAT providers are encouraged to start the plan of safe care prior to delivery, coordinating with the ob-gyn for all prenatal/postnatal care

- At a minimum the patient should expect a consultation with a social worker to ensure safe discharge for her and her infant
What is the CARE Act?

• New York’s CARE Act was initiated as part of AARP’s national campaign to advance state-by-state legislation that creates a process for hospital patients to formally identify a caregiver—such as a relative, partner, or neighbor—who may provide after-care assistance to a patient at home.

• If the patient identifies a caregiver, the hospital needs to include the caregiver in the discharge planning process and offer appropriate instruction related to administering certain after-care tasks.

• The legislation (S.676-B, Hannon/A.1323-B, Rosenthal) (Chapter #391) took effect on April 23, 2016. It aims to ensure that a patient’s support system has certain capabilities and an awareness of the after-care needs of the patient.
Resources: Home Visiting Services in New York State

**Searchable (by county) list of all evidence-based home visiting programs**
https://www.health.ny.gov/community/pregnancy/home_visiting_programs/provider.htm

**Pregnant & Parenting Families Support**
https://www.health.ny.gov/community/pregnancy/home_visiting_programs/pregnant_parenting_fam.htm

**Council on Children & Families Interactive Map of Programs Available in which Counties**
http://arcg.is/H5OnD
211 CNY Central New York Service Search
https://211cny.com/

Drug User Health Hubs
Offer an array of appropriate health, mental health and MAT services
https://www.health.ny.gov/diseases/aids/consumers/prevention/

NYC Opioid Resources
https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-opioid.page
Resources: Patient Education

**OPIOID USE DISORDER AND PREGNANCY**

- Are you using more opioids than prescribed?
- Does your opioid use cause work, school, or family problems?
- Do you need more opioids even though you're taking them as directed?
- Do you feel strong urges to use opioids?

If you answered YES to any of these questions, you may have an opioid addiction, also called opioid use disorder.

Opioid use disorder during pregnancy can harm you and your fetus. If you are pregnant and addicted to opioids, you need medical treatment.

**How Treatment Works**

The recommended treatment for opioid addiction involves the following:

- Taking medication that reduces your cravings (methadone or buprenorphine)
- Getting behavioral therapy and counseling

**Why Treatment Matters**

In the right doses, methadone or buprenorphine can:
- Prevent withdrawal symptoms, cravings, and unhealthy use of opioids
- Help prevent overdose
- Make it more likely that your fetus will grow normally
- Help prevent an early birth

Counseling and good prenatal care can:
- Help you avoid and cope with situations that might lead to relapse
- Help you have a healthier baby
- Help you regain control of your health and life

**Treatment and Your Newborn**

Babies born to women taking methadone or buprenorphine can have short-term withdrawal symptoms. Swaddling, breastfeeding, skin-to-skin contact, and sometimes medications can help make babies feel better.

**Did You Know?**

- If you are prescribed an opioid during pregnancy, you should discuss the risks and benefits with your obstetrician-gynecologist (ob-gyn) or other health care professional.
- When taken under a doctor’s care, prescription opioids can be safe for both you and your fetus.
- It is important to take the medication only as prescribed.

**WATCH A VIDEO**

marchofdimes.org/prescriptionmeds

**HEALTH ACTION SHEET**

Are you taking a prescription painkiller?

These are prescription painkillers called opioids. If you take these or other opioids during pregnancy, it can cause serious problems for your baby.

- Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
- Methadone (Dolophine, Methadone)
- Morphine (Astramorph, Avinza, Darvon, Roxanol)
- Oxycodone (OxyContin, Percodan, Percocet)
- Tramadol (ConZip, Rynal, Ultram)

The illegal drug heroin is an opioid, too. Some prescription opioids, like fentanyl, are made and sold illegally.

Opioids can be dangerous and addictive. They can cause problems for a baby in the early weeks of pregnancy, even before you know you’re pregnant.

If you take opioids during pregnancy, your baby can be exposed to them and grow through withdrawal after birth. This is called neonatal abstinence syndrome or NAS. Even if you use an opioid exactly like your provider says to, it still may cause NAS in your baby.

**TAKING ACTION**

Ask about your medicine.

If you’re taking a prescription painkiller, ask your provider these questions:

1. Is the painkiller an opioid?  Yes  No
2. Why do I need to take an opioid?
3. What are the risks to my baby?
4. Is there a safer medicine to take?  Yes  No
5. If yes, what is it?

If you’re pregnant and using opioids:

- Don’t stop taking any opioid until you talk to your health care provider. Stopping suddenly can cause severe problems for you and your baby.
- Tell your prenatal care provider about any meditne you take, even if it’s prescribed by another health care provider.
- If another provider prescribes you an opioid, make sure she knows you’re pregnant.

If you’re not pregnant and you’re using opioids:

- Use effective birth control until you’ve stopped taking the opioid.
- Talk to your provider about taking a safer pain medicine.
### Ready to Come Home Checklist:

**Things my baby needs**

1. A safe unexpired car seat
2. A crib / bassinet
3. Sensitive skin products i.e. wipes, diapers etc.
4. Formula for sensitive digestive systems
5. A smoke free car and home
6. An appointment with the pediatrician
7. I know the warning signs to watch for if my baby gets ill and the precautions to take
8. A safe residential environment

Source: Catholic Health System

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
**Resources: Hospital Discharge Plan**

**Discharge Plan:**

1. **OBGYN Visit after Discharge:**

2. **Home Care Phone Number and visit dates:**

3. **Following up with the MAT Appointment Date:**
   - Substance Use Disorder counselor appointment:
   - Mental health counselor appointment:

4. **Pediatrician and Appointment:**

5. **Specialty medical appointment (pediatric cardiology, physical therapy, occupational therapy, neurology, cleft palate, etc.)**

Source: Catholic Health System

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
## Resources: Shared-Decision Making at Discharge

### Joint Commission R³ Report: Requirement, Rationale, Reference

| Requirement | EP 8: The hospital educates the patient and family on discharge plans related to pain management including the following:
- Pain management plan of care
- Side effects of pain management treatment
- Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues
- Safe use, storage, and disposal of opioids when prescribed |

| Rationale | During the discharge process, patients and families need education on the importance of how to manage the patient’s pain at home. Unmanaged pain may cause a patient to regress in their recovery process or have uncontrolled pain at home leading to a readmission to the hospital. It is necessary to have a discussion with patients and their families regarding their home environment and activities of daily living that may increase the need for pain management. When a patient is being discharged with an opioid, medication education on safe use, including when and how much medication to take, should be included in the discharge plan. Opioid disposal education is also critical in order to both reduce diversion and decrease the risk of accidental exposure |


| Resources | • U.S. Food and Drug Administration: [How to Dispose of Unused Medicines](https://www.fda.gov/Drugs/ResourcesForYou/Consumers/). FDA Consumer Health Information. 2013. |

Source: [https://www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_5_30_18_REV_FINAL.pdf](https://www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_5_30_18_REV_FINAL.pdf)

ACOG District II, 2019
Resources: Provider Tools – Collaborative Approach

A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS

Compared to efforts by individual agencies and systems, collaboration across multiple agencies and systems, coupled with strong leadership and consistent communication, offers a more effective approach, a more efficient way of doing business, and ultimately leads to better outcomes.

Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers


https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy

ACOG District II, 2019
**Children and Recovering Mothers (CHARM) Collaborative**

The CHARM Collaborative meets once a month for 2 hours to discuss the needs of client families and how to address their needs. Decisions about solutions and follow-up tasks are made for each family before the next family is discussed. To support these discussions, the facilitator distributes a list of client families at each meeting. The lists of client families are divided into four categories: families that are new to CHARM, those with a woman expected to give birth within 30 days, those with a woman who recently gave birth, and those for whom a collaborative member has concerns. Within each category, the names are listed alphabetically, and families are discussed in that order. Typically, about 40 families are discussed at each meeting. Periodically, the first 15 minutes are used for providing cross-disciplinary training, sharing outcomes, and discussing related projects and other non-case-specific process issues.
Additional Resources

ACOG District II Readiness Provider Education Bundle Part 1

ACOG Maternal Opioid Bundle

ACOG Maternal Opioid Bundle Resource Listing

American Correctional Association Document

ASAM Patient, Family, and Friends Pocket Guide

Implementing Transmucosal Buprenorphine for Treatment of Opioid Use Disorder Best Practices from New York State Department of Health and Office of Alcoholism and Substance Abuse Services

Information-Sharing Considerations for Health Plan Members with OUD Q&A with Legal Experts

NYSDOH Buprenorphine Webpage

NYS OASAS Know the Facts Campaign Materials

NYS OASAS Substance Use Disorder Service Description

SAMHSA MATx APP with Patient Resources

SAMHSA Factsheets