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Opiate Use Disorder Pathway in the Perinatal Period

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Improving the Model of Care

Pregnant Women With Opioid Use Disorder

Our Problem

- 52% of maternal deaths in Alaska in the past 6 years were related to alcohol abuse or substance use disorders
- Overall, there is a steady increase in opioid related deaths
- Infants identified with Neonatal Abstinence Syndrome has increase from 4.4 per 1000 live birth to 23.2 per 1000 live births over the last 10 years

Neonatal Abstinence Syndrome

Source: Alaska Medicaid claims and Alaska Health Analytics and Vital Records

- In 2017 PAMC experienced a significant increase in pregnant women presenting actively using opioids. 138 women or about 5% of the patient population tested positive for opioids
- In review of these cases, it was clear we had an inconsistent way we identified, treated, and supported these women
- A review of the literature identified protocols for women prenatally and in the postpartum period
- There was a lack of protocols for women presenting in labor with opioid use

Our History

- During case review and interviews with staff and providers, it became clear that the care of these women was highly variable
- A large number of patients who were tested for opioids because of demonstrating signs of withdrawal had their positive drug screen dismissed by providers
- Examples of treatment included:
  - Denial of opioid replacement or medication assisted treatment
  - Room searches or belongings confiscation
  - Room sitters
  - Limited visitors
  - Prevented from leaving the unit
  - Limited nicotine replacement
  - Behavioral contracts

Team

- Maternity Nurses, Leaders and Care Providers
- Behavioral Health Leaders, Nurses, Therapists, and Psychiatrists
- Pain Service/ Anesthesia Physicians
- Social Workers, Risk Managers, and Security
- Pharmacist

Aligning Our Work

- The team recognized that the care of these patients did not align with the Providence St. Joseph Health's mission and core values
- The team set out to create a list of Guiding Principles that would shape the Clinical Pathway
- At the center of this work was embracing the principles of Trauma Informed Care
- The team encouraged collaboration amongst caregivers and departments
- This process brought forth open and frank conversations with patients and caregivers and became the basis of our culture change.

Guiding Principles

- The disease of addiction is a chronic medical condition that can be managed through compassionate respectful clinical interventions.
- Patients that have opioid use disorder will be treated with evidence-based strategies for withdrawal prevention, management of withdrawal symptoms, and pain management.
- Caregivers will learn about the disease of addiction and develop communication tools that allow them to partner with patients around the disease.
- It is possible and necessary to build a positive relationship between caregivers and patients that suffer from substance use disorders. Patients can learn to be curious about the disease and talk with their providers around their readiness for change and goals for health.
- Caregivers recognize that moral judgments do not produce positive health outcomes.
- Caregivers will use appropriate clinical terms that describe behaviors and symptoms of disease to decrease the stigma associated with addiction.
- Caregivers will partner with patients and visitors to discuss the safety issues that present around substance use.
- Trauma informed care will guide all practice.
- Patients will not routinely have their room searched or be placed on continuous visual observation, unless it is determined they are at imminent risk of harm to themselves. Patients are autonomous and ultimately in charge of their own health.
- Visitors and designated care providers will not be restricted as long as they follow the visitation policy.
- All patients that are suffering from the disease of addiction deserve effective medical care. When patients suffer from an addiction they use substances to manage their addiction. We will not criminalize the use of substances while patients are in medical care.
- Any decisions to report use or possession are made by the entire care team, in conjunction with Security and Risk Management.
- The focus of care is on reducing the negative consequences and high risk behaviors of substance use (harm reduction); it neither condones nor condemns any behavior.
- In situations where the medical team and/or the family feel it is in the best interest of the family and child, breastfeeding is encouraged and supported.
- Opioid replacement will be the standard of care and implemented with current evidence-based standards including multi-modal pain control.
- Care plans will be created by a multidisciplinary team including mental health, chemical dependency specialists, social work, and pain management.

Clinical Pathway

- Created to guide care and provide consistency
- Begins with the Guiding Principles
- Meets patients where they are
- Identifies a list of interventions to be initiated on admission
- Divided into three phases of care (antepartum, intrapartum, postpartum)
- Separated by system (cardiac, respiratory, digestive…..)
- Helps the caregiver recognize signs of withdrawal (COWS scoring)
- Includes evidence based Medication Assisted Treatment (MAT) guidelines
- The basis of the work:
  - Identify signs of withdrawal
  - Replace opioids
  - Refer to an outpatient replacement program
- Pathway contains suggestive scripting
  - Incudes a change in vocabulary
  - Scripting was vetted with patients in treatment
- Begins with a conversation initiated by nurses:
  - "What does withdrawal look like to you"
  - "I want to partner with you to keep you from experiencing withdrawal symptoms
- Creates a pathway to transition women to MAT while in the hospital and immediately refer them to Providence Breakthrough for additional treatment and support

Pathway Example

Admission

- Screen all women privately. Patients must feel safe and have a sense of trust.
- Assess for Risk Factors:
  - Little or no prenatal care (High risk)
  - Inappropriate behaviors (High risk)
  - Physical signs of opioid use or withdrawal (High risk)
  - Smell of alcohol or illicit substances (High risk)
  - Recent history or use (High risk)
  - History of physical abuse or neglect
  - Intimate partner violence
  - Mental illness
  - Previous child with fetal alcohol syndrome
  - History of repeat spontaneous abortions
  - Placenta abruption
  - Preterm labor
  - Intrauterine growth restriction
  - Previous unexplained fetal demise
  - Hypertensive episodes
  - History of stroke or heart attack
  - Severe mood swings
- Observe for signs of opioid intoxication or withdrawal (Attachment A)
- Send urine drug screen to confirm use of opioids
- Initiate COWS Scoring (Attachment B)
- Contact the Maternity Social worker during weekdays and during the daytime hours and/or On-Call Social Worker during nights and weekends. Inform them of the need for a social work consult for a patient with Opioid Use Disorder. Also place the consult in EPIC.
- Social work will complete a psychosocial assessment and determine motivation to change.
- Social work will provide therapeutic support and resources to the patient as determined via their assessment.
- Social work will initiate conversations about OCS involvement
- If admitted for reasons other than opioid use and the patient desires Medication Assisted Treatment (MAT), social work will partner with the attending physician and Breakthrough Clinic to determine transition of care from inpatient to outpatient community.
  - Initiate consults to Chemical Dependency Clinician
  - If admitted for other reason than opioid use and desires medication assisted treatment (MAT), initiate consult to Breakthrough Clinic
  - When medically appropriate, attending physician to initiate medication assisted treatment.
- Initiate No Prenatal Care orders if applicable
- Assess for smoking and desire for nicotine replacement; replace as appropriate with combined Nicotine Replacement Therapy (NRT) [patch daily and lozenge/gum/inhaler prn]

	Antepartum	Intrapartum	Postpartum
Pain *Goals*: • Attain adequate pain control • Achieve pain control with lowest possible opioid dose • Minimize side effects associated with analgesic agents	***Patients without current opioid replacement*** ▪ Score q4hour with COWS ○ For COWS 5 – 12 give oxycodone 5 mg OR hydromorphone 2 mg po ○ For COWS 13 – 24 give oxycodone 10 mg OR hydromorphone 4 mg po ○ For COWS 25 – 36 give oxycodone 15 mg OR hydromorphone 6 mg po ○ For COWS > 36 give oxycodone 20 mg OR hydromorphone 8 mg po ○ For break through pain management: ▪ Hydromorphone 0.4-0.8 mg IV q2 hours prn *For those who are anticipated to have a long pre-delivery length of stay, initiate discussions regarding Medication Assisted Treatment (MAT)* • If patient desires MAT, and it is medically appropriate, perform buprenorphine induction (per attachment) • In pregnancy, buprenorphine-only formulations (without naloxone) should be utilized. • Once buprenorphine initiated, follow "patients on buprenorphine" section for intrapartum and post-partum care • Methadone MAT is an alternative if this is desired by the patient. Methadone should be titrated to target not only withdrawal symptoms, but cravings. Split dosing (bid) recommended in pregnancy.	***Patients without current opioid replacement*** ▪ Score q4hour with COWS ○ For COWS 5 – 12 give oxycodone 5 mg OR hydromorphone 2 mg po ○ For COWS 13 – 24 give oxycodone 10 mg OR hydromorphone 4 mg po ○ For COWS 25 – 36 give oxycodone 15 mg OR hydromorphone 6 mg po ○ For COWS > 36 give oxycodone 20 mg OR hydromorphone 8 mg po ○ For break through pain management: ▪ Hydromorphone 0.4-0.8 mg IV q2 hours prn *When a patient is in labor with impending delivery, it is not an appropriate time to initiate MAT, this conversation can continue after delivery.*	***Patients without current opioid replacement*** • Begin/resume discussion regarding MAT. • Once acute pain managed, as below, if patient desires MAT, perform buprenorphine induction Attachment D). • Methadone MAT is an alternative if this is desired by the patient. Methadone should be titrated to target not only withdrawal symptoms, but cravings. ***Pain management following vaginal delivery:*** • Continue COWS and prn oxycodone/hydromorphone for withdrawal symptoms • Ibuprofen 600 mg po 4h prn mild to moderate pain • Tylenol 650 mg po q6h prn moderate to severe pain ***Pain management following c-section*** • Consider "TAP"- Transversus abdominis plane block. Administered by Anesthesiologist. Consent obtained prior to procedure. • Continue COWS and prn oxycodone/hydromorphone for withdrawal symptoms • Acetaminophen 650 mg po q6h • Ketorolac 30 mg IV q6 hr for 24 hours, followed by: • Ibuprofen 600 mg po q6h • Consider prn IV Opioids if breakthrough pain persists

Results

- Instead of avoiding caring for this patient population, the nurses became excited
- Patient's reported increase in trust, compassion, and acceptance
- Women were successfully transitioned to MAT
- Patients presenting in labor on MAT had better pain management plans

Lessons Learned

- Collaboration takes time. This project took over a year to develop
- You can never have enough stakeholders
- Not every patient will follow the guideline
- You can change culture…a bit at a time
- The disease of addiction allows for failure
- Opioid Use Disorder is not going away
- Connection and compassion are magical

For More Information

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