

>> Oregon Pregnancy  
and Opioids  
Workgroup  
Recommendations

# Acknowledgments

The Oregon Health Authority (OHA) greatly appreciates the time workgroup members spent sharing their knowledge with the goal of improving outcomes for Oregon mothers and infants.

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# Executive summary

Opioid use among pregnant and parenting women and neonatal abstinence syndrome (NAS) are complex public health issues. They cut across health and behavioral health providers, families, child welfare, the criminal justice system and other community organizations.

A variety of life experiences can lead to opioid-exposed pregnancies. These experiences include chronic pain or other conditions managed by medication, misuse of prescribed medication, recovery from opioid addiction and receiving MAT, and active abuse of heroin. Each of these experiences calls for differing prevention and intervention opportunities.

The Oregon Health Authority convened the Oregon Pregnancy and Opioids Workgroup to develop recommendations that can optimize the outcome for both mother and infant. The workgroup included experts from a variety of disciplines, including maternity and pediatric health care providers, public health, child welfare, and substance abuse treatment. The group met from December 2017 to March 2018.

This report includes clinical recommendations for all women of reproductive age as well as those specific to women with an opioid use disorder and their infants. The recommendations focus on care preconception through postpartum and infancy. For these recommendations to be effective, health care providers must recognize the role that trauma and adverse childhood experiences (ACEs) play in substance use disorders. It is also important to incorporate trauma-informed prevention and treatment in a significant way.

This report recognizes the barriers to optimal care faced by women with an opioid use disorder and their infants. The system and policy recommendations encourage Oregon health care leaders and policy makers to better support families affected by opioid use disorder.



## **Recommendations in brief:**

### **Clinical recommendations**

#### **Primary prevention (for all women)**

1. Ask all women of reproductive age about their pregnancy intentions prior to initiation and continuation of any opioid, including medication-assisted treatment (MAT) for an opioid use disorder (OUD).
2. Ask all pregnant women and women seeking pregnancy or preconception care about opioid use.
3. For all pregnant women without an OUD, avoid prescribing opioids when possible but, if necessary, do so with safeguards in place.
4. Prevent opioid overdose.
5. Upon discharge after a delivery, encourage all women without an OUD who need ongoing pain treatment to use non-opioid therapies (i.e., NSAIDs). If opioids are indicated, they should receive a limited number of opioid pills to last until a scheduled follow-up visit and no more than seven days of treatment.

#### **Secondary prevention (for women with an opioid use disorder and their infants)**

6. Coordinate care for pregnant and parenting women with an OUD.
7. Manage OUDs during pregnancy by following evidence-based approaches.
8. Include additional screenings and services when caring for pregnant women with an OUD.
9. Provide appropriate pain control for women with an OUD during labor.
10. Provide necessary postpartum services and support for women with an OUD.
11. Encourage breastfeeding for women with an OUD on MAT.
12. Closely monitor an infant born to a mother who used opioids during pregnancy. Manage care with a standardized protocol for the assessment and treatment of infants at risk for neonatal abstinence syndrome (NAS).

### **System and policy recommendations**

13. The Oregon Health Authority, in partnership with the Oregon Maternal Data Center, should implement a surveillance strategy for in utero opioid exposure and NAS. The strategy should be mindful of any unintended negative consequences and seek a balance between patient confidentiality and the state's ability to truly understand the scope of the problem.
14. Oregon health care leaders and policy makers should work to advance systems change that supports families affected by OUD.

# Introduction

The Oregon Pregnancy and Opioids Workgroup formed in recognition of the need for a comprehensive approach to optimizing health outcomes for mothers with OUD and their infants. Optimizing outcomes requires collaborative efforts among state agencies, health care providers and community organizations that address the entire spectrum of prevention across the lifespan. The workgroup developed statewide recommendations on opioid prescribing during pregnancy, identification and treatment of OUD during pregnancy, and care and treatment of prenatally exposed infants. The recommendations are intended to help health care providers incorporate best practices when caring for women and their substance-exposed infants and to encourage local efforts to provide coordinated care for families.

The workgroup adopted the principles of the [World Health Organization](#): prioritizing prevention; ensuring access to prevention and treatment services; respecting patient autonomy; providing comprehensive care; and safeguarding against discrimination and stigmatization. The workgroup recognizes evidence showing a strong correlation between opioid addiction and traumatic experiences, particularly early childhood adversity and the need to use trauma-informed approaches to prevent and treat opioids addiction.

The “Oregon Pregnancy and Opioids Workgroup Recommendations” provide Oregon health care providers with a consolidated set of recommendations for the management of opioid use during pregnancy, women with OUD during pregnancy, and care of the opioid-exposed newborn. The content is intended to complement standard medical care, the [Oregon Opioid Prescribing Guidelines](#), and other resources available through the [American College of Obstetrics and Gynecology](#), [American Academy of Pediatrics](#) and Substance Abuse and Mental Health Services Administration.



# Clinical recommendations

## Primary prevention: Consider recommendations 1-5 for all women.

### Recommendation 1:

**Ask all women of reproductive age about their pregnancy intentions prior to initiation and continuation of any opioid (including MAT for OUD).**

- a. Offer patient-centered contraceptive counseling and services to women who do not desire pregnancy.
- b. Inform women who do desire pregnancy of potential obstetric and newborn risks associated with opioid use in pregnancy and encourage them to seek early and regular prenatal care.

### Recommendation 2:

**Ask all pregnant women and women seeking pregnancy or preconception care about opioid use.**

- a. Routinely ask all pregnant women and women seeking pregnancy or preconception care about use of opioids, including appropriate use of prescription opioids, illicit use of prescription opioids and other illicit opioids such as heroin. Because polysubstance use is common, rely on short validated tools that screen for other substance use. Examples of tools include [CAGE-AID](#), [SBIRT Oregon's Brief Screen for all adults](#), [4P's Plus/Integrated Screening Tool](#) for women who are pregnant, or [CRAFFT](#) for adolescents.
- b. Any positive initial screen should prompt more in-depth discussion, screening with interview tools such as [Drug Abuse Screen Test \(DAST\)](#) or other strategies to determine if an OUD exists.
- c. Ask all pregnant women and women seeking pregnancy or preconception care about their history of a substance use disorder.
- d. Ask all pregnant women and women seeking pregnancy or preconception care about current and past participation in substance use disorder treatment programs. If a woman is currently in treatment, seek out appropriate consents to facilitate communication between care providers.

- e. Toxicology screens to monitor reported or suspected drug use should only be done with the woman's informed consent. Toxicology screens can provide evidence of abstinence from substance use and can be used to support a woman's recovery efforts.
- f. Follow positive toxicology screens for substances of concern with a confirmatory drug assay such as gas chromatography/mass spectrometry.
- g. Clinicians should check the [Oregon Prescription Drug Monitoring Program \(PDMP\)](#) for women who use opioids, have a history of OUD or are suspected of using opioids shortly before or during pregnancy. The woman should be informed that the clinician is checking the PDMP, and this should be documented in the medical record.

### Toxicology Screening

Toxicology screens have high rates of false results and do not substitute for verbal, interactive questioning and screening for substance use disorders. Universal drug toxicology screening is not recommended.

## Recommendation 3:

**Avoid prescribing opioids when possible to all pregnant women without OUD. If necessary, prescribe opioids with safeguards in place.**

- a. If a pregnant woman without an OUD needs pharmacologic management for acute pain (dental, surgical, injury), manage pain with a multi-modal approach, minimizing the use of opioids.

### Resource

Consider the [Oregon Opioid Prescribing Guidelines](#) when determining whether to initiate or continue prescribing opioids for chronic pain.

- b. Before prescribing opioids to a pregnant woman without an OUD, clinicians should check the Oregon Prescription Drug Monitoring Program (PDMP) (excluding post-surgical pain control). The woman should be informed that the clinician is checking the PDMP, and this should be documented in the medical record.
- c. If a woman becomes pregnant while using prescription opioids for chronic pain, evaluate her for physical dependence and reevaluate the treatment plan. Inform her of potential obstetric and newborn risks associated with ongoing use. If there is no OUD, it's medically appropriate to taper and the woman is willing, taper her to

the lowest effective dose (or off) opioids and manage her pain with other modalities (e.g., exercise, physical therapy, behavioral approaches) and nonopioid pharmacologic treatments.

- d. If a woman becomes pregnant while using prescription opioids for chronic pain and the prescriber is not the maternity care clinician, the prescriber and the maternity care clinician should have a conversation to determine:
- Whether an assessment for physical dependence or OUD is needed
  - Who will prescribe during the maternity episode
  - A schedule for ongoing consultation and a plan for care after the maternity episode. The ongoing consultation should facilitate co-management and prevent the prescriber from discharging the woman due to pregnancy.

Pain management specialists, in collaboration with the maternity care clinician, should initiate and continue care for pregnant women in need of services.

## Recommendation 4:

### **Prevent opioid overdose.**

- a. Make pregnant women taking opioids aware of the risk for overdose and how to prevent one. Anyone taking chronic opioids should have access to naloxone in case of an overdose.
- b. Prescribe naloxone to pregnant women at risk of overdose; e.g., history of overdose, higher opioid dosages ( $\geq 50$  MME/day), concurrent benzodiazepine use or history of a substance use disorder. Pregnant women can safely use naloxone to manage opioid overdose.
- c. Avoid prescribing other sedating medications (e.g., benzodiazepines) to pregnant women using opioids due to the risk of enhanced respiratory depression.

## Recommendation 5:

**Upon discharge after a delivery, encourage all women without an OUD who need ongoing pain treatment to use non-opioid therapies (i.e. NSAIDs). If opioids are indicated, they should receive a limited number of opioid pills to last until a scheduled follow-up visit and for no more than seven days of treatment.**

See recommendation 10 for postpartum recommendations specific to women with opioid use disorder.

## Secondary prevention: Consider recommendations 6–11 for women with an OUD as well as for their infants.

### Coordinated care

An essential component of effective, coordinated care is reducing discrimination and punitive approaches associated with opioid use disorders during pregnancy and supporting women in feeling safe when accessing treatment services. All professionals involved in care need to understand the different contexts of opioid use by a pregnant woman to accurately assess her distinct needs and those of her family members to implement the most appropriate and comprehensive plan of care.

### Recommendation 6:

#### **Coordinate care for pregnant and parenting women with an opioid use disorder.**

- a. Develop a comprehensive plan of care that lists each health and social problem, how to address it and who is responsible for addressing it.
- b. Communication and coordination between substance disorder treatment providers, maternity care clinicians, behavioral health providers, DHS Child Welfare (when involved) and local social services organizations, as well as the woman, are necessary to ensure an optimal continuum of care.
- c. Put consent forms in place to secure information releases necessary to coordinate care. Sharing information about substance use disorder treatment requires special permission.

### Medication-assisted treatment (MAT)

Engaging pregnant women with opioid use disorders in comprehensive services is essential for optimal recovery and parenting outcomes. The standard of care for pregnant women with an opioid use disorder is MAT and evidence-based behavioral interventions. MAT's efficacy has been widely acknowledged and endorsed as a highly effective tool in recovery, including for pregnant women.

## Recommendation 7:

### Manage opioid use disorders during pregnancy by following evidence-based approaches.

- a. Refer all pregnant women with an OUD to substance use disorder treatment and behavioral health treatment. If local resources are not available, consider that some women are willing to travel. Telemedicine may also be available. Health Care providers should document any lack of available services to advocate for more services in their community.
- b. An individual familiar with American Society for Addiction Medicine (ASAM) criteria should assess all pregnant women with an OUD to determine the recommended treatment setting. Treatment setting recommendations should include the woman, consider barriers to treatment and include active coordination to ensure follow-through.
- c. Offer a pregnant woman with an OUD MAT. Both buprenorphine and methadone are appropriate medications; the woman's preference, clinical indications and access should guide the choice between the two medications.
- d. A woman who becomes pregnant while on buprenorphine should continue buprenorphine. A woman who becomes pregnant while on buprenorphine/naloxone should discuss with her maternity care clinician the pros and cons of remaining on it while pregnant versus transitioning to buprenorphine only.
- e. A woman who becomes pregnant while on methadone should continue methadone and not transition to buprenorphine.
- f. Assess a woman for a dose increase during pregnancy if she was previously stable on buprenorphine or methadone. Women in this situation typically need a dose increase in the third trimester. Coordinate care with the substance use disorder treatment provider. An increased dose does not increase the risk for neonatal abstinence syndrome.
- g. A pregnant woman who was previously stable on buprenorphine or methadone, but relapses to opioid use should have her treatment plan reevaluated and care coordinated among providers. Return to substance use is common; do not view it as a reason to discontinue treatment.
- h. Only consider medically supervised withdrawal of a pregnant woman from opioids on a case-by-case basis if intensive behavioral health supports are in place. The

#### Surveillance

Pregnant women with opioid use disorders often have co-occurring health conditions requiring surveillance in addition to routine pregnancy surveillance.

clinician should assess the woman's motivation and discuss risk of relapse with her. Unsuccessful medically supervised withdrawal presents substantial adverse maternal risks such as relapse and overdose.

## Recommendation 8:

### **Include additional screenings and services when caring for pregnant women with OUD.**

- a. Obtain ultrasound measurement as early as possible in pregnancy. Women with OUD often present later to care and/or have irregular menses. To establish accurate dating of pregnancy, see the [recommendations](#) from the American Congress of Obstetricians and Gynecologists, the American Institute of Ultrasound in Medicine, and the Society for Maternal Fetal Medicine.
- b. Use fundal height measurements and ultrasound surveillance to assess fetal growth more often if signs of growth restriction are present. Pregnant women with OUD have a higher risk of fetal growth restriction.
- c. Screen pregnant women with an OUD for other substance use at presentation for care. If a woman with an OUD is also using alcohol and/or tobacco, offer her evidence-based services to support the discontinuation of these substances while she is starting MAT.
- d. Assess pregnant women with an OUD for iron deficiency, vitamin D deficiency and macronutrient imbalance. Prenatal vitamin use throughout pregnancy and nutrition counseling are especially important as many pregnant women with OUD experience poor nutrition, malnutrition and eating disorders.
- e. Screen for hepatitis C, hepatitis B and HIV at start of prenatal care and repeat during the third trimester. Screen for syphilis at the start of care, during the third trimester and then again at delivery. Screen for other STIs more often.
- f. Refer early for dental cleaning and care.
- g. Ask about skin infections; monitor and treat as needed.
- h. Have a baseline EKG on file for women who are using methadone for MAT.
- i. Add a comprehensive metabolic panel (CMP) to the routine prenatal panel to assess liver and renal function.
- j. Screen for behavioral health conditions, intimate partner violence (IPV) and social risk during the first prenatal care visits and repeat the screenings during the pregnancy. Behavioral health conditions may require pharmacotherapy. Prescribers need to keep in mind possible drug interactions with MAT. Women with OUD often struggle with a history of trauma, abuse or neglect. They may have mental illness such as depression, anxiety or post-traumatic stress disorder (PTSD). They are disproportionately more likely to be in an abusive relationship and struggling with social isolation, homelessness

and food insecurity.

- k. Check and monitor the [Oregon Prescription Drug Monitoring Program](#) as part of routine management for pregnant women with an OUD.
- l. Identify and provide referrals to appropriate services including behavioral health treatment, counseling and peer support.
- m. Schedule more frequent visits to identify medical and psychosocial problems early.
- n. Discuss possible effects of opioids on the newborn and risk of NAS. Advise on possibility of extended stay for newborn and process for reporting drug-exposed newborn.
- o. Consider an antenatal pediatric consultation for pregnant women with an OUD.
- p. Provide education on the benefits of breastfeeding.
- q. Offer patient-centered contraceptive counseling and make a plan.

## Recommendation 9:

### **Provide appropriate pain control for women with an OUD during labor.**

- a. Consider an antenatal anesthesia consult and make a plan for managing pain during labor.
- b. Do not hesitate to offer pain management including an epidural and/or a short-acting opioid analgesic to a pregnant woman with an OUD (including women on MAT) to manage pain during labor.
- c. A pregnant woman with an OUD should not receive butorphanol, nalbuphine or pentazocine.
- d. Continue a pregnant woman with an OUD on her same daily dose during the hospital stay if she is currently maintained on either methadone or buprenorphine. Reassure patients of this plan to reduce their anxiety. When possible, contact the substance use treatment provider to confirm dose of methadone or buprenorphine and notify of admission. Dividing the usual daily maintenance dose of buprenorphine or methadone into three or four doses every 6–8 hours may provide partial pain relief; however, the woman will likely require additional analgesia. While the woman is in the hospital, any attending clinician who can prescribe opioids may legally order buprenorphine and methadone to maintain a patient's outpatient dose during his/her hospitalization. Documentation of this federal regulation is available [here](#).
- e. A pregnant woman with an OUD currently maintained on either methadone or buprenorphine may require higher doses of opioid analgesics to experience pain relief. This is true whether she is having a vaginal delivery or a C-section. Health

care providers may be anxious about the high dosages required. If the woman is alert and has a normal respiratory rate, the woman has not overdosed. Aggressive pain management will not worsen addiction and may improve the postpartum medical course.

- f. Do not administer buprenorphine to a woman who takes methadone.
- g. Consider alternative pain management strategies such as doulas, mindfulness and relaxation training, laboring in water and pudendal blocks. Consider nitrous oxide with caution; bear in mind that it may accentuate the levels of narcotics, and that cannabinoids will slow nitrous oxide's metabolism.

## Recommendation 10:

### **Provide necessary postpartum services and support for women with an OUD.**

- a. After a vaginal delivery, women can generally achieve adequate pain relief with nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen.
- b. After a C-section, a woman who is stable on buprenorphine or methadone for OUD should continue her outpatient dose.
- c. Judicious use of injectable nonsteroidal anti-inflammatory agents can be highly effective in postpartum and post-cesarean pain control. Also consider alternate pain management strategies including gabapentin, lidocaine patches and transversus abdominus plane blocks.
- d. If a woman with an OUD needs opioids for pain control postpartum, she may require higher than usual doses of opioid analgesics to accomplish pain relief due to tolerance of opioids.
- e. After delivery, women usually do not require immediate dosage adjustments of methadone or buprenorphine. However, monitor for sedation. Assess women experiencing drowsiness for medical illness, relapse to substance use and dose adjustment.
- f. Avoid discontinuation of MAT and encourage continuation in a substance use disorder treatment program. Give the woman a list of medications administered during hospitalization as well as those prescribed at discharge. Notify the substance use treatment provider upon discharge to confirm the woman has a follow-up appointment. Be sure to indicate the timing of the last dose. Confirm who will reevaluate the woman's dose postpartum and provide outpatient prescriptions. Check hours for the methadone clinic prior to discharge so she does not miss a dose.
- g. Screen any new mother with OUD for behavioral health disorders before discharge.
- h. Provide patient-centered contraception counseling to all women before discharge.

- i. Consider sooner and more frequent postpartum follow-up with the maternity care clinician. The discharge plan should include strategies for the mother to get support.

## Recommendation 11:

### **Encourage breastfeeding for women with an OUD on MAT.**

- a. Provide education on the benefits of breastfeeding. Any amount of breastfeeding can decrease the infant's need for pharmacological treatment.
- b. Treatment with methadone or buprenorphine is not a contraindication to breastfeeding. Encourage women to breastfeed unless the mother is HIV-positive or Hepatitis C positive with cracked or bleeding nipples. The current buprenorphine package insert advises against breastfeeding; however, an [American College of Obstetricians and Gynecologists \(ACOG\)](#) and AAP consensus panel stated that the effects on the breastfed infant are likely to be minimal and that breastfeeding is not contraindicated.
- c. Provide lactation support.
- d. If a new mother returns to substance use, carefully review the mother's situation before recommending a discontinuation of breastfeeding.

## Recommendation 12:

### **Closely monitor an infant born to a mother who used opioids during pregnancy. Manage care with a standardized protocol for the assessment and treatment of infants at risk for neonatal abstinence syndrome (NAS).**

- a. Infant toxicology testing should not be the primary way to screen for substance use during pregnancy. If there is suspicion of substance use, first interview the mother about her medical and substance use history.
- b. Only perform infant toxicology testing (using urine, meconium or cord blood) if there are clear clinical indications (unable to obtain a history from the mother, infant with unexplained symptoms, severe obstetrical complications such as abruption, etc.). Seek parental consent for infant toxicology testing in all cases. Infant toxicology testing without parental consent may sometimes be necessary. The decision to perform infant toxicology testing without parental consent should be based on perceived risk of substantial harm to infant and clearly documented in the medical record.
- c. Closely monitor all infants born to women who used opioids during pregnancy; assess the infant for symptoms of NAS. Most infants who will develop NAS needing pharmacologic treatment will do so in the first 96 hours after birth; however, NAS symptoms can develop later as well. Monitor either in the hospital or in an outpatient setting based on clinical judgement and the availability of flexible and prompt follow-up. When possible, partner with parents in this monitoring.

- d. When using a standardized scoring system to assess NAS, neonatal health care providers should undergo training and periodic updates to assure interrater reliability.
- e. First line therapy for infants with NAS symptoms is non-pharmacological care such as non-nutritive sucking, swaddling, uninterrupted sleep, a low-stimulation environment, skin-to-skin contact, frequent feeding and rooming-in with mom. Proactively employ these strategies in an infant at risk of developing NAS.
- f. Infants with NAS can typically be managed outside of neonatal intensive care. Health care providers should determine whether the infant can remain in low-acuity settings or be transferred depending upon the need for pharmacologic therapy, the severity of symptoms, local protocols and the comfort level of the care team.
- g. If pharmacological treatment for NAS is indicated, the American Academy of Pediatrics (AAP) recommends commencing pharmacologic treatment with oral morphine or oral methadone, preferably preservative-free formulations. When a second-line agent is indicated, clonidine is preferable to phenobarbital.
- h. However, any infant with significant NAS symptoms and any infant requiring pharmacologic treatment should receive routine assessments and close attention to development following [AAP guidelines](#) for developmental screening for all young children. Little is currently known about the neurodevelopmental effects of intra-uterine opioid exposure and postnatal pharmacologic treatment for NAS.
- i. Educate infant caregivers about the signs of opioid withdrawal in infants, techniques to sooth the infant, and safe sleep recommendations.
- j. Refer infant caregivers to a pediatric clinician who is knowledgeable about NAS and accessible from the time of infant hospital discharge.
- k. Consider referral to home visiting programs (e.g., Healthy Families, Babies First), infant mental health services and early intervention depending on community availability.
- l. Assess for smoking in the home. Encourage all smokers to quit or smoke outside
- m. Health care providers should understand their legal responsibility for reporting substance exposure of an infant and be sensitive to the social and legal consequences for the mother and infant.

# Health systems and policy recommendations

## Recommendation 13:

**The Oregon Health Authority, in partnership with the Oregon Maternal Data Center, should implement a surveillance strategy for in utero opioid exposure and NAS. The strategy should be mindful of any unintended negative consequences and seek a balance between patient confidentiality and the state's ability to truly understand the scope of the problem.**

- a. Health care systems and health care providers should collect data on screening for substance use in pregnancy.
- b. Health care systems and providers should participate in and support efforts to collect data on use of opioids in pregnancy, rates of OUDs in pregnant women, infants exposed to opioids in utero and all adverse perinatal outcomes related to opioid use.
- c. Health care systems should consider outcomes that include the mother, infant and family well-being and go beyond the immediate prenatal and postpartum period.

## Recommendation 14:

**Oregon health care leaders and policy makers should work to advance systems change that supports families affected by OUD.**

- a. Provider organizations should educate health care providers on the use of validated substance use screening tools as the standard of care.
- b. Provider organizations should educate and train clinicians on prescribing MAT during pregnancy.
- c. Health care providers should educate patients in non-narcotic treatment of pain.
- d. Support the expansion of telemedicine services.
- e. Substance use disorder treatment agencies and systems throughout Oregon should increase access to residential and other treatment programs for pregnant women and mothers with an OUD. This is a particular challenge in rural and frontier Oregon.
- f. Substance use disorder treatment agencies and systems should support innovation to bring more family-centered, wraparound services to communities, including peer support.

- g. Substance use disorder treatment agencies should promote attachment and bonding by supporting strategies that discourage separation of mothers and infants (e.g., residential treatment allowing mothers and infants to remain together).
- h. Department of Human Services Child Welfare should have systems in place to facilitate access to the supports families need for long-term stability (e.g., ongoing medication-assisted treatment and other substance use treatment services, early intervention services for infants, home visiting services).
- i. Correctional facilities and jails should facilitate access to medication-assisted treatment without interruption for pregnant and parenting women with OUDs.



# Definitions\*

## **Behavioral health**

The condition of well-being aligned with prevention and intervention, treatment and recovery supports for people with mental and substance use problems or disorders

## **Clinician**

Physician or midwife

## **Health care provider**

All providers of health care including physicians, midwives, nurses and doulas

## **Maternity care**

Health care services provided during pregnancy, labor and delivery and postpartum

## **Medication-assisted treatment (MAT)**

Type of comprehensive substance use disorder (SUD) treatment that provides maintenance pharmacotherapy

## **Neonatal abstinence syndrome (NAS)**

This is a group of physiological and neurobehavioral signs of withdrawal that may occur in a newborn exposed to substance in utero. This document does not use the term “neonatal opioid withdrawal syndrome” (NOWS) referring to manifestations of withdrawal specifically attributable to opioids. However, “neonatal opioid withdrawal syndrome” is becoming more common in practice and literature.

## **Opioid use disorder (OUD)**

OUD is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The diagnosis of OUD can be applied to someone who uses opioid drugs and has at least two of the 11 symptoms occurring within a 12-month period.

\*Definitions listed are terms that are found in this report.

# Resources and additional information

## Recommendation 1

### Family planning

- Centers for Disease Control and Prevention. Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. April 25, 2014 / 63(RR04);1-29 [cited 2018 May 10]. Available from: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>
- Centers for Disease Control and Prevention. US medical eligibility criteria (US MEC) for contraceptive use, 2016 [cited 2018 May 10]. Available from: <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html>

### Pregnancy intention screening tools

- **One Key Question®**, developed by the Oregon Foundation for Reproductive Health. [cited 2018 May 10]. Available from: <https://powertodecide.org/one-key-question>
- **Preconception Resource Guide for Clinicians**  
<https://beforeandbeyond.org/toolkit/>

## Recommendation 2

### Oregon Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help health care providers and pharmacists provide patients better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies. <http://www.orpdmp.com/>

### Screening tools

- Substance Abuse and Mental Health Services Administration. Screening tools. <https://www.integration.samhsa.gov/clinical-practice/screening-tools>
- Oregon SBIRT (Screening, Brief Intervention, Referral to Treatment). Screening forms. <http://www.sbirtoregon.org/screening-forms/>

## Recommendation 3

### Oregon Opioid Prescribing Guidelines

The task force adopted the CDC guideline as the foundation for opioid prescribing for Oregon and developed a brief addendum to address Oregon-specific concerns. <http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>

## **Oregon Prescription Drug Monitoring Program**

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help health care providers and pharmacists provide patients better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies.  
<http://www.orpdmp.com/>

## **Recommendation 4**

**Oregon Public Health Division** naloxone rescue for opioid overdose

<http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/naloxone.aspx>

## **Recommendation 5**

**Postdischarge opioid use after cesarean delivery**

Osmundson, Sarah S. MD, MS; Schornack, Leslie A. MD; Grasc, Jennifer L. BS; Zuckerwise, Lisa C. MD; Young, Jessica L. MD; Richardson, Michael G. MD  
Obstetrics & Gynecology: July 2017 - Volume 130 - Issue 1 - p 36–41

## **Recommendation 6**

**Consent2Share:** Web-based application to share personal health information across the health system <http://www.feisystems.com/what-we-do/health-it-application-development/consent2share/>

**Substance Abuse and Mental Health Services Administration:** A collaborative approach to the treatment of pregnant women with opioid use disorders

[https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)

## **Recommendation 7**

**American Society for Addiction Medicine (ASAM) National practice guideline for the use of medications in the treatment of addiction involving opioid use**

<https://www.asam.org/resources/guidelines-and-consensus-documents/npg>

**American Society for Addiction Medicine (ASAM) Criteria**

<https://www.asam.org/resources/the-asam-criteria/about>

**Oregon 211:** Find local community resources

<http://211info.org/>

**Oregon medication-assisted treatment and recovery,** including Oregon-approved opioid treatment programs

<http://www.oregon.gov/oha/hsd/amh/Pages/umatr.aspx>

### **Oregon Substance Use Disorders Services Directory**

<http://www.oregon.gov/oha/HSD/AMH/Publications/provider-directory.pdf>

**Substance Abuse and Mental Health Service Administration:** Methadone treatment for pregnant women (brochure)

<https://store.samhsa.gov/shin/content/SMA14-4124/SMA14-4124.pdf>

**Substance Abuse and Mental Health Service Administration:** Medication-assisted treatment

<https://www.samhsa.gov/medication-assisted-treatment>

**Substance Abuse and Mental Health Services Administration: Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants.** Page 29, Decision Considerations When Selecting an Opioid Agonist Medication for a Pregnant Woman.

<https://store.samhsa.gov/product/SMA18-5054>

## **Recommendation 8**

**The American College of Obstetricians and Gynecologists, the American Institute of Ultrasound in Medicine, and the Society for Maternal-Fetal Medicine: Methods for estimating the due date** <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice-Methods-for-Estimating-the-Due-Date>

**Centers for Disease Control and Prevention. Treating for two**

<https://www.cdc.gov/pregnancy/meds/treatingfortwo/index.html>

### **Family planning**

- Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs recommendations and reports. April 25, 2014 / 63(RR04);1-29  
<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>
- US medical eligibility criteria (US MEC) for contraceptive use, 2016 <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html>

### **Oregon Prescription Drug Monitoring Program**

Check and monitor the Oregon prescription drug monitoring program as part of routine management for pregnant women with an opioid use disorder.

### **Oregon Tobacco Quit Line**

<https://www.quitnow.net/oregon/>

**Oregon marijuana: Health and safety** <http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/MARIJUANA/Pages/health.aspx>

**Substance Abuse and Mental Health Services Administration: Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants.** Page 48, Management options for SUDs other than OUD during pregnancy. <https://store.samhsa.gov/product/SMA18-5054>

### **Syphilis during pregnancy**

- Centers for Disease Control and Prevention. Syphilis during pregnancy <https://www.cdc.gov/std/tg2015/syphilis-pregnancy.htm>
- Oregon Health Authority letter to providers <http://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/HIVSTDVIRALHEPATITIS/SEXUALLYTRANSMITTEDDISEASE/Documents/spr/ProviderMessageSyphilisLaneFinalNov16.pdf>

## **Recommendation 9**

**U.S. Department of Justice Drug Enforcement Administration Diversion Control Division.** Title 21 Code of Federal Regulations PART 1306 — prescriptions general information. §1306.07 Administering or dispensing of narcotic drugs. [https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306\\_07.htm](https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm)

## **Recommendation 10**

**The American College of Obstetricians and Gynecologists: Postpartum birth control** <https://www.acog.org/Patients/FAQs/Postpartum-Birth-Control>

**The American College of Obstetricians and Gynecologists: Committee opinion: Opioid use and opioid use disorder in pregnancy** <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>

**Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for breastfeeding and substance use or substance use disorder, revised 2015** <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4378642/pdf/bfm.2015.9992.pdf>

**Centers for Disease Control and Prevention: Contraindications to breastfeeding or feeding expressed breast milk to infants** <https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html>

## Recommendation 12

### **An initiative to improve the quality of care of infants with neonatal abstinence syndrome**

Matthew R. Grossman, Adam K. Berkwitt, Rachel R. Osborn, Yaqing Xu, Denise A.

Esserman, Eugene D. Shapiro, Matthew J. Bizzarro

Pediatrics May 2017, e20163360; DOI: 10.1542/peds.2016-3360

<http://pediatrics.aappublications.org/content/early/2017/05/16/peds.2016-3360>

**American Academy of Pediatrics:** Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening

<http://pediatrics.aappublications.org/content/118/1/405.full>

### **Home visiting**

- Babies First!: Public health nurse home visiting program  
<http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Pages/index.aspx>
- Healthy Families Oregon  
<https://oregonearlylearning.com/healthy-families-oregon>

### **Mandatory reporting of child abuse and neglect**

A positive toxicology screening may or may not require a mandatory report of child abuse or neglect to Department of Human Services (DHS) Child Welfare. **Oregon law** states that mandatory reporters must report “unlawful exposure to a controlled substance, as defined in ORS 475.005, that subjects a child to a substantial risk of harm to the child’s health or safety.” Make a report if substantial risk is present in conjunction with a positive toxicology screen.

### **Mandatory reporting of substance-affected infants**

Federal law requires that health care providers involved in the delivery or care of infants notify the Oregon Department of Human Services (DHS) Child Welfare when they identify an infant as affected by substances or withdrawal symptoms from prenatal substance exposure, or a fetal alcohol spectrum disorder, including both legal and illegal drugs.

A plan of care must be developed and the plan must ensure the safety and well-being of the infant by addressing the health and substance use disorder needs of the infant and the affected family/caregiver.

- Neonatal Abstinence Syndrome: A Guide for Families. Developed by the Ohio Perinatal Quality Collaborative  
[https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/Resources/Neonatal%20Abstinence%20Syndrome/opqc\\_nas\\_parent\\_guide\\_092914.pdf](https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/Resources/Neonatal%20Abstinence%20Syndrome/opqc_nas_parent_guide_092914.pdf)

- National Center on Substance Abuse and Child Welfare (NCSACW)  
<https://ncsacw.samhsa.gov/default.aspx>

### **Safe sleep**

- American Academy of Pediatrics: SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment  
<http://pediatrics.aappublications.org/content/early/2016/10/20/peds.2016-2938>
- Oregon safe sleep for babies  
<http://www.oregon.gov/oha/ph/healthypeoplefamilies/babies/pages/sids.aspx>

# Collaborative approaches

## Collaborative approaches for caring for pregnant women with an opioid use disorder and their infants

**Project Nurture (Oregon)** A Center of Excellence model integrating maternity care and addiction treatment for pregnant women with substance use disorders

<http://www.projectnurtureoregon.org/projectnurture>

**Children and Recovering Mothers (CHARM) Collaborative (Vermont)**

[http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/CARS/Well-Baby/CHARM\\_CaseStudy.pdf](http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/CARS/Well-Baby/CHARM_CaseStudy.pdf)

**Fir Square (Vancouver, BC):** Combined Care Unit that cares for women who use substances and their newborns exposed to substances in a single unit

<http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/pregnancy-drugs-alcohol>



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