Addiction is a serious disease with significant maternal and neonatal risks. The 2010 National Survey on Drug Use and Health estimated 4.4% of pregnant women reporting illicit drug use within the last 30 days of being surveyed. Opiates include heroin, morphine, and codeine. Synthetic opioids meperidine, fentanyl, propoxyphene, methadone, and buprenorphine (partial agonist). Hydromorphone and oxycodone are opioid analgesics that are being used with increased frequency in pregnancy.

Opiate use in pregnancy has varied between 1-21% and readily crosses the placenta, entering the fetus within 1 hour of maternal use. Perinatal complications from heroin use and untreated addiction include but are not limited to fetal growth restriction, placental abruption, preterm delivery, IUFD, meconium staining, chorioamnionitis, neonatal abstinence syndrome (NAS observed 50-95% of neonates), and prolonged neonatal hospitalizations. Many of these complications have been implicated to the repeated exposure of the fetus to opioid withdrawal and effects of withdrawal on placental function. Psychiatric disorders complicate 56-73% of patients with an opioid addiction. Treatment with an opioid agonist markedly reduces the likelihood of heroin overdose and death, which is important because the risk of drug-related death for a patient with a history of substance-use disorder is nearly 10 times as high in the first month after hospital discharge as it is in subsequent months. Cigarette smoking is a high risk behavior that contributes to risky behaviors and conditions leading to death and morbidity in addition to perinatal complications including but not limited to preterm birth, congenital birth defects, low birth weight and sudden infant death syndrome.

Signs of opioid toxicity include: drowsiness, decreased respirations, miosis, constipation, track marks.

Signs of opioid withdrawal include: drug craving, lacrimation, sweating, anorexia, diarrhea, flushing. With short-acting opioids (heroin), withdrawal symptoms may develop within 4-6 hours of use, progressing to 72 hours and subside within a week. For long-acting opioids (oxycodone, methadone, buprenorphine), symptoms may begin between 24-36 hours and can last for several weeks.

Signs of NAS include: hyperactivity of the autonomic & central nervous system, uncoordinated suckling reflexes, poor feeding, irritability, and high-pitched cry. Methadone maintained patients’ neonates usually manifest symptoms within 72 hours of birth but anytime during the first 2 weeks. Buprenorphine-exposed infants may develop symptoms within the first 24-48 hours and peak within 72-96 hours.

1. SCREENING TOOLS

☐ 4 P’s (any positive answer should trigger further questions)
   1) Parents: did any of your parents have a problem with alcohol or other drug use?
   2) Partner: does your partner have a problem with alcohol or used other drugs?
   3) Past: In the past, have you drunk any alcohol or used other drugs?
   4) Present: During pregnancy have you drank any alcohol or used other drugs?

☐ CRAFFT – Substance Abuse Screen for Adolescents and Young Adults (≥2 positive answers should prompt further assessment)
   - C – Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?
   - R – Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
   - A – Do you ever use alcohol or drugs while you are by yourself or ALONE?
   - F – Do you ever FORGET things you do while using alcohol or drugs?
   - F – Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?
   - T – Have you ever gotten in TROUBLE while you were using alcohol or drugs?
2. LABS TO ORDER AT FIRST VISIT, EVERY TRIMESTER, AND TRIAGE ENCOUNTERS

☐ Positive pregnancy test (first visit only)

☐ Urine drug screen. You need to order 2: (1) rapid drug screen, and (2) comprehensive drug screen to identify/document opioids or ongoing use of buprenorphine or methadone (write in the comments that you specifically want to determine narcotics/methadone/buprenorphine)

☐ Hepatitis C & B
☐ Comprehensive metabolic panel
☐ Complete blood count
☐ Tuberculosis (first visit only)
☐ Syphilis
☐ Gonorrhea and Chlamydia
☐ HIV

3. GENERAL TREATMENT OF OPIATE-DEPENDENT PREGNANT PATIENTS

☐ Only specifically licensed and regulated providers may dispense methadone/buprenorphine for maintenance therapy.

☐ Only providers that are specifically licensed and qualified may dispense opiates for treatment of addiction. Inpatients hospitalized for other indications (i.e. preterm labor, pprom, etc) may be treated with methadone/buprenorphine.

☐ As a general policy, our Ob/Gyn department will not begin inpatient treatment of opiate-dependent patients without arrangement of co-management of care. Such patients, who present in our outpatient or acute care venues, should be encouraged to seek care with providers who can provide addiction services (See providers below).

☐ Comprehensive care includes registered substance abuse treatment program, prenatal care, chemical dependency counseling, family therapy, nutritional education, and psychosocial services.

☐ An opiate-dependent patient must have actual documentation of treatment provider and facility in her EPIC chart. Doses should be verified by the methadone/buprenorphine provider before providing it to the patient during any hospital admission.

☐ Naloxone (antagonist) therapy is contraindicated. Withdrawal may theoretically precipitate preterm labor or fetal distress, and antagonist therapy should only be used in case of a life-threatening maternal overdose.

☐ Federal law specifies that only 3 days outpatient methadone may be provided before subsequent treatment with a licensed methadone maintenance provider must be started. Patients can only receive an “urgent” prescription for methadone 3 separate times in her lifetime and should not be prescribed to supply as a 3-day prescription.

4. PATIENTS WHO PRESENT FOR PRENATAL CARE WITH AN OPIATE ADDICTION

☐ Obtain an unrestricted UC Medical Center Release of Information Request for all records, all drug screens and clinic notes from the methadone/buprenorphine provider for the patient’s entire pregnancy and send on behalf of the patient to her methadone/buprenorphine provider to allow communication from the Center for Women’s Health/UCMC to the methadone/buprenorphine provider.
☐ The patient must agree to provide urine or other body tissue drug screens on request and to remain compliant in her methadone/buprenorphine care program with her addiction treatment provider.

☐ A social service consult is to be initiated and should not be declined because coordination of care is a central component of effective treatment.
  •  **CWH Social Worker**: 4-4114
  •  Inpatient OB Social Worker: 4-8552

5. WHAT TO DO WHEN PATIENT’S PRESENT IN TRIAGE WITH WITHDRAWAL SYMPTOMS

☐ Patients need to be evaluated and ruled out for obstetric complications/indications for admission.

☐ Decision regarding admission for inpatient care of the untreated opiate addicted patient that is pregnant is a faculty general OB/GYN or MFM on-duty decision. Appropriate faculty-level documentation regarding rationale for admission or denial of admission and plan of care is required.

☐ Patients are to be educated that UCMC is not a treatment facility and will be treated for the symptoms associated with their withdrawal but treatment cannot be started in triage unless such treatment is at the specific direction of addiction services providers.

☐ If patients are already participating in a treatment program, verify the current dose prior to ordering/administering methadone/buprenorphine, which should be documented in her prenatal records or obtain through the treatment facility.

☐ In-patient OB Social Worker can be notified for all inpatients who have not established maintenance treatment or established patients who need further assistance to initiate the process and support. **Steve Rutemueller**, Behavioral Health and Addiction Social Worker, is available to provide support information (584-8257).

☐ An Epic “flag” or “message” should be sent to **Sandee Ernst**, CWH Social Worker, for all untreated patients seen in triage who to plan establish prenatal care at UC Center for Women’s Health.

6. INTRAPARTUM MANAGEMENT

☐ Patients should receive pain relief as if they were not taking opioids. Maintenance dosage will not provide adequate pain relief in labor.

☐ Avoid butorphanol, nalbuphine, and pentazocine (narcotic agonist-antagonist) because may precipitate acute withdrawal.

☐ Do not give buprenorphine to patients maintained on methadone.

☐ Notify NICU of the neonate exposed to narcotics.

☐ Anesthesiology consultation and management is a component of the successful control of intrapartum pain and should be notified upon delivery admission.

☐ Usually treated opioid-addicted patients will require higher doses of opioids to achieve adequate pain control. Using Toradol (ketorolac) IM or IV in **addition** to short-acting opioids are effective for pain management in addition to maintenance doses of methadone/buprenorphine.
  •  UCMC Pain Management team (pager ID# 7246) should be consulted in patients admitted for antepartum or postpartum care who require complex pain management.

☐ Women should be encouraged to breastfeed if they do not have other contraindications. Minimal
levels of methadone/buprenorphine pass through breastmilk but breastfeeding may reduce NAS and contributes to bonding between mother and neonate.

☐ Patients should have an absolute plan for contraception prior to discharge from the hospital.

☐ Treatment centers should be notified of the patients’ delivery and follow up should be written in discharge paperwork to encourage continuity of care and follow up.

7. WHERE CAN PATIENTS GET HELP

☐ Central Community Health Board (CCHB) – Methadone Maintenance Treatment Program (OH).
   ACCEPTS MEDICAID
   • T: 513-559-2051; F: 513-559-2077
   • Physician can see patients only on Tuesdays and Thursdays → Primary Counselor Intake Assessment and complete labs must be done by Monday/Tuesday or the week prior to be seen that week.

☐ NKY Med Clinic LLC - Methadone Maintenance Treatment Program (KY). ACCEPTS MEDICAID
   • T: 859-360-0250; F: 859-261-0801

☐ Good Samaritan Hospital/First Step Home; T: 513 961-4663; F: 513 961-4681
   • Inpatient/Outpatient treatment available but must be assessed by First Step Home

☐ Center for Chemical Addictions Treatment (CCAT) House; T: (513) 381-6672
   • Suboxone and alcohol detox providers.

☐ The Crossroads Center’s Suboxone Treatment Program & Chaney Allen Perinatal/Postpartum.
   • T: 513-475-5300; F: 513-281-2530.
   • Phone screen by the medical staff within 24 hours of contacting the program and if appropriate will usually be seen for their initial evaluation within one week.
   • Chaney Allen Women’s Continuum of Care provides the structures, progressive treatment with education, community outreach, centralized assessment, individual/group therapy, psychiatric treatment, childcare, and case management services

☐ Suboxone.com → Locates closest provider
   • Private pay doctors usually out of pocket treatment programs (Approximately $450/month)

☐ Cincinnati Exchange Project
   • T: 513-377-7114. Libby Harrison (CEP Project Manager; elizabeth.harrison@uc.edu)
   • Judith Feinberg, MD – Medical Director (T: 584-5897; F: 513-584-6040; Judith.feinberg@uc.edu)
   • Local advocacy organization that promotes education and the harm reduction model, committed to making the drug using community healthier while increasing drug treatment enrollment.

☐ UC Health Addiction Sciences; T: 513-585-8227.
   • Treatment $15/day → 2nd/3rd TM $5/day

☐ OARS (Opiate Addiction Recovery Services) through Crossroads MAP (Medication Assisted Treatment Program); T: 513-332-0350; F: 513-332-0368
   • Administer and dispense narcotic medications for either detoxification treatment or maintenance therapy to persons who have become addicted to narcotics.

☐ Clermont Recovery Center; T: 513-735-8100
☐ East Indiana Treatment Center; T: 812-537-1668
☐ Having the Courage to Change: T: 513-345-1087
☐ Narcotics Anonymous; T: 513-820-2947
☐ Premier Care (Methadone/Suboxone); T: 513-671-7117
☐ Sojourner Recovery Services (Inpatient/Outpatient Suboxone); T: 513-868-7654
☐ Sunrise Treatment Center (Suboxone); T: 513-941-4999
☐ Talbert House; T: 513-641-4300
☐ WRAP Covington; T: 859-491-2090
Notification to Opiate Addiction Treatment Provider of Prenatal Care

To: ___________________________  From: UC Health Center for Women’s Health
___________________________ 3130 Highland Avenue, 1st floor
___________________________ Mail Location 0754
___________________________ Cincinnati, Ohio 45267

Re: Patient Name ___________________________________
DOB: ___________________________________
MRN: ___________________________________

Dear Addiction Provider:

   The above patient is under our care for her pregnancy. Her current estimated date of delivery (due
date) is ________________ . She has identified you as the care provider for her opiate addiction treatment
with methadone or buprenorphine maintenance. Our unit is not licensed for methadone or buprenorphine
maintenance. In order for us to accept this patient for her obstetrical care, we will need for her to continue in
your care for her addiction. Enclosed are the patient’s signed requests for records from your facility. The
duration of the request should encompass the patient’s entire pregnancy. We would like to be notified of the
following:

1. If the patient is non-compliant or is discontinued from your program.
2. If the patient is found to have a urine or bodily fluid screen that either-
   a) Is indicative of use of other drugs of abuse.
   b) Is not indicative of ongoing ingestion of methadone or buprenorphine by the patient.
3. If treatment is changed or a decision is made to discontinue treatment.
4. If you have any concerns regarding this patient or her care.

We may be contacted (daytime) at 513-584-3459. Our afterhours number is 513-584-3999 (ask for OB
physician on call). Thank you again for your help in the care of this pregnant patient. Together, we hopefully
can help this patient and her unborn child.

Sincerely,

UC Health Center for Women’s Health
Opiate Dependent Pregnant Patient Agreement

To: ______________________________________

DOB: ___________________________

MRN: ___________________________

Address: ___________________________

Dear Ms. ___________________________,

Thank you for seeking obstetric care in our system. Since we are not an opiate addiction treatment center, Federal law does not allow us to treat you unless you are in a licensed methadone or related treatment program. You have told us that you are in a licensed program or have an appointment to initiate care.

As long as you are in a licensed program (being successfully treated and attending all appointments, visits and sessions), we will be happy and excited to provide your pregnancy care. Please be aware of the following:

I. We will need a release of information from your methadone (or related) clinic or program. We will want your permission to access any and all of your clinic records from the methadone (or related) clinic while you are pregnant.

II. You will submit a urine sample for drug screen at any time, as we request.

III. If you become non-compliant with your program, are discontinued or do not initiate care, please know that we will not be able to provide opiate addiction treatment for you in our unit. Since we cannot treat you, we will need you to seek other care for your pregnancy.

IV. Social Services will be involved in your care throughout your care, as well.

Thank you for your help and for your understanding of these requirements. By signing below, you understand what we require from you in order to give you prenatal care.

Signed: ______________________________

Patient

Witness: ______________________________

Interpreter (if necessary) ___________________________
References:

- ACOG Committee Opinion No 524; May 2014 (reaffirmed 2014)