# ANTEPARTUM

## FIRST PRENATAL VISIT

- ☐ SBIRT (Screening, Brief Intervention, Referral to Treatment) for all pregnant patients
- ☐ Refer to Addiction Medicine Specialist or obtain records from current treatment provider
- ☐ Check patient's record in the Controlled Substance Monitoring Database (CSMD)
- ☐ Patient receiving prescriptions for chronic pain should have a drug agreement in place per TN Together
- ☐ Add HIV, Hepatitis C, Hepatitis B, Gonorrhea, Chlamydia, Syphilis screening to routine lab panel
- ☐ Risk screening for tuberculosis
- ☐ Consider bowel regimen of stool softeners, fluids, fiber products and hemorrhoid cream
- ☐ Screen for co-occurring mental health disorders such as depression, anxiety, and PTSD
- ☐ Enroll in text4baby.org for anticipatory guidance during pregnancy and first year of life
- ☐ Refer to insurance case manager, Strongwell, and/or social worker
- ☐ Make appropriate referrals such as education and career building support, domestic violence counseling, WIC, public assistance, food stamps (SNAP), transportation and mental health services
- ☐ Provide education on maternal drug use including maternal and fetal risks
- ☐ Provide education on NAS/NOWS
- ☐ Provide Narcan education and Narcan prescription

## 2ND TRIMESTER

- ☐ Work with patient to develop pain management plan
- ☐ Order monthly growth ultrasounds at 24 weeks gestation
- ☐ Discuss contraceptive plan and give contraceptive education

## 3RD TRIMESTER

- ☐ Repeat labs (Hepatitis-C/HIV and other STI screening as indicated) in the third trimester
- ☐ Confirm contraceptive plan. For Medicaid patients who desire sterilization, ensure TN sterilization form is signed after counseling on risks and benefits
- ☐ Consider anesthesia consultation if IV access is difficult or severe anxiety, or coexisting medical issues could prevent spinal analgesia
- ☐ Discuss importance of having trained newborn providers care for infant after delivery
- ☐ Encourage communication between patient and newborn care provider. Consider prenatal appointment with pediatrician/neonatologist who will care for infant after birth
- ☐ If delivering hospital is not able to provide care for infant with NAS, discuss patient preference for transfer of care in last trimester of pregnancy vs. transfer of newborn after delivery if pharmacologic management is required
- ☐ Confirm that hospital has Buprenorphine or Methadone available on formulary. If not available, discuss local hospital policy for administering home medications
- ☐ Advise families that recommended length of stay of newborns is at least 5 days and that infant will be monitored for signs of NAS/NOWS. Infants may need to stay longer if treatment or prolonged monitoring is required
- ☐ Review hospital breastfeeding guidelines with mothers
  - ☐ Women stable in treatment including buprenorphine or methadone MAT and who do not use illicit drugs should be encouraged to breastfeed.
- ☐ Refer for Childbirth education
- ☐ Perform toxicology testing when clinically indicated
  - ☐ Routine toxicology tests may differ by institution.
  - ☐ Testing for Methadone, Buprenorphine, and/or their metabolites may need to be specially ordered. Positive toxicology tests should be sent for confirmation

# Opioid Use Disorder Pregnancy Checklist

TIPQC

Tennessee Initiative for Perinatal Quality Care

# DELIVERY ADMISSIONS

- Obtain release of information for addiction treatment provider and confirm dose of Methadone or Buprenorphine and notify of admission. An attending provider may prescribe Buprenorphine and Methadone to maintain outpatient dose during hospitalization
- Consult addiction specialist or Maternal Fetal Medicine if illicit substance use and not already in treatment
- Consider acute withdrawal in the differential diagnosis of a patient with intractable nausea, vomiting or abdominal pain
- PICC or central line may be needed when peripheral venous access is too difficult due to history of IV drug use
- Review newborn testing recommendations with patients privately
- Review hospital breastfeeding and marijuana policy guidelines with mother. Women stable in treatment on Buprenorphine or Methadone should be encouraged to breastfeed
- Encourage skin to skin contact and rooming-in
- Complete Plan of Safe Care
- Refer to appropriate social services agencies
  - Department of Children's Services per hospital and state policy (evaluate on case by case basis)
  - Nurses for Newborns
  - CHANT
  - Strongwell
- Notify addiction treatment provider upon discharge to confirm follow up appointment
- Give patient list of medications administered during hospitalization and those prescribed at discharge
- If on methadone, give dose prior to discharge and ensure that patient can return to methadone clinic on the following day
- Be alert for symptoms of over-medication
- When a patient appears somnolent, evaluate medications and consider decreasing dosages. Consult addiction treatment provider prior to adjusting MAT dose
- Schedule postpartum visit to develop a reproductive plan, screen for postpartum depression, and connect patient to a primary care provider
- Provide overdose and Narcan education and Narcan prescription
- Provide comprehensive education on all contraceptive options
- Ensure HIV, Hep C, Hep B, syphilis screening is up to date and complete as needed



# PAIN MANAGEMENT

Patients on chronic opioids are more sensitive to pain and pain should be managed appropriately. Schedule doses of NSAIDS and Acetaminophen for mild to moderate pain if there are no contraindications to these medications. Short acting Opioids can be added as needed. Hydromorphone may offer better pain relief for patients on buprenorphine MAT.

- Continue patient's regular maintenance dose of Methadone or Buprenorphine. Evaluate dose with the addiction treatment provider after delivery as needed
- Patients undergoing C-section should also continue their maintenance dose of Buprenorphine or Methadone. Patient controlled IV Analgesia and/or Duramorph added to the spinal are effective options for the first 24 hours
- Oral opioids can be added for break-through pain in addition to the maintenance dose of Methadone or Buprenorphine
- Schedule NSAIDS/acetaminophen and maximize multi-modal analgesia options
- Neuraxial Analgesia (spinal or epidural) may be the most safe and effective way to control pain both for vaginal births and cesarean sections. Surgical patients delivered with general anesthesia will usually need a PCA with Morphine or Dilaudid to control post cesarean section pain
- Patients using illicit substances may require increased doses of pain medication