

# What We Wish We Had Known: Implementing A Program for Managing Opioid Use Disorder in Pregnancy

Brandi Brinkerhoff, MSN, RN, WHNP-BC

Catherine “Bizz” Steele Grimes, ASN, BS, M.Ed., RN

Tara Benjamin, MD, MS, FACOG

Assistant Professor, Clinical Obstetrics & Gynecology

Division of Maternal-Fetal Medicine

Director, Maternal Recovery Program, Riley Maternity & Newborn Health



- I. You'll need more than that 8 hour CME
- II. The three P's: Prior authorizations, Pharmacies, Patient Phone Calls
- III. The Complexities

# Overview

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- Encourage buprenorphine/addiction practitioners to provide care for pregnant women.
- Encourage obstetric practitioners to provide buprenorphine/addiction services.
- Offer our assistance to any of the above, anytime.
- Allow others to learn from our mistakes.
- Improve stakeholder awareness of the challenges in caring for pregnant women with Opioid Use Disorder.

# Why?

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You'll need more than that 8 hour  
CME



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- A mentor
- A pharmacy
- A laboratory
- Facilities that meet ASAM placement criteria—**and accept pregnant women.**
- Referring provider(s) therapy, dual diagnoses, & trauma counseling.
- Inpatient & outpatient staff who want to manage this population.
- Case Management.
- Social Work.
- Staff to handle prior authorizations and phone calls.
- +/-Nurse Practitioner.

**Find the Following** Resources



- Induction strategy- inpatient or outpatient
- UDS protocol
  - Screening frequency
  - Management of positive screens
  - Routine screens are controversial
- Future opportunities for education



# Find the Following

## Protocols/Strategies:

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ASAM UDS document

- IN State Policy on Substance use During Pregnancy:  
When drug use is suspected, testing is required, reporting is not.

# Keep in mind

<https://iga.in.gov/legislative/2016/bills/senate/186#document-9e4e1dbb>

<https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>



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- Indiana Senate Enrolled Act No. 186:
- Prohibits MDs, PAs, midwives, & NPs
- Informing law enforcement agencies of the results of drug tests (verbal, urine tests, blood tests)
- Done on pregnant women without consent
- Unless under court order.

# Keep in mind

<https://iga.in.gov/legislative/2016/bills/senate186#document-9e4e1dbb>

<https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>



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The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS



**ASAM** American Society of  
Addiction Medicine

## ACOG COMMITTEE OPINION

- Universal Screening- supported by ACOG/ASAM
- UDSs---perform with patient consent and in compliance with state laws.
- Inform pregnant women of any potential ramifications of testing.

# Keep in mind

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## Barriers

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- Stigma of addiction
- Fear of losing custody
- Threat of incarceration and/or mandated treatment.
- Pressure from partners
- Lack of child care
- Lack of transportation

## The Therapeutic Alliance

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- Welcoming, nonjudgmental attitudes.
- Keep promises
- Listen
- Be available, helpful, & positive
- Keep patient informed
- Address complaints
- Take the extra step

# Seeking & Engaging in Treatment

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Jones HE, Kaltenbach K (2013). Treating women with substance use disorders during pregnancy: A comprehensive approach to caring for mother and child. Oxford University Press.



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## Educational resources

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- Join American Society of Addiction Medicine
- Join the Indiana Society for Addiction Medicine.
- Join ACOG
- Attend conferences

## Establish a network of

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- Addiction providers with OB experience.
- Multidisciplinary prof.: counselors, social workers, case managers, pediatrician, lactation consultant, psychiatrist, therapist, treatment facilities.

# Find the Following

Further education

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Jones HE, Kaltenbach K (2013). Treating women with substance use disorders during pregnancy: A comprehensive approach to caring for mother and child. Oxford University Press.



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## Remove these:

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- Addict/User/Junkie
- Abuse
- Clean/Dirty
- Dope sick
- Street drugs

## Replace with these:

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- Person with Opioid Use Disorder
- Opioid Misuse
- Positive/negative urine screen or expected test result
- Withdrawal
- Illicit substances

# Educate Staff Vocabulary

Botticelli, MP, Koh, HK. Changing the Language of Addiction. JAMA October 4, 2016 Volume 316, Number 13.



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- “Buprenorphine is a legal replacement for heroin.”
- “Her baby will be born addicted.”
- “Why can’t she just stop everything.”
- “Buprenorphine is for the weak.”
- “How can she love her baby.”

## **Educate Staff** Dispel Misconceptions

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- Chronic disease
- The withdrawal experience
- Treatment philosophy
- Rationale for decision to manage pregnant women or pregnant women with opioid use disorder, and what may be different.
- Patient interactions
- Patient confidentiality (42 CFR Part 2)
- Record keeping requirements
- Discuss protocols & available community resources

# Educate Staff Clinical

Opioid Use Disorder in Pregnancy. ACOG Committee Opinion Number 711; August 2017.



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- Medication-assisted treatment
- Contract
- Antepartum considerations
- Intrapartum considerations
- Immediate postpartum management
- Late postpartum management



# What's Different in Pregnancy



- Preferred Treatment
- Buprenorphine vs Methadone

# Pregnancy Medication-Assisted Treatment

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- Buprenorphine vs. Methadone in pregnancy
- Buprenorphine risks
  - Maternal
  - Fetal
- Neonatal Abstinence Syndrome
- Alcohol and benzodiazepines

# Pregnancy Contract

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- Hepatitis C antibody
- TB skin test
- Baseline liver function tests, repeat 3<sup>rd</sup> trimester if Hep C+
- Establish pregnancy dating
- Edinburgh Postnatal Depression Scale (EPDS)
- Refer to Women Infants & Children (WIC) nutritional program
- Smoking cessation
- Contraception
- Breastfeeding
- Comprehensive biopsychosocial assessment

# Pregnancy Antepartum

Jones HE, Kaltenbach K. Treating women with substance use disorders during pregnancy: A comprehensive approach to caring for mother and child. Oxford University Press; 2013.



- Titrate buprenorphine to achieve symptom control.
- Physiology may necessitate split dosing and/or higher dosages.
- Coordinate obstetric & addiction care.
- Increased fiber/stool softener.
- Delivery at a hospital comfortable with NAS.
- Duration of neonatal observation.
- Social work and/or DCS involvement.
- Identify a post partum provider. (Insurance company case management.)

# Pregnancy Antepartum



- Continue buprenorphine as prescribed.
- Usual pain control with neuraxial anesthesia.
- AVOID Nalbuphine (Nubain) and butorphanol (Stadol) mixed opioid agonists-antagonists which precipitate withdrawal.

# Pregnancy Intrapartum

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## Early Postpartum

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- Continue buprenorphine maintenance.
- Higher narcotic doses for post cesarean analgesia.
- Breastfeeding encouraged- unless on codeine or tramadol, HIV+, or +for illicit substances.
- Based on recent reports of post cesarean overprescribing, we discharge with Percocet #30.

## Late Postpartum

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- Dose reductions should not be routine, but individualized.
- Assess early and frequently (individualize) for relapse and postpartum depression.

# Pregnancy Postpartum

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Opioid Use Disorder in Pregnancy. ACOG Committee Opinion Number 711, August 2017.

Bateman BT, et al (2017). Patterns of opioid prescription and use after cesarean delivery. *Obstet & Gynecol*;130:29-35.

Osmundson SS, et al (2017). Postdischarge opioid use after cesarean delivery. *Obstet & Gynecol*;130:36-41.



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- 1) **Find the following:** a team of ancillary services, protocols/strategies, referring providers, education.
- 2) **Educate Staff:** vocabulary, dispel misconceptions, clinical details.
- 3) **What's different in pregnancy?** Contract differences and management changes antepartum, intrapartum, postpartum.

**You'll need more than that 8h  
CME**



# Prior Authorizations, Pharmacies, and Patient Phone Calls



Catherine “Bizz” Steele Grimes, ASN, BS, M.Ed., RN



- Forms
- Denials
- 30-day rolling calendar

# Prior Authorizations

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# The Plethora of PA forms

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# The World

8:10-17  
 "Jessica" 1430 1800 356-1204 (wrong #  
 Hold for PA dept @ 1435 through provided  
 comment controlled on "appeal"  
 substances (P. work)  
 back: 1440  
 "getting voice" MDWISE  
 call back in 10"  
 1441 - 1844 336 2677 → hold @ 1442 10420278-3699  
 1443 - apt. situation, i.e., 1st visit  
 "Amber" explain situation supervisor  
 hold 1445  
 1450  
 "Miata" hold 1457 Catherine  
 1500  
 "Ebony" E  
 "escalation" 1502 Supervisor: Kathy  
 5th "Julene" hold 1506 "brief"  
 transfer → pharmacy team 1507  
 "1509" hold again  
 "Lisa" 1514 "all clin members  
 pharm bus. analyst training session" → hold 1517  
 provided callback  
 "immediate"

# Of Denials

② Back 1529 Clin review manager  
 attempt to transfer → transfer (provided callback  
 Julene gone @ 1531 87625  
 Hold 1530 Hung up @ 1532  
 called back 1537 "Kailey" pharm. clin review manager  
 1545  
 1645 - "refill too soon"  
 Tawna @ 1700 → hold @ 1708 → calling pharm.  
 back 1730 → "holding for  
 hold 1731 ← pharmacy  
 back 1742  
 • rev. claim  
 to be reimbursed  
 @ receipt.  
 10 remaining paid 8/13  
 1745

Longest call on record-3hrs, 43min

5-30-17 13764820999 Start 0948 → hold

MHS Pt approved 5-24-17 - 5-24-17 • 0953 → 0958

- Denial letter 5-23 stating "Stavara" <sup>12</sup> 0958 hold for supervisor
- ∅ justification for admin. of subtext - 1006
- Pt. DNS for 5130/17 WS at ROB. Only provided
- 3-d emer. close on 5-23-17 while PA pending. - [with drawings]
- MHS - appeals at grievance coord. 777-647-4848
- wrong # again 10-17 →

out) "Angela" • Started 0948 → 1044 <sup>56 min</sup>

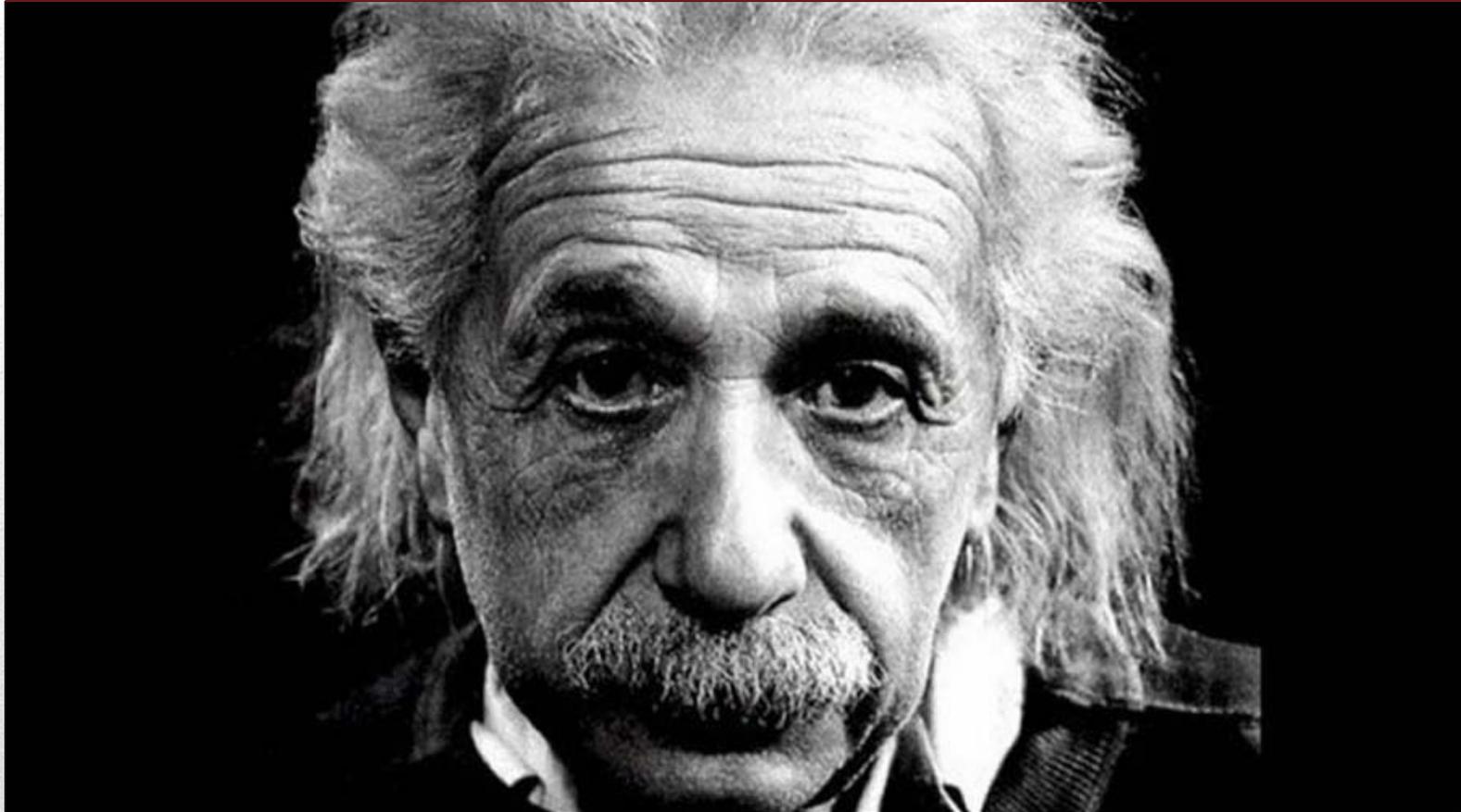
5-30-17 put on hold 1020 → MHS doesn't read letter, Envolv does.

1025 - Envolv 1 200-413-7721

"Amber" 1027 → wrong department → 1033 → PA dept.

"Denise" hold 1038 → MHS sends letter 1044

# Punt, pass, and Kick



Huh?!

**The Rolling 30-Day Calendar**

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- No buprenorphine
- Not enough buprenorphine
- The emergency supply
- Judgment

# Pharmacies

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- Pending 1<sup>st</sup> appointment, low supply
- Lost, stolen, or damaged supply
- Precarious social situations

# Patient Phone Calls

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# The Complexities

Tara Benjamin, MD, MS, FACOG

Assistant Professor, Clinical Obstetrics & Gynecology

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- A. Utilization of the drug screen
  - B. Concurrent Conditions
  - C. The Postpartum Period

# The Complexities

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- Assesses for current or recent substance use.
- Positive UDS is not diagnostic for opioid use disorder.
- Negative UDS doesn't exclude opioid use disorder or sporadic use.
- False positives can occur
- May not detect some benzodiazepines, designer drugs, or synthetic opioids (fentanyl, oxycodone, methadone, buprenorphine).
- Validated verbal screens are preferred for initial screen.

# Urine Drug Screen Controversies

Opioid Use Disorder in Pregnancy. ACOG Committee Opinion Number 711; August 2017



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## **DRUGS**

## **Substances That May Trigger False-Positive Results**

Opiates

Poppy seeds, quinolones, rifampin, cough suppressants, anti-depressants

Methadone

Diphenhydramine, verapamil, quetiapine, promethazine, thioridazine

Buprenorphine

Tramadol

Cocaine

Coca leaf tea, topical anesthetics containing cocaine

Amphetamines

Pseudoephedrine, bupropion, ranitidine, trazodone, selegiline, ephedrine, phentermine, Adderall

Cannabinoids

Dronabinol, efavirenz, hemp seed oil

Benzodiazepines

Sertraline

# **Urine Drug Screen** False-Positives

Rastegar D, Fingerhood M (2016). "Screening and Brief Interventions." ASAM Handbook of Addiction Medicine. Oxford University Press; 20.



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- Useful predictor of treatment outcomes.
- Effective as part of contingency management.
- Useful in assessing changes in clinical status.
- Useful in exploring denial, motivation, and actual substance use with patients.
- Assists with monitoring adherence and abstinence.
- Educate patients that UDS is therapeutic rather than punitive to avoid an “us versus them” mentality.
- Should be unannounced with frequency based on patient acuity & level of care.

# Urine Drug Screen The Evidence

American Society of Addiction Medicine. Consensus statement: Appropriate use of drug testing in clinical addiction medicine. April 5, 2017.



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- Refer to as presumptive positive until confirmed.
- Non-judgmental, non-confrontational discussion
- Ask about possible cross-reactivity.
- Perform a confirmatory test
- Discuss unclear results with lab or medical review office.
- Patient with a negative confirmatory test may have engaged in use outside the window of detection of the test.

# Urine Drug Screen Approaching the Positive

American Society of Addiction Medicine. Consensus statement: Appropriate use of drug testing in clinical addiction Medicine. April 5, 2017.



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- +Confirmatory → Definitive positive test
- Look for a cause & maintain humility
- Usual causes:
  - Inadequately treated withdrawal
  - Untreated depression/anxiety/PTSD
  - Boredom
  - Frustration & anger
  - Stressful social situation
  - Reversion to previous people, places, and things.
- Address the cause



## Urine Drug Screen Approaching the Positive

American Society of Addiction Medicine. Consensus statement: Appropriate use of drug testing in clinical addiction Medicine. April 5, 2017.

- Part of the natural history of the disease (don't impart this to patients).
- Opportunity for patient and provider to learn from mistakes, and correct them by **strengthening therapy**.
- Each relapse should be evaluated clinically with a graduated response tailoring treatment intensification to relapse severity.

# Urine Drug Screen Relapse

Rastegar D, Fingerhood M (2016). "Screening and Brief Interventions." ASAM Handbook of Addiction Medicine. Oxford University Press; 28.



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1<sup>st</sup> lapse → Weekly urine screens, Outpatient therapy

1<sup>st</sup> relapse → Intensive outpatient therapy

2<sup>nd</sup> relapse → Monitored inpatient care

3<sup>rd</sup> relapse → Transition to methadone

- Developed based on available resources and ASAM Levels of Care.

# Urine Drug Screen Relapse Protocol





ASAM Dimension	ASAM Patient Placement Criteria/Levels of Care			
	<b>Outpatient Level I</b>	<b>Intensive Outpatient Level II</b>	<b>Monitored Inpatient Level III</b>	<b>Medically Managed Inpt Level IV</b>
Acute Intoxication &/or Withdrawal	No risk	Minimal	Mild- Moderate	Severe
Biomedical Conditions & Complications	No risk	Manageable	Monitoring needed	24h acute medical needs
Emotional, Behavioral, Cognitive Conditions	No risk	Mild	Monitoring needed	24h acute psych needs
Readiness to change	Action	Preparation/a ction	Contemplation	N/A
Relapse, continued use, problem potential	Maintains abstinence	More symptoms	Unable to stop using	N/A
Recovery/Living Environment	Supportive	Can cope with structure	Actively undermining recovery	N/A



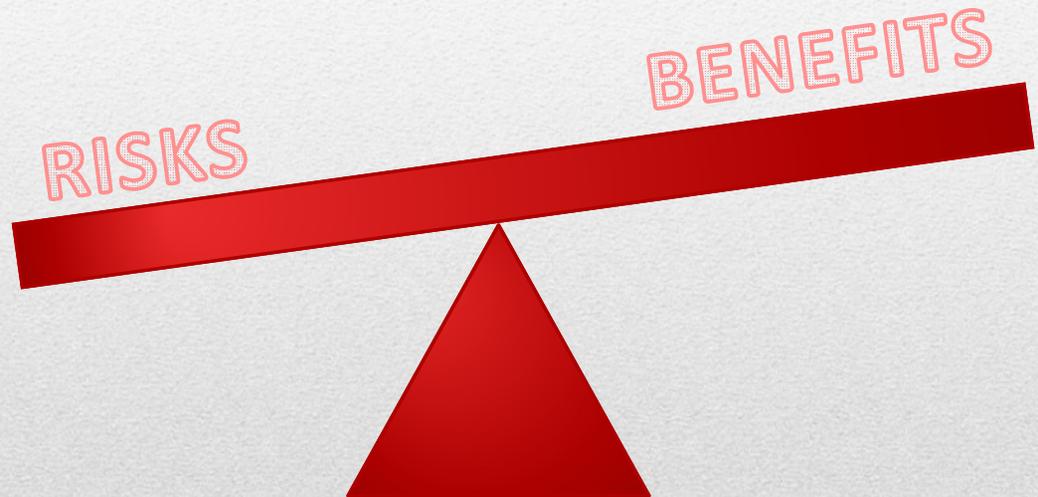
- American Society of Addiction Medicine. Consensus statement: Appropriate use of drug testing in clinical addiction medicine. April 5, 2017.



## Recommended Reading

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- Marijuana use
- Benzodiazepine use
- Tobacco use
- Stimulant use
- SSRI & SNRI use

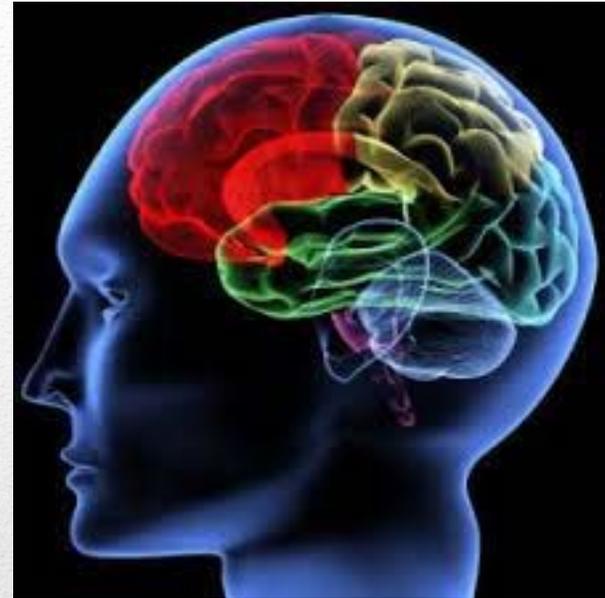


# Concurrent Conditions

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- Depression
- Anxiety
- PTSD
- Bipolar Disorder
- Trauma History



# Concurrent Conditions

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- Insurance instability
- Do NOT wean
- New provider



# Postpartum



- Refer women of childbearing age for contraceptive care.
- Please CONTINUE MAT if a woman gets pregnant.
- Consider continuing her care, but referring for co-management with an obstetric provider (minimizes transitions of care).
- Prioritize accepting postpartum patients.

## How Non-Obstetric providers can help



# References

- American Society of Addiction Medicine. Consensus statement: Appropriate use of drug testing in clinical addiction medicine. April 5, 2017.
- American Society of Addiction Medicine (2017). Drug Testing Appropriateness Document. Retrieved from <https://www.asam.org/docs/default-source/quality-science/asam-drug-testing-appropriateness-document-draft4779199472bc604ca5b7ff000030b21a.pdf?sfvrsn=2>
- Bateman BT, et al (2017). Patterns of opioid prescription and use after cesarean delivery. *Obstet & Gynecol*;130:29-35.
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- Jones HE, Kaltenbach K. Treating women with substance use disorders during pregnancy: A comprehensive approach to caring for mother and child. Oxford University Press; 2013.
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Maternal Recovery Program  
Riley Maternity & Newborn Health  
[bbrinkerhoff@iuhealth.org](mailto:bbrinkerhoff@iuhealth.org)  
[tarabenj@iupui.edu](mailto:tarabenj@iupui.edu)

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Tara Benjamin

