Don't Quit the Quit Resource Guide:

First Steps to Serving Perinatal Clients with OUD

Getting Started with MAT/MOUD for Clients with OUD Who are Pregnant, Postpartum or Breastfeeding (WPPB): General Guidelines

Definitions:
MAT: Medication Assisted Treatment. Includes behavioral health supports and counseling in addition to treatment with medications.
MOUD: Medications to Treat Opioid Use Disorder. Refers to Methadone, Buprenorphine, and Buprenorphine/Naloxone products used to treat women with opioid use disorder during the perinatal period.

Postpartum: Begins with the birth of the infant and continues through the entire first year after delivery, regardless if the mother is parenting and/or breastfeeding.

SAMHSA Advisory: Addressing the Specific Needs of Women for Treatment of Substance Use Disorders (3/2021).
https://store.samhsa.gov/product/advisory-addressing-specific-needs-women-treatment-substance-use-disorder/pep20-06-04-002

General Considerations for Office Based Opioid Treatment (OBOT) in Your Facility
Treatment of opioid use disorders (OUD) can occur in specialized opioid treatment programs or through general health care practices in an office based opioid treatment program model. Office-based opioid treatment (OBOT) commonly refers to outpatient treatment services provided outside of licensed Opioid Treatment Programs (OTPs) by clinicians to clients with addiction involving opioid use.

- **Methadone, Buprenorphine, Buprenorphine/Naloxone and/or Naltrexone** are available for treatment of opioid use disorders.
    - Methadone
        - Requires DATA 2000 waiver to prescribe
        - Requires dispensing from an OTP
    - Buprenorphine, Buprenorphine/Naloxone

    - Requires DATA 2000 waiver to prescribe
    - May be prescribed from office settings (OBOT)
  - Naltrexone
    - Not a controlled substance
    - Requires no special training
    - Not subject to DATA 2000 regulations
    - Currently insufficient information about safety of extend-release injectable during pregnancy
    - Patients need to be opioid free prior to starting

- There is no special licensing required for the facility to be an OBOT, however, prescribing providers (Only physicians; nurse practitioners; physician assistants; and, until October 1, 2023, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives) must have completed additional waiver training and hold an XDEA number.
  - **Providers Clinical Support System Free Waiver Training** **https://pcssnow.org/medications-for-addiction-treatment/**

SAMHSA TIP 63: Executive Summary
https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Executive-Summary/PEP20-02-01-005
SAMHSA TIP 63: Full Document
https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

Staff Buy-In for OBOT for WPPB
Fact: Expanding access to MOUD for women with OUD who are pregnant, postpartum and or breastfeeding is an important public health strategy. Science supports the use of Buprenorphine products for OUD, even in WPPB, so often times it is helpful to present and explain this information to your staff. If your facility already cares for WPPPB, OBOT offers an additional resource to help them stabilize. Many providers who have started OBOT have discovered that this is an incredibly rewarding practice!

In general, many providers and clinic staff are overwhelmed by the prospect of taking on 30-100 clients with OUD, and especially women with OUD who are pregnant, postpartum and/or breastfeeding, but the reality is, that if willing providers would simply take a handful of clients, that would be helpful. This would allow clients to receive the care that they need in their home communities at their home clinics with people who already know them. You WILL make a HUGE difference in their lives!

Tips To Introduce OBOT:

1. Meet with staff to discuss the anticipated addition of OBOT for WPPB
2. Provide facts and address concerns or misconceptions with staff
    a. Correct misinformation related to MOUD during pregnancy, postpartum and while breastfeeding
    b. Discuss Stigma-It is real and it needs to be addressed!
        i. Ensure a safe, non-judgmental space for staff to learn and express feelings
        ii. FREE Stigma knowledge courses: **https://healtheknowledge.org/course/search.php?search=stigma**
3. Staff orientation
    a. Work-flow for visits
        i. Is your agency providing prenatal care AND OUD treatment or will you need to have referrals in place for prenatal care?
    b. Screening phone calls/questions: How will this be handled?
        i. For example, nurses may gather necessary information during an initial phone visit and then schedule a clinic appointment with the provider for induction or continuation of care or you may choose to have a full intake during the initial visit only.
    c. Encourage clinic nurses to complete knowledge training. **https://pcssnow.org/education-training/sud-core-curriculum/**
4. Include the Business office
    a. Billing and Coding
        i. Billing for a MOUD visit from a Primary care office is no different billing for any other chronic disease

visit. Document level of service and complexity – will vary based on what else you cover.

ii. HCPCS Codes and modifiers (pg5): Updated 0/2020

iii. https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/mat-policy.pdf

b. Understand prescription billing and insurance coverage

i. Most insurance carriers pay for Buprenorphine as well as the regular office visits, which are billed in the same way as any other office visit for medical management.

ii. MOUD visits may need to be billed separately from prenatal visits. Check with insurance carriers.

iii. Different insurance carriers have preferred products, whether that is generic tablets or strips. Plan to check requirements prior to prescribing. Prior authorizations are occasionally required but it may depend on quantity prescribed per day. For example (as of 3/1/21):

1. Medicaid and Medicaid Expansion will not cover Suboxone strips unless the patient has failed all 8 manufacturers of generic Suboxone tabs which are not all available in ND.
2. BC/BS requires a prior authorization for strips if more than 2 daily.
3. BOON (insurance offered to enrolled members of the MHA Nation Tribal community) does not require prior authorizations but they do require the client's SSN for billing purposes.

5. Treatment agreements: Provider/Agency discretion (please see below)
   a. Does your organization want to use a standard agreement?
   b. Will this be different for pregnant women?
6. Lab
   a. What tests do you need to order?

i. The ASAM NATIONAL PRACTICE GUIDELINE For the Treatment of Opioid Use Disorder: 2020 Focused Update (p. 23)

1. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

   b. Urine Drug Testing
      https://cpnp.org/guideline/urine-screen
      i. Things to Consider:
         1. Have clear criteria for collecting urine and for determining what is an acceptable sample.
         2. Are you using UDS to "catch" someone or to ensure engagement in treatment?
         3. What will you do if you get unexpected results? Remember MOUD are only approved to treat OUD, so think about what unexpected results will mean in your practice.
         4. "Firing" clients is not evidence-based.
         5. DO NOT make any treatment decision based on point of care testing only (there are a variety of reasons for false positive and false negative results).
         6. Utilize confirmatory testing as needed.
   c. Pregnancy testing
7. Seek out local mentors who can share their experiences and offer advice!
8. Have education resources readily available
   a. Prenatal resources
   b. MOUD resources
      i. SAMHSA's Clinical Guidance For Treating Pregnant And Parenting Women With Opioid Use Disorder And Their Infants (Prenatal Facts Sheets: Sections I,II, III)
      ii. **https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054**
9. Debrief and Review as needed
   a. You will have "bad" days. You will have "confusing" days. This happens with any change. Stick with it. You are making a difference for mothers and families!
10. Mandated Reporting: May pose a threat and deter women from seeking prenatal care. Providers must understand legal mandates in their state, including care for women who reside in other states

a. Guttmacher Institute website: Current summary of state policies: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Getting Started!
MOUD Goals:
Prevent or reduce withdrawal symptoms
Prevent reduce drug cravings
Prevent return to use and/or overdose
Improve health outcomes for the maternal-fetal/infant dyad
Help persons move back to or establish their desired quality of life

Education Goals:
Include client centered education that increases knowledge of the disease of addiction, increasing understanding of treatment options, increases awareness of areas of personal growth, and empowers persons in their recovery. Have appropriate prenatal education resources available.

MOUD in Pregnancy and Postpartum Resources:
SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants
https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

American Society of Addiction Medicine: The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update, Part 8: Special Populations: Pregnant Women, pg 49
https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

ACOG Committee Opinion Number 711 (August, 2017): Opioid Use and Opioid Use Disorder in Pregnancy
https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-

opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.pdf

Council on Patient Safety in Women's Health Care patient safety bundle: Obstetric Care for Women with Opioid Use disorder
https://safehealthcareforeverywoman.org/council/patient-safety-bundles/maternal-safety-bundles/obstetric-care-for-women-with-opioid-use-disorder-aim/

SAMHSA: Healthy Pregnancy Healthy Baby Fact Sheets
https://store.samhsa.gov/product/Healthy-Pregnancy-Healthy-Baby-Fact-Sheets/SMA18-5071

Pregnant clients with OUD may be reluctant to seek prenatal care for many reasons including fear of being incarcerated, lack of funds to pay for services, transportation or day care, fear of losing custody of their children, shame, or they may not recognize they are pregnant.

Subsequently, pregnant clients with OUD are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication. They may also have a higher risk of HIV and viral hepatitis which can impact pregnancy, labor management and recommendations related to breastfeeding (ASAM, 2020, pg. 50)

Initial Prenatal Substance Use Assessment:

1. Identify any emergent or urgent medical conditions requiring immediate attention
2. Universal screening for substance use
    a. Options for validated screening tools in pregnancy include: 4Ps (free), 4P's Plus (cost for use), NIDA Quick Screen
        i. 4 P's (Box 2): **https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy**

ii. NIDA Quick Screen: **https://archives.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen**

Diagnosis of OUD:
Diagnosis should meet the DSM-5 Criteria for Moderate-Severe OUD (has 6 or more symptoms) **https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf**

1. Nurses may gather necessary information during an initial phone visit and then schedule clinic appointment or information may be collected at first scheduled appointment.
2. If client has previously met criteria but has returned to use, is worried about relapse, or is no longer incarcerated (recent return to use = > double risk of overdose); Do not need to wait for some to use or overdose to resume medications or consider medications after incarceration.
3. New rules released during COVID-19 pandemic allow for use of televisits for initial intake visit and follow up visits.

Consideration of medication choice (Tip 63, pg 3-10; Chapter 3D: Buprenorphine pg 3-51):
Tailor medication and care decisions to clients' medical, psychiatric, and substance use histories; to their preferences, pregnancy status; and to treatment availability when deciding which medication and treatment to provide.

Female clients who wish to begin MOUD during their pregnancy:
Methadone or buprenorphine maintenance is recommended for OUD treatment during pregnancy, as these medications have better maternal and infant outcomes than no treatment or medically supervised withdrawal.

Methadone and buprenorphine are not associated with birth defects and have minimal long-term neurodevelopmental impact on infants. Neonatal Abstinence Syndrome or Neonatal Opioid Withdrawal Syndrome can occur with their use; however, symptoms are often less

severe and managed with few pharmacotherapies. This is expected and can be treated but may require hospitalization.

Female clients who are already established on MOUD:
Ideally, education for all female clients who are on MOUD should include preconception counseling and information on family planning. Clients who become pregnant while receiving MOUD, should usually be continued at their currently established dose. Some women may need increased doses during pregnancy, especially during the second half of pregnancy. Currently, tapering or stopping MOUD during pregnancy is not appropriate or advisable during pregnancy for most clients.

Clients already on Buprenorphine/Naloxone do not need to switch to Buprenorphine only products during the pregnancy or if breastfeeding. It is SAFE to breastfeed while on MOUD in most circumstances.

The American College of Obstetricians and Gynecologists notes that limited data exist on the safety and effectiveness of naltrexone in pregnancy. Starting naltrexone rather than opioid agonist treatment in pregnancy is not recommended, given the risk of precipitated withdrawal.

Treatment Agreements:
MOUD providers may consider treatment agreements that outline responsibilities of providers, offices, and clients.
The MOUD provider may want to present the client with written information about their treatment. Many offices will assure evidence of understanding by including signature of the client. The following items are suggested for your consideration:

a. All relevant facts concerning the use of MOUD that are clearly and adequately explained;
b. Other treatment options and detoxification rights;
c. A written estimate of expenditure including the amount expected to be covered by insurance and/or other payment sources and out of pocket expenditures for the member;

d. Written program participation expectations and a list of incidents that require termination of program participation;
e. Written procedures for non-compliance and discharge including administrative medication withdrawal; and
f. Education pertaining to their prescription.

North Dakota Human Services has developed a MAT Guide for additional review:
https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/mat-policy.pdf

General Medication Coverage Guidelines (as of 3/1/21; subject to change):
NDMA and Sanford Expansion:
Generic Buprenorphine/Naloxone tablets – No prior authorization (PA) is required.

Buprenorphine only tablets- Need PA unless the client is pregnant.

Sublocade (SQ injectable) – No PA required

Buprenorphine/Naloxone sublingual strips – Not on formulary and require PA

Most private insurances and MN list the strips as the preferred method

Clients may need additional nausea medication for sublingual method

Induction of MOUD (Buprenorphine or Buprenorphine/Naloxone) for WPPB:
Many clients may have already used buprenorphine before, either licitly or illicitly, to help with withdrawal symptoms, to stop using, or have shared with another person to assist them with withdrawal or stopping use. Please remember the concept of harm reduction: Use of buprenorphine is typically safer than injecting heroin.

Consider using the five A's at every visit: Assess, Advise, Agree, Assist, and Arrange.

a. https://www.icsi.org/guideline/healthy-lifestyles/five-as-model-of-patient-centered-care-and-self-management-support/

The provider must review the PDMP for the member's past and current use of Category II and III prescriptions prior to the induction.

In-Clinic induction:
If you have concerns about vitals or anxiety, this may be very appropriate.
Use of the Clinical Opiate Withdrawal Scale (COWS) may assist with induction.
https://www.asam.org/docs/default-source/education-docs/cows_induction_flow_sheet.pdf?sfvrsn=b577fc2_2

For pregnant clients:
If your OBOT program's providers are not covering the client's prenatal care, communication with the prenatal provider is encouraged to discuss current pregnancy status (as long as consent is obtained and documented) at the time of induction.

At-home induction:
Follow up at 2-3 days until maintenance dose achieved.
Typically start with 4mg (1/2 tablet of an 8mg) BID then increase from there. Dose to tolerable/decreased cravings and withdrawal symptoms. Most clients are on 16-24 mg daily.

Establishing Prenatal Care in Addition to MOUD Treatment:
If your OBOT program is not offering prenatal care, it is imperative that you have a process developed for referral to obstetric care as soon as possible. It is always desirable to establish the first prenatal care appointment in the first trimester whenever possible.

Key Points of Prenatal Education
It is also important to obtain informed consent regarding the continuation of a Buprenorphine/Naloxone combination medication or switching to a

Buprenorphine alone product during pregnancy. The guidelines do not specify that there needs to be a change and currently available information notes that the combination product is most likely safe.

A. Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS)

a. It is important pregnant clients are educated about the risks of and likelihood that her infant may experience NAS/NOWS. The literature notes that as many as 50% of pregnant clients were not aware of NAS/NOWS prior to their delivery.

B. Labor and Delivery

a. People with an OUD tend to experience pain differently than people without a history of OUD. It is important to educate clients regarding perception of pain and understand that someone with an OUD will most likely experience greater pain during labor and delivery.
b. Buprenorphine may help with pain control but most likely the pregnant client will need additional pain management. Remember that because she is taking Buprenorphine there will be some blockade of the opioid agonist so required doses may be higher than for other clients.

C. Perinatal Mood and Anxiety Disorders and Post-Partum Depression

a. Clients with OUD are at particularly high risk for perinatal mood and anxiety disorders and post-partum depression after delivery, so screening should take place at every visit or at least at every trimester and postpartum.
b. The Edinburgh Postnatal Depression Scale is often used. It is available in many languages, is health literacy appropriate. There are 10 self-reported questions.
    i. **https://psychology-tools.com/epds/**
c. After delivery and adequate pain control, the client can return to the previous dose of Buprenorphine relatively quickly.

d. Clients with OUD are at an elevated risk for recurrence of use in the postpartum period, which often peaks between 7-12 months postpartum.

D. Breastfeeding

a. Breastfeeding is encouraged for clients stable on MOUD. It may help with bonding and it may help mitigate the risk for and withdrawal symptoms of NAS.

b. Breastfeeding should not be encouraged if client is using illicit substances.

c. The Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015 **https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/21-drug-dependency-protocol-english.pdf**

Sexual Reproductive Health (SRH) Services:

Stigma related to substance use is one of the most significant barriers to accessing sexual reproductive health services noted by both providers and clients. Treatment also presents a critical opportunity to offer SRH services, including STI screening and contraception, as many clients have not had access to these services prior to treatment and many may lose contact with providers quickly following treatment.

Family Planning:

Clients in treatment for OUD may wish to discuss pregnancy planning and timing. *One Key Question* **(** **https://powertodecide.org/one-key-question**) offers suggestions for a starting point for this conversation. Providers are encouraged to ask clients if they would like to become pregnant in the next year. This question will prompt targeted education for preconception planning and/or contraception counseling.

Contraception:

Health care professionals have the privilege of understanding the various contraceptive options that are available to those persons

wishing to prevent pregnancy. Unfortunately, women with SUDs/OUD have often been targeted for forced and coerced sterilization or directed to use long-acting reversible contraceptive products only. Respectful discussions should include client choice preferences. North Dakota Family Planning offers several resources for providers wishing to prescribe contraceptives.
http://www.ndhealth.gov/familyplanning/contraceptives/

The National Clinical Training Center for Family Planning has several options for Contraception training webinars including up to date information on fertility based awareness methods.
https://www.ctcfp.org/category/contraception/

The Bedsider offers client appropriate information on contraception.
https://www.bedsider.org/methods

Sexual Health Screening:
Providers should offer routine sexual health screening options for clients in treatment for OUD. Mammograms, pap tests, sexually transmitted infection screening and testing are highly encouraged.

The Women’s Preventive Services Initiative offers a new 2021 Recommendations for Well-Woman Care Chart and a new product, “Recommendations for Well-Woman Care Clinical Summary Tables”. Both can be downloaded.

https://www.womenspreventivehealth.org/wp-content/uploads/WPSI_WWC_11x17_2021Update.pdf

https://www.womenspreventivehealth.org/wp-content/uploads/WPSI_ClinicalSummaryTables_2021Updates.pdf

The work that you are doing as providers who serve women with OUD is incredibly important! Thank you!

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