



Medication for Opioid Use Disorder (MOUD)

Overview

While the ideal timing for initiation of Medication for Opioid Use Disorder (MOUD) would be early in the pregnancy, implementation of an inpatient protocol for evidence-based evaluation, treatment, and discharge of pregnant patients with opioid use disorder (OUD) is the next best opportunity to address the chronic disease of OUD and improve long term outcomes for the pregnant woman and her affected infant.

Why We Recommend this Best Practice

The patient with OUD who presents to labor and delivery in labor also presents with a unique opportunity to initiate treatment for opioid use. While the provider and nursing staff may initially find such a patient challenging, they can introduce life-changing therapy at this distinct moment. Providers often feel uncomfortable prescribing MOUD for various reasons. A clear, informed protocol that providers can leverage for safe management of OUD in pregnant women will increase provider comfort in caring for these patients and optimizing health outcomes for patients and their newborns

Not all birth parents may require or accept inpatient induction of MOUD. If a person presenting for care declines inpatient or emergency department induction, ensure that the institution has referral processes in place to directly connect the patient with outpatient services, such as office-based outpatient treatment or an opioid treatment program, and provide a warm handoff.

Strategies for Implementation

Step 1: Utilize a multidisciplinary team to create a facility-specific MOUD protocol

Ideally this team includes obstetricians, midwives, psychiatrists, nurses, anesthesiologists, addiction and pain medicine specialists, pharmacists, and social workers.

The MOUD protocol should address the following:

- Evaluation of patients for OUD with a non-judgmental, trauma-informed approach (see the resources: [stigma, language, and implicit bias](#), [trauma-informed care](#), [screening and brief intervention](#), and [outpatient buprenorphine induction algorithm](#)).
- Shared decision making for OUD treatment, emphasizing the risks of OUD in pregnancy and options for MOUD, as well as the risks of supervised withdrawal (see the resource: [Considerations for Treatment of Opioid Use Disorder in Pregnancy](#)).
- Development and utilization of a treatment algorithm for inpatient MOUD initiation for both buprenorphine and methadone, including adjunctive therapies to optimize MOUD induction (see the resources: [Sample Inpatient Medication-Assisted Treatment Induction Algorithms](#) and the [Buprenorphine Quick Start in Pregnancy Algorithm](#)).
- Development and utilization of a treatment algorithm for outpatient buprenorphine induction. If capacity for close follow up with provider(s) comfortable with outpatient induction of buprenorphine in pregnancy is available, develop guidelines for which patients can consider outpatient induction of MOUD and develop a protocol for outpatient buprenorphine induction. Consider partnering with local residential treatment facilities and withdrawal management (detoxification) centers.

If your hospital does not already have a provider that is on-site or on-call that can begin or titrate maintenance medication, your MOUD protocol should include a process to receive a consultation.

These two resources are free program that provide perinatal mental and behavioral health consultation, including substance use disorder and MOUD.

- 1-833-937-9362 (YESWECAN): Swedish Perinatal Addiction Provider Consultation Line, available Monday—Friday 8:00 am — 5:00 pm
- Call 877-72504666 (PAL4MOM): [Perinatal Psychiatry Consult Line \(PCL\) for Providers](#), available Monday—Friday 9:00 am—5:00 pm

Step 2: Development of a dyad-centered Plan of Safe Care

Not all people may require or accept inpatient induction of MOUD. If a person presenting for care declines inpatient or emergency department induction, ensure that the hospital has referral processes and Plan of Safe Care in place to directly connect the patient with outpatient services, such as office-based outpatient treatment or an opioid treatment program, and provide a warm handoff.

Strategies for Implementation

Step 3: Educate physicians, nurses, and other care team members on OUD in pregnancy, strategies for caring for patients with OUD, and implementation of developed protocols.

- Create awareness of OUD in Pregnancy through various mediums to educate hospital staff about OUD in pregnancy (e.g., emails, physical bulletin boards, staff meetings) and mitigate stigma, bias and discrimination toward patients with OUD.
- Create opportunities for the workforce to learn about trauma-informed care in the inpatient setting (see [trauma-informed care](#)).
- Train providers on OUD treatment protocols for pregnancy and encourage them to obtain a waiver to prescribe buprenorphine. [Apply for a buprenorphine waiver](#).

Step 4: Train nurses on OUD treatment protocols and the use of the [Clinical Opiate Withdrawal Scale](#), the [Ramsey Sedation Scale](#), and [Considerations for Administration of Buprenorphine and Methadone](#)

MOUD Myths:

- Myth: Inpatient providers believe they cannot treat OUD because they do not have a waiver to prescribe MOUD (“X waiver”).
 - ◇ *Fact: federal law allows providers without an X waiver to administer or dispense (but not prescribe) buprenorphine on an inpatient basis for up to 72 hours. This law is known as the “three-day rule” and provides for effective treatment of acute withdrawal in the emergency department or inpatient setting.*
- Myth: There may be possible deleterious fetal effect.
 - ◇ *Fact: MOUD, particularly buprenorphine, is the gold standard for treatment of OUD and is safe during pregnancy. Split dosing or even higher overall dosing may be required during pregnancy. On the other hand, withdrawal is associated with high rates of relapse and poor outcomes for both mother and infant.*
- Myth: Neonatal abstinence syndrome (NAS) will be more severe, especially with the higher doses of buprenorphine needed during pregnancy.
 - ◇ *Fact: Buprenorphine reduces NAS severity and the dose is not correlated with NAS severity.*

Resources

- [Become a Buprenorphine Waivered Practitioner | SAMHSA](#)
- [CDC: Opioid Use and Pregnancy](#)
- [Clinical care for opioid-using pregnant and postpartum women: the role of obstetric providers](#)
- [Ensure methadone and buprenorphine doses are not tapered in the immediate postpartum period](#)
- [Implement care pathways for peripartum and postpartum pain management for pregnant patients without opioid use disorder to minimize opioid use](#)
- [Implement evidence-based anesthesia practices in the peripartum period for opioid use disorder in pregnancy](#)
- [Pharmacologic stepwise multimodal approach for postpartum pain management](#)
- [Medication-Assisted Treatment \(MAT\) | SAMHSA](#)
- [National Practice Guideline for the Treatment of Opioid Use Disorder](#)
- [NNEPQIN Toolkit for the Perinatal Care of Women with Substance Use Disorders](#)
- [MBSE Toolkit \(nastoolkit.org\)](#)
- [Provider's Clinical Support System \(PCSS\)](#)
- [Utilize shared decision making to tailor post-procedure pain control](#)
- [TIPQC OUD/OEN: Buprenorphine & Pregnancy \(OB Training Course\)](#)
- [WSHA OUD Management](#)

References

- ACOG committee opinion no 711: opioid use and opioid use disorder in pregnancy. *Obstet Gynecol.* 2017; 130(2): e81-94. doi: 10.1097/AOG.0000000000002235.
- Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy. World Health Organization. https://www.who.int/substance_abuse/publications/pregnancy_guidelines/ Published March 21, 2014. Accessed December 19, 2019.
- The ASAM National Practice Guideline . American Society of Addiction Medicine . <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>. Accessed December 19, 2019.
- Jones HE, Martin PR, Heil SH, et al. Treatment of opioid-dependent pregnant women: clinical and research issues. *J Subst Abuse Treat.* 2008; 35(3): 245-259. doi:10.1016/j.jsat.2007.10.007.
- Buprenorphine QuickStart in Pregnancy Algorithm. ED Bridge. <https://static1.squarespace.com/static/5c412ab755b02cec3b4ed998/t/5d6d85+9-1-2019.pdf>. Accessed December 19, 2019.
- Alford DP, Compton P, Samet JH. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Ann of Intern Med.* 2006;144(2):127-134. doi: 10.7326/0003-4819-144-2-200601170-00010.
- Macintyre PE, Russell RA, Usher KA, Gaughwin M, Huxtable CA. Pain relief and opioid requirements in the first 24 hours after surgery in patients taking buprenorphine and methadone opioid substitution therapy. *Anaesth Intensive Care.* 2013; 41(2): 222-230. doi: 10.1177/0310057X1304100212.