LOGO

Pregnant Patients Policy (informed by 32.5. in 69-12)

This policy is intended to reflect the special needs of patients who are pregnant. Prenatal care and other gender-specific services of pregnant patients are provided either by this MAT program or by referral to appropriate health care provider(s). Gender-specific counseling services may be rendered to pregnant patients in the form of individual substance abuse counseling without group counseling if there are not a sufficient number of patients who desire gender-specific therapy group.

Pregnant women seeking and needing treatment shall be enrolled in the MAT program as soon as possible and provided treatment in accordance with guidelines and protocols from ASAM and SAMHSA.

The MAT program will ensure referrals, either in house or our, for every pregnant who does not have an obstetrical provider. Care for the pregnant patient with an opioid use disorder will be co-managed by the MAT program and the patient's OB provider. The MAT program will make sure there is a coordination of care agreement with the patient's OB provider, including a completed informed consent to ensure exchange of pertinent clinical information regarding compliance with the recommended plan of care provided by both providers.

If not available elsewhere, the MAT program will offer basic instruction on maternal, physical and dietary care as part of the counseling services and document the provision of this education in the MAT medical record.

Relative to the pharmacotherapy for the opioid dependent pregnant women in the MAT program, the MAT program will ensure that:

- Maintenance medication levels shall be maintained at the lowest possible dose that is medically appropriate and therapeutic as determined by the medical director or program physician working in conjunction with the patient.
- The initial medication dose for the newly admitted MAT pregnant patient and subsequent induction and maintenance dosing strategy reflect the same effective protocols used for all other patients.
- The dose is monitored carefully to supply increased or split dose if it becomes necessary.
- If a pregnant woman elects to withdrawal from the MAT program against medical advice, the program will inform the patient of the risks of withdrawal to the patient and the effects on the pregnancy.
- The MAT program shall document referral or follow-up and primary care for the mother and infant post-partum.
- A pregnant patient will not be discharged without an arranged appointment with another provider scheduled before the patient leaves the clinic. Everything possible will be done to retain the patient in the MAT clinic unless clinically inadvisable. Any referral that is arranged for a

pregnant patient to an outside provider will be documented in the patient's medical record.
- The MAT program will offer onsite parenting education and training to all male and female patients who are parents or will refer interested patients to alternative service providers for training. Any referral to an outside provider for such services will be documented in the patient's medical record.

Research Regarding Contraindications of Detoxing Pregnant Women

Opioid detoxification is not recommended during pregnancy, because withdrawal can lead to fetal distress or death, and even medically supervised withdrawal is associated with a high rate of relapse (ACOG & ASAM, 2012). Instead, women should continue to use methadone or buprenorphine under a provider's care. Methadone and buprenorphine are related compounds used in Medication Assisted Treatment (MAT) that suppress and reduce cravings for opioids while preventing withdrawal symptoms (SAMHSA, 2015). In choosing between methadone and buprenorphine, one consideration is that methadone may only be dispensed in daily doses from specific treatment facilities, while only specially credentialed providers can prescribe buprenorphine. "Compared with methadone clinics, the less stringent structure of buprenorphine treatment may make it inappropriate for some patients who require more intensive structure and supervision," ACOG and ASAM note in a committee opinion (ACOG & ASAM, 2012). The need to visit a clinic daily may also present logistical barriers to patients with childcare or transportation challenges.

While less research has been completed on buprenorphine than methadone for use during pregnancy, the two appear to have similar effectiveness (Wisner et al., 2017). A review and meta-analysis of comparison studies found infants born to women who took buprenorphine were larger at birth and less likely to be treated for NAS than those born to women who took methadone (Brogly, Saia, Walley, Du, & Sebastiani, 2014). A randomized controlled trial that assigned 175 pregnant women with opioid dependence to either methadone or buprenorphine found that the buprenorphine-exposed infants required less NAS treatment and shorter hospital stays than methadone-exposed infants; however, women in the buprenorphine group were more likely to discontinue treatment, largely due to dissatisfaction (H. E. Jones et al., 2010).

A 2016 review and meta-analysis of studies comparing the two substances found a lower risk of preterm birth and greater birthweight in buprenorphine-exposed infants, but concluded, "evidence is currently insufficient to establish superior safety of either opioid agonist during pregnancy for all maternal, fetal and child outcomes" (Zedler et al., 2016). Jones and colleagues recommend, "Medication choices for each opioid-dependent patient during pregnancy need to be made on a patient-by-patient basis, taking into consideration the patient's opioid dependence history, previous and current treatment experiences, medical circumstances and treatment preferences" (H. E. Jones, Finnegan, & Kaltenbach, 2012).

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