OPIOID USE DISORDER IN THE PERINATAL PERIOD

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OBJECTIVES

- Define opioid use disorder (OUD) and review the epidemiology
- Review the SOGC *Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding*
- Review IWK Health Policy # 4.07: Care of patients on OAT for OUD including a review of the relevant "PPOs"
- Review screening for and management of OAT patients during the perinatal period with emphasis on integrated care models
- Provide an overview of NOWS management

OVERVIEW

- Opioid Crisis and Epidemiology
- Risk Factors & Screening
- Management of OUD & OAT
- Labour & Postpartum Considerations
- NOWS

STATEMENT ON GENDER

"While the majority of pregnant individuals identify as women, this term does not reflect the identities and experience of all pregnant people … Respect for individual identities and use of corresponding pronouns is vital when treating all patients"

BCCSU, 2018

OPIOID USE DISORDER

"Chronic use of op **istress or**
impairment" with **a 1 year period.**

Impaired c

Social impa

Risky use

Pharmacol

- 2-3 criteria met =
- 4-5 criteria met =
- 6-7+ criteria met =

Possible signs of OUD:

- Spending time alone
- Losing interest in activities enjoyed previously
- Decline of personal hygiene
- Depression
- Change in appetite
- Overly energetic
- Acting nervous or cranky
- Rapid mood changes
- Changes in sleeping patterns
- Missing appointments
- Criminal behaviour
- Ignoring responsibilities (work / school / family)

"OPIOID USE DISORDER IS ASSOCIATED WITH ACCIDENTAL OVERDOSE, TRAUMA, SUICIDE, SEPSIS AND INFECTIOUS DISEASES AS WELL AS CRIME AND PARENTING ISSUES"

SOGC, 2023

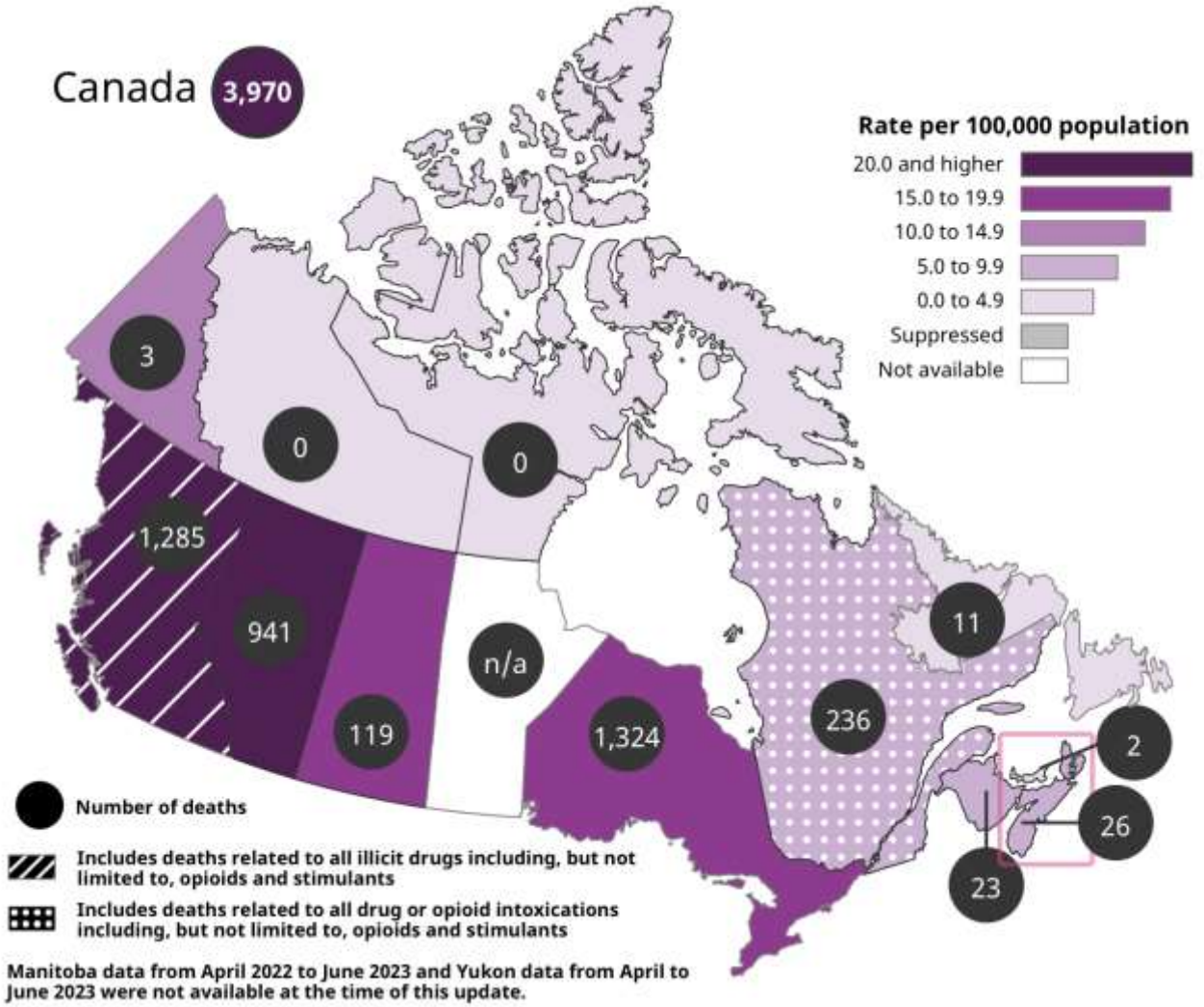
OPIOID CRISIS

1 in 8 Canadians have a close friend/family member who has become dependent on opioids

AFMC, 2023

OPIOID CRISIS

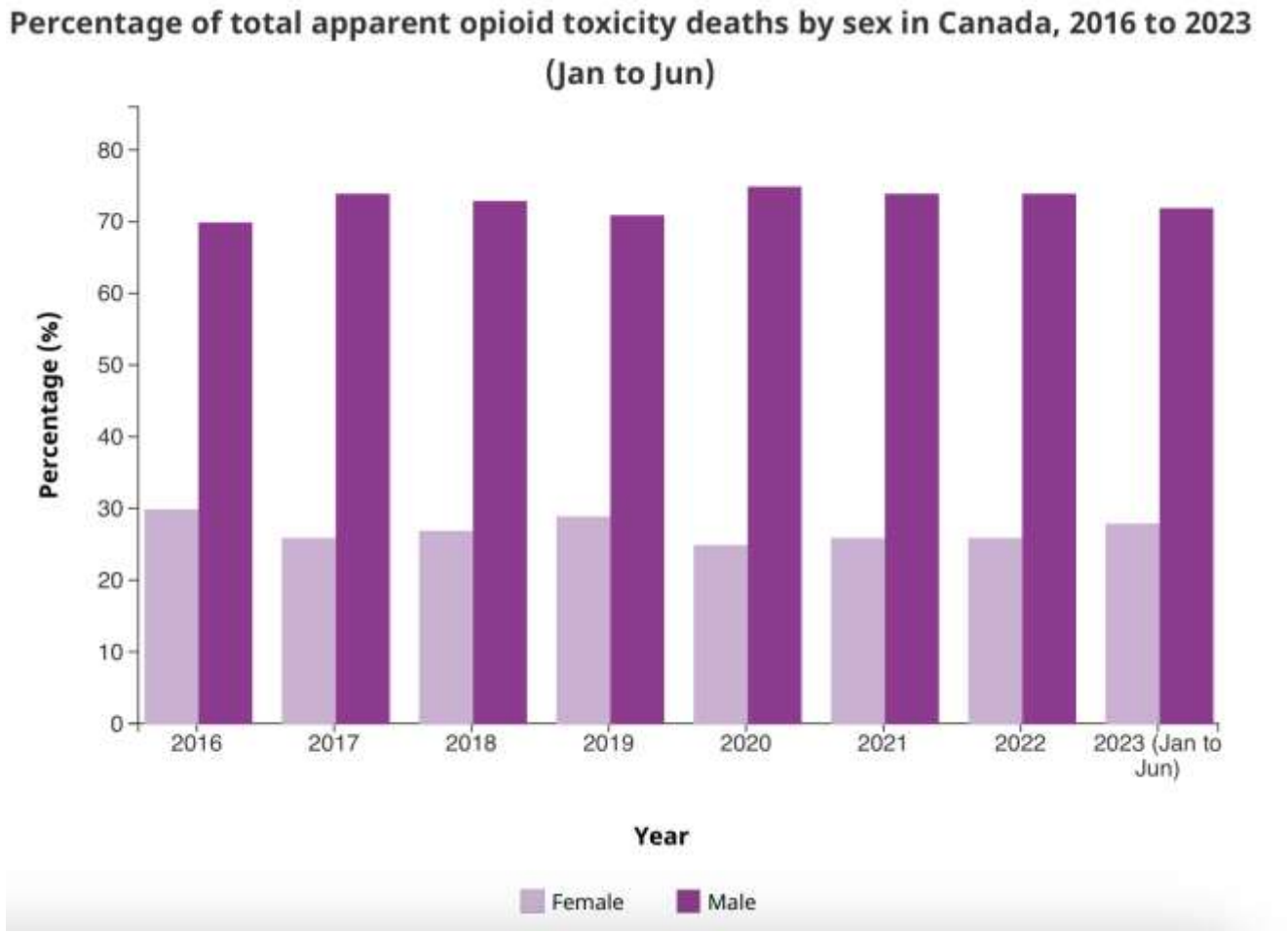
Number and rates (per 100 000 population) of total apparent opioid toxicity deaths by province and territory in 2023 (Jan – June)



NS crude rate = 5.1 per 100 000

PHAC, 2023

OPIOID CRISIS AND WOMEN



PHAC, 2023

OPIOID CRISIS AND WOMEN

- Women account for **40%** of the substance-using population in Canada
- **7%** women reported street drug use 3 months pre-pregnancy and **1%** during pregnancy
- Women are more likely than men to:
  - Be prescribed opioids
  - Initiate opioid use from a prescription
  - Use concurrent sedating medications
  - Develop physical dependence or opioid use disorder (OUD) faster
  - Experience chronic pain
  - Have severe psychiatric illness alongside OUD
  - Functional impairment alongside OUD

OUD AND REPRODUCTIVE HEALTH

- Opioid use affects women from preconception to menopause
- Hormonal changes
  - Dose-dependent hypogonadism
  - Less estradiol, progesterone, DHEAS, LH -> depressed HPA function -> amenorrhea or oligomenorrhea
- Fertility
- Contraception
  - No method contraindicated; LARCs encouraged
- Menopause
  - Distinguish opioid-induced Sx from menopausal Sx
  - LT opioid use confers higher risk of osteopenia/osteoporosis

SOGC, 2023

OUD AND REPRODUCTIVE HEALTH

- Hx illicit opioid use confers **greater rate of unintended pregnancy**
  - Menstrual abnormalities
  - Low libido
  - Low pregnancy risk perception
  - Unprotected intercourse
  - Sexual assault
- Most present for treatment prior to pregnancy
- May present late to prenatal care due to barriers/stigma
- Routine prenatal care provides **many opportunities for engagement**, education and support

OUD AND REPRODUCTIVE HEALTH

- **Maternal risks**: STIs, violent/illegal activity, mental health disorders, polysubstance use, poor nutrition, reliance on social assistance
- **Fetal risks:** Prenatal opioid exposure associated with preterm birth*, SGA, decreased FHR, minor congenital malformation, FGR**, NOWS and NICU admission, adverse neurodevelopmental outcomes
- **Strongest determinant of risk** for adverse outcomes is IV injection as a route of administration
- **Most harmful consequence** is overdose

*findings are inconsistent

**tobacco as a confounder

RISK FACTORS AND SCREENING

- "*All individuals who are or may become pregnant should be offered regular screening for alcohol, tobacco, and non-medical drug use, and informed about relevant risks and available risk reduction strategies. Screenings should be accompanied by brief support*"

BCCSU, 2018

RISK FACTORS AND SCREENING

- Screen at the 1st prenatal visit and periodically when relevant
- Ascertain concurrent use of psychotropic medications

Risk factors:

- Unemployment
- FHx or personal Hx substance use
- Young age
- Criminal activity/legal problems
- Regular contact with high-risk people or environments
- Heavy tobacco use
- Hx depression, anxiety, PTSD (diagnosed or not)
- Stressful circumstances
- Hx trauma/violence (includes intergenerational)

URINE DRUG TESTING

IWK Health Centre

Clinical Manual
Guideline

TITLE:	Managing Requests for Newborn and/or Parental Drug Screens for Non-Medical Purposes	**NUMBER:**	1335
Sponsor:	Women's & Newborn Health Program	**Page:**	1 of 6
Approved by:	IWK Childbirth Care Team	**Approval Date:** **Effective Date:**	October 23, 2018 July 25, 2019
Applies To:	Physicians, Nurses, Social Workers		

MANAGEMENT

The 4 goals of management:

1. **Establish collaboration and trust**
   - Emphasize no legal obligation to report
2. **Trauma-informed care**
   - Pregnancy is an especially vulnerable time
   - Remember this during procedures, investigations, examinations
   - Recognize fear of apprehension and influence on disclosure
3. **Integrated medical management**
   - Making referrals to address SDOH (with consent!)
   - Assessing motivation and exploring ideas for change
4. **Harm reduction**
   - Education on safer use
   - OAT
   - Take-home naloxone kits
   - Education on safer sex and contraception

MANAGEMENT

- **General prenatal considerations:**
  - Specialist consultation (OB/MFM, anesthesia, addiction medicine, pain team, pediatrics, psychiatry, nutrition, social services)
  - STI testing (chlamydia/gonorrhea) and screening (Hep B and C, HIV, syphilis)
    - Accelerated Hepatitis B vaccine
  - Screening for depression/behavioural health conditions
  - 1st trimester dating ultrasound
  - Growth ultrasound(s) and NST(s)
  - Anticipatory breastfeeding consultation
  - Discussion with pediatrics/OB prior to birth for optimal neonatal management
  - Support/cessation services for other substances
  - Review policies/practices regarding pain management, postpartum care, and infant apprehension

OPIOID AGONIST THERAPY (OAT)

- **Purpose**: prevent withdrawal, reduce cravings and drug-related harms, avoid detoxification
- Should be offered to all pregnant persons with OUD
- Reduces non-medical opioid use and leads to better maternal/neonatal outcomes than withdrawal/untreated OUD
- **Options**:
  - Methadone
  - Buprenorphine/Naloxone (Suboxone)
  - Buprenorphine monotherapy
  - SROM
  - iOAT
  - Naltrexone

Lowest effective dose and individualized titration

Avoid switching if stable on one type

PREGNANCY PHYSIOLOGY

- Greater total body water, blood volume, cardiac output, hepatic blood flow, GFR, decreased plasma protein concentrations, increased hepatic metabolism
- Expect need for dose increases in 2nd and 3rd trimesters due to increased volume of distribution
- Opioids can cross the placenta and increase the risk of developing NOWS
- **Split dosing** can be considered to prevent withdrawal Sx

METHADONE

- Improved neonatal outcomes (longer gestation, higher live birth rates, greater birth weight, early discharge) compared to untreated OUD
- Long-acting nature helps eliminate fetal stress caused by cyclical intoxication/withdrawal
- Use with erythromycin increases methadone levels
- Use with domperidone can prolong QTc

Onset	Peak plasma levels	Half life	Duration	Time to steady state
30 min	2-4 h	22-48 h	24-36 h	5-7 d

METHADONE

- **IWK supply:** 10 mg/mL cherry oral concentrate liquid prefilled syringe
  - Only available during pharmacy hours
- **Patient's supply:** 100 mL juice or tang; typically 1 bottle per dose
  - If cannot tolerate cherry oral concentrate
  - Refusal of IWK supply
  - If pharmacy closed and patient has carries
  - Identified, inspected, controlled by IWK staff and stored in pharmacy
  - Ensure community prescriber aware carries used in hospital

Witness dose and have patient talk or drink water after each dose

BUPRENORPHINE

3 key types: sublingual with/without naloxone and extended release injectable

- Pregnancy no longer a contraindication for Buprenorphine/Naloxone (Suboxone)
- With naloxone is as safe/effective as methadone or buprenorphine monotherapy
- Less preterm labour, greater head circumference and birth weight compared to methadone
- Less likely than methadone to require significant dose changes throughout pregnancy

Onset	Peak plasma levels	Half life	Duration	Time to steady state
30-60 min	90 min	48-72 h	28-37 h	5-10 d

BUPRENORPHINE

Buprenorphine/Naloxone (Suboxone) – Sublingual

- Available via IWK supply or patient carries
- Naloxone is inactive by mouth and used to deter injection
- Dosing based on active buprenorphine component
- **Check dose carefully**

Buprenorphine (Subutex) – Sublingual

- Only available via Health Canada's Special Access Program or patient carries
- IWK Pharmacy must contact community pharmacy to obtain
- Consider switching to Suboxone *at same dose* to avoid delays

SLOW RELEASE ORAL MORPHINE (SROM)

- 3rd line option
- Not well studied with no long-term safety data for neonates/childhood
- Require high doses for stabilization

INJECTABLE OAT

- Diacetylmorphine or hydromorphone
- Used in non-pregnant patients when other methods fail
- Limited evidence for use in pregnancy
- Recommend switching to PO options

NALTREXONE

- Oral opioid antagonist
- Not recommended due to high risk of relapse (must be abstinent before initiation)
- Limits pain management options in labour
- Limited data on breast milk production or breast feeding safety
- Limited data on maternal/neonatal outcomes
- Continue with caution

CHOOSING OAT

Methadone	Buprenorphine/Naloxone
• Potentially better treatment retention • If withdrawal during induction hazardous (i.e. cardiovascular instability, pregnancy) • For difficult to control withdrawal symptoms (no maximum dose)	• Less side effects/drug interactions • Quicker initiation • Flexible dosing • Consider if prolonged QTc • Less risk of harm if diverted

IWK Health

Medication Management Policy / Procedure

TITLE:	Care of Patients on Opioid Agonist Treatment (OAT) [methadone, buPRENorphine/ naloxone (Suboxone®)] for Opioid Use Disorder	NUMBER:	4.07

IWK Health Centre

Opioid Agonist Treatment (OAT) [methadone, buPRENorphine/naloxone (Suboxone®)] for Opioid Use Disorder High Alert

K07002307 Jun/7/2002 M
SCA,TEST Visit
ER0000145/12 **HCN:** 22222222
Van den Hof, TEST / TEST, Maureen
Dec/8/2012

Patient: _____

❑ Alert Record Reviewed ❑ No Allergies Known

For patients requiring OAT while in hospital

IWK POLICY 4.07

General principles from Policy 4.07:

- All residents and staff can Rx OAT (exemption lifted 2018)
- All orders must be written on OAT order form
- Initial Rx or dose changes require consultation with experienced prescribers
- Interdisciplinary approach
- **Closed loop communication & continuity of care**
- Always seek 2 sources to confirm home dosing
- Manage nausea/vomiting and missed dosing carefully

ADMISSION

Patient on OAT before admission:

- Alert community pharmacy of admission
- Complete BPMH using **2 sources***
  - Current dose, last dose, witnessed or not, missed doses, adherence, carries dispensed and remaining, stability of dose (is it being titrated or tapered?)
  - DIS does not accurately reflect date/time of witnessed ingestion
- Complete OAT order form; not repeated if transferred between units

*patient history + community pharmacy or DIS or prescriber or health record

Patien

- IWH
  - M
- IWH

ADDICTION MEDICINE CONSULT SERVICE (AMCS)

Nova Scotia Health - Mental Health and Addictions Program

Addiction Medicine Consult Service (AMCS) provides rapid Addiction Medicine consultant advice to community pharmacists as well as physicians and nurse practitioners working in Mental Health and Addictions (including Correctional Health Services), Primary Care, Emergency Departments, Long Term Care, and Acute Care in Nova Scotia.

AMCS is available Monday to Friday from 8:30 a.m. to 4:30 p.m.

Voicemail only evenings, weekends, and holidays.

AMCS provides verbal evidence-informed clinical advice and guidance to:

- Support clinicians so they can better diagnose and manage substance use disorders.
- Coach clinicians on medication management related to substance use.

Call AMCS toll-free at :

1-855-970-0234

To learn more about our Mental Health and Addictions Program visit:
MHAhelpns.ca

nova scotia health

- **OAT Flow Sheet** has 6 steps from admission to discharge
  - Steps 1-3 done by IWK pharmacist, OB resident/staff, CNS or nurse & faxed to pharmacy
- 1 – identify & contact community pharmacy
- 2 - identify dose information via 2 sources (*must be done before ordering OAT*)
- 3 – identify and contact community prescriber
- 4 – carries
- 5 – dose changes in hospital
- 6 – discharge planning (future visits, notifications of discharge)

IWK Health Centre

Opioid Agonist Treatment (OAT) [methadone, buPRENorphine/naloxone (Suboxone®)] for Opioid Use Disorder High Alert

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Patient: _____

❑ Alert Record Reviewed ❑ No Allergies Known

- **OAT Order Form**
  - For new orders and dose changes
  - Verify home dose and last dose ingestion

Medications (check one of the following):

❑ **Methadone** liquid (Dose in mg) _____ mg PO q _____ h at _____ (times)

❑ **Methadone** liquid (Dose in mg) _____ mg PO at _____ (times) and _____ mg PO at _____ (times)

❑ **buPRENorphine** 8 mg/naloxone 2 mg (Suboxone® or equivalent) _____ tab(s) SL q _____ h at _____ (times)

❑ **buPRENorphine** 2 mg/naloxone 0.5 mg (Suboxone® or equivalent) _____ tab(s) SL q _____ h at _____ (times)

❑ Other _____

- Next dose due: _____ at _____ hours

Physical Symp

MSK pain
Headache
Abdominal cram
Nausea, emesis,

ess

ension

COWS Score for Opiate Withdrawal

Quantifies severity of opiate withdrawal.

When to Use | Pearls/Pitfalls | Why Use

Resting Pulse Rate (BPM) Measure pulse rate after patient is sitting or lying down for 1 minute	≤80	0
	81-100	+1
	101-120	+2
	>120	+4
Sweating Sweating not accounted for by room temperature or patient activity over the last 0.5 hours	No report of chills or flushing	0
	Subjective report of chills or flushing	+1
	Flushed or observable moistness on face	+2

0 points

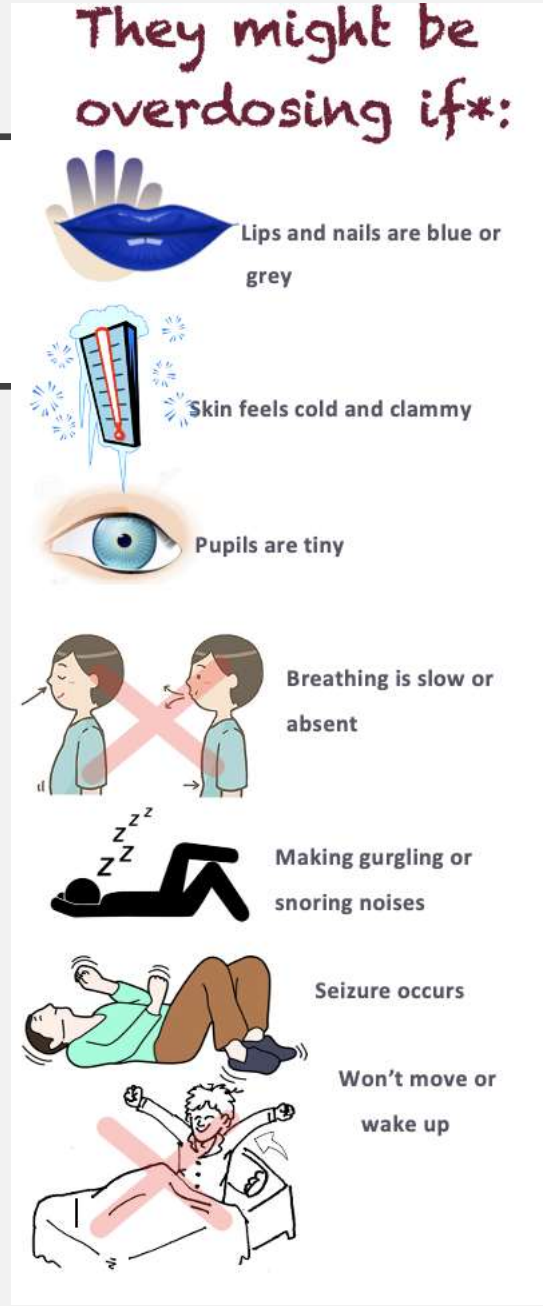
No active withdrawal

MANAGING WITHDRAWAL

Drug	Dose	Target Symptom
Buprenorphine	Initial: 4-8 mg sublingually. Increase by 2-4 mg per day until therapeutic dose (usual range: 8-16 mg) Reduce by 2 mg every 1-3 days if inpatient or every week if outpatient	Most withdrawal symptoms
Methadone	20 mg loading dose, 3 hours after loading dose, add 5 mg q3h until stable, (max 40 mg in 24 hours) Day 3-7, taper to zero	
Clonidine	0.1 – 0.2 mg po BID – TID	Agitation, sweating, increased heart rate and blood pressure
Acetaminophen	1 gram po QID prn	Headache, musculoskeletal pain, other pain
Ibuprofen	200 -600 mg po QID prn	
Loperamide	2 mg po prn (max 12 mg per day)	Diarrhea
Ondansetron	4 mg po q8h prn	Nausea
Trazodone	50 -100 mg po HS prn	Insomnia
Benzodiazepine	At Specialist discretion, risk of respiratory depression and death	Agitation, anxiety

RECOGNIZING OVERDOSE

- **Mental signs:** disorientation, confusion, over sedation
- **Physical signs:** pinpoint pupils, slurred speech, impaired coordination
- OAT Order form states to hold dose and contact prescriber if above
- Use Naloxone
  - **IV/IM:** 0.1 to 0.2 mg; may repeat with escalating doses every 2 to 3 minutes, as prn



MISSED DOSES

MANAGEMENT OF MISSED DOSES
(For patients on maintenance phase of treatment)

METHADONE

Missed doses

- 1 or 2 doses: do not reduce the dose unless there are concerns about loss of tolerance or adverse events
- 3 doses: decrease the dose by 50 per cent
- 4+ doses: decrease the dose to 30 mg or less.

Re-establish a stable methadone dose in cases of several missed doses, as appropriate. This may not be the same as the previous dose.

BUPRENORPHINE

Missed doses[1]

For missed doses with no relapse to full opioid agonist use:

- ≤ 5 days: resume previous dose
- ≥ 6 days: adjust the dose based on the total daily dose and number of missed doses; for example:

Missed days	Dose	Suggested adjustment
≥ 6 days	2 mg/0.5 mg–4 mg/1 mg	No change
≥ 6 days	6 mg/1.5 mg–8 mg/2 mg	Restart at 4 mg/1 mg
6–7 days	> 8 mg/2 mg	Restart at 8 mg/2 mg
> 7 days	> 8 mg/2 mg	Restart at 4 mg/1 mg

- 2 alternate-day doses: suspend bup/nlx until the patient can be reassessed. Then return the patient to a daily dose schedule, possibly at a lowered dose, to restabilize them before resuming an alternate-day schedule.

For missed doses due to relapse or return to full agonist opioid use: advise the patient to stop using bup/nlx until they are ready to resume OAT. Schedule a new induction date and proceed as described in the "Induction phase" section above.

MANAGEMENT OF VOMITED METHADONE DOSES

SITUATION	ACTION
Vomited Dose (including postpartum patients)	• Offer one replacement dose of methadone (no more than 50% of the regular dose) if the patient has emesis that was witnessed by a health care provider and that occurred within 15 minutes of an observed dose. • Any replaced doses require a new physician order
Vomited Dose in Pregnancy	• Risk to the fetus associated with vomited doses is high • Replace 50% of vomited dose if witnessed within 15 minutes of receiving dose. • Consider replacing doses at a maximum of 50% of the full dose should be considered if vomiting occurs within 15 minutes of receiving the dose, even if not witnessed • Where emesis can occur due to pregnancy, consider spreading the dosing over 30 minutes. In addition, if emesis is emerging as a recurrent reason for dose replacement, observation for 15 to 20 minutes after dosing may be warranted. • Any replaced doses require a new physician order

VOMITED DOSES

MANAGEMENT OF VOMITING AFTER BUPRENORPHINE/NALOXONE OR BUPRENORPHINE DOSES

SITUATION	ACTION
Vomited Dose (Including postpartum)	• Vomiting has no impact on buprenorphine or buprenorphine/naloxone doses as they are absorbed sublingually. • No dose replacement required.
Vomited Dose in Pregnancy	• Vomiting has no impact on buprenorphine or buprenorphine/naloxone doses as they are absorbed sublingually. • No dose replacement required.

FETAL HEALTH SURVEILLANCE

"consider the suppression of fetal heart rate due to opioids and reduced variability and accelerations in fetal heart rate at the opioid's biological peak"

No consensus on type or timing of fetal health surveillance in those who use opioids

SOGC, 2023

LABOUR & ACUTE PAIN

- Continue maintenance OAT intrapartum
- OAT is not labour or acute pain analgesia
- Consider hyperalgesia and early epidural
- Optimize non-opioid options
- Expect higher/more frequent dose requirements of short-acting opioid
- Consider high affinity opioids (i.e. dilaudid/fentanyl) if on buprenorphine
- Consider concurrent nicotine use and trauma Hx a risk factor
- Deliver where NOWS treatment available

POST-PARTUM

- Expect dose reductions (often 20% of total daily dose methadone) due to decreased blood volume & metabolism
- Consider discontinuing split dosing
- Discontinuation of OAT is high
- Monitor closely for at least 12 weeks post-partum
- Pain SVD – Tylenol and NSAIDs
- Pain C/S – short course short-acting opioids
- Cannot be made ALC until not requiring additional opioids for pain
- **"Rooming In"** as the standard of care

BREASTFEEDING

- Breastfeeding & Opioids
  - Opioids are not a contraindication; good evidence of safety regardless of dose
  - Monitor neonates for excessive somnolence
  - Protective/minimizes risk of NOWs
  - Promotes skin-to-skin and bonding
  - Avoid if HIV+ or actively using non-medical substances

NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

A cluster of symptoms affecting many systems: nervous, gastrointestinal, respiratory

- Irritability, feeding issues, respiratory problems, seizures, inconsolable, poor feeding, weight loss
- Pathophysiology: ?methylation dysregulation of placental tissue
- 50-80% experience NOWS but most do not require pharmacotherapy
- Might require medication management or extended hospital stay
- Risks to neonate from NOWS/maternal OAT are less than untreated OUD or withdrawal
- Less severe and less common with partial agonist OAT
- Rooming-in, STS, and breast feeding reduce need for pharmacotherapy

NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

Non-pharmacologic Treatment	Pharmacologic Treatment
• Breastfeeding • Minimizing environmental stimuli • Rooming-in • Skin-to-skin • Swaddling	• Buprenorphine • Clonidine • Morphine • Methadone • Phenobarbital

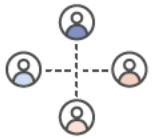
DISCHARGE PLANNING

- Complete discharge section of **Flow Sheet**
- CNS, clinical pharmacist and OB team all made aware of readiness for discharge
- Ensure patient can receive OAT in community by either:
  - continuity of existing Rx with community pharmacy and prescriber
  - Providing bridging Rx via DIS or duplicate form by NSPMP
- **Do not send home/transfer until supply and future appointment with community Rx secured**
- Notify community pharmacy and prescriber of:
  - date/time discharge
  - any dose changes and last dose
  - status of carries (used, returned or destroyed)
- NS Take Home Naloxone Program
- Additional opioid Rx discussed with addictions medicine

TAKE-HOME NALOXONE

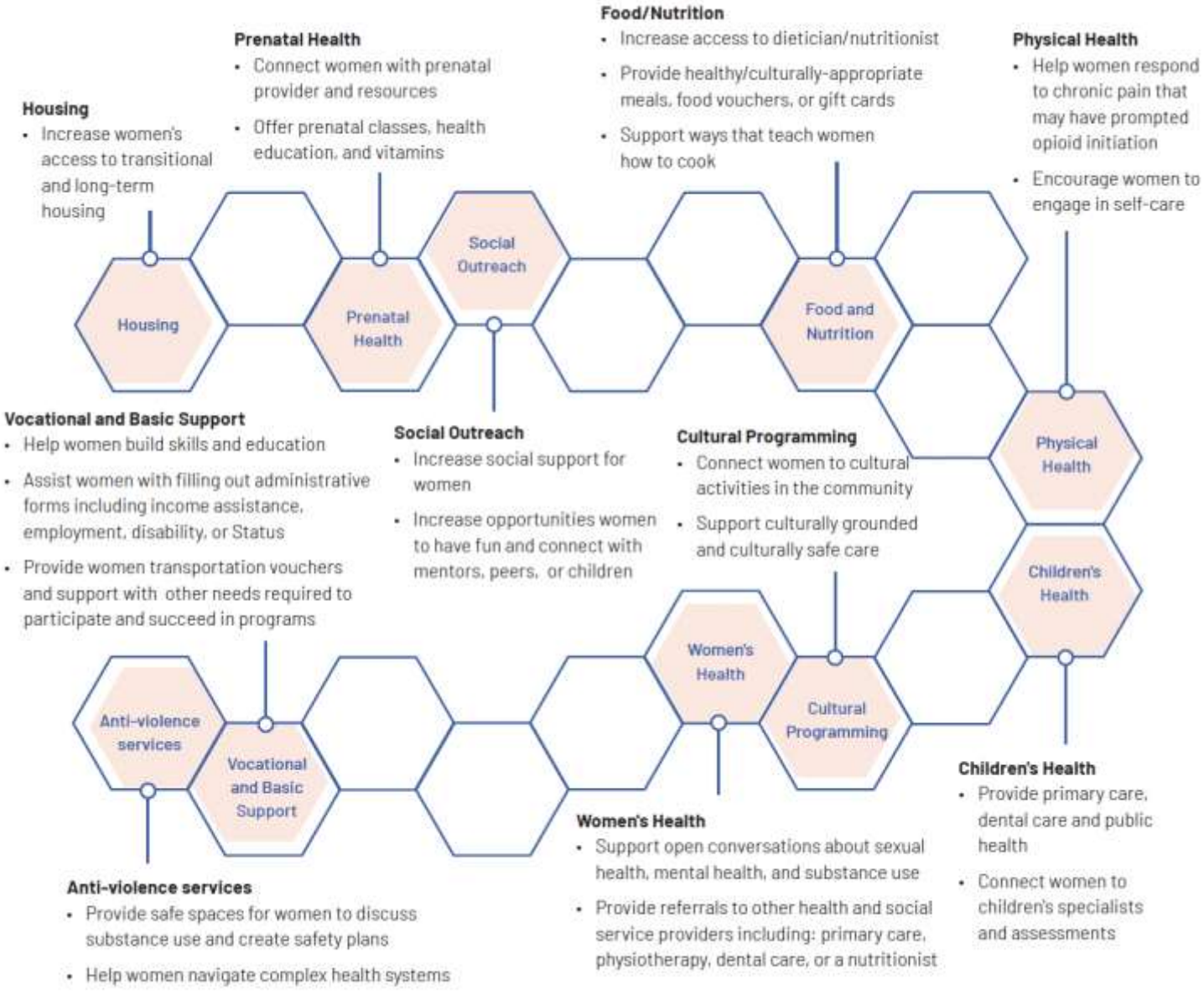
- Overdoses are most common in the 7-12 months post-partum
- Training to distribute take home naloxone, train others, and administer it
- Anyone can get trained on LMS via Pulse
- IWK Policy 4.75 Take Home Naloxone Training and Distribution; Procedure 4.85

BARRIERS

Key Barriers	How can programs address these barriers? (Examples)
 **Stigma** • Prevents women from accessing prenatal care or substance use treatment • Increases surveillance and discrimination from providers	Employ non-judgemental, trauma informed, and harm-reduction oriented approaches
 **Fear of Child Apprehension** • Paralyzes women from seeking substance use treatment • Exacerbates trauma histories • Can increase substance use due to limited healthy coping mechanisms	Engage in early identification and planning during the pregnancy to better support women to ultimately care for their babies or be involved in planning their care
 **Lack of Women and Family Centred Programs** • Prevents women from staying in treatment due to fear of child apprehension or lack of available childcare • Less able to respond to gender-specific issues or concerns	Integrate parenting or opportunities for childminding into existing substance use treatment programs
 **High Expectations on Women** • Increases women's stress to perform as a 'good' mother • Encourages women to meet an unrealistic number of tasks including proof of treatment completion, employment, and of safe housing • Demonstrates lack of coordination when tasks are dictated from multiple sources that may be in conflict	Work with women to identify and prioritize expectations that meet their goals
 **Lack of Coordination** • Limits communication, cross-training, and awareness across substance use and child welfare fields • Forces women to act as intermediaries and having to meet all of the providers' needs	Cross-train child welfare and substance use workers to build an understanding of each other's systems, goals, approaches, and shared interests

Centre of Excellence for Women's Health, 2019

COLLABORATIVE CARE



Centre of Excellence for Women's Health, 2019

TAKE-HOME POINTS

- Prevalence of illicit opioid use is increasing in women/pregnancy
- OAT is recommended for all pregnant women with OUD (commonly methadone or buprenorphine)
- OAT is safe for breastfeeding and reduces risk of NOWS
- The three C's: **C**ontinuity of care, **C**losed loop communication and **C**ollaboration

RESOURCES

- J Obstet Gynaecol Can 2023;45(11):102144
- J Obstet Gynaecol Can 2023;45(11):102143
- Schmidt, R., Wolfson, L., Stinson, J., Poole, N., & Greaves, L. (2019). Mothering and Opioids: Addressing Stigma and Acting Collaboratively. Vancouver, BC: Centre of Excellence for Women's Health.
- British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions, & Perinatal Services BC. A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement. Published June 1, 2018. Available at: http://www.bccsu.ca/care-guidance-publications/
- Care of Patients on Opioid Agonist Treatment (OAT) (methadone, buPRENorphine/naloxone) for Opioid Use Disorder Policy #4.07 (IWK Pulse - OP3)
- Opioid Agonist Treatment (OAT) (methadone, buPRENorphine/naloxone (Suboxone) for Opioid Use Disorder High Alert Clinical Order Set IWK_OAT
- Opioid Agonist Treatment Flow Sheet Form #IWKMEMATH
- Association of Faculties of Medicine of Canada. (2023). *Best Evidence Training for the Next Generation and Practicing Physicians on Pain Management: Chronic Pain, Opioid Use Disorder, and Opioid Use In Women* [Online learning module]. https://www.afmc.ca/opioids/
- Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses. Opioid- and Stimulant-related Harms in Canada. Ottawa: Public Health Agency of Canada; December 2023. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

Maddie Gallant BScN RN PhD(c) & Perinatal Nurse Consultant

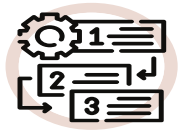
COMPREHENSIVE TOOL KIT FOR INDIVIDUALS ON OAT AND THEIR INFANTS DIAGNOSED WITH NOWS.

The Reproductive Care Program of NS (RCP) is leading the development of a comprehensive tool kit

- This tool kit reflects the best available evidence and reflections of a multidisciplinary team across the province
- The toolkit is also reflective of patient perspectives

COMPREHENSIVE SUMMARY DOCUMENT OF THE EVIDENCE & RECOMMENDATIONS

SUPPORTIVE CLINICAL TOOLKIT: INFOGRAPHICS



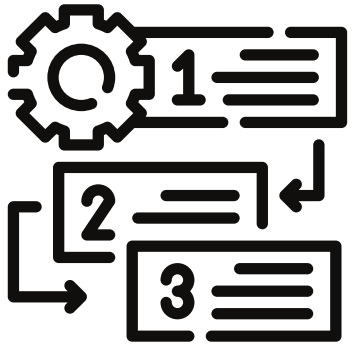
IMPLEMENTATION SUPPORT: EDUCATION MODULES & IMPLEMENTATION PLAN

OBJECTIVES OF THE TOOL KIT:

- To guide the care for pregnant individuals diagnosed with opioid use disorder perinatally.
- To inform care practices and policy development of pregnant individuals diagnosed with OUD in Nova Scotia.
- To develop a standardized approach to care for pregnant individuals diagnosed with OUD in Nova Scotia across the perinatal continuum.

OVERARCHING GOAL: KEEPING FAMILIES AT HOME

1. **Finalizing** comprehensive summary document
2. **Piloting** an implementation plan with South Shore Regional Hospital
3. Fall **Implementation** and dissemination of the tool kit across the province.



WHERE ARE WE NOW?

THANK YOU