NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Section 3: Screening for Substance Use During Pregnancy Using SBIRT as a Framework

Note: This section is designed to be used as a companion to the NNEPQIN guideline: Screening for Alcohol, Tobacco & Drug Use During Pregnancy (link: https://www.nnepqin.org/wp-content/uploads/2018/05/Screening-for-Alcohol-Tobacco-and-Drug-Use-During-Pregnancy_4-1-18.pdf).

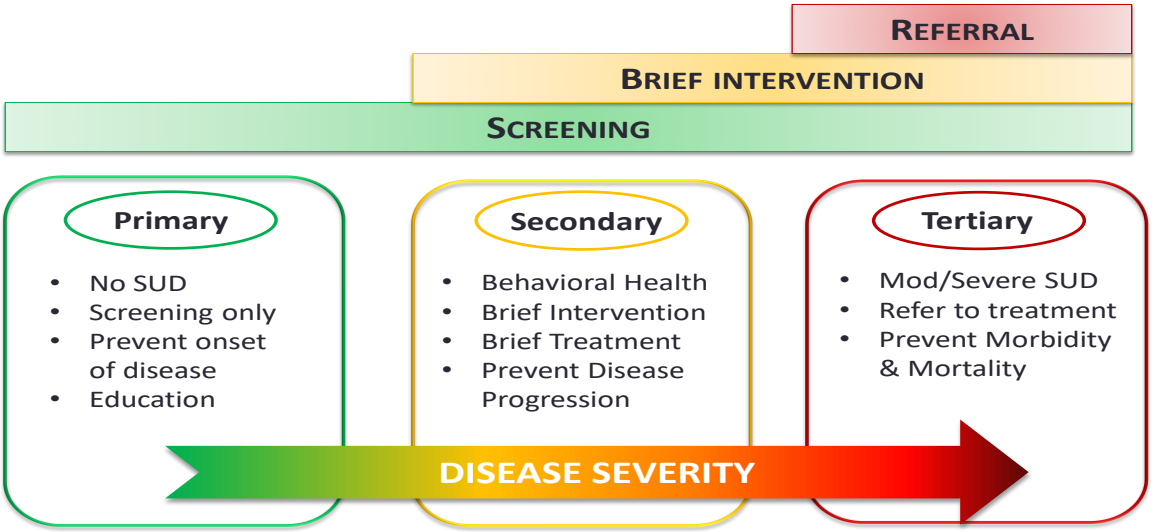
Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and wellbeing of women and their infants. Universal screening for drug and alcohol use is an essential first step in identifying women with harmful substance use or use disorders, and linking them with services at the appropriate level of care (World Health Organization [WHO], 2014; Patrick and Schiff, 2017; American College of Obstetricians and Gynecologists [ACOG], 2017; American Society of Addiction Medicine [ASAM], 2016; American College of Nurse Midwives[ASCNM], 2004). Because women often use more than one substance, screening should always include illicit drug, tobacco, and alcohol use.

Perinatal substance use exists across all sociodemographic groups (National Survey on Drug Use and Health, 2015). NNEPQIN recommends a population based approach, in which all pregnant women are screened at entry to maternity care and again in the third trimester and at delivery. It is the responsibility of all maternity care providers to ensure that women who are at increased risk for perinatal substance use have access to follow up assessment, intervention, and are linked to services. A number of screening tools have been validated for use during pregnancy, among these the Substance Use Risk Profile, AUDIT-C (alcohol only), CRAFFT (for women under age 26), ASSIST, 4 Ps Plus are commonly used (Bush, et al, 1998; Chang, et al 2011; Chasnoff, et al, 2005; Hotham, et al, 2013; Yonkers, et al, 2011).

NNEPQIN recommends universal screening for drug and alcohol use at the initiation of prenatal care, using validated instrument(s) and a screening, brief intervention, referral for treatment (SBIRT) framework (Guidelines for Screening for Alcohol, Tobacco, and Drug Use During Pregnancy, 2017). The aim of population based screening is to identify women engaged in harmful use of drugs or alcohol, to provide support, arrange follow up, and make appropriate referrals as indicated by the level of need.

The SBIRT approach is specifically recommended in *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018).

Universal screening and layered follow-up in the maternity care context



SBIRT resources contained in this chapter:

I. Developing an SBIRT process:
- Overview of process
- Example process map
- Sample patient letter
- Coding and billing tips

II. Screening:
- Example screening tool from NIAAA

III. Brief Intervention:
- BNI ART algorithm
- SBIRT training video

IV. Referral to Treatment:
- Algorithm for choosing level of care
- Template for local resources
- Sample consent forms

I. Developing an SBIRT process in the maternity care context

SBIRT implementation requires modification of existing clinic workflows. Each context is different. We recommend incorporating SBIRT into the existing intake process for new OB patients, which includes screening for other risk medical risks.

Brief description of a typical SBIRT implementation process

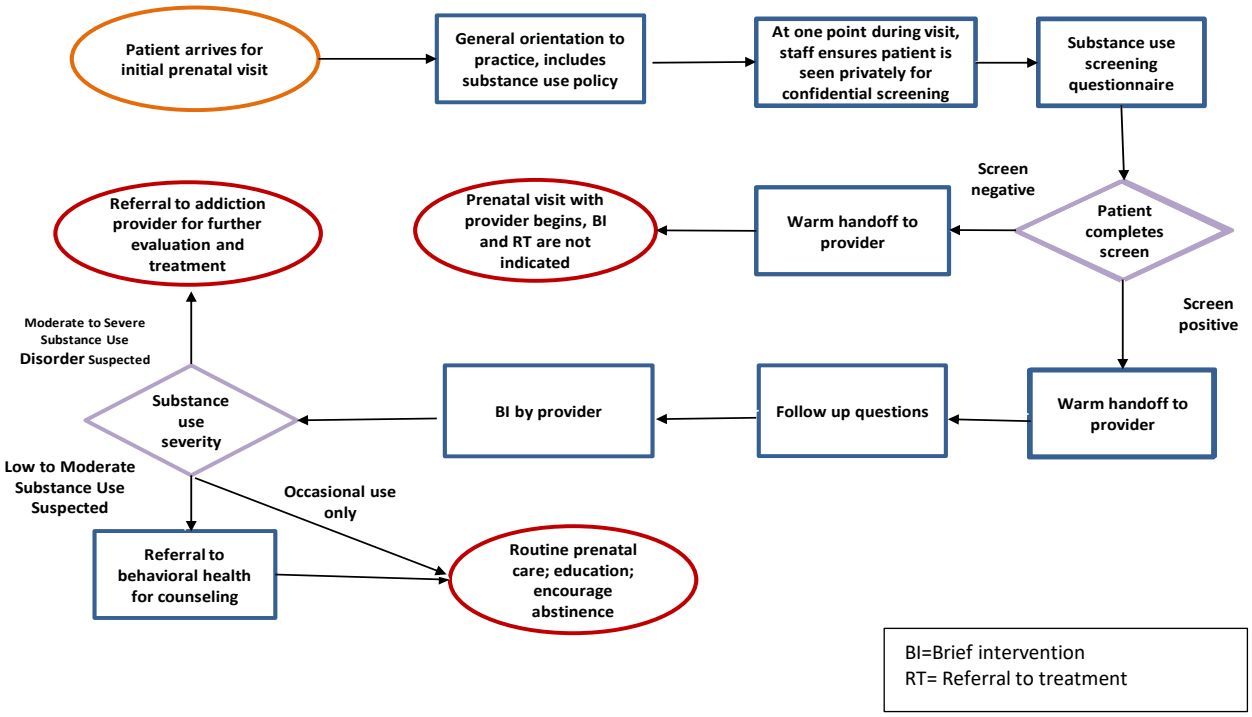
1. **SBIRT Preparation:**
    - Review institutional policies and update as needed to include use of the SBIRT framework for prenatal patients
    - Develop a plan for modifying workflow to incorporate screening
    - Train appropriate staff for screening process
    - Train appropriate staff in brief intervention techniques
    - Identify follow up plan and key personnel when screening is positive
    - Create a list of resources to support women in need of referrals for substance use
    - Identify billing requirements and opportunities
    - Develop patient information script or written materials about substance use screening and institutional policies on substance use
2. **Implementation:**
    - Implement workflow modification to include confidential screening and response
    - Provide information about institutional substance use policy as part of new patient orientation
    - Screen using a validated questionnaire on paper, or the electronic equivalent
    - Ensure a warm handoff occurs from staff performing screening to staff who will address positive screening results
    - Implement Brief Negotiated Interview [BNI] algorithm following positive screening
    - Develop a follow up plan when screening is positive
    - Make referrals if needed
    - Plan follow up at next visit

In the example below, screening is performed by a member of the nursing staff, and brief intervention is performed by an APRN or physician when indicated. This practice has identified both a target addiction treatment program and a behavioral health provider as resources for patients who need help with substance use. These resources may be available inside the practice or may need to be developed externally. *Before implementing SBIRT it is essential to have a plan for referral to treatment when needed.*

Guidance regarding follow up assessment after a pregnant woman disclosures opioid use disorder is discussed in Factsheet 1 of the SAMHSA *Clinical Guidance* document (SAMHSA, 2018, pp 17-24)

An example of a clinic screening process using a validated questionnaire is depicted below. Additional resources for implementing SBIRT into clinical practice workflows is available from the Department of Family Medicine at Oregon Health Sciences University: http://www.sbirtoregon.org/contact-us/

Process Map for SBIRT at Initial OB Visit



SAMPLE PATIENT ORIENTATION LETTER

_____

Congratulations!

Our team looks forward to supporting you through your pregnancy.

An important part of prenatal care is identifying any risks that might exist for you, your pregnancy, or your baby after birth. These might include medical conditions such as diabetes, asthma, depression, or other issues that make it hard to take care of yourself.

Substance use is one concern that could affect the care of you and your baby. Therefore, we ask all of our patients about the use of tobacco, alcohol, or drugs at the first prenatal visit and again in the third trimester.

Facts about substance use during pregnancy:

- Smoking cigarettes and other forms of tobacco may keep oxygen from flowing through the placenta, causing low birth weight and preterm birth
- Alcohol may cause birth defects and problems with brain development, known as “fetal alcohol spectrum disorders”
- Some drugs cause miscarriage, bleeding, or preterm labor
- Other drugs, especially opioids like heroin or oxycodone cause symptoms of withdrawal in newborn babies
- Marijuana may cause problems with learning and depression as children get older
- Drug and alcohol use may affect your ability to care for your new born baby

Federal law requires healthcare providers to report to child protective services when a baby is born affected by drug or alcohol use. Please let us know if you have questions or concerns about any information shared here. If you are a smoker and have been unable to quit, please let us know if you would like a nicotine replacement while you are at our tobacco free campus. We are here to help.

Thank you for choosing to partner with us and including us in your pregnancy journey.

[Your Ob/Gyn Team]

Coding and billing for substance-related services

SBIRT services are reimbursable under the Affordable Care Act. Routine screening using a validated screening tool can be billed as a preventative service. Screening followed by Brief Intervention is billed using the time-based codes described below.

1. **SBIRT**
   - Routine screening without brief intervention: can be performed periodically, must reference use of a validated screening tool.
   - Billing code: 96160
   - If brief intervention is required, may bill for screening and brief intervention as "additional E&M code"
     - if > 15 minute= 99408
     - if > 30 minutes= 99409
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Specify minutes of counseling provided

2. **Tobacco Counseling**
   - Bill as "additional E&M code"
     - If 3-10 minutes= 99406
     - If > 10 minutes= 99407
   - Must be face to face
   - Include sufficient documentation to support time spent; reference the patient's willingness to change, and describe the plan formulated during the discussion
   - Include tobacco-related diagnosis for visit (for example):
     - Tobacco Use Disorder: F17.2

3. **Billing for counseling related to substance use issues for obstetric patients**
   - Counseling must account for > 50% of total visit time
     - D-H requires the number of minutes of counseling be specified
   - Substance-related diagnosis must be included for visit (for example):
     - Tobacco Use Disorder: F17.2
     - Marijuana Use: F12.9
     - Opioid Use Disorder: F11.2
   - If occurring in context of routine OB care, may bill as "additional E&M code"
     - If total visit lasted 10-14 minutes = 99212
     - If total visit lasted 15-24 minutes = 99213
     - If total visit lasted >=25 minutes = 99214

II. SBIRT Process: SCREENING

All pregnant women should be screened using a validated instrument.

- All pregnant women should be informed about the health system's policy on prenatal drug, tobacco, and alcohol use at the first prenatal encounter, as part of their orientation to the practice (see example patient letter)

- Screening for substance use should be conducted while a woman is alone or accompanied only by young children

- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as their reproductive health history, and to safely screen women for domestic violence
    - If a woman cannot be confidentially screened, screening should be deferred

- Timing of screening
    - Screening should be done at initiation of prenatal care, and repeated in the third trimester
    - Screening should also be repeated on admission for delivery

- A number of substance use screening tools have been validated for use during pregnancy. The best tool is the one which is easy to use in a given context

- A positive screen does not equate to a diagnose a substance use disorder, but rather to the need for further exploration about risk of substance exposure during pregnancy

Example screening tool:

Alcohol and Other Drug Screening Questions
NIAAA Guidelines

1) **On average, how many days per week do you drink alcohol (beer, wine, liquor)?**

2) **On a typical day when you drink, how many drinks do you have?**

_____ days per week x ____drinks per day = ____drinks per week

Positive Screen: Above NIAAA Guidelines
>14 drinks/week for men
>7 drinks/week for women or men over 65 years
Any use of alcohol for pregnant women

3) **What is the maximum number of drinks you had in a 2-hour period during the last month?**

Positive Screen: Above NIAAA Guidelines
5+ drinks/2hrs for men
4+ drinks/2hrs for women
>1 drink/day for adults over 65 years
Any use of alcohol for pregnant women

4) **How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?**

https://www.integration.samhsa.gov/clinical-practice/sbirt/Brief-negotiated_interview_and_active_referral_to_treatment.pdf)

III. SBIRT process: BRIEF INTERVENTION

A positive screen indicates the presence of at-risk substance use at some point, but does not necessarily identify current substance use or risk to the mother or fetus. For example, a woman might screen positive for moderate alcohol use prior to pregnancy, but has since discontinued drinking. However, a positive screen should always be followed up with a discussion about current and anticipated future risk.

- Pregnant women who screen positive for prenatal drug or alcohol use should meet with an obstetric provider for brief intervention and a discussion about follow up. When indicated, a referral should be made to the appropriate level of care (see decision tree, below).
- If a woman has discontinued substance use due to pregnancy, brief advice is indicated to congratulate her, and to advise against returning to risky use after the baby is born.
- In providing a brief intervention, providers should strive to use evidence based approaches such as the Brief Negotiated Interview described below, but do not require extensive training in Motivational Interviewing skills.
- The obstetric provider performing the brief intervention will provide information to a woman about and document discussion regarding:
    - Potential harm of identified substance(s) used to the fetus and newborn
    - Discuss specific risks of identified substances used with breastfeeding
    - Explore indication for and acceptance of follow up care, including referral to Behavioral Health or Addiction Medicine specialist
    - Review institutional policy regarding urine toxicology testing during pregnancy and upon admission for labor
    - Review institutional policy regarding collection of urine and/or meconium for drug of abuse screening for the newborn
    - Advise patient regarding Federal and State requirements for mandated reporting and development of a Safe Plan of Care for newborns identified as being affected by maternal substance use
    - Offer referral to case management/social worker if available at institution

ACOG recommends that obstetrical providers learn the skills of brief intervention and active referral to treatment (ACOG, 2008; ACOG, 2017). The Brief Negotiated Interview (BNI) developed by the Boston University School of Public Health is a simple approach designed to help providers quickly explore a patient's motivation to change behavior, while eliciting action steps from the patient: https://www.integration.samhsa.gov/clinical-practice/sbirt/Brief-negotiated_interview_and_active_referral_to_treatment.pdf

Brief Intervention Training Video: A virtual training, including examples of brief interventions for marijuana, alcohol, and opioid use during pregnancy (Acquavita, S.P. & Barker, A. (2017). *Online Module to train healthcare providers in SBIRT with pregnant women* [included with permission]). http://cahsmedia2.uc.edu/host/PregnancyModule/story.html

Brief Negotiated Interview (BNI) during pregnancy: Modified from the BNI-ART Institute by Caitlin Barthelmes, MPH *(Used with permission)*

1) BUILD RAPPORT & BRING IT UP	One health issue we discuss with all pregnant patients is alcohol and drug use. Having an honest conversation about these behaviors helps us provide you and your baby the best possible care. You don't have to answer any questions if you feel uncomfortable. Would it be okay to talk for a minute about alcohol/drugs?
2) PROS AND CONS	People use alcohol and drugs for lots of reasons • Help me understand, through your eyes, what do you like about using [X]? • What do you like less about using [X]? • So, on the one hand [PROS], and on the other hand [CONS].
3) INFORMATION & FEEDBACK Elicit Provide Elicit	I have some information on risks of drinking and drug use during pregnancy. Would you mind if I shared them with you? (Refer to appropriate handouts/ cards as needed) **There is no known amount of alcohol that is safe to drink during pregnancy or when trying to get pregnant.** Drinking anything containing alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorders ("FASDs"), which include physical problems, intellectual and behavioral disabilities. Use of drugs during pregnancy can also increase the risk for other pregnancy complications and health problems for your baby and behavioral and developmental problems in childhood. Use of drugs and alcohol while breastfeeding can also have negative effects on your baby. What are your thoughts on any of that?
4) READINESS RULER Reinforce positives	This Readiness Ruler is like the Pain Scale we use in the hospital. On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any kind of changes in your [X] use? You marked ___. That's great. That means you are ___ % ready to make a change. Why did you choose that number and not a lower one like a 1 or a 2?
5) ACTION PLAN Affirm ideas Write down steps	What are some steps you could take to reduce the things you don't like about using [X]? What ideas do you have to keep you and your baby healthy and safe? Those are great ideas! Is it okay for me to write down your plan, your own **prescription for change,** to keep with you as a reminder? What should I write down on here?
6) SEAL THE DEAL Offer appropriate resources Thank patient	I have some additional resources that people sometimes find helpful; would you like to hear about them? • Introduce the XXX team at _____. Offer a warm handoff if possible. • Offer handouts or brochures as appropriate. Thank you for talking with me today.

IV. SBIRT process: REFERRAL TO TREATMENT

Intensity of use, availability of treatment options, and conflicting responsibilities and preferences are critical factors in determining the appropriate level of care for a pregnant woman in need of treatment for substance use disorders. Most women are highly motivated to seek treatment during pregnancy, and a shared decision making approach is essential to ensure that the treatment plan developed is feasible and acceptable. Maternity care practices should maintain a list of substance use treatment providers who accept a variety of insurance types. A simple algorithm (below) outlines key steps in this discussion. Follow up assessments are listed in the Section 01 of this toolkit. Readers are encouraged to review Factsheet 2 of *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018, pp25-33) for supporting evidence and clinical considerations relevant to this discussion.

Understanding levels of care for the treatment of opioid and other substance use disorders:
Treatment for substance use disorders during pregnancy may occur at different levels of intensity and duration. Access to pregnancy specific treatment varies widely by region. Some programs may not accept pregnant women, and many do not allow children to accompany their mothers.

Office-based treatment

Combines behavioral treatment for substance use with buprenorphine/naloxone or buprenorphine monotherapy. Physicians can complete special training to be eligible for a waiver to prescribe buprenorphine for this purpose. Recent changes in Federal legislation will allow Nurse Practitioners and Physicians Assistants to undergo similar training to obtain a buprenorphine waiver starting in 2017.

Methadone maintenance programs

Combine behavioral treatment with daily observed treatment with methadone. In the United States, methadone can only be provided for the treatment of addiction at Opioid Treatment Programs certified by the Substance Abuse and Mental Health Services Administration.

Intensive outpatient program

Intensive Outpatient Treatment usually consists of 9 hours of treatment for substance use disorders per week, although programs vary. Clients often begin treatment in IOP/IOT programs and graduate to weekly office-based treatment once doing well.

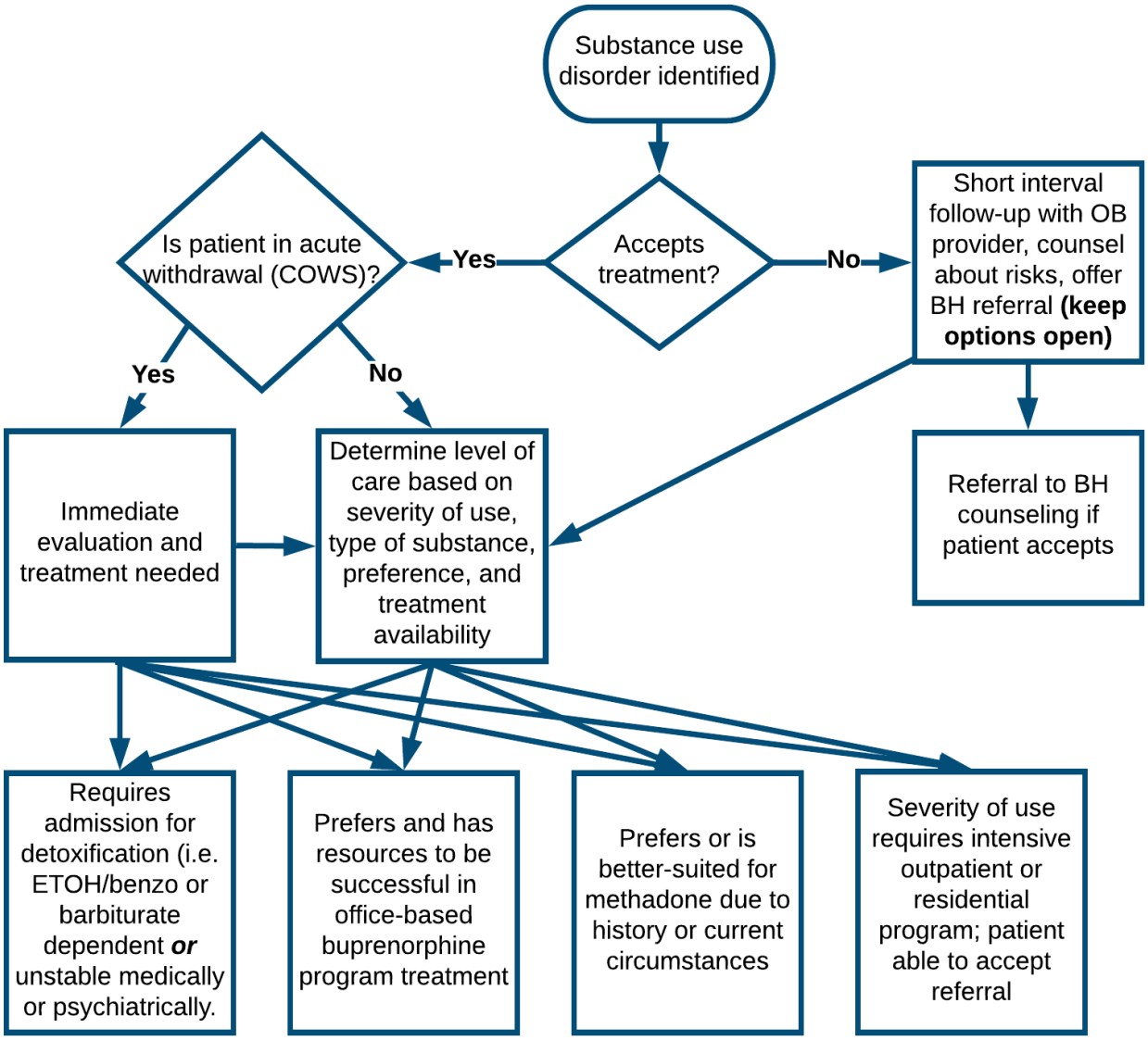
Residential treatment program

Substance use treatment programs which offer daily treatment in a residential setting. Residential programs may or may not be gender-specific. A few residential programs are also equipped to accommodate children whose mothers are seeking treatment.

Additional information about levels of treatment for substance use disorders may be obtained from:

http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

Algorithm for determining appropriate level of substance use care



(BH= Behavioral Health clinician; COWS: Clinical Opioid Withdrawal Scale; CIWA: Clinical Institute Withdrawal Scale for Alcohol)

State Treatment Resources

NH Treatment Locator: http://nhtreatment.org/

VT Treatment locator: http://www.healthvermont.gov/adap/treatment/opioids/index.aspx

ME Treatment locator: http://www.maine.gov/dhhs/samhs/help/index.shtml

Local Treatment Providers:

Office-based Buprenorphine Treatment Programs:

Program Name:

Contact:

Program Name:

Contact:

Program Name:

Contact:

Recovery Coaches:

Program Name:

Contact:

Licensed Alcohol and Drug Counselors (LADC)

Program Name:

Contact:

Narcotics Anonymous:

Methadone Maintenance programs

Program Name:

Contact:

Program Name:

Contact:

Intensive Outpatient Program

Program Name:

Contact:

Program Name:

Contact:

Residential Treatment Program

Program Accepts Pregnant Women

Program Name:

Contact:

Program Accepts Women and Children

Program Name:

Contact:

Consent to share information with Treatment Providers

Once a substance use disorder has been diagnosed and a patient referred or treatment started, consent to share information between members of the care team is essential. Additional federal rules protect the privacy and confidentiality of substance use treatment records.

A summary of these rules and sample consent forms may be accessed from PCSS-MAT and the American Osteopathic Academy of Addiction Medicine:
http://c.ymcdn.com/sites/www.aoaam.org/resource/resmgr/Clinical_Tools/Sample_Consent_for_release_o.pdf

A fillable electronic version of the same form is available through PCSS-MAT:
https://www.pdffiller.com/en/project/88623518.htm?f_hash=f7ab01&reload=true