



A Toolkit for the Perinatal Care of Women with Substance Use Disorders

Developed with funding from the March of Dimes with Support from the Department of Obstetrics and Gynecology at Dartmouth Hitchcock Medical Center and the New Hampshire Charitable Foundation.





The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

A Toolkit for the Perinatal Care of Women with Substance Use Disorders

This toolkit was developed by a multidisciplinary group of obstetric, pediatric, neonatal, and addiction treatment providers and nurses to assist front-line perinatal care providers to improve the quality and safety of care provided to pregnant women with substance use disorders in northern New England. Funding for toolkit development and implementation has been generously provided by the New England Chapter of the March of Dimes and the New Hampshire Charitable Foundation. In 2017, its scope was expanded to include guidelines for screening and care of alcohol use disorders.

This toolkit builds upon the work of many dedicated professionals across the region. It is designed to facilitate best practice based on prior research as well as regional and national guidelines addressing the care of this population. Our aim is to accelerate the application, spread and sustainability of previous work in this area, promote an evidence-based and contextually sensitive approach, and to improve outcomes for both mothers and babies.

Between January 2017 and December 2018, the content of this toolkit is being implemented and tested by a learning collaborative comprised of prenatal care providers in diverse contexts across Maine, New Hampshire, and Vermont. In February, 2018, toolkit content was revised to ensure alignment with recommendations in *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorders and their Infants* released by the federal Substance Use and Mental Health Services Administration (SAMHSA). More information about the work of this collaborative can be found at: www.nnepqin.org.

Feedback, questions, and suggestions are welcome and may be directed to the following individuals:

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Section 1: Best Practice Recommendations for Perinatal Care Complicated by Substance Use Disorders

The following checklist reflects recommendations in the 2018 *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*, available from the Substance Use and Mental Health Services Administrations at:

<https://store.samhsa.gov/product/SMA18-5054>. Providers are encouraged to download and consult the Clinical Guidance document for a more complete discussion of the topics included below.

ANTEPARTUM CARE

1. Screening for substance use in pregnancy

All pregnant people should be screened for drug and alcohol use at the first prenatal visit and subsequently, including patients for whom substance use has already been identified as a concern (World Health Organization [WHO], 2014, Substance Use and Mental Health Services Administration [SAMHSA], 2018). Screening should be done with empathy, using a validated screening instrument (American College of Obstetricians and Gynecologists [ACOG], 2012), and positive screens should be followed up with brief intervention to determine use patterns, motivation, and level of need for substance use treatment services (see NNEPQIN Screening Guidelines, and **Section 03** (Screening for Substance Use in Maternity Care)).

All healthcare professionals providing maternity care should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist patients to obtain further evaluation and/or treatment (ACOG, 2015a; Wright, 2016; Reddy, 2016). Providers caring for women with opioid use disorders (OUD) are referred to Factsheet 1 (p17) of the 2018 SAMHSA guidelines <https://store.samhsa.gov/product/SMA18-5054> for a review of supporting evidence for this approach.

2. Initial encounter after disclosure of probable substance use disorder (SUD), alcohol use disorder (AUD) and/or opioid use disorder (OUD)

If patient is already in treatment for SUD/OUD, obtain written consent for two-way exchange of information with treatment provider for the purpose of care coordination (SAMHSA, 2018).

Education/discussion/referral: Discuss level of care and choice of treatment mode for substance use/opioid use disorder

- Counsel that the recommended management of alcohol use disorder (AUD) during pregnancy is complete abstinence from alcohol, explore options with the pregnant woman, and arrange appropriate referrals as needed
- Counsel that the recommended management of marijuana use during pregnancy is abstinence, and explore options with the woman
 - Assess withdrawal risk according to guidelines (below: facilitating treatment for OUD/facilitating treatment for AUD). Consultation with internal medicine is strongly recommended if risk for alcohol withdrawal is suspected.
- Counsel that the recommended treatment for opioid use disorders during pregnancy is medication assisted treatment with buprenorphine or methadone, explore options with the patient, and arrange appropriate referrals. Discussion should include the following key points:
 - Methadone has been used during pregnancy since the 1970s and is the accepted standard of care, but that buprenorphine has been shown to be a safe and effective alternative (ACOG, 2012)
 - Detoxification from opioids is associated with a high risk of relapse and is therefore not the recommended choice during pregnancy (Jones, 2014)
 - Provide information about neonatal opioid withdrawal syndrome (NAS/NOWS), practice policies regarding antepartum drug testing, maternal and neonatal in-patient drug testing, birth hospital policies, including institutional policy about breastfeeding in the context of a substance use history
- Determine the appropriate level of care based on substances used, use history, available resources, and patient preferences, and facilitate an appropriate referral
- Provide information about federal and state laws regarding mandated reporting of women using substances during pregnancy including the requirement for a Plan of Safe Care at the time of discharge
- Provide education about risks of polysubstance use during pregnancy
 - Counsel regarding the risks of tobacco exposure and offered strategies to help with cessation (ACOG, 2015b)

- Provide education about the risks associated with alcohol and specific types of drug use, including marijuana
- Counsel regarding prevention of hepatitis and HIV
- Counsel about and offer a prescription for a Naloxone rescue kit (Narcan)

Comprehensive Assessment

- Refer to Social Worker, Care Management, and/or appropriate services if available
 - If not available, screen for food and housing insecurity at minimum
 - Use of a validated screening tools is recommended (examples include [PRAPARE](http://www.nachc.org/research-and-data/prapare/) <http://www.nachc.org/research-and-data/prapare/> or the [Hunger Vital Signs](https://www.aap.org/en-us/aap-voices/Pages/Hunger-Screening.aspx) <https://www.aap.org/en-us/aap-voices/Pages/Hunger-Screening.aspx>.)
- Screen for comorbid psychiatric conditions using validated screening tool (**Section 10**)
 - If positive, treat and/or refer to Behavioral Health
- Screen for intimate partner violence using validated screening tool (**Section 11**)
 - If positive, refer to domestic violence advocacy service
- Obtain complete medical history
- Obtain substance use history to help identify an appropriate treatment plan, including type, amount, duration, and time of last use (SAMHSA, 2018).
- Consult Prescription Drug Monitoring database for the appropriate state (SAMHSA, 2018).
- Obtain consent for urine toxicology to determine nature of prenatal exposure (SAMHSA, 2018), including alcohol metabolites.
 - The 2018 SAMHSA *Clinical Guidance* includes the following recommendations regarding consent for urine toxicology testing:

The pregnant woman should be asked to provide informed consent for urine, blood, or saliva screenings for substance use. Although oral informed consent is used in many labor-and-delivery clinics, as signed paper or electronic form is preferred. The healthcare professional should review with the pregnant woman the risks and limitations of each type of test and the need for confirmatory testing for any positive results.... (SAMHSA, 2018, p. 18)

Orders

- Labs: Women with IV use history are often difficult to draw. This should be discussed in advance with the patient, and if possible, an experienced technician should be available. Drawing in the

OB clinic may make the procedure more acceptable to patients. Women initiating treatment may be under physiologic stress and may not be well hydrated. Core labs include:

- HIV
- HBsAg, anti-HBcore, HBsAb: (to verify absence of disease and immunity)
- HCV antibody: if + draw HCV PCR and genotype
- Hepatic Function (LFTs) and serum creatinine
- Consider gamma-glutamyl transferase (GGT) if active alcohol use is suspected (<https://www.mayomedicallaboratories.com/test-catalog/Clinical+and+Interpretive/8677>)
- Consider testing for tuberculosis if history of incarceration, other risk factors, or symptomatic
- Obtain consent for urine drug test with confirmation
- Avoid ondansetron (Zofran) for women treated with methadone, to avoid increasing risk for prolonged QTc interval
- Naloxone Rx and instructions should be offered to all patients with opioid use disorders
- Obtain baseline ECG for patients on methadone if dose \geq 100 mg/day
- Ask about and initiate prophylaxis when indicated for patients with history of deep vein thrombosis. All will need postpartum enoxaparin or warfarin. Some women will need antepartum medication. Consult or refer to Maternal Fetal Medicine or hematology.
- Recommend immunization for hepatitis B if HBsAg, anti-HBcore, HBsAb all negative

Medical referrals/ care coordination

- Referral to substance use treatment: when possible, telephone call/warm handoff to appropriate treatment provider. Give phone number of treatment provider to patient
 - Obtain federally compliant written consent for release of medical information (CFR42 pt2) to allow communication between maternity care and substance use treatment providers
- Ensure patient has appropriate follow up for identified psychiatric needs unless this will be provided by treatment program (section 12)
- Schedule short interval follow up with maternity care provider of choice
- Refer for Cardiology consultation if history of pericarditis
- Refer patient with HIV to infectious disease specialist

- Refer patient with HCV/HBV to infectious disease or gastroenterology/hepatology
 - Ensure notification of pediatric provider for infants exposed to HIV, HCV, HBV
- Refer to dentist: for patients without dental coverage, provide dental education and assist in enrolling in free dental services as available

3. **Ongoing Assessment**

- **Document treatment coordination using toolkit chart template/handoff tool**
- Reassess for and treat opioid side effects (constipation/nausea)
- Repeat screening for changes in social needs
- Ask about cravings, non-prescribed drug, and alcohol use at every visit
- Provide tobacco cessation counseling and offer treatment at every visit for patients who smoke
- Consider reviewing prescription drug monitoring program (PDMP) records if concerns for diversion or multiple prescribers exist

4. **Third trimester**

- Verify medication/dose and treatment status with treatment provider and record on checklist

Additional orders

- U/S for fetal growth at 32 weeks; repeat study at 36 weeks if clinical suspicion for growth restriction (Reddy, 2017)
- Repeat Labs:
 - Urine toxicology with confirmation (**consent required**)
 - HIV if previously negative
 - HCVab, if previously negative
 - HCV viral load if HCVab previously positive AND viral load negative
 - HBsAg if previously negative
 - Syphilis if risk for recent infection (SAMHSA, 2018)
 - Urine GC/CT/Trichomonas if risk for recent infection (SAMHSA, 2018)

Education and discussion

- Delivery plan:

- Ask about status of family support for treatment. If needed, offer assistance talking with family/partner about plan of care. Address concerns about privacy and hospital policies
- Discuss management of neonatal opioid withdrawal after birth. Prepare for 4-7 days of hospitalization recommended for neonate for NAS/NOWS observation, address need for longer stay if pharmacologic treatment for NAS/NOWS is required. For summary guidance for prenatal patient education on NAS/NOWs see Factsheet 7 (p. 53) of SAMHSA's 2018 *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*: <https://store.samhsa.gov/product/SMA18-5054>
- Discuss possibility of infant transfer to a tertiary care center if community hospital not able to medically manage newborn needing treatment for NAS/NOWS
- Arrange hospital tour/meeting with pediatric staff and nursing
- Advise to bring medication to hospital with her for safety and verification

Newborn care

- Provide education regarding safety and recommendations for breastfeeding for women who are HIV negative and not using illicit drugs
- Provide safe sleep/safe newborn care education
- Help identify pediatric provider of choice
- Emphasize importance of regular pediatric follow up after discharge

Pain management

- Review pain management options during labor, including non-pharmacologic measures; epidural/spinal anesthesia and short-acting opioid analgesics (SAMHSA, 2018);
- Consider Anesthesia consultation (SAMHSA, 2018)

Hospital policies

- Hospital policy re: NAS/NOWS assessment and management, especially non-pharmacologic measures such as rooming-in if available
- Breastfeeding policy and support services
- Hospital policies re: maternal and newborn toxicology testing (meconium or umbilical cord segment)
- Federal, state and hospital policies regarding mandated reporting and Plan of Safe Care

Care Coordination

- Review requirements specific to Plan of Safe Care
- Assist patient identify pediatric provider to discuss NAS management and neonatal follow up
- Ensure patient has seen a Social Worker/Care Management at least once during pregnancy
- Recommend and refer to home visiting services if accepted
- Repeat screening for food and housing insecurity
- Remind patient on buprenorphine to bring medication with her for safe storage and dose verification
- Verify dose with methadone prescriber

Contraceptive counseling

- Discuss intention regarding repeat pregnancy and preference for pregnancy spacing
- Explore contraceptive preferences: offer post-placental IUD insertion if available at institution, or etonogestrel implant or medroxyprogesterone injection prior to discharge or 2-6 weeks postpartum (SAMHSA, 2018)
- If tubal ligation is desired, ensure consent is signed at appropriate interval to comply with applicable federal requirements

INTRAPARTUM CARE

Maternity care providers should be aware of the particular issues of concern to women with substance use disorders at the time of delivery. Women should be offered information and reassurance about adequate pain management, IV access, management of neonatal abstinence syndrome, and state and hospital policies regarding mandated reporting. Caregivers should be guided by awareness that both childbirth and hospitalization are potentially re-traumatizing for women with trauma history.

- General
 - Address concerns about pain management promptly and ensure timely re-assessment
 - Provide continuity of care providers whenever possible
 - Maintain strict confidentiality during any discussion of NAS/substance use disorder
 - Promote transparency about Child Protective Service involvement
- Screen for illicit drug and alcohol use
 - Consider interview-based or electronic self-screening using validated instrument (see NNEPQIN guideline)
 - Urine drug test with confirmation (consent required)

- Standard admission orders:
 - Confirm MAT medication/dose; maintain dose/frequency throughout hospitalization
 - Nicotine replacement if needed
 - Labs: Repeat HIV/HCV antibody if not obtained in third trimester
 - Obtain verbal or written consent for urine toxicology
 - Notify attending pediatric provider
 - Refer to Social Worker/Care Management to discuss mandated reporting
 - Lactation consultation if available
 - Anesthesia consultation
- Pain management:
 - A shared decision making approach is essential as many women experience anxiety about adequate pain management, or fear treatment with opioids will challenge recovery
 - **Nalbuphine and butorphanol are contraindicated** for patients with opioid dependence as they can precipitate withdrawal
 - Epidural/spinal analgesia is recommended and most effective for labor pain. Solutions with higher concentrations of local anesthetic and less reliance on short acting opioid may be more effective due to cross tolerance (Reddy et al, 2017)
 - Fentanyl IV, titrated to effect, may be used for analgesia if patient declines epidural
 - Non-pharmacologic methods should be optimized with/without pharmacologic agents
 - Maintenance medication does not treat pain (SAMHSA, 2018)
 - Cross-tolerance [methadone] and partial blockade [buprenorphine] can increase dose needed for effective analgesia; a multimodal approach is therefore most effective
 - 50% higher dose may be needed for oral agonists to achieve adequate postoperative pain relief (Meyer, 2010; Jones, 2014)
 - Consider PCA or epidural for post-operative pain if oral medication is not adequate
 - Avoid acetaminophen in patients with hepatic damage
 - Anticipate that IV access may be difficult, consider PICC or central line if unable to achieve
 - If history of deep vein thrombosis, initiate anticoagulation postpartum as indicated (see above)

Discharge plan

- Work with patient and multidisciplinary team to complete a Plan of Safe Care as required by institutional and state policies (Section 13)
- If treatment of postoperative pain with opioids is required at discharge, prescribe only the quantity likely to be used, maximizing NSAIDs and nonpharmacologic measures (Reddy, et al, 2017).
- Copy medication administration record to give patient *and* fax to treatment provider
- Ensure plan for postpartum MAT is in place (if applicable) and patient has transportation to next scheduled treatment appointment
- Monitor women on methadone for increased somnolence, and contact treatment provider if dose decrease seems indicated. Risk for sedation is highest several hours after dosing, increasing risk for infant falls especially in the early postpartum period when women are frequently sleep deprived. This should be discussed with the woman's treatment provider. Additional guidance regarding adjusting pharmacotherapy can be found in Factsheet 14 (p. 113) of *Clinical Guidance for Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018): <https://store.samhsa.gov/product/SMA18-5054>
- Explore pregnancy intention, desired pregnancy spacing, and contraceptive preference. Offer post-placental long acting reversible contraception (LARC) if available at institution, or etonogestrel implant or medroxyprogesterone injection prior to discharge.
- Schedule for postpartum visits at 1-2, 4 and 6 weeks prior to discharge, verify contact numbers for communication about these appointments
- Refer to public health nursing or other home visiting services, coordinate with pediatric follow up schedule

POSTPARTUM CARE

- Consider scheduling at 1-2, 4, and 6 weeks postpartum to screen for depression, encourage family planning, and monitor for relapse
 - Screen for onset of postpartum depression at 2, 4, and 6 week visits
 - Refer/treat as needed
- Repeat intimate partner violence screening at 6 weeks and any time concern exists
- Provide breastfeeding support as needed

- Ask about pregnancy intention, provide contraception as needed/desired
- Reinforce smoking cessation to prevent relapse; or continue cessation counseling if still smoking
- Reinforce safe infant care practices, including safe sleep
- Communicate with treatment provider at 6 weeks to ensure patient has continuing care.
Providers of maternity care should consider continuing supportive services for longer than 6 weeks post-delivery, to avoid loss of continuity for a woman (SAMHSA, 2018).
- Assess resource needs at each visit and coordinate with case worker/social service providers
- Assist patient to follow up on referrals to public health nursing and other services
- Assist patient to schedule follow up for infectious disease management (HCV/HBV/HIV)
- Facilitate transition to a recovery-friendly primary care practice if not already established
- The postpartum period is one in which women are particularly vulnerable to relapse to opioids, other drugs, or alcohol. Collaboration between prenatal care providers, pediatricians, mental health and substance use treatment providers as outlined in the 2016 SAMHSA recommendations: *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders* (2016) can facilitate early identification of the need for additional support. Members of a woman’s healthcare team should request her written consent to communicate with each other to coordinate care (SAMHSA, 2016; see also SAMHSA, 2018, Factsheet 16 [p. 119-122]).

Element	Date	Comments
Federal consent to share information with treatment provider		
HIV status		
HBsAg, HBcAb, HBsAb		
Hepatitis C antibody		
HCV viral load and genotype (if indicated)		
Hepatic Function Panel		
Serum Creatinine		
Institutional drug testing policy reviewed		
Plan of Safe Care introduced		
Behavioral Health		
Needs assessment / Care Management referral		
Risks of non-prescribed drugs and alcohol discussed		
Marijuana counseling		
Tobacco counseling/treatment		
Narcan discussed /offered		
Third Trimester		
Repeat HIV, HBsAg, HCVAb GC/CT		
Ultrasound (growth/fluid)		
Urine toxicology with confirmation, (consent required)		
Ethyl glucuronide/ethyl sulfate (alcohol metabolites)		
Third trimester education		
Review Plan of Safe Care		
Review institutional drug testing policy		
NAS/newborn care		
Breastfeeding		
Pain management		
Family Planning		
Pediatrician identified		
OTHER		

Section 2: Facilitating Treatment for Opioid Use Disorders

SCREENING AND DIAGNOSIS OF OPIOID USE DISORDER

1. Screening for substance use in pregnancy

All pregnant women should be screened for drug and alcohol use at the first prenatal visit and subsequently (WHO, 2013). Screening should be done with a validated screening instrument (ACOG, 2012), and positive screens should be followed up with brief intervention to determine a woman’s use pattern, motivation, and level of need for substance use treatment services (SAMHSA, 2018).

All healthcare professionals should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist women to obtain further evaluation and/or treatment.

2. Criteria for a presumed diagnosis of Opioid Use Disorder

- Definition of Opioid Use Disorder: “A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.” (DSM-V)
- The following criteria are used to diagnose Opioid Use Disorder:

DSM-V Diagnostic Criteria	Present/date	Comments	
1. Opioids are often taken in larger amounts or over a longer period than was intended.			
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.			
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.			
4. Craving, or a strong desire or urge to use opioids.			
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.			
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.			

7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.			
8. Recurrent opioid use in situations in which it is physically hazardous.			
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.			
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount. (This may also be true for those taking prescribed opioids, in which case this should not be considered diagnostic of opioid use disorder)			
11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal). b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms (see above – this may also hold true for those taking prescribed opioids).			

- The severity of Opioid Use Disorder can be estimated from this table, using the levels described below:
 - Mild: Presence of 2–3 symptoms**
 - Moderate: Presence of 4–5 symptoms**
 - Severe: Presence of 6 or more symptoms**
- The clinical opioid withdrawal scale (COWS) may be used to measure severity of symptoms in patients who present in acute withdrawal from opioids. A copy of the COWS checklist can be downloaded here: <http://pcssmat.org/wp-content/uploads/2015/03/Clinical-Opiate-Withdrawal-Scale.pdf>

3. Levels of care for the treatment of Opioid Use Disorders

Pharmacotherapy for OUD is strongly recommended during pregnancy, due to high rates of relapse and poor outcomes when pharmacotherapy is *not* used (SAMHSA, 2018).

However, the decision to enter treatment for opioid use disorder is not an easy one for pregnant and parenting women, due to stigma and other potential consequences of disclosure. The 2018 SAMHSA *Clinical Guidance* states that “Pregnant women should receive counseling and education on the medical and social consequences of pharmacotherapy for OUD,” noting that “owing to differing state, county, and local laws and regulations, there is no universal approach to assessing the social and legal consequences of legitimate pharmacotherapy for OUD or other substance use during pregnancy” (SAMHSA, 2018, p. 17). Providers counseling women about options should be knowledgeable about the regulatory environment in which their patients live.

Supporting evidence and expert clinical guidance for initiating and managing pharmacotherapy for OUD during pregnancy can be found in Factsheets 2-4 of *Clinical Guidance for Treatment of Pregnant and Parenting Women with Opioid Use Disorder and Their Infants* (SAMHSA, 2018, pp 25-41).

Treatment for opioid use disorders during pregnancy may occur at several levels of intensity and duration described below. 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 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 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

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 opioid use disorders may be obtained from:

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

<https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone>

<https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>

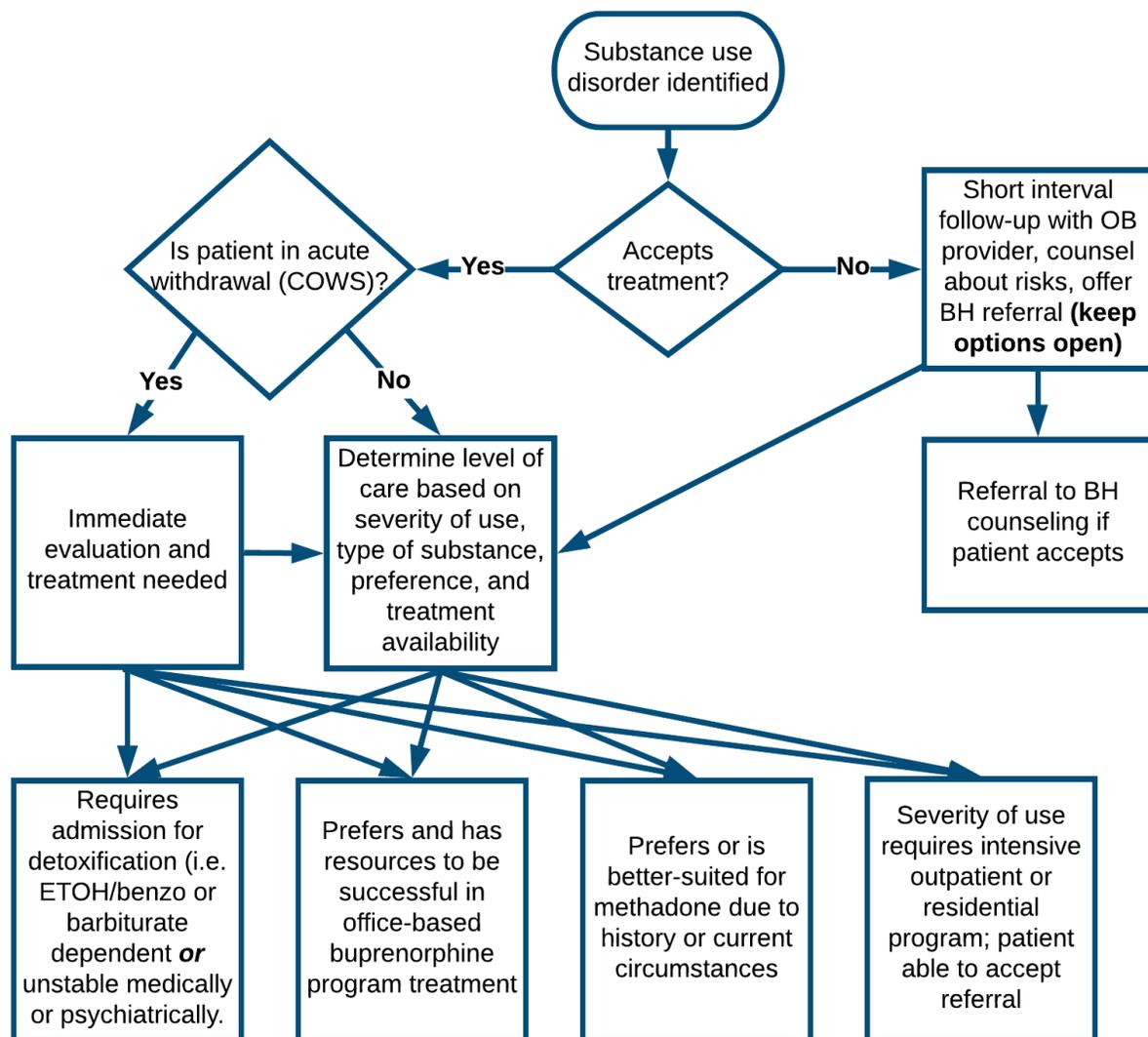
Pocket Summary of Medication Assisted Treatment for Opioid Use Disorders for Healthcare Providers

<http://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf>

4. Choosing the right level of care

The severity of a woman’s use, availability of treatment, resources, and a woman’s conflicting responsibilities and preferences are all factors which will determine the appropriate level of care for a pregnant woman in need of treatment for opioid use disorder. A shared decision making approach will improve the likelihood that the treatment plan will be acceptable to a woman (Friedrichs, et al, 2015; SAMHSA, 2018; WHO, 2014). Providers should be sensitive to the prevalence of trauma history among women with substance use disorders, which may influence what feels safe for a woman (Poole and Greaves, 2012). Most women are highly motivated to seek treatment during pregnancy (Boyd and Marcellus, 2009). The following simple algorithm outlines several key steps in this discussion.

Figure 1. Algorithm for discussing levels of care during pregnancy (BH= Behavioral Health clinician)



5. Consent to share information with Treatment Providers

Once OUD 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 a sample consent form 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

Additional Resources for Providers

The Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) is a national training and mentoring project for the education of medical professionals about opioid use disorders and pharmacotherapies to address them, developed in collaboration with leading Addiction Medicine organizations and the American Psychiatric Association. "The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, substance use disorder treatment, and pain management settings." (<http://pcssmat.org>)

Resources and trainings are free of charge, and available through the PCSS-MAT website

<http://pcssmat.org/education-training/>

General Information about Opioid Use and Pregnancy for Patients

Opioid use and pregnancy

http://pcssmat.org/wp-content/uploads/2013/10/WAGBrochure-Opioid-Pregnancy_Final.pdf

Opioid use, labor, and childbirth

http://pcssmat.org/wp-content/uploads/2013/10/ASAM-WAGBrochure-Opioid-Labor_Final.pdf

Facilitating Access to Naloxone (NARCAN)

Patients who are at risk of overdose, or have family or community members at risk, should have access to and carry Naloxone for the reversal of opioid overdose.

State supported access to Naloxone in New Hampshire

- Access to Naloxone in NH:
<http://anyoneanytimenh.org/naloxone-in-new-hampshire/>
- NH Pharmacies with standing orders in place for Naloxone:
https://www.google.com/maps/d/viewer?mid=1wtF40V57_WsFO9WQFvg9PPYI9w&ll=43.54134739609208%2C-71.50058845136721&z=9
- General information about Naloxone in NH:
<http://anyoneanytimenh.org/>

State supported access to Naloxone in Vermont

- Access to Naloxone in VT:
<http://www.healthvermont.gov/response/alcohol-drugs/narcan-naloxone-overdose-rescue>
<http://healthvermont.gov/adap/treatment/naloxone/#pilots>

How to use Naloxone

- How to use a Naloxone overdose kit- short video from Maine General Medical Center:
<https://www.youtube.com/watch?v=NLo25AQNyeM&feature=youtu.be>
- Frequently asked questions about opioid addiction and naloxone
<http://anyoneanytimenh.org/wp-content/uploads/2016/10/FAQ-opioid-naloxone-rack-card.pdf>
- What to do in the event of an overdose (in English and Spanish)
http://www.healthvermont.gov/sites/default/files/documents/2017/01/RESP_Narcan_HowToGiveBrochure2016.pdf

Resources for Providers:

- General information about Naloxone: <http://www.getnaloxonenow.org/>
- Health Professionals Toolkit for expanding access to Naloxone- available from the Substance Abuse and Mental Health Services Administration (SAMHSA):
https://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf

Sample Naloxone prescription:

Patient Name: _____	
Address: _____	

Rx	Naloxone Nasal Spray 4 mg/1mL # <u>2</u>
	Administer x 1 intranasally
	Repeat in alternate nostril if no response
	after 2-3 minutes
Do Not Refill _____	_____ (Signature)
Refill <u>2</u> Times	D.E.A. Number _____
Date _____	Print Last Name _____

Summary of the Rule (Title 42 CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records)

Generally, a program may disclose any information about a patient if the patient authorizes the disclosure by signing a valid consent form (§ 2.31, 2.33). A consent form under the Federal regulations is much more detailed than a general medical release. It must contain all of the following nine elements. If the form is missing even one of these elements, it is not valid:

1. The name of the patient.
2. The name or general designation of the program making the disclosure.
3. The recipient of the information.
 - Although the recipient should not be as general as an entire agency or department, it need not be as specific as the name of an individual. Instead, the consent form may describe the recipient's job title and/or job functions
 - It is permissible to list more than one recipient on a single consent form and to authorize disclosures between and among all the parties listed. When doing such multiple-party consents, however, it is important that the "information" and "purpose" and all other elements of the form (see below) be the same for all of the authorized disclosures.
4. The purpose of the disclosure. The purpose should be narrowly described and should correspond with the information to be released. The purpose should never be as broad as "for all client care."
5. The information to be released. The information should be described as exactly and narrowly as possible in light of the purpose of the release. Releases for "any and all pertinent information" are not valid.
6. That the patient understands that he or she may revoke the consent at any time - orally or in writing- except to the extent that action has been taken in reliance on it.
 - A consent for a patient referred by the criminal justice system, however, may be made irrevocable for a period of time (§ 2.35). (But note that some State statutes and regulations provide for the automatic expiration of such consents after 60 or 90 days.)
 - When a patient revokes a consent form, the program is advised to note the date of the revocation clearly on the consent form and to draw an X through the form.
7. The date or condition upon which the consent expires, if it has not been revoked earlier. Although the Federal regulations do not provide for any time limit on the validity of a consent form, some State laws provide for the automatic expiration of consents after a certain period of time.
8. The date the consent form is signed.

Summary of the Rule (Title 42CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records) Con't

9. The signature of the patient.
 - If the patient has died, the executor or administrator of the estate, or if there is none, the spouse or, if none, then any responsible member of the patient's family may sign (§ 2.15(b)(2))
 - No consent is needed to disclose information relating to the cause of death to such agencies which are empowered to collect vital statistics or inquire into causes of death (§ 2.15(b)(1))
 - If the patient is an adjudicated incompetent, a guardian or other person authorized by State law to act on the patient's behalf may sign (§ 2.15(a)(1))
 - If the patient is a minor, the patient generally must sign the consent form - even if the disclosure is to the minor's parent.

For example, if State law requires a program to obtain a parent's consent in order to treat a minor, the minor must sign a consent form authorizing the disclosure to the parent (§ 2.14(b)-(c)). The only exception is for minors who are applying for alcohol and other drug services and yet lack the capacity to make a rational decision about whether to sign a consent form authorizing a disclosure that the program director determines is necessary to reduce a threat to the life or physical well-being of the applicant or anyone else (§ 2.14(d)).

In addition to the minor's signature, the parent's or other legal guardian's signature is only required if State law requires parental authorization for treating a minor. If the State permits the minor to be treated without the legal guardian's authorization, the minor's signature alone may authorize a disclosure (§ 2.14(b)-(c)).

- A client should never sign or be requested to sign a consent form before all of the blanks have been filled in.
- If any changes are made to a consent form after a client signs it, the client should initial the changes when they are made to indicate that the patient understands and agrees to the changes.

Whenever a disclosure is made pursuant to a consent, it must be accompanied by a written notice prohibiting redisclosure (§ 2.32). The written statement, which can be in the form of a separate sheet of paper or a rubber stamp on the disclosed document, warns the recipient that the information disclosed is protected by Federal law and may not be redisclosed except with the patient's consent or under other authorization. The language in the warning must be identical to that set forth in § 2.32 of the regulations. The prohibition on redisclosure notice must be sent to the recipient even if the disclosure was made orally.

Copies of all consent forms should be kept in the patient's file.

Sample informed consent forms for the disclosure of program participant confidential

information:

Sample consent forms #1 and #2 can be utilized as a guide for grantee programs to either request program participant confidential information from other sources (i.e., other treatment facilities) or release program participant confidential information to other sources.

Sample Form #1

PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, Jane Doe, authorize
(NAME OF PATIENT)

ABC Treatment Program
(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to: Mary Roe or another TANIFF counselor
(NAME OF PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

the following information:
my attendance and compliance in substance abuse treatment
(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:
Assist the Hill Co. Dept of Welfare to determine my eligibility for benefits and/or to evaluate my readiness/ability to participate in a training program.
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

XX/XX/2003 or upon program discharge
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

(Date) (Print Name) (Signature of Participant)

(Date) (Print Name) (Signature of Parent, Guardian or Authorized Rep. when required)

Sample Form #2

MULTIPARTY CONSENT FORM FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, Jane Doe, authorize
(NAME OF PATIENT)

ABC Treatment Program
(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to:

- 1.
- 2.
3. _____
(NAME OF PERSONS OR ORGANIZATIONS TO WHICH DISCLOSURE IS TO BE MADE)

the following information:
my attendance and compliance in substance abuse treatment
(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:
Assist the Hill Co. Dept of Welfare to determine my eligibility for benefits and/or to evaluate my readiness/ability to participate in a training program
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

XX/XX/2003 or upon program discharge
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

(Date) (Print Name) (Signature of Participant)

(Date) (Print Name) (Signature of Parent, Guardian or Authorized Rep. when required)

Notice to accompany release of confidential information consent form. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

State and Local 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:



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](https://www.nnepqin.org/wp-content/uploads/2018/05/Screening-for-Alcohol-Tobacco-and-Drug-Use-During-Pregnancy_4-1-18.pdf) (link: https://www.nnepqin.org/wp-content/uploads/2018/05/Screening-for-Alcohol-Tobacco-and-Drug-Use-During-Pregnancy_4-1-18.pdf).

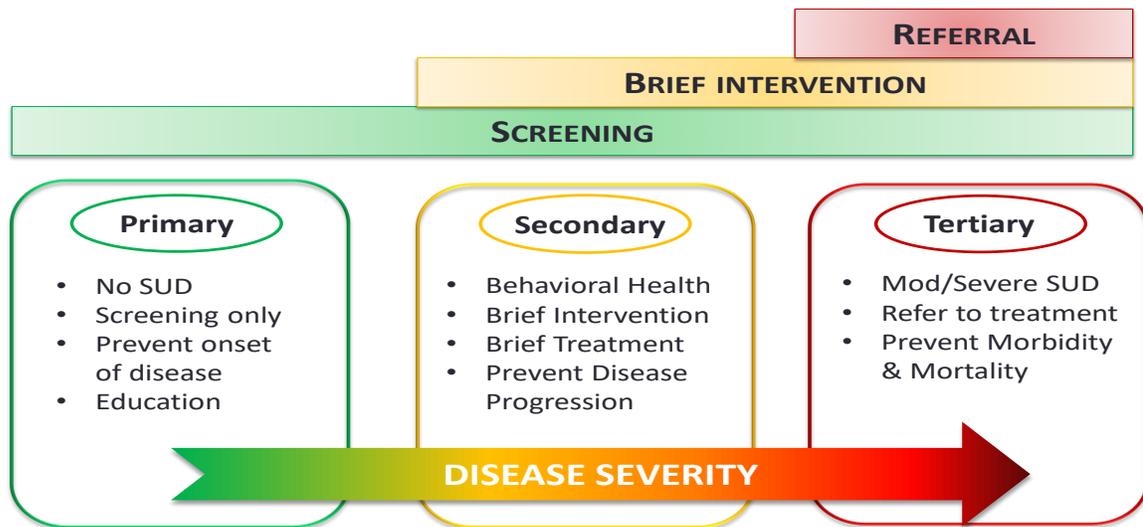
Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and wellbeing of women and their infants. Universal screening for drug and alcohol use is an essential first step in identifying women with harmful 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[ACNM], 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:

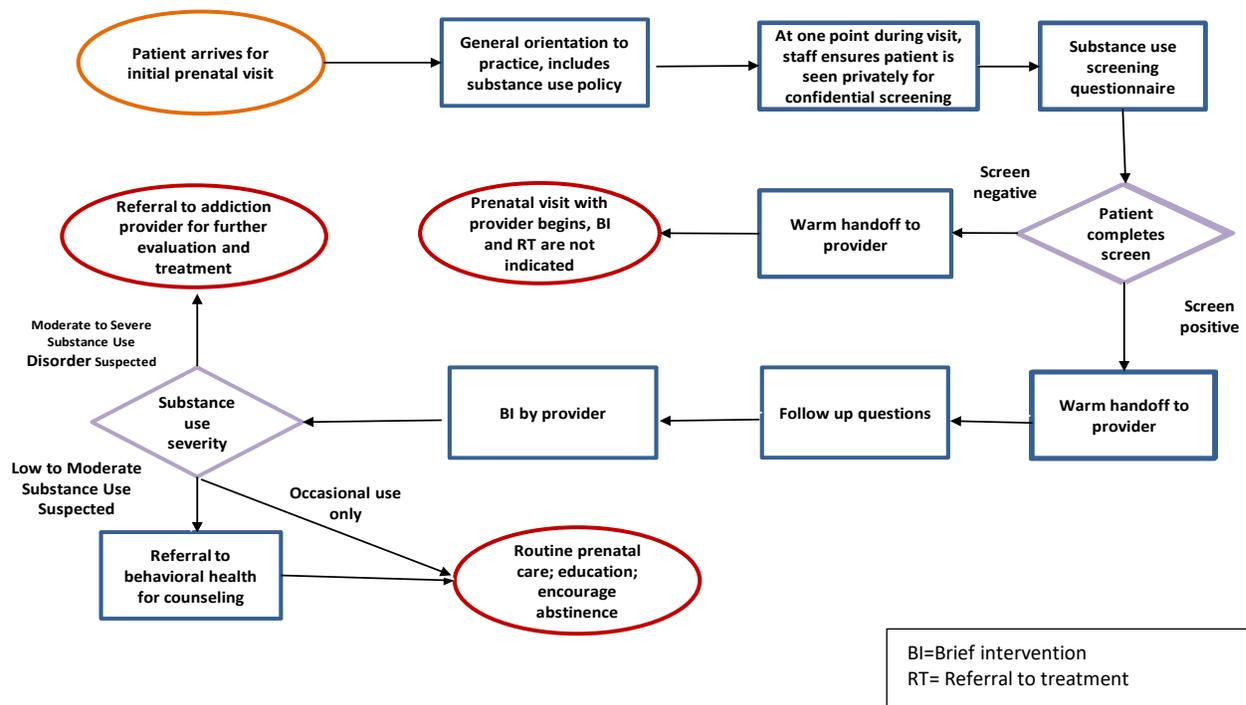
- Implement workflow modification to include confidential screening and response
- Provide information about institutional substance use policy as part of new patient orientation
- Screen using a validated questionnaire on paper, or the electronic equivalent
- Ensure a warm handoff occurs from staff 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 discloses 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 \geq 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)

<p>1) BUILD RAPPORT & BRING IT UP</p>	<p>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?</p>
<p>2) PROS AND CONS</p>	<p>People use alcohol and drugs for lots of reasons</p> <ul style="list-style-type: none"> • 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].
<p>3) INFORMATION & FEEDBACK</p> <p>Elicit</p> <p>Provide</p> <p>Elicit</p>	<p>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)</p> <p>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.</p> <p>What are your thoughts on any of that?</p>
<p>4) READINESS RULER</p> <p>Reinforce positives</p>	<p>This Readiness Ruler is like the Pain Scale we use in the hospital.</p> <p>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?</p> <p>You marked _____. That's great. That means you are _____% ready to make a change.</p> <p>Why did you choose that number and not a lower one like a 1 or a 2?</p>
<p>5) ACTION PLAN</p> <p>Affirm ideas</p> <p>Write down steps</p>	<p>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?</p> <p>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?</p> <p>What should I write down on here?</p>
<p>6) SEAL THE DEAL</p> <p>Offer appropriate resources</p> <p>Thank patient</p>	<p>I have some additional resources that people sometimes find helpful; would you like to hear about them?</p> <ul style="list-style-type: none"> • Introduce the XXX team at _____. Offer a warm handoff if possible. • Offer handouts or brochures as appropriate. <p>Thank you for talking with me today.</p>

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.

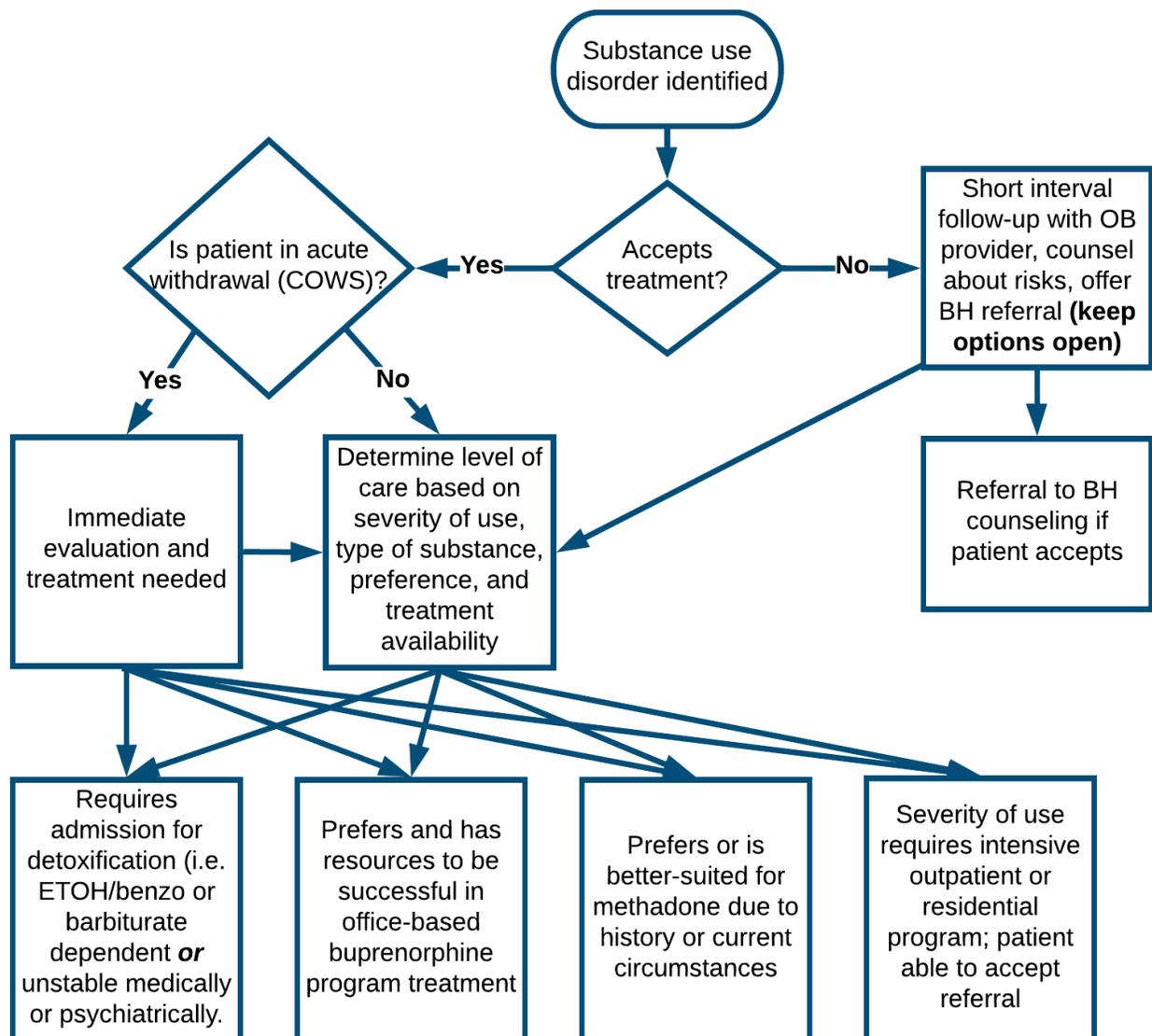
Residential treatment program

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

Section 4: Strategies for Treating Concurrent Tobacco Use Disorder

TREATING CONCURRENT TOBACCO USE DISORDER

- Nicotine readily crosses the placenta, and concentrates in fetal blood, amniotic fluid, and breast milk. Concentrations in the fetus can be as much as 15 percent higher than maternal levels (NIDA, 2012)
- Growth restriction seen in infants of mothers who smoke reflect a dose-dependent relationship—the more the woman smokes during pregnancy, the greater the reduction of infant birthweight (NIDA, 2012)
- Tobacco use is associated with greater impact on birthweight than illicit drug use (Bailey, et al 2012)
- Among women with opioid use disorders, over 90% smoke (Winklbauer, 2008)
- Concurrent tobacco and opioid use is associated with earlier onset and increased severity of neonatal abstinence symptoms
- **Research shows that treating tobacco use does not have a negative impact on recovery** (Reid, et al, 2008)
- **When smoking cessation interventions are provided during addiction treatment, the likelihood of long term recovery is increased by 25%** (Prochaska, 2004)

Strategies for Providers

Pregnant women who smoke should be asked about their tobacco use at each prenatal visit and assisted to quit by providers. Women who are considering quitting should be referred to the tobacco helpline in their home state.

A simple approach may be used to address smoking during pregnancy:

- **ASK** every patient at each encounter about tobacco use and document status
- **ASSIST** every tobacco user to quit with a clear, strong personalized message about the benefits of quitting

- **REFER** patients who are ready to quit tobacco within the next 30 days to the appropriate Tobacco Helpline

Tools

- Quick Reference for tobacco counseling from Centers for Disease Control:
<https://www.cdc.gov/tobacco/campaign/tips/partners/health/materials/twyd-5a-2a-tobacco-intervention-pocket-card.pdf>
- New Hampshire QUITnow (services provided include phone counseling and nicotine replacement during pregnancy if prescribed):
 - For providers: <http://quitnownh.org/for-providers/>
 - For patients: <https://quitnownh.org/category/i-want-to-quit/>
- Vermont 802quits (includes incentives for each counseling all attended, phone counseling; nicotine replacement with Rx during pregnancy):
 - For providers: <http://802quits.org/providers/>
 - For patients: <http://802quits.org/quit-help-by-phone/baby/>

Additional Patient Resources

- Impact of tobacco on women’s reproductive health: http://quitnownh.org/wp-content/uploads/2016/05/fs_womens_health.pdf
- Impact of tobacco on the baby: http://quitnownh.org/wp-content/uploads/2016/05/fs_shsBaby.pdf
- Mobile text message support for quitting smoking during pregnancy:
<https://www.smokefree.gov/smokefreemom>
- General mobile text message pregnancy education and support: <https://text4baby.org/>
- Patient fact sheet from American College of Nurse Midwives (ACNM):
<http://ourmomentoftruth.com/your-health/smoking-womens-health-learn-the-facts/>
- Smoking during pregnancy fact sheet from March of Dimes:
<http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>

Additional Provider Resources

- **Strategies for treating tobacco use for patients with other addictive disorders:**
 - Mary Brunette, MD, Medical Director, Bureau of Behavioral Health, NH Department of Health & Human Services speaks about common myths about treating tobacco in the context of other addictive disorders <https://youtu.be/kOqwF4JkXK4>

- **Information on prenatal tobacco risk:**
 - From the Centers for Disease Control (CDC):
https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/
 - From the National Institute on Drug Abuse (NIDA):
<https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/what-are-risks-smoking-during-pregnancy>
 - From the American College of Nurse Midwives (ACNM):
<http://www.ourmomentoftruth.com/Smoking-and-Womens-Health>
 - American College of Obstetricians and Gynecologists Committee Opinion on Tobacco Use and Women’s Health: <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Tobacco-Use-and-Womens-Health>

- **No-cost virtual provider training on best practice for smoking cessation:**
 - [“Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic”](#)
Sponsored by the CDC’s Division of Reproductive Health, this continuing education offering allows providers to learn and practice evidence-based interventions for smoking cessation during and after pregnancy. Included is a free, online training module on e-cigarettes and pregnancy. Additional learning tools include interactive case simulations, mini-lectures from leading experts, interviews with real patients who have quit, and a variety of online office resources. *This training is eligible for continuing medical education credit, AMCB CEUs for Nurse-Midwives, and for Maintenance of Certification credit for OB/GYN physicians.*

Other Useful Resources

- CDC tobacco intervention pocket card:
<https://www.cdc.gov/tobacco/campaign/tips/partners/health/materials/twyd-5a-2a-tobacco-intervention-pocket-card.pdf>
- EPA community action toolkit: https://www.epa.gov/sites/production/files/2014-08/documents/community_action_kit.pdf
- NH Quitworks fact sheet on smoking and women’s health: http://quitnownh.org/wp-content/uploads/2016/05/fs_womens_health.pdf
- NH Quitworks fact sheet on second hand smoke: http://quitnownh.org/wp-content/uploads/2016/05/fs_shsBaby.pdf

- Patient education fact sheet from American College of Nurse Midwives (ACNM):
<http://www.ourmomentoftruth.com/Smoking-and-Womens-Health>
- Smoking during pregnancy fact sheet from March of Dimes:
<http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>
- Smoking cessation strategies for providers from National Institute on Drug Abuse:
<https://www.drugabuse.gov/publications/research-reports/tobacco/smoking-pregnancy%E2%80%94what-are-risks>
- EPA “smoke free home pledge” for families:
https://www.epa.gov/sites/production/files/2015-09/documents/certificate_en.pdf

Section 5: Facilitating Treatment for Alcohol Use and Use Disorders

Alcohol use during pregnancy is the leading cause of preventable birth defects in the United States. Despite this, more than 10% of pregnant women ages 18-44 report alcohol use, and at least 3% report binge drinking (defined as more than 3 drinks at one time) during the past month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013; SAMHSA, 2014). Because alcohol metabolites are not included in most standard urine toxicology tests, alcohol is sometimes also used without being detected by women who are in treatment for other substance use.

Alcohol is a teratogen, and its use during pregnancy is associated with fetal alcohol spectrum disorders (FASD), a term which includes a range of alcohol related effects on the brain, heart, and central nervous system, resulting in characteristic facial features, cardiac anomalies, and impaired growth, through more subtle learning, communication, and behavior problems. The most severe form of FASD, Fetal Alcohol Syndrome (FAS), is associated with higher doses of prenatal alcohol exposure, and includes the presence of congenital anomalies and lifelong neurodevelopmental impairment (Popova, et al 2017). As many as 5% of children in the United States may be affected by FASD (March of Dimes, 2017). The prevalence of the more severe manifestation of prenatal alcohol exposure, FAS, is thought to impact between 30-39 per 10,000 individuals in the United States (Popova, et al, 2017).

There is no safe amount of alcohol use during pregnancy, and no safe period for exposure. However, the effects of alcohol on the fetus are dependent on the timing, frequency and amount of exposure (Association of Reproductive Health Professionals [ARHP], 2015). Therefore, although the goal of prenatal intervention for alcohol use must be complete abstinence, reducing use is preferable to continuing at the same level (ARHP, 2015). Because alcohol use is so harmful to fetal growth and development, screening, early identification and intervention is critical. Women who cannot stop drinking alcohol should be referred for specialty care for substance use.

In *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*, SAMHSA endorses parallel management of alcohol withdrawal during pregnancy with that of the non-pregnant patient. Behavioral health interventions and peer support are

the most widely used approaches for nonpregnant patients but must be used in conjunction with pharmacologic management of withdrawal when that is indicated (SAMHSA, 2018). Evidence is extremely limited regarding the safety of pharmacologic agents (disulfiram, naltrexone, acamprosate, or gabapentin) for the long term treatment of alcohol use disorder during pregnancy (SAMHSA, 2018).

Many women discontinue alcohol use during pregnancy, but resume postpartum, often with similar harmful use patterns. Therefore, a history of moderate to heavy pre-pregnancy use requires brief intervention and education *even when women are not drinking during pregnancy*. Alcohol also transfers readily into breastmilk. Levels in breastmilk parallel maternal serum levels, with peak levels at 30-60 minutes, or longer if taken with food (Academy for Breastfeeding Medicine, 2015; LactMed, 2017). Alcohol suppresses milk ejection, and nursing after use can decrease the quantity of milk the infant receives. Although occasional use is not considered harmful, the impact of daily alcohol use, especially at moderate to heavy levels (>1 drink/day) is not well understood, but may impact sleep and early psychomotor development. Based on the pharmacokinetics of alcohol, women who wish to avoid alcohol exposure for their infants should delay breastfeeding until 2-2.5 hours after drinking 1 standard drink, increasing the time before resuming breastfeeding by the same amount for each additional drink (LactMed, 2017).

Screening and Diagnosis of Alcohol Use and Use Disorder

1. Screening for alcohol use in pregnancy

All pregnant women should be screened for drug and alcohol use at the first prenatal visit and subsequently (WHO, 2014). Screening should utilize a validated screening instrument (ACOG, 2012) and positive screens followed by brief interventions to determine a woman's use pattern, motivation, and level of need for alcohol treatment services.

All healthcare professionals should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist women to obtain further evaluation and/or treatment. Providers should be sensitive to the prevalence of trauma history, particularly childhood sexual and physical abuse among women with alcohol use disorders.

Screening using a validated screening instrument (examples below), followed by a respectful conversation is the optimal approach to identify harmful alcohol use prior to and during pregnancy. Alcohol use is rarely detected in standard urine toxicology tests. The AUDIT-C, TWEAK and T-ACE are

brief alcohol screening tools validated for use with pregnant women, and the ASSIST, 4Ps Plus and Substance Use Screening Tool are valid screening tools for both alcohol and drug use during pregnancy (WHO, 2014).

2. Criteria for a presumed diagnosis of alcohol use disorder

- DSM-V Definition of Alcohol Use Disorder:
 “A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.” (American Psychiatric Association, 2013)
- The following checklist can be used to determine whether diagnostic criteria are present for Alcohol Use Disorder:

DSM-5 Diagnostic Criteria	Present	Comments	
1. Alcohol is often taken in larger amounts or over a longer period than was intended.			
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.			
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.			
4. Craving, or a strong desire or urge to use alcohol.			
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.			

<p>6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.</p>			
<p>7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.</p>			
<p>8. Recurrent alcohol use in situations in which it is physically hazardous.</p> <p><i>[For example: this criterion would be fulfilled if a woman regularly operated a motor vehicle while intoxicated]</i></p>			
<p>9. Continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.</p> <p><i>[For example: this criterion would be fulfilled if a woman is aware of the teratogenic effects of alcohol and continues to drink]</i></p>			
<p>10. Tolerance, as defined by either of the following:</p> <p>a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.</p> <p>b. A markedly diminished effect with continued use of the same amount of alcohol</p> <p><i>[Note that a person can have an alcohol use disorder even in the absence of tolerance or withdrawal symptoms]</i></p>			

<p>11. Withdrawal, as manifested by either of the following:</p> <p>a. The characteristic alcohol withdrawal syndrome.</p> <p>b. Alcohol (or a closely related substance such as benzodiazepines) is taken to relieve or avoid withdrawal symptoms.</p>			
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- The severity of Alcohol Use Disorder can be estimated from this table, using the levels described below:

Mild (ICD-10 CM code F10.10): Presence of 2–3 symptoms

Moderate (ICD-10 CM code F10.20): Presence of 4–5 symptoms

Severe (ICD-10 CM code F10.20): Presence of 6 or more symptoms

3. Toxicology tests for alcohol

The standard rapid test for alcohol intoxication is the breathalyzer, which detects the presence of ethanol. Most health care settings do not utilize this technology. Urine can be tested for the presence of two alcohol metabolites, ethyl glucuronide and ethyl sulfate, which can detect alcohol use for several days after its complete elimination from the body (detection window from 30-110 hours, based on quantity of use (Helander, et al, 2009; Wurst, et al, 2003)

Gamma-glutamyl transferase is often used as a screening serum test for heavy alcohol use although it can be elevated with other forms of liver damage (<https://www.mayomedicallaboratories.com/test-catalog/Clinical+and+Interpretive/8677>).

4. Alcohol Withdrawal

The majority of pregnant women who use alcohol are not physiologically dependent, meaning that they may not experience tolerance or withdrawal. However, physiologic dependence and subsequent withdrawal from alcohol can result from heavy and prolonged alcohol use. Withdrawal symptoms usually occur within several hours to a few days after cessation or significant reduction of alcohol use

(American Psychiatric Association,2013). **Unlike opioid withdrawal, alcohol withdrawal can be fatal if untreated.** SAMHSA's *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* endorses use of the same management approach for alcohol withdrawal during pregnancy as for the non-pregnant patient (SAMHSA, 2018)

Characteristic symptoms of alcohol withdrawal* include:

- Autonomic hyperactivity (sweating, pulse < 100 bpm)
- Hand tremor
- Insomnia
- Nausea/vomiting
- Transient visual, tactile, or auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Generalized tonic-clonic seizures
- May include confusion or delirium (Delirium Tremens or "DTs")

*symptoms of benzodiazepine withdrawal may be very similar to alcohol withdrawal

The Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) or other similar standardized assessments are used to assess the severity of alcohol withdrawal. Scores <10 on the CIWA do not generally require medication to prevent escalation. If alcohol withdrawal is suspected in a pregnant or postpartum patient, immediate consultation and stabilization is required. The CIWA-Ar can be accessed from: <https://www.merckmanuals.com/medical-calculators/CIWA.htm>

Benzodiazepines can and should be used for the treatment of alcohol withdrawal during pregnancy, as the risks of untreated alcohol withdrawal exceed the risks of short term use of benzodiazepines.

5. Levels of Care for the treatment of Alcohol Use Disorders

The National Institute for Alcohol Abuse and Alcoholism maintains a treatment navigator to assist patients in finding the right level of treatment near their home communities:

<https://alcoholtreatment.niaaa.nih.gov/>

Treatment for alcohol use disorders during pregnancy may require varying levels of intensity and duration. If physiologic dependence and risk for withdrawal is suspected, acute hospitalization with addiction medicine, psychiatric, and/or maternal-fetal medicine consultation is necessary.

Residential Treatment Programs

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. Access to gender-specific residential programs varies widely by region. Many programs may not accept pregnant women, and many do not allow children to accompany their mothers.

Intensive Outpatient Programs

Intensive Outpatient Treatment usually consists of 9 hours of treatment for substance use disorders split between 3 days per week, although programs vary.

Mutual Aid Groups

Alcoholics Anonymous (AA) and other 12-step programs provide peer support for people who wish to decrease or stop alcohol use. Twelve step programs, in combination with treatment by health professionals, are very effective in helping to maintain day to day sobriety. Many people utilize mutual aid groups as their main recovery support for alcohol use disorders.

Medication Assisted Treatment for Alcohol Use Disorders

Medication assisted treatment for alcohol use disorders includes three medications approved by the U.S. Food and Drug Administration: acamprosate, disulfiram, and naltrexone. *None of these medications are currently recommended for use in pregnancy;* however, there is emerging evidence supporting the safety of naltrexone for the treatment of *opioid* use disorder during pregnancy, which may support its use for perinatal alcohol use in the future (see Jones, et al, 2013). The use of benzodiazepines as “maintenance treatment” for alcohol use disorders is not supported by evidence and is not recommended.

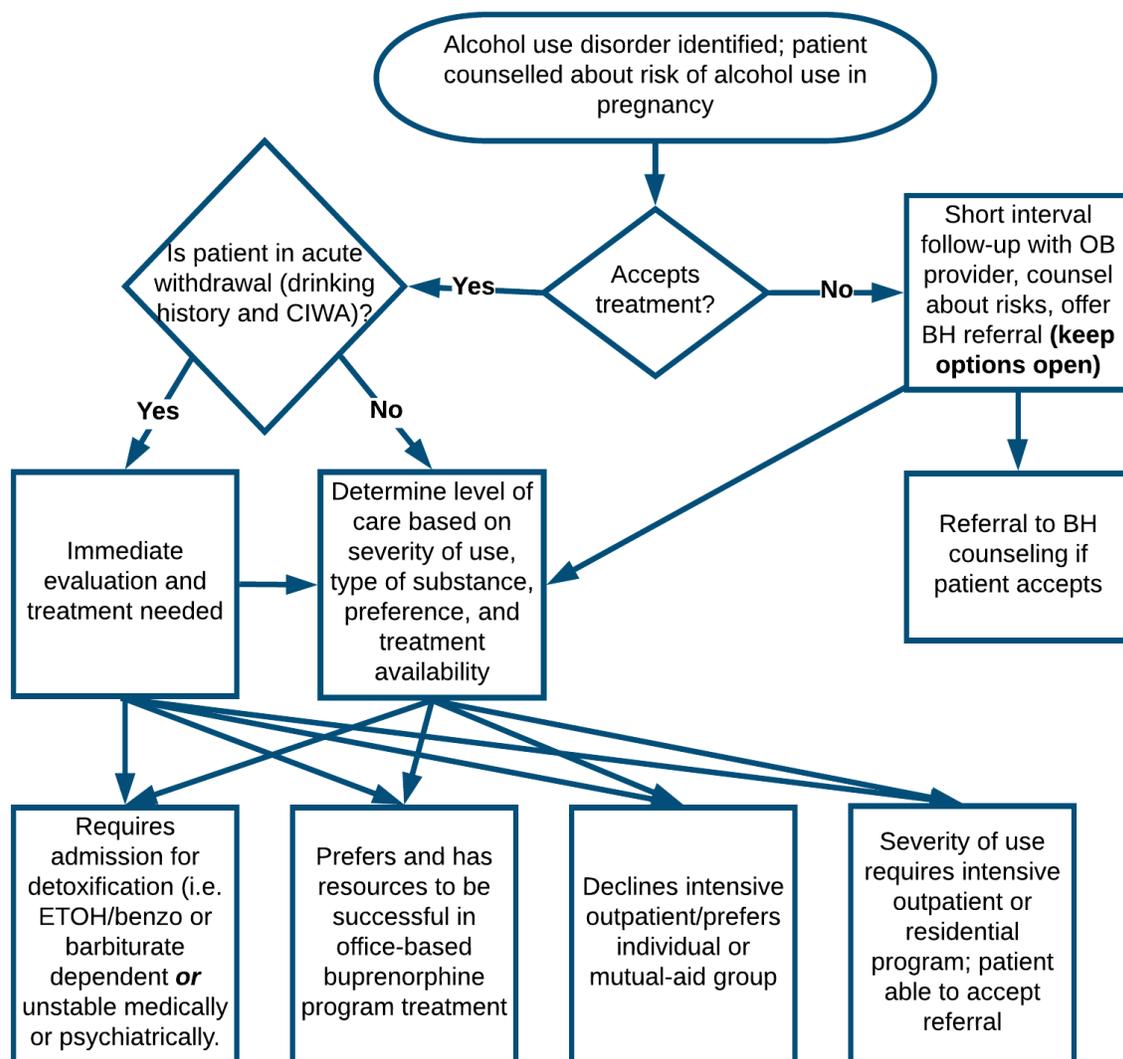
Additional information about levels of treatment for alcohol use disorders may be obtained from:

<https://pubs.niaaa.nih.gov/publications/Treatment/treatment.htm#chapter04>

6. Choosing the right level of care

Severity of use, presence or absence of physiologic dependence, availability of treatment, financial resources, health insurance status, conflicting responsibilities and personal preference are all factors which will inform the level of care chosen by a pregnant woman in need of treatment for alcohol use disorder. Most women are highly motivated to seek treatment during pregnancy, and a shared decision making approach is appropriate to facilitate engagement. The following simple algorithm outlines several key steps in this discussion.

Algorithm for discussing levels of care during pregnancy (BH= Behavioral Health clinician)



Additional Provider Resources about prenatal alcohol use and FASD

Substance Abuse and Mental Health Services Administration: Treatment Improvement Protocols

- Addressing Fetal Alcohol Spectrum Disorders (FASD). Accessed from: <https://store.samhsa.gov/shin/content//SMA13-4803/SMA13-4803.pdf>
- National Organization on Fetal Alcohol Syndrome: <https://www.nofas.org/>
- Public awareness fact sheet on FAS from NOFAS: https://www.nofas.org/wp-content/uploads/2014/08/Fact-sheet-what-everyone-should-know_old_chart-new-chart1.pdf

The Arc: Fetal Alcohol Spectrum Disorders Prevention Project:

- Provider training opportunities on FASD
<http://www.thearc.org/FASD-Prevention-Project/training/webinar-archive>
- Summary of current knowledge about the impact of alcohol use during pregnancy:
<http://www.thearc.org/document.doc?id=5011>
- Association of Reproductive Health Professionals: Fetal Alcohol Spectrum Disorders Consensus Meeting, Meeting Report 2015: <http://www.thearc.org/file/FASD-Consensus-Meeting-Report---FINAL-VERSION.pdf>
- Evidence-based “Choices” curriculum for FASD prevention: **free from CDC**:
<https://www.cdc.gov/ncbddd/fasd/documents/facilitatorguide.pdf>

Additional Patient Resources about prenatal alcohol use and FASD

Centers for Disease Control information and infographics:

- <https://www.cdc.gov/ncbddd/fasd/alcohol-use.html>
- <https://www.cdc.gov/vitalsigns/fasd/index.html>
- <https://www.cdc.gov/vitalsigns/fasd/infographic.html/#graphic1>

Free to download:

- “Think before you drink”
<https://www.cdc.gov/ncbddd/fasd/documents/ThinkBeforeYouDrinkbrochure.pdf>
- “An alcohol-free pregnancy is the best choice for your baby”
https://www.cdc.gov/ncbddd/fasd/documents/FASDBrochure_final.pdf
- “Alcohol use in pregnancy” (fact sheet):
https://www.cdc.gov/ncbddd/fasd/documents/fasd_alcoholuse.pdf
- Order free fact sheets for patients from CDC:
<https://www.cdc.gov/ncbddd/fasd/factsheets.html>
- March of Dimes: <https://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx>

- <https://www.marchofdimes.org/complications/fetal-alcohol-spectrum-disorders.aspx>
- National Organization on Fetal Alcohol Syndrome: <https://www.nofas.org/wp-content/uploads/2014/05/Facts-prevention.pdf>
- The Arc: <http://www.thearc.org/learn-about/fasd>

Consent to share information with Treatment Providers

Once a patient has been referred for treatment, 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 form 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_form_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

Section 6: Counseling Women about Cannabis (Marijuana) Use

1. Cannabis exposure during pregnancy

- The primary psychoactive constituent of cannabis is delta 9-tetrahydrocannabinol (Δ^9 -THC). Early THC exposure may affect fetal and newborn brain development due to its interaction with the brain's endocannabinoid system (Trezza, et al 2008)
- Children prenatally exposed to cannabis are at increased risk for memory, problem solving, and attention deficits (Goldschmidt, et al 2000; Richardson, et al, 2002)
- It is difficult to attribute causation due to potential impact of environmental factors including maternal nutrition and other substance exposure (Shempf, et al 2008)

Adapted from: <https://www.drugabuse.gov/publications/research-reports/marijuana/can-marijuana-use-during-pregnancy-harm-baby>

In *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*, SAMHSA endorses abstinence from cannabis for either recreational or medicinal purposes during pregnancy and the postpartum (SAMHSA, 2018)

2. Cannabis exposure during breastfeeding

- Cannabis use while parenting can result in impaired ability to safely care for an infant
- Although more research is needed, potential risks of marijuana exposure through breastmilk are related to its ready bioavailability and known psychoactive properties
- THC accumulates in breastmilk due to its long half-life (25–57 hours) and its affinity to fat in the mother's milk. THC can be present in human milk up to 8 times the level in the mother's blood.
- THC is absorbed and metabolized by an infant, rapidly distributed to the infant's brain, and can be stored in an infant's fat tissue for weeks to months
- Breastfeeding is NOT recommended with daily or frequent use of cannabis

*The NNEPQIN **Breastfeeding Guidelines for Women with a Substance Use Disorder** further addresses breastfeeding with cannabis use.*

Additional Patient Resources

- Cannabis/Marijuana and pregnancy:
<http://www.marchofdimes.org/pregnancy/marijuana.aspx>

Additional Provider Resources

- A summary of current research on marijuana use and Cannabis/Marijuana Use Disorder from the National Institute on Drug Abuse:
<https://www.drugabuse.gov/drugs-abuse/marijuana>

Have more questions?

Talk to your prenatal care and/or pediatric provider about any questions you may have.

Need help quitting?

Call the _____ Program at (xxx) xxx-xxxx or visit _____ to find a treatment center near you.

Who We Are

Our _____ program provides support and treatment for pregnant and parenting women with substance use disorders.

If you have questions or would like more information about our services, contact us at (xxx) xxx-xxxx or visit our website at:

Original content developed collaboratively by members of Dartmouth-Hitchcock's Obstetrics and Gynecology, Pediatrics and Psychiatry teams and their patients.

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Risks of Marijuana Use During Pregnancy and Breastfeeding



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<http://www.nnepqin.org/clinical-guidelines/>

What you eat, smoke and drink during pregnancy and after birth passes to your baby through your placenta and breastmilk.

How can marijuana harm my baby while I'm pregnant?

Marijuana contains a chemical called THC, which makes the user feel high. THC crosses the placenta from the mother to the baby's bloodstream. While its exact effects are not completely understood, THC may change the way your baby's brain grows and develops, including problems with learning during childhood. Smoking marijuana also exposes your baby to carbon monoxide (5 times more than with cigarettes), which lowers the amount of oxygen available in the baby's bloodstream.

With marijuana use in pregnancy, your baby may also be more likely to have:

- A lower birth-weight
- Higher risk of cigarette and marijuana smoking as a teenager
- Higher rates of behavior problems
- Higher rates of mental health problems

There may also be a higher risk of some birth defects, premature birth and admission to the Neonatal Intensive Care Unit (NICU).

Should I use marijuana if I breastfeed?

It is not safe to use marijuana while you are breastfeeding. THC builds up in breast milk as much as 8 times higher than in a mother's bloodstream. THC is then absorbed into a baby's bloodstream and can be stored in a baby's fat tissue for weeks to months. THC also gets into a baby's brain and can make a baby extra sleepy and not feed very well. It can also cause delays in a baby's development. Marijuana has also been shown to contain other dangerous substances.

What is marijuana use?

Marijuana use affects your ability to think clearly, stay alert, make good decisions and respond to the needs of your baby. Marijuana use includes:

- Smoking marijuana
- Eating and drinking marijuana in any form
- Using vaporizers
- Eating or smoking wax or hash
- Any other methods

Is medical marijuana safe?

Medical marijuana is not regulated or approved by the Food and Drug Administration. Talk to your prenatal care and/or pediatric provider about safer options.

Section 7: Counseling Women about Polysubstance Use

Optimal pregnancy outcomes for women with opioid use disorders are associated with **treatment** with methadone or buprenorphine and **abstinence** from other substances, including tobacco, alcohol, marijuana, and other substances of abuse. However, recognizing that complete abstinence is sometimes not attainable, a harm reductive approach based on maximizing information and support for the pregnant woman is essential.

Pregnancy risks associated with polysubstance use

- Placental insufficiency
- Preterm labor
- Miscarriage
- Stillbirth

Neonatal impacts

- Premature birth
- Low birthweight
- Reduced head circumference
- Birth defects (alcohol, benzodiazepines)
- Perinatal infection, including Hepatitis B, C, and HIV
- Increased duration and severity of Neonatal abstinence syndrome (NAS/NOWS)

Child development

- Delayed growth
- Sudden infant death syndrome (SIDS)
- Learning and behavior problems

In contrast to OUD, evidence-based treatment for other substance use disorders during pregnancy consists primarily of behavioral interventions, especially cognitive behavioral therapy. Heavy use of some substances, specifically alcohol or benzodiazepines, can result in physiologic dependence requiring

medically managed detoxification (alcohol) or tapering (benzodiazepines). [Factsheet 6](#) of SAMHSA's *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* includes a summary table describing recommended treatment approaches for perinatal substance use disorders other than OUD (SAMHSA, 2018, p. 48). An individualized plan of care is essential taking into account each patients' drug/alcohol use history, the presence of medical and co-occurring mental health conditions, social needs, family responsibilities, and preferences.

Substance-specific resources for providers

- <https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding>

Substance-specific patient education materials

- Cocaine:
<http://www.marchofdimes.org/pregnancy/cocaine.aspx>
- Amphetamines and club drugs:
<http://www.marchofdimes.org/pregnancy/ecstasy-methamphetamine-and-other-amphetamines.aspx>
- Marijuana:
<http://www.marchofdimes.org/pregnancy/marijuana.aspx>
- Prescription opioid abuse:
<http://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx>
- Tobacco:
<http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>
- Alcohol:
<http://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx>

Counseling Women about Risks of Synthetic Cathinones (“Bath Salts”)

In Europe, Canada, and the northeastern and central U.S, the use of a group of stimulant-like chemicals commonly known as “bath salts” or “salts” is increasing. These compounds are described generally as synthetic cathinones, but what is sold often varies in chemical makeup due to manufacturing in unregulated labs. The most common chemical constituent of “bath salts” is methylenedioxypropylamphetamine (MDPV), which is difficult to detect through standard testing approaches. These compounds are highly toxic with potentially life-long effects.

Key points:

- Bath salts are available via the internet as a powder which can be swallowed, snorted, or injected
- This group of compounds is highly toxic, impacting the central and autonomic nervous systems, the cardiovascular system, and renal and hepatic function (White et al, 2016; Imam, et al, 2013; Banks, et al, 2014; Winder, et al 2011)
- Immediate symptoms following bath salts ingestion can include
 - Euphoria and sexual excitement
 - Paranoia
 - Confusion
 - Hallucinations and blurred vision
 - Hyperthermia
 - Profuse sweating
 - Muscle twitching or seizure
 - Tachycardia and chest pain
 - Hypertension
 - Decreased peripheral circulation
- Long term effects may include
 - Depression and suicidality
 - Psychosis

- Kidney damage or failure
 - Skin breakdown at injection site, rash, cellulitis
 - Muscle injury
 - Tolerance and withdrawal
- Risks of bath salts ingestion during pregnancy are unknown but given the physiological effects of the chemical, highly concerning given the autonomic and cardiovascular symptoms which can develop (see Gray and Holland, 2014)
 - Treatment is supportive, and patients should be linked to intensive outpatient or residential treatment programs
 - Routine toxicology tests are unable to reliably detect cathinones, and tests sent out to specialty laboratories have high false negative rates.

Information for providers about synthetic cathinones (“bath salts”)

- From the National Institute on Drug Abuse:
<https://www.drugabuse.gov/publications/drugfacts/synthetic-cathinones-bath-salts>
- From Health Canada:
<https://www.canada.ca/en/health-canada/services/substance-abuse/controlled-illegal-drugs/bath-salts.html>

Information for patients about bath salts

- From the National Institute on Drug Abuse:
<https://teens.drugabuse.gov/drug-facts/bath-salts>

How to Contact Us

If you have questions, contact us at:

You may also visit us at:

Our Address

Original content developed by Dartmouth-Hitchcock
Moms in Recovery providers.

A Drug Called "Bath Salts"

Do You Know the Risks?



More people are using stimulant chemicals known as “bath salts” (“salts”) to get high. But these are not the same thing your mom used to put in the tub.

The exact makeup of “salts” changes according to which lab makes them, so you never know exactly what is in them. The most common chemical in “bath salts” is called methylenedioxypropylvalerone (MDPV for short). MDPV is highly toxic to the kidneys, heart, brain and the rest of the nervous system, and can have life-long effects.

Things to Know About “Salts”

- “Bath salts” are poisonous in any form: swallowed, snorted or injected
- Immediate symptoms after using bath salts may include:
 - Excitement
 - Paranoia
 - Confusion
 - Hallucinations and blurred vision
 - Fever
 - Sweating
 - Muscle twitching or seizures
 - Chest pain and rapid heart beat
 - High blood pressure

- Long term effects can include:
 - Depression
 - Suicidal thoughts and actions
 - Kidney failure
 - Sores and tissue death at injection site
 - Tremors
 - Withdrawal
- The risks of using “salts” during pregnancy are not fully known, but are probably very serious since MDPV passes easily through the placenta and concentrates in the fetal brain
- If you are using “salts,” get help now! Ask your health care provider or visit nhtreatment.org or www.healthvermont.gov/alcohol-drugs

For more information about bath salts go to teens.drugabuse.gov/drug-facts/bath-salts

Section 8: Supporting Breastfeeding for Mothers with Substance Use Disorders

Breastfeeding should be encouraged for women on Medication Assisted Treatment with either buprenorphine or methadone, in the absence of maternal or infant medical contraindications (World Health Organization, 2014; Kocherlakota, 2014).

- Breastfeeding is associated with decreased length and severity of neonatal abstinence syndrome (Abdel-Latif, 2006)
- Women who have experienced sexual trauma may be reluctant to breastfeed and their wishes must be respected. The option to feed pumped breastmilk may be more acceptable
- Breastfeeding may be complicated by NAS symptoms; therefore, support of a certified lactation consultant or other experienced provider is highly recommended
- Continued alcohol and non-prescribed drug use carries with it potential risk to both mother and the breastfeeding infant. However, substance use is not necessarily a contraindication to breastfeeding (WHO 2014). Therefore, a recommendation to abstain from breastfeeding should be made only if a woman expresses intent to continue substance use and declines appropriate treatment (see NNEPQIN Breastfeeding Guidelines for Women with a Substance Use Disorder for discussion of risks associated with specific substances)
- Rapid urine drug screening is associated with a significant rate of false positives and confirmatory testing should be performed if results are inconsistent with what woman reports

SUBSTANCES FOR WHICH ADVERSE EFFECTS ON THE BREASTFEEDING INFANT HAVE BEEN REPORTED

Adapted from: AAP COMMITTEE ON DRUGS. The Transfer of Drugs and Therapeutics Into Human Milk: An Update on Selected Topics. *Pediatrics*. 2013. **Consult source for substance specific references.**

Drug	Reported Effect or Reason for Concern*
Alcohol	Impaired motor development or postnatal growth, decreased milk consumption, sleep disturbances. Occasional, limited ingestion (0.5 g alcohol/kg/d; equivalent to 8 oz wine or 2 cans of beer per day) may be acceptable
Amphetamines	Hypertension, tachycardia, seizures. In animal studies of postnatal exposure, long term behavioral effects, including learning and memory deficits and altered locomotor activity, were observed
Benzodiazepines	Accumulation of metabolite, prolonged half-life; chronic use not recommended
Cocaine	Intoxication, seizures, irritability, vomiting, diarrhea, tremulousness
Heroin	Withdrawal symptoms, tremors, restlessness, vomiting, poor feeding
LSD	Potent hallucinogen, passes through blood/brain barrier easily; research limited
Methamphetamine	Potentially fatal, persists in breast milk for 48 h
Methylene dioxy-methamphetamine (ecstasy)	Closely related products (amphetamines) concentrated in human milk
Marijuana (cannabis)	Neurodevelopmental effects, delayed motor development, lethargy, less frequent and shorter feedings, high milk-plasma ratio in heavy users
Phencyclidine (PCP)	Potent hallucinogen, intoxication
Tobacco	Nicotine exposure, reduction in milk supply, second and third hand smoke exposure

*In addition to effect of substance, alteration in maternal judgment or mood may impact ability to care for infant.

Additional resources for providers

- AAP Committee on Drugs. The Transfer of Drugs and Therapeutics Into Human Milk: An Update on Selected Topics. *Pediatrics*. 2013;132:3:e796-e809. Retrieved on October 27, 2016 from <http://pediatrics.aappublications.org/content/132/3/e796>.
- LactMed. Drug and Lactation Database. Retrieved on October 27, 2016 from <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

Additional resources for patients

- http://pcssmat.org/wp-content/uploads/2013/10/ASAM-WAGBrochure-Opioid-Labor_Final.pdf

Section 9: Neonatal Abstinence Syndrome

Women with opioid use disorders, whether receiving medication assisted treatment with methadone or buprenorphine, or using illicitly, should receive prenatal education about neonatal abstinence syndrome in preparation for birth and newborn care.

Key points

- Neonatal Abstinence Syndrome (NAS), also known as Neonatal Opioid Withdrawal Syndrome (NOWS), refers to a cluster of symptoms due to neonatal withdrawal after chronic prenatal exposure to opioids, whether prescribed or non-prescribed.
- NAS symptoms mirror symptoms experienced by adults in withdrawal: neurologic symptoms including anxiety/irritability, and seizures; rhinorrhea/sneezing; gastrointestinal symptoms.
- More severe NAS symptoms are associated with polysubstance use and/or the use of illicit opioids
- Buprenorphine is associated with similar rates but later onset, shorter duration, and less severe NAS symptoms than methadone in most studies (Jones, Kaltenbach, Heil, et al, 2010)
- There appears to be no significant difference in NAS symptoms for infants exposed to buprenorphine monoproprietary compared to buprenorphine-naloxone (Jumah, Edwards, Balfour-Boehm, et al, 2016; Debelak, Morrone, O’Grady, et al, 2013) although research is limited
- There is no clear association between methadone or buprenorphine dose and severity of NAS symptoms (Jones, Kaltenbach, Heil, et al, 2010; Jones, Deppen, Hudak, et al 2014)
- With appropriate treatment, NAS is a time-limited condition. Research about long term neurodevelopmental effects is ongoing, but results so far are reassuring (Kocherlakota, 2014).
- Nonpharmacologic care is the first line of treatment for NAS, and includes maximizing skin to skin contact, rooming-in with mother, a quiet environment, and breastfeeding unless contraindicated (Kocherlakota, 2014; Patrick, Schumacher, Horbar, et al 2016)
- Pharmacologic treatment is required if symptoms escalate and cause functional difficulty for the infant (see discussion of Eating, Sleeping, and Consoling Care Tool, below). Morphine is the most commonly used medication, although some programs use methadone, and the use of buprenorphine is being investigated (Kocherlakota, 2014; Kraft, Adeniyi-Jones, Chervoneva et al, 2017)

- Breastfeeding is beneficial unless contraindicated by maternal drug use or HIV positive status (Jones, Deppen, Hudak, et al 2014).
- Tobacco use during pregnancy and subsequent nicotine withdrawal is linked to greater intensity and earlier onset of NAS symptoms

Other medication linked to neonatal symptoms

Other classes of medications are also linked to transient discontinuation syndromes in newborns after prenatal exposure. These include sedative-hypnotics (ex: barbiturates), anxiolytics (ex: benzodiazepines), anticonvulsants (ex: gabapentin), selective serotonin reuptake inhibitors (ex: fluoxetine, sertraline), and selective norepinephrine reuptake inhibitors (ex: venlafaxine). These medications do not cause the same neonatal abstinence symptoms seen following prenatal opioid exposure, but when they are used in combination with opioids during pregnancy, NAS symptoms can be prolonged or more intense. Typically these medications are associated with central nervous symptoms such as jitteriness, increased tone, and fussiness, but not gastrointestinal or metabolic symptoms. However, experts caution not to discontinue medications such as antidepressants which are essential to maintaining women’s mental health (<https://womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy/>)

Assessing and Treating Neonatal Abstinence Syndrome

Symptoms of NAS usually start within 1-2 days after birth, but onset can be delayed for 4-5 days in the case of exposure to long acting opioids such as buprenorphine. Since the 1970s, assessment of the need for pharmacologic treatment for NAS has relied on the Finnegan Scoring System, named for one of its developers, Dr. Loretta Finnegan (Finnegan, 1975; Kocherlakota, 2014). This 21 item scoring system focuses on the three physiologic systems most impacted by withdrawal in newborns, the central and autonomic nervous systems, and the gastrointestinal system. The Finnegan Scoring System is used to guide decisions by pediatric providers regarding need for pharmacologic treatment of NAS. This scoring system remains the most commonly used internationally.

More recently, researchers at Yale-New Haven Children’s Hospital, Boston Medical Center, and Children’s Hospital at Dartmouth-Hitchcock have developed an alternative scoring system and care approach (the Eating, Sleeping, and Consoling [ESC] Care Tool) which focuses specifically on three essential functions for newborns: the ability to eat, sleep, and console (Grossman, et al, 2017) and ensuring maximization of non-pharmacologic care first (e.g., rooming-(Holmes et al Pediatrics,

MacMillian et al (in press: JAMA Peds) and parental presence (Howard et al, 2017) prior to considering pharmacologic treatment.

The ESC Care Tool was designed to help care for opioid-exposed babies in a more baby-friendly and more specific manner. Eating, sleeping and consoling are the things that are most important to a baby functioning as a baby, and the scoring method focuses on these as main determinants of the baby's need for pharmacotherapy. Definitions are provided for when to consider that a baby's difficulties with eating, sleeping, or consoling are due to opioid withdrawal versus related to other factors instead.

Although a baby will likely still show other signs of withdrawal such as jitteriness, increased tone, sneezing, yawning, and loose stools, the baby is not started on a medicine unless she is having significant problems eating, sleeping, or consoling, and only after all possible non-pharmacologic care measures are optimized first.

The ESC Care Tool also encourages staff to provide parents with education about ways they can help their baby do best with opioid withdrawal by encouraging rooming-in, parental presence, skin-to-skin contact, holding by a caregiver or cuddler, swaddling, breastfeeding and feeding the baby when she is hungry and until she is content, providing a quiet room, and limiting visitors if the baby is having difficulties with withdrawal.

The 3 centers mentioned have all noticed significant improvements in care related to NAS including decreased need for pharmacologic treatment, decreased length of stay, and lower hospital costs when using this ESC care method. Most importantly, this care approach helps mothers and their families learn best ways to care for their own baby, helping them for their transition home.

Additional Resources for providers

- Finnegan, L, Connaughton, J, Kron, R, Emich, J. Neonatal abstinence syndrome: assessment and management. *Addct. Disorders* 1975; 2; 1-2: 141-58.
- Grossman, M, Berkwitt, A, Osborn, R, Xu, Y, Esserman, D, Shapiro, E, Bizzarro, M. An initiative to improve the quality of care of infants with Neonatal Abstinence Syndrome. *J Pediatrics* 2017 139; 6: e1-8.
- Holmes AV, Atwood EC, Whalen B, et al. Rooming-In to Treat Neonatal Abstinence Syndrome: Improved Family-Centered Care at Lower Cost. *Pediatrics*, 2016; 137(6).
- Howard MB, Schiff MD, Penwill N, et al. Impact of Parental Presence at Infants' Bedside on Neonatal Abstinence Syndrome. *Hosp Pediatr*, 2017; 7(2): 63-69.
- MacMillan KDL, Rendon CP, Verma K, et al. Rooming-in for Neonatal Abstinence Syndrome: A Systematic Review and Meta-analysis. *JAMA Peds* (in press).
- Kocherlakota, P. Neonatal Abstinence Syndrome. *Pediatrics* 2014; 134; 2. Accessed from <http://pediatrics.aappublications.org/content/134/2/e547>
- Patrick, S, Schumacher, R, Horbar, J et al. Improving care for Neonatal Abstinence Syndrome. *Pediatrics* 2016; 137; 5. Accessed from <http://pediatrics.aappublications.org/content/early/2016/04/13/peds.2015-3835>

Resources for patients

- Pregnancy, methadone, buprenorphine, and NAS from PCSSMAT: http://pcssmat.org/wp-content/uploads/2013/10/WAGBrochure-Opioid-Pregnancy_Final.pdf
- Neonatal Abstinence link for parents from March of Dimes: [http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-\(nas\).aspx](http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx)

Sample Letter to Parents Regarding NAS

Dear Parent(s),

Congratulations on your pregnancy and/or the birth of your new baby! As you may know, your new baby may experience signs of withdrawal because of the medicines or drugs that you are taking. Our team at the [hospital x] is committed to providing you and your baby with the best care possible. The information in this letter will help you learn how to best care for your baby after birth.

When a baby shows symptoms of withdrawal from an opiate medicine, like methadone or buprenorphine, it is called **Neonatal Abstinence Syndrome (NAS)**. Symptoms of NAS usually start within 1 to 2 days of a baby's birth, but can sometimes take 4 to 5 days. Some babies will need medicine to treat the symptoms of withdrawal. However, most babies can get through the withdrawal with their parent's touch, holding, and care as their only treatment.

Babies do best when their parents are close by to provide a feeling of comfort and safety. Babies also do best when they are cared for in a calm, quiet space without lots of noises or people around. When you care for your baby in your own room, it is called "**rooming in.**" When babies "room in" with their parents, they are able to eat and sleep better. They are also easier to console or calm down. Babies are much less likely to need medicine to treat their withdrawal if their parent is close by. If a baby does need medicine, they will likely need less medicine and be able to go home faster if their parent is there taking care of them all of the time. **You are your baby's best treatment for NAS!**

We will take the following steps to make sure your baby is as healthy as he or she can be:

1. After birth, your baby will stay with you in the **Birthing Pavilion** if he or she is born at 35 weeks or more and does not require intensive care for any reason.
2. Nurses and doctors will check your baby for symptoms of NAS after feedings every few hours.
3. We will monitor your baby in the hospital for **at least 4 days**. We will let your baby go home when we know that your baby has gone through the peak of withdrawal symptoms.
4. If your baby has **problems eating, sleeping, or consoling**, we will teach you ways to help your baby through the withdrawal problems such as with skin-to-skin contact and quietly rooming-in together.
5. If there are still problems with eating, sleeping, or consoling despite all comfort care measures, your baby may be moved to the **Pediatrics Unit** to start medicine unless intensive care is needed for another reason.
6. While on the Pediatrics Unit, you will be able to room in with your baby 24 hours a day. **On average, babies being treated with medicine need to stay in the hospital for one to two weeks.** However, it sometimes takes longer. It is important that you **room in with your baby this whole time**. Once your baby is off medicine and showing no symptoms of NAS for at least a day, your baby is ready to go home!

During your baby's time in the hospital, you will be your baby's primary caregiver. We will be here to help you, but ***your baby will do best if you are the one providing all of his or her care.***

➤ **Care for your baby in a calm, quiet room with the lights down low**

- ❖ Keep your baby close to you “*skin to skin*” when you are awake and not sleepy.
- ❖ Talk to and sing to your baby.
- ❖ Gently sway your baby.
- ❖ Feed your baby when he/she shows you hunger or feeding cues (licking lips, bringing hands to mouth, opening mouth to something touching lips or cheek) and until content (at least every 3 hours).
- ❖ Breastfeed your baby (unless told not to by a provider for medical reasons).
- ❖ Wrap (“swaddle”) your baby in a thin blanket keeping the top of the blanket away from his or her face.

➤ **Be with your baby 24/7**

Babies with NAS do not do as well when they are in bright, loud settings such as at the Nurse’s station.

- ❖ Stay with your baby in your private room as much as possible. **If you need to leave the unit for some reason** (such as for an appointment or a walk) and someone else cannot stay with your baby, please let your nurse know so we can **make a plan ahead of time**. We will work to find a “cuddler” to help hold your baby in your own room if you need to be away. The sooner you can tell us about these needs, the better we can work together to help you and your baby.
- ❖ Help us watch your baby for symptoms of NAS. Let us know if your baby has **any problems with eating, sleeping, or consoling**. These are the symptoms that are most important to your baby. You can also keep track of these symptoms, and other symptoms of NAS, in your baby’s “Newborn Care Diary.”
- ❖ We will be nearby to help you if you have any questions or concerns.

➤ **Make a plan to stay with your baby for as long as he or she needs to be in the hospital**

It is very important that you are able to stay with your baby the whole time he/she is in the hospital. Your baby will be much less likely to need medicine, or will need medicine for a shorter period of time, if you are here to care for your baby all of the time. Here are a few tips to help prepare you for your baby’s hospital stay:

- ❖ Bring enough clothes and personal items with you to last for 2 weeks or more.
- ❖ Plan to have someone watch your other children and/or pets while you are away.
- ❖ Tell your family and your employer that you might need to be in the hospital for a couple of weeks.
- ❖ Plan to have a home visiting nurse come to your home and to follow up with your baby’s primary care provider the first 2 days after your baby’s discharge.

We look forward to working with you to help you and your baby have the best experience possible. If you have any questions about any of the information in this letter, please contact Dr. [name of contact], a social worker, or a nurse manager in the Birthing Pavilion at 603.555.5555.

Thank you and congratulations again!

The Newborn Care Staff at [insert name of your hospital here]

What happens if my baby does need medicine to treat NAS?

Right now, most babies who need medicine to treat NAS will be in the **hospital and on medicine for 10 to 14 days**. Some babies may need even longer. It is very important that you are able to stay with your baby this whole time as **you are still the most important treatment for your baby**. It is very important to plan ahead in case this happens!

- ★ Plan to have at least one family member or friend here with you to help care for your baby in your room.
- ★ Bring enough clothes and personal items with you to last for 2 weeks or more.
- ★ Plan to have someone watch your other children and/or pets while you are away.
- ★ Sometimes it is hard to talk to your family about why your baby might need to stay in the hospital. If this is true for you, ask your OB or Pediatric provider to help.



When can I take my baby home?

Your baby's care team will help decide when it is safe for your baby to go home. We will need to watch your baby for at least 4 to 5 days in the hospital to make sure all of the medicine or drug is out of your baby's body.

Your baby is ready to go home when he or she is:

- ★ Feeding and sleeping well.
- ★ Easy to console (calm down).
- ★ Has not lost too much *or* is gaining weight.
- ★ Able to maintain a healthy temperature, heart rate, and breathing.
- ★ Has received the hepatitis B vaccine and all newborn screening is done and normal.
- ★ No longer needs medicine, if it was started.
- ★ Has an appointment made with a home visiting nurse and primary care provider (PCP) for the first few days after discharge.

We look forward to working with you to help you and your baby have the best care possible. If you have any questions about any of the information in this pamphlet, please ask your pediatrician, a social worker or a nurse in the Birthing Pavilion.

NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK



Neonatal Abstinence Syndrome (NAS): Caring for your newborn

This informational pamphlet was developed by Dr. Bonny Whalen and staff at the Children's Hospital at Dartmouth-Hitchcock (CHaD).

Congratulations on your pregnancy and/or the birth of your new baby!

Our team is committed to providing you and your baby with the best care possible. The information in this pamphlet will help you learn how to best care for your baby after birth.

What is NAS?

- ★ Neonatal Abstinence Syndrome, or NAS, occurs when a baby withdraws from opioids after birth. It is also sometimes called Neonatal Opioid Withdrawal Syndrome (NOWS).
- ★ Most babies show signs of withdrawal 2 to 3 days after birth, but some may not show signs until day 4 or 5.
- ★ Your baby should stay in the hospital until most of the symptoms of NAS are over.

What are the most common signs of NAS?

- ★ Tremors, jitteriness, or shaking of arms and legs
- ★ Tight muscles in arms and legs
- ★ Fussiness
- ★ Problems eating or sleeping
- ★ Hard to console or calm down
- ★ Need for sucking when not hungry
- ★ Frequent spit ups or vomiting
- ★ Loose or watery stools (poops)
- ★ Trouble losing too much or not gaining enough weight (after day 4)

Serious symptoms like stopping breathing or seizures are possible but very rare.

v.8/29/18

NAS Scoring /Assessments

We will watch your baby closely for signs of withdrawal every few hours. Let your nurse know when your baby is done feeding as this is a good time to check your baby. *You can also help us watch your baby by keeping track of:*

- ★ How well your baby eats
- ★ How well your baby sleeps
- ★ How well your baby consoles (calms)
- ★ What kinds of things help your baby calm (holding, skin to skin contact, swaddling, sucking, a calm room)
- ★ Very loose or watery stools (poops)

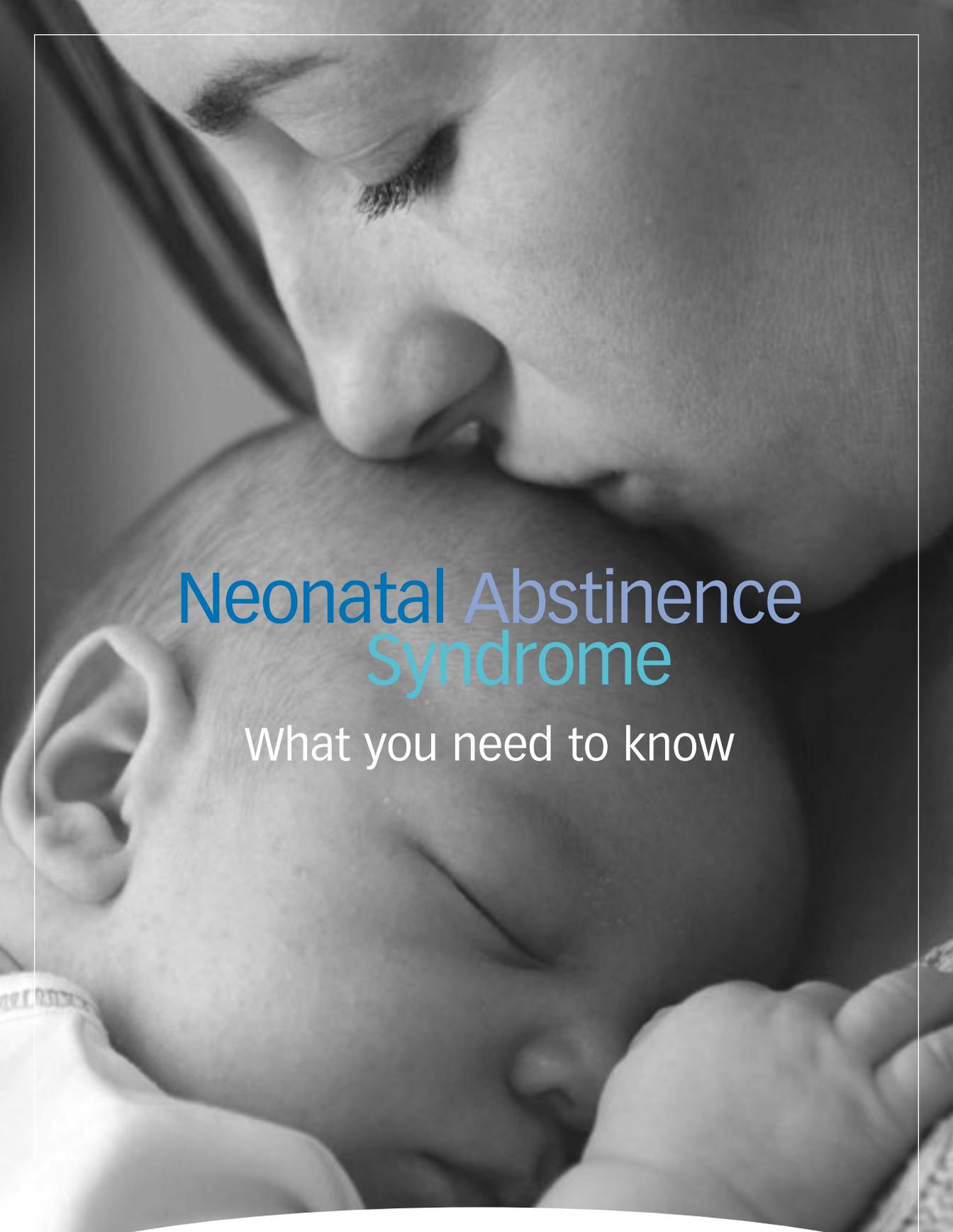
We will give you a Newborn Care Diary to keep track of all of these things!

What will my care team do to make sure my baby is healthy?

- ★ During your baby's time in the hospital, you will be your baby's primary caregiver. We will be here to help you, but **your baby will do best if you are the one providing all of his/her care.**
- ★ We will monitor your baby in the hospital for **at least 4 to 5 days.**
- ★ If your baby has problems with eating, sleeping, or consoling we will teach you ways to help your baby.
- ★ If there are still problems after all that you and we have done to help your baby, medicine may be needed.

How can I best help my baby?

- ★ **ROOM IN TOGETHER:** One of the best things you can do for your baby is to keep him/her with you at all times in your own room. Being close to your baby helps you respond quickly to his/her needs. *Your baby will feel safest and most comfortable when close to you.*
- ★ **SKIN TO SKIN:** Spend as much time "skin to skin" with your baby when you are awake. This helps your baby eat and sleep better, and will help calm your baby. It can also help decrease other symptoms of withdrawal. *It also helps your milk supply when breastfeeding.*
- ★ **SWADDLE/CUDDLE:** Hold your baby or swaddle your baby in a light blanket. Just being close to someone, or "tucked" in a swaddle, helps your baby feel safe and comfortable. *Take advantage of our "Cuddler Program" if you need it!*
- ★ **A CALM ROOM:** Keep your room calm and quiet with the lights down low. Loud noises and bright lights may upset your baby.
- ★ **FEED AT EARLY HUNGER CUES:** Feed your baby whenever s/he is hungry and until content, at least every 3 hours. Breastfeed your baby, unless you are unable to do so for medical reasons.
- ★ **SUCKING:** If your baby still wants to suck after a good feeding, offer a finger or pacifier to suck on. This can be very comforting for your baby. *Always make sure your baby is not hungry first!*
- ★ **LIMIT VISITORS:** Try to have only one or two visitors in your room at a time as more may make your baby fussy or not sleep as well.



Neonatal Abstinence Syndrome

What you need to know

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Neonatal Abstinence Syndrome (NAS)

Congratulations on your pregnancy or the birth of your new baby! Your baby may be at risk for having some problems after birth due to the drugs or medicines you are on. We hope that the information in this booklet will help you care for your baby in the first few days and weeks of life.

Withdrawal refers to a group of symptoms that develop after a baby is born and is no longer getting a certain drug or medicine from its mother in the womb. When a newborn baby has withdrawal from opiates or narcotics it is called Neonatal Abstinence Syndrome (NAS). Examples of opiates and narcotics include methadone, subutex or suboxone, heroin, Vicodin and Percocet.

We can't predict which babies will have NAS. Some babies will have NAS with exposure to small amounts of drugs or medicines, and other babies may only have symptoms with high exposures to the drugs or medicines.

Most babies with NAS show signs of withdrawal within 24 to 96 hours after birth. Your baby will need to be monitored in the hospital for at least 2 to 4 days. If your baby has signs of withdrawal, he or she will need to stay in the hospital longer. If needed, your baby will start a medication to treat the symptoms of withdrawal.

When will my baby show signs of NAS?

The time it takes to show symptoms can depend on the following:

- How long the medication or drug is active in the mother
- The dose of the medicine
- Whether other drugs or substances were used at the same time, such as nicotine, opiates or narcotics that were not prescribed to the mother

What are the signs of NAS?

- High-pitched cry / crankiness
- Shaking / jitters
- Trouble sleeping
- Stuffy nose / sneezing
- Yawning
- Difficulty feeding due to problems sucking
- Stiff arms, legs and back
- Vomiting / diarrhea
- Poor weight gain after the 4th day of life
- Fast breathing
- Skin breakdown, particularly in the diaper area or on the face

Your nurse will be collecting your baby's first bowel movement (called meconium) for testing in the lab. A sample of the baby's urine may also be collected.

What is NAS Scoring?

NAS scoring can help tell us how much the baby is withdrawing. There is an example of the NAS scoring chart at the end of this information booklet (see page 12). Your baby's nurse will score your baby every 2 to 4 hours. Your baby receives points if he or she is showing signs of NAS. The nurse will use the chart to keep a record of the points. A score of 8 points or higher may mean your baby is having problems with withdrawal. The nurse will continue to check your baby closely to see if it is NAS or some other problem. Your nurse will teach you how to check your baby for signs of withdrawal.

Where will my baby and I be while he or she is being monitored?

If your baby only needs to be monitored for 2 days, you and your baby will be cared for in the Birthing Pavilion. If your baby needs to be monitored for 3 to 4 days, we will try our best to have you and your baby stay in the Birthing Pavilion. In some cases, when the Birthing Pavilion is very busy, you and your baby may need to move to the Pediatric Unit after 2 or 3 days. On the Birthing Pavilion and the Pediatric Unit, you will stay with your baby. If your baby is not having signs of withdrawal, you will be discharged home together.

If your baby has signs of withdrawal, and needs treatment with medication, he or she will be cared for in the Intensive Care Nursery (ICN). If your baby is in the ICN, you will not be able to stay with your baby, but we will encourage you to stay as close to your baby as possible. This will help you care for your baby during his or her withdrawal. We will help you find a place to stay nearby if this happens.

What can I do to help my baby?

One of the best things you can do for your baby is to keep him or her with you at all times. This is called "rooming in." Being close to your baby helps you respond quickly to your baby's needs (such as hunger or needing to be held when fussy). Your baby will feel most comfortable by being close to you. This will help you offer reassurance, love and safety. For comfort, hold your baby "skin to skin" (naked in a diaper against your skin) or gently swaddled (wrapped) in a blanket. Pay careful attention to how you position your baby during feeding and settling down. During your time in the hospital, the nurses will show you how to do this. A baby's nervous system is sensitive, so keep your baby's environment quiet and calm. It is helpful to limit visitors in the first few days of life.

What will happen if my baby has problems with withdrawal?

How will I know if my baby needs treatment for NAS?

- If your baby's NAS score is 8 or higher, the nurse will ask the doctor to evaluate your baby.
- If your baby's NAS score is 8 or higher on 3 occasions or 12 or higher on 2 occasions, your baby is likely having problems with NAS or withdrawal. If the doctor feels that your baby is having withdrawal from your medicine, the doctor will transfer your baby to the ICN to receive a special medicine called morphine.

What happens when my baby is given morphine?

- Morphine will be given to your baby to reduce the symptoms of NAS.
- Morphine will also reduce your baby's risk for having seizures (convulsions).
- Morphine will make your baby more calm and comfortable, but should not make your baby sleepy.
- Each baby is different in how they respond to morphine.
- The dose of morphine needed will depend on your baby's NAS scores and birth weight.
- When your baby's withdrawal is better, we will start to wean (lower) the dose of morphine.
- If we are not able to control your baby's withdrawal with the morphine alone, we may start another medicine called Phenobarbital.

How can I help my baby if he is having problems with NAS?

- You can help your baby with withdrawal by staying nearby and holding your baby close.
- You can also help by feeding your baby whenever he shows signs of hunger (licking his lips, opening mouth to something that touches his lips or mouth), and by keeping the environment calm and quiet.
- Many parents find their baby settles best when handled gently and held close to their body. This is because you and your baby know each other best.

How long will my baby be in the hospital?

- Your baby will need to stay in the hospital until he or she is able to come off the morphine.
- If your baby needs Phenobarbital, it is possible to go home on this medicine.
- Your baby will require close follow-up if he or she goes home on Phenobarbital.
- Even if your baby does not go home on this medicine, we will recommend that your baby be seen in the first few days after bringing your baby home.

Babies are sometimes transferred from the ICN to the Pediatric Unit if the weaning process is taking a while. Mothers can stay in their baby's room while in the Pediatric Unit and are strongly encouraged to do so. A baby needs close contact with his or her mother during this difficult time. A mother can offer some of the best medicine available: love and comfort.

How long will my baby have problems?

NAS can last from one week to a few months. It is difficult to know how long it will last. The length of the withdrawal depends on what medicines or drugs the baby was exposed to. It also depends on how much of these the baby got while you were pregnant. It is important to let your baby's health care provider know what drugs and medicines your baby was exposed to during the pregnancy.

Can I breastfeed my baby?

Breastfeeding is best for your baby. If you are on a medication that your doctor has prescribed for you, the baby will get small amounts of your medication through the breastmilk. This is generally considered safe and may help reduce withdrawal symptoms, depending on the medicine you are on. Breastfeeding is beneficial for all babies, but for babies with special needs, it is even more important. The closeness of breastfeeding offers a baby comfort and reassurance. However, there are some times when breastfeeding would not be recommended.

It is very important that you not take any other medications while breastfeeding, unless your baby's doctor says the medicines are safe. If you are or will be using any drugs or illegal medicines (medicines prescribed to someone else), it is best that you do not breastfeed. This is because the dangers are too great for your baby. If you are on a medicine called methadone or buprenorphine (subutex or suboxone), it is important that you do not stop breastfeeding suddenly. When you are ready to wean (stop or decrease breastfeeding), talk to your baby's doctor as it is best to do this slowly. Your doctor can teach you ways to do this safely.

What do I do if my baby experiences NAS?

Your baby will need a lot of attention in the beginning. He or she may be fussy and hard to calm, but don't give up on comforting your baby. You have everything your baby needs.

It can be stressful for parents to have a baby who cries a lot. Many parents describe the time their baby spends in withdrawal as an emotional roller coaster. We understand that this is a very stressful and emotional time for you. Take comfort in knowing that we all have the same goal: to help you and your baby through the withdrawal so you can go home as soon as possible. Ask friends and family for help so that you get the breaks and the support you need.

When can I take my baby home?

Your baby's medical team will help decide when it is safe for your baby to go home and will help you learn about caring for your baby.

Your baby is ready to go home when he or she:

- Has had monitoring completed depending on the medicine you were on during the pregnancy.
- Is no longer needing medicine, if it was started.
- Is feeding without difficulty.
- Is able to maintain a stable heart rate, breathing rate, and temperature.
- Has referrals in place for community support such as a home visiting nurse.
- Has a primary care provider (PCP) and a follow-up appointment.
- Has completed all the newborn health care (hearing screen, hepatitis B shot, newborn blood screening).

If your baby needed to stay in the ICN, it will be especially important for you to spend a full day or two taking care of your baby on your own before you go home. This will help you feel comfortable and confident in caring for your baby at home.

Will my baby have problems after we go home?

The symptoms of NAS may continue for more than a week and possibly up to several months. Over this time, the symptoms will start to fade. Your baby will be discharged when there is little risk for serious problems at home.

Once at home, your baby may continue to experience the following:

- Problems feeding.
- Slow weight gain.
- Poor sleeping patterns.
- Sneezing, stuffy nose or trouble breathing.

Your baby's doctor and nurse will help teach you ways to take care of your baby. They will also teach you how to help your baby if he or she is having any of the problems listed above. Practice different ways of caring for your baby while in the hospital. You will learn what works best for your baby. Ask your baby's doctor or nurse if you have any questions. We feel that **any** question you have is an **important** one. We want you to feel comfortable taking care of your baby in the hospital and when going home.

Going home with my baby

Before discharge, you will be given appointments with your baby's doctor and visiting nurse. If you are concerned or worried about your baby's health at any time, contact your baby's doctor and ask for an appointment. We will help you identify support systems in your community to help you during this busy, and sometimes difficult, time in your baby's life.

What should I do if my baby cries a lot?

It will be helpful to feed and settle your baby in a room that is very quiet. Gentle rocking and swaying are also ways to soothe your baby, but be careful never to shake your baby. It is important to know that your baby's cries may be hard to take at times. This is normal. Never hold anything over your baby's mouth or nose in hopes that it will stop the crying. If your baby is making you feel stressed, **put your baby down in a safe place such as the bassinette or crib**, and go take a break somewhere else in your home. It is best to get some space from your baby if you are feeling stressed. You can also call a friend, family member or your baby's health care provider if you feel like you need a break from your baby. You can also call one of these people if you would like extra help caring for your baby.

Where can I find more tips on how to help my baby?

Some resources are listed at the end of this information packet. During your hospital stay, talk with your baby's social worker or resource coordinator if you need resources closer to home. Before you go home from the hospital, you will be given a special booklet called "Going Home with Your Newborn." This booklet teaches you how to take care of your new baby. The part on "Ten Tips for Great Beginnings with Your New Baby" has nice tips for getting the best start with your newborn. If your baby is being discharged home from the ICN, you will be given special ICN Discharge Instructions to help you further.



Ways to support and care for your baby

Control your baby's environment:

- Keep your baby's room quiet with the lights down low.
- Maintain a routine.
- Limit visitors so your baby does not get over-stimulated.

Learn your baby's "I'm upset" cues:

- Your baby will tell you "I'm upset" by yawning, sneezing, having tremors (shaking), showing color changes (pale or blue skin color), frowning, looking away or closing eyes.
- If you see the above cues, stop what you are doing as your baby is trying to tell you "I'm upset".

Special ways to help your baby if he or she is crying or showing "I'm upset" cues:

- If you see the above cues, stop what you are doing.
- Hold your baby skin-to-skin or gently swaddled in a blanket.
- Hold your baby on your chest, or on your arm laying on his or her side.
- Let your baby calm down before trying anything new.
- Gently rock or sway your baby side to side (back and forth).
- If your baby is still crying, place your baby's swaddled back against your chest. Hold your baby in a curled C-position facing away from you. Place your hand on your baby's chest and sway your baby gently side to side. Facing a blank wall may also help calm down your baby.

Gently introduce new things to your baby one at a time:

- Introduce new stimuli (things that cause your baby to be alert) to your baby one at a time.
- Watch your baby's cues and allow a "time out," if needed. A "time out" is a quiet time without stimulation.
- Swaddle your baby and try a pacifier to help your baby maintain an alert and calm state.
- Limit visitors so your baby does not get over-stimulated.
- Talk to your baby when he or she is calm and alert.

Gently increase the number of stimuli:

- Add visual sight, auditory (sound), and touch stimuli when your baby is calm.
- Look for cues as to how well he or she can tolerate the new stimuli.
- Know that your baby's ability to handle new stimuli may vary from minute to minute and day to day.

As your baby's calm periods increase, unwrap your baby for short periods of time:

- This allows your baby to become used to controlling his or her own body.
- Re-swaddle your baby if he or she shows signs of distress.

Extra ways to calm and help your baby

Behavior

Calming Suggestions

<p>Prolonged or high-pitched crying (crying that lasts a long time or is louder than normal)</p>	<ul style="list-style-type: none"> ■ Hold your baby close to your body, skin-to-skin or swaddled in a blanket. ■ Decrease loud noises, bright lights, and any excessive handling. ■ Gently rock or sway your baby while humming or singing.
<p>Sleeplessness (problems sleeping)</p>	<ul style="list-style-type: none"> ■ Reduce noise, bright lights, patting, or touching your baby too much. ■ Play soft, gentle music. ■ Gently rock or sway your baby while humming or singing. ■ Change your baby's diaper if dirty. ■ Check for and treat diaper rash with a lotion or ointment, such as Vaseline®, A&D®, or Desitin®.
<p>Excessive sucking of fists (sucking on fists a lot)</p>	<ul style="list-style-type: none"> ■ Feed your baby when hungry and until content. ■ Offer a pacifier or finger if your baby wants to suck but isn't hungry. ■ Cover hands with mittens or sleeves if skin becomes raw. ■ Keep areas of damaged skin clean. ■ Avoid lotions or creams on the hands as the baby may suck on them and swallow these products.
<p>Difficult or poor feeding (problems feeding)</p>	<ul style="list-style-type: none"> ■ Feed your baby when hungry and until content. ■ If your baby is having problems with spitting up, feed smaller amounts and more often. ■ Feed in a calm and quiet area. ■ Limit visitors so that your baby does not get handled too much. ■ Feed your baby slowly. ■ Allow your baby to rest a little during and after the feedings. ■ Help your baby feed by supporting his or her cheeks and lower jaw (if needed).

Extra ways to calm and help your baby

Behavior

Calming Suggestions

<p>Sneezing, stuffy nose</p>	<ul style="list-style-type: none"> ■ Keep baby's nose and mouth clean with a soft washcloth.
<p>Breathing troubles</p>	<ul style="list-style-type: none"> ■ Avoid over dressing or wrapping your baby too tightly. ■ Always have your baby sleep on his or her back, never on the tummy. ■ Call your baby's provider if your baby is having trouble breathing (breathing is fast, labored, noisy, and/or there is a bluish tinge to the skin).
<p>Spitting up</p>	<ul style="list-style-type: none"> ■ Burp your baby each time he or she stops sucking. ■ Hold your baby upright for a period of time after feeding. ■ Keep your baby's bedding and clothes free of spit up.
<p>Hyperactivity (too much activity)</p>	<ul style="list-style-type: none"> ■ Use a soft thin blanket to snugly wrap your baby. ■ Swaddle and carry your baby, offering gentle words, humming or singing. ■ Gently sway or rock your baby.
<p>Trembling</p>	<ul style="list-style-type: none"> ■ Keep your baby in a warm quiet room. ■ Avoid excessive handling of your baby during care routines or when people come to visit.
<p>Fever</p>	<ul style="list-style-type: none"> ■ Do not over dress or over bundle your baby. ■ Report a temperature greater than 100° F to your baby's doctor.



NAS Scoring Chart

Infants at risk of narcotic withdrawal:

- Should be assessed for signs of withdrawal every 3 to 4 hours.
- Should have all symptoms scored within the preceding 3 to 4 hour interval, not just symptoms that occur during assessment.
- Should not be awakened unless they have been asleep for more than 3 hours.
- Should be fed before they are scored, and calmed prior to assessing muscle tone and respiratory rate.

The scoring chart, adapted from L.P. Finnegan (1986), is designed for term infants who are fed every 2 to 3 hours. Allowances must be made for infants who are preterm or beyond the initial newborn period.

Neonatal Abstinence Syndrome (NAS) Scoring Chart

Infants should receive only one score from options in categories: Cry, Sleep, Moro, Tremors, Stools, Fever, Respiratory Rate			Date											
System	SIGNS AND SYMPTOMS	Score	Time											
CENTRAL NERVOUS SYSTEM DISTURBANCES	Excessive High Pitched (or other) Cry	2												
	Continuous High Pitched (or other) Cry	3												
	Sleeps < 1 Hour After Feeding	3												
	Sleeps < 2 Hours After Feeding	2												
	Sleeps < 3 Hours After Feeding	1												
	Hyperactive Moro Reflex	2												
	Markedly Hyperactive Moro Reflex	3												
	Mild Tremors Disturbed	1												
	Moderate-Severe Tremors Disturbed	2												
	Mild Tremors Undisturbed	3												
	Moderate-Severe Tremors Undisturbed	4												
	Increased Muscle Tone	2												
	Excoriation (Specify Area): _____	1												
	Myoclonic Jerks	3												
Generalized Convulsions	5													
METABOLIC/VASOMOTOR/ RESPIRATORY DISTURBANCES	Fever <101 (99 - 100.8 F/37.2 - 38.3 C)	1												
	Fever >101 (38.4 C and Higher)	2												
	Sweating	1												
	Frequent Yawning (≥ 3 Times/Interval)	1												
	Mottling	1												
	Nasal Stuffiness	1												
	Sneezing (≥ 3 Times/Interval)	1												
	Nasal Flaring	2												
	Respiratory Rate > 60/min	1												
	Respiratory Rate > 60/min with Retractions	2												
GASTRO- INTESTINAL DISTURBANCES	Excessive Sucking	1												
	Poor Feeding	2												
	Regurgitation	2												
	Projectile Vomiting	3												
	Loose Stools	2												
	Watery Stools	3												
*See next section for further details of scoring	TOTAL SCORE													
	RN INITIALS													
	Morphine (mg/kg dose)													
	Phenobarbital (mg/kg dose)													

Instructions for NAS Scoring

High-pitched Cry	Score 2 if cry is excessive, score 3 if cry is continuous. Note in progress note if cry is alleviated by picking up infant or with feeding.
Sleep	Do not awaken infant to score unless infant has been asleep for more than 3 hours. If infant is awakened for scoring sooner, do not score for diminished sleep.
Moro Reflex*	<p>Hyperactive Moro reflex</p> <ul style="list-style-type: none"> Extension of arms/legs that lasts a few seconds, with pronounced jitteriness in the hands during or at the end of Moro reflex. <p>Markedly hyperactive Moro reflex</p> <ul style="list-style-type: none"> Marked and persistent extension of the arms/legs, accompanied by hyper-alert state and/or continued arm/leg tremors.
Tremors	Assign only one score from one of the 4 categories. Score for increasing severity. "Undisturbed" refers to baby's tremors occurring during sleep or when at rest in bassinette.
Muscle Tone	Note degree of resistance when attempting to straighten baby's arms and legs. Baby should resist slightly but examiner should be able to move baby's arms and legs against resistance; inability to do so indicates increased muscle tone. Lack of head lag and/or baby's ability to stand in ventral suspension indicates increased tone.
Excoriation	Note location of excoriation. Score 1 when excoriation first presents. Rescore only if excoriation site worsens or excoriation appears in another area. Buttocks should not be scored for excoriation unless stools are normal.
Myoclonic Jerks	Myoclonus refers to a short quick contraction of a muscle or extremity (not jitteriness or quivering). Note location / muscle group.
Generalized Convulsions	Score for any seizure (tonic / clonic) activity during the period. Immediate evaluation should be requested by infant's covering medical provider.
Sweating	Observe for beads of sweat or moist skin, do not score for environmental factors.
Fever	Temperature parameters refer to axillary temperature readings. Follow unit guidelines for confirming elevated axillary temperatures with rectal temperatures.

Instructions for NAS Scoring

Yawning	Score for 3 or more yawns that occur during scoring interval.
Mottling	Observe for skin mottling on the chest, trunk and extremities.
Nasal Stuffiness	Score for nasal congestion. Rhinorrhea may or may not be present.
Sneezing	Score for 3 or more sneezes that occur during scoring interval.
Nasal Flaring	Score if nasal flaring is present in absence of other evidence of airway disease.
Respiratory Rate	Count respirations over a full minute and observe for retractions.
Excessive Sucking	Score for frantic rooting or sucking behaviors (e.g., sucking on fists, hands, pacifier or clothing), and/or if evidence of sucking blisters on fingertips or knuckles present.
Poor Feeding	Score if baby is slow to feed or feeds inadequate amounts unrelated to prematurity. Score if baby demonstrates uncoordinated and ineffectual suck/swallow in presence of rooting and/or sucking behaviors.
Regurgitation	Regurgitation = effortless return of gastric/esophageal contents from infant's mouth. Score only if regurgitation occurs more frequently than is usual for a newborn.
Projectile Vomiting	Forceful ejection of stomach contents.
Loose Stools	Score if stools are loose but lack surrounding water ring.
Watery Stool	Score if stools are loose and have water ring present.
For any score ≥ 8	Initiate Q2 hr scoring for 24 hours and continue until scores are < 8 for 24 hours
Pharmacologic therapy and transfer to the ICN should be considered for:	<ul style="list-style-type: none"> Three consecutive scores ≥ 8 Average of any three consecutive scores ≥ 8 Two consecutive scores ≥ 12 Average of any two consecutive scores ≥ 12 Severe symptoms (e.g., apnea, seizures)

Upper Valley Community Resources

CHILD PROTECTIVE SERVICES		
■ Department of Children and Families (VT)		802-295-8840
■ Department of Children, Youth and Families (NH)		603-894-5533
■ Prevent Child Abuse America		800-244-5373
DOMESTIC/FAMILY VIOLENCE		
■ Safeline/Randolph VT		800-639-7233
■ Wise/Upper Valley		603-448-5922
EMERGENCY FINANCIAL ASSISTANCE		
■ Claremont Soup Kitchen		603-543-3290
■ Listen Community Services		603-448-4553
■ Newport Food Pantry		603-863-3411
■ NH Health and Human Services		603-543-3111
■ PATH/VT		802-295-8855
■ Tri County CAPP/NH		603-752-7001
■ Town Welfare Offices		
GENERAL INFORMATION AND REFERRAL		
■ NH Resource 211		802-652-4636
■ VT Resource 211		866-444-4211
HEALTH AND MENTAL HEALTH		
■ Clara Martin (Bradford, Randolph area, VT)		802-222-4477
■ Counseling Center of Newport		603-542-5128
■ DHMC Psychiatry 24 Hour		800-556-6249
■ Health Care and Rehabilitation Services of Southeastern VT (White River Junction, VT area)		800-888-5144
■ VT Dental Clinic at the VA (White River Junction, VT area)		800-827-1000
■ West Central Behavioral Health (Lebanon, NH area)		603-542-5128
HOUSING		
■ 10 Bricks Homeless Programs		603-443-6150
■ Hartford Housing Authority		802-295-5047 mornings
■ Hodges Corporation		603-298-5610
■ Lebanon Housing Authority		603-298-5733
■ Listen Community Services		603-448-4353
■ Upper Valley Haven		802-295-6500
LEGAL ASSISTANCE		
■ Have Justice Will Travel/VT		802-685-7809
■ NH Legal Assistance Program		800-562-3994
■ Pro Bono Referral/NH		603-224-3333
■ Reduced Fee Referral Program/NH		603-229-0002
■ South Royalton Legal Clinic/VT		802-831-1500

Upper Valley Community Resources

LEGAL ASSISTANCE (CONT'D)		
■ VT Legal Aid		800-889-2047
■ VT Protection and Advocacy		802-834-7890
■ Wise/Upper Valley, Lebanon, NH		603-448-5992
PREGNANCY/HEALTH REPRODUCTIVE SERVICES		
Dartmouth-Hitchcock Medical Center:		
■ Breastfeeding Support/Birthing Pavilion Continuing Care Center and Lactation Clinic		603-650-6159
■ Maternal Fetal Medicine Service at DHMC		603-653-9306
■ Women's Health Resource Center		603-650-2600
Community Resources:		
■ Care Net Pregnancy Center of the Upper Valley		603-298-6123
■ Planned Parenthood		603-298-7766
SUPPORT/HOME BASED PROGRAMS		
■ Bradford VT Parent Child Center		802-222-5787
■ Central VT Parent Child Center		802-485-8430
■ Family Infant Toddler (VT)		800-649-2642
■ Good Beginnings (VT/NH)		603-298-9524
■ Hannah House		603-448-5339
■ Healthy Babies		800-649-4357
■ Orange County Parent Child Center		802-685-2264
■ Parent to Parent of NH		603-448-6393
■ Springfield Area Parent Child Center		802-885-5424
■ Support Group: Circle of Parents , White River Junction, VT Wed. 6:30 pm-8:00 pm (Noreen Lake)		802-498-0606
■ The Family Place (Hartford area, VT)		802-649-3268
TRANSPORTATION		
■ NH Medicaid Transportation		603-852-3345 x3770
■ VT Medicaid Transportation		802-885-5165
TREATMENT PROGRAMS		
■ 2nd Wind Foundation; Turning Point		802-295-5206
■ Alcoholics Anonymous		802-295-7611
■ DHMC/Subutex		603-650-5805
■ Habit Opco/Methadone West Lebanon, NH		603-298-2146
■ Habit Opco/Methadone Brattleboro, VT		802-258-4623
■ Habit Opco/Methadone Manchester, NH		603-258-4623
■ Headrest		603-448-4400
■ Narcotics Anonymous		603-645-4777
■ Recovery Center of Lebanon		603-448-5610
■ Valley Vista		802-222-5201

Notes

■ Ideas for spending time with me:

■ How I tell you when I am happy:

■ How I tell you when I am unhappy:

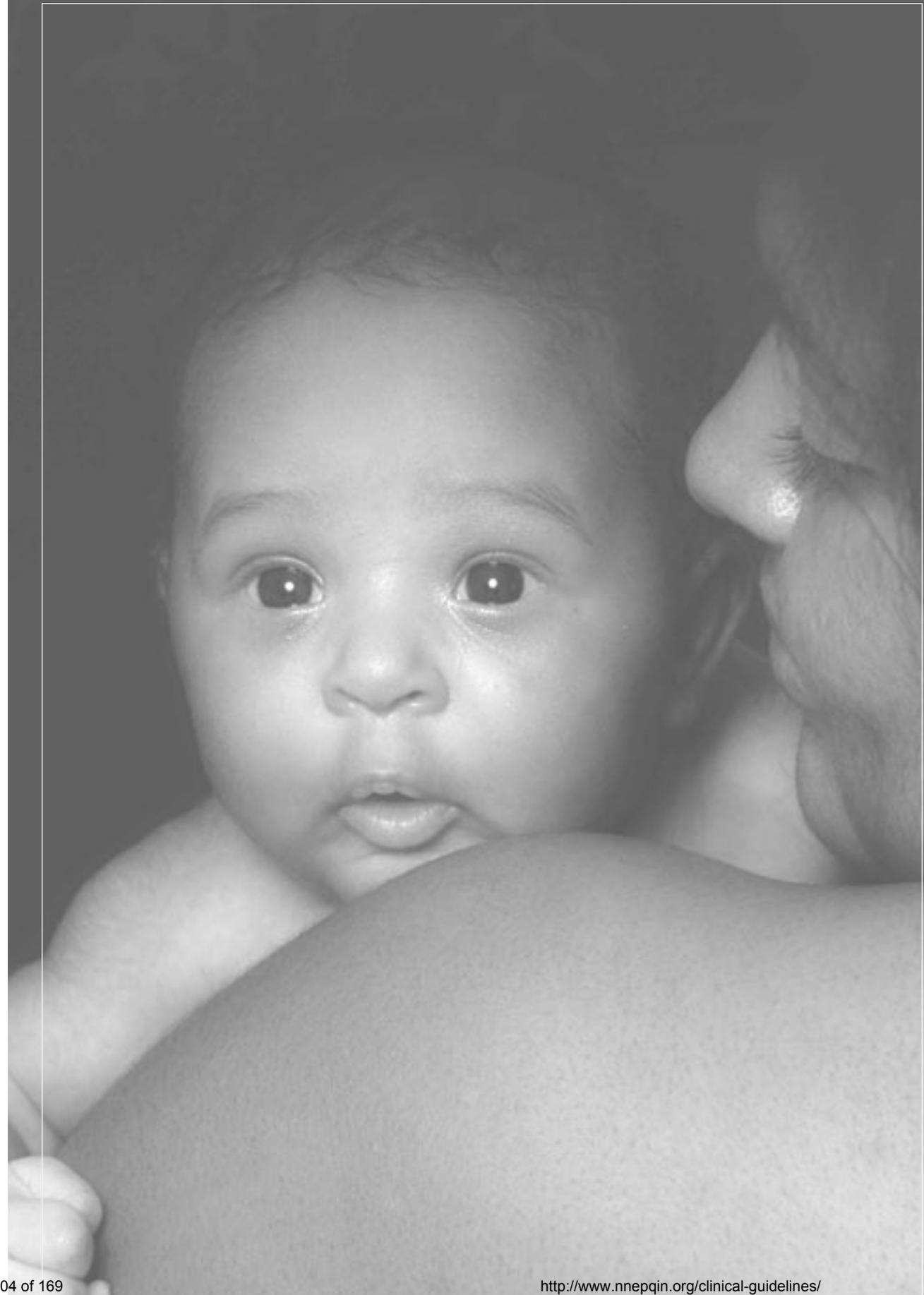
■ Ways I like to relax:

■ Things I can do for myself:

■ How you can help me:

■ Things I'm good at:

■ Special things I need:



Section 10: Infectious Disease Diagnosis and Treatment

Hepatitis C Diagnosis and Treatment

Key points

- All patients with opioid use disorders, history of injection drug use or inhalation (“snorting”), or non-professional tattoos or piercings should be screened for the hepatitis C virus (HCV). People who are HCV antibody positive should have follow-up viral load testing to determine whether chronic active disease is present. Testing for HCV *genotype* is optional during pregnancy, as it will not change perinatal management, but is useful to guide treatment after delivery
- Patients who are viral load positive should receive the following information:
 - Hepatitis C is a chronic disease of the liver which should be treated to avoid liver damage. New medications for HCV are highly effective and have minimal side effects. They are not currently recommended for use during pregnancy or lactation
 - A positive viral load indicates that Hepatitis C is contagious and precautions are necessary to prevent transmission to partners and household members
 - The rate of sexual transmission of HCV is estimated to be about 15% (CDC, 2016). Condom use is recommended unless a partner is already infected with the same HCV genotype
 - Avoid contact with the blood of an infected person, including sharing razors, toothbrushes, etc.
- The rate of vertical transmission from mother to fetus is around 6% (CDC, 2016), higher if the mother is also HIV positive. This rate is similar for vaginal and cesarean birth
- There is no known case of transmission through breastmilk (CDC, 2016). However, breastfeeding is not recommended if nipples are cracked or bleeding, or open lesions are present on the breast. CDC guidance is available at: <https://www.cdc.gov/breastfeeding/disease/hepatitis.htm>
- Infants exposed to Hepatitis C prenatally should have follow up testing by their pediatric provider at 18 months of age (CDC, 2016)
- People who have active Hepatitis C should be referred to a specialist or primary care provider with experience in hepatitis management

Resources for providers

- From the Centers for Disease Control: <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#g1>
- Interpretation of HCV test results: https://www.cdc.gov/hepatitis/hcv/pdfs/hcv_graph.pdf

Resources for patients

- American College of Obstetricians and Gynecologists
<http://www.acog.org/~media/For%20Patients/faq093.pdf>
- American College of Nurse Midwives:
<http://onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2005.03.020/pdf>
- Centers for Disease Control: <https://www.cdc.gov/hepatitis/hcv/cfaq.htm>
- *Link to video: "Hepatitis C in Pregnancy:" A conversation with Dr. Tim Lahey, Infectious Disease.*
<https://dhmc.wistia.com/medias/dhsjkydhv1>

Hepatitis B Screening and Diagnosis

Key points

- Patients with opioid use disorders, a history of injection drug use or inhalation (“snorting”), non-professional tattoos or piercings, or sexual or household contact with people with hepatitis B or injection drug history should be screened for hepatitis B virus (HBV).
- Increased injection drug use has led to a rise in the prevalence of Hepatitis B due to injection drug use in some regions of the United States (see <https://www.cdc.gov/hepatitis/statistics/2015surveillance/pdfs/2015HepSurveillanceRpt.pdf>)
- Standard prenatal labs include screening for **HBsAg** (hepatitis B surface antigen, indicating the presence of active infection). Persons at risk for HBV infection should also be tested for **anti-HBc** (hepatitis B core antibody, indicating previous or current infection) and **anti-HBs** (hepatitis B surface antibody, indicating immunity from either disease or vaccination). This additional testing determines whether the person is vulnerable to infection and should be offered vaccination (CDC, 2017). Additional information about hepatitis B serologic testing, including clinical guidelines for perinatal management, see <https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>
- Patients who test positive for HBsAg should be referred for further evaluation and management to an infectious disease specialist, gastroenterologist, or hepatologist.
- Patients who test positive should receive the following information:
 - Hepatitis B is a chronic disease of the liver which can cause permanent liver damage.
 - Hepatitis B is highly contagious, and precautions are necessary to prevent transmission to partners and household members. All household members should be screened and offered immunization if non-immunes.
 - HBV is spread through contact with semen or vaginal secretions (CDC, 2016). Condoms should be used for sexual activity involving exposure risk.

- Avoid sharing razors, toothbrushes, etc. Hepatitis B is not spread through kissing an infected person, eating or preparing food, or via the respiratory route.
- Infants exposed to hepatitis B prenatally should receive hepatitis B immunoglobulin (HBIG) and HBV immunization immediately after birth. Without prophylaxis, an estimated 40% of exposed newborns will develop chronic hepatitis B. The need for treatment should be discussed prenatally and the delivery hospital notified in preparation (see algorithm: <https://www.cdc.gov/hepatitis/hbv/pdfs/PrenatalCareProviderPoliciesAndProcedures.pdf>)
- Breastfeeding is not contraindicated in the context of hepatitis B infection (CDC, 2016). However, breastfeeding is *not* recommended if nipples are bleeding, or open lesions present. <https://www.cdc.gov/breastfeeding/disease/hepatitis.htm>

Resources for patients

- From the American College of Obstetricians and Gynecologists: <https://www.acog.org/Patients/FAQs/Hepatitis-B-and-Hepatitis-C-in-Pregnancy>
- From the Centers for Disease Control:
 - *Educational powerpoint about prenatal exposure to Hepatitis B:* https://www.cdc.gov/hepatitis/Partners/Perinatal/Presentations/HealthyBaby/HepB_And_YourHealthyBaby-eng.pdf

Resources for providers

- From the Centers for Disease Control:
 - The ABCs of hepatitis: <https://www.cdc.gov/hepatitis/resources/professionals/pdfs/abctable.pdf>
 - Recommendations for screening and follow up of patients at risk for hepatitis B: <https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>
 - Interpretation of HBV test results: <https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>



HIV Resources for Providers

All pregnant women should be screened for HIV at onset of prenatal care. Women with risk factors for infection, including recent injection drug history, a partner who uses injection drugs, or are incarcerated, should also be screened in the third trimester. Because it is difficult to be sure who has ongoing risk, NNEPQIN recommends that all women with opioid use disorder should be re-screened for HIV towards the end of pregnancy. Screening at the time of delivery is acceptable if expedited results are obtainable within one hour at the delivery hospital, although earlier screening is preferred as it allows time to confirm results, initiate antiretroviral therapy during pregnancy, and develop a follow up plan for the newborn (<https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0>).

Women testing positive for HIV should be referred to an infectious disease specialist experienced in the treatment of HIV during pregnancy, and consent to disclose information to their infants' pediatric providers should be incorporated in the care plan to ensure appropriate follow up. Maternal Fetal Medicine consultation should be obtained and/or care transferred.

- **AIDSinfo** is the U.S. Department of Health and Human Services site, a comprehensive resource for clinical guidelines, factsheets, and infographics to facilitate evidence-based care for people living with HIV: <https://aidsinfo.nih.gov/>
- The NIH perinatal treatment guidelines can be accessed through: <https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0>
- Information for patients is available at: <https://aidsinfo.nih.gov/understanding-hiv-aids>

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis helps people avoid infection with HIV and should be offered to anyone at risk, including people who use injection drugs or exposed through sexual contact with an HIV positive partner. PrEP consists of HIV medication taken daily to proactively lower risk of infection. When taken daily, PrEP reduces the risk of HIV transmission through sexual contact by greater than 90%, and from injection drug use by greater than 70% (<https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis>).

PrEP must be prescribed, and is covered by many insurance plans. A medication assistance program is available if PrEP is not covered by a specific insurance plan (<http://www.gilead.com/responsibility/us-patient-access/truvada%20for%20prep%20medication%20assistance%20program>)

Other resources for providers

- CDC Information About PrEP
<https://www.cdc.gov/hiv/basics/prep.html>
- Provider education on HIV and pregnancy from CDC
<https://www.cdc.gov/hiv/group/gender/pregnantwomen/>
- Medication Assistance Program for PrEP
<http://www.gilead.com/responsibility/us-patient-access/truvada%20for%20prep%20medication%20assistance%20program>

Additional resources for patients

- HIV Treatment Guidelines for Pregnant Women (Rutgers)
http://womenandhiv.org/sites/default/files/pdf/WhatWomenKnow_En_Booklet_2013_FXB.pdf
- Patient education on HIV and pregnancy from CDC:
<https://www.cdc.gov/hiv/basics/index.html>
- ACOG FAQs about HIV and Pregnancy
<http://www.acog.org/Patients/FAQs/HIV-and-Pregnancy>
- What Women Need to Know about Pregnancy and HIV Treatment (ACOG)
http://womenandhiv.org/sites/default/files/pdf/WhatWomenKnow_En_Booklet_2013_FXB.pdf
<https://www.cdc.gov/breastfeeding/disease/>
- CDC Information About PrEP
<https://www.cdc.gov/hiv/basics/prep.html>

Section 11: Assessing Women’s Social Needs: Screening for Social Determinants of Health

“Pregnancy may be an opportunity for women, their partners and other people living in their household to change their patterns of alcohol and other substance use. Health workers providing care for women with substance use disorders during pregnancy need to understand the complexity of the woman’s social, mental and physical problems in order to provide appropriate advice and support throughout pregnancy and the postpartum period.”

(World Health Organization, 2014)

The World Health Organization recommends that all pregnant women with opioid use disorders receive a full assessment for psychosocial needs which may create barriers to care. Ideally, this should be performed by a clinical social worker or other care management specialist. However, many practices do not have access to case management or other support services. A validated screening instrument for social determinants of health can be administered by any member of the care team, and is recommended in this context to help identify patient needs.

A statement by the American College of Obstetricians and Gynecologists, calling for integrating screening for social determinants of health in routine women’s health care, can be accessed at:

<https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Importance-of-Social-Determinants-of-Health-and-Cultural-Awareness-in-the-Delivery-of-Reproductive>

One such tool is [PRAPARE](#), developed and owned by the National Association of Community Health Centers (NACHC) in partnership with the Association of Asian Pacific Community Health Organization (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF). PRAPARE can be downloaded and used without charge from:

http://nachc.org/wp-content/uploads/2016/09/PRAPARE_One_Pager_Sept_2016.pdf

Additional background on the [development and validation](#) of PRAPARE, as well as information on incorporating the tool in a variety of electronic health records systems is available from:

<http://nachc.org/research-and-data/prapare/> (PRAPARE is protected by copyright)

The American Academy of Pediatrics' Screening Technical Assistance and Resource (STAR) Center offers a full toolkit for screening for Social Determinants of Health. These resources are available without charge from:

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>

Screening for and responding to disclosure of Intimate Partner Violence

Substance use disorders in women is strongly associated with current and past histories of partner violence (http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf)

What is Intimate Partner Violence?

Intimate partner violence (IPV) is a preventable public health problem that affects millions of people regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. IPV is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation of personal needs, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.

Reproductive and sexual coercion and IPV are health issues that disproportionately affect women, although they affect people of all genders. Women are at significantly higher risk than men of experiencing IPV, of sustaining serious injuries, and being killed by an intimate partner. Human trafficking and substance use coercion are closely associated.

- Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner
- Nearly half (45.9%) of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner In a nationally representative sample, and 1 in 4 women reported lifetime coerced sex
- Among women reporting coerced sex, more than one-third were 15 years old or younger at the time of their first coerced sexual experience
- Childhood sexual trauma is strongly associated with adult substance use in women

Why does this belong in healthcare?

IPV has serious implications for health and wellbeing of its survivors

- Leading cause of female homicides and injury-related deaths during pregnancy
- Accounts for a significant proportion of injuries and emergency room visits for women
- May lead to lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and death.
- Women who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of physical and mental health conditions including headaches, gastrointestinal problems, depression, anxiety, sleep problems, post-traumatic stress disorder (PTSD), and substance use disorders.

There is a substantial body of research describing the dynamics and effects of IPV on health. Abusive and controlling behaviors range from sexual assault and forced sex, to more hidden forms of victimization that interfere with a partner's choices about sexual activities, contraception, safer sex practices, and pregnancy. IPV is often a barrier to accessing reproductive health care.

Screening for IPV:

- All women should be screened for interpersonal violence before, during, and after pregnancy. Although optimal timing of screening has not been determined, repeated screening is recommended.
- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as reproductive health history, infectious disease history, and to safely screen women for domestic violence
- When a woman cannot be confidentially screened, screening should be deferred

Validated screening tools exist for intimate partner violence (<http://ipvhealth.org/>; <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>).

If a patient screens positive, what should I do?

It is important to validate the patient's experience and to thank them for sharing this very personal information with you. Some helpful, scripted responses are included below. If a person declines an offer of resources, that's okay. It's important to validate their experience and to meet them where they are today.

- *"I am glad you told me. We see many patients here with similar situations, and there are services in the area that can be of help. Can I give you some more information?"*
- *"Would you be interested in talking further about this with one of us [social worker, behavioral health clinician, domestic violence advocate] today?"*

Always offer referral: Domestic violence advocacy programs are available 24/7. During clinic hours, they may be available to come to the clinic for a warm referral if the patient has time, so it's good to offer this whenever possible. This can also be planned for a future date as it may be safer for a person to come to a medical appointment than to make other arrangements.

If a person does not have time or is not sure about accepting a referral, provide them with local and/or national contact information. It's important that every clinic has this information readily available.

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233)

(TTY) 1-800-787-3224

www.thehotline.org

For patients who screen negative: It's important to talk about why screening for IPV is necessary. Normalizing the discussion of IPV and providing reassurance that the practice is a safe place to disclose may encourage survivors who are afraid to disclose in the future. It may also help them counsel a friend or family member who is in an abusive relationship. Normalizing these conversations is valuable.

Documentation following a positive screen:

- Provider notes, especially with objective findings related to trauma may be helpful evidence in custody or divorce proceedings. However, **including a diagnosis of adult physical abuse or other documentation in your note can increase risk if the abusive partner has access to your patient's electronic medical records.**
 - **2018 ICD-10-CM Diagnosis Code T74.11XA: Adult physical abuse, confirmed, initial encounter**
 - **2018 ICD-10-CM Diagnosis Code Z91.410: Personal history of adult physical and sexual abuse**

- Some EHR systems have the option of hiding documentation to protect highly confidential information, this is recommended if available.

*The 3 question **Partner Violence Screen (PVS)** is a short screening tool for interpersonal violence that may be used as a follow up tool to screen a pregnant or parenting MIHP beneficiary. It may not be used in place of the Maternal Risk Identifier (MRI) or Infant Risk Identifier (IRI) which ask additional questions.*

- 1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?**
- 2. Do you feel safe in your current relationship?**
- 3. Is there a partner from a previous relationship who is making you feel unsafe now?**

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF.(2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. Journal of Trauma, 54, 352-55.

If a woman answers the PVS screen affirmatively. Please pull the POC2 for Abuse/Violence.

WOMAN ABUSE SCREENING TOOL¹ (WAST)

1. In general, how would you describe your relationship?
 - a lot of tension
 - some tension
 - no tension

2. Do you and your partner work out arguments with:
 - great difficulty
 - some difficulty
 - no difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
 - often
 - sometimes
 - never

4. Do arguments ever result in hitting, kicking or pushing?
 - often
 - sometimes
 - never

5. Do you ever feel frightened by what your partner says or does?
 - often
 - sometimes
 - never

6. Has your partner ever abused you physically?
 - often
 - sometimes
 - never

7. Has your partner ever abused you emotionally?
 - often
 - sometimes
 - never

8. Has your partner ever abused you sexually?
 - often
 - sometimes
 - never

Source: Brown, J., Lent, B., Schmidt, G., & Sas, S. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice*, 49, 896-903.

¹ Note: this tool is validated

Section 12: Facilitating Access to Mental Health Services

Screening for co-occurring psychiatric conditions

All pregnant women with substance use disorders should be screened for depression and anxiety at the first and subsequent prenatal visits. Screening should be done with empathy, using validated screening instruments. Positive screens should be followed up by a healthcare provider to ensure that women receive follow-up care and, if needed, referral to behavioral health clinicians or psychiatry.

Healthcare professionals are encouraged to screen women for depression and anxiety, and assist women to obtain further evaluation and/or treatment. Ideally all women with substance use disorders should receive a psychiatric evaluation to ensure that untreated psychiatric needs are met. However, access to behavioral health and psychiatry is often limited; therefore, initial screening and consultation can be accomplished in the obstetric or primary care setting. Healthcare providers should be sensitive to the prevalence of trauma history among women with substance use disorders, and care should be informed by the assumption that any woman is likely to have experienced sexual and/or physical violence in her lifetime.

Screening instruments for depression and anxiety which are valid for use during pregnancy and postpartum include the Patient Health Questionnaire (PHQ-9), the Center for Epidemiologic Studies Depression Scale (CES-D), the Edinburgh Postnatal Depression Scale (EPDS), and the Generalized Anxiety Disorders Scale (GAD-7). If post-traumatic stress disorder is suspected, the Abbreviated PCL-C is a brief, validated screening tool which can be used in the primary care setting (SAMHSA, 2017). The Mood Disorders Questionnaire (MDQ) is a brief screening tool to help clinicians differentiate symptoms of depression from bipolar affective disorder. Links to these non-proprietary screening tools are included below.

Maternity care providers who are comfortable treating uncomplicated depression, anxiety, and PTSD during pregnancy and postpartum should be aware of potential drug-drug interactions between methadone and antidepressant medications (SSRIs or tricyclics) (SAMHSA, 2018). Benzodiazepines are not indicated for the long term treatment of anxiety or PTSD symptoms, are associated with a neonatal benzodiazepine withdrawal syndrome, and may cause life-threatening respiratory depression for

mothers when combined with opioids. Exposure to SSRIs for the treatment of co-occurring depression and anxiety disorders in addition to treatment with buprenorphine or methadone may increase symptoms of NAS/NOWs. However, not treating mental health disorders during pregnancy and postpartum can have serious consequences for both mother and baby, and therefore benefits often outweigh risks. Supporting evidence and clinical considerations regarding these decisions can be found in [Factsheet 5](#) of SAMHSA'S *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants* (SAMHSA, 2018, pp 42-44).

The Massachusetts Child Psychiatry Access Project provides a publicly available toolkit for assessment and management of uncomplicated perinatal mood disorders.

<https://www.mcpapformoms.org/Docs/Adult%20Toolkit.pdf>

Additional resources for providers

- May 11, 2017 Learning Collaborative Session on treatment of co-occurring mental health disorders by Dr. Julia Frew, Assistant Professor, Geisel School of Medicine and Medical Director of the *Dartmouth-Hitchcock Perinatal Addiction Treatment Program*:
<https://dhvideo.webex.com/dhvideo/ldr.php?RCID=41ad25307bbc0b6a3333885938808c22>
- MGH Women's Mental Health Program: <https://womensmentalhealth.org/>
- Organization of Teratology Information Specialists (useful info on psychiatric medications in pregnancy, including patient handouts): <https://mothertobaby.org/>
- A Primary Care posttraumatic stress disorder (PTSD) screener:
<https://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf>
- Patient Health Questionnaire (PHQ-9):
<https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218>
- Generalized Anxiety Disorders (GAD-7):
<https://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>
- Center for Epidemiologic Studies Depression Scale (CES-D):
<http://www.chcr.brown.edu/pcoc/cesdscale.pdf>
- Scoring and follow up for Edinburgh Postnatal Depression Scale, from McPap for Moms toolkit:
<https://www.mcpapformoms.org/Docs/Assessment%20of%20Depression%20Severity%20and%20Tx%20Options%2009.8.14.pdf>
- Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women, from the McPap for Moms toolkit:
<https://www.mcpapformoms.org/Docs/Key%20Clinical%20Considerations%2010%2006%2015.pdf>
- A summary of Emotional Complications during Pregnancy and the Postpartum Period, from McPap for Moms Toolkit:

<https://www.mcpapformoms.org/Docs/Summary%20of%20Emotional%20Complications%2010%206%2015.pdf>

Additional resources for patients

- American College of Nurse Midwives. Postpartum Depression. *J Midwifery and Women's Health* 2014; 58; 6: <http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12144/pdf>
- American College of Obstetricians and Gynecologists. Postpartum Depression. <https://www.acog.org/Patients/FAQs/Postpartum-Depression#cope>
- Postpartum Support International: www.postpartum.net
- Mental Health self-care guides for reproductive mental disorders (online CBT) <https://reproductivementalhealth.ca/resources/self-care-guides>

Section 13: Federal Legislation Regarding Infant Plan of Safe Care

Federal law requires that all infants determined to be affected by maternal substance use must have a Plan of Safe Care in place on discharge from the birth hospital.

Key points

- The required elements of the Plan of Safe Care vary from state to state
- Some states are working to develop specific guidance for hospitals and providers.
- This law specifically includes neonatal withdrawal
- Prenatal providers should discuss relevant state rules and hospital policies about the Plan of Safe Care with patients prior to delivery

Relevant Federal legislation

As amended in 2010, the Child Abuse Prevention and Treatment Act (CAPTA) requires states to include in their state plans an assurance that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program relating to child abuse and neglect that includes the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

- **The CAPTA Reauthorization Act of 2010:**
<https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf>

S524, *The Comprehensive Addiction and Recovery Act of 2016* was signed into law on July 22, 2016. Title V, Section 503, “Infant Plan of Safe Care” amends CAPTA to address the health and substance use disorder treatment needs of the infant and affected family or caregiver; and to ensure the development and implementation by the State of monitoring systems regarding the implementation of plans to determine whether and in what manner local entities are providing referrals to and delivery of appropriate services for the infant and affected family or caregiver.

- **The Comprehensive Addiction and Recovery Act of 2016:**
<https://www.congress.gov/bill/114th-congress/senate-bill/524>

SAMHSA’s *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants* emphasizes that the Plan of Safe Care includes both mother and infant, and should address potential maternal comorbid medical or mental health conditions (SAMHSA, 2018). Therefore, the plan must include accessible and timely supports available to the mother when needed.

The 3 question PVS is a short screening tool for interpersonal violence that may be used as a follow up tool to screen a pregnant or parenting MIHP beneficiary. It may not be used in place of the Maternal Risk Identifier (MRI) or Infant Risk Identifier (IRI) which ask additional questions.

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF.(2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. Journal of Trauma, 54, 352-55.

If a woman answers the PVS screen affirmatively. Please pull the POC2 for Abuse/Violence.

WOMAN ABUSE SCREENING TOOL¹ (WAST)

1. In general, how would you describe your relationship?
 - a lot of tension
 - some tension
 - no tension

2. Do you and your partner work out arguments with:
 - great difficulty
 - some difficulty
 - no difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
 - often
 - sometimes
 - never

4. Do arguments ever result in hitting, kicking or pushing?
 - often
 - sometimes
 - never

5. Do you ever feel frightened by what your partner says or does?
 - often
 - sometimes
 - never

6. Has your partner ever abused you physically?
 - often
 - sometimes
 - never

7. Has your partner ever abused you emotionally?
 - often
 - sometimes
 - never

8. Has your partner ever abused you sexually?
 - often
 - sometimes
 - never

Source: Brown, J., Lent, B., Schmidt, G., & Sas, S. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice*, 49, 896-903.

¹ Note: this tool is validated

Section 14: Postpartum Care

The postpartum period is a particularly vulnerable time for women who have substance use disorders due to rapid physiologic changes, sleep deprivation, and family stress. Anxiety related to both internal and external factors is often high, and frequent visits for emotional support and problem solving are strongly recommended. The American College of Obstetricians and Gynecologists recommends a revised approach to postpartum care, including a postpartum visit within the first three weeks postpartum and a comprehensive exam at or before 12 weeks after delivery (ACOG, 2018). However, women with substance use disorders may benefit from additional support. Providers should consider scheduling an initial postpartum visit within 1-2 weeks after delivery, and biweekly until at least 6 weeks (SAMHSA, 2018; Alliance for Innovation in Maternal Health, 2018). A warm handoff to primary care should be made at the conclusion of postpartum care, whenever that occurs.

Postnatal visits may include usual obstetrical assessments, including healing from delivery itself and support for breastfeeding; as well as sequential screening for postpartum depression; intimate partner violence; assessment of material needs; and counseling for tobacco cessation if indicated. Pregnancy intention and need for contraception should be assessed at each visit unless a woman received immediate postpartum long acting reversible contraception (LARC). The traditional 6-week postpartum period should be extended for women with OUD/SUD as continuity of relationships is critically important and this is a vulnerable time (ACOG, 2018).

Postpartum screening

We recommend the use of validated screening instruments for depression, intimate partner violence, and social determinants of health at each postpartum visit, as described elsewhere in this toolkit.

Supporting breastfeeding

Methadone, buprenorphine, and naloxone are all compatible with breastfeeding, and breastfeeding is highly recommended for infants at risk for neonatal opioid withdrawal (NAS/NOWS). Please refer to the NNEPQIN Breastfeeding Guidelines for Women with Substance Use Disorders

Family Planning

Immediate post-placental long acting reversible contraception (LARC) is a convenient option for women desiring long-term contraception that is compatible with breastfeeding. Placement under epidural anesthesia or trans-cesarean is particularly attractive for women who have a history of sexual trauma or/and experience anxiety related to pelvic examination. Clinicians providing care for women with

substance use disorders should work to ensure that this option is available at the anticipated birth hospital, and offer it prenatally.

Whether prenatally or postpartum, conversation about pregnancy intention should always be conducted with respect and a shared decision-making approach which honors women's right to choose whether or not to use contraception. Using an approach which inquires about pregnancy intention, such as "One Key Question" (<https://powertodecide.org/one-key-question>), rather than implying that a woman should use contraception, is respectful and aligned with the 10 best contraceptive practices included in this toolkit.

Transitions of care

Maternity care providers should ensure that women have access to medication assisted treatment for OUD and continuing SUD counseling as relapse risk is high and increases with time. If a woman leaves the SUD treatment program she had attended during pregnancy, it is important to help her find an alternate. Every effort should also be made to link women to a recovery-friendly primary care provider as well. Maternity care providers should continue to support for women's health needs at least until this transition has occurred. Finally, maternity care providers can play an important role both prenatally and postnatally in ensuring that women establish pediatric care for their infants.

Working with treatment providers

Maternity care providers should request written consent from mothers with SUD/OUD to communicate with their treatment providers prenatally, and to confirm this consent postnatally. Treatment providers may need reassurance that both methadone and buprenorphine/naloxone are compatible with breastfeeding (SAMHSA, 2018). Most antidepressant medications are also compatible with breastfeeding, but if started in the maternity care context, the SUD treatment provider should be advised as there are potential interactions with psychiatric medications and methadone.

Referral to specialty care

Women diagnosed with chronic Hepatitis C during pregnancy should be referred to Infectious Disease or Gastroenterology/Hepatology specialists after delivery, as treatment is indicated as soon as breastfeeding is concluded. Women receiving antiretroviral therapy for HIV should be supported in continuing treatment, and should not breastfeed. Women who do not respond as expected to antidepressants should be referred to a psychiatric provider if possible for assessment and management recommendations.

Referral for home visiting and other services

At each postpartum visit, providers should ask about and assist women to follow up on referrals to public health nursing and other child and family services available in the community

Additional resources for providers:

ACOG Committee Opinion #236, Optimizing Postpartum Care. Available from <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20180522T1442482827>

SAMHSA Clinical Guidance for the Care of Pregnant and Parenting Women with Opioid Use Disorder and their Newborns. Available from <https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf>

Alliance for Innovation in Maternal Health: Patient Safety Bundle for Women with Opioid Use Disorder. Available from <https://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Obstetric-Care-for-OUD-Bundle.pdf>

Bedsider Birth Control Support Network: resources and educational materials for contraceptive practice. <https://providers.bedsider.org/articles/changing-the-conversation-about-contraception>

Resources for patients:

Bedsider Method Explorer: interactive site with digital patient education materials, available from <https://www.bedsider.org/methods>

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Klaman SL, Isaacs K, et al. Treating women who are pregnant and parenting for opioid use disorder and the concurrent care of their infants and children: Literature review to support national guidance. *J Addict Med* 2017;11(3);178-190. doi: 10.1097/ADM.0000000000000308

Reddy UM, Davis JM, Ren Z, et al. Opioid use in pregnancy, neonatal abstinence syndrome, and Childhood Outcomes. *Obstet Gynecol* 2017;130:10-28. doi: 10.1097/AOG.0000000000002054

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The Snuggle ME Guidelines: Tools for caring for women with addiction and their babies, Embracing drug affected babies and their families in the first year of life to improve medical care and outcomes Maine. Maine for Disease Control, Department of Health and Human Services. Available at: <http://www.maine.gov/dhhs/SnuggleME/documents/SnuggleME-2018-GuidelinesFINAL.pdf>. Accessed April 6, 2018.

Postpartum care (Outpatient)

- Close postpartum follow-up with frequent visits
 - Rescreen and brief intervention for return to substance use ([SAMHSA Factsheet #16](#))
 - Postpartum depression screening
 - Monitor for relapse
 - Screen for intimate partner violence at 6 weeks and whenever indicated
 - Smoking cessation reinforcement or continued cessation counseling when indicated.
 - Consider providing support services for longer than the traditional 6 week postpartum period
 - Assess resource needs at each visit and coordinate with case worker/social service providers
 - Assist patient in scheduling appointments for infectious disease management where indicated
 - Facilitate transition for recovery-friendly primary care provider if not established
 - Breast-feeding support
 - Provide contraception and counsel on birth spacing

10 Best Practices in Contraceptive Counseling

Background

Origin

The 10 Best Practices in Contraceptive Counseling were developed to improve contraceptive use and help families prevent unintended pregnancies through a partnership between the Center for Latino Adolescent and Family Health at the NYU Silver School of Social Work and Planned Parenthood Federation of America.

In 2011, almost half of pregnancies nationwide were unintended, and 41% of those unintended pregnancies were due to inaccurate or inconsistent use of a birth control method. An additional 54% of unintended pregnancies were due to nonuse of any contraceptive method.¹ The 10 Best Practices in Contraceptive Counseling provides an evidence-based framework for healthcare providers to use in discussing birth control options with patients, supporting them to use the method of their choice consistently and correctly so their reproductive life plans can be achieved.

Application for Women with SUDs

This framework is especially needed for women who use substances.. Among women with opioid use disorders, nearly 9 out of 10 pregnancies (86%) are unintended.² For providers who are supporting women with substance use disorders (SUDs) through an existing pregnancy and birth, both the prenatal and post-partum periods are a crucial window to implement these practices and discuss future reproductive intentions and birth control options.

This protocol was created through a lens of reproductive justice, and is designed to maximize patient choice and autonomy. It is especially important to maintain this lens in counseling women with SUDs, who represent a marginalized population that has faced a history of contraceptive coercion.

Framework Design

The 10 Best Practices in Contraceptive Counseling were designed to be implemented in a healthcare setting that offers the full range of contraceptive options, including IUDs and implants, and can be delivered by a variety of staff, including healthcare assistants, nurses, doctors, etc. In cases in which the medical practice does not offer certain methods of contraception, the 10 Best Practices can still be delivered, along with a referral to someone who can provide the patient's chosen method.

Further Training

The following summary was adapted by Planned Parenthood of Northern New England (PPNNE) from an extensive full-day training protocol, and is not intended to replace the more in depth program. To inquire about receiving training on the 10 Best Practices in Contraceptive Counseling, please contact Whitney Parsons at PPNNE (whitney.parsons@ppnne.org).

¹ Guttmacher Institute. (2016, September). Fact Sheet: Unintended Pregnancy in the United States. Retrieved from https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

² Heil SH, Jones HE, Arria A, et al. Unintended Pregnancy in Opioid-abusing Women. *Journal of substance abuse treatment*. 2011;40(2):199-202. doi:10.1016/j.jsat.2010.08.011.

Summary

The 10 Best Practices in Contraceptive Counseling:

#1	Demonstrate the “key three” attributes of an effective counselor –trustworthiness, expertise, and accessibility (TEA)
#2	Use active as opposed to passive learning strategies to engage the patient in learning and remembering important points
#3	Ask about pregnancy plans and offer resources
#4	Simplify choice process
#5	Make a plan for accurate use
#6	Make a plan for side effects
#7	Address lifestyle and broader context (POISE)
#8	Make a plan for method switching
#9	Talk about condoms for STI protection
#10	Mention use of quick start

Key Points:

- Through contraceptive counseling, providers can help patients prevent unintended pregnancy by helping them:
 - Choose a method that is best for them and their lifestyle,
 - Be consistent and correct in the use of their chosen method, and
 - Make a plan for switching methods if they choose to in the future.
- A year-long study of over 1,300 women at three Planned Parenthood Health Centers evaluated the effectiveness of the 10 Best Practices in Contraceptive Counseling. Compared to those patients who did not receive the new counseling protocol, those who did receive the 10 Best Practices were:
 - More likely to use birth control,
 - More likely to use condoms plus another method of birth control,
 - More likely to choose an IUD or implant because they decided it was the best method for them, and
 - More positive about the person who provided the counseling, the process, and the health center itself.
- Providers must be cognizant of potential for reproductive coercion, and respect and support patient autonomy and decision-making.
 - Minority and low-income women are more likely to report being pressured to use a birth control method and limit their family size.³
 - Providers are more likely to recommend IUDs to low-SES black and Latina women than to low-SES white women.⁴
- Patients will remember information and instructions better when they talk more and the provider talks less.

³ Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010). Disparities in Family Planning. *American Journal of Obstetrics and Gynecology*, 202(3), 214–220. <http://doi.org/10.1016/j.ajog.2009.08.022>

⁴ Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., & Steinauer, J. (2010). Recommendations for Intrauterine Contraception: A Randomized Trial of the Effects of Patients’ Race/Ethnicity and Socioeconomic Status. *American Journal of Obstetrics and Gynecology*, 203(4), 319.e1–319.e8. <http://doi.org/10.1016/j.ajog.2010.05.009>

How and Why to Implement 10 Best Practices in Contraceptive Counseling:

1 – Demonstrate the “key three” attributes of an effective counselor – trustworthiness, expertise, and accessibility (TEA)

Research says	Patients who see their provider as accessible are more likely to contact that provider and are less likely to experience gaps in protection when switching methods. Research also shows that patients do not automatically think that counselors have expertise or are looking out for their patient’s best interests. Counselors are more effective if they are seen as trustworthy, expert, and accessible.	What to say & do	<ul style="list-style-type: none">• “We want to help you find the birth control method that’s best for you.” (trustworthiness)• “I have dealt with this before.” (expertise)• “We are here for you. Call us anytime and I or one of my co-workers will get back to you. Here’s a card with my name on it and the health center’s contact info.” [Write your name on the card in front of the patient and give to patient.] (accessibility)
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2 – Use active as opposed to passive learning strategies to engage the patient in learning and remembering important points

Research says	People are more likely to remember important information when they actively process it as opposed to passively listen to it. For example, remembering how to accurately use a method is critical. Active processing of such information will help them recall it later.	What to say & do	<ul style="list-style-type: none">• Ask open-ended questions:<ul style="list-style-type: none">○ What questions do you have about this chart?○ How will you make sure that you...?○ Tell me more about that...○ So am I understanding you correctly that you want...?• Ask patient to repeat important information back to you in their own words.
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3 – Ask about pregnancy plans and offer resources

Research says	<p>Pregnancy ambivalence—including among women who want to leave the prospect of having a baby to “chance”—is associated with gaps in protection, less accurate and consistent use of birth control, more method switching, and extended periods without using contraception.</p>	What to say & do	<p>Ask the One Key Question[®]: “Would you like to become pregnant in the next year?”</p> <ul style="list-style-type: none"> • If “no,” discuss preventing pregnancy • If “yes,” discuss preconception care • If patient is unsure, here are key points to communicate: <ol style="list-style-type: none"> i. Pregnancy is healthiest when planned. ii. Being unsure can lead to gaps in protection. iii. Making a Reproductive Life Plan is a great way to reflect on goals of having or not having children and to identify steps to take to reach those goals. iv. Continue counseling as usual
<p>Additional Resources:</p> <ul style="list-style-type: none"> • One Key Question[®] - https://powertodecide.org/select360-consulting. • Main, M. (2016). One Key Question: Would You Like to Become Pregnant in the Next Year? <i>Northwest Bulletin: Family and Child Health</i>, 30. Center of Excellence in Maternal and Child Public. Retrieved from https://depts.washington.edu/nwbfc/archives/one-key-question-would-you-become-pregnant-next-year. • Delaware Health and Social Services- Division of Public Health. Adult Life Plan Brochure. Retrieved from http://dhss.delaware.gov/dhss/dph/chca/dphfpservices1c.html. • U.S. Department of Health and Human Services: Office of Population Health. Preconception Health and Reproductive Life Plan. https://www.hhs.gov/opa/title-x-family-planning/preventive-services/preconception-health-and-reproductive-life-plan/index.html. 			

4 – Simplify choice process

Research says	<p>There are about a dozen methods of birth control and each method differs on about a dozen different dimensions. Patients must therefore wade through about 150 pieces of information to make a choice—an overwhelming task. Research shows that in situations where people are faced with information overload, they “jump around” from one piece of information to another and make decisions based on what is salient (what happens to come to mind at that particular moment), not what is important.</p>	What to say & do	<p>→ SHOW: Star Chart of birth control options “This is a chart of all the birth control options. They are organized into three groups:</p> <ul style="list-style-type: none"> • <u>Group A</u> methods are the best at preventing pregnancy and most convenient. They are inserted here at the health center by a clinician. • <u>Group B</u> methods require some sort of action to work, like taking a pill every day, but are also very good at preventing pregnancy when used accurately. • <u>Group C</u> methods still work to prevent pregnancy as long as you use them every time you have sex.” <p>“Are there any methods you would like to learn more about?”</p>
<p>Additional Resources</p> <ul style="list-style-type: none"> • See Appendix 1: Star Chart 			

5 – Make a plan for accurate use

Research says	Using a method inaccurately or inconsistently undermines the efficacy of many methods. For example, the perfect use effectiveness rate of the pill is greater than 99% but the typical use effectiveness rate is 91%. This disparity is because of inaccurate and inconsistent use of the pill and translates into thousands of unintended pregnancies. Issues of use accuracy and consistency are critical to address	What to say & do	<ul style="list-style-type: none">• “How will you remember to take your method as described?”• “What will you do if you make an error using your method?”• “How will you remember to pick up your refills?” <p>→ Discuss common errors made when using method the patient is considering.</p>
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6 – Make a plan for side effects

Research says	Switching methods is often associated with gaps in protection or switches to less effective methods. Side effects are one of the most common reasons patients give for switching methods.	What to say & do	<ul style="list-style-type: none">• “Most side effects are temporary, usually lasting 2-3 months.• I’m going to share a few common side effects. Tell me which, if any, might be hard for you and I’ll help you make a plan to deal with them.” <p>→ Discuss common side effects for the method the patient is considering</p>
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7 – Address lifestyle and broader context (POISE)

Research says	In addition to the attributes of a given contraceptive method, you need to make sure that the chosen method fits with the lifestyle and life circumstances of the patient, more generally. It is not enough to just talk about effectiveness, side effects, and other method characteristics. A good choice considers broader considerations as well.	What to say & do	<ul style="list-style-type: none">• Pros and Cons: “What are the positives and negatives for you using this method?”• Others’ Views: “How would people important to you feel about you using this method?”• Image: “How does this method fit with how you see yourself?”• Self-Efficacy: “If you decided to use this method, how easy or hard do you think it would be for you to use it correctly?”• Emotions: “What positive and/or negative feelings do you have about this method?”
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8 – Make a plan for method switching

Research says	Switching to a less effective method increases the risk of an unplanned pregnancy, sometimes substantially so. Research shows that if people have “action plans” ahead of time for what to do when encountering unanticipated difficult situations, they are more likely to cope with and resolve those situations effectively – in this case, by avoiding a gap in protection.	What to say & do	“If you decided you wanted to switch, how would you switch to another method?” [Call the health center and continue taking a method of birth control.]
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9 – Talk about condoms for STI protection

Research says	STIs are widespread, far more than most people realize. There are over 8,000 new, serious infections in the United States every day. Some STIs, like herpes, are incurable and others, like HIV, are deadly. Some STIs do not show symptoms, but left untreated, can have serious health consequences. The methods most effective at preventing pregnancy offer no protection against STIs.	What to say & do	“This method doesn’t prevent STIs so if you are concerned about that it’s a good idea to use condoms.”
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10 – If possible, begin patient on chosen method that same day

Research says	For some birth control methods, women who start a method on the day of the clinic visit, instead of waiting for the next menstrual cycle or for another appointment, are more likely to start the method, use it correctly, and continue to use the method.	What to say & do	“We can start you on this method today so that you don’t have any gaps in protection.”
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Choosing a Method of Birth Control

Group A (Low-maintenance; health center sets it and you forget it)	Implant	★ ★ ★ ★
	IUD (Hormonal)	★ ★ ★ ★
	IUD (Non-hormonal)	★ ★ ★ ★
	Sterilization (Vasectomy, Tubal Ligation, Essure)	★ ★ ★ ★
Group B (Once every 3 months, monthly, weekly, daily)	Shot (Depo)	★ ★ ★
	Vaginal Ring	★ ★ ★
	Patch	★ ★ ★
	Pill	★ ★ ★
Group C (Must use every single time)	Male Condom	★ ★
	Female Condom	★ ★
	Diaphragm	★ ★
	Sponge	★ ★
	Cervical Cap	★ ★
	Fertility Awareness Method	★
	Withdrawal	★
	Spermicides	★

Approximate effectiveness: ★ ★ ★ ★ = 99% ★ ★ ★ = 91% ★ ★ = 85% ★ = 75%

Remember, most of these methods do not protect against STDs.
 Use a condom to lower your chances of getting an STD.



Section 15: References

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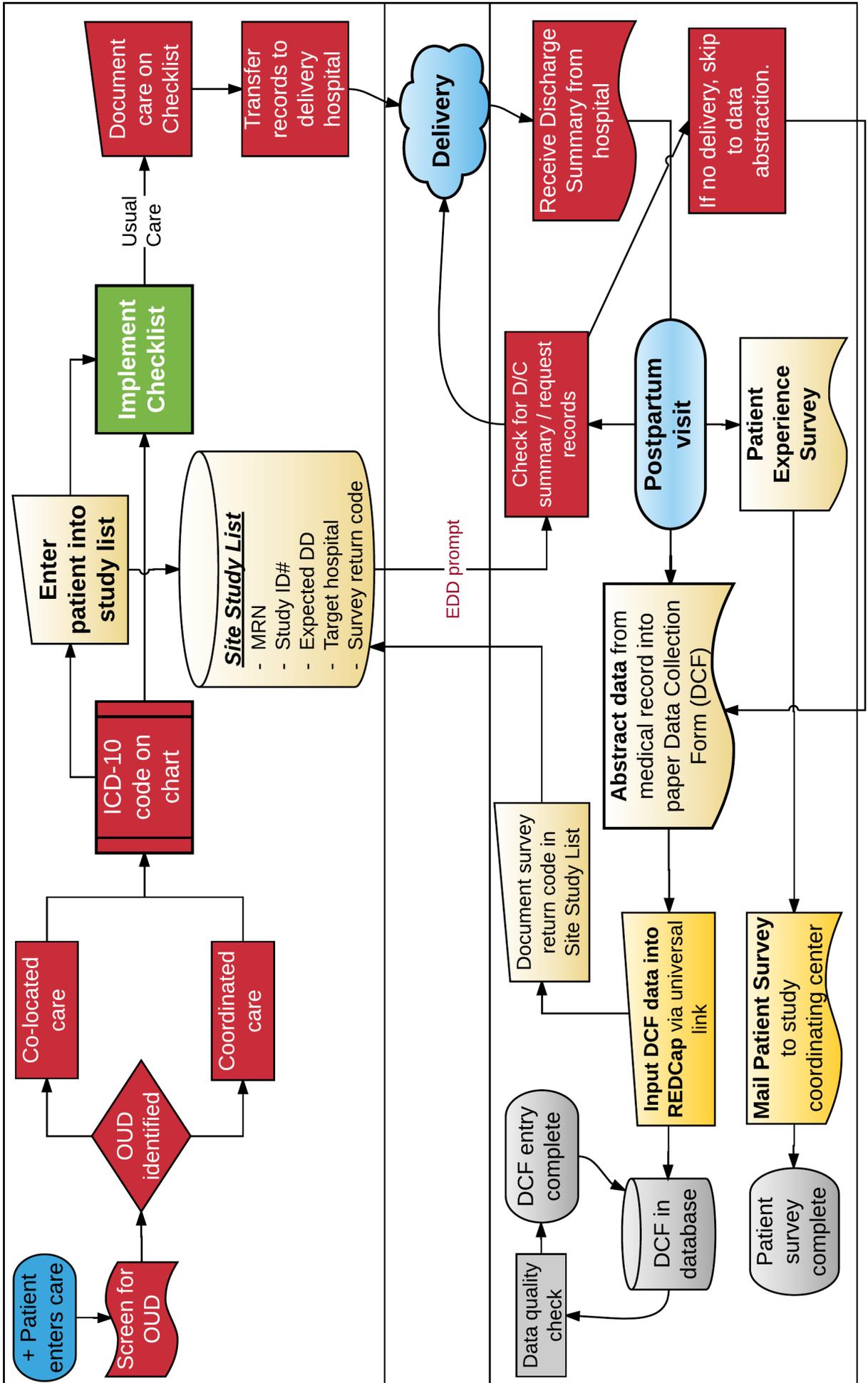
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Section 16: Implementation Tools

Best Practice Checklist for use in EMR

Element	Date	Comments
Federal consent to share information with treatment provider		
HIV status		
HBsAg, HBcAb, HBsAb		
Hepatitis C antibody		
HCV viral load and genotype <i>(if indicated)</i>		
Hepatic Function Panel		
Serum Creatinine		
Institutional drug testing policy reviewed		
Plan of Safe Care introduced		
Behavioral Health		
Needs assessment / Care Management referral		
Risks of non-prescribed drugs and alcohol discussed		
Marijuana counseling		
Tobacco counseling/treatment		
Narcan discussed /offered		
Third Trimester		
Repeat HIV, HBsAg, HCVAb GC/CT		
Ultrasound (growth/fluid)		
Urine toxicology with confirmation, (consent required)		
Ethyl glucuronide/ethyl sulfate (alcohol metabolites)		
Third trimester education		
Review Plan of Safe Care		
Review institutional drug testing policy		
NAS/newborn care		
Breastfeeding		
Pain management		
Family Planning		
Pediatrician identified		
OTHER		

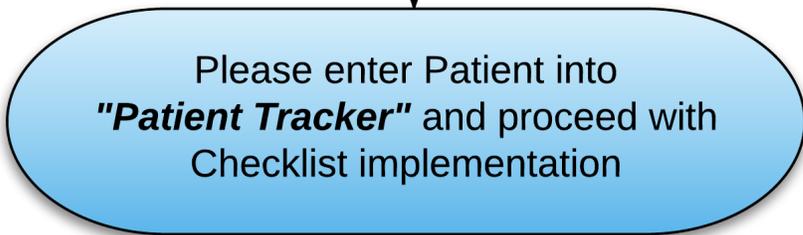
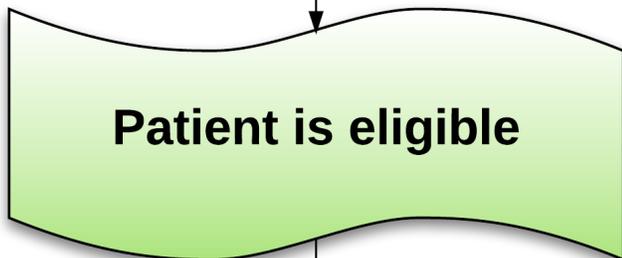




Yes



Yes



	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
ex:	027374-6	9/9/16	OH/AC	00001	complete	00000000
1						
2						
3						
4						
5						
6						
7						
8						
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10						
11						

iMAT OB Patient Tracking List

Instructions: Please use this document to keep track of all eligible patients. Enter data into REDCap after each timepoint.

REDCap Data Collection Link: www.redcap.hitchcock.org

					Data Collection Timepoints											
					T1		T2		T3		T4					
					Intake Visit		24-28 Weeks		38-39 Weeks		Delivery	Newborn Data			12 Weeks Postpartum	
					Patient Demographics		Patient Demographics		Patient Demographics		Delivery Outcomes	Infant Outcomes			Patient Demographics	Outcomes summary
	MRN	EDC	Delivery HOSPITAL	Site-specific Patient ID	Intake Date	Gestational Age at Intake	Expected Date	Expected Date	ACTUAL Date	Expected Date	Expected Date		REDCap Data entry status:	REDCap Return Code		
ex:	827374-6	09/09/18	DHMC	DH001	02/02/18		06/03/18	09/02/18	09/09/18	09/16/18	12/02/18	12/02/18	partial			
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Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

INSTRUCTIONS

Please use this document to keep track of all eligible patients. It must be kept in a secure location at all times.

UPLOADING DATA INTO REDCap

No later than 8 weeks after the Expected Delivery Date, please complete the **Data Collection Form**:

<https://redcap.hitchcock.org/redcap/surveys/?s=AYTYKCK3MT>

In case you need to return to a record in REDCap, EACH time you save or submit data, you will be given a unique code that allows you to return to that specific record. This code will change EACH time you save or submit data, so please write down the new code with every save or submission. There is a column in the Patient Tracking form for this purpose.

If you forget to record the return code and need assistance getting back into a particular record, please email Alex, the Project Manger Alexandra.B.Zagaria@hitchcock.org.

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
<i>ex:</i>	<i>827374-6</i>	<i>9/9/16</i>	<i>DHMC</i>	<i>DH001</i>	<i>complete</i>	<i>AMWNRFX9</i>
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
16						
17						
18						
19						
20						
21						
22						
23						
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27						
28						
29						
30						

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
31						
32						
33						
34						
35						
36						
37						
38						
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41						
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43						
44						
45						

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
46						
47						
48						
49						
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52						
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58						
59						
60						

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
61						
62						
63						
64						
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75						

Patient Tracker (Site Study List)
Perinatal Opioid Use Learning Collaborative Project

	MRN	Delivery Date (expected)	Delivery Hospital (expected)	Site-specific Patient ID	REDCap Data entry status:	REDCap Return Code
76						
77						
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90						

Care Improvement Questionnaire

Please answer the questions below as openly as possible. This is a completely anonymous survey and your honest feedback is really important to us.

Thank you for taking the time to let us know how we're doing!

**This is a completely anonymous survey and your honest feedback is really important to us.
Thank you for taking the time to let us know how we're doing!**

In thinking about the care you received during your pregnancy, please answer the following questions as openly as possible:

- | | |
|---|---|
| 1) My prenatal care helped me feel ready to care for my baby... | <input type="radio"/> Not at all
<input type="radio"/> Slightly
<input type="radio"/> Somewhat
<input type="radio"/> Moderately
<input type="radio"/> Extremely |
| 2) I felt treated with dignity and respect... | <input type="radio"/> Never
<input type="radio"/> Almost never
<input type="radio"/> Occasionally/Sometimes
<input type="radio"/> Most of the time
<input type="radio"/> All the time |
| 3) My care team explained things in a way that was easy to understand... | <input type="radio"/> Strongly disagree
<input type="radio"/> Disagree
<input type="radio"/> Neither agree or disagree
<input type="radio"/> Agree
<input type="radio"/> Strongly agree |
| 4) My care team was interested in what I had to say... | <input type="radio"/> Strongly disagree
<input type="radio"/> Disagree
<input type="radio"/> Neither agree or disagree
<input type="radio"/> Agree
<input type="radio"/> Strongly agree |
| 5) Was there anything you experienced during your hospital stay that you didn't feel adequately prepared for? If so, please describe. | <hr/> |
| 6) What was the most helpful part of the care you received during your pregnancy? | <hr/> |
| 7) What would you change about the care you received during your pregnancy? | <hr/> |

Provider Survey

Please answer the following questions as accurately as possible. All responses are completely anonymous.

Thank you!

- | | Not at all | | Moderately | | Very |
|--|---|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. To what extent are adverse life circumstances likely to be responsible for a person's problematic drug use? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. To what extent is an individual personally responsible for their problematic drug use? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. To what extent do you feel angry towards people using drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. To what extent do you feel disappointed towards people using drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. To what extent do you feel sympathetic towards people using drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. To what extent do you feel concerned towards people using drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. To what extent do people who use drugs deserve the same level of medical care as people who don't use drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. To what extent are people who use drugs entitled to the same level of medical care as people who don't use drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Which of the following best describes your role? | <input type="radio"/> Provider
<input type="radio"/> Nurse
<input type="radio"/> Other professional
<input type="radio"/> Prefer not to answer | | | | |

Source: National Centre for Education and Training on Addiction, 2006. Health Professionals' Attitudes Towards Licit and Illicit Drug Users: A Training Resource. NCETA, Adelaide, South Australia.

Instructions: Please use this Data Collection Form (DCF) to abstract data from the medical record for each eligible patient. Enter all data into REDCap via the following link: <https://redcap.hitchcock.org/redcap/surveys/?s=AYTYKCK3MT>. Please complete this form no later than 8-12 weeks from the expected delivery date. Thank you! 😊

Patient Information	
<i>For internal site use only. Please keep secure.</i>	
Patient Name:	_____
DOB:	____/____/____
MRN:	_____
Expected delivery date:	____/____/____
Expected delivery hospital:	_____
Study ID #:	_____
REDCap return code:	_____

Data Collection Form	
REDCap link:	
Site:	_____
Patient Study ID: <i>Please assign each patient a unique study ID. The Patient Study ID should consist of your site's two-letter identifier followed by a 3-digit number (e.g. 'DH001').</i>	Patient Study ID: _____
Is this PRE- or POST- implementation?	<input type="radio"/> PRE-implementation <input type="radio"/> POST-implementation
Expected delivery date (month/year):	_____ / _____ (month) (year)

Demographics:	
Age in years at time of delivery:	_____ years
Number of living children (not including this delivery):	_____
Race: <i>Please check all that apply.</i>	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown (check all that apply)

Ethnicity:	<input type="radio"/> Hispanic or Latino origin <input type="radio"/> Not Hispanic or Latino origin <input type="radio"/> Other/Unknown
Tobacco/nicotine use during pregnancy: <i>Please check all that apply.</i>	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Smoked during pregnancy <input type="checkbox"/> Quit during pregnancy <input type="checkbox"/> Vaped during pregnancy <input type="checkbox"/> Smokeless tobacco use <input type="checkbox"/> Nicotine replacement therapy (NRT) → <input type="checkbox"/> Unknown (check all that apply)
<i>If NRT used, please specify type:</i> <i>Please check all that apply.</i>	<input type="checkbox"/> Patch <input type="checkbox"/> Gum <input type="checkbox"/> Lozenges <input type="checkbox"/> Other (check all that apply)
Transportation status: <i>Please check all that apply.</i>	<input type="checkbox"/> Has own transportation <input type="checkbox"/> Medicaid ride service <input type="checkbox"/> Bus/public transportation <input type="checkbox"/> Unknown (check all that apply)
Housing status: <i>Please check all that apply.</i>	<input type="checkbox"/> Rents/owns <input type="checkbox"/> Staying with others <input type="checkbox"/> At risk for losing housing <input type="checkbox"/> Incarcerated <input type="checkbox"/> Unknown (check all that apply)
<i>Comments on patient demographics (optional):</i>	

Treatment History:	
Did patient transfer care from another prenatal practice?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If transfer, how many visits did patient have at previous provider?</i>	<input type="radio"/> 1 visit <input type="radio"/> More than 1 visit <input type="radio"/> Unknown
<i>If transfer, gestational age at first OB visit at previous care site (in weeks):</i>	_____ weeks

Is treatment for OUD co-located (provided within the same institution)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not receiving MAT
Treatment for opioid use disorder during pregnancy: <i>Please check all that apply.</i>	<input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine/Subutex/Suboxone → <input type="checkbox"/> None <input type="checkbox"/> Unknown (check all that apply)
Buprenorphine type (if applicable):	<input type="radio"/> Buprenorphine (Subutex) <input type="radio"/> Buprenorphine/Naloxone (Suboxone)
Is psychiatric diagnosis included on the problem list?	<input type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Unknown
If yes, specify psychiatric diagnosis: <i>Please check all that apply.</i>	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> PTSD <input type="checkbox"/> Other psychiatric diagnosis: _____ (check all that apply)
Is patient being treated with a psychiatric medication?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Total number of prenatal visits at your site:	_____ visits
Gestational age at first prenatal visit at your site (in weeks):	_____ weeks
Treatment history comments (optional):	

Process Measures:	
Is a substance use diagnosis included on the problem list?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Is the checklist present in the record?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was information about the risk of non-prescribed drugs and alcohol given?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Was smoking cessation education and/or treatment given?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was marijuana use discussed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was breastfeeding education given?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was Naloxone (Narcan) discussed and Rx offered?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was Plan of Safe Care discussed?	<input type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Unknown
<i>If yes, was a plan <u>initiated</u>?</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Did domestic violence screening take place using a validated screener?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
<i>Checklist process comments (optional):</i>	

Outcome Measures:

Hepatitis C antibody:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
Hepatitis C viral load (if HCV antibody positive):	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
HIV status:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
Third trimester <u>drug screening results</u> for non-prescribed drugs:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
If positive, please specify type(s) of drugs used: <i>Please check all that apply.</i>	<input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown (check all that apply)
Was patient <u>admitted during pregnancy</u> for any reason other than for delivery?	<input type="radio"/> Yes → <input type="radio"/> No
If yes, please specify reason for admission:	

Delivery Outcomes:

Was discharge summary received?	<input type="radio"/> Yes <input type="radio"/> No
Gestational age at delivery (weeks and days):	_____ weeks _____ days
<i>If <38 weeks, please specify <u>reason for early delivery</u>:</i>	
Birthweight in grams:	_____ grams
<i>Was this a <u>multiple or twin birth</u>?</i>	<input type="radio"/> Yes <input type="radio"/> No

Maternal length of stay during delivery hospitalization: <i>Elapsed time from delivery to maternal discharge.</i>	_____ days
<i>If >3 days, please specify <u>reason for prolonged stay</u>:</i>	<input type="radio"/> Normal OB management <input type="radio"/> Complications →
<i>If complications, please specify type:</i>	<input type="radio"/> Prenatal <input type="radio"/> Delivery-related <input type="radio"/> Postpartum <input type="radio"/> Other
Admission drug screening results for non-prescribed drugs:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
<i>If positive drug test result, specify type(s) of drugs used:</i> <i>Please check all that apply.</i>	<input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown (check all that apply)
What type of feeding was infant receiving at discharge?	<input type="radio"/> Breast milk only <input type="radio"/> Breast milk and formula <input type="radio"/> Formula only <input type="radio"/> Unknown
Did baby require NICU care?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
APGAR Scores available?	<input type="radio"/> Yes → <input type="radio"/> No
<i>APGAR Scores (1, 5, and 10-minute, as available):</i>	<ul style="list-style-type: none"> ▪ 1-minute: _____ ▪ 5-minute: _____ ▪ 10-minute: _____
<i>Outcomes comments (optional):</i>	

Postpartum Visit:

<p>Did postpartum visit occur within 8 weeks after delivery?</p>	<p><input type="radio"/> Yes → <input type="radio"/> No →</p>
<p><i>If yes, please check all that apply:</i></p>	<p><input type="checkbox"/> Visit within 2 weeks <input type="checkbox"/> Visit within 4 weeks <input type="checkbox"/> Visit within 6 weeks <input type="checkbox"/> Visit within 8 weeks (check all that apply)</p>
<p><i>If no postpartum visit, please specify reason:</i></p>	
<p>What type of feeding was infant receiving at postpartum visit?</p>	<p><input type="radio"/> Breast milk only <input type="radio"/> Breast milk and formula <input type="radio"/> Formula only <input type="radio"/> Unknown</p>
<p>Tobacco/nicotine use at postpartum visit: <i>Please check all that apply.</i></p>	<p><input type="checkbox"/> Non-smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Smoking <input type="checkbox"/> Quit during pregnancy <input type="checkbox"/> Vaping <input type="checkbox"/> Using smokeless tobacco <input type="checkbox"/> Nicotine replacement therapy (NRT) → <input type="checkbox"/> Unknown (check all that apply)</p>
<p><i>If NRT used, please specify type:</i> <i>Please check all that apply.</i></p>	<p><input type="checkbox"/> Patch <input type="checkbox"/> Gum <input type="checkbox"/> Lozenges <input type="checkbox"/> Other (check all that apply)</p>
<p>Was patient continuing substance use treatment at time of postpartum visit?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p>
<p><i>Postpartum visit comments (optional):</i></p>	

Dept. Procedure Title:	Buprenorphine Induction (inpatient) for Pregnant Women Procedure - BP	Procedure ID:	
Keywords	SUD, Substance Use Disorder, Withdrawal, COWS, pregnancy, OUD, Opioid Use Disorder		
Department:	Birthing Pavilion, Perinatal Addiction Treatment Program, OB/GYN Clinic		

I. Purpose of Procedure

To standardize inpatient buprenorphine/naloxone induction during pregnancy.

II. Procedure Scope

Providers and RNs caring for pregnant women on the Birthing Pavilion

III. Definitions

- "Moms in Recovery Program" provides consultation and medication-assisted treatment for pregnant women with substance use disorder (SUD).
- Buprenorphine/naloxone (Suboxone): Appropriate adjunctive treatment for certain women with opioid use disorder utilizing three phases: induction, stabilization and maintenance.
 - A partial agonist at the mu opioid receptor and antagonist and the kappa receptor. It can precipitate an opioid withdrawal syndrome if it is administered to a patient who is dependent on opioids and has receptors occupied by opioids.
 - A patient should no longer be intoxicated or be experiencing residual effects from her last dose of an opioid when receiving her first dose of buprenorphine. Therefore, a period of abstinence is required (a minimum of 12-24 hours after last use of a short acting opioid) and patients should be experiencing moderate withdrawal symptoms before initiating buprenorphine treatment.
 - Suboxone (buprenorphine/naloxone) will be used for inpatient buprenorphine induction.
- Buprenorphine Induction: Transition of substance use from illicit opioids to buprenorphine/naloxone utilizing the lowest dose needed to minimize symptoms of withdrawal and cravings and prevent use of illicit opioids.
- Inpatient Induction Criteria: Women with acute medical or surgical illness, significant polysubstance use, use of long acting opioids or presenting at a gestational age post-viability often require inpatient admission for close monitoring. Women prior to 23 weeks gestation or ≥ 23 weeks without complicating factors may be candidates for closely monitored induction in the ambulatory setting [see outpatient protocol]
- Clinical Opioid Withdrawal Scale (COWS): A scoring tool to quantify withdrawal symptoms and guide in the buprenorphine/naloxone induction process. Withdrawal symptoms classified with the following score ranges: Mild (5-12). Moderate (13-24). Moderately Severe (26-36). Severe (greater than 36). *Tool attached with link in upper right hand corner and with online access listed in References.*

IV. Equipment – N/A

V. Procedure

A. The OB Provider

- a. Notifies Moms in Recovery Medical Director or Psychiatric Consult Service of patient’s admission .
 - i. The Psychiatry Consult Service is available if concerns arise related to a co-occurring psychiatric disorder.
- b. Notifies resources for questions during induction process:
 - i. Care provider with buprenorphine waiver.
 - ii. BIT team at pager 3352.
- c. Review with and ask patient to sign “consent for initiation of buprenorphine/naloxone treatment”
- d. Verifies that patient has not taken an opioid for a minimum of 12-24 hours (short-acting opioid).
- e. Determines baseline COWS score, verifying at least a Moderate score of 13-24.
 - i. Common physical symptoms of opioid withdrawal:

Early Withdrawal (8-24 hours after last use)	Fully Developed Withdrawal (1-3 days after last use)
Lacrimation and/or rhinorrhea	Tachycardia
Diaphoresis	Hypertension
Yawning	Tachypnea
Restlessness	Fever
Insomnia	Anorexia or nausea
Dilated pupils	Extreme restlessness
Piloerection	Diarrhea and/or vomiting
Muscle twitching	Dehydration
Myalgia	Hyperglycemia
Arthralgia	Hypotension
Abdominal pain	

- f. Diagnosis: “Maternal drug use complicating pregnancy, antepartum.”
- g. Obtains baseline laboratory testing to include:
 - i. DAU: Lab 4103 (with confirmation, includes fentanyl)
 - ii. Ethinyl Glucoronide/Ethyl Sulfate: Lab 3990 (alcohol metabolites, send out only)
 - iii. Complete metabolic panel
 - iv. CBC with differential and platelet count
 - v. Hepatitis B Surface antigen, hepatitis B surface antibody, hepatitis B core antibody IgM and Total, and hepatitis C antibody
 - vi. If known hepatitis C antibody positive, draw Hepatitis C quantitative RNA and genotype.
 - vii. HIV (identify what specific lab...PCR?)
 - viii. Prenatal Lab Panel or components, if not completed (GC, Chlamydia and Rubella for instance).**
- h. First day:
 - i. Orders **buprenorphine**/naloxone as indicated by COWS score.
 - ii. Do not give more than 12 mg buprenorphine/naloxone on first day.
- i. Second day:
 - i. Evaluates patients still experiencing withdrawal symptoms.

- ii. May **increase the dose by 2-4 mg of buprenorphine**, up to a maximum dose of 16 mg of buprenorphine.
- iii. A reactive NST should be obtained prior to discharge for patients with gestational age equal to or greater than 28 weeks.
- iv. Patient may be discharged on day 2 with next day follow up with a waived buprenorphine prescriber in the OB clinic, or substance use treatment provider. If discharged on Friday or Saturday, follow up may be at the Birthing Pavilion.
- j. Third day: Outpatient follow up
 - i. Evaluates patients still experiencing withdrawal symptoms.
 - ii. May increase dose by 2-4 mg up to a maximum dose of 20 mg. Most women will not require doses greater than 16mg.
- k. Adjunctive therapy may be used with or without buprenorphine/naloxone induction for the treatment of opioid withdrawal symptoms.
 - i. Clonidine 0.1 mg Q 6 hours prn withdrawal symptoms (hold if SBP < 105mmHg)
 - ii. Dicyclomine 20 mg Q 6 hours prn abdominal cramps
 - iii. Loperamide 2 mg Q 6 hours prn diarrhea
 - iv. Acetaminophen 650 mg prn q 4 hrs mild-moderate pain
 - v. Acetaminophen 1000 mg prn q 6 hrs moderate-severe pain
 - vi. Hydroxyzine HCl 50 mg Q 6 hours prn anxiety
 - vii. Diphenhydramine 50 mg prn sleep

B. The RN performs the following:

- a. Assesses vital signs and fetal heart tones (FHTs) or nonstress test (NST), if ordered based on gestational age. Note: A reactive NST is not a prerequisite to initiating buprenorphine as opioid withdrawal can affect NST reactivity.
- b. Collects witnessed urine sample for “Drug screen with confirmation-urine and alcohol metabolites-urine” (LAB4103, LAB 3990).
- c. Collects and send ordered blood tests
- d. Assesses initial COWS score prior to administration of buprenorphine/naloxone.
 - i. If greater than or equal to 12, give buprenorphine/naloxone 4 mg/1mg sublingual.
 - ii. If fewer than 12, do not give buprenorphine/naloxone.
- e. Observe for 2 hours, then repeat COWS assessment
 - i. Notify provider if less than or equal to 4.
 - ii. If greater than or equal to 5, give buprenorphine/naloxone 4 mg/1mg sublingual.
- f. Observe for 2 hours, and then repeat COWS assessment and FHTs or NST.
 - i. If less than 4 and FHTs are 110-160 bpm or NST is reactive, patient can be discharged to home
 - ii. If greater than or equal to 5, consult provider.
- g. Once maximum dose is reached for day, decrease COWS frequency to q 4 hours while awake to guide administration of adjunctive medications (above).

C. Patients who wish to leave against medical advice:

- a. Patients should be reminded of the dangers to the fetus with untreated withdrawal and/or continued illicit substance use.
- b. An AMA discharge may be considered a failed induction and the patient may not be eligible for buprenorphine therapy during pregnancy at the Moms in Recovery Program.
- c. Patient who are unable to complete induction onto buprenorphine/naloxone therapy should receive a referral to an alternative program:
 - i. Outpatient methadone program or a program in the patient’s home region.

- ii. Inpatient or residential addiction treatment program.
- d. A list of state treatment providers is available at: www.nhtreatment.org and VT treatment providers at (802) 651-1550 or <http://healthvermont.gov/alcohol-drugs/help>

D. Outpatient Follow Up:

- a. Refer to the Moms in Recovery Program appointment and schedule first appointment if possible before discharge, or arrange appointment with other buprenorphine treatment provider (contact BIT team for assistance if needed).
- b. If the appointment cannot be made within 24 hours (i.e. weekend or holiday) arrange for waived provider for buprenorphine/naloxone prescription as needed to bridge patient to the next available appointment
- c. Prior to discharge provide prescription for Naloxone Nasal Spray 4mg/0.1 mL, administer 1 spray in nostril for opioid overdose, repeat in 5 minutes in other nostril PRN if unresponsive; #2, RF #5.

VI. References

- Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD. Substance Abuse and Mental Health Services Administration, 2004.
- National Alliance of Advocates for Buprenorphine Treatment. (2011). Clinical Opiate Withdrawal Scale(COWS) Flowsheet. Retrieved on January 27, 2017 from https://www.naabt.org/documents/NAABT_PrecipWD.pdf.
- http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm#b
- http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf
- <http://www.deadiversion.usdoj.gov/pubs/manuals/narcotic/appendixa/treatment.htm>

Responsible Owner:	Birthing Pavilion	Contact(s): email	
Approved By:		Version #	1
Current Approval Date:	Not Approved Yet	Old Document ID:	New
Date Procedure to go into Effect:	Not Approved Yet		
Related Policies & Procedures:			
Related Job Aids:			