



A TOOLKIT FOR THE PERINATAL CARE OF WOMEN WITH SUBSTANCE USE DISORDERS

Developed with support from the March of Dimes Foundation, the New Hampshire Charitable Foundation, the Department of Obstetrics and Gynecology at Dartmouth Hitchcock Medical Center, and from the Dartmouth Collaboratory for Implementation Science



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 was implemented and tested by a learning collaborative comprised of prenatal care providers in diverse contexts across Maine, New Hampshire, and Vermont. In 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), and the Alliance for Innovation in Maternal Health's Patient Safety Bundle *Obstetric Care for Women with Opioid Use Disorder*, with the purpose of facilitating implementation of these recently released national guidelines. 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:

Daisy Goodman, CNM, DNP, MPH Project Coordinator Department of OB/GYN DHMC Phone: (603) 643-9300 daisy.j.goodman@hitchcock.org	Victoria A. Flanagan, RN, MS Director of Operations, NNEPQIN Perinatal Outreach Educator DHMC Phone: (603) 653-6896 victoria.a.flanagan@hitchcock.org	Timothy J. Fisher, MD, MHCDS Medical Director, NNEPQIN Department of OB/GYN DHMC timothy.j.fisher@hitchcock.org
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The Alliance for Innovation in Maternal Health (AIM) is a coalition of over 30 organizations working toward reducing preventable maternal mortality and severe morbidity across the U.S. AIM is funded through the federal Health Resources and Services Administration and administrated by the American College of Obstetricians and Gynecologists (ACOG). AIM 's multidisciplinary groups of national experts compile best practices around maternal health conditions and strategies for their implementation to form maternal safety bundles. Metrics for the AIM bundles assist facilities in the process of data driven quality improvement.

In 2017, AIM published the bundle “Obstetric care for women with opioid use disorder” followed by the development of web-based resources including clinical pathways. NNEPQIN has been a leading contributor to this AIM bundle, and we are proud to be an early adopter of the following AIM clinical pathway which is included in it.

Section 1.

Opioid Use Disorder Clinical Pathway

Antepartum Care (Outpatient)	
Upon entry into care and identification of substance use in pregnancy (Snuggle ME Checklists)	
<input type="checkbox"/>	Assess for signs and symptoms of acute withdrawal (Ohio MOMS F.1-F.9) <ul style="list-style-type: none">• Early: agitation, anxiety, muscle aches, increased tearing, insomnia, runny nose, sweating, yawning• Late: abdominal cramping, diarrhea, dilated pupils, goose flesh, nausea, vomiting
<input type="checkbox"/>	Refer immediately to one of the following for treatment and/or stabilization depending on acuity: <ul style="list-style-type: none">• Emergency Room• Obstetric ER/Triage• Inpatient treatment center
<input type="checkbox"/>	Screen for co-morbid psychiatric conditions <ul style="list-style-type: none">• If positive refer to Behavioral Health, unless this will be provided by treatment program
<input type="checkbox"/>	Screen for co-morbid domestic violence <ul style="list-style-type: none">• If positive refer to domestic violence advocacy service
<input type="checkbox"/>	Complete a detailed medical, surgical, obstetric, and prenatal history
<input type="checkbox"/>	Provide a thorough physical examination
<input type="checkbox"/>	Assess for other immediate psychosocial needs
<input type="checkbox"/>	Obtain recommended lab testing in addition to routine prenatal labs (NNEPQIN checklist) <ul style="list-style-type: none">• HIV• HepBsAg, anti-HBcore, HBsAb<ul style="list-style-type: none">○ Consider immunization as indicated• HCV antibody<ul style="list-style-type: none">○ If positive draw HCV PCR, LFTs• Serum creatinine• Consider gamma-glutamyl transferase (GGT) if active alcohol use suspected• Assess risk factors for tuberculosis and screen if indicated• Urine toxicology with woman's consent.<ul style="list-style-type: none">○ Synthetic opioids (e.g., buprenorphine, fentanyl, oxycodone) may not be detected with standard drug test and may require more specific testing. Consult with individual lab• Baseline EKG before starting methadone
<input type="checkbox"/>	Perform dating ultrasound upon entry to care

<input type="checkbox"/> Determine appropriate level of care and arrange referrals to treatment when indicated and accepted by woman (Wright et al, Figure 1) <ul style="list-style-type: none"> • Assess Risk (Ohio MOMS F.1-F.9) • Refer for medically supervised inpatient detox if alcohol or benzo dependent • If psychiatric or medical instability, refer for appropriate emergency psychiatric or medical care services.
<input type="checkbox"/> Give the woman information re. treatment provider/center contact (SAMHSA treatment directory)
<input type="checkbox"/> If woman is currently in a treatment program: <ul style="list-style-type: none"> • Obtain appropriate CFR42 Part 2 consent to communicate with treatment provider (Legal Action Center sample consents) • Coordinate care with mental health/treatment provider or center • Women receiving treatment for chronic pain should have drug agreement in place with treatment provider
<input type="checkbox"/> Provide a “warm” handoff to treatment provider whenever possible
<input type="checkbox"/> Counsel woman on recommended substance use management, risks to pregnancy, fetus, infant and explore treatment options (NNEPQIN toolkit) <ul style="list-style-type: none"> • Recommended treatment for OUD during pregnancy is MAT with buprenorphine or methadone; explore options and arrange appropriate referrals. • Recommended management of alcohol use during pregnancy is complete abstinence; explore options and arrange appropriate referrals as needed. • Recommended management of marijuana use during pregnancy is abstinence; explore options.
<input type="checkbox"/> Counsel woman regarding risks of tobacco use and offer smoking cessation strategies
<input type="checkbox"/> Counsel woman on maternal/fetal/neonatal risks of polysubstance use (SAMHSA Factsheet #6)
<input type="checkbox"/> Check the woman's record in state Prescription Monitoring Program
<input type="checkbox"/> Be aware of pharmacologic interactions with Buprenorphine/Methadone (McCance-Katz et al, Table 2)
<input type="checkbox"/> Discuss Narcan rescue and offer prescription (Narcan toolkit)
<input type="checkbox"/> Assess need for bowel regimen for constipation
<input type="checkbox"/> Assess need for anti-emetics and antacids for hyperemesis/reflux <ul style="list-style-type: none"> • Note: avoid Zofran for women on methadone to avoid prolonged QTc interval
<input type="checkbox"/> Consultation and Referral considerations may include, but are not limited to: <ul style="list-style-type: none"> • Social Work • Case Management • Maternal Fetal Medicine if medically complex

<ul style="list-style-type: none"> • Cardiology with prior history of pericarditis • Infectious Disease if HIV positive • Infectious Disease or Gastroenterology if HCV/HVB • Dental • Dietary
<input type="checkbox"/> Schedule short interval follow up for prenatal care
Follow-Up Care
<input type="checkbox"/> Reassess and treat for opioid side effects
<input type="checkbox"/> Assess for changes in psychosocial and medical needs
<input type="checkbox"/> Ask about cravings, on-prescribed drug and alcohol use at every visit
<input type="checkbox"/> Provide continued tobacco cessation counseling and treatment for patient who smokes
<input type="checkbox"/> Periodically review PDMP for patient prescription history
<input type="checkbox"/> Repeat urine toxicology with consent when indicated
<input type="checkbox"/> More specific tests may need to be ordered to identify methadone, buprenorphine, fentanyl, other synthetics or alcohol metabolites. Consult individual lab for guidance.
<input type="checkbox"/> Document treatment coordination
Second and Third Trimester Care
<input type="checkbox"/> Schedule and/or provide second trimester anatomy scan
<input type="checkbox"/> Schedule and/or provide third trimester growth scan <ul style="list-style-type: none"> • Monitor growth with serial assessments as indicated
<input type="checkbox"/> Antenatal testing only if clinically indicated; e.g., IUGR. (Reddy et al, Box 1) <ul style="list-style-type: none"> • If antenatal testing performed, reduce false positive NST and/or BPP by performing at least 4-6 hours after last treatment dose
<input type="checkbox"/> Repeat HIV, HCV, RPR, GC/CT in third trimester <ul style="list-style-type: none"> • Repeat HBsAg if initial testing negative
<input type="checkbox"/> Verify and update MAT medication/dose/status with treatment provider/center prior to birth <ul style="list-style-type: none"> • Advise woman to bring buprenorphine to hospital admission for safe storage and dose verification
<input type="checkbox"/> Discuss pain management options for labor and birth and assist woman in development of plan <ul style="list-style-type: none"> • Consider Anesthesiology consult for the woman with high anxiety, difficult IV access, or other co-existing medical issues pertinent to anesthesia

<input type="checkbox"/> Educate woman and support persons importance maternal participation in newborn care/safety, NAS/NOWS, breastfeeding <ul style="list-style-type: none"> • Maternal participation in newborn care (Mommies Toolkit) <ul style="list-style-type: none"> ○ Options for Rooming in ○ Maternal participation in Eat, Sleep, Console (ESC tool) ○ Encourage skin to skin and breastfeeding (SAMHSA factsheet #11)
<input type="checkbox"/> Provide Patient/family education to include: <ul style="list-style-type: none"> • Hospital policies (SAMHSA Factsheet #7) <ul style="list-style-type: none"> ○ NAS/NOWS assessment/management/length of stay ○ Breastfeeding ○ Maternal/newborn toxicology and reporting requirements • Signs and symptoms of potential pregnancy complications <ul style="list-style-type: none"> ○ Preterm labor ○ Preterm premature rupture of membranes • Importance of prenatal care • Plan for fetal surveillance • NAS/NOWS assessment/management/length of stay • Maternal/newborn toxicology and reporting • Parenting classes
<input type="checkbox"/> Consider prenatal consult appointment with pediatrician/neonatologist at delivering institution
<input type="checkbox"/> If delivering hospital is unable to care for infant with NAS/NOWS, discuss antenatal transfer of care versus neonatal transfer after delivery if treatment necessary
<input type="checkbox"/> Provide contraceptive counseling (SAMHSA Factsheet #7) <ul style="list-style-type: none"> • If tubal ligation desired, sign federally required consent for Medicaid patients • Offer post-placental IUD insertion or implant prior to discharge, if available at institution.
General Considerations of Methadone MAT in Pregnancy
<input type="checkbox"/> For women on methadone MAT prior to pregnancy, continue current dosing. <ul style="list-style-type: none"> • May need increased dose in 3rd trimester to increase plasma volume.
<input type="checkbox"/> Patient/family education (MAT in pregnancy patient education) <ul style="list-style-type: none"> • Risk and benefits of methadone treatment in pregnancy • Daily visit requirement at treatment center • Insurance coverage and/or cost • Incidence of NAS 50-66% • Possible effects of newborn head circumference and white matter tracts • Conflicting long-term studies on outcomes in children exposed in utero
<input type="checkbox"/> Initiation of methadone:

<ul style="list-style-type: none"> Start at 10-20 mg and titrate to eliminate withdrawal symptoms without producing intoxication.
General Considerations of Buprenorphine MAT in Pregnancy <i>If on suboxone prior to pregnancy, can consider continuing suboxone during pregnancy</i>
<input type="checkbox"/> In order to maintain plasma concentrations above 1ng/mL to prevent withdrawal symptoms, consider frequent dosing (3-4 times per day) (Caritis, S.N. et al)
<input type="checkbox"/> Patient/family education <ul style="list-style-type: none"> Risk and benefits of buprenorphine treatment in pregnancy Insurance coverage and/or cost Higher dropout rate than methadone (33% v. 18%) (MOTHER trial) Higher relapse rate Limited providers with prescription training and authority Use with caution with antiretrovirals, antiseizure, dexamethasone, and SSRI medications
<input type="checkbox"/> Initiation of buprenorphine: <ul style="list-style-type: none"> Note: Little data on appropriate way to initiate dosing during pregnancy Must be in moderate withdrawal Must be at least 12 hours since last dose of short-acting opioid Start with 2-4 mg and titrate for relief of withdrawal symptoms
<input type="checkbox"/> Consider possible “graduation” to monthly prescription as indicated
Inpatient Obstetric Care
If Initial Contact is in Obstetric ED/Triage or L&D
<input type="checkbox"/> Refer to above “Upon entry into care and identification of substance use in pregnancy”
<input type="checkbox"/> Ohio Moms OB.5-OB.8
<input type="checkbox"/> NNEPQIN checklist
<input type="checkbox"/> Initiate clinical pathway for acute opiate withdrawal or elective induction to MAT <ul style="list-style-type: none"> ASAM buprenorphine course <ul style="list-style-type: none"> ASAM Induction Protocol ASAM Sample Inpatient Nursing Protocol Miami Valley Protocol example
<input type="checkbox"/> Consider acute withdrawal in DDX of woman with intractable, nausea, vomiting, or abdominal pain
<input type="checkbox"/> Assess for signs and symptoms of placental abruption
Admission for Labor and Birth
<input type="checkbox"/> When possible, confirm MAT medication and dose with addiction provider <ul style="list-style-type: none"> Note: Inpatient provider may legally prescribe buprenorphine and methadone to maintain the woman’s treatment dose during hospitalization

<input type="checkbox"/> Continue buprenorphine/methadone at usual dosing (SAMHSA Factsheet #8) <ul style="list-style-type: none">Consider dividing total daily dose into every 6-8 hour dosing for maximal analgesic effects (ACOG Committee Opinion 711)
<input type="checkbox"/> Prescribe nicotine replacement as indicated
<input type="checkbox"/> Labs <ul style="list-style-type: none">Routine labs for labor and birthRepeat HIV/Hepatitis screening if not repeated in third trimesterUrine drug test with consent
<input type="checkbox"/> Notify pediatric provider of admission for delivery and determine need for neonatal team at birth
<input type="checkbox"/> Consults <ul style="list-style-type: none">Neonatology consult if not previously doneSocial work/Care managementAnesthesiologyLactationIf illicit substance use first disclosed at time of birth, consider consultation with addiction specialist or phone consultation with addiction specialist/center, or MFM.
<input type="checkbox"/> Offer immediate postpartum long-acting contraception as provided by facility (ACOG Committee Opinion #670)
<input type="checkbox"/> Involve the woman, social work, and pediatrics/neonatology to establish a Plan of Safe Care. (ACOG District II Slides 31-32)
Peripartum Pain Management (Ohio MOMS Pain Management Protocol)
<input type="checkbox"/> General Considerations: (Zhou Pain Management Presentation) <ul style="list-style-type: none">Maintenance medication does not treat painWomen using MAT or with history of long term opioid exposure may require higher and more frequent dosing of narcotic medications for intrapartum and postpartum pain<ul style="list-style-type: none">Opioid dependent women have increased sensitivity to painful stimuli (hyperalgesia)Opioids dependent women experience tolerance to opioid treatment for analgesiaHigher doses of full opioid agonists will be required to displace buprenorphine and provide analgesia
<input type="checkbox"/> Pharmacologic interactions <ul style="list-style-type: none">Avoid partial agonist/antagonists in treating pain (i.e., nalbuphine or butorphanol)
<input type="checkbox"/> Neuraxial analgesia is preferred for cesarean birth or other procedures <ul style="list-style-type: none">If general anesthesia is necessary, be aware of increased risk of airway compromise or drug interactions with concomitant use of stimulants

Intrapartum (Executive Summary on Opioid Use in Pregnancy Box 2)	
<input type="checkbox"/>	Educate L&D and postpartum staff on opioid pharmacology and appropriate pain control
<input type="checkbox"/>	Provide continuous labor support during active labor <ul style="list-style-type: none"> • 1:1 staffing • Consider Doula services if available
<input type="checkbox"/>	Avoid fetal scalp electrodes in women with HIV or HCV
<input type="checkbox"/>	Recommend early labor neuraxial anesthesia with continuous dosing to provide pain relief for labor and birth <ul style="list-style-type: none"> • Epidural analgesia using opioids (e.g. fentanyl) in usual labor doses may not be effective in opioid dependent patients. • May be necessary to use higher doses of local anesthetics or nonopioid adjuvants such as clonidine • If neuraxial anesthesia is not feasible or available, consider the following: <ul style="list-style-type: none"> ○ Nitrous oxide ○ Short acting opioids ○ Do not use nalbuphine or butorphanol for analgesia or pruritis as these can precipitate withdrawal <ul style="list-style-type: none"> ▪ If withdrawal inadvertently precipitated, withdrawal symptoms can be reversed with full agonists or for those in treatment with buprenorphine a 2–4 mg dose (confirm with current ASAM buprenorphine recommendations/ course slides)
Postpartum Care (Reddy et al)	
<input type="checkbox"/>	Vaginal birth pain management <ul style="list-style-type: none"> • Consider scheduled doses of NSAIDs and acetaminophen rather than prn dosing <ul style="list-style-type: none"> ○ Avoid acetaminophen with evidence of liver impairment
<input type="checkbox"/>	Cesarean birth pain management may include the following: <ul style="list-style-type: none"> • Intrathecal or epidural opioids for postpartum pain control <ul style="list-style-type: none"> ○ May not be fully effective requiring other options <ul style="list-style-type: none"> ▪ Higher concentrations of local anesthetics or non-opioid adjuvants (e.g., clonidine) in epidural solutions ▪ Consider PCA for additional coverage if needed but use PCA by demand only and patient monitored carefully for respiratory depression • Intraoperative ketorolac when appropriate • Scheduled Nonsteroidal anti-inflammatory drugs and acetaminophen <ul style="list-style-type: none"> ○ Avoid acetaminophen with evidence of liver impairment • Alternative pain management includes gabapentin, transversus abdominis plane (TAP) blocks, and IV Tylenol but further data needed
<input type="checkbox"/>	When opioids used for complicated vaginal or cesarean birth: <ul style="list-style-type: none"> • Monitor closely for over sedation.

<ul style="list-style-type: none"> ○ If somnolent, decrease pain medication dose or consult the addiction treatment provider to adjust dose of MAT ● Provide close follow-up ● Prescribe limited quantities ● Taper rapidly transitioning for non-opioid options ● Consider avoiding triggering opioids with “high likeability” (e.g., oxycodone) and instead use oral morphine or hydrocodone.
Postpartum Support
<input type="checkbox"/> If the woman desires to breast feed, provide lactation consultation and breast feeding support (SAMHSA Factsheet #11)
<input type="checkbox"/> Provide patient and family education to include: <ul style="list-style-type: none"> ● Caring for NAS babies (Stronger Together video) ● Signs and symptoms of newborn withdrawal ● Comfort care measures ● Maternal care needs ● Signs and symptoms of postpartum depression ● When to notify a provider (obstetric and newborn)
<input type="checkbox"/> If on methadone, monitor for increased somnolence and contact treatment provider if dose decrease appears necessary.
Discharge Planning (SAMHSA factsheet #15)
<input type="checkbox"/> Avoid postpartum discontinuation of treatment due to increased relapse rates for SUD after delivery
<input type="checkbox"/> Coordinate hospital discharge with addiction treatment provider/center and release planned so treatment can continue after discharge without interruption
<input type="checkbox"/> Provide contraception counseling and determine contraception plan <ul style="list-style-type: none"> ● Offer option to receive postpartum LARC if not already provided
<input type="checkbox"/> Develop Plan of Safe Care <ul style="list-style-type: none"> ● Engage woman, care coordination, and pediatric/neonatal team to define plan of safe care.
<input type="checkbox"/> Determine discharge pain management plan <ul style="list-style-type: none"> ● Maximize NSAIDs and nonpharmacologic measures ● If opioids are required at discharge, prescribe only the quantity likely to be used
<input type="checkbox"/> Ensure that plan for postpartum MAT is in place
<input type="checkbox"/> Schedule for more frequent postpartum visits with first postpartum visit within 1-2 weeks.
<input type="checkbox"/> Safe storage of medications

Postpartum care (Outpatient)	
Close postpartum follow-up with frequent visits	
<input type="checkbox"/>	Rescreen and brief intervention for return to substance use (SAMHSA Factsheet #16)
<input type="checkbox"/>	Provide postpartum depression screening
<input type="checkbox"/>	Monitor for relapse
<input type="checkbox"/>	Screen for intimate partner violence at 6 weeks and whenever indicated
<input type="checkbox"/>	Provide smoking cessation reinforcement or continued cessation counseling as indicated.
<input type="checkbox"/>	Consider providing support services for longer than the traditional 6-week postpartum period
<input type="checkbox"/>	Assess resource needs at each visit and coordinate with case worker/social service providers
<input type="checkbox"/>	Assist the woman in scheduling appointments for infectious disease management as indicated
<input type="checkbox"/>	Facilitate transition for recovery-friendly primary care provider if not previously established
<input type="checkbox"/>	If breast feeding, provide support
<input type="checkbox"/>	Provide contraception and counsel on birth spacing if immediate postpartum LARC not used

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Checklist Chart Template

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		
Offer Hepatitis A or A/B vaccine		
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		
Repeat Hepatitis A or A/B vaccine		
OTHER		



Opioid Use Disorder and Pregnancy

Taking helpful steps for a healthy pregnancy

Introduction



If you have an opioid use disorder (OUD) and are pregnant, you can take helpful steps now to ensure you have a healthy pregnancy and a healthy baby. During pregnancy, OUD should be treated with medicines, counseling, and recovery support. Good prenatal care is also very important. Ongoing contact between the healthcare professionals treating your OUD and those supporting your pregnancy is very important.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know, about OUD and pregnancy, as well as the Do's and Don'ts for making sure you have a healthy pregnancy and a healthy baby.

Things to know

- OUD is a treatable illness like diabetes or high blood pressure.
- You should not try to stop opioid use on your own. Suddenly stopping the use of opioids can lead to withdrawal for you and your baby. You may be more likely to start using drugs again and even experience overdoses.
- For pregnant women, OUD is best treated with the medicines called methadone or buprenorphine along with counseling and recovery support services. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- Tobacco, alcohol, and benzodiazepines may harm your baby, so make sure your treatment includes steps to stop using these substances.
- Depression and anxiety are common in women with OUD, and new mothers may also experience depression and anxiety after giving birth. Your healthcare professionals should check for these conditions regularly and, if you have them, help you get treatment for them.
- Mothers with OUD are at risk for hepatitis and HIV. Your healthcare professionals should do regular lab tests to make sure you are not infected and, if you are infected, provide treatment.
- Babies exposed to opioids and other substances before birth may develop neonatal abstinence syndrome (NAS) after birth. NAS is a group of withdrawal signs. Babies need to be watched for NAS in the hospital and may need treatment for a little while to help them sleep and eat.

About OUD

People with OUD typically feel a **strong craving for opioids** and find it hard to cut back or stop using them. Over time, many people **build up a tolerance** to opioids and need larger amounts. They also spend more time looking for and using opioids and less time on everyday tasks and relationships. Those who suddenly reduce or stop opioid use may suffer **withdrawal symptoms** such as nausea or vomiting, muscle aches, diarrhea, fever, and trouble sleeping.

If you are concerned about your opioid use or have any of these symptoms, please check with your **healthcare professionals** about treatment or tapering or find a provider at this website:
www.samhsa.gov/find-help.





Do talk with your healthcare professionals about the right treatment plan for you.

Do begin good prenatal care and continue it throughout your pregnancy. These two websites give helpful information on planning for your pregnancy:

<http://bit.ly/ACOGprenatal> and <http://bit.ly/CDCprenatal>.

Do stop tobacco and alcohol use. Call your state's Tobacco Quit Line at 800-QUIT-NOW (800-784-8669).

Do talk to your healthcare professionals before starting or stopping any medicines.

Do get tested for hepatitis B and C and for HIV.

Do ask your healthcare professionals to talk to each other on a regular basis.



Don't hide your substance use or pregnancy from healthcare professionals.

Don't attempt to stop using opioids or other substances on your own.

Don't let fear or feeling embarrassed keep you from getting the care and help you need.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy



The healthcare professionals who are treating your OUD and providing your prenatal care need a complete picture of your overall health. Together, they will make sure you are tested for hepatitis B and C and for HIV. They will ask you about any symptoms of depression or other feelings. You should be ready to answer questions about all substances you have used. They need this information to plan the best possible treatment for you and to help you prepare for your baby. These issues may be hard to talk about, but do the best you can to answer their questions completely and honestly. Expect them to treat you with respect and to answer any questions you may have.



Remember: Pregnancy is a time for you to feel **engaged** and **supported**. Work with your healthcare professionals to gain a better understanding of what you need for a healthy future for you and your baby.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Treating Opioid Use Disorder During Pregnancy

Getting the help and support you need from your healthcare professionals

Introduction



Opioid use disorder (OUD) is a treatable disease. When OUD is managed with medicines and counseling, you *can* have a healthy pregnancy and a healthy baby. However, during pregnancy, adjustments to your OUD treatment plan and medicines may be needed.

The actions you take or don't take play a vital role during your pregnancy. Below are some important things to know about OUD treatment during pregnancy, as well as the Do's and Don'ts for making sure you receive the best treatment possible.

Things to know

- Methadone and buprenorphine are the safest medicines to manage OUD during your pregnancy. Both of these medicines stop and prevent withdrawal and reduce opioid cravings, allowing you to focus on your recovery and caring for your baby.
- If you have used opioids, methadone and buprenorphine medicines can help you stop.
- Many pregnant women with OUD worry about neonatal abstinence syndrome (NAS), a group of withdrawal signs that may occur in babies exposed to opioids and other substances before birth. NAS *can* be diagnosed and treated.
- You may need medicine other than those for OUD to treat pain during or after delivery. Other options, such as an epidural and/or a short-acting opioid, can be used to keep you comfortable.
- All hospitals must report to state child welfare agencies when a mother who is using substances gives birth. This report is used to make sure that a safe care plan is in place to deal with both your and your baby's well-being. It is not used to remove your baby from your care. Participating in OUD treatment before and after the birth of your baby shows your commitment to providing a safe, nurturing environment for your baby.

Treatment vs. Withdrawal

Some pregnant women with OUD consider completely withdrawing from using opioids, but seeking treatment is always the most helpful course of action. Withdrawal may make you more likely to start using drugs again and even experience overdoses.



If you are not currently in treatment, talk with your healthcare professionals about treatment medicines and behavioral counseling. If you need to find a provider, visit this website: www.samhsa.gov/find-help.



Do ask about the risks and benefits of taking one of the medicines for OUD during pregnancy.

Do talk to your healthcare professionals about your OUD treatment medicine dose if you are experiencing cravings or withdrawal symptoms.

Do ask your healthcare professionals about counseling and recovery support services.

Do make sure your treatment plan includes steps to treat other medical or behavioral health problems such as depression or anxiety.

Do request that your medical chart includes several ways to address your pain during and right after delivery.

Do ask your healthcare professionals to help you make and keep follow-up visits and to talk to each other on a regular basis.



Don't consider changing your OUD medicine unless you are taking naltrexone, which has not been studied in pregnancy. Changing your OUD medicine may increase your risk of returning to substance use.

Don't use alcohol or any medicines that might make you sleepy, especially benzodiazepines, when taking OUD medicines.

Don't let your OUD go untreated because you want to prevent your baby from experiencing NAS. Treatment medicines can be used safely during pregnancy and dosing changes will not change the risk or severity of NAS for your baby.

What to expect when you meet with healthcare professionals about OUD treatment and your pregnancy



Creating a treatment plan requires your healthcare professionals to talk to you about the risks and benefits of different medicines and then together select the one that's best for you. You and your healthcare professionals will also discuss other medical conditions or behavioral health problems that could affect your treatment. Your healthcare professionals will help you decide how best to involve your family and friends in your recovery. They can also suggest support groups to join and other services that can help you throughout your recovery.



Remember: The **benefits** of taking methadone or buprenorphine during pregnancy far outweigh the risks of not treating your OUD. You and your healthcare professionals can **work together** to adjust your treatment plan to achieve success.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

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Treating Babies Who Were Exposed to Opioids Before Birth

Support for a new beginning

Introduction



Many pregnant women with an opioid use disorder (OUD) worry about harmful effects of opioids to the fetus. Neonatal abstinence syndrome (NAS) is a group of withdrawal signs that may occur in a newborn who has been exposed to opioids and other substances. NAS signs may include high-pitched and excessive crying, seizures, feeding difficulties, and poor sleeping. **NAS is a treatable condition.**

The actions you take or don't take play a vital role in your baby's well-being. Below are some important things to know about what to expect if your baby needs special care after birth, as well as the Do's and Don'ts for understanding and responding to your baby's needs.

Things to know

- A baby born to a mother who used opioids or took OUD medicine during pregnancy is typically observed in the hospital by a medical provider for 4–7 days for any physical signs of NAS. A care plan is created for your baby right away if signs of NAS are noted.
- Some babies with NAS may need medicines such as liquid oral morphine or liquid oral methadone in addition to non-medicine care supports.
- Other parts of treatment in hospitals include rooming-in and putting the baby's crib near your bed. You can also give this type of care to your baby through skin-to-skin contact, gentle handling, swaddling, using pacifiers, breastfeeding, and spending quiet time together.
- Your baby will be able to leave the hospital when he/she is successfully feeding and has been monitored for at least 24 hours after no longer needing medicine (if it is used). Some hospitals may also provide medicine for your baby in an outpatient clinic after he/she has been discharged from the hospital.
- Breastfeeding has many benefits for your baby. Breastfeeding can decrease signs of NAS and reduce your baby's need for medicine and hospitalization. Sometimes, breastfeeding is not recommended, so talk with your healthcare professionals to find out what's right for you and your baby.

Medicine Dose and NAS

If you are taking medicine for your OUD, reducing your dose will NOT help your unborn baby, but it might put your baby at risk. Changing or reducing your OUD medicine while pregnant is not a good idea because it can increase your risk for a return to substance use and might increase the chances of having your baby too early or having a miscarriage. The goal for your OUD medicine dose is to minimize withdrawal and to reduce the chances of going back to substance use.





Do

Do gain the skills and knowledge to understand and respond to your baby's needs. Your baby may need extra contact and cuddling to reduce NAS signs.

Do continue breastfeeding as long as possible when recommended.

Do ask for support so you feel prepared and comfortable with breastfeeding.



Don't

Don't change your medicine or dose of medicine without talking to your healthcare professionals.

Don't be afraid to mention any cravings or urges to use opioids to your healthcare professionals and seek the help you need.

What to expect when you meet with healthcare professionals about OUD treatment after birth



Before you leave the hospital, your healthcare professionals should describe the signs of NAS and provide you with contact information of someone who can help you if you have concerns. They will make sure that you know how to soothe your baby (for example, dimming lights, softly playing white noise, skin-to-skin contact, using a pacifier, and swaddling). They will also explain that the safest sleeping and napping position for a baby is on the back and will show you how to place your baby in the [Safe to Sleep](http://bit.ly/NIHSafeSleep) position (<http://bit.ly/NIHSafeSleep>). This position, and having babies sleep in their own space with nothing in the sleep area, reduces the risk of sudden infant death syndrome. You should also expect to have follow-up plans that include home visits and early pediatric follow-up visits (within 5 days of leaving the hospital).



Remember: Before leaving the hospital, make sure you **receive information** on caring for your baby if there are special needs as well as names and contact information of others who can give you additional support.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

Next Appointment Date: _____ Time: _____ Location: _____



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Good Care for You and Your Baby While Receiving Opioid Use Disorder Treatment

Steps for healthy growth and development

Introduction



If you have an opioid use disorder (OUD), receiving the right medicine along with counseling and recovery support services is important at all stages in your life. From pregnancy to delivery to caring for your baby, addressing your OUD and taking care of yourself is a continuous process. You will be better able to protect and care for your baby with a focus on creating and updating your treatment plan and getting the support you need. In all situations, your commitment to treatment and recovery will go a long way.

After your pregnancy, the actions you take or don't take matter. Below are some important things to know about OUD and caring for your baby, as well as the Do's and Don'ts for creating a healthy environment for your family.

Things to know

- Birth control is important to prevent pregnancies you do not want as well as to ensure proper space between pregnancies. Talk to your healthcare professionals about the full range of birth control options, including long-acting reversible contraception and the best birth control options while you are breastfeeding.
- Breastfeeding is healthy for you and your baby, so you should continue breastfeeding as long as possible. The amount of OUD medicine that passes into breast milk is extremely small. Talk with your healthcare professionals to find out what's best for you and your baby.
- You may need additional treatment and support to help with your recovery. It is important to seek help early!
 1. To find a treatment provider in your area, visit this website: www.samhsa.gov/find-help.
 2. Join a support group: LifeRing (<https://lifering.org>); Mothers on Methadone (www.methadonesupport.org/Pregnancy.html); Narcotics Anonymous (www.na.org/); Secular Organizations for Sobriety (SOS; www.sossobriety.org/); SMART Recovery (www.smartrecovery.org/); Young People in Recovery (www.youngpeopleinrecovery.org/).

Medicine Dose

Now is a good time to ask your OUD treatment professionals to check your medicine dose. An effective dose during pregnancy may be too high or too low once your baby is born. It is normal to feel tired and stressed, but if these feelings are causing you to have cravings or urges to use opioids again, tell your healthcare professionals.





Do schedule a follow-up visit with your healthcare professionals as soon as possible after you leave the hospital.

Do talk to your healthcare professionals before starting or stopping any medicines.

Do talk to your healthcare professionals about birth control and family planning.

Do continue breastfeeding for as long as possible and ask for support if you need it.



Don't change the type of OUD medicine right after delivery.

Don't hesitate to ask for help when you are feeling stressed or depressed.

Don't be afraid to tell your healthcare professionals that you are having cravings or urges for opioids.

What to expect when you meet with healthcare professionals about OUD treatment while caring for your baby



If your medicine is no longer working and you feel sleepy or are tempted to start using again, your healthcare professionals can help. Be honest about any cravings or urges you may have to use opioids. The stress that comes with being a new mother may increase these urges.

Your healthcare professionals can offer counseling and other support services. But before they do, they need to know if you have other medical and mental health problems. They will test you for these conditions before you leave the hospital and at your follow-up visits to make sure you get the treatment you need. They will continue to recommend support services that allow you and your baby to receive the high-quality health care that you need.

Your healthcare professionals will work with you to create a birth control plan. Together, you will discuss if you want to have another child, how many children you would like to have, and how you would like to space out the births of your children. At this time, they will check in on how you are doing with breastfeeding and make sure you have the support you need.



Remember: The longer you follow your OUD treatment plan, the better your chances are of **staying in recovery** and strong for your baby. **Counseling** and **support services** are important to keep you and your baby safe and healthy at home.

Do you have questions for your healthcare professionals? If so, write them down and take them to your next visit.

Next Appointment Date: _____ Time: _____ Location: _____



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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.

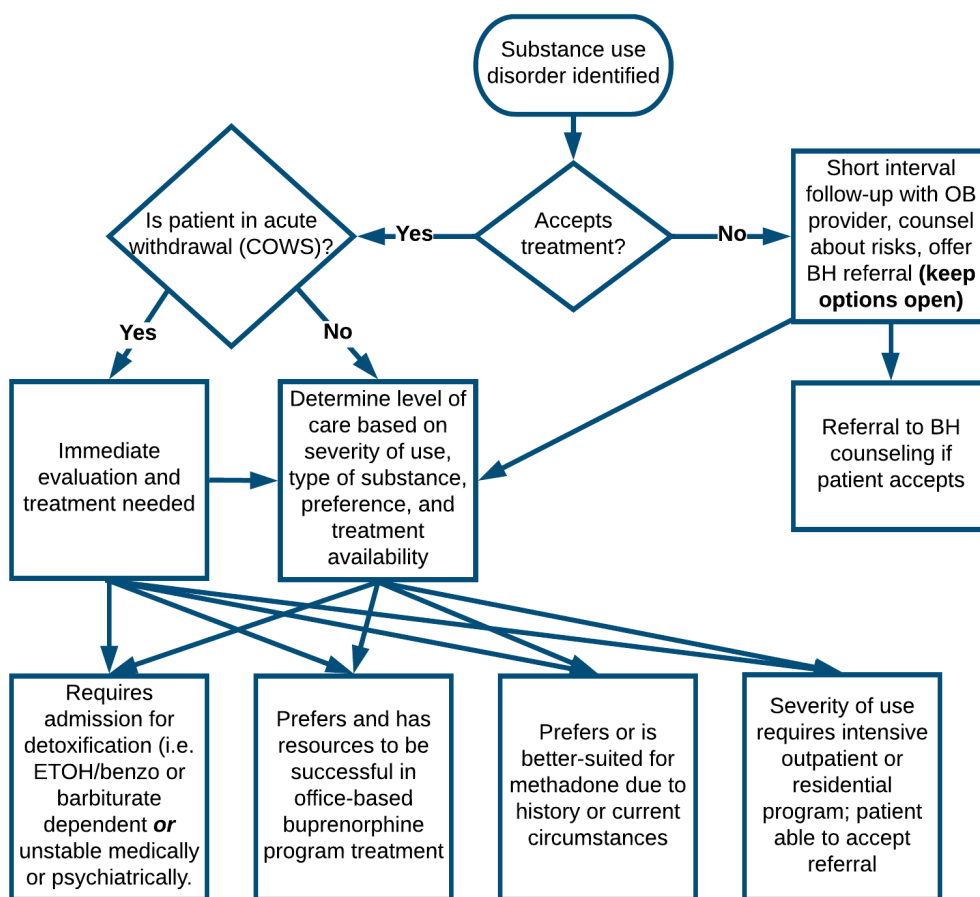
Additional information about levels of treatment for opioid use disorders may be obtained from:

<http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>
<https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone>

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)



4) 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/>

Resources 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

2a. 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 TANIIF 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).

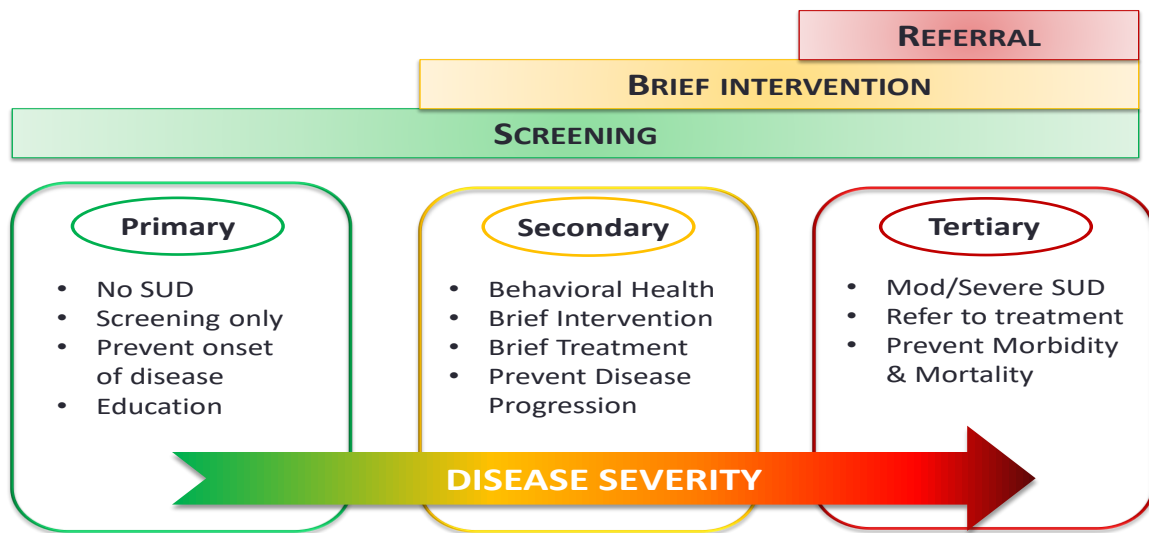
Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and wellbeing of women and their infants. Universal screening for drug and alcohol use is an essential first step in identifying women with harmful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

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 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:

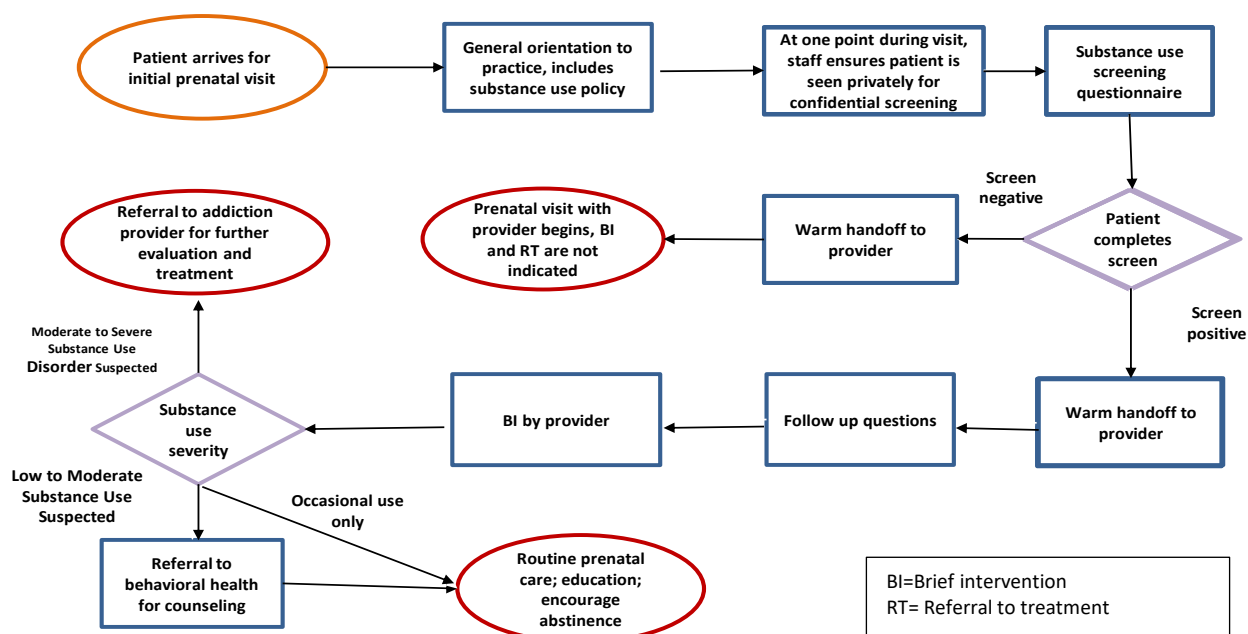
- Implement workflow modification to include confidential screening and response
- Provide information about institutional substance use policy as part of new patient orientation
- Screen using a validated questionnaire on paper, or the electronic equivalent
- Ensure a warm handoff occurs from staff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

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

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

[Your Ob/Gyn Team]

Coding and billing for substance-related services

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

1. SBIRT

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

2. Tobacco Counseling

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

3. Billing for counseling related to substance use issues for obstetric patients

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

I. 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 diagnosis of 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

II. 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 during pregnancy and 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) to the fetus and newborn
 - Discuss specific risks of identified substances used with breastfeeding and parenting (e.g., sleepiness increasing risk for unsafe sleep, Sudden Infant Death Syndrome (SIDS), not able to attend fully to baby's needs)
 - 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, umbilical cord, 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 substance-exposed newborns
 - Offer referral to case management/social worker if available at institution

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

<https://www.integration.samhsa.gov/clinical-practice/sbirt/Brief-negotiated-interview-and-active-referral-to-treatment.pdf>

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

<http://cahsmedia2.uc.edu/host/PregnancyModule/story.html>

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

1) BUILD RAPPORT & BRING IT UP	One health issue we discuss with all pregnant patients is alcohol and drug use. Having an honest conversation about these behaviors helps us provide you and your baby the best possible care. You don't have to answer any questions if you feel uncomfortable. Would it be okay to talk for a minute about alcohol/drugs?
2) PROS AND CONS	People use alcohol and drugs for lots of reasons: Help me understand, through your eyes, what do you like about using [X]? What do you like less about using [X]? So, on the one hand [PROS], and on the other hand [CONS].
3) INFORMATION & FEEDBACK Elicit Provide Elicit	I have some information on risks of drinking and drug use during pregnancy. Would you mind if I shared them with you? (Refer to appropriate handouts/ cards as needed) There is no known amount of alcohol that is safe to drink during pregnancy or when trying to get pregnant. Drinking anything containing alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorders ("FASDs"), which include physical problems, intellectual and behavioral disabilities. Use of drugs during pregnancy can also increase the risk for other pregnancy complications and health problems for your baby and behavioral and developmental problems in childhood. Use of drugs and alcohol while breastfeeding can also have negative effects on your baby. What are your thoughts on any of that?
4) READINESS RULER Reinforce positives Ask about lower #	This Readiness Ruler is like the Pain Scale we use in the hospital. On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any kind of changes in your [X] use? You marked _____. That's great. That means you are _____ % ready to make a change. Why did you choose that number and not a lower one like a 1 or a 2?
5) ACTION PLAN Affirm ideas Write down steps	What are some steps you could take to reduce the things you don't like about using [X]? What ideas do you have to keep you and your baby healthy and safe? Those are great ideas! Is it okay for me to write down your plan, your own prescription for change , to keep with you as a reminder? What should I write down on here?
6) SEAL THE DEAL Offer appropriate resources. Thank patient	I have some additional resources that people sometimes find helpful; would you like to hear about them? <ul style="list-style-type: none"> • Introduce the XXX team at _____. Offer a warm handoff if possible. • Offer handouts or brochures as appropriate. Thank you for talking with me today.

III. **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 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

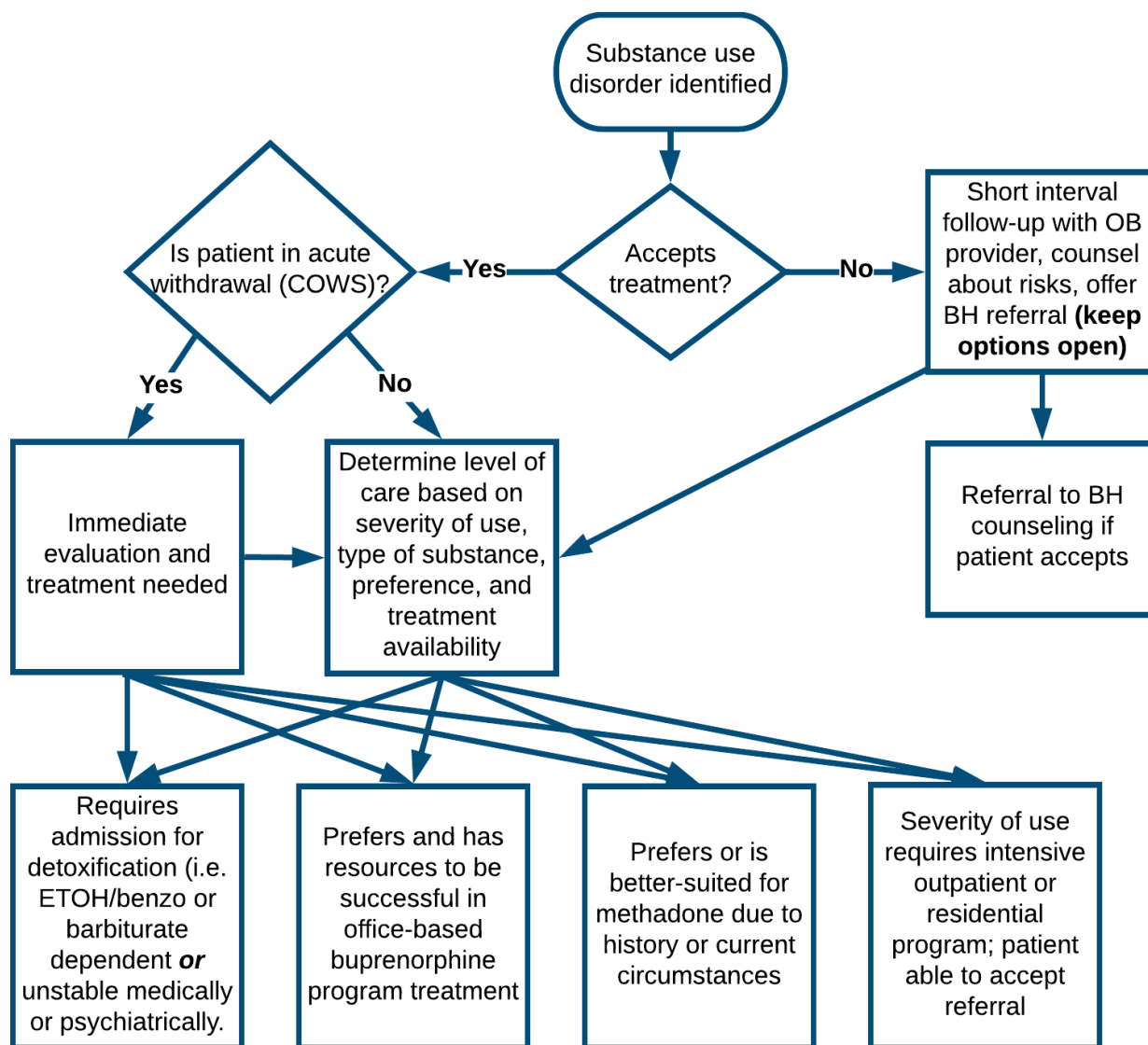
Substance use treatment programs which offer daily treatment in a residential setting. Residential programs may or may not be gender-specific. A few residential programs are also equipped to accommodate children whose mothers are seeking treatment.

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

- 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 Disorder

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.			
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.			
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.			
8. Recurrent alcohol use in situations in which it is physically hazardous. <i>[For example: this criterion would be fulfilled if a woman regularly operated a motor vehicle while intoxicated]</i>			
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. <i>[For example: this criterion would be fulfilled if a woman is aware of the teratogenic effects of alcohol and continues to drink]</i>			
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.			

b. A markedly diminished effect with continued use of the same amount of alcohol <i>[Note that a person can have an alcohol use disorder even in the absence of tolerance or withdrawal symptoms]</i>			
11. Withdrawal, as manifested by either of the following: a. The characteristic alcohol withdrawal syndrome. b. Alcohol (or a closely related substance such as benzodiazepines) is taken to relieve or avoid withdrawal symptoms.			

- 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.

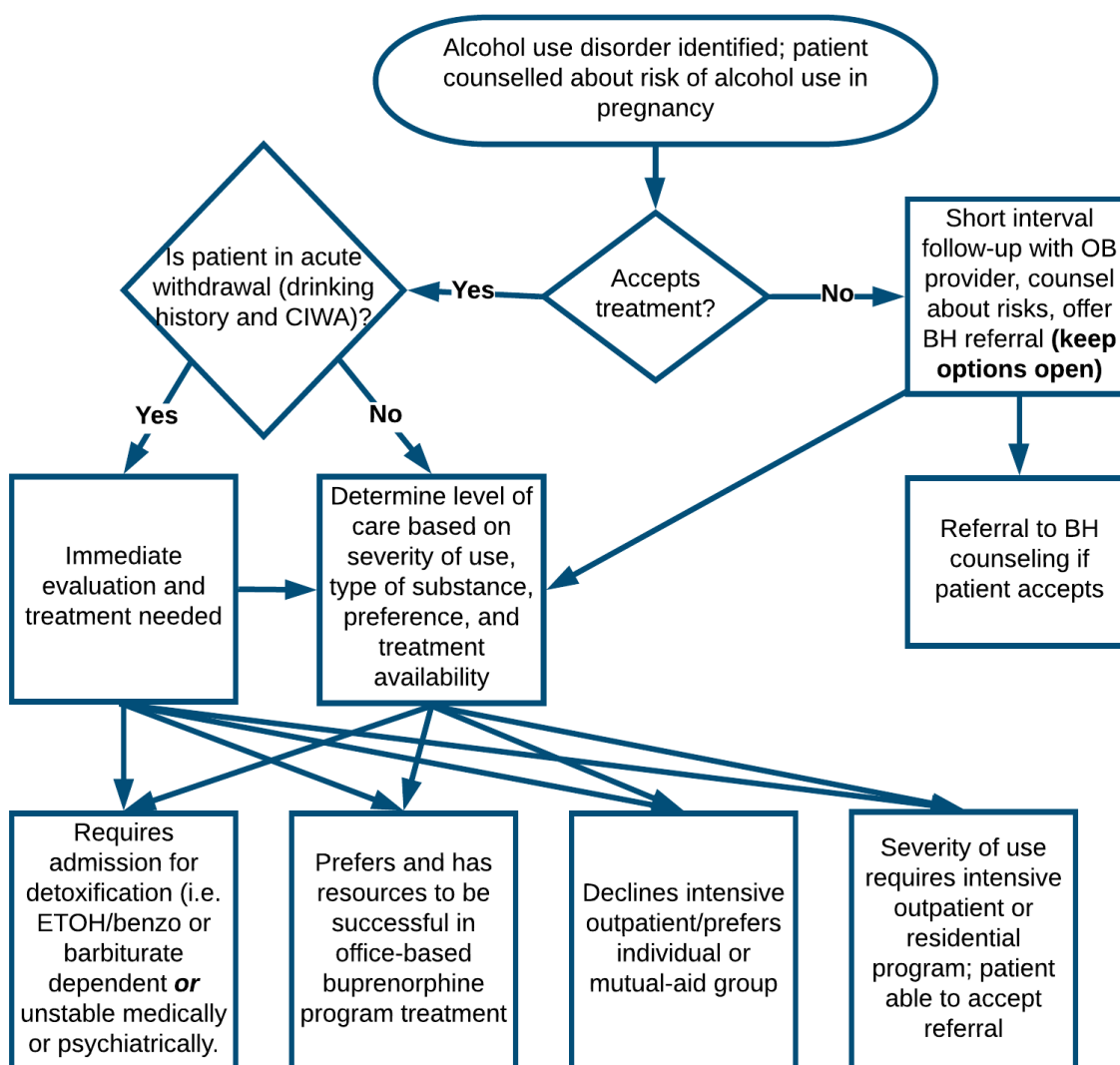
Additional information about levels of treatment for alcohol use disorders may be obtained from:

<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_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 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/cann-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 and up to one week in some mothers.
- 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.

[Insert your logo here]
v.3/20/19

Risks of Marijuana Use During Pregnancy and Breastfeeding



[Insert your logo here]
www.nnepqn.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>

7a. 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 methylenedioxypyrovalerone (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
(603) 653-1860. You may also visit us at:

Moms in Recovery

[dartmouth-hitchcock.org/psychiatry/
moms-in-recovery.html](http://dartmouth-hitchcock.org/psychiatry/moms-in-recovery.html)

Substance Use Intensive Outpatient Program

[dartmouth-hitchcock.org/psychiatry/
substance-use-outpatient.html](http://dartmouth-hitchcock.org/psychiatry/substance-use-outpatient.html)

Our Address

Dartmouth-Hitchcock
Addiction Treatment Program
Rivermill Complex
85 Mechanic Street, Suite 3-B1
Lebanon, NH 03766

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 methylenedioxypyrovalerone (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 carry potential risk to both the 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 monopreparation 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-in (Holmes et al Pediatrics, MacMillan et al (MacMillan, et al, 2018) 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. Rarely, more serious difficulties such as seizures or apnea would necessitate treatment for opioid withdrawal, but other more common etiologies (e.g., infection) should be considered and managed appropriately as per routine standard care.

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. *Addict. 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.
- MacMacMillan KDL, Rendon CP, Verma K, Riblet N, Washer DB, Volpe Holmes A. Association of rooming-in with outcomes for neonatal abstinence syndrome: a systematic review and meta-analysis. *JAMA Pediatr* 2018; 172: 345-351.
- 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 Parent Letter

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]

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.

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.

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.

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PERINATAL QUALITY IMPROVEMENT NETWORK
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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).

www.nnepqin.org/clinical-guidelines/

Section 10. Infectious Disease Diagnosis & Treatment

10.1. Hepatitis C Diagnosis & 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:
<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12623>
- 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>

10.2. Hepatitis B Screening & 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 testing negative for HBsAb (Hepatitis B surface antibody) are not immune, and should be offered immunization. The combination Hepatitis-B/Hepatitis A vaccine has the advantage that it provides immunization against both, however, 3 doses are required to be fully effective. Immunization is recommended during pregnancy because the benefits in terms of averting infection outweigh hypothetical risks, see adult immunization schedule: <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-shell.html>
- 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-immune.
 - 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.

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 (CDC)--Educational slide show 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>



10.3. HIV Resources for Providers & Patients

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/>
- UCSF HIVE: <https://www.hiveonline.org/>
- Project inform: www.projectinform.org
- 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>).

Project Inform: www.projectinform.org/prep/

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:

<https://www.gilead.com/purpose/medication-access/us-patient-access>

Additional 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/>

Additional resources for patients:

- 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)
<https://www.cdc.gov/breastfeeding/disease/>
- CDC Information About PrEP
<https://www.cdc.gov/hiv/basics/prep.html>

10.4. Hepatitis A

Hepatitis A is an acute viral infection of the liver. In 2019, an outbreak of hepatitis A in New Hampshire occurred initially in among people who were homeless or using drugs. In order to prevent the development of an epidemic, immunization was therefore widely promoted in these two communities. Unlike hepatitis B and C, which are primarily blood born, hepatitis A is spread through fecal-oral or other close physical contact. It can persist for months outside the body and can be destroyed by washing surfaces with chlorine solution.

Hepatitis A has an average incubation period of 28 days and can last from weeks to months. Severe morbidity and rarely mortality are most likely to occur in those with co-occurring liver disease (hepatitis C) or immune compromise. Unlike hepatitis C, infection is typically symptomatic, including the following:

- Fever
- Fatigue
- Loss of appetite
- Nausea
- Vomiting
- Abdominal pain
- Dark urine
- Diarrhea
- Clay-colored bowel movements
- Joint pain
- Jaundice

Additional information for providers

<https://www.cdc.gov/hepatitis/HAV/HAVfaq.htm#general>

Immunization

The U.S. Centers for Disease Control (CDC) recommend immunization of members of high risk groups, including people who use drugs (whether by injection or not). Testing for immunity to hepatitis A is not required prior to vaccination, and vaccine may be after probable exposure to Hepatitis A. Both the hepatitis A vaccine and combination hepatitis A/B vaccine may be given during pregnancy when indicated. Please see the CDC adult vaccination recommendations and schedule for more information about indications, precautions and contraindications:

<https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-shell.html>

Additional information for patients

<https://www.cdc.gov/hepatitis/hav/pdfs/HepAGeneralFactSheet.pdf>

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; it 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>

11a. Screening for and responding to disclosure of Intimate Partner Violence

Substance use disorders in women are 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 for intimate partner violence:

- <http://ipvhealth.org/>
- <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandscreening.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 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 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%206%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. Developing an Infant Plan of Safe Care

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

Key points

- The required elements of the Plan of Safe Care (POSC) vary from state to state
- This requirement applies to exposure to substances that are both prescribed and not prescribed
- Includes neonatal withdrawal from buprenorphine or methadone prescribed for treatment of opioid use disorder
- Some states (NH, VT) have developed a template for the POSC which can be shared with women

The goal of the POSC is to list existing supports and coordinate referrals to new services to help infants and their families after hospital discharge. The POSC is developed by a woman and her family's care team. How the POSC is intended to be used subsequent to discharge varies by state and institution.

Federal legislation requires notification by states regarding the number of infants born with prenatal substance exposure (aggregated) and the proportion of these for whom a POSC was created. This is not equivalent to making a mandated report about any individual to child protective services, and the fact that an infant is born with prenatal exposure to drugs or alcohol does not itself require a mandated report *per federal law*, although state laws differ in this regard.

Both Vermont and New Hampshire have developed a dual pathway by which a hospital-based care team determines for any infant whether (1) a POSC is required due to prenatal substance exposure, and (2) whether a mandated report is also required. Details about these requirements and how to determine need can be found on the relevant state websites:

Vermont

Information about the VT POSC process (patient-facing):

<https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Safe-Care-Mothers.pdf>

Flowchart describing the VT POSC process: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/CAPTA-Flowcharts.pdf>

VT POSC template: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Hospital-Plan-Safe-Care.pdf>

New Hampshire

Information about the NH POSC process: <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>

Frequently Asked Questions about the NH POSC: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_FAQ_v.6-1.pdf

NH POSC template: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_Template_v.14_FillableForm-2.pdf

Maine

Maine has not passed legislation regarding the care of substance affected infants since 2013. This law, LD 257, includes the following language:

For each infant whom the department determines to be affected by illegal substance abuse or, to be suffering from demonstrating withdrawal symptoms resulting from prenatal drug exposure or to have fetal alcohol spectrum disorders, develop, with the assistance of any health care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant and, in appropriate cases, refer the child or mother or both to a social service agency or voluntary substance abuse prevention service (HP 194-LD257, June 4, 2013)

This is currently accomplished through notifying the Maine Office of Child and Family Services about the birth of an infant meeting the criteria described above.

Additional resources for providers:

From the Substance Use and Mental Health Services Administration (SAMHSA): *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders:*

<https://store.samhsa.gov/system/files/sma16-4978.pdf>

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>

Title V, Section 503, “Infant Plan of Safe Care,” of S. 524, “Comprehensive Addiction and Recovery Act of 2016” was signed into law on July 22, 2016. The bill 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, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

The Comprehensive Addiction and Recovery Act of 2016 (CARA):

<https://www.congress.gov/bill/114th-congress/senate-bill/524>

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).

NNEPQIN/AIM Checklist for Post-Discharge Care

- Close postpartum follow-up with frequent visits
 - ☐ Review relevant portions of the *Plan of Safe Care* made at hospital discharge
 - ☐ 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 when indicated
 - ☐ Smoking cessation reinforcement or continued cessation counseling when indicated

- ☐ Rescreen for social determinants of health and assess resource needs at each visit, coordinate with case worker/social service providers
- ☐ Assist patient in scheduling appointments for infectious disease management when indicated
- ☐ Facilitate transition for recovery-friendly primary care provider if not established
- ☐ Breast-feeding support
- ☐ Provide contraception and counsel on birth spacing (*10 Best Contraceptive Practices; Postpartum Contraceptive Access Initiative (PCAI)*)
- ☐ Consider providing support and services for longer than the traditional 6 week postpartum period (*ACOG Committee Opinion #236*)

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/ODU 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>
- *Link to video*: “Hepatitis C in Pregnancy:” A conversation with Dr. Tim Lahey, Infectious Disease at Dartmouth Hitchcock Medical Center: <https://dhmc.wistia.com/medias/dhsjkydhv1>

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	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 data-bbox="800 191 834 436">What to say & do</p> <p data-bbox="865 212 1409 275">Ask the One Key Question®: “Would you like to become pregnant in the next year?”</p> <ul data-bbox="878 281 1419 743" style="list-style-type: none"> <li data-bbox="878 281 1377 312">• If “no,” discuss preventing pregnancy <li data-bbox="878 317 1357 348">• If “yes,” discuss preconception care <li data-bbox="878 352 1419 743">• If patient is unsure, here are key points to communicate: <ol style="list-style-type: none"> <li data-bbox="932 417 1333 480">i. Pregnancy is healthiest when planned. <li data-bbox="932 485 1377 548">ii. Being unsure can lead to gaps in protection. <li data-bbox="932 552 1419 709">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. <li data-bbox="932 714 1338 743">iv. Continue counseling as usual
<p data-bbox="110 785 402 816">Additional Resources:</p> <ul data-bbox="159 821 1438 1092" style="list-style-type: none"> <li data-bbox="159 821 992 852">• One Key Question® - https://powertodecide.org/select360-consulting. <li data-bbox="159 856 1438 940">• 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/nwbfch/archives/one-key-question-would-you-become-pregnant-next-year. <li data-bbox="159 945 1373 1008">• Delaware Health and Social Services- Division of Public Health. Adult Life Plan Brochure. Retrieved from http://dhss.delaware.gov/dhss/dph/chca/dphfpsservices1c.html. <li data-bbox="159 1012 1438 1092">• 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	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 data-bbox="800 1228 834 1474">What to say & do</p> <p data-bbox="865 1249 1430 1346">→ 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 data-bbox="878 1352 1419 1719" style="list-style-type: none"> <li data-bbox="878 1352 1419 1478">• <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. <li data-bbox="878 1482 1419 1614">• <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. <li data-bbox="878 1619 1419 1719">• <u>Group C</u> methods still work to prevent pregnancy as long as you use them every time you have sex.” <p data-bbox="865 1724 1373 1782">“Are there any methods you would like to learn more about?”</p>
<p data-bbox="110 1822 391 1854">Additional Resources</p> <ul data-bbox="159 1858 513 1885" style="list-style-type: none"> <li data-bbox="159 1858 513 1885">• 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	<p>“If you decided you wanted to switch, how would you switch to another method?”</p> <p>[Call the health center and continue taking a method of birth control.]</p>
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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	<p>“This method doesn’t prevent STIs so if you are concerned about that it’s a good idea to use condoms.”</p>
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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	<p>“We can start you on this method today so that you don’t have any gaps in protection.”</p>
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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.



Who are we?

The **American College of Obstetricians and Gynecologists** (ACOG) is the premier professional membership organization dedicated to the improvement of women's health. With more than 63,000 members, comprised of the nation's leading group of professionals providing health care for women, ACOG has served as the preeminent source of clinical guidance on women's health for over six decades.

ACOG created the **Postpartum Contraceptive Access Initiative** (PCAI) in consultation with more than 20 family planning clinicians and experts, many of whom implemented immediate postpartum (IPP) LARC at their own institutions.

What do we do?

The IPP period can be a particularly favorable time to provide LARC methods, and research shows that postpartum LARC provision is safe and effective. Expanding access to immediate postpartum initiation of effective contraception, including LARC methods, can empower women to choose the best method for them and reduce rapid repeat and unintended pregnancies.

Our mission is to ensure all women have access to the full range of postpartum contraceptive methods before leaving the hospital after a delivery.

How can we help?

In collaboration with local hospital staff, ACOG provides hands-on clinical and operational support training at participating institutions at no cost. Partners have included hospitals, perinatal quality collaboratives, residency programs, and more.

Key program design components: Key components include comprehensive knowledge and skill building, insights from local leadership, and tailored training based on an institution's unique needs. Such as:

Onsite Training

Hands-On Clinical Training

- Grand Rounds program & hands-on insertion simulation for OBGYNs & other clinicians
- Training specific to L&D & postpartum nurse staff
- Patient-centered & reproductive justice-based counseling
- Learn more [here](#)

Operational Support Training

- Onsite operational systems support for billing, coding, payment, pharmacy & more
- Training specific to billing, coding & pharmacy staff, L&D & postpartum nurses & nurse managers, L&D directors, neonatal services & lactation consultants & other key audiences
- Learn more [here](#)

Web-Based & Virtual Support

Web-Based Resource Hub

- General, clinical, coding, billing, payment & logistics resources
- PowerPoints, archived webinars, patient education resources & FAQs
- IPP LARC resources at pcainitiative.org

Expert Technical Assistance

- Follow up technical assistance with LARC experts through a conference call or the [LARC Program Help Desk](#)
- IPP LARC expert answers clinical and/or operational support questions

How can you learn more?

Please visit pcainitiative.org or email pcai@acog.org for more information.

Overview of the Postpartum Contraceptive Access Initiative

Project Rationale and Description: Unintended pregnancy persists as a public health challenge with significant adverse health and economic consequences. LARC methods remain the most effective forms of reversible contraception and have the highest continuation and satisfaction rates among all users. Increasing access to LARC methods can empower women, improve health, and reduce unintended pregnancy.

The immediate postpartum (IPP) period can be a particularly favorable time to provide LARC methods, and research shows that postpartum LARC provision is safe and effective. Expanding access to immediate postpartum initiation of effective contraception, including LARC methods, can empower women to choose the best method for them and reduce rapid repeat and unintended pregnancies.

The LARC Program created the Postpartum Contraceptive Access Initiative (PCAI) in consultation with more than 20 family planning clinicians and experts, many of whom implemented IPP LARC at their own institutions. The insights and best practices gleaned from these experts inform PCAI's program design.

Mission: The mission of ACOG PCAI is to ensure all women have access to the full range of postpartum contraceptive methods before leaving the hospital after a delivery.

Action: In collaboration with local hospital staff, ACOG will provide hands-on clinical and operational support training at participating hospitals.

Target Audience: The target audience of ACOG's onsite trainings will be clinical and administrative staff at hospitals as determined by the local hospital and ACOG staff.

Approach and Training Methods

a. Three-Pronged Implementation Model: A year of research and consultations with more than 20 family planning experts, many of whom successfully implemented IPP LARC at their own institutions, informs ACOG PCAI's program design. In addition to providing onsite training, research and expert recommendations highlight the importance of setting the stage at hospital sites prior to implementation, as well as continued support after onsite trainings occur.

Further, evidence-based research supports the use of a tiered approach for implementing IPP LARC. One study of 10 hospital sites in Georgia concluded that, "Hospital teams report that implementing [IPP LARC] programs involved multiple departments and a number of important steps to consider. A stage-based approach to implementation and a standardized guide detailing these steps, may provide the necessary structure for the complex process of implementing [IPP LARC] programs in the hospital setting."

ACOG staff incorporated these best practices into the PCAI three-pronged implementation model to support successful IPP LARC provision at participating hospitals. These phases include: 1) setting the stage for implementation, 2) onsite, hands-on clinical simulation and operational support trainings, and 3) ongoing support through a web-based resource hub and follow up technical assistance with IPP LARC implementation experts. Based on current research and expert recommendations, addressing all three phases is crucial for success, and the PCAI program design implements this evidence-based model.

c. Key Program Design Components: ACOG PCAI's program components include comprehensive knowledge and skill building, local leadership, and tailored training based on a hospital staff's stated needs.

1. Comprehensive Knowledge and Skill Building: Many women do not have access to the full range of contraceptive methods, including LARC, in the hospital after giving birth. ACOG uses a multifaceted, systems approach to offset these barriers. The main program components include:

Onsite Training

Web-Based & Virtual Support

Hands-On Clinical Training

- Grand Rounds program & hands-on insertion simulation for OBGYNs & other clinicians
- Training specific to L&D & postpartum nurse staff
- Patient-centered & reproductive justice-based counseling

Operational Support Training

- Onsite operational systems support for billing, coding, payment, pharmacy + more
- Training specific to billing, coding & pharmacy staff, L&D & postpartum nurses & nurse managers, directors of L&D, neonatal services & lactation consultants & other key audiences

Web-Based Resource Hub

- General, clinical, coding, billing, payment & logistics resources
- PowerPoint presentations, archived webinars, patient education resources, job aids & FAQs
- IPP LARC resources at pcainitiative.org and the LARC Program Help Desk

Expert Technical Assistance

- Follow up technical assistance with LARC experts through a conference call or the LARC Program Help Des
- IPP LARC expert answers clinical and/or operational support questions

2. Local Leadership and Insights. Prior to onsite training, the ACOG LARC Program staff will identify the individual(s) from the participating hospital to serve as the LARC Champion(s). This person will serve as the point of contact and provide interdepartmental leadership throughout IPP LARC implementation. The LARC Champion will also be a liaison between the participating hospital and ACOG staff and trainers.

ACOG recommends that at least one Champion be a practicing physician within the participating hospital. With technical assistance from ACOG staff, the Champion(s) will work with ACOG staff to develop a training plan for his/her hospital.

3. Needs Assessment Informs Individualized Training Plan. Before any onsite training occurs, the Physician Champion(s), Choose Well staff, and ACOG staff will discuss the history and status of IPP LARC implementation at their hospital.

With information gleaned from these conversations, the Physician Champion(s), Choose Well staff, and ACOG staff will create an individualized training plan to meet a hospital's specific training needs. The training options include:

- Billing, Coding, and Payment for Immediate Postpartum LARC Services
- Contraceptive Counseling for the Immediate Postpartum Period
- Immediate Postpartum Contraception and Breastfeeding
- Immediate Postpartum LARC for Clinicians Doing Deliveries
- Pharmacy Considerations for Immediate Postpartum LARC Implementation
- Setting the Stage for Immediate Postpartum LARC Implementation: Systems and Sustainability
- The Role of Nurses in Immediate Postpartum LARC Implementation

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Implementation Tools

Included:

- Checklist Chart Template
- Process map outlining data collection process
- Sample data collection form
- Sample patient tracking form
- Sample patient experience survey
- Sample provider survey
- Buprenorphine Induction (inpatient) for Pregnant Women Procedure Draft
- Buprenorphine Induction Algorithm (inpatient)

Checklist Chart Template

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		
Offer Hepatitis A or A/B vaccine		
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		
Repeat Hepatitis A or A/B vaccine		
OTHER		

Universal Demographics Form

Please complete this form for every OB patient with OUD.

Care Site:	
Patient Study ID: <i>Please assign each patient a unique Study ID. The Study ID should consist of <u>your site's two-letter identifier</u>.</i>	Patient Study ID: _____
Estimated Date of Delivery:	_____ (mm/dd/yy)
iMAT patient?	<input type="radio"/> Yes → <input type="radio"/> No →
→ If <i>iMAT patient</i> , did patient enter iMAT prenatally or postpartum.	<input type="radio"/> Prenatal <input type="radio"/> Postpartum
→ If <i>NOT iMAT patient</i> , please indicate reason:	<input type="radio"/> Prefers no treatment <input type="radio"/> Prefers external MAT provider <input type="radio"/> Requires higher level of care <input type="radio"/> iMAT not yet started, referred to external MAT prov. <input type="radio"/> iMAT not yet started, seeing external MAT prov. <input type="radio"/> Does not want ANY treatment or assistant at this time <input type="radio"/> Unknown <input type="radio"/> Other: _____
Date of first OB visit at your site:	_____ (mm/dd/yy)
Mother's age at first OB visit:	_____ years
Gestational age at first OB visit at your site:	_____ weeks
Number of living children, not including this pregnancy:	_____
Race:	<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
Ethnicity:	<input type="radio"/> Hispanic or Latino origin <input type="radio"/> Not Hispanic or Latino origin <input type="radio"/> Other/Unknown

Sample Data Collection Form
Universal Demographics

MRN: _____

Patient Study ID: _____

Primary payer:	<ul style="list-style-type: none"><input type="radio"/> Private insurance<input type="radio"/> Medicaid only<input type="radio"/> Medicare only<input type="radio"/> Medicare & Medicaid (dual eligible)<input type="radio"/> Uninsured<input type="radio"/> Other
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Outcomes Summary

Please complete for all OUD patients at 12 weeks postpartum.

Did patient transfer care or become lost to follow up prior to delivery?	<input type="radio"/> Yes <input type="radio"/> No
Date of delivery:	_____ (mm/dd/yy)
Social/Behavioral Demographics	
Tobacco/nicotine use during pregnancy:	<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"/> Used Smokeless tobacco <input type="checkbox"/> Nicotine replacement therapy (NRT) → <input type="checkbox"/> Unknown <i>(check all that apply)</i>
<i>If NRT prescribed, please specify type:</i>	<input type="checkbox"/> Patch <input type="checkbox"/> Gum <input type="checkbox"/> Lozenges <input type="checkbox"/> Other <i>(check all that apply)</i>
Transportation status:	<input type="checkbox"/> Has own transportation (driver's license and car) <input type="checkbox"/> Receives ride from family member, friend, or partner <input type="checkbox"/> Medicaid ride service <input type="checkbox"/> Public transportation <input type="checkbox"/> Unknown <i>(check all that apply)</i>
Housing status:	<input type="checkbox"/> Rents/owns (includes staying with partner) <input type="checkbox"/> Staying with family member <input type="checkbox"/> Staying with friend <input type="checkbox"/> At risk for losing housing <input type="checkbox"/> Incarcerated <input type="checkbox"/> Staying in shelter <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <i>(check all that apply)</i>

Integrated MAT-OB Program Treatment History (skip this section if not integrated)

Did patient continue iMAT program participation through at least 12 weeks postpartum?	<input type="radio"/> Yes <input type="radio"/> No →
<i>If no, please indicate reason for discontinuation:</i>	
Number of iMAT program visits <u>prior to</u> delivery:	_____ visits
Number of iMAT program visits <u>after</u> delivery (from delivery to 12 weeks postpartum):	_____ visits
Additional comments on iMAT participation (optional):	

Prenatal Treatment History

Did patient <u>transfer</u> care from another prenatal practice?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If transferred, 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 transferred, what was the gestational age at first OB visit at previous provider?</i>	_____ weeks
Was MAT treatment for OUD co-located?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not receiving MAT
Treatment for opioid use disorder during pregnancy:	<input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine (Subutex) <input type="checkbox"/> Buprenorphine/Naloxone (Suboxone) <input type="checkbox"/> Naltrexone, oral <input type="checkbox"/> Naltrexone, injectable <input type="checkbox"/> No MAT <input type="checkbox"/> Other/Unknown <i>(check all that apply)</i>

Is psychiatric diagnosis other than OUD included on the problem list?	<input type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Unknown
If <u>yes</u> , please specify psychiatric diagnosis:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> PTSD <input type="checkbox"/> Bipolar <input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Eating disorder <input type="checkbox"/> Other: _____ (check all that apply)
Is patient being treated with a psychiatric medication?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Did patient receive behavioral health counseling?	<input type="radio"/> Yes <input type="radio"/> No
If <u>yes</u> , was behavioral health counseling co-located?	<input type="radio"/> Yes <input type="radio"/> No
Number of prenatal care visits at your site:	_____ visits
Gestational age at first prenatal visit at your site:	_____ weeks
Treatment history comments (optional):	

Care Process Measures	
Is a substance use diagnosis included on the problem list?	<input type="radio"/> Yes <input type="radio"/> No
Is the checklist present in the record?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If yes, was checklist used?</i>	<input type="radio"/> Yes <input type="radio"/> No
Was information about the risk of non-prescribed drugs and alcohol given?	<input type="radio"/> Yes <input type="radio"/> No
Was smoking cessation education and/or treatment given?	<input type="radio"/> Yes <input type="radio"/> No
Was marijuana use discussed?	<input type="radio"/> Yes <input type="radio"/> No
Was breastfeeding education given?	<input type="radio"/> Yes <input type="radio"/> No
Was Naloxone (Narcan) discussed and Rx offered?	<input type="radio"/> Yes <input type="radio"/> No
Was Plan of Safe Care discussed?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If <u>yes</u>, was a plan of safe care initiated?</i>	<input type="radio"/> Yes <input type="radio"/> No
Did domestic violence screening take place using a validated screener?	<input type="radio"/> Yes <input type="radio"/> No
Checklist process comments (optional):	

Prenatal Screening	
Hepatitis C antibody screen:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
Hepatitis C viral load screen (if Ab positive):	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
HIV screen:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
Drug screening in Third Trimester for non-prescribed substances:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
If positive , please indicate substance(s):	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: _____ (check all that apply)
If opioids , please indicate opioid(s):	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine (non-prescribed) <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) (check all that apply)
Was patient screened (or re-screened) for hepatitis C in the third trimester?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A already known

Was patient screened (or re-screened) for HIV in the third trimester?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A already known
Was patient screened for sexually transmitted infections (gonorrhea, chlamydia, or syphilis)?	<input type="radio"/> Yes → <input type="radio"/> No
Gonorrhea:	First trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested Third trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested
Chlamydia:	First trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested Third trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested
Syphilis:	First trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested Third trimester: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not tested
Prenatal Complications	
Was patient admitted during pregnancy for any reason other than for delivery?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If yes, please specify reason for admission:</i>	

Delivery Outcomes	
Was discharge summary received?	<input type="radio"/> Yes <input type="radio"/> No
Mother's age in years at time of delivery:	_____ years
Gestational age at delivery (weeks and days):	_____ weeks _____ days
<i>If <38 weeks, please specify reason:</i>	
Birthweight in grams:	_____ grams
Was this a multiple or twin birth?	<input type="radio"/> Yes <input type="radio"/> No
Mode of delivery:	<input type="radio"/> NSVD (nonsurgical vaginal delivery) <input type="radio"/> Operative vaginal delivery (vacuum assisted/forceps) <input type="radio"/> Cesarean section
Did patient experience severe maternal morbidity during hospitalization?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If yes, please indicate type of maternal morbidity:</i>	
Maternal length of stay during delivery hospitalization (elapsed time from delivery to discharge):	_____ days
<i>If >3 days, please specify reason for prolonged stay:</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

Drug screening for non-prescribed substances at time of delivery hospital admission:	<input type="radio"/> Positive → <input type="radio"/> Negative <input type="radio"/> Not tested or results not available
<i>If positive, please indicate substance type(s):</i>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: _____ <i>(check all that apply)</i>
<i>If opioids used, please specify type of opioid(s):</i>	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) <i>(check all that apply)</i>
What type of feeding was infant receiving at discharge?	<input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Unknown <i>(check all that apply)</i>
Are APGAR Scores available?	<input type="radio"/> Yes → <input type="radio"/> No
APGAR Scores (1, 5, and 10-minute):	<ul style="list-style-type: none"> ▪ 1-minute: _____ ▪ 5-minute: _____ ▪ 10-minute: _____

Neonatal Outcomes	
Infant length of stay in hospital (days):	_____ days
Did baby require NICU care?	<input type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Unknown
<i>If yes, how many days were spent in NICU?</i>	_____ days
Did baby require medication to treat symptoms of neonatal abstinence syndrome (NAS)?	<input type="radio"/> Yes <input type="radio"/> No
Did umbilical cord or meconium test positive for non-prescribed substances?	<input type="radio"/> Yes → <input type="radio"/> No
<i>If positive, please specify:</i>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: _____ <i>(check all that apply)</i>
<i>If opioids used, please specify:</i>	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) <i>(check all that apply)</i>
Was infant referred to DCYF?	<input type="radio"/> Yes <input type="radio"/> No
Was infant discharged home with mother?	<input type="radio"/> Yes <input type="radio"/> No → <i>If no, please indicate reason:</i>

Postpartum Care	
Did postpartum visit occur within 8 weeks after delivery?	<input type="radio"/> Yes → <input type="radio"/> No →
<i>If yes, please check all that apply:</i>	<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 <i>(check all that apply)</i>
<i>If no postpartum visit, please specify reason:</i>	
What type of feeding was infant receiving at postpartum visit?	<input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Unknown <i>(check all that apply)</i>
Did patient receive contraception at hospital discharge?	<input type="radio"/> Yes <input type="radio"/> No
<i>If yes, please indicate type of contraception:</i>	<input type="radio"/> IUD <input type="radio"/> Nexplanon <input type="radio"/> Depo <input type="radio"/> Prescription
Tobacco/nicotine use at postpartum visit:	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Smoking at the time of postpartum visit <input type="checkbox"/> Quit during pregnancy <input type="checkbox"/> Vaped <input type="checkbox"/> Used smokeless tobacco <input type="checkbox"/> Nicotine replacement therapy (NRT) → <input type="checkbox"/> Unknown <i>(check all that apply)</i>
<i>If NRT prescribed, please specify type:</i>	<input type="checkbox"/> Patch <input type="checkbox"/> Gum <input type="checkbox"/> Lozenges <input type="checkbox"/> Other <i>(check all that apply)</i>
Was patient continuing substance use treatment at time of postpartum visit?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

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	
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														

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.

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 at 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 (555-555-5555).
 - 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 5555.
- 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 Diaphoresis Yawning Restlessness Insomnia Dilated pupils Piloerection Muscle twitching Myalgia Arthralgia Abdominal pain	Tachycardia Hypertension Tachypnea Fever Anorexia or nausea Extreme restlessness Diarrhea and/or vomiting Dehydration Hyperglycemia Hypotension

- 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:

- ii. Inpatient or residential addiction treatment program.
- d. A list of state treatment providers is available at:

D. Outpatient Follow Up:

- a. Refer to the Moms in Recovery Program appointment and schedule first appointment if possible before discharge (555-5555), 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.

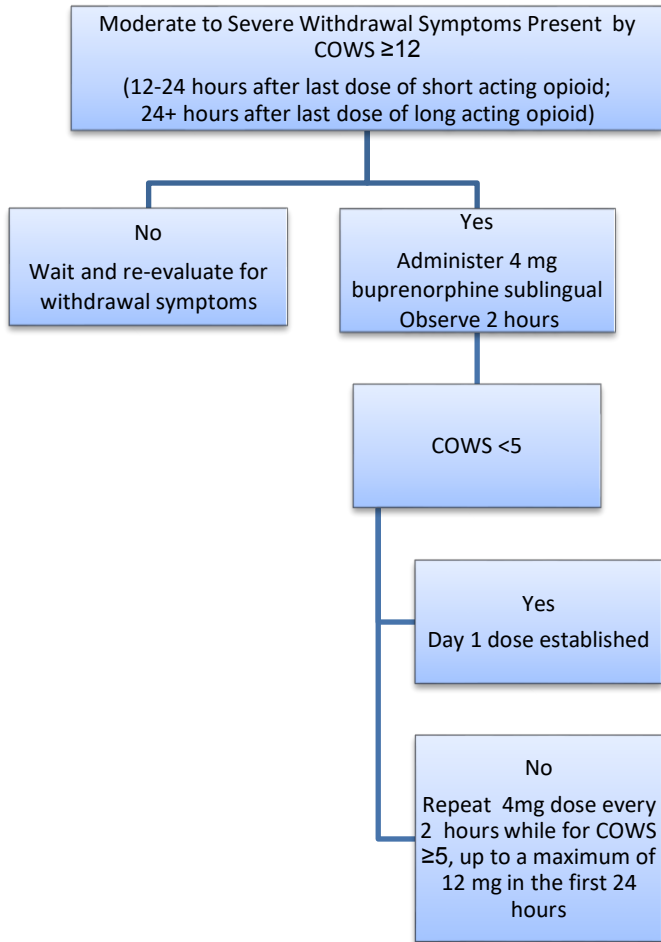
VI. References

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- http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm#b
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- <http://www.deadiversion.usdoj.gov/pubs/manuals/narcotic/appendixa/treatment.htm>

Responsible Owner:	Birthing Pavilion	Contact(s): email	C
Approved By:		Version #	
Current Approval Date:		Old Document ID:	
Date Procedure to go into Effect:			
Related Policies & Procedures:			
Related Job Aids:			

Buprenorphine Induction Algorithm (inpatient)

Day 1



Day 2

