PLAYBOOK

NH S·BI·RT Implementation Playbook for Perinatal Providers

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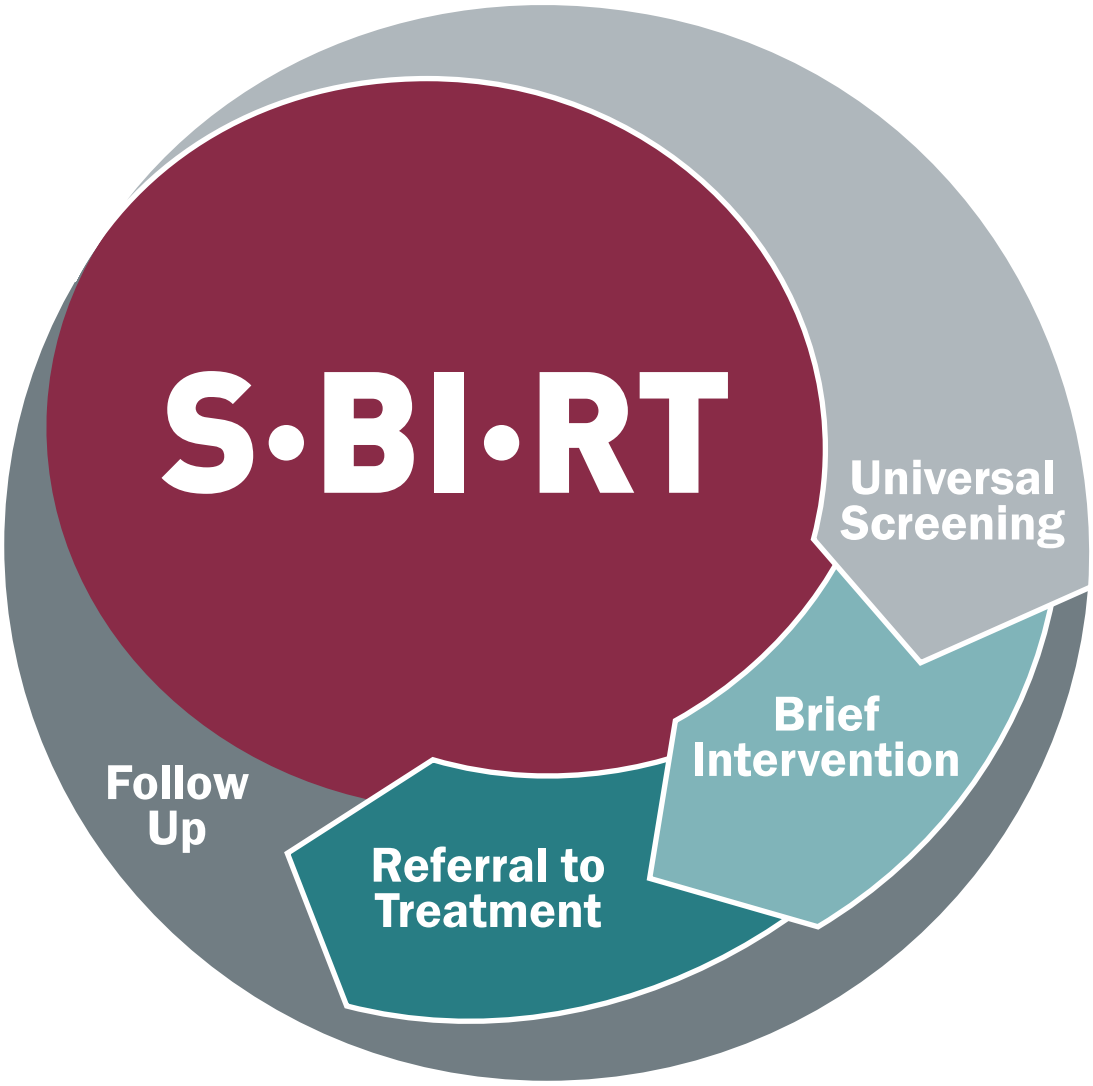

NEW HAMPSHIRE CHARITABLE FOUNDATION

CENTER FOR EXCELLENCE | Addressing Alcohol & Drug Misuse in NH

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This Playbook was developed as a companion to Screen and Intervene: NH S·BI·RT Playbook, providing a compendium of actions and/or strategies to support S·BI·RT implementation in obstetrics settings. Thank you to co-developers of Screen and Intervene: NH S·BI·RT Playbook: Kara Sprangers, BS, RN[Δ] and Kathleen M. Thies, PhD, RN[◊]

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ACRONYMS USED

ACOG	American College of Obstetricians and Gynecologists
ASAM	American Society for Addiction Medicine
BI	Brief Intervention
CFR	Code of Federal Regulations
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
E & M Code	Evaluation and Management Code
EHR	Electronic Health Record
FASD	Fetal Alcohol Spectrum Disorders
HIPAA	Health Insurance Portability and Accountability Act
IT	Information Technology
MAT	Medication Assisted Treatment
NAS	Neonatal Abstinence Syndrome
NNEPQIN	Northern New England Perinatal Quality Improvement Network
NRT	Nicotine Replacement Therapy
NTD	Neural Tube Defects
OUD	Opiate Use Disorder
PDSA	Plan, Do, Study, Act
POSC	Plan of Safe Care
S•BI•RT	Screening • Brief Intervention • Referral to Treatment
SAMHSA	Substance Use and Mental Health Services Administration
SIDS	Sudden Infant Death Syndrome
SUD	Substance Use Disorder
TA	Technical Assistance

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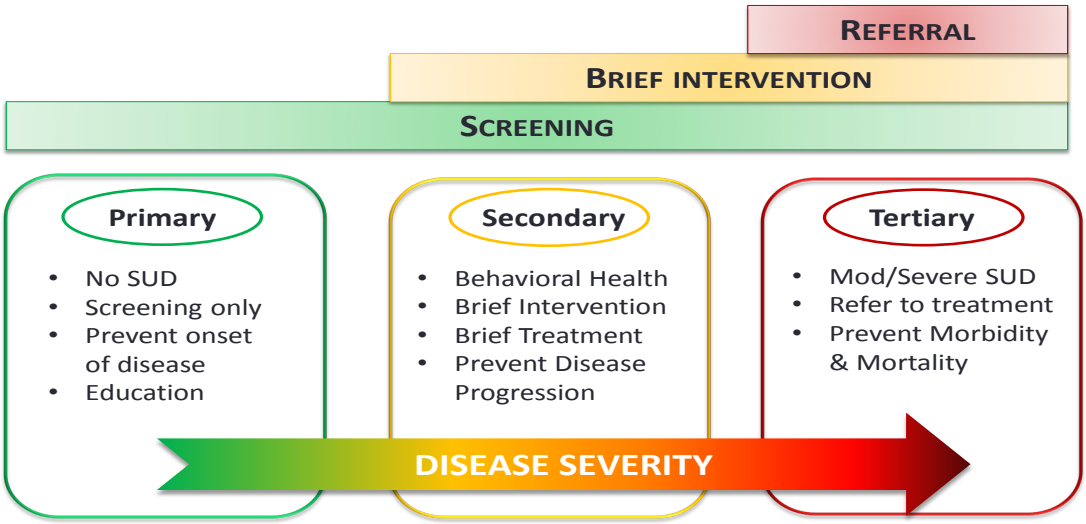
INTRODUCTION

Prevention, identification, and reduction of perinatal opioid and other substance 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 substance use disorders and linking them with services at the appropriate level of care.[1] [2] [3] Screening should be inclusive of illicit drug, alcohol, and tobacco use.

Perinatal substance use exists across all sociodemographic groups and geographic areas.[4] Approximately 10% of pregnant women report the use of alcohol during pregnancy, including 4% who drink more the 5 drinks at one time, 5% who report the use of illicit drugs, and more than 15% who report smoking tobacco.[5] The prevalence of a specific type of substance use may vary according to sociodemographic groups and geographical region. For example, continued use of alcohol is more prevalent in women who are over age 35, identify as white, are college educated, married, and obtain care from a private physician,[6] and perinatal opioid use is most prevalent in the northeastern and central areas of the United States.[7] [8] [9]

The Northern New England Perinatal Quality Improvement Network (NNEPQIN) recommends universal screening for drug and alcohol use as an essential component of prenatal care, using validated instrument(s) and a screening, brief intervention, referral for treatment (S·BI·RT) framework.[10] Obstetrical care providers have a professional obligation to screen all patients for substance use in pregnancy.[11] Population-based screening enables providers to identify women engaged in harmful use of drugs or alcohol, assess level of risk in order to provide support at the appropriate level of need, arrange follow up, and make referrals as indicated. The use of S·BI·RT as a framework for screening is consistent with recommendations by the American College of Obstetricians and Gynecologists (ACOG), the American College of Nurse Midwives, the American Academy of Pediatrics, the Alliance for Innovation in Maternal Health, and the Substance Use and Mental Health Services Administration (SAMHSA).[12] [13] [14] [15] [16] [17]

FIGURE 1. POPULATION HEALTH MODEL FOR SUBSTANCE USE SCREENING AND INTERVENTION



DEFINITION: SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

S-BI-RT – **S**creening, **B**rief **I**ntervention and **R**eferral to **T**reatment – denotes an approach to systematic universal screening for problematic alcohol and drug use and the routine steps taken to address screening results. By utilizing S-BI-RT, healthcare providers can identify problematic alcohol and drug use, provide early intervention for patients at risk for developing a substance use disorder (SUD),[i] and coordinate effective care and referral to treatment for those who likely already have an SUD.

S-BI-RT represents a process of discrete components that includes S (screening), BI (brief intervention), and RT (referral to treatment). Beginning with screening, each component builds on the previous one, as needed. S-BI-RT services are reimbursed by both private and public health insurance. **A primary goal of S-BI-RT as part of early pregnancy risk assessment is to facilitate identification of need for treatment and linkage to services, so that women are engaged in recovery and in a good position to parent safely at the time of birth.**

Role of the Women's Health Care Provider

ACOG describes the responsibilities of the obstetrical care provider in the prevention and evaluation of substance use and use disorders as follows:[18] [19] [20]

- Incorporate screening, brief intervention and referral to treatment (S-BI-RT) into routine practice in order to benefit the patient and nurture the therapeutic relationship.
- Provide appropriate information and education to encourage healthy behaviors.
- Adhere to safe prescribing practices.
- Identify referral resources and develop other members of the health care team to assist with counseling, referral and treatment.
- Evaluate at-risk patients for associated medical and social problems such as partner violence, sexually transmitted diseases, and other medical complications of substance misuse such as cardiac and respiratory compromise.
- Be aware of local mandated reporting rules.

NNEPQIN's population-based approach is based on universal screening of pregnant women on entry to maternity care, in the third trimester, and at the time of admission for delivery, with appropriate mechanisms in place to link those who screen as "at risk" to follow up assessment, appropriate intervention, and assistance linking to services.[21] Each antepartum care provider and hospital in-patient unit should develop policy and procedures that include universal screening for alcohol, drug and tobacco use. Guidelines should include a description of the screening approach used, guidance for making referrals, and links to resources for support, education, and treatment.

[i] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), substance use disorders (SUD) are defined as mild, moderate, or severe to indicate the level of severity, as determined by the number of diagnostic criteria met by an individual. SUDs occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Available from: https://www.samhsa.gov/disorders/substance-use

Screen and Intervene: NH S·BI·RT Implementation Playbook for Perinatal Providers

This document, *Screen and Intervene: NH S·BI·RT Implementation Playbook for Perinatal Providers* (Playbook), developed as a companion to *Screen and Intervene: NH S·BI·RT Playbook* (available at https://S·BI·RTnh.org/playbook/), provides a compendium of actions and/or strategies to support implementation of S·BI·RT in obstetric settings. The Playbook is organized by actions/strategies called "Plays" as they are meant to be put into action at the right time, in the right place, and in the right sequence of S·BI·RT implementation based on the unique context of each organization and site. The Plays were developed based on review of other 'how to' S·BI·RT guides and the recommendations and experiences of NH implementation team members across diverse sites, including specific recommendations from perinatal practices.

Implementing a new process requires a quality management approach that includes quality planning to systematically design a process that will be able to work, monitoring alignment of the process with identified goals and aims, and using data-driven actions to make processes better through quality improvement. This Playbook provides an organizing framework for this quality management approach.

The Playbook is organized in three sections: Introduction and Overview, S·BI·RT Implementation Plays including recommendations for sustainability, and Appendices (Tools and Resources). Although the Playbook layout suggests that Plays are implemented in a linear fashion, as in a football game, in practice they are intricately intertwined and should be implemented in the order that best fits the unique organizational structure, team experience, and culture of each practice. Throughout this Playbook, each Play includes: a) Description of the Play including an overview with a table that summarizes Play Purpose, Definitions, Team Members, and Measure(s); b) *Recommended Approach*, and c) key factors to *Keep in Mind* as the Play is implemented. Selected examples are included in the Appendix, along with further information and resources about that Play. There are references throughout this Playbook to NNEPQIN's A Toolkit for the Perinatal Care of Women with Substance Use Disorders (NNEPQIN Perinatal Toolkit), which includes clinical information and guidelines availbile at https://www.nnepqin.org/clinical-guidelines/.

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 or medical decision making for specific healthcare environments and patient situations.

PLAY 1: BEGINNING PRACTICE CHANGE – THE WORK BEFORE THE WORK

Establishing an interdisciplinary team, clear objectives, and an implementation plan are necessary components of successful S·BI·RT implementation. S·BI·RT implementation is a layered process, touching the system at multiple points. It is critical to success and sustainability that a team addresses planning and implementation issues together systematically, and that the team agrees about decisions. Establishing how agreement is operationalized will depend upon each practices' unique culture, and is part of "the work before the work".

Forming a Team

Team members involved in any aspects of workflow (e.g., MD and/or APRN, CNM, PA, RN, MA, behavioral health provider, practice manager, information technology, and administrative staff, including schedulers) will lend crucial insight to guide successful and sustainable implementation. Each discipline will have a role, not only in implementing S·BI·RT, but also in creating a sensible workflow that will become a sustainable component of care. Prioritize communication and participation for all stakeholders involved with or affected by S·BI·RT implementation. The involvement of a clinical champion is key.

It is helpful to establish a team structure that includes holding regular meetings (we recommend bi-weekly to start) using meeting rules, following an agenda guided by the checklist (Appendix A), and incorporating a meeting evaluation. When someone other than a formal leader within the organization assumes leadership of the team, more creative/out-of-the-box assessment and problem solving ideas may arise and be fostered.

> ***Corresponding Appendix Section(s)***
>
> Appendix A: Implementation Checklist
>
> ***Resource***
>
> *Preventing Youth Substance Misuse Through Integrated Primary Care: Strategies for S·BI·RT Implementation* (Pages 25-27)
>
> See https://sbirtnh.org/playbook/play-1/ for more detail and sample agenda.

Using a Change Model

A change model defines the processes the team will use to implement S·BI·RT – how will the team bring the clinical practice of S·BI·RT into its unique setting. It provides a framework to help reach goals and measure success quickly and effectively. We recommend applying the microsystems framework (See examples in Appendix B and Appendix C) however if the team already uses a change model for improving practice such as Lean, Six Sigma, or the Model for Improvement, continue using it. As a team, review and understand the change model prior to beginning the implementation work. This provides a baseline understanding of the process the team will follow to achieve its goals. Regardless of the change model used, the process of improvement builds on an understanding of the "current state". Therefore, start by assessing the organization's current screening processes, asking the following questions: How does screening for drug and alcohol use during pregnancy currently happen? Who performs the screening? Which patients get screened? What is the current work flow? What screening questions or tools are currently used? Are data about

screening rates or results collected? Making a flowchart or map of the current screening process will help identify how the S·BI·RT process might best be implemented through modifying rather than disrupting existing workflow.

> ***Corresponding Appendix Section(s)***
>
> Appendix B: Change Model Example
>
> Appendix C: Example Change Process

Developing a Plan - Goals and Strategies

To be successful, everyone in the practice should understand the population health concepts underlying S·BI·RT. Buy-in from stakeholders, including both leadership and front-line staff who will be performing S·BI·RT, is essential to success. Share the goals, aims and measures of S·BI·RT implementation with colleagues in the practice. Articulating the goals of S·BI·RT implementation and its value for patients should be a focus of the first implementation team meetings. Be aware of and discuss potential biases regarding perinatal substance use. List team members' concerns about implementation, and review and resolve the list as the team works through it. This may impact the order in which the team prioritizes its aims and the order in which it works through the Plays. The Team S·BI·RT Plan Template (Appendix D) can be used to guide this discussion.

> ***Corresponding Appendix Section(s)***
>
> Appendix D: S·BI·RT Implementation Team Plan Template

PLAY 2: CONFIDENTIALITY

The confidentiality of patient information is an issue that cuts across all Plays. Each practice will need to incorporate compliance strategies for managing confidential drug and alcohol use information into the design of every Play. Confidentiality considerations will impact flow, electronic health record (EHR) integration, referral relationships, and other decision points throughout preparation and implementation. Substance use is a highly sensitive issue for families, and identification of perinatal substance use can have significant implications for women, especially those who are caring for children already or are involved with the criminal justice system. Respecting the confidentiality of screening results while facilitating appropriate referrals for treatment and supports is essential. There are state and federal laws and regulations that govern confidentiality of patient health, alcohol and other substance use information, including HIPAA[22] and 42 CFR Part 2.[23] It is important to determine how these regulations impact the practice, and to manage compliance strategies incorporating the goals of respecting confidentiality and patient-centered care.

S-BI-RT for pregnant women entails routinely asking all women about substance use, and providing supportive interventions as a standard component of clinical assessment. A woman is more likely to answer sensitive screening questions honestly when she has a trusting relationship with her provider. It is important to develop integrated workflows that respect patient trust and privacy concerns.

Some questions to consider with regards to privacy of S-BI-RT screening include: How will you explain the purpose and possible implications of substance use screening in advance? Are your policies up to date to ensure those who need access to the important patient care information, including screening results, are authorized to access? If a practice refers a patient for SUD treatment to a provider not integrated with or part of the practice's treatment team or unit, a written consent from the patient consistent with special federal privacy rules for programs which provide substance use treatment services may be needed (see Appendices E, F and G).

Purpose of Play	• To explore privacy and trust considerations for pregnant women. • To understand heightened confidentiality requirements protecting a patient's substance use disorder diagnosis, treatment and referral information. • To be clear in the site/organization's policies regarding confidentiality of substance use information by population. • To communicate clearly and consistently with patients in a caring and trusting way about the confidentiality of their records, including when their records may be shared, why and with whom.
Definition	• The confidentiality protocol (verbal or written) is a site's process for how to manage and protect the information about a patient's substance use.
Team Members	• Practitioners can be particularly helpful in clarifying confidentiality responsibilities and protocols. • Behavioral health and obstetrics practitioner representatives can be key to this decision-making.
Measure(s)	• Decision regarding privacy policies and protocols. • Management of confidential information throughout the visit flow (including on post-visit print outs and throughout the EHR). • All staff know the privacy policies and protocols and their responsibility for managing this information in the context of the patient's care and treatment.

Recommended Approach

- Review current policies and procedures about confidentiality of patient treatment information involving behavior now, e.g., regarding sexual behavior, sexually transmitted diseases, depression, self-harm, etc.
- Review the information included in Appendix E and Appendix F regarding federal and state laws and consult legal counsel with questions.
- Information regarding positive screens, drug testing, management of results, and institutional policies regarding perinatal substance use should be communicated first to the patient privately, and then only to the necessary members of the health care team.
- Be aware of state mandates that require health care providers to report to child protection agencies when they suspect that the safety of an infant or child is at risk due to abuse or neglect.
    - Maternal use of nonprescribed substances in the third trimester is generally considered equivalent to risk for harm in terms of the mandate, so the need for a report should be anticipated.
    - DCYF does not accept reports until after a child is born. Therefore, if a pregnant woman is using and is caring for other children without guarantees for their safety (i.e. living in a house with a sober caregiver), a report is probably mandated.[24]
- Any prenatal practice and practitioners need to be knowledgeable about policies at the birth hospitals with which they work, so they can provide accurate information to their patients.
- Develop a clear set of policies and procedures regarding confidentiality and a process for managing difficult decisions, such as when disclosures must be made for purposes of child protection reporting. Consult legal counsel with any concerns about liability pertaining to the team's decisions.
- Incorporate confidentiality decisions into training and communications planning.
- Finalize and disseminate confidentiality/privacy policy decision(s).

Keep in Mind

- Federal and state laws protect the confidentiality of private health information. Special confidentiality rules apply to certain SUD treatment records pursuant to 42 CFR Part 2. If a provider is not an SUD treatment provider and the practice does not hold itself out as one, it is unlikely 42 CFR Part 2 applies to the practice's patients or their records. It may apply to a specific embedded alcohol and drug treatment provider or program, but as an obstetric practice it is only the specialty treatment unit or specialty treatment personnel to which federal confidentiality regulations apply.
- Information on the Consent (sometimes referred to as a Release of Information) during a referral for SUD and a sample Consent Form are provided in Appendix G. Patients should be counseled about the dissemination of information regarding the results of screening. In most cases, 42 CFR Part 2 will not be applicable, as the majority of patients will either be only screened, or screened with brief advice or brief intervention. **Only when SUD treatment is part of the care plan are these rules in play. Regardless, scrupulous privacy practices always apply.**
- When a practitioner who is not an SUD treatment provider under 42 CFR Part 2 engages in screening, and/or brief advice or intervention, the heightened protections of 42 CFR Part 2 will not likely apply. However, if a patient is referred to SUD treatment and confidential patient disclosures need to be made or exchanged, it is important to ensure that the appropriate consent forms and policies are in place to enable integrated care and treatment regarding the patient's SUD.

- State laws may differ regarding mandated reporting for cannabis use.
- The Plan of Safe Care (Appendix K) is a separate mandate which is required for all newborns prenatally exposed to nonprescribed drugs, alcohol, or treatment medications which can cause withdrawal.

Corresponding Appendix Section(s)

Appendix E: Federal Alcohol and Drug Confidentiality Overview

Appendix F: Health Centers and Confidentiality Overview – 42 CFR Part 2

Appendix G: Sample Consent Form

Appendix K: NH Plan of Safe Care Template and Guidance

Resources

Additional information and educational materials on substance use treatment confidentiality and 42 CFR Part 2 are available, including through Lucy Hodder, Esq., Director of Health Law and Policy, UNH Law at https://chhs.unh.edu/institute-health-policy-practice/focal-areas/health-law-policy.

Preventing Youth Substance Misuse Through Integrated Primary Care: Strategies for S-BI-RT Implementation (Pages 36-37)

PLAY 3: SCREENING

Screening provides a means to identify the level of a patient's use behavior, from no/low risk to high risk use. From the perspective of prenatal exposure, any use of substances is potentially high risk, especially when the substance used is alcohol. Screening responses provide an opportunity for a discussion about substance use as part of the healthcare visit (see Play 4: BI). Screening using a validated instrument facilitates identification of patients likely to benefit from a brief intervention and distinguishes them from patients likely to need a referral for substance use treatment. **Conducting screening is not making a substance related diagnosis.**

Screening using a validated tool should be standardized and universal for all pregnant women at entry to maternity care and again in third trimester and at delivery. This should include patients for whom substance use has already been identified as a concern.[25] [26] All healthcare professionals providing maternity care should feel empowered to respond to disclosure of prenatal drug or alcohol use with concern and assist patients to obtain further evaluation and treatment.[27] [28] [29]

Purpose of Play	To identify the evidence-based screening tool(s) to be utilized in S-BI-RT implementation for prenatal women.
Definition	Screening for potential health problems is standard in perinatal care. The addition of screening for alcohol and drug misuse and other potential behavioral health conditions strengthens the patient-centered approach to care. S-BI-RT implementation requires modification of existing clinical workflows and each context is different. We recommend incorporating S-BI-RT into the existing intake process for new OB patients, which includes screening for other medical risks. The screening process may reveal one of three possible results, explained further below: • No Risk • Currently using substances, unlikely to have substance use disorder • High risk of substance use disorder **No Risk:** This is a "negative screen," there is no current use at the time of the screening. It is important to provide positive reinforcement. **Currently using substances, unlikely risk of substance use disorder:** This is considered a "positive screen" but this woman is not considered at high risk of having a substance use disorder as defined by the DSM-5 (Appendix H). **Any current use of non-prescribed substances during pregnancy indicates the need for a BI (See Play 4: BI).** **High risk of substance use disorder**: When a woman screens at risk for SUD this warrants further assessment to determine the appropriate level of treatment and resources to access. A positive screen of "at risk" should be followed by further questions to determine if the level of risk warrants referral for evaluation and diagnosis of possible substance use disorder. Each tool has a threshold to identify sufficient risk requiring referral. However, a provider can initiate a referral for evaluation at any time, based on clinical judgment, the provider's own level of experience and comfort, and knowledge of the patient.

Team Members	All healthcare professionals in the OB/GYN practice and integrated behavioral health clinicians play crucial roles in determining the screening tool to be utilized. Selection should be based on relevance to the population served, ease of implementation and use by clinical staff, and degree of training needed to interpret results.
Measure(s)	• Selection of a validated screening tool(s). • Development of written policy/procedure. • Proportion of patients screening at intake and in third trimester (Specific aim example: 100% of patients presenting for their initial prenatal visit will be screened for substance use at their first prenatal appointment).

Several validated screening tools appropriate for the perinatal population exist (Appendix I). [30 31 32 33 34] The team should select the tool(s) that will best fit its practice and patients.

Recommended Approach

- Review institutional policies and update as needed to include use of the S-BI-RT framework for prenatal patients.
- Review recommended screening tools. We strongly recommend screening for tobacco, alcohol, cannabis and other non-prescribed drug use.
- Ask whether the patient is in recovery from SUD. This provides an opportunity for a patient to disclose current treatment medications, if any, and allows the provider to ask if she has any concerns related to her care.
- If the practice uses an electronic health record (EHR), the team should explore what tools may already be built/available for the EHR and, therefore, potentially available at a reduced cost in a shorter time frame.
- Discuss pros/cons of suggested screening tool(s) such as length, information gathered, and ease of interpretation.
- Patients should be screened at initiation of prenatal care, and in the third trimester.
- Screen electronically if possible, as electronic screening facilitates data capture. If flow and resources cannot accommodate electronic screening, screening using paper questionnaires is also effective. Be sure to provide staff time required to input information into an EHR and maintain confidentiality with hard copies prior to scanning into an EHR. If screening verbally choose a tool which has been validated for verbal administration, and ask questions exactly as written. Consider costs of staff/provider time for administration and regular booster training to maintain efficacy.
- Patients who are unable to read at the level of the questionnaire may require verbal screening.
- Confidentiality considerations must be incorporated into every step of the screening process. Unless accommodations for translation or literacy are necessary, screen patients privately so that they are at liberty to make personal disclosures safely. Considerations include:
    - Does the space provide for patient privacy when completing the screener?
    - Where is the screening information saved in the EHR?
    - If screens are administered on paper, how will the practice dispose of the screen after results are documented?
    - How is the screen incorporated into the record?

- Patients with positive screens indicating current use, but unlikely to be at risk of having an SUD should receive a BI to determine use pattern and motivation to change behaviors (See Play 4: BI).
- Patients with positive screens indicating a high risk of SUD warrant further assessment by a provider qualified to diagnose SUDs, in order to determine the appropriate level of treatment (See Play 5: RT).
- If a woman cannot be confidentially screened, screening should be deferred.
- Training in screening administration for each new staff member is imperative to receive consistent quality results.
- Each practice should have specific guidelines for when urine drug testing is recommended, and how verification of presumptive positive results will occur. Documentation of patient verbal or written consent is required for urine testing.[35]

Keep in Mind

- All pregnant women should be informed about the health systems' policy on prenatal drug, tobacco, and alcohol use at the first prenatal encounter, as part of their orientation to the practice. An example patient letter is available in Appendix J.
- Screening should be administered electronically or on paper if possible so patients can answer privately. Accommodations will need to be made for patients requiring translation or who have difficulty reading.
- Some screening instruments are available in multiple languages; others will require verbal translation at the time of administration.
- **Based on the screening tool utilized, a positive screen for a pregnant woman does not necessarily identify current substance use or risk to the mother or fetus.** Women may have discontinued their substance use prior to pregnancy; nevertheless, a positive screen should always be followed up with a discussion about current and anticipated future risk.
- A positive screen does not equate to a diagnosis of an SUD, but rather to the need for further exploration to evaluate whether an SUD and the appropriate level of intervention to reduce risk of substance exposure during pregnancy.
- We recommend screening any patient who is identified as using substances for comorbid psychiatric conditions such as depression and anxiety, social determinants of health,[36] and intimate partner violence, using validated screening instruments for each. Repeating intimate partner violence screening is recommended at 6 weeks postpartum, and any time concern exists. Examples of tools are available in the NNEPQIN Perinatal Toolkit.
- Providers should be sensitive to the prevalence of trauma history for any woman screening positive for prenatal substance because of the strong association between childhood sexual and physical abuse and the development of SUDs.[37]
- Screening should be repeated on admission for delivery.
- During the postpartum period, screening for onset of postpartum depression is recommended at 2, 4 and 6 week visits.
- The NH template for a Plan of Safe Care and guidance on its use are available in Appendix K.
- Consultation and training on the use of specific screening tools is available through the NH Center for Excellence at https://nhcenterforexcellence.org.

Corresponding Appendix Section(s)

Appendix H: Substance Use Disorder Diagnosis Overview

Appendix I: Selected Validated Screening Tools for Use with Perinatal Women

Appendix J: Sample Patient Letter – Orientation to the Practice

Appendix K: NH Plan of Safe Care Template and Guidance

PLAY 4: BRIEF INTERVENTION

Positive screening should be followed up with brief intervention (BI), with an aim to increase the patient's motivation to abstain from substance use. However, BI often requires a harm reduction approach, with a goal of developing motivation to reduce, rather than to eliminate, substance use and agreement to ongoing conversation. This can be difficult for maternity care providers to accept due to the risk of harm associated with prenatal substance use.

The term brief intervention encompasses responses by the provider to the patient following screening. This is a conversation in which the healthcare provider explores the level of risk indicated by screening results, assesses a patient's readiness to change, specific needs, and life circumstances, and the appropriate level of follow up to actively facilitate positive change.[15] [16] [17] **Just as the purpose of screening is not to diagnose, the purpose of a brief intervention is not to provide counseling.**

Regardless of the substance used or the patient's readiness to change behaviors, the BI is the start of a meaningful conversation between provider and patient. These conversations are intended to help pregnant women better understand the risks of using substances and to reinforce the benefits of quitting or cutting back during pregnancy. For the conversations to be successful and encourage open dialogue, they need to be judgment free.

Brief Intervention encompasses three approaches depending on screening results: positive reinforcement, brief advice, and BI, lasting from a few minutes to a series of conversations. It is a patient-centered response, ideally a conversation between provider and patient, that utilizes motivational interviewing techniques to:

- Educate regarding the potential or actual health consequences of current use.
- Motivate towards changing using behavior.
- Support the patient in making choices that reduce her risk of problems related to substance use and/or developing a chronic substance use disorder.

The goal of BI is to create an opportunity for a patient to consider a health affirming change and open the door to further assessment and treatment if needed. The conversation can be built upon at subsequent appointments.

Purpose of Play	To understand Brief Intervention as part of the S-BI-RT process.
Definition	**Positive Reinforcement:** When a woman screens as "no current use," this is a negative screen. Positive reinforcement is an important acknowledgment of healthy behavior. It can be as simple as "I see that you report not using any alcohol or other drugs. I'm really glad to see you are making this choice for the health and safety of yourself and your baby." This unique prevention opportunity is a key benefit of the S-BI-RT approach. **Brief Advice:** When the results of the screen indicate that current use is infrequent with no apparent evidence of a substance use disorder, brief advice is warranted. This very quick follow up acknowledges the positive screen, explains the risks of the substance used to the developing baby, advises against further use, and facilitates development of strategies to support abstinence. If a woman has discontinued substance use due to pregnancy, brief advice is appropriate to congratulate her, and to advise against returning to risky use after the baby is born. **Brief Intervention:** When the screening indicates a woman is at moderate or high risk of a substance use disorder, or continues to use alcohol or non-prescribed drugs during pregnancy, a BI is indicated. Practitioners are trained to engage in a different kind of conversation using simple motivational interviewing techniques. When the use suggests moderate risk (e.g. irregular cannabis use), the goal of the conversation is to increase awareness of problematic substance use, encourage reduction in use, and changes to risky behavior. Severe substance use necessitates a referral for further assessment/evaluation, diagnosis, and treatment, by a behavioral health or substance use treatment provider. The BI conversation is required to engage the patient in the decision to participate in further evaluation and to actively facilitate a successful referral. (See Play 5: RT) This may take several follow-up conversations between provider and patient.
Team Members	All team members need to understand what brief intervention encompasses. This is vital to integration of documentation into the EHR and determination of flow.
Measure(s)	• Team members understand the scope of brief intervention. • Team members establish target measure(s).

Recommended Approach

- Review recommended BI techniques and tools for pregnant women.
- Discuss potential pros/cons of suggested BI techniques and impact on flow. For example, how long is the screening process, who conducts the BI, how is documentation done, and how is follow up captured?
- Brief intervention by the medical practitioner is ideal - if flow and resources can accommodate. However, it is within the scope of practice for a registered nurse with appropriate training to conduct a BI.
- **Please refer to the NNEPQIN Perinatal Toolkit for specific recommendations for managing patients who disclose opioid use or who screen at risk for requiring further assessment.**
- Using a trauma-informed approach acknowledges the link between childhood trauma and SUD, and may enhance communication between patient and provider. Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement, and also decrease the risk for re-traumatization.[38] See Appendix L for a conversation guide for delivering a trauma-informed BI.
- Example BI dialogue,[39] as well as suggested responses for casual use of alcohol, tobacco, cannabis, and other illicit drugs are available in Appendix M.
- BI tools are available in Appendix N.
- Alcohol is a teratogen, and **any level of continued alcohol use should be considered high risk.** If unable to immediately stop alcohol use, a woman should be referred to a behavioral health provider.
- The recommended management of cannabis and tobacco use during pregnancy is abstinence. Explore options with the patient and arrange referrals as indicated.
- Regular cannabis use suggests the possibility of cannabis use disorder and a referral to a behavioral health provider should be offered to explore need for treatment.
- Because women often underreport use during pregnancy, any disclosure of non-prescribed stimulant or opioid use requires BI and referral.
- The recommended treatment for opioid use disorders (OUD) during pregnancy is medication assisted treatment (MAT) with buprenorphine or methadone accompanied by psychosocial therapy. Explore options with the patient, and arrange appropriate referrals (See Play 5: RT).
- If the patient is already in treatment for SUD or OUD, obtain written consent for two-way exchange of information with treatment provider for the purpose of care coordination. Information related to confidentiality and consent is available in Appendix E.
- For all other substance use identified (e.g. cocaine, non-prescribed stimulant use), further behavioral health evaluation is needed to develop a treatment plan.

Keep in Mind

- Providers of maternity care may find it difficult to accept the harm reduction approach of BI due to the risk of harm associated with prenatal substance use. When in doubt about appropriate management, refer the patient for further evaluation (See Play 5: RT).
- Brief Intervention approaches are evidence-based, and incorporate motivational interviewing techniques. MOTIVATIONAL INTERVIEWING EXPERTISE IS NOT REQUIRED.
- Patients may be using to relieve symptoms common to pregnancy, such as nausea, that can be addressed through other medications or treatments.
- Screening tools augment, but do not replace, a provider's clinical judgment.
- Guidance on counseling for specific substances is available in the NNEPQIN Perinatal Toolkit.
- Consultation and training on brief intervention is available through the NH Center for Excellence at https://nhcenterforexcellence.org.

Corresponding Appendix Section(s)

Appendix L: Conversation Guide for Delivering a Trauma-Informed Brief Intervention

Appendix M: Example of Brief Intervention Dialogue With Talking Points for Selected Substances

Appendix N: Brief Intervention Tools

Appendix E: Federal Alcohol and Drug Confidentiality Overview

PLAY 5: REFERRAL TO TREATMENT

In the context of S-BI-RT, referral to treatment is shorthand for a well-planned process of care coordination through which a healthcare professional provides an active referral to behavioral health resources for evaluation and diagnosis, and in some cases specialty treatment. These may exist within or outside of the provider's organization and the type of referral will depend on patient needs and available resources. **It is critical that patients indicate a willingness/desire for such services during the brief intervention conversation.**

Whether the process includes an obstetrical provider with a buprenorphine waiver to provide MAT, internal behavioral health providers, and/or external specialty referral sources, an established relationship and referral protocol are key components to successful referral. The intensity of a woman's use, availability of treatment options, and conflicting responsibilities and preferences are factors to consider in determining the appropriate level of care for a pregnant woman in need of treatment for a substance use disorder.

Purpose of Play	To identify how referrals will occur and to whom, and to determine how/how often to follow up.
Definitions	Managing the referral process and ensuring that the patient receives the necessary management and follow up support is critical to the recovery process. **Warm Handoff to Internal Clinicians** Practices in which behavioral health practitioners are available on-site through co-located or integrated service provision can create a flow that incorporates a warm handoff. This approach includes a physical introduction by the referring provider, and increases the likelihood of a patient's participation in further assessment and treatment. In some cases, a treatment option that is not available on-site will be necessary and the patient is then referred to a higher level of care. Depending on flow decisions, integrated behavioral health staff may also be responsible for evaluation, diagnosis, and external referrals to specialty care. **External Substance Use Disorder Specialists** An efficient and successful referral to external specialty care requires initially establishing and cultivating relationships with specialty providers for all levels of care. Obstetric practices should establish protocols for obtaining consent for release of information early in the implementation process in anticipation of sharing and receiving pertinent patient information with the referral provider prior to the need to refer a patient (see Play2: Confidentiality). Each practice should maintain an up to date list of local referral options, or access existing resources that identify and maintain currently referral resources.
Team members	• Who determines the need for referral? How is the referral ordered and documented? Who is responsible for assisting the patient in making a connection to the referral source (warm handoff)? Who receives information back from the referral source? • Who will be responsible for developing referral relationships and/or updating the referral and resources list?

Measure(s)

- The team has a plan in place for how patients are identified for internal and/or external referral.
- The team maintains an updated list of local referral sources, or utilizes tools that identify and maintain current referral sources, such as the Doorway NH.

Recommended Approach

- Referral for further assessment is generally indicated if a patient meets two or more of the DSM-5 criteria for SUD (Appendix H). See the NNEPQIN Perinatal Toolkit for a decision-making algorithm and clinical recommendations.
- In NH, the Doorway NH (http://www.thedoorway.nh.gov/) maintains up to date information about local referral resources for treatment, recovery and self-sufficiency services.
- If screening reveals that a patient is at risk of having a SUD, provide a warm handoff when possible to a professional qualified to diagnose SUD.
- SUD evaluation includes a multidimensional assessment, mental status examination, and screening for co-occurring disorders utilizing a framework provided by the American Society for Addiction Medicine (ASAM) for assessing level of substance use severity and treatment need.[40]
- Interpretation of assessment information must be within the provider's scope of practice, which would include behavioral health providers and buprenorphine-waivered perinatal providers. Consultation with an interdisciplinary team is required if the assessment is outside a provider's scope of practice.
- If the practice does not have a qualified clinician on staff, make an external referral.
    - Access to community-based providers and support services is available through the Doorway NH website at http://www.thedoorway.nh.gov/ or by calling 211, or accessing 211NH.org.
    - Obtain written consent for two-way exchange of information with treatment provider (Appendix G– See Play 2: Confidentiality) for the purpose of care coordination if referral is made, and if patient is already in treatment for SUD/OUD.[41]
    - Utilize the Plan of Safe Care[42] (Appendix K) to optimize available community resources such as peer recovery supports, child care, home visiting programs, and other social services.

Keep in Mind

- Most women are highly motivated to seek treatment during pregnancy. A shared decision making approach is essential to ensure that the treatment plan developed is both feasible and acceptable.[43 44 45]
- Getting a signed consent for ongoing communication with the referral service allows coordination of care.
- The Doorway NH (http://www.thedoorway.nh.gov/) includes access to The NH Alcohol and Drug Treatment Locator website, www.nhtreatment.org which provides a searchable data base with contact information for treatment providers including by location, level of care, and type(s) of payment accepted.
- **It is critical that patients indicate a willingness/desire for treatment during the brief intervention conversation for referral to be successful.**
- Training and consultation to help identify which patients need referrals, identification of referral resources, and techniques for successful connection to referral sources is available from the NH Center for Excellence at https://nhcenterforexcellence.org/.

Corresponding Appendix Section(s)

Appendix H: Substance Use Disorder Diagnosis Overview

Appendix K: NH Plan of Safe Care Template and Guidance

Resources:

NH 211: 211NH.org

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

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

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

Massachusetts Helpline: https://helplinema.org/

University of Vermont Perinatal Tools and Resources: https://www.med.uvm.edu/vchip/perinatal-resources: https://www.med.uvm.edu/vchip/perinatal-resources

Consumer's Guide for Substance Use Treatment in the Upper Connecticut River Valley: http://www.mtascutneyhospital.org/sites/default/files/content/documents/ConsumersGuideforSubstanceUseTreatmentinUpperValley2017.pdf

PLAY 6: FOLLOW UP

Following up on a screening result, BI conversation, or referral for evaluation and/or treatment is crucial to on-going, whole health management with each patient.

Purpose of Play	To determine which patients will need a follow up, how, by whom and in what time frame.
Definition	In the context of S-BI-RT, "Follow Up" refers to any contact with a patient that closes the loop with the obstetric practice. It is appropriate for any patient who has a positive screen – whether that patient receives a BI, receives MAT through the obstetric practice, or is referred to specialty services/treatment. It may involve proactive outreach rather than waiting to receive a formal report. In the case of follow up, a BI means checking back in with a patient who has been identified as needing an intervention; in the case of referral, it may mean checking in with the patient, or checking in with the person or organization to which the patient was referred. Care coordination may be as simple as a phone call (e.g., "were you able to make the appointment with XXX?") or a short interval follow-up appointment. It may be done by the provider, a care coordinator, educator, or other staff, depending upon the staffing work flow within a specific practice site.
Team Members	Include EHR/IT personnel.
Measure(s)	The team establishes a target measure for percentage of patients identified for follow up who receive follow up within a set timeframe.

Recommended Approach

- Discuss which patients need a follow up, for what, and by whom.
- Ensure that consent forms are up to date, reflecting the changes adopted by SAMHSA in 2018.[46]
- If a provider receives Part 2 information, the provider is only prohibited from redisclosing if it is provided pursuant to a patient consent. In those circumstances the consent will indicate what information can be disclosed. If the patient consents to a provider receiving information, that provider can discuss the information with the patient. The provider should have consent from the patient allowing the provider to share information with the patient's treatment team and her other treatment providers, and they should be listed by name.
- Ensure that internal and external behavioral health referrals can be tracked, whether in the EHR or on paper, depending upon the system in place.

Keep in Mind

- No consent is needed If the intervention is being provided by the treatment team; patient information can be shared with providers on the treatment team.
- If a provider refers a patient to other providers and wants to share information to and from those providers, then a consent that fills in the appropriate “to whom” is required.
- Follow up is essential to the provider:patient relationship. It reinforces the connection between substance use and health, and helps to normalize the conversation.
- At some sites, there may be an option for follow up by telephone or text communication, with signed informed consent, by behavioral health or case management staff.

> ***Resource***
>
> *Preventing Youth Substance Misuse Through Integrated Primary Care: Strategies for S·BI·RT Implementation* (Pages 28-30)

PLAY 7: FLOW

S-BI-RT implementation requires modification of existing clinic workflows. We recommend incorporating S-BI-RT into the existing intake process for all new OB patients, as part of screening for medical risks. The nuts and bolts of how S-BI-RT will actually happen depends on the unique context of each practice, e.g.:

- How exactly will the screening occur? On a tablet? On paper?
- Who does the screening? A medical assistant? A registered nurse? Another licensed provider?
- Where is the screening done? How is the screening documented in the EHR?
- Who scores the screening and how are the screening results reviewed?
- Who/How is the next step determined? (Who provides a BI? How is an RT to internal or external behavioral health provider accomplished?)

Purpose of Play	To determine the physical who, what, when, where and how of all S-BI-RT components.
Definitions	"Flow" refers to the logistics of an encounter and the associated S-BI-RT process in its entirety. Describing the flow requires identifying roles and responsibilities for each staff person, in addition to how and when screening, brief intervention, and/or referral to treatment occurs and is documented.
Team members	The entire implementation team is needed to discuss and analyze flow, test the proposed flow with "walk-throughs," and modify as necessary.
Measure(s)	The team has successfully incorporated the new flow into daily practice.

Recommended Approach

- Map current routine visit flow. Discuss what works and what doesn't. Then, map out potential S-BI-RT flow – who can do what, when, where and how, and who can be responsible for what parts? (Appendix O).
- Test the potential S-BI-RT flow as a mock patient, then pilot with a subset – perhaps one provider team member; trial the process and revise until it works as needed. Set a target implementation date for a first evaluative cycle.
- Ensure that all pregnant women are informed about the S-BI-RT process and the health system's policies on prenatal drug, tobacco and alcohol use at the first prenatal encounter as part of their orientation to the practice (Appendix J).
- Screening should be done before the provider's component of the visit in a place that provides privacy, while the woman is alone or accompanied only by young children - to ensure confidential screening and response. If a woman cannot be confidentially screened, screening should be deferred.
- Capitalize on any opportunity to educate all staff on the new flow until it is part of daily practice.

Keep in Mind

- Brief Intervention is most effective when it is delivered by the healthcare practitioner (See Play 4: BI).[47 48] Embedding all S-BI-RT components into the EHR is optimal for ease of documentation and data capture.
- Working from existing flow patterns and protocols as much as possible aids sustainability.
- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as reproductive health history, and to safely screen women for domestic violence.

Corresponding Appendix Section(s)

Appendix J: Sample Patient Letter – Orientation to the Practice

Appendix O: NNEPQIN Recommended Flow Chart

Resource

Preventing Youth Substance Misuse Through Integrated Primary Care: Strategies for S·BI·RT Implementation (Pages 28-30)

PLAY 8: ELECTRONIC HEALTH RECORD MODIFICATION

There are important implications regarding S-BI-RT implementation for practices utilizing an EHR. The EHR is a critical tool for implementing, sustaining, and improving S-BI-RT.

Purpose of Play	To support consideration of uses for the EHR throughout the S-BI-RT process.
Definition	This play is not a "how to". It is included to ensure consideration of the myriad of ways that the EHR might be helpful in ensuring that all components of the S-BI-RT process are completed and documented.
Team Members	It is essential to include the person who will be creating and/or communicating about the required changes in the EHR from the beginning.
Measure(s)	Success may include things such as no additional staff time for screening or data entry, prompts which practitioners utilize and find helpful, automatically updated local referral list included in EHR, automatic prompts to follow up on positive screens/brief interventions at subsequent appointments, etc.

Recommended Approach

Consider the following given the capacity of the EHR to automate, remind, encourage, and report:

- **Screening** – Incorporating the screening tool is the lowest level of utilization of the EHR. Can it then score and recommend next steps based on that score?
- **Brief Intervention** – Can practitioner supports (best practice guidelines or clinical decision supports) be created within the EHR that not only recommend next steps based on screening results but also capture data for reporting and quality improvement (QI)?
- **Referral to Treatment** – Can the EHR receive information regarding patient progress from the referral site? If information is not received within an identified number of days can it automatically generate a reminder? Are appropriate written patient consents in place to allow for the sharing of information between treating providers?
- **Follow up** – How can the team use the EHR to document the outcome of BI and set reminders at the next visit?
- **Confidentiality** – How will the practice maintain the confidentiality of patients' drug and alcohol information in the portal? How will record requests from other providers be managed? Covered providers must provide the patient a notice of privacy and an appropriate consent form, as well as a non-redisclosure notices when 42 CFR Part 2 protected information is disclosed (See Play 2: Confidentiality). If SUD treatment information is redisclosed pursuant to a consent, does the EHR have the capacity to include the appropriate non-redisclosure notice required by 42 CFR Part 2?
- **Flow** – How can the EHR facilitate streamlining flow and not add to staff time? Can the team incorporate tablets that automatically populate the chart?
- **Quality Planning and Data** –Are there data that the team wants to track for improvement purposes? How will the team receive feedback from flow staff as to the utility of the EHR screens after initial rollout? How will the team decide to update or improve?
- **Training** – How will EHR modifications be incorporated into "booster" and new staff training?

Keep in Mind

- Information received from SUD treatment providers may not be re-disclosed without specific patient consent. This stipulation is included in the consent form.
- Strategies to ensure confidentiality on the EHR will vary by practice sites. Some practices have addressed this issue by scanning notes, restricting access to the record, embedding electronic reminders not to re-disclose, and training staff on 42 CFR Part 2 regulations.
- Practices that have already implemented S·BI·RT may be helpful resources to promote optimal use of the EHR by sharing how they use their EHR. The NH Center for Excellence may be able to connect the team to other users of the same EHR vendor, or to practices that have managed software with similar capacities.

> ***Resource***
>
> *Preventing Youth Substance Misuse Through Integrated Primary Care: Strategies for S·BI·RT Implementation* (Pages 31-34)

PLAY 9: RECOMMENDATIONS FOR SUSTAINABILITY

In order to ensure progress and success of S-BI-RT, practices will need to optimize billing and communication, plan for ongoing training, continue data collection and review, and reflect on their processes.

Quality Improvement and Data Collection

Success will be measured by meeting planned implementation goals. Once processes are in place and the team has established baseline measures for each component of S-BI-RT, the measures can guide the development of clear aim statements that will enable measurable improvement using the team's identified change model (see Appendix B and Appendix C for examples). Including data collection and reporting into the work plan can be especially valuable. The team should determine roles and responsibilities for fulfilling data collection/submission, reporting, and ongoing quality improvement tasks. All team members should review the data and reports at regular intervals. Keep in mind that QI is an iterative process. The process will require corrections along the way as the team tests changes, learns from experiences, and identifies other actions and strategies. Be prepared to refocus aim statements.

> ***Corresponding Appendix Section***
>
> Appendix B: Change Model Example
>
> Appendix C: Example Change Process

Billing and Reimbursement

Reimbursement is critical to sustainability. As such, exploring billing and reimbursement opportunities for S-BI-RT components is crucial to long term implementation and sustainability. Reimbursement from private insurers and NH Medicaid is available for S-BI-RT in NH. Optimized billing will differ from site to site with negotiated contracts, federally qualified health center status, and other factors. Be sure to include financial, billing, and coding staff in order to finalize a successful billing plan. Coding guidance is available in Appendix P to help determine what codes, for which service, provided by whom, for what time period, is reimbursed by which insurer. However, it is important to stay abreast of developments in a changing policy environment that could impact coding and billing.

> ***Corresponding Appendix Section***
>
> Appendix P: Coding and Billing Information

Communications

Each of the many stakeholders in S-BI-RT implementation requires a consistent message about S-BI-RT and what it means for them. Successful implementation depends a great deal on relationships with internal as well as external stakeholders. A communication plan should include a list of stakeholders, the message to be conveyed to them, who will reach out to them, how and when. The team may anticipate questions and be prepared to respond with consistent answers. Key stakeholders to consider include practice staff, administrators, patients, their families, services to which the practice may refer patients, and other community based resources. Try to diversify the messenger to the extent it is possible – do not have one person be the only one that talks to people about S-BI-RT, but rather, convey that this is a multidisciplinary, team based activity.

Training

Sustaining effective implementation requires incorporating training into new staff orientation and regularly offering boosters to existing staff beyond initial training and implementation. Be sure that all staff and practitioners understand the S·BI·RT implementation plan, and are trained in and implementing their components of the S·BI·RT process successfully, using evidence based tools. Training and technical assistance (TA) for S·BI·RT implementation is available from the NH Center for Excellence (see Appendix Q).

> ***Corresponding Appendix Sections***
>
> Appendix Q: NH Center for Excellence Learning Opportunities Card

Reflection and Celebration

Implementation of new processes and ongoing quality improvement are challenging work. Periodic reflection provides an opportunity to evaluate what happened and why, and to use that knowledge to sustain strengths and improve upon weaknesses. Sharing and celebrating success provide opportunities for professional development, opportunities to highlight the work of the entire team, promote the team's work to organization leadership, and to spread what works to other setting, promoting better care for everyone. Be sure to document enablers and barriers to the work, and to acknowledge successes. Accomplishments are easier to remember when marked with celebrations. Celebrate even small successes. Take the time to commemorate a team's achievements and never underestimate the human factor; having people's support for sustaining changes can make or break success.

APPENDIX A: IMPLEMENTATION CHECKLIST

Implementation Checklist				
Play	**Activities**	**Complete? Yes/No?**	**Staff trained/ informed? (Y/N)**	**Written Procedures?**
Play 1: Beginning Practice Change - The Work Before the Work	**Structure the team**			
	Who will be on the team?			
	How will the team make decisions?			
	What is the timeframe for project development and implementation			
	What are the responsibilities of each team member?			
	Identify change model			
	Create a Team Plan			
	Develop a Work Plan			
	Identify measurable project goal(s)			
	Identify measures to track success toward project goals.			
Play 2: Confidentiality	Develop written protocol			
	Explore confidentiality consider-ations for target population(s)			
Play 3: Screening	Identify Target population(s)			
	Identify evidence-based screening tool			
	Screening process protects confidentiality			
	Screening documentation process determined			
Play 4: Brief Intervention	Type of BI identified			
	BI staffing determined			
	Initial BI training completed			
	BI booster training scheduled			
Play 5: Referral to Treatment	Internal referral mechanisms in place			
	Community provider partnership(s) in place			
	Protocol for organizing how referrals will occur and to whom			

Play 6: Follow Up	Protocol for identifying patients requiring follow up, method of follow up, and frequency of follow up			
Play 7: Flow	Determine the physical who, what, when where aspects of the S-BI-RT components			
	Document outlining the flow			
Play 8: Electronic Health Record (EHR) Modification (for practices utilizing electronic health records)	**Consider capabilities & limitations of your organization's EHR capacity regarding:**			
	Screening			
	Brief Intervention			
	Referral to Treatment			
	Follow up			
	Confidentiality			
	Flow			
	Quality Planning and Data			
	Training			
Play 9: Recommendations for Sustainability	Data Reporting Tool			
	PDSA mechanism			
	Data shared with staff			
	Coding identified			
	Outreach to Health Plans			
	Billing			
	Develop a communication plan			
	Promote dissemination of lessons learned			
	Develop a plan for initial and on-going training of existing and new staff			
	Promote dissemination of lessons learned			
	Acknowledge successful implementation			

APPENDIX B: CHANGE MODEL EXAMPLE

The Clinical Microsystem Approach to Process Improvement

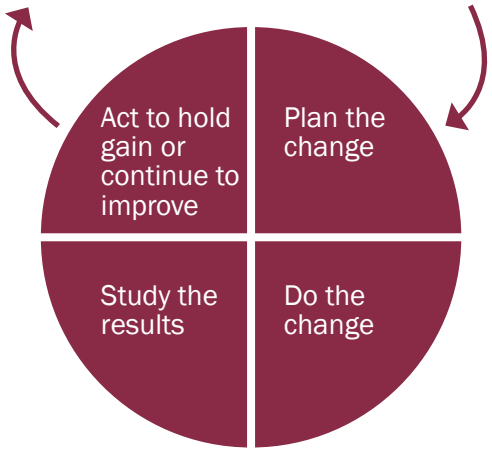
Implementing a new process requires systematically designing a process that will be able to work, monitoring alignment of the process with identified goals and aims, and using data-driven actions to make processes better through quality improvement (QI). Utilizing a change model as a framework for implementation will help our team apply a structured planning approach to evaluate current practice processes and improve systems and processes to achieve goals and measure success faster and more effectively.

FIGURE 1: THE MODEL FOR IMPROVEMENT

Aim: What are we trying to accomplish?

Measures: How will we know that a change is an improvement?

Changes: What changes can we make that will result in an improvement?



Langley, Gerald J., et al. *The improvement guide: a practical approach to enhancing organizational performance*. John Wiley & Sons, 2009.

There are many approaches and models for QI. Regardless of the approach, it will include a basic systematic process of planning, trying out a plan, examining what happened when you tried it, and basing next steps on what you learned from your examination. Essentially, it starts with three basic questions:

1. What is your team trying to accomplish?
2. How will you know that you were successful?
3. What changes can you make to get there?

Once you answer those three questions, the Plan-Do-Study-Act (or PDSA) cycle kicks into gear.

Any learning is forward progress- even if it is only learning about what does not work!

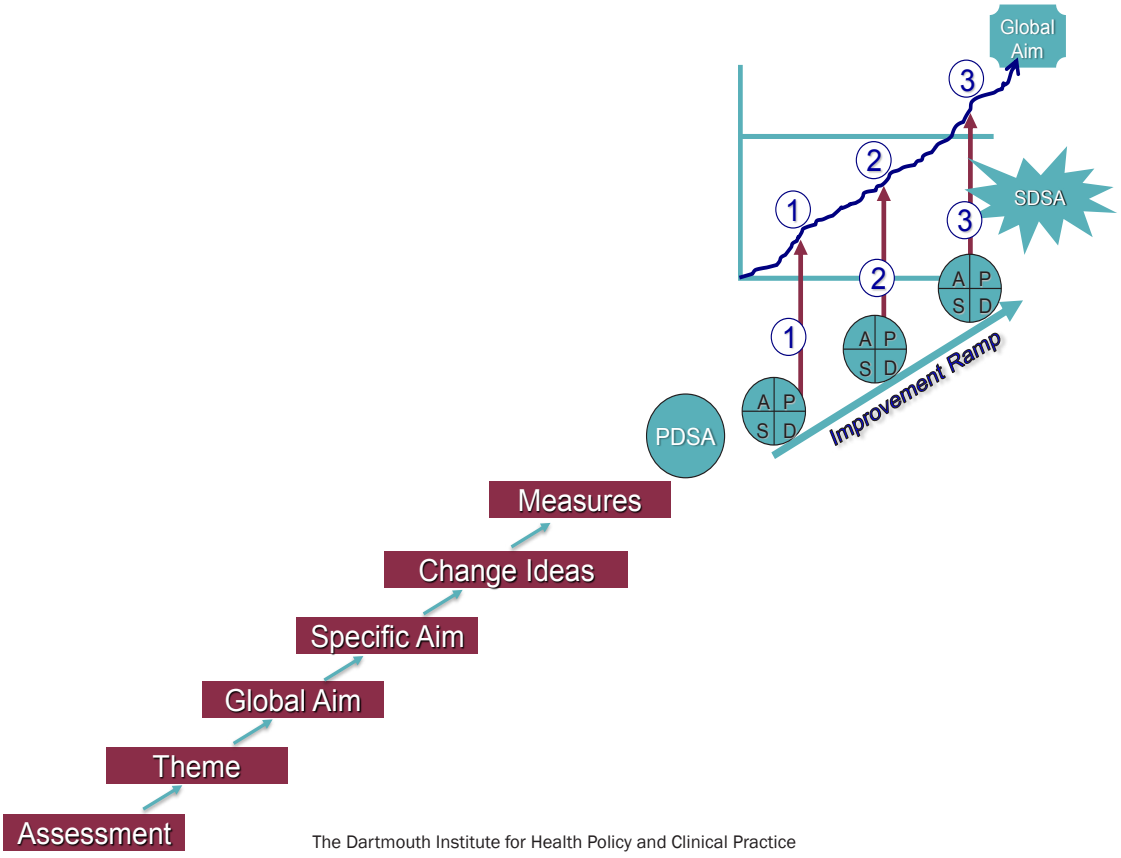
The Clinical Microsystems Approach

The Clinical Microsystems framework captures the structure, processes and outcomes of the services provided by a practice, and provides a systematic approach to process change. It was developed by The Dartmouth Institute for Healthcare Policy and Clinical Practice, and has been used worldwide as a model for improving practice.

A clinical microsystem is defined as “a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a shared information environment, and it produces performance outcomes.”

The Model for Improvement is embedded in the Clinical Microsystem Approach to process improvement. The Microsystem Improvement Ramp provides a schematic illustrating the “big picture” or a map of the steps entailed in a quality improvement initiative

THE DARTMOUTH MICROSYSTEMS IMPROVEMENT RAMP



The Dartmouth Institute for Health Policy and Clinical Practice

Establish the Foundation: TEAM and MEETING STRUCTURE

a. Identify who the core team will be that will implement this change in practice. In your first meeting, do not talk about S·BI·RT, talk about how you will work together. In a clinical microsystem, all team members are considered of equal importance, and each team member brings a different yet critical skill set to the direct care environment. Everyone who is part of the microsystem (including patients) shares accountability for the care that is provided to patients. Members of a microsystem make the decisions about how to improve their own work.

b. Review and use meeting rules.

CONDUCT AN ASSESSMENT and IDENTIFY THEMES

a. Discuss your current practice for assessing substance use in youths, even if it is inconsistent. Try to make a flowchart or map of how it works—or doesn't work—now.

b. What seem to be the issues (themes)?

c. Review the new practice and reach consensus on its value. Make a list of everything you are concerned about, and make sure that you address these concerns as you work.

d. Review the Playbook.

AIMS AND MEASURES: What are you trying to accomplish and how will you know that you accomplished it?

a. Aims should be measurable. There should be a numerator and denominator if applicable. There should be a time frame. For example: If your aim is to screen prenatal women, how will you know that you screened them? You could say "we screened 50 prenatal patients," but if you have 300 in your practice, that is only 16.6% of your population. A good aim: "Screen 100% of prenatal patients on their first prenatal visit between January and June of 2019."

b. Revise the work plan to reflect your aims and measures.

CHANGE IDEAS: What can we put into place to accomplish our aim?

a. Your overall goal is to increase the number of prenatal patients screened for substance use. Implementing S·BI·RT is your overall strategy.

b. If your specific aim is "Screen 100% of prenatal patients on their first prenatal visit between January and June of 2019" what strategies/change ideas do you need? Changes in workflow? Changes in policies and protocol? Communication plans? These are examples of strategies and the work plan should help you map out the details over time.

Implement Plan-Do-Study-Act (PDSA) Cycles

a. Plan the details of how you would change workflow, as an example: Map it out. Who does what when where and how?

b. Do it. Try out the new workflow.

c. Study: How did it work out? What worked? What did not work?

d. Act on what you learned: What can you do differently?

STANDARDIZE

a. Once your plan for your change idea works, sustain it. Codify it in policy, procedures.

b. Train staff.

For more information, see the Clinical Microsystem Assessment Action Guide at http://www.clinicalmicrosystem.org/.

APPENDIX C: EXAMPLE CHANGE PROCESS

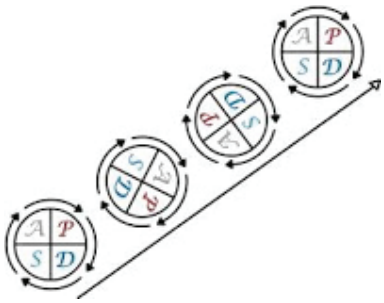
Site Plan-Do-Study-Act (PDSA) Example

Change, Test, Repeat: Using NIATx to implement SBIRT

By: Catherine Ulrich Milliken, former Director, Addiction Treatment Program; Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire

Introducing a new practice like SBIRT can be a challenge in any setting. In the Dartmouth Hitchcock Medical Center (DHMC) Perinatal Addiction Treatment Program (PATP) we faced the added challenge of implementing a new practice across three departments and two institutions.

That's where my previous experience with the NIATx model came into play. I was fortunate to be a part of a NIATx STAR-SI grant in Maine while working for Crossroads for Women (Crossroadsme.org). Over three years beginning in late 2006, the ten state-provider partnerships used the NIATx diffusion model to accomplish four goals: build state capacity to improve access and retention; build payer/provider partnerships that drive the improvement process; implement payer improvement strategies; and implement performance monitoring and feedback systems.



The incremental and iterative approach that NIATx teaches was key to the success in our SBIRT integration project. We used rapid-cycle testing or PDSA Cycles so our change teams could try out a change to make sure it was working and that it was an actual improvement.

Visit the NIATx website to learn How to conduct a PDSA Cycle.

As I wrote in my last blog post, Integrating Care and Improving Birth Outcomes with SBIRT, we launched the PATP in fall 2013. By September 30, 2014, SBIRT was fully implemented across all three OB/Gyn divisions at the Dartmouth Hitchcock Medical Center.

Here are some lessons that have emerged from the four Plan-Do-Study-Act (PDSA) cycles we ran to get SBIRT in place:

Cycle 1: Confidential screening in Maternal Fetal Medicine (MFM) Team

Perceived barrier: Patient reluctance to separate from family members for screening.

Change tested: Nurses' perceptions that patients would not want to be seen alone.

Data:

Before: Patients were screened for drug/alcohol use with their family members present, unless they came alone.

After: Only five of the first 386 patients declined to be seen alone (and therefore were not screened.)

Results or lessons learned: Sequestering patients is much easier than anticipated, and provided unexpected opportunities for disclosure of a number of important issues, both substance-related and not.

Cycle 2: SBIRT pilot in Maternal Fetal Medicine (MFM) Team

Perceived barrier: Fitting SBIRT into nursing workflow will be difficult and make visits longer.
Change tested: Nurse training in screening techniques and BI/Implementation
Data (Qualitative from nursing): Nurse workflow was not adversely affected and communication about prenatal substance use was enhanced, improving the care delivered.

Results or lessons learned: Nurses report "We are finally starting to deal with this issue in a practical way. SBIRT provides a framework for making this happen!"

Cycle 3: SBIRT implemented in Certified Nurse Midwife (CNM) Team

Perceived barrier: Provider discomfort with providing brief intervention (BI)
Change tested: Provider training in BI
Data: (Qualitative) CNMs are able to manage BI and referral process to PATP; and patients with SUD are no longer required to transfer care to the MFM team.

Results or lesson learned: Provider training can increase comfort level in caring for pregnant women with SUD.

Cycle 4: SBIRT implemented in General OB/GYN Division

Perceived barrier: Nurses' discomfort with process
Change tested: Nurse and provider training; followed by additional training session (Grand Rounds) six months after implementation
Data: Not available from all nurses or providers; APRN staff has adopted SBIRT as standard practice and feels comfortable with BI and referral process.

Results or lesson learned: Need to be able to collect department/division level data to assess whether program goal of evidence-based screening for SUD for all PN patients has been met.

What else did we learn from these change cycles? For one thing, developing a timeline and planning out cycles strategically is key. What we wish we'd known at the onset was how difficult it would be to access data to measure process and outcomes. Electronic implementation of screening (available soon, with the implementation of mobile tablets) should improve data capture.

Our next PDSA cycle will be used to implement electronic record-keeping. The OB departments have not had sufficient staffing to assess what proportion of new OB patients are actually getting screened. With the help from The New Hampshire Charitable Organization, the OB/GYN Department was able to purchase mobile tablets that will be used to make the switch from pen and paper screening to electronic screening. Once electronic screening is operationalized, we will be able to compare the number of patients screened to the number of new OB visits scheduled. Electronic screening will allow for better data collection, outcomes tracking, and consistent billing practices. Adding an electronic best practice alert for positive screens will be included with the electronic roll-out, and this will prompt providers to enter the correct charges.

What has become clear to us is that this partnership of integrated care is benefiting all involved. As we continue to share our experience, new champions come forward, and our vision becomes clearer and more comprehensive, despite the perceived barriers.

APPENDIX D: S·BI·RT IMPLEMENTATION TEAM PLAN TEMPLATE

S·BI·RT Implementation Team Plan
Team Leader: **Team Members:** **Date of Team Formation:** **Anticipated length of time the team will focus on S·BI·RT Implementation:**
The Problem: *{According to the 2013 National Survey on Drug Use and Health, perinatal substance use exists across all sociodemographic groups and geographic areas. Approximately 10% of pregnant women report the use of alcohol during pregnancy, including 4% who drink more the 5 drinks at one time, 5% report the use of illicit drugs, and over 15% report smoking tobacco.* *Prevention, identification, and reduction of perinatal opioid and other substance 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 substance use disorders and linking them with the appropriate services.}*
The Goal of S·BI·RT Implementation is: *{To increase the number of obstetrics patients screened in our practice and who receive clinical response and referral appropriate to their level of risk.}*
The Global Aim of the S·BI·RT Team is: *{To screen universally for substance use in our practice and provide appropriate clinical response including brief intervention, referral, and follow up appropriate to their level of risk by [date], by incorporating S·BI·RT into our practice.}*
The S·BI·RT process begins… *{…when a designated staff person initiates the screening of a patient.}*
The S·BI·RT process ends… *{…when the screening results have received identified response including documentation of brief intervention, results of referral, and follow up visits.}*
Out of scope… *{Providing ongoing treatment for patients with substance use disorders.}*
In scope… *{Providing universal screening, brief intervention and supported referrals as indicated.}*

Team Structure

1. Identify the leader for S·BI·RT at your practice site:
2. List the leader's responsibilities:
3. List the responsibilities of the team members:
4. Decide how often your team will meet, where, and for how long:
5. Decide how decisions will be made:
6. Develop a plan for communicating among team members between meetings:

Example Team Deliverables

- List team goals (refer to Implementation Checklist)
- Make a flow chart or map of how substance use screening is done currently. Identify issues to inform priority areas to address in S·BI·RT implementation.
- Develop aims and measures based on an assessment of your practice and the goals of S·BI·RT.

APPENDIX E: S·BI·RT: FEDERAL ALCOHOL AND DRUG CONFIDENTIALITY OVERVIEW

SHARING INFORMATION WITH CO-LOCATED/INTEGRATED BEHAVIORAL HEALTH PROVIDERS

A program can share information with co-located/integrated providers utilizing these four exceptions:

Exception One: Written patient consent

Patient can sign a written consent form, with all elements required by 42 CFR Part 2, authorizing her alcohol/drug treatment providers (program) to communicate with her primary care (and/or other) providers. The program must provide the Notice Prohibiting Re-disclosure when it discloses a patient's protected alcohol/drug information pursuant to consent.

Valid consent form

Most disclosures are allowed if patient signed a valid consent form (called "authorization" under HIPAA) that has not expired or been revoked. The consent must adhere to proper format; otherwise, it is NOT sufficient.

The proper format for consent to release information includes the following documentation: 1. Name/general designation of program making disclosure; 2. Name of individual/entity receiving disclosure; 3. Name of patient who is subject of disclosure; 4. Purpose/need for disclosure; 5. Description of how much and what type of information will be disclosed
(must be limited to that information which is necessary to carry out the purpose of the disclosure); 6. Patient's right to revoke consent and any exceptions; 7. Date/event/condition
on which consent expires; 8. Patient's signature; 9. Date signed; and further, 10. HIPAA: program's ability to condition treatment, payment, enrollment, or eligibility on the consent.

Minors and Consent

Both HIPAA and 42 CFR Part 2 leave the issue of who is a minor and whether a minor can obtain health care or alcohol/drug treatment without parental consent entirely to State law. However, under 42 CFR Part 2, the program must always obtain a minor's consent for disclosure, and must also obtain parental consent for disclosure only if State law requires parental consent to treatment. In NH, youth aged 12 and older can seek treatment for substance use disorders without parental consent.

Key Points

42 CFR Part 2 Valid Written Patient Consent Form Must Include:

1. Name/general designation of program making disclosure
2. Name of individual/entity receiving disclosure
3. Name of patient who is subject of disclosure
4. Purpose/need for disclosure
5. Description of how much and what type of information will be disclosed (This must be specified, e.g., medication, substance use history, employment information, etc.)
6. Patient's right to revoke consent, and any exceptions
7. Date/event/condition on which consent expires
8. Patient's signature
9. 9. Date signed

Prohibition on Re-disclosure

Any disclosure made pursuant to written patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient may not disclose it further unless permitted by the regulations. This is true even for verbal disclosures. This language is dictated by regulations. In the 2018 Final Rule, SAMHSA adopted an abbreviated notice of the prohibition on re-disclosure that can be used in any instance in which a notice is required

"Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records"

Exception Two: Internal communications

Programs covered by 42 CFR Part 2 may disclose information without patient consent to an entity with administrative control over the program, to the extent the recipient needs the information in connection with providing alcohol/drug services. The "entity with administrative control" could include, for example, a records or billing department of a general medical facility. Information may also be disclosed to other program staff but only to the extent the recipient needs information in connection with provision of drug/alcohol services (purpose and amount).

Exception Three: Medical emergency

Disclosure may be made to medical personnel to the extent necessary to meet a bona fide medical emergency of the patient or any other individual. A medical emergency meets two criteria: 1) it is an immediate threat to the health of the individual, AND 2) it requires immediate medical attention. The determination of a medical emergency can be made by personnel based on professional judgment. The patient must be incapable of consent. If the patient is capable, but refuses to consent, information may not be shared under this exception.

Documentation of medical emergency

A disclosure made in connection with a medical emergency must include the following documentation in the patient's record: name and affiliation of recipient of information; name of person making disclosure; date and time of disclosure; and nature of emergency.

Exception Four: Qualified Service Organizations/Business Associates (QSO/BA) Agreement

Disclosure without patient consent to certain outside organizations that provide services to the program or its patients may be made with a QSO Agreement. These outside organizations are referred to as Qualified Service Organizations (QSOs) in 42 CFR Part 2, and as Business Associates (BAs) by HIPAA. QSOs may provide services such as medical services, population health management, data processing, dosage prep, lab analyses, vocational counseling, patient transport, legal or accounting services, electronic storage of patient records, etc. An organization serving as QSO that is also covered by HIPAA must also meet BA agreement requirements.

Requirements of a QSO Agreement

The program must enter into written agreement with the QSO, agreeing that the QSO:

- is fully bound by 42 CFR Part 2
- will resist an effort to obtain access to patient information except as permitted by 42 CFR Part 2
- agrees that all disclosures must include a written notice that the records are subject to 42 CFR Part 2, and re-disclosure without additional consent is prohibited, that is *"Federal law 42 CFR Part 2 prohibits unauthorized disclosure of these records."*

INCORPORATING ALCOHOL/DRUG TREATMENT RECORDS INTO EHR SYSTEMS

Regardless of the EHR system in place, providers must be mindful of the requirements of 42 CFR Part 2 when including alcohol/drug patient records. Records protected by 42 CFR Part 2 can be integrated into EHR systems with providers not covered by 42 CFR Part 2 in the same ways that a program can share information with co-located/integrated providers:

Written patient consent

The system must be able to implement patients' consent choices. For alcohol/drug records, the EHR system must be able to ensure records are disclosed only 1) pursuant to proper written consent (Consent Form Must Be 42 CFR Part 2 Compliant), 2) with the amount/type of information listed on the consent form, and 3) for the purpose listed on the consent form. The systems must be able to ensure information ceases to flow when consent expiration is reached, including providing notice prohibiting re-disclosure with information disclosed. The consent form must comply with 42 CFR Part 2 requirements, and the system must be able to comply with medical emergency requirements, and be capable of implementing QSO/BA agreement limitations.

Internal communications exception

Programs covered by 42 CFR Part 2 may disclose information without patient consent to an entity with administrative control over the program, to the extent the recipient needs the information in connection with providing alcohol/drug services.

Medical emergency exception

When information protected by 42 CFR Part 2 is disclosed in connection with medical emergency, the program must document certain information and the EHR system must be able to:

- Notify the program when its patients' records are disclosed in medical emergency;
- Capture the information that the program is required to document in its records; and
- include the information with the notification.

QSO Agreement

A QSO/BA agreement is a two-party agreement between the program and the QSO/BA; the QSO/BA cannot re-disclose the information. When alcohol/drug patient information is included in an EHR system pursuant to a QSO/BA agreement, the EHR system must have the capability to ensure the information is not re-disclosed without proper patient consent.

Sources:

SAMHSA, Applying the Substance Abuse Confidentiality Regulations, https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs

https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

APPENDIX F: HEALTH CENTERS AND CONFIDENTIALITY OVERVIEW – 42 CFR PART 2

Health Centers and Confidentiality Overview

42 CFR Part 2 applies only if you, your program or your facility are both a drug and alcohol treatment and prevention *program* and are *federally assisted.*

Definitions:

What is a **PROGRAM** and what does **FEDERALLY ASSISTED** mean according to 42 CFR Part 2?

Program

There are three definitions of a drug and alcohol treatment and prevention program:

a. An individual or entity, other than general medical facility, that "holds itself out as providing" and does provide, drug/alcohol diagnosis, treatment, or referral for treatment is a program;

b. An identified unit within a general medical facility that holds itself out as providing, and does provide, drug/alcohol diagnosis, treatment, or referral for treatment is a program; or

c. Medical personnel or other staff, in a general medical care facility, whose primary function is the provision of drug/alcohol diagnosis, treatment, or referral for treatment, and who are identified as such is a program (even if it is only one person).

Although the law does not define "general medical facility," SAMHSA2 provides some examples: hospitals, trauma centers, and Federally Qualified Health Centers (FQHCs). Likewise, the law does not define "holds itself out" but SAMHSA provides examples: State licensing procedures, advertising, or posting notices in office, certifications in addiction medicine, listings in registries, internet statements, consultation activities for non-"programs," information given to patients and families, any activity that would reasonably lead one to conclude those services are provided.

Federally Assisted

A program is federally assisted when it receives federal funds in any form (even if not used for drug/alcohol services), or is authorized, licensed, certified, registered by the Federal government, such as assisted by IRS by grant of tax-exempt status, has Drug Enforcement Administration (DEA) registration to dispense controlled substances to treat drug/alcohol abuse, is authorized to provide methadone treatment, and/or is certified to receive Medicaid or Medicare reimbursement.

If the entity conducting S-BI-RT services is not a federally-assisted program, then the S-BI-RT services and patient records generated by such services would not be covered under 42 CFR Part 2, although HIPAA and state laws may apply.

42 CFR Part 2 prohibits the disclosure of information that identifies a patient (directly or indirectly) as having a current or past drug or alcohol problem (or participating in a drug/alcohol program) unless the patient consents in writing or another exception applies.

Definitions:

What is **DISCLOSURE** and what are the **EXCEPTIONS** according to 42 CFR Part 2?

Disclosure

Disclosure of identifying information is communication (oral or written) of information that identifies someone as having a past or current drug/alcohol problem or being a past or current patient in a drug/alcohol program. This includes communications to people who already know the information.

Exceptions

There are ten exceptions to the general rule prohibiting disclosure:

1. Written consent;
2. Internal communications;
3. Medical emergency;
4. Qualified service organization agreement;
5. No patient-identifying information;
6. Crime on program premises/against program personnel;
7. Research;
8. Audit;
9. Court order; and
10. Reporting child abuse/neglect.

Restrictions on Re-disclosure

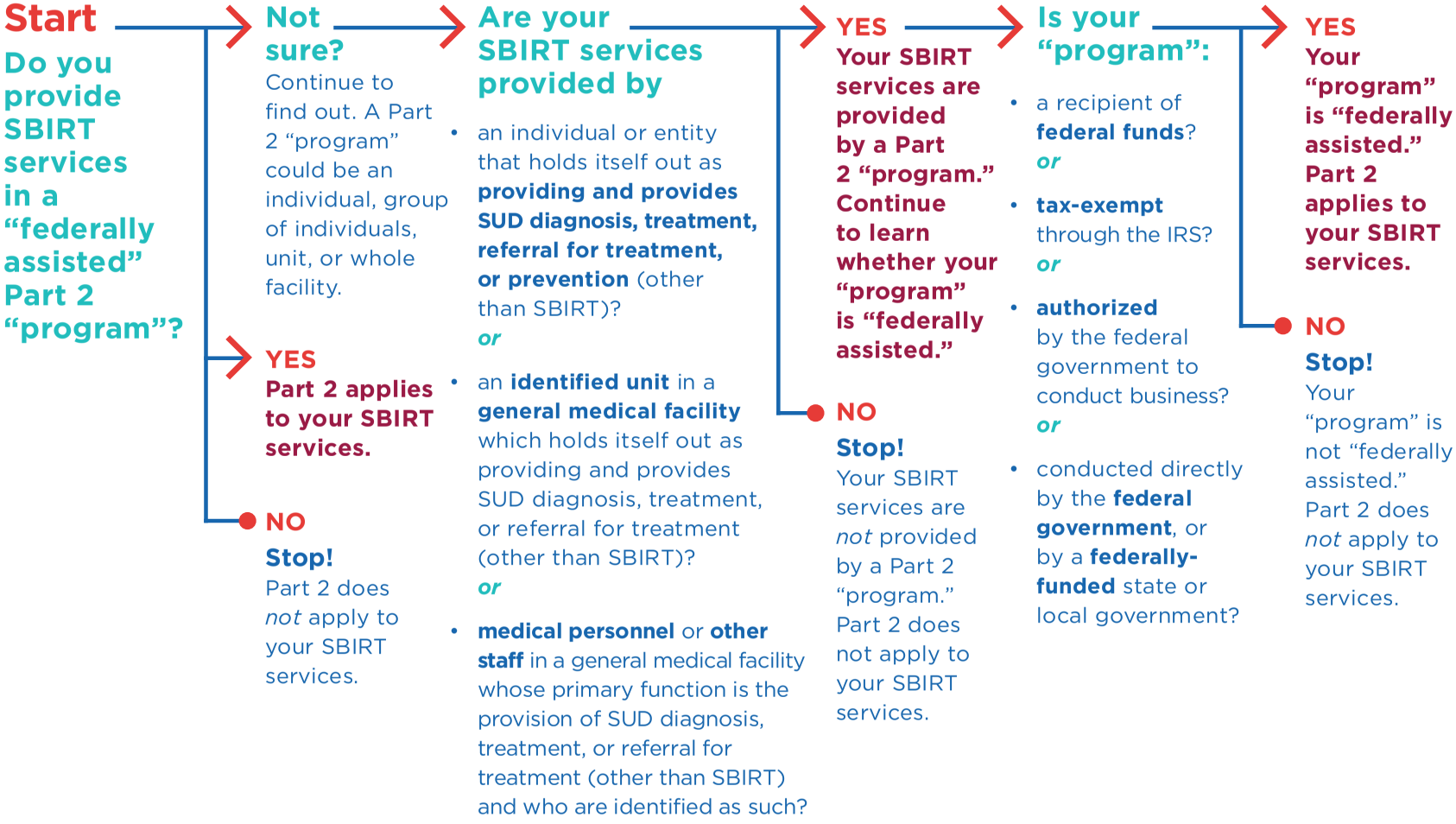
Part 2 requires covered parties making a disclosure of SUD records pursuant to a patient's written consent to include with the disclosed records a written notice that the records are subject to Part 2 and that re-disclosure without additional patient consent is prohibited. In the 2018 Final Rule, SAMHSA adopted an abbreviated notice of the prohibition on re-disclosure that can be used in any instance in which a notice is required. The abbreviated notice reads: **"Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records".**

Sources

https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

https://lac.org/samhsa-revises-42-cfr-part-2-new-final-rule-confidentiality-substance-use-disorder-treatment-information/

DOES 42 CFR PART 2 APPLY TO YOUR SBIRT SERVICES?



The tools in this series are useful even for SBIRT providers who are not required to follow Part 2; they may need to communicate with programs who are. Also make sure to learn about other applicable confidentiality laws, such as HIPAA and state privacy laws.

Additional information available at lac.org/confidentiality-sbirt/

APPENDIX G: SAMPLE CONSENT FORM

Draft 2018- For Reference Purposes Only
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2018. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

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SUBSTANCE USE DISORDER SERVICES:

AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

DRAFT Form B

Name: _____ Date of Birth:_____

Medical Record # (if known):_____

I understand ***[Name of SUD/Part 2 ENTITY making disclosure]***_____[*If part of hospital system, include affiliated entities if necessary, i.e., "I am a patient of Mount Ida Primary care, Mount Ida Capital partners and affiliated entities"]* will be providing me care and treatment and will need to share private health information about my referral, diagnosis and/or treatment for substance use disorder [and mental health] with my treatment team, with other treating providers, with entities responsible for payment and with others listed below as authorized by me or by law.

[Treating Providers]
I authorize [my Part 2 Program treatment team] to access, use, disclose and communicate both verbally and in writing my health information, including my private substance use disorder and mental health information, [*which is maintained as part of my integrated electronic health record]* to and from my past, current and/or future *treating providers* [define if necessary] for the purpose of *my ongoing treatment and recovery and helping me manage my care*, including but not limited to:
[Check all that apply]

- ☐ [Treating Provider Entity 1][Include Clinic]
- ☐ [Treating Provider Entity 2]
- ☐ [Treatment Provider Entity 3]
- ☐ [My treating providers through the [Health Information Exchange]]: (Name/Title of Supervisor of HIE)_____
- ☐ My Care Coordinator(s) at: _____
- ☐ *Other: (specify)*_____
- ☐ *Other:(specify)*_____

Draft 2018- For Reference Purposes Only
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2018. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

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[Non-treating providers]
I also authorize [my treatment team] to access, use, disclose and communicate both verbally and in writing the following private substance use disorder and mental health information [*which is maintained as part of my integrated electronic health record*], including:
[check all that apply]

- ☐ My medical events, care management plan and medication list
- ☐ My attendance at my recovery program
- ☐ Information confirming my compliance with my care and recovery plan
- ☐ *Other:*_____
- ☐ *Other:*_____

To and from the following individuals involved in my well-being and recovery:

- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ Agency: (Title/Name of Individual/Tel #) _____
- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ Agency: (Title/Name of Individual/Tel #)_____
- ☐ *Other:*_____
- ☐ *Other:* _____

For the purpose of: [check all that apply]

- ☐ Monitoring and supporting my ongoing recovery
- ☐ Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training
- ☐ Confirming compliance with court ordered treatment, probation or parole
- ☐ For the purpose of the care and treatment of my children
- ☐ *Other:*_____
- ☐ *Other:*_____

[Payment and Healthcare Operations]
I authorize [my treatment team] to use, disclose and communicate both verbally and in writing my health information including substance use and mental health information to and from my health insurance company or other entity responsible for my medical bills for the purpose of eligibility, payment and health care operations. *[Either insert the name of the payer or refer to your program's policy regarding notification of payment]:*

Draft 2018- For Reference Purposes Only
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2018. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

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Authorization to Discuss Health Status with Family, Friends or Advocates Members

If I am not present or available, I authorize [ENTITY] affiliated treating providers and staff to discuss my relevant health information, including my substance use disorder [and mental health] treatment, with the family members, friends and/or advocates named below.

Authorized individuals (please provide full names):

Name: _____ Tel #_____
Name: _____ Tel#_____
Name: _____ Tel #_____
Name: _____ Tel#_____
Name: _____ Tel #_____
Name: _____ Tel#_____

Draft 2018- For Reference Purposes Only
SAMHSA has promised but has not yet published sub-regulatory guidance or draft Forms consistent with the 42 CFR Part 2 regulations published January 2018. Any Form should be reviewed with and revised by your provider's leadership/compliance team and counsel as necessary.

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Acknowledgement of Rights

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my treating providers disclose my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure.

[**For Use When General Designation is A Third Party Without A Treatment Provider Relationship, e.g., a health information exchange (HIE)]** I understand I have a right to request a list of treating providers who have received my substance use disorder information from the [HIE/general designation] _____pursuant to 42 CFR Part 2.

I also understand that I may revoke this consent, orally or in writing by contacting [APPROPRIATE ENTITY INFORMATION MANAGEMENT OFFICE_____] at [PHONE NUMBER_____] at any time except to the extent that action has been taken in reliance on it. We are unable to take back any disclosures we have already made with your consent and we are required to retain as records of the care we provide to you.

If not already revoked, this consent will expire on _____ *[Example: One year/specified date/upon my death.]* Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.

[I understand that I may be denied services if I refuse to consent to a disclosure for purposes of my treatment [or payment]. I will not be denied services if I refuse to consent to a disclosure for other purposes.][1]

If I have any questions about disclosure of my private health information, I can contact _____ at [PHONE NUMBER].I understand I can ask for a copy of this authorization and consent form.

_____ _____
Signature of Patient or legal representative or guardian Date and Time

_____
Authority/Relationship of representative to patient (attach copy)

[1] This provision is not necessary and may be different depending upon the type of provider offering services.

APPENDIX H: SUBSTANCE USE DISORDER DIAGNOSIS OVERVIEW

Substance Use Disorder Diagnosis Overview

Reference Sheet: DSM 5 Substance Use Disorder Criteria

The *Diagnostic and Statistical Manual of Mental Disorders* 5 (DSM-5), published in May 2013, replaces the two categories of substance abuse and substance dependence with a single category: *substance use disorder*. The disorder is diagnosed substance specific and with a severity qualifier. The number of criteria met generally measures severity. M*ild* (2–3 criteria); M*oderate* (4–5 criteria); or S*evere* (6 or more criteria). For example: *Alcohol Use Disorder, Mild* or *Marijuana Use Disorder, Severe*. The DSM-5 utilizes the same criteria regardless of the substance.

The 11 Criteria

1. Taking more or for longer than intended
2. Unsuccessful efforts to stop or cut down use
3. Spending a great deal of time obtaining, using, or recovering from use
4. Craving for substance
5. Failure to fulfill major obligations due to use
6. Continued use despite problems caused or exacerbated by use
7. Important activities given up or reduced because of substance use
8. Recurrent use in hazardous situations
9. Continued use despite physical or psychological problems that are caused or exacerbated by substance use
10. Tolerance to effects of the substance*
11. Withdrawal symptoms when not using or using less*

**People who are using medication as prescribed; for example opioids, may exhibit only these last two symptoms and not have an opioid use disorder.*

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

APPENDIX I: SELECTED VALIDATED SCREENING TOOLS FOR USE WITH PERINATAL WOMEN

Selected Validated Screening Tools for Use with Perinatal Women[1]			
Screening Tool Name	Number of Items	Target Substance	Further Information (sample tool, scoring, references, developers, etc.)
TWEAK* (Tolerance, Worried, Eye-openers, Amnesia, K[C] Cut Down)	5	Alcohol	https://pubs.niaaa.nih.gov/publications/assessingalcohol/InstrumentPDFs/74_ TWEAK.pdf
T-ACE*	4	Alcohol	https://www.mirecc.va.gov/visn22/t-ace_alcohol_screen.pdf
5 Ps Prenatal Substance Abuse Screen for Alcohol, Drugs and Tobacco*	8	Alcohol and other substances, including tobacco	https://www.pathwaysfl.org/blog/integrated-screening-tool-5-ps-for-pregnant-and-child-bearing-years/
Alcohol Use Disorders Identification Test (AUDIT)	10	Alcohol	http://auditscreen.org/
Alcohol Use Disorders Identification Test- Concise (AUDIT-C)	3	Alcohol	https://www.integration.samhsa.gov/images/res/tool_auditc.pdf
Drug Abuse Screening Test (DAST-10)*	10	Drugs	https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
Substance Use Risk Profile - Pregnancy Scale (SURP-P)*	3	Alcohol and other substances	http://www.ilpqc.org/docs/toolkits/MNO-OB/Substance-Use-Risk-Profile-Pregnancy-Scale.pdf
CRAFFT 2.1 (for patients up to 26 years old)*		Alcohol and other substances	http://crafft.org/
NIDA Quick Screen/ASSIST*	4 / 8	Alcohol and other substances, including tobacco	https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

*Denotes tools that have been validated for use with prenatal women.

[1]Note: These tools were developed and validated prior to any states legalizing marijuana, so questions about illicit drug use may not provide information about cannabis use. Your practice may want to include a specific question related to cannabis to avoid confusion regarding cannabis use and "illicit" drug use.

APPENDIX J: SAMPLE PATIENT LETTER – ORIENTATION TO THE PRACTICE

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 (cannabis) may cause problems with learning and depression as children get older
- Drug and alcohol use may affect your ability to care for your new born baby

We will support you in your effort to engage in recommended treatment and recovery services and supports, to avoid use of alcohol, and to use specific substances only as recommended by your healthcare provider. If you smoke please let us know if you are interested in nicotine replacement options.

Please let us know if you have questions or concerns about any information shared here.

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

[Your Ob/Gyn Team]

This letter may be amended to meet the approach and needs of the practice.

APPENDIX K: NH PLAN OF SAFE CARE TEMPLATE AND GUIDANCE

Developed by the Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery

- For more information: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/

Draft ***POSC Template, v.14, 01.11.19***

Supported Care for Mothers and Infants

This Plan of Safe Care, developed collaboratively with the mother, coordinates existing supports and referrals to new services to help infants and families stay safe and connected when they leave the hospital. This Plan of Safe Care is to be shared with the infant's and the mother's providers and supports.

I. DEMOGRAPHIC INFORMATION	
Name of Mother:	Mother's Medical Providers:
Name of Infant:	Infant's Medical Providers:
Name of Father:	Mother's Admission Date:
Infant's DOB:	Mother's Discharge Date:
Mother's Phone Number:	Infant's Discharge Date:
Mother's Health Insurance:	Father's Phone Number:
Current Address:	

II. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

III. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, recovery)

IV. HOUSEHOLD MEMBERS						
Name	Relationship to Infant	Age		Name	Relationship to Infant	Age

V. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS		
Name	Relationship to Infant	Phone Number

VI. NOTES/HELP NEEDED (please time/date entries)

Draft ***POSC Template, v.14, 01.11.19***

VII. SERVICES, SUPPORTS, and NEW REFERRALS					
	Discussed Y/N	Active	Referred	Contact Name	Organization/Phone Number
Visiting Nurse Association (VNA)		☐	☐		
Women, Infants, and Children Program (WIC)		☐	☐		
health insurance enrollment		☐	☐		
Family Resource Center (FRC)		☐	☐		
parenting classes		☐	☐		
safe sleep education/plan		☐	☐		
childcare		☐	☐		
other home visiting		☐	☐		
Early Supports and Services		☐	☐		
voluntary child welfare services		☐	☐		
family planning		☐	☐		
mental health		☐	☐		
smoking cessation/no smoke exposure		☐	☐		
housing assistance		☐	☐		
Temporary Assistance for Needy Families (TANF)		☐	☐		
financial assistance		☐	☐		
transportation		☐	☐		
legal assistance		☐	☐		
personal security/DV		☐	☐		
substance use		☐	☐		
Medication Assisted Treatment		☐	☐		
recovery support services (e.g. recovery coaching, meetings)		☐	☐		
Drug Court participation		☐	☐		
Other ( )		☐	☐		
Other ( )		☐	☐		

VIII. PRENATAL EXPOSURE		
	Y/N	Notes
Does the infant have prenatal substance exposure?		
Is the prenatal substance exposure a result of prescribed medication?		
Is there prenatal substance exposure in addition to prescribed medication?		

IX. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE MOTHER?		
Name:	Relationship to Infant:	Court Involvement (Y/N):
Phone Number/Address:		

X. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share the Plan of Safe Care with my baby's pediatrician and primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Signature: _____ **Date:** _____

XI. STAFF SIGNATURE

I, _____provided _____ with the Plan of Safe Care upon discharge.

Signature: _____ **Date:** _____

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

2

Federal Law/42 CFR Part 2 prohibits unauthorized disclosure of this record.

Plans of Safe Care in New Hampshire

Helpful Question and Answers

What is a Plan of Safe Care? What is its purpose?

A Plan of Safe Care (POSC), developed collaboratively with the mother, coordinates existing supports and referrals to new services to help infants and families stay safe and connected when they leave the hospital. The POSC is to be shared with the infant's and the mother's providers and supports.

Who needs a POSC?

A POSC must be developed for any infant exposed to drugs and/or alcohol prenatally and the affected caregiver.[1] One POSC is developed for both the mother and infant. Many providers may decide to develop POSCs with all new mothers and infants.

Who develops the POSC? When is it developed?

The POSC is developed collaboratively by a healthcare provider and the mother before the mother's discharge from the hospital. According to best practices, the POSC should be started prenatally and serve as a living document throughout the pregnancy and after birth. If that is not possible, the POSC must be developed after birth and completed before the mother's discharge.

What is "Notification"? How is it different than a mandatory report?

New Hampshire has a federal data reporting requirement, which means the state reports annually to the federal Children's Bureau the *aggregate* number of infants born with prenatal drug and/or alcohol exposure for whom a POSC was created and for whom services were referred. This federal data reporting requirement is called "notification."

Mandatory reporting is required under NH RSA 169-C:29 whenever anyone has a reason to suspect child abuse and/or neglect. The fact an infant is born with prenatal exposure to drugs and/or alcohol does not itself require a mandatory report.

Are hospitals required to make a mandatory report for all infants exposed prenatally to drugs and/or alcohol?

No. A provider may determine it is not necessary to make a report of child abuse and/or neglect to the Division for Children, Youth & Families (DCYF) even though a POSC is developed for the infant due to the infant's prenatal drug and/or alcohol exposure. For example, an infant exposed prenatally to drugs due to prescribed medication under a clinician's direction AND without any child safety concerns does not need to be reported to DCYF.

What happens to the POSC when a report of child abuse and/or neglect is made?

If providers make a report of child abuse and/or neglect, the POSC must be shared with DCYF according to New Hampshire's Plan of Safe Care development law.

[1] New Hampshire's Plan of Safe Care development law for the protection of maternity and infancy, effective June 26, 2018, can be found at RSA 132:10-e and 10-f.

What types of information about infants exposed prenatally to drugs and/or alcohol is shared and with whom?

Birth Certificate Worksheet Data

Upon the infant's birth, the birthing center or hospital will answer the birth certificate worksheet or other required questions about the infant's substance exposure. New Hampshire will then fulfill its federal data reporting requirements by aggregating data received and submitting de-identified data to the federal Children's Bureau on an annual basis.

POSC

The POSC must be given to the mother upon the mother's discharge. In addition, the POSC should go to the infant's primary care provider along with the infant's other medical records. The POSC is not shared with DCYF unless a report of child abuse and/or neglect is made. When a provider reports child abuse and/or neglect, the POSC must be shared with DCYF.

Does the POSC contain information protected by 42 CFR Part 2 (Part 2)?

The mother may, and is encouraged to, share this POSC with others. The POSC, however, contains information identifying the mother and child that is private and may be protected from disclosure by health and substance use disorder record confidentiality laws. However, if a report of child abuse and/or neglect is made, the POSC may be shared with DCYF. Otherwise, the POSC should be treated like other patient information and shared consistent with your privacy practices.

What types of services are included in the POSC?

A POSC may include referrals for both the infant and caregiver. Referrals for caregivers may include family resource centers, parenting support groups, home visiting, mental health counseling, substance use counseling, peer recovery coaching, medication assisted treatment, and Drug Court, as well as others.

What if a mother declines to participate in developing a POSC?

Even though the goal is for all mothers to engage in the development of a POSC, there will be times a mother will decline to participate. Absent child protection concerns, the refusal to develop a POSC does not itself warrant a mandatory report under NH RSA 169-C:29.

This document was drafted in collaboration with the Perinatal Substance Exposure Task Force of the New Hampshire Governor's Commission on Alcohol and other Drugs.

APPENDIX L: CONVERSATION GUIDE FOR DELIVERING A TRAUMA-INFORMED BRIEF INTERVENTION

CONVERSATION GUIDE *for Delivering a* TRAUMA-INFORMED BRIEF INTERVENTION

The link between childhood trauma and substance use disorders is well-documented in the literature. This resource acknowledges that link and is intended to help healthcare providers deliver a brief intervention for substance use using a trauma-informed care approach. Whether you are well-versed in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, or just looking for an effective way to address substance use concerns with your patients, this guide provides practical examples to facilitate that conversation. The left column provides scripts and concrete strategies to move through the brief intervention process, while the right column provides considerations to ensure trauma-informed care principles are integrated into the delivery.

BRIEF INTERVENTION COMPONENT	TRAUMA-INFORMED CARE CONSIDERATIONS
1. RAISE THE SUBJECT & ENGAGE	

• **Ask** permission to review screening results:
"Would you be willing to review these results?"
• **Express** appreciation for answering sensitive screening questions.
• **Request** permission to proceed with next steps including:
  • Educating about the connection between substance use, health, and behaviors.
  • Sharing how these connections are applicable in their life.
  • Discussing meeting with a behavioral health specialist, if applicable.
	• **Be mindful** of the impact our behaviors can have on people with a history of trauma:
	  • Utilize universal precautions for creating a calm environment (e.g., minimizing noise, decreasing clutter, maintaining a comfortable temperature).
	  • Be aware of internal emotions and thoughts and focus on those that bolster support for the patient.
	• **Be aware** of tone, volume, energy level and physical space as you introduce yourself, your role and explain what you will be doing.
	• **Set realistic expectations** and goals for your time together to create a predictable and structured environment.
	• **Respond** and communicate respectfully (e.g., ask what name they would like to be called, be validating and affirming).

2. CONFIRM SCREENING RESULTS & EXPLORE/ASK FOR MORE DETAILS ABOUT USE	
• **Explore** perceived benefits versus downsides: *"How does _____ fit into your life?"* *"What, if any concerns do you have about…?"* • **Express** empathy: *"I am so sorry that you went through that."* *"I can't imagine what that was like."* • **Validate** the experience/event: *"Going through something like that must be so difficult."* • **Educate** about the connections between substance use, trauma, physical health, and behaviors.	• **Listen** intently to understand results and their context. • **Commit** to setting aside your own judgements and thoughts about screening results to strengthen your ability to be patient and persistent. • **Maintain** awareness of the language, tone and volume used when responding. Use person-first language and avoid a judgmental tone and generalizations. ***For Example:*** ***Say This*** / ***Not That*** *Alcohol or drug poisoning* / *Overdose* *Person with substance use disorder* / *Addict* *Unhealthy substance use* / *Substance misuse* • **Focus** on competence and internal capacity for change versus knowledge or skills deficits. Strengths-based approaches increase the effectiveness of interventions.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

CONVERSATION GUIDE *for Delivering a* TRAUMA-INFORMED BRIEF INTERVENTION

BRIEF INTERVENTION COMPONENT	TRAUMA-INFORMED CARE CONSIDERATIONS
3. PERSONALIZE ADDITIONAL INFORMATION & CORRECT MISINFORMATION	
• **Elicit** information on thoughts and beliefs: *"What would you most like to know about…?"* *"What is your understanding of…?"* • **Advise** on the facts: *"Yes, and…"* *"What we also know is…"* • **Elicit** reactions to facts shared: *"What are your thoughts on this?"* *"Where does this leave you?"*	• **Maintain** the motivational interviewing spirit by providing information in the context of compassion, partnership, evocation and acceptance. • **Invest** time and energy in building and reinforcing protective factors and advising on potential risks. • **Honor** patient voice and choice, especially when it is in contradiction to your own by consistently requesting feedback and ensuring comfort.
4. ASSESS READINESS & NEGOTIATE CHANGE	
• **Explore** the ways substance use and/or trauma is impacting the patient's life. Ask questions that build on the information learned: *"You mentioned that _____ affects your ability to _____. What has helped you succeed at _____ in the past?"* • **Ask** about motivation to change. Use the **Readiness Ruler** to help guide the conversation. • **Establish** a concrete idea of what change means for the patient: *"What would a shift in use look like for you?"* *"What would be a first step?"* *"Would you be willing to…?"*	• **Client-driven** readiness assessment and change negotiation is most effective. • **Identify** positive health assets and strengths that can contribute to a healthier, longer life. • **Utilize** strengths-oriented open-ended questions: *"How have you been successful in the past?"* *"What coping skills have you learned from your life experiences?"* • **Promote** resilience through language choices (I have, I am, I can); model and practice with your patient. • **Focus** **Readiness Ruler** discussion on why the patient did not choose a lesser number. Identifying strengths rather than deficits will enhance change talk; use this approach when discussing how to achieve a higher number if that's their goal.
5. FOLLOW UP	
• **Inform** of next steps, which include: • Referral to internal or external behavioral health services. • Permission to follow up to see how treatment went. • **Understand** if the patient rejects the referral and let them know that sometimes a person needs to feel ready to take this step. Provide them with information on who to contact if at any point they would like to seek treatment or discuss their options more thoroughly. • **Frame** as an ongoing conversation: *"I'd like to follow up with you to see how you're doing. Would it be okay with you if we revisit this at your next appointment?"*	• **Recognize** that anything the patient is willing to do to address the issue is a step in the right direction. • **Connect** the patient to others who may be able to meet any needs that are outside your scope of practice. • **Reinforce** that you are here to help and that this is an ongoing discussion. Ideally, you want patients to always feel comfortable to discuss these issues with you during visits. • **Make** warm handoffs/referrals when possible. • **Document** the agreed upon plan so you can engage in informed follow-up during the next appointment.

Though this guide contains helpful brief intervention tips, it is not a comprehensive SBIRT or trauma-informed care guide.
For more information on SBIRT, please visit **TheNationalCouncil.org**, or contact Stephanie Swanson (**StephanieS@TheNationalCouncil.org**) to inquire about consulting services. For more information on trauma-informed care, please visit **TheNationalCouncil.org**, or contact Gabe Abbondandolo (**GabeA@TheNationalCouncil.org**) to inquire about consulting services.

APPENDIX M: EXAMPLE OF BRIEF INTERVENTION DIALOGUE WITH TALKING POINTS FOR SELECTED SUBSTANCES

In general, all brief interventions address the following aspects of a woman's use:

- Provide feedback on the screening results.
- Educate on the safe levels of use. In the case of pregnancy, there are no safe levels of use at any time during the pregnancy of <<tobacco, alcohol, cannabis (marijuana) or casual use of other drugs not prescribed by her provider>>.
- Discuss the role that using the substance(s) has on the woman's current health.

This framework is adapted from UMASS BNI.[39] It provides extensive talking points, and you may choose to use all, some, or none of them.

#1 **Build Rapport/Ask Permission**	**Ask permission to engage in an open dialogue.** Suggested talking points: • Thank you for completing the screening on the use of alcohol and other drugs. We ask all our pregnant patients because it is really important to know how to help you. Would you mind if we take a few minutes to discuss your answers?
#2 **Share Screening Results**	**Give feedback on the screening results.** Suggested talking points: • Your screening results put you in a zone that suggests <<no/low, moderate or high risk>>. • Would you mind taking a few minutes to talk with me about your use of [XXX]?
#3 **Explore Pros and Cons [Readiness Ruler/ Open-ended Questions]**	**Explore her situation and circumstance around using substances. Ask open-ended questions.** Suggested talking points: • Thank you for your willingness to talk – what's your reason you choose to use these substances? • Can you tell me a little bit about a day in your life? Where does your [XXX] use fit in? • Let's talk about the reasons you use or what you like about it. What are the good aspects and not so good aspects of using?

#4 **Provide Information**	**Educate on the safe levels of use. [See recommendations below for points related to specific substances.]** Suggested talking points: • The best way to reduce harm to your baby is to avoid all types of [X] throughout your pregnancy. There is no safe time or amount to use. • As a healthcare provider, I recommend to all my pregnant patients to avoid [X] while pregnant or breastfeeding. All pregnancies carry some background risk in terms of risk of birth defects, and using [X] increases your risk. • In case of opioid use during pregnancy, do not recommended abrupt cessation. [For more information about managing the care of patients who disclose using opioids, please see NNEPQIN Perinatal Toolkit] • If you are thinking about breastfeeding, it is best to avoid [XXX] during this time too. • What do you think about any of this?
#5 **Reinforce Positives**	**Encourage her to consider taking some action and provide resources.** Suggested talking points: • 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 changes in your [XXX] use? • You marked ___. That's great. That means you are ___ % ready to make change. • Why did you choose that number and not a lower one like a 1 or a 2? Sounds like you have some important reasons for change. • What are some options/steps that will work for you? • What do you think you can do to stay healthy and safe? • Tell me about a time when you overcame challenges in the past. What kinds of resources did you call upon then? Which of those are available to you this time? • What are some steps you would be willing to take between now and your next appointment to cut back or quit? • What types of changes are you willing to make (i.e. drink few days, smoke marijuana few times during the week, never use a substance and drive?) • Thank you for sharing your use of [XXX]. It is really helpful to understand how you are feeling. As your provider I recommend that while you are pregnant and breastfeeding, you do not use any [XXX]. Let's talk about a plan to help you stop using while you are pregnant so when you deliver your baby, your baby will be as healthy as possible and will not test positive. In some cases, healthcare providers are required to inform the Division of Children and Family Services of a positive screen. This is not a report of abuse or neglect, but rather the start of a plan to link your family to support and services.

#6 **Offer Appropriate Resources/ Thank Patient**	**Summarize your conversation.** Suggested talking points: • It sounds like you really want to cut back and you have had times when you successfully quit in the past. You have lots of good reasons to quit and you want to give your baby a healthy start. You have identified that you could start with cutting back by doing [XYZ]. • You have identified that you use [XXX] to help relieve your stress and anxiety. You are willing to see a counselor to talk about some strategies to deal with these feelings. That is a good first. We will make a referral for you and check in on it at your next appointment. • I really appreciate your honestly today. It sounds like you are on the fence and unsure of what to do next. Is it okay if I refer you to a behavioral health specialist to help you sort through some of your concerns?

Below are educational talking points specific to selected substances.

POLYSUBSTANCE USE

For the best pregnancy outcomes we recommend abstinence from tobacco, alcohol, cannabis, and other substances of abuse. However, recognizing that quitting completely is sometimes not possible, I want to share some information with you about how use of multiple substances may impact your pregnancy, or your baby's birth and growth and development.

Pregnancy risks associated with polysubstance use

- Placental insufficiency
- Preterm labor
- Miscarriage
- Stillbirth

Impacts on your baby's birth

- 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)

Longer term child development

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

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

TOBACCO

1-800-Quit-Now is a national helpline that will connect you to services and support in your state. Every state offers free coaching and access to free Nicotine Replacement Therapy (NRT).

- Smoking during pregnancy can cause problems for your baby, like premature birth. Quitting smoking, even if you're already pregnant, can make a big difference in your baby's life.
- Smoking harms nearly every organ in the body and can cause serious health conditions, including cancer, heart disease, stroke, gum disease and eye diseases that can lead to blindness. If you smoke during pregnancy, you're more likely than nonsmokers to have:
    - Preterm labor
    - Premature birth
    - Ectopic Pregnancy
    - Bleeding from the vagina
    - Problems with your placenta
    - Have miscarriages or stillbirths
- Tobacco contains a drug called nicotine. Nicotine is what makes you become addicted to smoking. When you smoke during pregnancy, chemicals like nicotine, carbon monoxide and tar pass through the placenta and umbilical cord into your baby's bloodstream, and are harmful to your baby. They can lessen the amount of oxygen that your baby gets, which can slow your baby's growth before birth and can damage your baby's heart, lungs and brain. If you smoke during pregnancy, your baby is more likely to:
    - Be born prematurely, and have increased risk of health problems
    - Have birth defects (such as cleft palate or cleft lip)
    - Have low birth weight.
- It's true that the less you smoke, the better for your baby. But quitting is best.

Even if you don't smoke...

- It is important that you avoid breathing in smoke from someone else's cigarette, cigar or pipe when you are pregnant. And it is important that your baby does not breathe in second-hand smoke. Babies who are around secondhand smoke are more likely than babies who aren't to have health problems, like pneumonia, ear infections and breathing problems, like asthma, bronchitis and lung problems. They're also more likely to die of SIDS.
- Secondhand smoke is smoke you breathe in from someone else's cigarette, cigar or pipe. Being around secondhand smoke during pregnancy can cause your baby to be born with low birthweight. Secondhand smoke also is dangerous to your baby after birth. Babies who are around secondhand smoke are more likely than babies who aren't to have health problems, like pneumonia, ear infections and breathing problems, like asthma, bronchitis and lung problems. They're also more likely to die of SIDS.

- In fact, there are health risks to you and your baby even if you do not breathe in smoke, but are near or around cigarette, cigar and pipe smoke. It's what you smell on things like clothes, furniture, carpet, walls and hair that's been in or around smoke. It can include lead, arsenic and carbon monoxide. Third-hand smoke is why opening a window or smoking in another room isn't enough to protect others when you smoke. I encourage you to stay away from cigarettes, cigars, or pipes altogether. Babies who breathe in third-hand smoke may have serious health problems, like asthma and other breathing problems, learning problems and cancer.

What to say about e-cigarettes:

- Just like regular cigarettes, you can become addicted to e-cigarettes. If you drink, sniff or touch the liquid in e-cigarettes, it can cause nicotine poisoning. Signs or symptoms of nicotine poison include feeling weak, having breathing problems, nausea (feeling sick to your stomach) and vomiting. Nicotine poisoning can be deadly. Liquid nicotine in e-cigarettes comes in different flavors and is sold in small tubes that may be bright and colorful. This may make e-cigarettes seem fun and appealing, especially to children.
- Liquid nicotine is unsafe to have around children. It can poison children.
- There are many chemicals in e-cigarettes besides nicotine. According to the Surgeon Generals' Report, e-cigarette aerosol is not harmless. The liquid solution in e-cigarettes contains propylene glycol, glycerin or some other solvents and additives. Although the aerosol of e-cigarettes generally has fewer harmful substances than cigarette smoke, e-cigarettes and other products containing nicotine are not safe to use during pregnancy. Studies have found other chemicals and toxins present in some e-cigarettes, including formaldehyde, acrolein, volatile organic compounds like toluene, tobacco-specific nitrosines and metals like nickel and lead. Nicotine is a health danger for pregnant women and developing babies and can damage a developing baby's brain and lungs. Also, some of the flavorings used in e-cigarettes may be harmful to a developing baby.
- E-cigarettes are often used as a strategy to quit smoking, but this is not considered FDA approved. There are several proven effective strategies to quitting such as the coaching available at 1-800-Quit-Now.

What to say about Nicotine Replacement Therapy (NRT):

- For pregnant women, the recommendations for NRT are a little more complicated. The U.S. Public Health Services and ACOG states NRT should be considered only after other methods to quit have been tried and the risk of continued smoking and the risks of NRT are understood. It is a pregnancy category D medication meaning there is evidence to show harm to the developing fetus. These groups state that women should show a clear resolve to quit smoking, therefore, NRT should be considered as a last resort. Start with the lowest level of the effective dose range and use forms of NRT that are intermittent vs continuous drug exposure.

https://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx

https://mothertobaby.org/fact-sheets/e-cigarettes/

https://mothertobaby.org/fact-sheets/cigarette-smoking-pregnancy/pdf/

https://mothertobaby.org/fact-sheets/cigarette-smoking-pregnancy/

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm

ALCOHOL

- Alcohol can cause problems for your baby at any time in pregnancy, even before you know you're pregnant. Alcohol includes wine, wine coolers, beer and liquor.
- Drinking alcohol during pregnancy makes your baby more likely to have premature birth, birth defects and fetal alcohol spectrum disorders.
- When you drink alcohol during pregnancy, the alcohol in your blood quickly passes through the placenta and the umbilical cord to your baby. The placenta grows in your uterus (womb) and supplies the baby with food and oxygen through the umbilical cord. Drinking any amount of alcohol at any time during pregnancy can harm your baby's developing brain and other organs. No amount of alcohol has been proven safe at any time during pregnancy.
- Drinking alcohol during pregnancy increases your baby's chances of being born too early and having:
  - Brain damage and problems with growth and development
  - Birth defects, like heart defects, hearing problems or vision problems.
  - Fetal alcohol spectrum disorders (also called FASDs). Binge drinking during pregnancy increases your chances of having a baby with FASDs. Binge drinking is when you drink four or more drinks in 2 to 3 hours.
  - Low birthweight
- It also increases the chances that you will have a miscarriage or stillbirth.
- Some women may drink alcohol during pregnancy and have babies who seem healthy. Some women may have very little alcohol during pregnancy and have babies with serious health conditions. Every pregnancy is different. Alcohol may hurt one baby more than another. The best way to keep your baby safe from problems caused by alcohol during pregnancy is not to drink alcohol when you're pregnant.

https://www.cdc.gov/ncbddd/fasd/alcohol-use.html

https://pubs.niaaa.nih.gov/publications/FASDFactsheet/FASD.pdf

https://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx

https://mothertobaby.org/fact-sheets/alcohol-pregnancy/

Moreno MA. Prenatal Alcohol Exposure: No Safe Amount. *JAMA Pediatr.* 2017;171(8):820. doi:10.1001/jamapediatrics.2017.1093

CANNABIS (MARIJUANA)

- No amount of cannabis has been proven safe to use during pregnancy. Using cannabis during pregnancy may cause problems for your baby, like premature birth, problems with brain development and stillbirth.
- Many women want to use cannabis or cannabis products during pregnancy to avoid nausea. Even if it's legal where you live for either personal or medical use, it's not safe to use cannabis (marijuana) during pregnancy, even to treat morning sickness. We can explore other options which might include medication, to help you feel better.
- When you use cannabis during pregnancy, THC and other chemicals may pass through the placenta to your baby. The placenta grows in your uterus and supplies your baby with food and oxygen through the umbilical cord. Chemicals from cannabis also may pass to your baby's brain.

- We need more research to find out how cannabis may affect you and your baby during pregnancy. Some studies suggest that if you use cannabis during pregnancy, your baby may have problems, including:
  - Premature birth
  - Low birthweight
  - Anencephaly. This is one of the most severe neural tube defects (also called NTDs). NTDs are birth defects in the neural tube, the part of a developing baby that becomes the brain and spine.
  - Anemia
  - Problems with brain development
  - Stillbirth
- If you use cannabis products during pregnancy, your baby may have problems after birth, too. He may be more likely than other babies to spend time in a neonatal intensive care unit (or NICU).
- Exposure to cannabis during pregnancy may cause these problems for your baby after birth:
  - Withdrawal symptoms, like tremors (shakes) or long periods of crying after birth. These symptoms usually go away within a few days after birth.
  - Problems with sleeping.
  - Problems with behavior, memory, learning, problem-solving, depression and paying attention.

Implications for breastfeeding:

- You may pass THC and other chemicals from cannabis to your baby through breast milk. If you breastfeed your baby and smoke cannabis, your baby may be at increased risk for exposure to cannabis, and the effects of cannabis exposure through breastmilk have not been adequately researched. Cannabis also may affect the amount and quality of breast milk you make. The American Academy of Pediatrics recommends that breastfeeding moms stay away from cannabis products to help keep breast milk safe and healthy.

https://www.marchofdimes.org/pregnancy/marijuana.aspx

https://mothertobaby.org/fact-sheets/marijuana-pregnancy/

https://www.acog.org/Patients/FAQs/Marijuana-and-Pregnancy?IsMobileSet=false#use

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OTHER SUBSTANCES NOT PRESCRIBED BY A PROVIDER (THIS MAY INCLUDE CASUAL USE OF COCAINE, OPIOIDS, BATH SALTS, NATURAL REMEDIES, ETC.)

- In every pregnancy, a woman starts out with a 3-5% chance of having a baby with a birth defect. This is called her background risk. Exposure to substances may increase the risk for birth defects over that background risk. This includes herbal products.
- It is not safe to take any substances that your provider is not aware of. For any substance that is not FDA approved, it is impossible to know how it is manufactured, or whether its use has been studied.
- The exact makeup of a substance changes according to which lab makes them, so you never know exactly what is in them.
- With many substances, the risks of use, particularly during pregnancy are not fully known. Many substances pass easily through the placenta, and can directly affect your baby's development.

https://mothertobaby.org/fact-sheets/herbal-products-pregnancy/

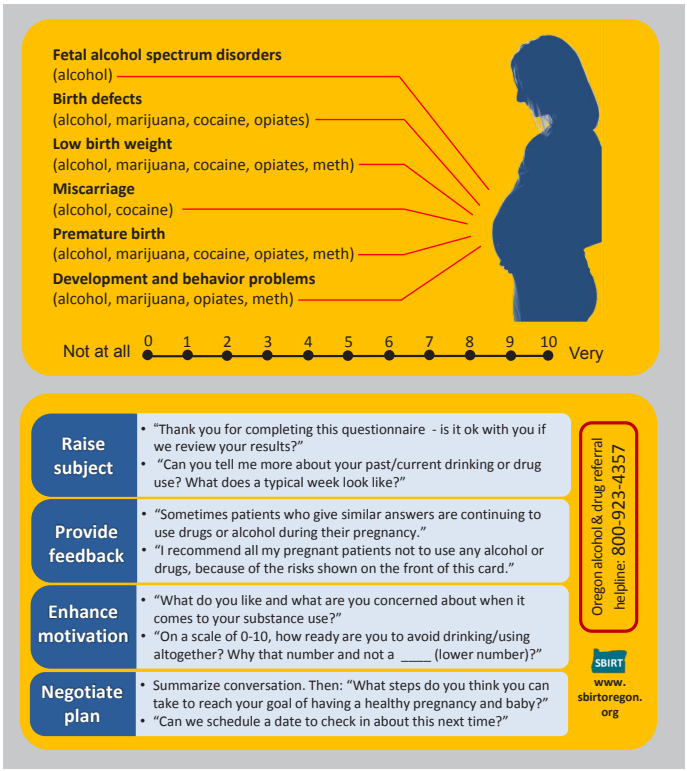
QUICK REFERENCE OF SIMPLIFIED DEFINITIONS OF ADVERSE PERINATAL OUTCOMES

Abstracted from:

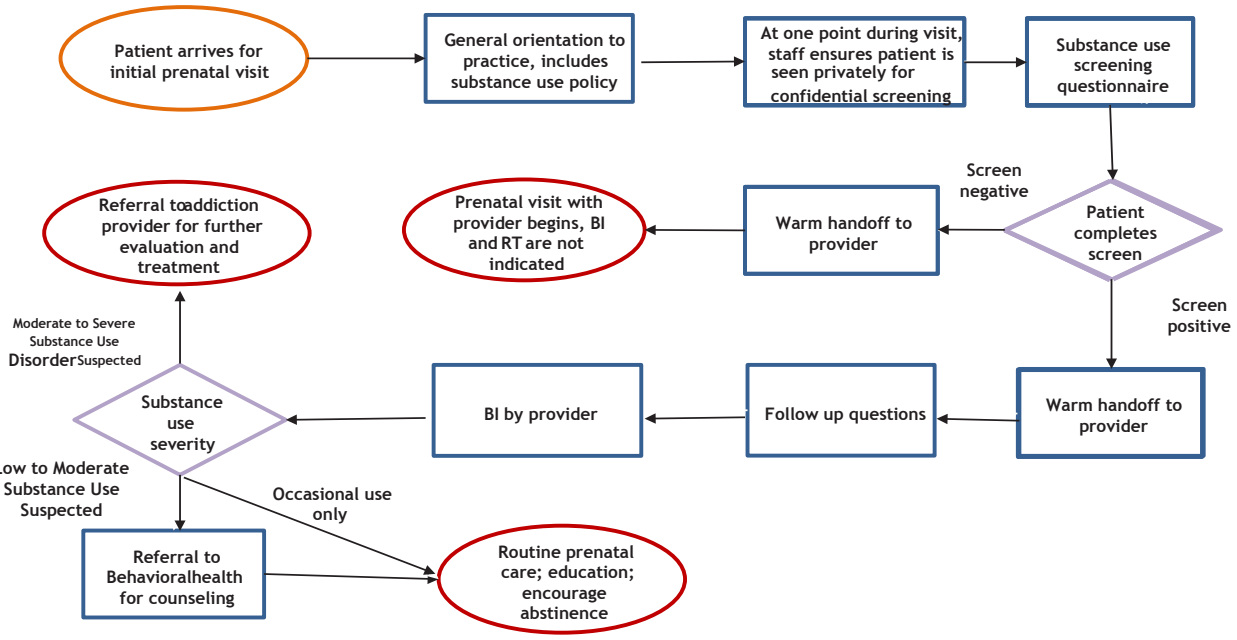
https://www.marchofdimes.org/complications/pregnancy-complications.aspx

- Birth defects, like heart defects, cleft lip or cleft palate, hearing problems, or vision problems are health conditions that are present at birth. Birth defects change the shape or function of one or more parts of the body. They can cause problems in overall health, how the body develops, or in how the body works. Neural tube defects (also called NTDs) are birth defects in the neural tube, the part of a developing baby that becomes the brain and spine. Babies with this condition are missing major parts of the brain, skull and scalp. They do not survive long after birth, usually for just a few hours. Babies exposed to cannabis during the first month of pregnancy are at increased risk of having anencephaly.
- Ectopic pregnancy occurs when a fertilized egg implants itself outside of the uterus (womb) and begins to grow. An ectopic pregnancy cannot result in the birth of a baby. It can cause serious, dangerous problems for the pregnant woman.
- Fetal alcohol spectrum disorders (also called FASDs). Children with FASDs may have a range of problems, including intellectual and developmental disabilities. These are problems with how the brain works that can cause a person to have trouble in learning, communicating, taking care of himself or getting along with others. They also may have problems or delays in physical development. FASDs usually last a lifetime. Binge drinking during pregnancy increases your chances of having a baby with FASDs. Binge drinking is when you drink four or more drinks in 2 to 3 hours.
- Low birthweight is when a baby is born weighing less than 5 pounds, 8 ounces. Your baby also may have short body length or small head size.
- Miscarriage is when a baby dies in the womb before 20 weeks of pregnancy.
- Placenta previa is when the placenta lies very low in the uterus and covers all or part of the cervix. The cervix is the opening to the uterus that sits at the top of the vagina. The placenta grows in your uterus (womb) and supplies the baby with food and oxygen through the umbilical cord. Placental abruption is a serious condition in which the placenta separates from the wall of the uterus before birth.
- Premature birth is birth that happens too early, before 37 weeks of pregnancy.
- Preterm labor is labor than starts too early, before 37 weeks of pregnancy. Preterm labor can lead to premature birth.
- Stillbirth is when a baby dies in the womb after 20 weeks of pregnancy.

APPENDIX N: BRIEF INTERVENTION TOOLS



APPENDIX O: NNEPQIN RECOMMENDED FLOW CHART



Additional resources for implementing S-BI-RT into clinical practice workflows is available from the Department of Family Medicine at Oregon Health Sciences University: http://www.S-BI-RToregon.org/contact-us/

APPENDIX P: CODING AND BILLING INFORMATION

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.

Type of Encounter		Criteria	Billing Codes
S-BI-RT	Routine screening without brief intervention: can be performed periodically, must reference use of a validated screening tool	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	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
Tobacco Counseling	Include tobacco-related diagnosis for visit (for example): Tobacco Use Disorder: F17.2 Bill as "additional E&M code"		If 3-10 minutes= 99406 If > 10 minutes= 99407

Coding and Billing Considerations for Counseling

Related to Substance Use Issues for Obstetrics Patients

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

APPENDIX Q: NH CENTER FOR EXCELLENCE LEARNING OPPORTUNITIES CARD

Screening, Brief Intervention, and Referral to Treatment (S·BI·RT)

LEARNING OPPORTUNITIES

S·BI·RT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for prevention and early intervention with individuals at greater risk before more severe consequences occur.

A variety of training opportunities are available that will increase your knowledge and skills to successfully implement S·BI·RT. Trainings can be tailored to your practice or program, and coordinated with regard to time, place, and length of training session. Each learning activity offers you tips, tools and resources to efficiently and effectively train your staff on their role with S·BI·RT and fully adopt all aspects of S·BI·RT.

S·BI·RT RESOURCES AVAILABLE THROUGH THE CENTER FOR EXCELLENCE

Workshops: Onsite tailored training to help overcome implementation barriers.

Topics include:

- S·BI·RT 101: Overview of the components and why they are important
- Advanced S·BI·RT Implementation
- Screening for Medical Assistants
- Brief Intervention, Parts 1 and 2: Based on skill level and may include:
  - Basic concepts of providing a brief intervention in response to a positive screening
  - Strategies for engaging patients in conversations that motivate them to reduce their risky use of alcohol or drugs, and/or
  - Interactive skill building using role-play and case studies

Technical Assistance: In-person & web-based for implementing S·BI·RT

SBIRTNH.org: Searchable website with evidence-based resources & tools including:

Kognito: Free online 1-hour interactive role-play simulation to build skills in screening and brief intervention, with CEUs

Webinars: A full listing of recommended current and recorded Web-based learning opportunities

Screen and Intervene: NH S·BI·RT Playbook: A step-by-step S·BI·RT implementation guide

Visit SBIRTNH.org or for more information,
contact nhcenterforexcellence@jsi.com or 603.573.3348

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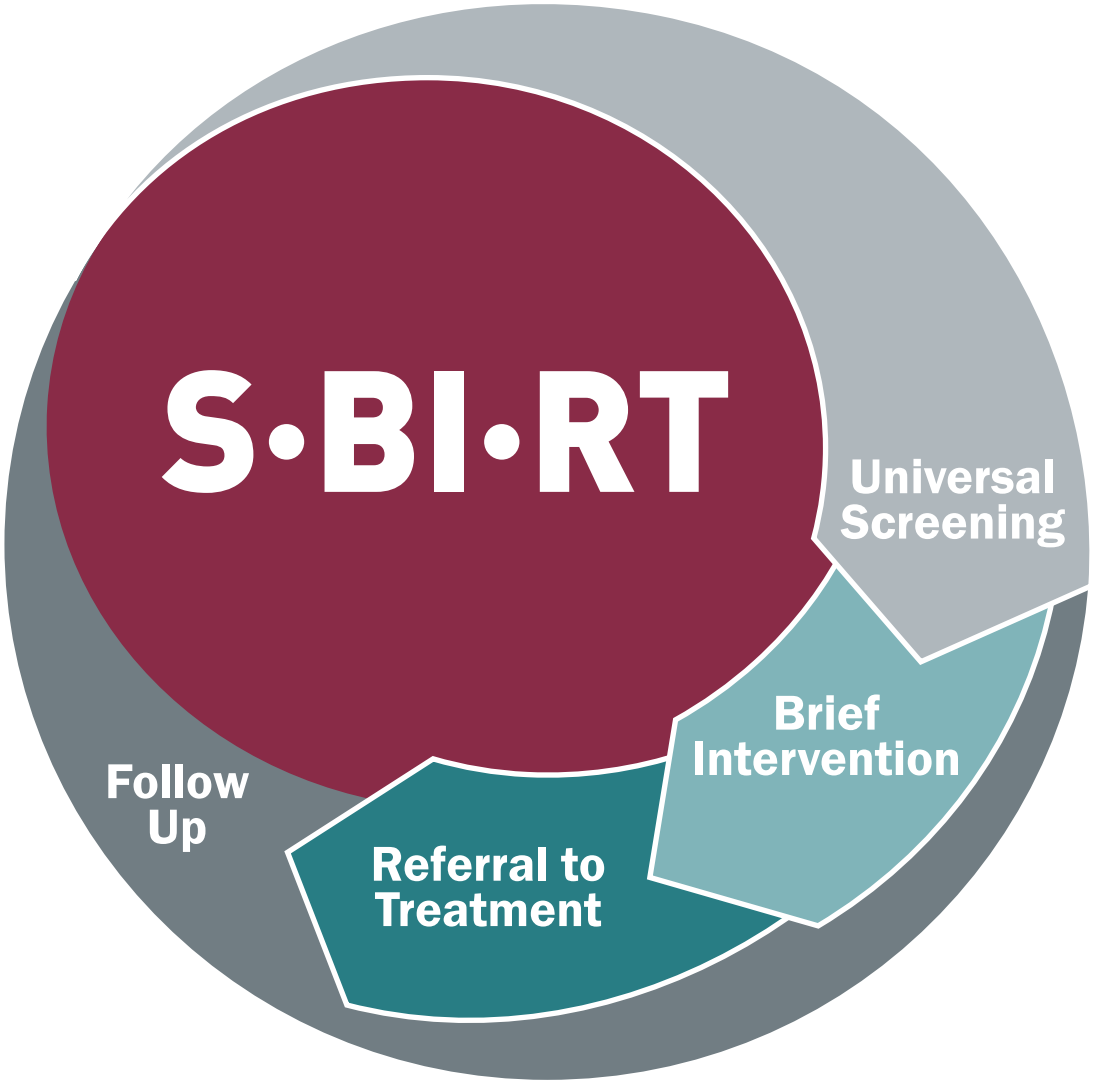
S·BI·RT
Universal Screening
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Referral to Treatment
Follow Up