



NNEPQIN

***A Toolkit for the
Perinatal Care of People
with Substance Use Disorders***

A TOOLKIT FOR THE PERINATAL CARE OF PREGNANT AND POSTPARTUM PEOPLE WITH SUBSTANCE USE DISORDERS

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



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

This toolkit was initially developed in 2017 by a multidisciplinary group of obstetric, pediatric, neonatal, and addiction treatment clinicians, initially to assist front-line perinatal care providers improve the quality and safety of care provided to pregnant and post partum people with opioid use disorders in northern New England. Funding for toolkit development and testing was generously provided by the New England Chapter of the March of Dimes. Over the past several years the focus has changed from perinatal opioid use to polysubstance use, and content has been added including sections on methamphetamine, alcohol and tobacco.

This toolkit builds upon the work of many dedicated professionals across the northern New England region. It is designed to facilitate implementation of evidence-based practice, to optimize the care of this vulnerable population. Toolkit content is aligned with recent national guidelines published by the Alliance for Innovation in Maternal Health (AIM) Patient Safety Bundle for the Obstetric Care of Women with Opioid Use Disorder (2018) and Care for Pregnant and Postpartum People with Substance Use Disorder (2021), and the SAMHSA Clinical Guidance for the Perinatal Care of Women with Opioid Use Disorder (2018). Our aim is to accelerate the application, spread and sustainability of these guidelines, promote an evidence-based and contextually sensitive approach, and improve outcomes for both birthing people and babies. We hope that its content will prove useful to you!

Language Disclaimer: Throughout this toolkit, the authors have chosen to use gender inclusive language in order to affirm birthing people of all gender identities and backgrounds. Some resources that are not proprietary to NNEPQIN use gender specific language and these were not changed because they are proprietary. Where research is cited, using the term “women”, the authors have assumed that it refers to “cisgender women” and may or may not reflect the experiences of trans and/or nonbinary birthing people.

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

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SECTION 1

RESPECTFUL PERINATAL CARE FOR PEOPLE WITH SUBSTANCE USE DISORDERS

Stigma, bias and discrimination impact the ability of pregnant and postpartum people with substance use disorders (SUDs) to get high quality care. In 2021, the [Alliance for Innovation in Maternal Health \(AIM\)](#) published a revised Patient Safety Bundle for the Care of Pregnant and Postpartum People with Substance Use Disorders. This toolkit aims to provide healthcare teams and health systems in New Hampshire with needed resources to ensure all people have access to comprehensive, supportive, equitable, and evidence-based perinatal services.

Although substance use disorders affect pregnant people in all demographic groups, not all people have equitable access to necessary services. Racism and discrimination against LGBTQ2S+ individuals, low income, and rural people impact their ability to access high quality treatment and patient-centered pre- and postnatal care. Therefore, AIM calls on every healthcare system to develop trauma-informed protocols and antiracism trainings to address team member biases and ensure a respectful care environment where all pregnant people are welcomed, including pregnant people with SUD.

This toolkit was designed and developed through collaboration between the Northern New England Perinatal Quality Improvement Network (NNEPQIN) and the New Hampshire Community Health Institute, with the generous support from the March of Dimes and the New Hampshire Charitable Foundation.

1. Alliance for Innovation on Maternal Health (AIM) Initiative



The Alliance for Innovation in Maternal Health (AIM) is a coalition of over 30 organizations working toward reducing preventable maternal mortality and severe morbidity across the U.S. AIM is funded through the federal Health Resources and Services Administration and facilitated by the American College of Obstetricians and Gynecologists (ACOG). AIM's multidisciplinary groups of national experts compile best practices around maternal health conditions and strategies for their implementation to form maternal safety bundles. Metrics for the AIM bundles assist facilities in the process of data driven quality improvement.

In 2017, AIM published the bundle “Obstetric care for women with opioid use disorder” followed by the development of web-based resources including clinical pathways. In 2021, the bundle was revised to address perinatal substance use disorders more generally. NNEPQIN has been a contributor to this AIM bundle and revision, and are proud to be an early adopter. [\[link to AIM SUD bundle and implementation guide here\]](#)



SECTION 2:
SCREENING AND ASSESSMENT

Section 2: Screening and Assessment

The Northern New England Perinatal Quality Improvement Network (NNEPQIN) promotes the recommendations of organizations like the World Health Organization, the American College of Obstetricians and Gynecologists, the American Society of Addiction Medicine, and the American College of Nurse Midwives to screen all pregnant patients for use of alcohol, Choo, R. E., Huestis, M. A., Schroeder, J. R., Shin, A. S., & Jones, H. E. (2004). Neonatal abstinence syndrome in methadone-exposed infants is altered by level of prenatal tobacco exposure. Drug and alcohol dependence, 75(3), 253-260., and other substances at entry to obstetric care, during the third trimester and at delivery. Screening should be conducted using a validated instrument, and a screening, brief intervention, and referral for treatment (SBIRT) framework. This section provides an overview of the SBIRT framework along with examples of validated screening tools and other helpful templates.

In addition, this section references resources to screen for other social determinants, including intimate partner violence. Identifying other needs and linking pregnant patients with substance use disorder (SUD) to available resources can enhance overall care and improve outcomes.

1. [Screening, Brief Intervention, and Referral to Treatment \(SBIRT\)](#)

1.1. [Provider Materials](#)

- 1.1.1. [Brief Negotiated Interview \(BNI\) During Pregnancy](#)
- 1.1.2. [Coding and Billing for Substance-Related Services](#)
- 1.1.3. [NH SBIRT Implementation Playbook for Perinatal Providers](#)
- 1.1.4. [Boston University BNI and Example Screening Tool](#)
- 1.1.5. [BNI Training Video](#)
- 1.1.6. [American Society of Addiction Medicine \(ASAM\) Levels of Care](#)
- 1.1.7. [Consent to Share Information with Treatment Providers](#)

1.2. [Patient Materials](#)

- 1.2.1. [Sample Patient Orientation Letter](#)
- 1.2.2. [State and Local Treatment Resources Template](#)

2. [Screening for Social Determinants of Health](#)

2.1. [Provider Materials](#)

- 2.1.1. [PRAPARE](#)
- 2.1.2. [Screening Technical Assistance and Resource \(STAR\) Center Toolkits](#)

3. [Screening for and Responding to Disclosure of Intimate Partner Violence](#)

3.1. [Provider Materials](#)

- 3.1.1. [Partner Violence Screen \(PVS\)](#)
- 3.1.2. [Woman Abuse Screening Tool \(WAST\)](#)
- 3.1.3. [ICD Diagnosis Codes](#)
- 3.1.4. [Mental Health and Substance Use Coercion Surveys-Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline](#)
- 3.1.5. [CDC Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings](#)
- 3.1.6. [IPVHealth.Org](#)

4. [Screening for Co-Occurring Psychiatric Disorders](#)

4.1. [Provider Materials](#)

- 4.1.1. [Massachusetts Child Psychiatry Access Project \(MCPAP\) Toolkit](#)
- 4.1.2. [Learning Collaborative Session- Treatment of Co-Occurring Mental Health Disorders](#)
- 4.1.3. [MGH Women's Mental Health Program](#)
- 4.1.4. [MotherToBaby](#)
- 4.1.5. [Primary Care Posttraumatic Stress Disorder \(PTSD\) Screener](#)
- 4.1.6. [PHQ-9 Patient Depression Questionnaire](#)
- 4.1.7. [GAD-7 Generalized Anxiety Disorder 7-Item Scale](#)

- 4.1.8. [Center for Epidemiologic Studies Depression Scale \(CES-D\)](#)
- 4.2. [Patient Materials](#)
 - 4.2.1. [Postpartum Depression and Anxiety Handout](#)
 - 4.2.2. [Information on Postpartum Depression](#)
 - 4.2.3. [Postpartum Support International](#)
 - 4.2.4. [Mental Health Self-Care Guides for Reproductive Mental Disorders](#)

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Note: This section is designed to be used as a companion to the [NNEPQIN guideline](#): Screening for Alcohol, Tobacco & Drug Use During Pregnancy

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

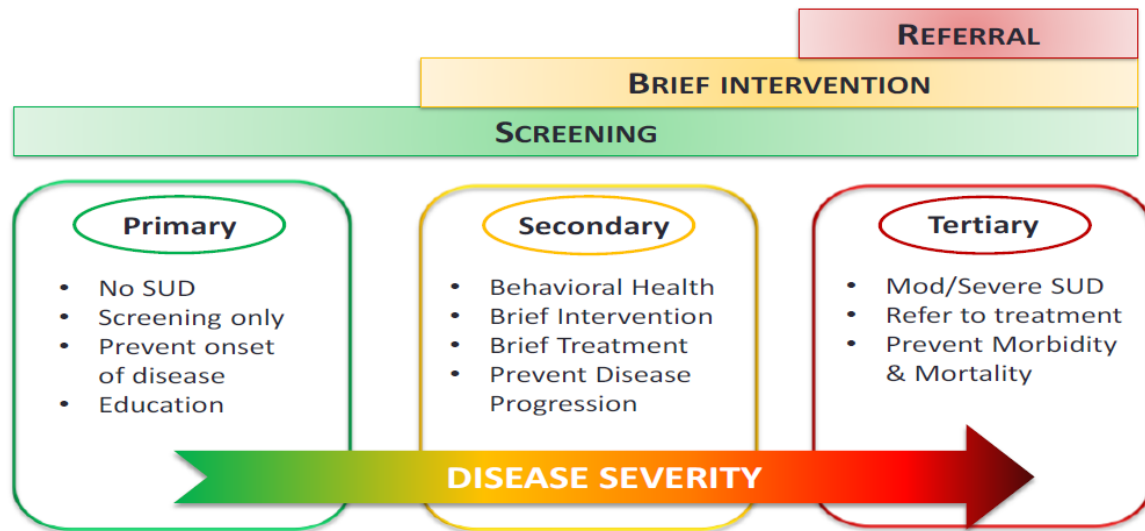
Perinatal substance use exists across all sociodemographic groups. (National Survey on Drug Use and Health, 2015) NNEPQIN recommends a population based approach, in which all pregnant people are screened at entry to maternity care and again in the third trimester and at delivery. It is the responsibility of all maternity care providers to ensure that pregnant people who are at increased risk for perinatal substance use have access to follow up assessment, intervention, and are linked to services. A number of screening tools have been validated for use during pregnancy:

- Substance Use Risk Profile
- Alcohol Use Disorders Identification Test-Concise (AUDIT-C)
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT for women under age 26)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Parents, Partner, Past, and Present (4 Ps) Plus

(Bush, et al, 1998; Chang, et al 2011; Chasnoff, et al, 2005; Hotham, et al, 2013; Yonkers, et al, 2011)

NNEPQIN along with other national organizations recommends universal screening for drug and alcohol use at the initiation of prenatal care, using validated instrument(s) and a screening, brief intervention, referral for treatment (SBIRT) framework (Guidelines for Screening for Alcohol, Tobacco, and Drug Use During Pregnancy, 2017). The aim of population based screening is to identify pregnant and parenting people who use drugs or alcohol, to provide counseling about harm reduction, support decreasing and eliminating use, arrange follow up, and make appropriate referrals as indicated by the level of need. The SBIRT approach is specifically recommended in [Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants](#) (SAMHSA, 2018).

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



SBIRT PROCESS: SCREENING

- All pregnant people should be screened using a validated instrument.
- All pregnant people should be informed about the health system's policy on prenatal drug, tobacco, and alcohol use at the first prenatal encounter, as part of their orientation to the practice (see example patient letter 1.2.1 under Patient Resources)
- Screening for substance use should be conducted while a person is alone or accompanied only by young children
- Creating space for confidential screening allows providers to ask questions about other sensitive topics such as reproductive health history, and to safely screen pregnant and postpartum people for domestic violence
 - If a person cannot be confidentially screened, screening should be deferred
- Timing of screening
 - Screening should be done at initiation of prenatal care, and repeated in the third trimester
 - Screening should also be repeated on admission for delivery
- A number of substance use screening tools have been validated for use during pregnancy. The best tool is the one which is easy to use in a given context
- A positive screen does not equate to a diagnosis of a substance use disorder, but rather to the need for further exploration about risk of substance exposure during pregnancy

SBIRT PROCESS: BRIEF INTERVENTION

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

- Pregnant people who screen positive for prenatal drug or alcohol use should meet with an obstetric provider for brief intervention and a discussion about follow up. When indicated, a referral should be made to the appropriate level of care (see decision tree, below).
- If a person has discontinued substance use due to pregnancy, brief advice should consist of congratulating them, and explore strategies to avoid return to risky use during pregnancy and after the baby is born.
- In providing a brief intervention, providers should strive to use evidence based approaches such as the Brief Negotiated Interview described below. Providing a brief intervention does not require extensive training in Motivational Interviewing skills.
- The obstetric provider performing the brief intervention should provide information to a pregnant person about and document discussion regarding:

- Potential harm of identified substance(s) to the fetus and newborn
- Discuss specific risks of identified substances used with breastfeeding and while parenting (e.g., sleepiness increasing risk for unsafe sleep, Sudden Infant Death Syndrome (SIDS), not able to attend fully to baby's needs)
- Explore indications for and acceptance of follow up care, including referral to Behavioral Health or Addiction Medicine specialist
- Review institutional policy regarding urine toxicology testing during pregnancy and upon admission for labor
- Review institutional policy regarding collection of maternal and newborn urine and newborn umbilical cord, and/or meconium toxicology testing.
- Advise patients regarding Federal and State requirements for mandated reporting and development of a Plan of Safe Care/ Family Care Plan for newborns who have been exposed to substances
- Offer referral to case management/social worker if available at institution to address social determinants of health needs

SBIRT PROCESS: REFERRAL TO TREATMENT

Intensity of use, availability of treatment options, and conflicting responsibilities and preferences are critical factors in determining the appropriate level of care for a pregnant person in need of treatment for substance use disorders. Most people are highly motivated to seek treatment during pregnancy, and a shared decision making approach is essential to ensure that the treatment plan developed is feasible and acceptable. Maternity care practices should maintain a list of substance use treatment providers who accept a variety of insurance types. A simple algorithm (below) outlines key steps in this discussion. Follow up assessments are listed in Section 1 of this toolkit. Readers are encouraged to review [Factsheet 2 of *Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*](#) (SAMHSA, 2018, pp25-33) for supporting evidence and clinical considerations relevant to this discussion.

Treatment for substance use disorders are available at different levels of intensity and duration. Access to treatment specific for pregnant people varies widely by region. Some programs do not have specific programming for pregnant people, and many do not allow children to accompany their parents.

Medication Assisted Treatment (MAT)

Medications used to help with withdrawal symptoms, cravings and to prevent the use of alcohol, tobacco, opioids, and other drugs. These medications may be prescribed in combination with counseling services.

Medication for Opioid Use Disorder (MOUD)

Medications used to reduce withdrawal symptoms, cravings, and prevent use of non-prescribed opioids. Methadone, buprenorphine, and naltrexone are commonly prescribed as MOUD. Both methadone and buprenorphine are commonly used to treat prenatal OUD, but data is lacking on the safety and efficacy of naltrexone during pregnancy.

Considerations for Detoxification:

Outpatient: Symptoms of withdrawal may be managed in an outpatient setting if an individuals' withdrawal symptoms are not life threatening (e.g. severe-level physiologic dependence on alcohol or benzodiazepines) and supports are available to help manage their symptoms without the need of a supervised setting. Withdrawal symptoms are managed by medical staff with medications prescribed as needed.

Residential (non-hospital): Symptoms of withdrawal may be managed in a residential, non-hospital setting if an individuals' withdrawal symptoms are not life threatening but a supervised setting is needed to control their access to alcohol and other drugs. Individuals must be cleared medically to seek care in a residential setting due to medical staff not being available on site. Staff may hold prescribed medication and observe self-administration.

Inpatient: Symptoms of withdrawal must be managed in an inpatient, hospital setting if an individuals' withdrawal symptoms are potentially life threatening (e.g. severe alcohol withdrawal) and require 24 hour medical care. Medical staff monitor withdrawal symptoms and medications are used to manage symptoms and reduce risk.

*Source: New Hampshire Bureau of Drug and Alcohol Services

Intensive outpatient programs (IOP)

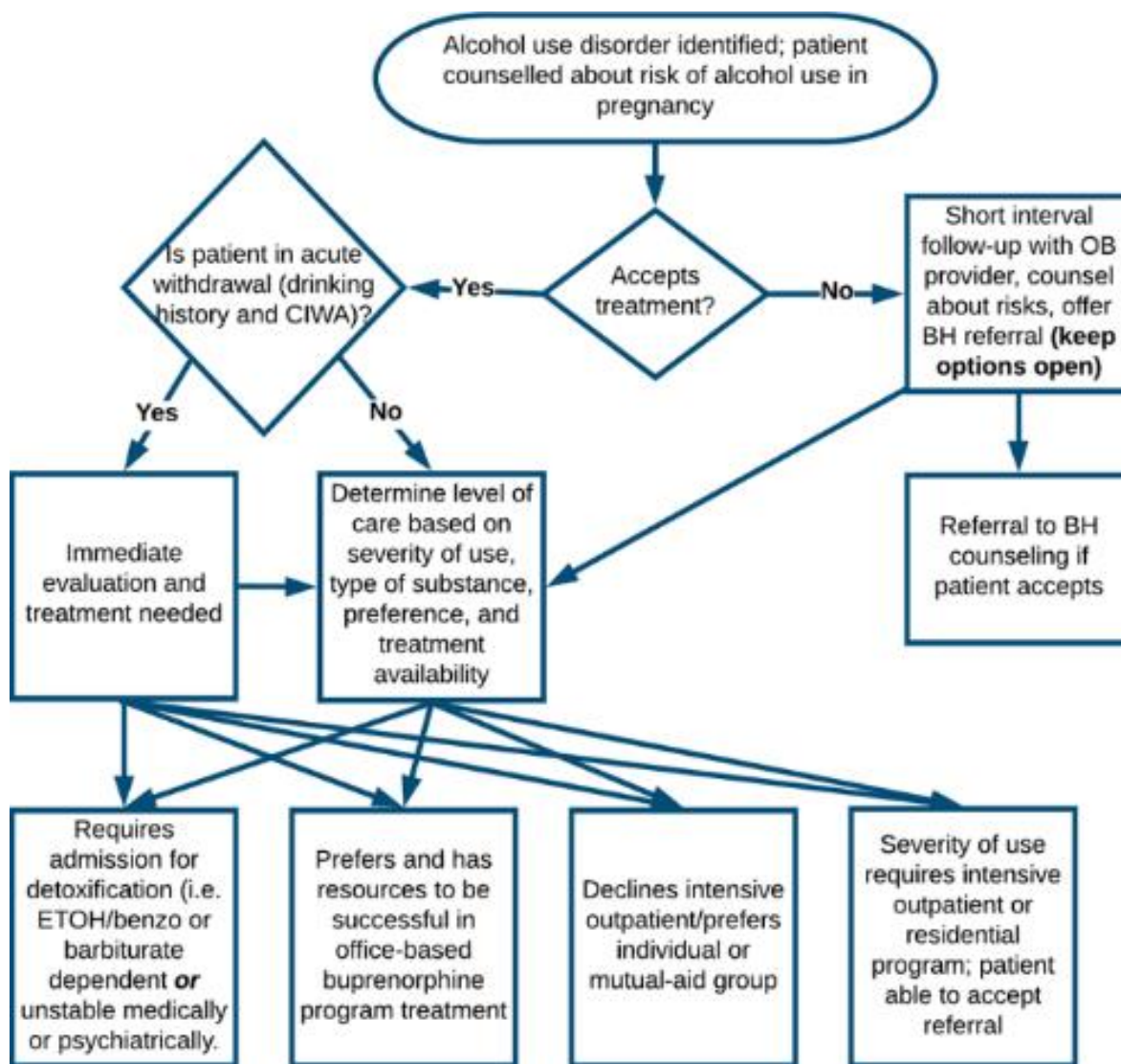
This service may involve structured individual, group, and family counseling, education, case management, and psychiatric services. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week.

Residential Services

Onsite full-time programs for individuals who are unable to achieve their goals in their current environment. Services may involve structured individual, group, and family counseling, education, case management, and psychiatric services. The length of the program should be based on the needs of the individual but is often driven by reimbursement, bed demand, etc.

Algorithm for determining appropriate level of substance use care

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



DEVELOPING AN SBIRT PROCESS IN THE MATERNITY CARE CONTEXT

SBIRT implementation requires modification of existing clinic workflows. Each context is different. Incorporating SBIRT into the existing intake process for new obstetrics (OB) patients, which includes screening for other medical risks is recommended.

Brief description of a typical SBIRT implementation process

1. SBIRT Preparation:

- Review institutional policies and update as needed to include use of the SBIRT framework for prenatal patients
- Develop a plan for modifying workflow to incorporate screening
- Train appropriate staff for screening process
- Train appropriate staff in brief intervention techniques
- Identify follow up plan and key personnel when screening is positive
- Create a list of resources to support women in need of referrals for substance use
- Identify billing requirements and opportunities
- Develop patient information script or written materials about substance use screening and institutional policies on substance use

2. Implementation:

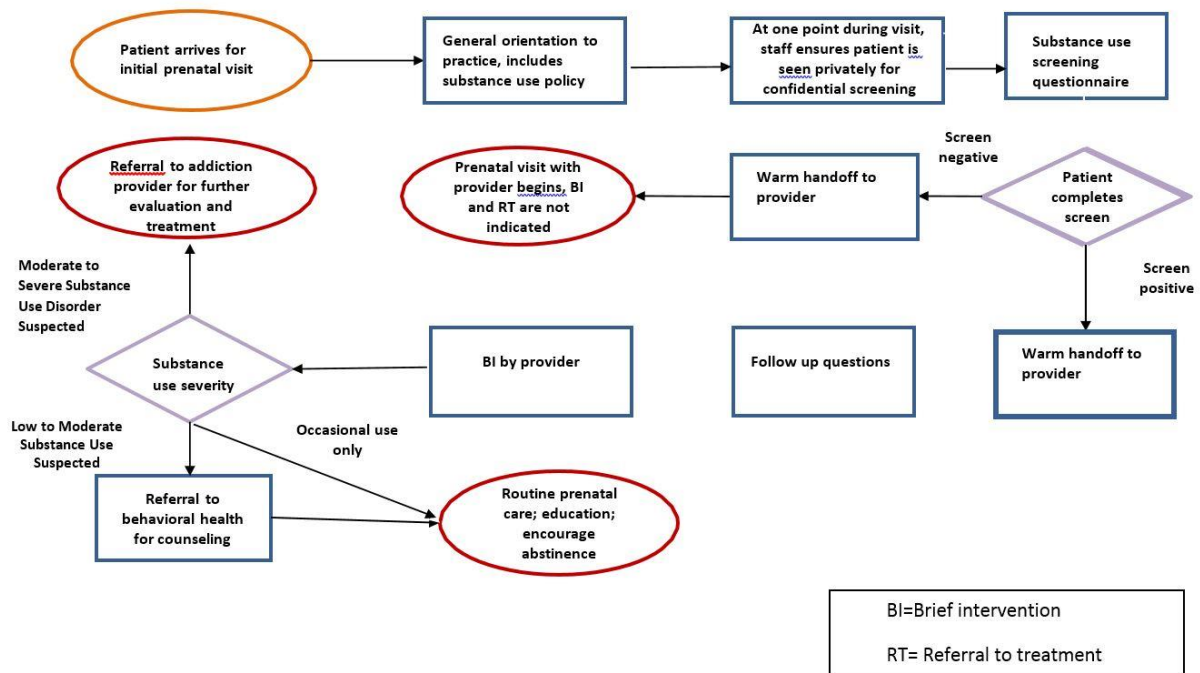
- Implement workflow modification to include confidential screening and response
- Provide information about institutional substance use policy as part of new patient orientation
- Screen using a validated questionnaire on paper, or the electronic equivalent
- Ensure a warm handoff occurs from staff performing screening to staff who will address positive screening results
- Implement Brief Negotiated Interview [BNI] algorithm following positive screening
- Develop a follow up plan when screening is positive
- Make referrals if needed
- Plan follow up at next visit

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

Guidance regarding follow up assessment after a pregnant person discloses an opioid use disorder is discussed in Factsheet 1 of the SAMHSA [Clinical Guidance](#) document (SAMHSA, 2018, pp 17-24)

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

Process Map for SBIRT at Initial OB Visit



1.1. Provider Materials

1.1.1. BRIEF NEGOTIATED INTERVIEW (BNI) DURING PREGNANCY: MODIFIED FROM THE BNI-ART INSTITUTE BY CAITLIN BARTHELMES, MPH (*USED WITH PERMISSION*)

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

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

1.1.2. CODING AND BILLING FOR SUBSTANCE-RELATED SERVICES

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

1. **SBIRT**

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

2. **Tobacco Counseling**

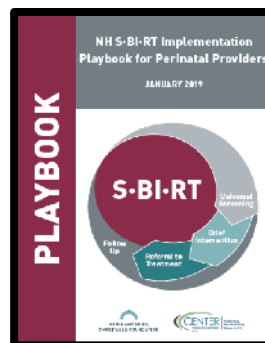
- Bill as “additional E&M code”
 - If 3-10 minutes = 99406
 - If > 10 minutes = 99407
- Must be face to face
- Include sufficient documentation to support time spent; reference the patient’s willingness to change, and describe the plan formulated during the discussion
- Include tobacco-related diagnosis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

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

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

1.1.3 NH SBIRT IMPLEMENTATION PLAYBOOK FOR PROVIDERS

Provides a compendium of actions and/or strategies to support implementation of SBIRT 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 SBIRT implementation based on the unique context of each organization and site.



<https://sbirtnh.org/wp-content/uploads/2019/02/perinatal-playbookFINALdig-2.pdf>

1.1.4. BOSTON UNIVERSITY BNI AND EXAMPLE SCREENING TOOL

The Brief Negotiated Interview (BNI) developed by the Boston University School of Public Health is a simple approach designed to help providers quickly explore a patient's motivation to change behavior, while eliciting action steps from the patient.

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

1.1.5. BNI TRAINING VIDEO

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



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

1.1.6. AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) LEVELS OF CARE

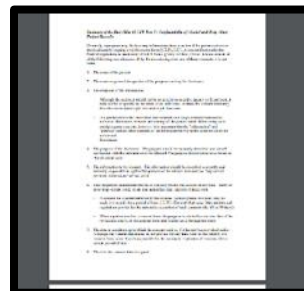
Additional information about the levels of care for the treatment of substance use disorders.



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

1.1.7. CONSENT TO SHARE INFORMATION WITH TREATMENT PROVIDERS

Once a substance use disorder has been diagnosed and a patient is referred for treatment, consent to share information between members of the care team is essential. Additional federal rules protect the privacy and confidentiality of substance use treatment records. A summary of these rules and sample consent forms may be accessed from the Providers Clinical Support System (<https://pcssnow.org/>) and the American Osteopathic Academy of Addiction Medicine.



https://aoaam.org/resources/Documents/ClinicalTools/Sample_Consent_for_release_o.pdf

1.2. Patient Materials

1.2.1. 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.

If you are a smoker and have been unable to quit, please let us know if you would like a nicotine replacement (patches, gum or lozenges) while you are at our tobacco free campus.

Some 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, fentanyl, or oxycodone cause symptoms of withdrawal in newborn babies
- Marijuana may cause problems with learning and depression as children get older
- Drug and alcohol use may affect your ability to care for your newborn baby

Federal law requires healthcare providers to develop a Plan of Safe Care/Family Care Plan when a baby is born affected by drug or alcohol use, including treatment medication that may cause withdrawal. This is intended to get people the help they need, and is not the same as a report to Child Protection Services. Our team would be happy to talk more with you about the information shared here! We are here to help.

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

[Your Ob/Gyn Team]

1.2.2. STATE AND LOCAL TREATMENT RESOURCES TEMPLATE

(Name of Provider)

(Address)

(Contact phone number)

STATE TREATMENT RESOURCES

NH Treatment Locator: www.nhtreatment.org

VT Treatment Locator: <http://www.healthvermont.gov/adap/treatment/opioids/index.aspx>

ME Treatment Locator: <http://www.maine.gov/dhhs/samhs/help/index.shtml>

2-1-1 - 211 is New Hampshire's statewide, comprehensive, information and referral service. New Hampshire residents need **only dial 211** to be connected, at no cost, with trained Information and Referral Specialists who can provide them with the health and human service information they need to get help, give help or discover options.

NH Doorway - <https://thedorway.nh.gov/home> - New Hampshire has 9 "Doorways" across the state through which people can ask for help for substance use- whether that be treatment, recovery, or local resources.

Plan of Safe Care (POSC) Materials (ask your provider if a POSC is right for you):

[POSC \(English\)](#), [POSC \(Spanish\)](#)

[POSC Brochure \(English\)](#), [POSC Brochure \(Spanish\)](#)

Note: A warm handoff is key when connecting patients to services. Providers should make referrals to the services and supports the patient may want and provide contact information. This may include medications for the treatment of opioid or alcohol use disorder, SUD treatment services, etc.

Below is a blank template that providers can fill out with local resources for the patient.

LOCAL TREATMENT PROVIDERS:

Office-based Buprenorphine Treatment Programs:

Program Name:

Contact:

Program Name:

Contact:

Program Name

Contact:

Recovery Centers/Recovery Coaches:

Program Name:

Contact:

Licensed Alcohol and Drug Counselors (LADC)

Program Name:

Contact:

Narcotics Anonymous:

Contact:

Methadone Maintenance programs

Program Name:

Contact:

Program Name:

Contact:

Intensive Outpatient Program

Program Name:

Contact:

Program Name:

Contact:

Residential Treatment Program *(Program Accepts Pregnant people)*

Program Name:

Contact:

2. Screening for Social Determinants of Health

“Health workers providing care for [people] with substance use disorders during pregnancy need to understand the complexity of the [person’s] social, mental and physical problems in order to provide appropriate advice and support throughout pregnancy and the postpartum period.”

(World Health Organization, 2014)

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

A statement by the American College of Obstetricians and Gynecologists, calling for integrating screening for social determinants of health in routine pregnant and parenting people’s health care, can be accessed at: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Importance-of-Social-Determinants-of-Health-and-Cultural-Awareness-in-the-Delivery-of-Reproductive>

[In 2021, revised E&M rules were released which allow providers to be reimbursed for medical decision making complicated by social determinants of health, with appropriate documentation. We recommend consulting the coding and compliance advisor at your institution for details \(https://www.cms.gov/files/document/zcodes-infographic.pdf\).](https://www.cms.gov/files/document/zcodes-infographic.pdf)

Some example diagnostic codes for common SDOH concerns:

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances

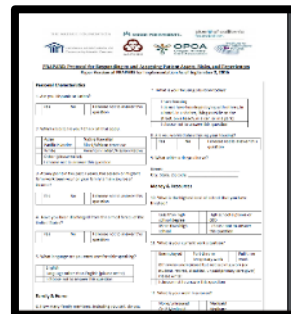
2.1. Provider Materials

2.1.1. PRAPARE

This toolkit was developed and is owned by the National Association of Community Health Centers (NACHC) in partnership with the Association of Asian Pacific Community Health Organization (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF). PRAPARE can be downloaded and used without charge.

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

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



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

2.1.2. SCREENING TECHNICAL ASSISTANCE AND RESOURCE (STAR) CENTER TOOLKITS

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



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

3. Screening for and Responding to Disclosures of Intimate Partner Violence

WHAT IS INTIMATE PARTNER VIOLENCE?

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

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

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

WHY SHOULD THIS BE INCLUDED IN HEALTHCARE?

IPV has serious implications for health and wellbeing of its survivors:

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

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

SCREENING FOR IPV:

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

IF MY PATIENT SCREENS POSITIVE, WHAT SHOULD I DO?

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

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

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

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

National Domestic Violence Hotline

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

(TTY) 1-800-787-3224

www.thehotline.org

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

DOCUMENTATION FOLLOWING A POSITIVE SCREEN:

- Provider notes, especially with objective findings related to trauma may be helpful evidence in custody or divorce proceedings. However, including a diagnosis of adult physical abuse or other documentation in your note can increase risk if the abusive partner has access to your patient's electronic medical records.

3.1. Provider Materials

3.1.1. PARTNER VIOLENCE SCREEN (PVS)

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

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

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

If a pregnant or parenting person answers the PVS screen affirmatively. Please pull the POC2 for Abuse/Violence.

3.1.2. WOMAN ABUSE SCREENING TOOL* (WAST)

1. In general, how would you describe your relationship?
 - ☐ a lot of tension
 - ☐ some tension
 - ☐ no tension
2. Do you and your partner work out arguments with:
 - ☐ great difficulty
 - ☐ some difficulty
 - ☐ no difficulty
3. Do arguments ever result in you feeling down or bad about yourself?
 - ☐ often
 - ☐ sometimes
 - ☐ never
4. Do arguments ever result in hitting, kicking or pushing?
 - ☐ often
 - ☐ sometimes
 - ☐ never
5. Do you ever feel frightened by what your partner says or does?
 - ☐ often
 - ☐ sometimes
 - ☐ never
6. Has your partner ever abused you physically?
 - ☐ often
 - ☐ sometimes
 - ☐ never
7. Has your partner ever abused you emotionally?
 - ☐ often
 - ☐ sometimes
 - ☐ never
8. Has your partner ever abused you sexually?
 - ☐ often
 - ☐ sometimes
 - ☐ never

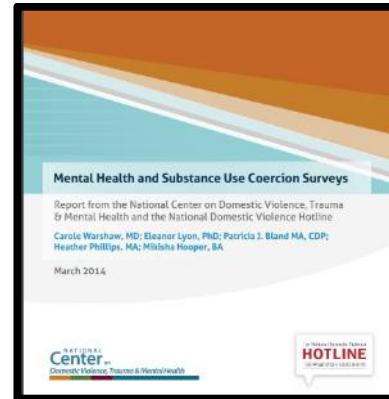
Source: Brown, J., Lent, B., Schmidt, G., & Sas, S. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice*, 49, 896-903.

*his tool is validated for use with pregnant people

3.1.3. ICD DIAGNOSIS CODES

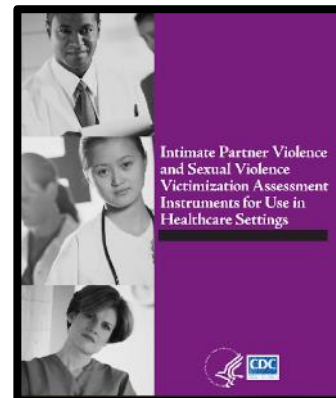
- **2018 ICD-10-CM Diagnosis Code T74.11XA: Adult physical abuse, confirmed, initial encounter**
- **2018 ICD-10-CM Diagnosis Code Z91.410: Personal history of adult physical and sexual abuse**
 - Some EHR systems have the option of hiding documentation to protect highly confidential information, this is recommended if available.

3.1.4. MENTAL HEALTH AND SUBSTANCE USE COERCION SURVEYS-REPORT FROM THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH AND THE NATIONAL DOMESTIC VIOLENCE HOTLINE



http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf

3.1.5. CDC INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE VICTIMIZATION ASSESSMENT INSTRUMENTS FOR USE IN HEALTHCARE SETTINGS



<https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>

3.1.6. IPVHEALTH.ORG

Contains various resources on IPV for healthcare providers from the National Resource Center on Domestic Violence



www.ipvhealth.org

4. Screening for Co-Occurring Psychiatric Conditions

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

Ideally all people with substance use disorders should receive a psychiatric evaluation to ensure that untreated psychiatric needs are met. However, many substance use treatment providers do not include other mental health needs in their initial evaluation, and access to behavioral health and psychiatry is often limited. Therefore, initial screening and consultation should be accomplished in the obstetric or primary care setting. Healthcare providers should be sensitive that trauma history is particularly prevalent among women with substance use disorders, and care should be informed by the assumption that any woman with active SUD is likely to have experienced sexual and/or physical violence in her lifetime.

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

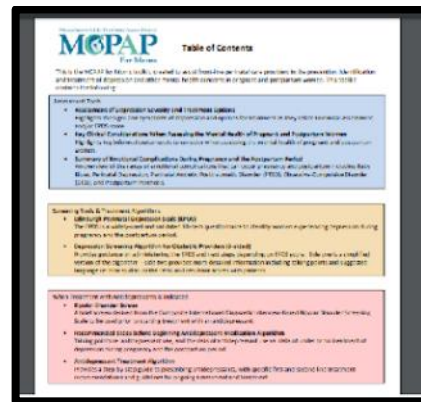
Maternity care providers who are comfortable treating uncomplicated depression, anxiety, and PTSD during pregnancy and postpartum should be aware of potential drug-drug interactions between methadone and antidepressant medications (SSRIs or tricyclics) (SAMHSA, 2018). Benzodiazepines are not indicated for the long term treatment of anxiety or PTSD symptoms, are associated with a neonatal benzodiazepine withdrawal syndrome, and may cause life-threatening respiratory depression for mothers when combined with opioids. Exposure to SSRIs for the treatment of co-occurring depression and anxiety disorders in addition to treatment with buprenorphine or methadone may increase symptoms of NAS/NOWs. However, not treating mental health disorders during pregnancy and postpartum can have serious consequences for both birthing person and baby, and therefore benefits often outweigh risks. Supporting evidence and clinical considerations regarding these decisions can be found in [Factsheet 5 of SAMHSA'S *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants*](#) (SAMHSA, 2018, pp 42-44).

4.1 Provider Materials

4.1.1 MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT (MCPAP) TOOLKIT

MCPAP provides a publicly available toolkit for assessment and management of uncomplicated perinatal mood disorders. Resources include:

- Scoring and follow up for Edinburgh Postnatal Depression Scale
- Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
- Complications during Pregnancy and the Postpartum Period

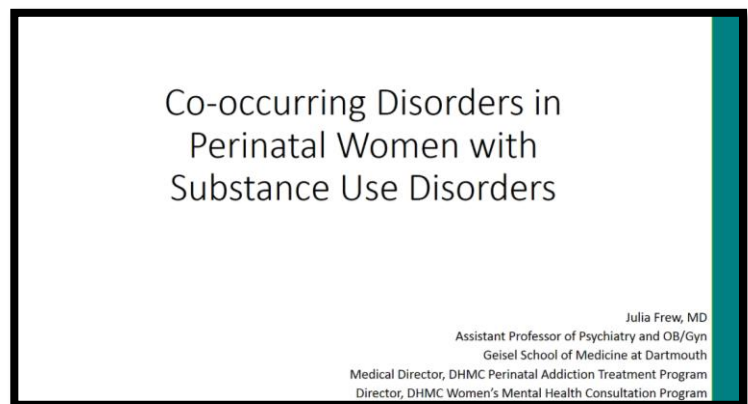


<https://www.mcpapformoms.org/Docs/Adult%20Toolkit.pdf>

4.1.2 LEARNING COLLABORATIVE SESSION ON TREATMENT OF CO-OCCURRING MENTAL HEALTH DISORDERS

Dr. Julia Frew, Assistant Professor, Geisel School of Medicine and Medical Director of the Dartmouth-Hitchcock Perinatal Addiction Treatment Program

May 11, 2017



<https://dhvideo.webex.com/dhvideo/ldr.php?RCID=41ad25307bbc0b6a3333885938808c22>

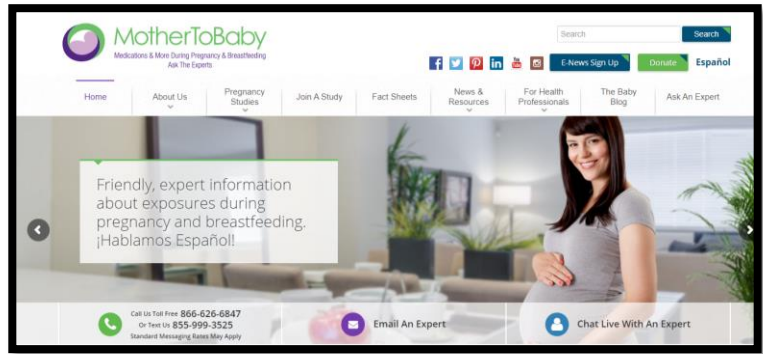
4.1.3 MGH WOMEN'S MENTAL HEALTH PROGRAM



<https://womensmentalhealth.org/>

4.1.4 MOTHERTOBABY

Organization of Teratology Information Specialists.
Useful info on psychiatric medications in pregnancy,
including patient handouts



<https://mothertobaby.org/>

4.1.5 PRIMARY CARE POSTTRAUMATIC STRESS DISORDER (PTSD) SCREENER

Primary Care PTSD Screen (PC-PTSD)

Description
The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered 'positive' if a patient answers 'yes' to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
YES / NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
YES / NO
3. Were constantly on guard, watchful, or easily startled?

<https://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf>

4.1.6 PHQ-9 PATIENT DEPRESSION QUESTIONNAIRE

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3

<https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218>

4.1.7 GAD-7 GENERALIZED ANXIETY DISORDER 7-ITEM SCALE

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____

<https://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>

4.1.8 CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE (CES-D)

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

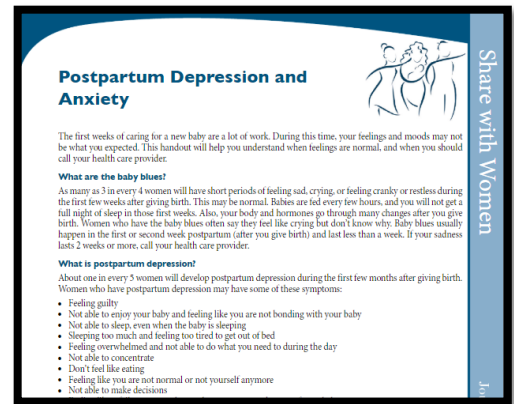
	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I did not feel like eating; my appetite was poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt that I could not shake off the blues even with help from my family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I felt I was just as good as other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I thought my life had been a failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<http://www.chcr.brown.edu/pcoc/cesdscale.pdf>

4.2 Patient Materials

4.2.1 POSTPARTUM DEPRESSION AND ANXIETY HANDOUT

American College of Nurse Midwives. Postpartum Depression. J Midwifery and Women's Health 2014; 58; 6



<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12949>

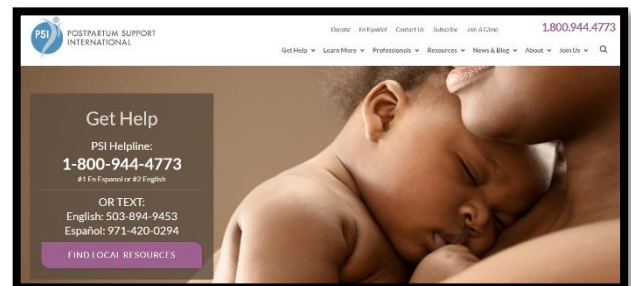
4.2.2 INFORMATION ON POSTPARTUM DEPRESSION

American College of Obstetricians and Gynecologists



<https://www.acog.org/Patients/FAQs/Postpartum-Depression>

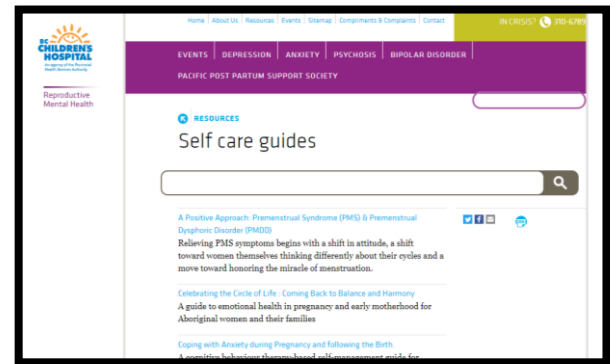
4.2.3 POSTPARTUM SUPPORT INTERNATIONAL



www.postpartum.net

4.2.4 MENTAL HEALTH SELF-CARE GUIDES FOR REPRODUCTIVE MENTAL DISORDERS

Cognitive Behavior Therapy



[https://reproductivementalhealth.ca/
resources/self-care-guides](https://reproductivementalhealth.ca/resources/self-care-guides)



SECTION 3:
TOOLS BY SUBSTANCE

Section 3: Tools organized by Substance Type

Treatment of a pregnant person with a substance use disorder should be individualized, and also reflect current evidence about effectiveness with regards to the substance(s) used. This section provides information about perinatal SUD care by substance.

1. [Opioids](#)

1.1. [Provider Materials](#)

- 1.1.1. [Neonatal Abstinence Syndrome \(NAS\)](#)
- 1.1.2. [Medication Assisted Treatment for Opioid Use Disorder Pocket Guide](#)

1.2. [Patient Materials](#)

- 1.2.1. [Sample Letter #1 to Patient about NAS](#)
- 1.2.2. [Sample Letter #2 to Patient about NAS](#)
- 1.2.3. [NAS Pamphlet-Caring for your Newborn](#)
- 1.2.4. [Opioid use and pregnancy](#)
- 1.2.5. [Opioid use, labor, and childbirth](#)
- 1.2.6. [Neonatal Abstinence link for parents from March of Dimes](#)

2. [Naloxone](#)

2.1. [Provider Materials](#)

- 2.1.1. [Sample Naloxone prescription](#)
- 2.1.2. [Sample Naloxone Policy](#)
- 2.1.3. [General information about Naloxone](#)
- 2.1.4. [SAMHSA Health Professionals Toolkit for Expanding Access to Naloxone](#)
- 2.1.5. [How to use Naloxone](#)
- 2.1.6. [State supported access to Naloxone in New Hampshire](#)
- 2.1.7. [State supported access to Naloxone in Vermont](#)

3. [Marijuana](#)

3.1. [Provider Materials](#)

- 3.1.1. [Current Research from the National Institute on Drug Abuse](#)

3.2. [Patient Materials](#)

- 3.2.1. [Risks of Marijuana Use during Pregnancy and Breastfeeding](#)
- 3.2.2. [Today is For Me Campaign](#)
- 3.2.3. [Cannabis/Marijuana and pregnancy](#)

4. [Alcohol](#)

4.1. [Provider Materials](#)

- 4.1.1. [Addressing Fetal Alcohol Spectrum Disorders \(FASD\)](#)
- 4.1.2. [National Organization on Fetal Alcohol Syndrome \(NOFAS\)](#)
- 4.1.3. [Public Awareness Fact Sheet on FAS from NOFAS](#)
- 4.1.4. [The Arc: Fetal Alcohol Spectrum Disorders Prevention Project](#)
- 4.1.5. [Substance Abuse and Mental Health Services Administration: Treatment Improvement Protocols](#)
- 4.1.6. [Evidence-based "Choices" curriculum for FASD prevention](#)

4.2. [Patient Materials](#)

- 4.2.1. [Today is For Me](#)
- 4.2.2. [Centers for Disease Control information and infographics](#)
- 4.2.3. [March of Dimes](#)
- 4.2.4. [National Organization on Fetal Alcohol Syndrome](#)
- 4.2.5. [The Arc: Fetal Alcohol Spectrum Disorders Prevention Project](#)

- 5. [Tobacco](#)
 - 5.1. [Provider Materials](#)
 - 5.1.1. [Quick Reference for tobacco counseling from Centers for Disease Control](#)
 - 5.1.2. [New Hampshire QUITWORKS](#)
 - 5.1.3. [Vermont 802quits](#)
 - 5.1.4. [Strategies for treating tobacco use for patients with other addictive disorders](#)
 - 5.1.5. [Information on prenatal tobacco risk](#)
 - 5.1.6. [No-cost virtual provider training on best practice for smoking cessation](#)
 - 5.2. [Patient Materials](#)
 - 5.2.1. [Information on prenatal tobacco risk](#)
 - 5.2.2. [New Hampshire QUITnow](#)
 - 5.2.3. [Vermont 802quits](#)
 - 5.2.4. [EPA Smoke-Free Homes Community Action Toolkit](#)
 - 5.2.5. [EPA “smoke free home pledge” for families](#)
 - 5.2.6. [Patient education fact sheet from American College of Nurse Midwives \(ACNM\)](#)
 - 5.2.7. [Smoking during pregnancy fact sheet from March of Dimes](#)
- 6. [Methamphetamines and Other Stimulants](#)
 - 6.1.1. [Provider Materials](#)
 - 6.1.2. [Patient Materials](#)
- 7. [Polysubstance Use](#)
 - 7.1. [Patient Materials](#)
 - 7.1.1. [March of Dimes](#)
- 8. [Synthetic Cathinones \(“Bath Salts”\)](#)
 - 8.1. [Provider Materials](#)
 - 8.1.1. [National Institute on Drug Abuse](#)
 - 8.2. [Patient Materials](#)
 - 8.2.1. [A Drug Called “Bath Salts” Brochure](#)

1. Opioids

SCREENING AND DIAGNOSIS OF OPIOID USE DISORDER

Please see Section 1- Screening and Assessment for more detailed information about the screening process

1) CRITERIA FOR A PRESUMED DIAGNOSIS OF OPIOID USE DISORDER (OUD)

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

DSM-V DIAGNOSTIC CRITERIA	PRESENT/DATE	COMMENTS
1. Opioids are often taken in larger amounts or over a longer period than was intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.		
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.		
4. Craving, or a strong desire or urge to use opioids.		
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.		
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.		
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.		
8. Recurrent opioid use in situations in which it is physically hazardous.		
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.		
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount. (This may also be true for those taking prescribed opioids, in which case this should not be considered diagnostic of opioid use disorder)		
11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal). b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms (see above – this may also hold true for those taking prescribed opioids).		

*for pregnant patients, symptoms do not have to be present for >12 months to meet criteria for diagnosis.

The severity of Opioid Use Disorder can be estimated from this table, using the levels described below:

- Mild: Presence of 2–3 symptoms
- Moderate: Presence of 4–5 symptoms
- Severe: Presence of 6 or more symptoms

The clinical opioid withdrawal scale (COWS) may be used to measure severity of symptoms in patients who present in acute withdrawal from opioids. A copy of the COWS checklist can be downloaded here:

<https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf>

2) Levels of care for the treatment of Opioid Use Disorders (OUD)

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

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

SUPPORTING EVIDENCE AND EXPERT CLINICAL GUIDANCE FOR INITIATING AND MANAGING PHARMACOTHERAPY FOR OUD DURING PREGNANCY CAN BE FOUND IN FACTSHEETS 2-4 OF [CLINICAL GUIDANCE FOR TREATMENT OF PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS](#) (SAMHSA, 2018, PP 25-41).

Treatment for opioid use disorders during pregnancy may occur at several levels of intensity and duration described below. Access to pregnancy-specific treatment varies widely by region. Some programs may not accept pregnant people, and many do not allow children to accompany their parents.

Detoxification*

Outpatient: Symptoms of withdrawal may be managed in an outpatient setting if an individuals' withdrawal symptoms are not life threatening and supports are available to help manage their symptoms without the need of a supervised setting. Withdrawal symptoms are managed by medical staff with medications prescribed as needed.

Residential (non-hospital): Symptoms of withdrawal may be managed in a residential, non-hospital setting if an individuals' withdrawal symptoms are not life threatening but a supervised setting is needed to control their access to alcohol and other drugs. Individuals must be cleared medically to seek care in a residential setting due to medical staff not being available on site. Staff may hold prescribed medication and observe self-administration.

Inpatient: Symptoms of withdrawal may be managed in an inpatient, hospital setting if an individuals' withdrawal symptoms require 24 hour inpatient care. Medical staff monitor withdrawal symptoms and medications are used to manage symptoms.

**Source: New Hampshire Bureau of Drug and Alcohol Services*

Medication Assisted Treatment

FDA approved medications for opioid use disorder are buprenorphine/naloxone, buprenorphine monotherapy, and extended-release injectable naltrexone. Physicians can complete training to be eligible for a waiver to prescribe buprenorphine for this purpose. Changes in Federal legislation also allows Nurse Practitioners, Physicians Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives to obtain a buprenorphine waiver.

Opioid Treatment Programs

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

Intensive outpatient programs (IOP)

This service may involve structured individual, group, and family counseling, education, case management, and psychiatric services. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week

Residential Services

Onsite full-time programs for individuals who are unable to achieve their goals in their current environment. Services may involve structured individual, group, and family counseling, education, case management, and psychiatric services. The length of the program is based on the needs of the individual.

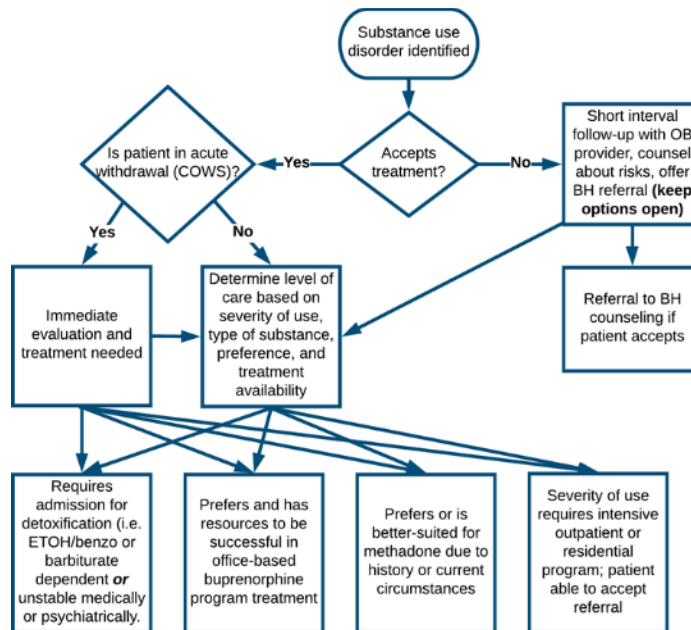
Additional information about levels of treatment for opioid use disorders may be obtained from:

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

Choosing the right level of care

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

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



Consent to share information with Treatment Providers

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

A summary of these rules and a sample consent form may be accessed from PCSS-MAT and the American Osteopathic Academy of Addiction Medicine

https://aoaam.org/resources/Documents/Clinical%20Tools/Sample_Consent_for_release_o.pdf

Please see Additional References section for literature.

1.1. Provider Materials

1.1.1 NEONATAL ABSTINENCE SYNDROME

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

Key points

- Neonatal Abstinence Syndrome (NAS), also known as Neonatal Opioid Withdrawal Syndrome (NOWS), refers to a cluster of symptoms due to neonatal withdrawal after chronic prenatal exposure to opioids, whether prescribed or non-prescribed.
- NAS/NOWS symptoms mirror symptoms experienced by adults in withdrawal: neurologic symptoms including anxiety/irritability, and seizures; rhinorrhea/sneezing; gastrointestinal symptoms.
- More severe NAS symptoms are associated with polysubstance use and/or the use of illicit opioids.
- Buprenorphine is associated with similar rates but later onset, shorter duration, and less severe NAS symptoms than methadone in most studies (Jones, Kaltenbach, Heil, et al, 2010).
- There appears to be no significant difference in NAS symptoms for infants exposed to buprenorphine monoproduct compared to buprenorphine-naloxone (Jumah, Edwards, Balfour- Boehm, et al, 2016; Debelak, Morrone, O'Grady, et al, 2013) although research is limited.
- There is no clear association between methadone or buprenorphine dose and severity of NAS symptoms (Jones, Kaltenbach, Heil, et al, 2010; Jones, Deppen, Hudak, et al 2014).
- With appropriate treatment, NAS is a time-limited condition. Research about long term neurodevelopmental effects is ongoing, but results so far are reassuring (Kocherlakota, 2014).
- Nonpharmacologic care is the first line of treatment for NAS, and includes maximizing skin-to-skin contact, rooming-in with mother, a quiet environment, and breastfeeding unless contraindicated (Kocherlakota, 2014; Patrick, Schumacher, Horbar, et al 2016).
- Pharmacologic treatment is required if symptoms escalate and cause functional difficulty for the infant (see discussion of Eating, Sleeping, and Consoling Care Tool, below). Morphine is the most commonly used medication, although some programs use methadone, and the use of buprenorphine is being investigated (Kocherlakota, 2014; Kraft, Adeniyi-Jones, Chervoneva et al, 2017).
- Breastfeeding is beneficial unless contraindicated by maternal drug use or HTLV or HIV positive status (Jones, Deppen, Hudak, et al 2014).
- Tobacco use during pregnancy and subsequent nicotine withdrawal is linked to greater intensity and earlier onset of NAS symptoms. (Choo, Huestis, Schroeder, et al 2004)

Other medication linked to neonatal symptoms

Other classes of medications are also linked to discontinuation syndromes in newborns after prenatal exposure. These include sedative-hypnotics (ex: barbiturates), anxiolytics (ex: benzodiazepines), anticonvulsants (ex: gabapentin), selective serotonin reuptake inhibitors (ex: fluoxetine, sertraline), and selective norepinephrine reuptake inhibitors (ex: venlafaxine). These medications do not cause the same neonatal abstinence symptoms seen following prenatal opioid exposure, but when they are used in combination with opioids during pregnancy, NAS symptoms can be prolonged or more intense (Seligman, Salva, Hayes, et al 2008) (Kaltenbach, Holbrook, Coyle, et al 2012) (Desai, Huybrechts, Hernandez-Diaz, et al 2015). Typically these medications are associated

with central nervous symptoms such as jitteriness, increased tone, and fussiness, but not gastrointestinal or metabolic symptoms.

However, experts caution not to discontinue medications such as antidepressants which are essential to maintaining pregnant people's mental health (MGH Center for Women's Mental Health <https://womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy/>)

Assessing and Treating Neonatal Abstinence Syndrome

Symptoms of NAS usually start within 1-2 days after birth, but onset can be delayed for 4-5 days in the case of exposure to long acting opioids such as buprenorphine. Since the 1970s, assessment of the need for pharmacologic treatment for NAS has relied on the Finnegan Scoring System, named for one of its developers, Dr. Loretta Finnegan (Finnegan, 1975; Patrick, 2020). This 21 item scoring system focuses on the three physiologic systems most impacted by withdrawal in newborns, the central and autonomic nervous systems, and the gastrointestinal system. The Finnegan Scoring System is used to guide decisions by pediatric providers regarding need for pharmacologic treatment of NAS. This scoring system remains the most commonly used internationally.

More recently, researchers at Yale-New Haven Children's Hospital, Boston Medical Center, and Children's Hospital at Dartmouth-Hitchcock have developed an alternative scoring system and care approach (the ESC Care Tool) which focuses specifically on three essential functions for newborns: the ability to eat, sleep, and console (Grossman, et al, 2017) and ensuring maximization of non-pharmacologic care first (e.g., rooming-in (Holmes et al Pediatrics, MacMillan et al (MacMillan, et al, 2018) and parental presence (Howard et al, 2017) prior to considering pharmacologic treatment.

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

Although a baby will likely still show other signs of withdrawal such as jitteriness, increased tone, sneezing, yawning, and loose stools, the baby is not started on a medicine unless they are having significant problems eating, sleeping, or consoling, and only after all possible non-pharmacologic care measures are optimized first. Rarely, more serious difficulties such as seizures or apnea would necessitate treatment for opioid withdrawal, but other more common etiologies (e.g., infection) should be considered and managed appropriately as per routine standard care.

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

The 3 centers mentioned have all noticed significant improvements in care related to NAS including decreased need for pharmacologic treatment, decreased length of stay, and lower hospital costs when using this ESC care method. Additionally, significant reductions in proportion of infants pharmacologically treated and hospital length of stay have also been demonstrated in 2 Northern New England regional improvement collaborations (manuscripts in preparation). Most importantly, this care approach helps birthing people and their families learn best ways to care for their own baby, helping them for their transition home. *Please see Additional References section for literature.*

1.1.5 MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDER POCKET GUIDE

From the SAMHSA Website: This guide is for physicians using medication-assisted treatment for patients with opioid use disorder. It discusses various types of approved medications, screening and assessment tools, and best practices for patient care.



<https://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG>

1.2 Patient Materials

1.2.1 SAMPLE LETTER #1 TO PATIENT ABOUT NAS

Dear Parent(s),

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

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

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

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

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

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

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

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

Be with your baby 24/7

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

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

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

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

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

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

Thank you and congratulations again!

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

1.2.2 SAMPLE LETTER #2 TO PATIENT ABOUT NAS

Neonatal Abstinence Syndrome (NAS): Caring for your Newborn

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

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

What is NAS/NOWS?

Neonatal Abstinence Syndrome, or NAS, occurs when a baby withdraws from opioids after birth. It is also sometimes called Neonatal Opioid Withdrawal Syndrome (NOWS). Most babies show signs of withdrawal 2 to 3 days after birth, but some may not show signs until day 4 or 5.

Your baby should stay in the hospital until most of the symptoms of NAS are over.

What are the most common signs of NAS?

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

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

NAS/NOWS Assessments

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

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

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

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

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

- We will monitor your baby in the hospital for **at least 4 to 5 days**.
- If your baby has problems with eating, sleeping, or consoling we will teach you ways to help your baby.
- If there are still problems with eating, sleeping, or consoling after all you and we have done to help your baby, we will talk with you about whether medicine may help your baby.
- Medicine may also be needed if other significant problems are present such as problems with breathing or losing too much weight.

How can I best help my baby?

- **ROOMING-IN & PARENT/CAREGIVER PRESENCE:** One of the best things you can do for your baby is to keep him/her with you in your own room. This is called "Rooming-in". This helps you provide a space that is quiet and calm. It also helps you respond quickly to your baby's needs. Your baby will feel safest and most comfortable when close to you. It will also help you feel most comfortable in caring for your baby on your own at home. If you are not able to "room-in" with your baby for any reason, be present as

much as possible to help hold, cuddle, feed, and talk to your baby. *Remember, you are your baby's best medicine!*

- **SKIN-TO-SKIN:** Spend as much time “skin-to-skin” with your baby when you are awake. This helps your baby eat and sleep better, and will help calm your baby. It can also help with other symptoms of withdrawal. It also helps your milk supply when breastfeeding and can help your baby grow better.
- **HOLDING/SWADDLING/CUDDLING:** Hold your baby in your arms, either skin-to-skin, in their clothes, or swaddled in a light blanket. Just being close to someone, or “tucked” in a swaddle, helps your baby feel safe and comfortable. This can help your baby sleep better. Ask your nurse to show you how to swaddle your baby safely.
- **FEEDING:** Feed your baby whenever s/he is showing hunger cues and until content, at least every 3 hours. It is best to breastfeed your baby unless you are unable to do so for medical reasons. Do not let your baby go more than one 4 hour stretch between feedings each day until your baby is back to birthweight. If your baby is having feeding problems, we will ask for a feeding specialist to help your baby feed better.
- **SUCKING:** If your baby still wants to suck after a good feeding, offer a clean finger or pacifier to suck on. This can be very comforting for your baby. Always make sure your baby is not hungry and is well fed first!
- **A CALM ROOM & SOOTHING NOISES:** Keep your baby's room/space calm and quiet with the lights down low. Use a quiet voice when talking or singing to your baby, or when softly “shushing” your baby. Try a “white noise” machine or app on your phone. Remember, loud noises and bright lights may upset your baby.
- **RHYTHMIC MOVEMENT:** Use slow, gentle “up and down”, rocking, or swaying movements when holding your baby. Pause or stop the movement if your baby becomes upset.
- **EXTRA HELP & SUPPORT:** It is also very important for you to be well rested so you can best take care of your baby. Ask for another parent, friend, or family member to help with your baby. Take as many naps/breaks as possible. Remember, your baby will do best by staying in your own room so having an extra helper is key! Let us know if you need help finding someone to help hold/care for your baby while you rest.
- **LIMITING VISITORS:** Try to have only one or two visitors in your room at a time as more may make your baby fussy or not feed or sleep as well. Encourage your visitors to use quiet voices.
- **UNDISTURBED SLEEP/CLUSTERING CARE/:** Allow your baby to rest/sleep undisturbed between feedings. Ask for your baby's nurse and provider to assess your baby when s/he is awake and has fed first.
- **SAFE SLEEP/FALL PREVENTION:** Always make sure you are wide awake when you are holding your baby. If you feel sleepy, ask for someone else to hold your baby. If you are on your own, call out to ask a staff member to help put your baby in the bassinet or to hold your baby.

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

- Some babies may need just 1 or 2 doses of medicine while others may need to be treated for 10 to 14 days. Some babies may need even longer. It is very important that you are able to stay with your baby this whole time as you are still the most important treatment for your baby. Please plan ahead in case this happens.
- Plan to have at least one family member or friend here with you to help care for your baby in your room.
- Bring enough clothes and personal items with you to last at least one week.
- Plan to have someone watch your other children and/or pets while you are away.
- Sometimes it is hard to talk to your family about why your baby might need to stay in the hospital. If this is true for you, ask your OB or Pediatric provider to help. We also have a social worker who can help you with this or any other difficult conversations.

When can I take my baby home?

Your baby's care team will help decide when it is safe for your baby to go home. We will need to watch your baby for **at least** 4 to 5 days in the hospital to make sure all of the medicine or drug is out of your baby's body. It is best to have your baby stay in the hospital until most of the symptoms of NAS are over.

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

- Is feeding and sleeping well.
- Is easy to console (calm down).
- Has not lost too much or is gaining weight.

- Is able to maintain a healthy temperature, heart rate, and breathing.
- Has received the hepatitis B vaccine and all newborn screening is done and normal.
- No longer needs medicine, if it was started.
- Has an appointment made with a home visiting nurse and primary care provider (PCP) for the first few days after discharge. These visits are needed to help watch your baby's weight and NAS symptoms.
- Has a referral made to Early Intervention Services to help monitor your baby's development.
- Has a plan of Safe Care [Family Care Plan] completed with referrals made to community supports and services. You will receive a copy of this Plan at the time of your baby's discharge.

For NNEPQIN/other hospitals: Original content developed by Dr. Bonny Whalen and the staff at the Children's Hospital at Dartmouth-Hitchcock. We thank other hospitals using this pamphlet for their additional suggestions for improvement

1.2.3 NAS PAMPHLET-CARING FOR YOUR NEWBORN

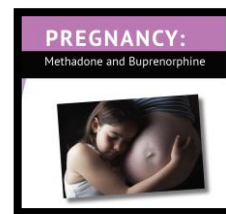
Gives patients an overview of NAS and how they can best care for their infant. *Please contact NNEPQIN for a Spanish Language version.*



<http://www.nnepqin.org/wp-content/uploads/2018/08/09b.-NNEPQIN-NAS-Pamphlet-REV-03.15.18.pdf>

1.2.4 OPIOID USE AND PREGNANCY

One pager for patients that includes information on safety and dosage around medication assisted treatment.



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

1.2.5 OPIOID USE, LABOR, AND CHILDBIRTH

One pager for patients that includes information on preparing for delivery, pain relief and NAS.



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

1.2.6 NEONATAL ABSTINENCE LINK FOR PARENTS FROM MARCH OF DIMES

Provides information for patients about NAS including signs, complications, screening, and treatment.



[http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-\(nas\).aspx](http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx)

2. Naloxone

FACILITATING ACCESS TO NALOXONE

AIM recommends that all birthing people with SUD have access to naloxone at or before the time of discharge following birth. The following materials are provided to help maternity care providers who wish to set up naloxone distribution programs:

[NH AIM/ERASE Implementing Naloxone Distribution Webinar Slides](#)

[March 11, 2021 Implementation of Naloxone Distribution Webinar Recording](#)

Naloxone is a short acting opioid antagonist which is used to reverse life-threatening central respiratory depression caused by opioid poisoning. Specifically, naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous systems, reversing associated respiratory depression. Intranasal Naloxone is easy to administer intranasally, and can be used legally by bystanders or healthcare providers. Patients who are at risk of overdose, or whose family or community members are at risk, should have access to and carry Naloxone for the reversal of opioid overdose.

2.1. Provider Materials

2.1.1 Sample Naloxone prescription:

Patient Name: _____	
Address: _____	
Rx	Naloxone Nasal Spray 4 mg/1mL # <u>2</u>
	Administer x1 intranasally
	Repeat in alternate nostril if no response
Do Not Refill _____	_____ (Signature)
Refill <u>2</u> Times	D.E.A. Number _____
Date _____	Print Last Name _____

2.1.2 Sample Naloxone Policy



Departmental Policy Title	ObGyn Naloxone Policy	Policy ID	22887
Keywords	naloxone, narcan, obgyn, obstetrics, gynecology, overdose		
Department	ObGyn Lebanon		

I. Purpose of Policy

To establish a process to dispense free NH State-issued naloxone kits to Obstetrics and Gynecology (Ob/Gyn) patients who are identified as being high risk for witnessing or experiencing an opioid overdose.

II. Policy Scope

This procedure applies to all Lebanon Ob/Gyn Registered Nurses (RNs), Physicians, Associate Providers (APRNs/PAs), and Licensed Practical Nurses (LPNs), Medical Assistants (MAs).

2.1.3 GENERAL INFORMATION ABOUT NALOXONE
Get Naloxone Now is an online resource to train people to respond effectively to an opioid overdose emergency.



<https://www.getnaloxonenow.org/#home>

2.1.4 HEALTH PROFESSIONALS TOOLKIT FOR
EXPANDING ACCESS TO NALOXONE- AVAILABLE
FROM THE SUBSTANCE ABUSE AND MENTAL
HEALTH SERVICES ADMINISTRATION (SAMHSA)



<https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf>

2.1.5 HOW TO USE NALOXONE

- How to use a Naloxone overdose kit- short video from Maine General Medical Center:
<https://www.youtube.com/watch?v=NLo25AQNyeM&feature=youtu.be>
- Frequently asked questions about opioid addiction and naloxone <https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/>
- What to do in the event of an overdose (in English and Spanish)
https://www.healthvermont.gov/sites/default/files/documents/pdf/RESP_Narcan_HowToGiveBrochure2016.pdf

2.1.6 STATE SUPPORTED ACCESS TO NALOXONE
IN NEW HAMPSHIRE

- General information about Naloxone in NH, including access: <https://thedoortway.nh.gov/avoid-overdose>
- NH Pharmacies with standing orders in place for Naloxone: <https://thedoortway.nh.gov/pharmacies>

2.1.7 STATE SUPPORTED ACCESS TO NALOXONE
IN VERMONT

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

3. Marijuana

1. Cannabis exposure during pregnancy

- The primary psychoactive constituent of cannabis is delta 9-tetrahydrocannabinol (Δ^9 -THC). Early THC exposure may affect fetal and newborn brain development due to its interaction with the brain's endocannabinoid system¹
- Children prenatally exposed to cannabis are at increased risk for sustained attention and memory difficulties²
- It is difficult to attribute causation due to potential impact of environmental factors including maternal nutrition and other substance exposure (Shempf, et al 2008)

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

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

2. Cannabis exposure during breastfeeding

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

The NNEPQIN [Breastfeeding Guidelines for Women with a Substance Use Disorder](#) further addresses breastfeeding with cannabis use.

3.1 Provider Materials

3.1.1 CURRENT RESEARCH FROM THE NATIONAL INSTITUTE ON DRUG ABUSE

Provides the latest statistics, trends, and research around marijuana and cannabinoid use.



<https://www.drugabuse.gov/drugs-abuse/marijuana>

¹ Bloomfield, M., Ashok, A., Volkow, N. et al. The effects of Δ^9 -tetrahydrocannabinol on the dopamine system. *Nature* 539, 369–377 (2016). <https://doi.org/10.1038/nature20153>

² Metz TD, Allshouse AA, Hogue CJ, et al. Maternal marijuana use, adverse pregnancy outcomes, and neonatal morbidity. *Am J Obstet Gynecol* 2017;217:478.e1-8

3.2 Patient Materials

3.2.1 RISKS OF MARIJUANA USE DURING PREGNANCY AND BREASTFEEDING

Patient brochure that can be customized with your organization's logo. *Please contact NNEPIN for version in Spanish.*



http://www.nnepqin.org/wp-content/uploads/2018/08/06a.-Cannabis-brochure_MODIFIED-for-website_v01.23.18.pdf

3.2.2 TODAY IS FOR ME

Public health campaign from the NH Charitable Foundation and the Perinatal Substance Exposure Task Force to increase awareness of the dangers of consuming alcohol and marijuana during pregnancy. Includes both print and online resources.



<https://todayisfor.me/pregnant-or-planning/marijuana-facts/>

3.2.3 CANNABIS/MARIJUANA AND PREGNANCY

Provides information for patients about marijuana including types and risks for both pregnant persons and their infants.



<http://www.marchofdimes.org/pregnancy/marijuana.aspx>

4. Alcohol

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

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

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

In [*Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants*](#), SAMHSA endorses parallel management of alcohol withdrawal during pregnancy with that of the non-pregnant patient. Behavioral health interventions and peer support are the most widely used approaches for nonpregnant patients but must be used in conjunction with pharmacologic management of withdrawal when that is indicated (SAMHSA, 2018). Evidence is extremely limited regarding the safety of pharmacologic agents (disulfiram, naltrexone, acamprosate, or gabapentin) for the long term treatment of alcohol use disorder during pregnancy (SAMHSA, 2018).

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

Screening and Diagnosis of Alcohol Use and Use Disorder

1. Screening for alcohol use in pregnancy

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

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

Screening using a validated screening instrument (examples below), followed by a respectful conversation is the optimal approach to identify harmful alcohol use prior to and during pregnancy. Alcohol use is rarely detected in standard urine toxicology tests. The AUDIT-C, TWEAK and T-ACE are brief alcohol screening tools validated for use with pregnant people, and the ASSIST, 4Ps Plus and Substance Use Screening Tool are valid screening tools for both alcohol and drug use during pregnancy (WHO, 2014).

2. Criteria for a presumed diagnosis of alcohol use disorder

- DSM-V Definition of Alcohol Use Disorder: "A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period."
(American Psychiatric Association, 2013)

- The following checklist can be used to determine whether diagnostic criteria are present for Alcohol Use Disorder:

DSM-V Diagnostic Criteria	Present/date	Comments
1. Alcohol is often taken in larger amounts or over a longer period than was intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.		
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.		
4. Craving, or a strong desire or urge to use alcohol.		
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.		
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.		
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.		
8. Recurrent alcohol use in situations in which it is physically hazardous. <i>[For example: this criterion would be fulfilled if a woman/birthing person regularly operated a motor vehicle while intoxicated]</i>		
9. Continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. <i>[For example: this criterion would be fulfilled if a woman/birthing person is aware of the teratogenic effects of alcohol and continues to drink]</i>		
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount. <i>[Note that a person can have an alcohol use disorder even in the absence of tolerance or withdrawal symptoms]</i>		
11. Withdrawal, as manifested by either of the following: a. The characteristic alcohol withdrawal syndrome. b. Alcohol (or a closely related substance such as benzodiazepines) is taken to relieve or avoid withdrawal symptoms.		

- The severity of Alcohol Use Disorder can be estimated from this table, using the levels described below:

- Mild (ICD-10 CM code F10.10): Presence of 2–3 symptoms
- Moderate (ICD-10 CM code F10.20): Presence of 4–5 symptoms
- Severe (ICD-10 CM code F10.20): Presence of 6 or more symptoms

3. Toxicology tests for alcohol

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

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

4. Alcohol Withdrawal

The majority of pregnant people who use alcohol are not physiologically dependent, meaning that they may not experience tolerance or withdrawal. However, physiologic dependence and subsequent withdrawal from alcohol can result from heavy and prolonged alcohol use. Withdrawal symptoms usually occur within several hours to a few days after cessation or significant reduction of alcohol use (American Psychiatric Association, 2013). **Unlike opioid withdrawal, alcohol withdrawal can be fatal if untreated.** SAMHSA's Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder and their Infants endorses use of the same management approach for alcohol withdrawal during pregnancy as for the non-pregnant patient (SAMHSA, 2018)

Characteristic symptoms of alcohol withdrawal* include:

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

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

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

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

5. Levels of Care for the Treatment of Alcohol Use Disorders (AUD)

The National Institute for Alcohol Abuse and Alcoholism maintains a treatment navigator to assist patients in finding the right level of treatment near their home communities: <https://alcoholtreatment.niaaa.nih.gov/>

Detoxification

Treatment for alcohol use disorders during pregnancy may require varying levels of intensity and duration. If physiologic dependence and risk for withdrawal is suspected in a pregnant patient, acute hospitalization for detoxification and management through consultation with addiction medicine, psychiatric, and/or maternal-fetal medicine is necessary. For non-pregnant patients, outpatient detoxification may be safe for some patients, while others will need to be admitted. Consultation should be sought with addiction medicine, psychiatric, internal medicine or family medicine to determine appropriate level of care.

Medications for AUD

Three medications are approved by the FDA for the treatment of AUD. **Naltrexone** is an opioid agonist, which also has effectiveness for the treatment of alcohol use disorder **in patients not being treated with opioid agonists**. Naltrexone reduces cravings for alcohol through blockade of opioid receptors, and is available in oral and injectable forms.

Although there is little evidence to support the safety of naltrexone during pregnancy for the treatment of AUD, a few studies exist of its use for treating OUD have been reassuring. Based on this, some treatment providers feel that the well-established risk of alcohol use during pregnancy outweighs possible risks of using naltrexone for AUD (Towers CV, Katz E, Weitz B, et al. Use of naltrexone in treating opioid use disorder in pregnancy. Am J Obstet Gynecol 2020;222:83.e1-8).

Disulfiram and Acamprosate, both medications for alcohol use disorder, are not recommended during pregnancy or lactation.

Residential Services

Onsite full-time programs for individuals who are unable to achieve their goals in their current environment. Services may involve structured individual, group, and family counseling, education, case management, and psychiatric services. The length of the program is based on the needs of the individual.

Intensive outpatient programs (IOP)

This service may involve structured individual, group, and family counseling, education, case management, and psychiatric services. Services for adults are provided at least nine hours per week and services for adolescents are provided at least six hours per week

Mutual Aid Groups

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

Medication Assisted Treatment for Alcohol Use Disorders

Medication assisted treatment for alcohol use disorders includes three medications approved by the

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

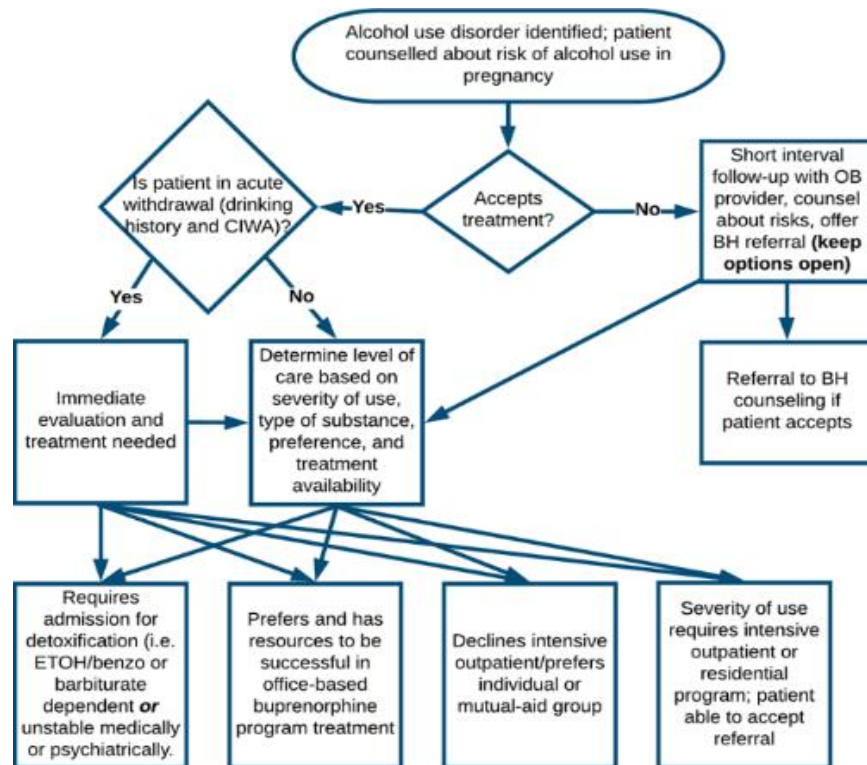
Additional information about levels of treatment for alcohol use disorders may be obtained from:

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

6. Choosing the right level of care

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

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



4.1 Provider Materials

4.1.1 ADDRESSING FETAL ALCOHOL SPECTRUM DISORDERS (FASD)

From SAMHSA: “This guide reviews screening tools for alcohol use and interventions for pregnant people and women of childbearing age to prevent fetal alcohol spectrum disorders (FASD). It also outlines methods for identifying people living with FASD and modifying treatment accordingly.”



<https://store.samhsa.gov/product/TIP-58-Addressing-Fetal-Alcohol-Spectrum-Disorders-FASD-/SMA13-4803>

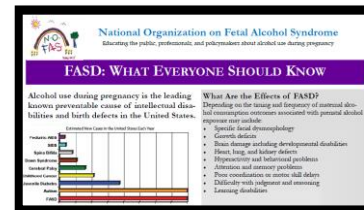
4.1.2 NATIONAL ORGANIZATION ON FETAL ALCOHOL SYNDROME

Prevention organization focused on raising awareness as well as supporting families with FAS.



<https://www.nofas.org/>

4.1.3 PUBLIC AWARENESS FACT SHEET ON FAS FROM NOFAS



<http://www.nofas.org/wp-content/uploads/2012/10/NOFAS-FASD-What-Everyone-Should-Know-2012.pdf>

4.1.4 THE ARC: FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION PROJECT



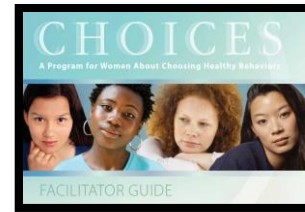
- [Provider training opportunities on FASD](#)
- [Summary of current knowledge about the impact of alcohol use during pregnancy](#)
- [Association of Reproductive Health Professionals: Fetal Alcohol Spectrum Disorders Consensus Meeting, Meeting Report 2015](#)

4.1.5 SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION: TREATMENT IMPROVEMENT PROTOCOLS



<https://store.samhsa.gov/series/tip-series-treatment-improvement-protocols-tips>

4.1.6 EVIDENCE-BASED “CHOICES” CURRICULUM FOR FASD PREVENTION



<https://www.cdc.gov/ncbddd/fasd/documents/facilitatorguide.pdf>

4.2 Patient Materials

4.2.1 TODAY IS FOR ME

Public health campaign from the NH Charitable Foundation and the Perinatal Substance Exposure Task Force to increase awareness of the dangers of consuming alcohol and marijuana during pregnancy. Includes both print and online resources.



<https://todayisfor.me/pregnant-or-planning/alcohol-facts/>

4.2.2 CENTERS FOR DISEASE CONTROL INFORMATION AND INFOGRAPHICS

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

<https://www.cdc.gov/vitalsigns/fasd/index.html>

<https://www.cdc.gov/vitalsigns/fasd/infographic.html/#graphic1>

“Think Before You Drink” (Brochure)

<https://www.cdc.gov/ncbddd/fasd/documents/ThinkBeforeYouDrinkbrochure.pdf>

“An Alcohol-Free Pregnancy is the Best Choice for your Baby”

https://www.cdc.gov/ncbddd/fasd/documents/FASDBrochure_final.pdf

“Alcohol use in pregnancy” (fact sheet)

https://www.cdc.gov/ncbddd/fasd/documents/fasd_alcoholuse.pdf

Order free fact sheets for patients from CDC:

<https://www.cdc.gov/ncbddd/fasd/factsheets.html>

4.2.3 MARCH OF DIMES



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



<https://www.marchofdimes.org/complications/fetal-alcohol-spectrum-disorders.aspx>

4.2.4 NATIONAL ORGANIZATION ON FETAL ALCOHOL SYNDROME Prevention factsheet



<https://www.nofas.org/wp-content/uploads/2014/05/Facts-prevention.pdf>

4.2.5 THE ARC: FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION PROJECT



<http://www.thearc.org/learn-about/fasd>

5. Tobacco

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

Strategies for Providers

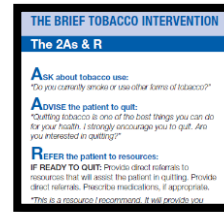
Pregnant people who smoke should be asked about their tobacco use at each prenatal visit and assisted to quit by providers. pregnant and post parenting people who are considering quitting should be referred to the tobacco helpline in their home state.

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

- **ASK** every patient at each encounter about tobacco use and document status
- **ASSIST** every tobacco user to quit with a clear, strong personalized message about the benefits of quitting
- **REFER** patients who are ready to quit tobacco within the next 30 days to the appropriate Tobacco Helpline

5.1 Provider Materials

5.1.1 QUICK REFERENCE FOR TOBACCO COUNSELING FROM CENTERS FOR DISEASE CONTROL



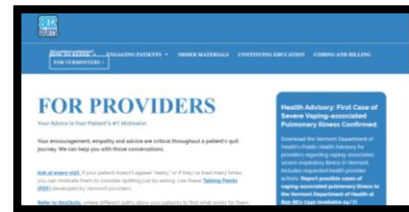
<https://www.cdc.gov/tobacco/campaign/tips/partners/health/materials/twyd-5a-2a-tobacco-intervention-pocket-card.pdf>

5.1.2 NEW HAMPSHIRE QUITWORKS Services provided include phone counseling and nicotine replacement during pregnancy if prescribed



<https://quitworksnh.org/>

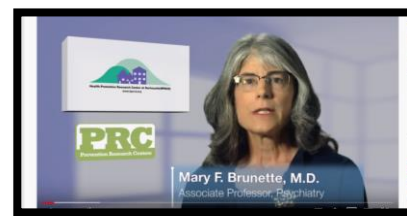
5.1.3 VERMONT 802QUITS Includes incentives for each counseling all attended, phone counseling; nicotine replacement with Rx during pregnancy



<http://802quits.org/providers/>

5.1.4 STRATEGIES FOR TREATING TOBACCO USE FOR PATIENTS WITH OTHER ADDICTIVE DISORDERS

Mary Brunette, MD, Medical Director, Bureau of Behavioral Health, NH Department of Health & Human Services speaks about common myths about treating tobacco in the context of other addictive disorders



<https://youtu.be/kOqwF4JkXK4>

5.1.5 INFORMATION ON PRENATAL TOBACCO RISK

From the Centers for Disease Control (CDC): https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/

From the National Institute on Drug Abuse (NIDA): <https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/what-are-risks-smoking-during-pregnancy>

From the American College of Nurse Midwives (ACNM): <https://ourmomentoftruth.com/tag/smoking-cessation/>

American College of Obstetricians and Gynecologists Committee Opinion on Tobacco Use and Women's Health: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/09/tobacco-use-and-womens-health>

6.1.6 NO-COST VIRTUAL PROVIDER TRAINING ON BEST PRACTICE FOR SMOKING CESSATION

"Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic" Sponsored by the CDC's Division of Reproductive Health, this continuing education offering allows providers to learn and practice evidence-based interventions for smoking cessation during and after pregnancy. Included is a free, online training module on e-cigarettes and pregnancy. Additional learning tools include interactive case simulations, mini-lectures from leading experts, interviews with real patients who

have quit, and a variety of online office resources. This training is eligible for continuing medical education credit, AMCB CEUs for Nurse-Midwives, and for Maintenance of Certification credit for OB/GYN physicians.

5.2 Patient Materials

5.2.1 INFORMATION ON PRENATAL TOBACCO RISK

- Impact of tobacco on women and babies: <https://quitnownh.org/pregnancy/>
- Mobile text message support for quitting smoking during pregnancy: <https://women.smokefree.gov/tools-tips-women/text-programs/smokefreemom>
- General mobile text message pregnancy education and support: <https://text4baby.org/>
- Patient fact sheet from American College of Nurse Midwives (ACNM): <http://ourmomentoftruth.com/your-health/smoking-womens-health-learn-the-facts/>
- Smoking during pregnancy fact sheet from March of Dimes: <http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>

5.2.2 NEW HAMPSHIRE QUITNOW

Services provided include phone counseling and nicotine replacement during pregnancy if prescribed



<https://quitnownh.org/category/i-want-to-quit/>

5.2.3 VERMONT 802QUITS

Includes incentives for each counseling all attended, phone counseling; nicotine replacement with Rx during pregnancy



<https://802quits.org/home/i-want-to-quit/free-quit-help-for-you-and-your-baby/>

5.2.4 EPA SMOKE-FREE HOMES COMMUNITY ACTION TOOLKIT



https://www.epa.gov/sites/production/files/2014-08/documents/community_action_kit.pdf

5.2.5 EPA “SMOKE FREE HOME PLEDGE” FOR FAMILIES



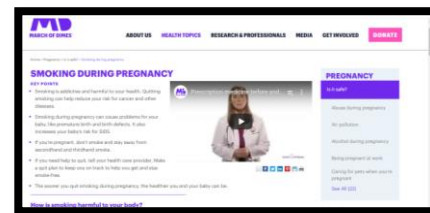
https://www.epa.gov/sites/production/files/2015-09/documents/certificate_en.pdf

5.2.6 PATIENT EDUCATION FACT SHEET FROM AMERICAN COLLEGE OF NURSE MIDWIVES (ACNM)



<https://ourmomentoftruth.com/your-health/smoking-womens-health-learn-the-facts/>

5.2.7 SMOKING DURING PREGNANCY FACT SHEET FROM MARCH OF DIMES



<http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>

6. Methamphetamine and Other Stimulant Use

Optimal pregnancy outcomes for women with stimulant use disorders are associated with **abstinence**. Recognizing that complete abstinence is sometimes not attainable, a harm reduction approach based on maximizing information and support for the pregnant person is essential.

Prenatal stimulant use is not associated with an increased rates of congenital anomalies, but is associated with lower birth weight and small for gestational age infants. The impact of stimulant use on pregnancy outcomes such as abruption, hypertension, and hemorrhage is poorly understood (ACOG, 2019).

Maternal impacts

- Weight loss
- Anxiety
- Tachycardia
- Hypertension
- Permanent cardiac injury with long term use
- Physiologic dependence

Neonatal impacts

- [Low birthweight](#)
- Reduced head circumference
- Small for gestational age

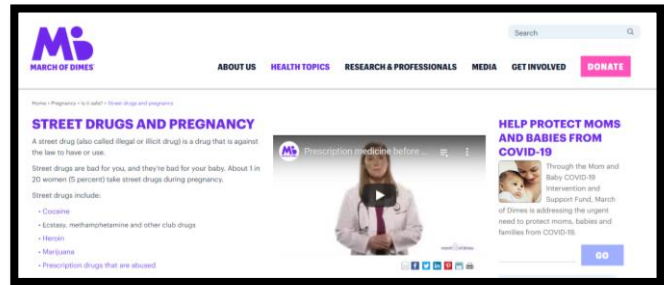
Child development

- Attention deficits
- Problems with memory

In contrast to OUD, evidence-based treatment for stimulant substance use disorders during pregnancy consists primarily of behavioral interventions, especially cognitive behavioral therapy. Heavy use of stimulants can result in severe psychiatric symptoms resembling psychosis, and in physiologic dependence. Withdrawal symptoms include significant irritability, anxiety, and depression, decreasing in severity over several weeks. An individualized plan of care is essential taking into account each patients' drug/alcohol use history, the presence of medical and co- occurring mental health conditions, social needs, family responsibilities, and preferences.

6.1 Patient Materials

6.1.1 MARCH OF DIMES RESOURCES



Amphetamines and club drug use:

<https://www.marchofdimes.org/pregnancy/street-drugs-and-pregnancy.aspx>

Cocaine use: <http://www.marchofdimes.org/pregnancy/cocaine.aspx>

6.1.2 AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS Committee Opinion: Methamphetamine Abuse in Women of Reproductive Age



<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/03/methamphetamine-abuse-in-women-of-reproductive-age>

7. Counseling Women about Polysubstance Use

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

Pregnancy risks associated with polysubstance use

- Placental insufficiency
- [Preterm labor](#)
- [Miscarriage](#)
- [Stillbirth](#)

Neonatal impacts

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

Child development

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

In contrast to OUD, evidence-based treatment for other substance use disorders during pregnancy consists primarily of behavioral interventions, especially cognitive behavioral therapy. Heavy use of some substances, specifically alcohol or benzodiazepines, can result in physiologic dependence requiring medically managed detoxification (alcohol) or tapering (benzodiazepines). [Factsheet 6 of SAMHSA's Clinical Guidance for the Treatment of Pregnant and Parenting Women with Opioid Use Disorder](#) and their Infants includes a summary table describing recommended treatment approaches for perinatal substance use disorders other than OUD (SAMHSA, 2018, p. 48). An individualized plan of care is essential taking into account each patients' drug/alcohol use history, the presence of medical and co- occurring mental health conditions, social needs, family responsibilities, and preferences.

7.1 Patient Materials

7.1.1 MARCH OF DIMES



Cocaine: <http://www.marchofdimes.org/pregnancy/cocaine.aspx>
Street drugs: <https://www.marchofdimes.org/pregnancy/street-drugs-and-pregnancy.aspx>
Marijuana: <http://www.marchofdimes.org/pregnancy/marijuana.aspx>
Prescription opioid abuse:
<http://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx>
Tobacco: <http://www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx>
Alcohol: <http://www.marchofdimes.org/pregnancy/alcohol-during-pregnancy.aspx>

8. Counseling Pregnant People about Risks of Synthetic Cathinones (“Bath Salts”)

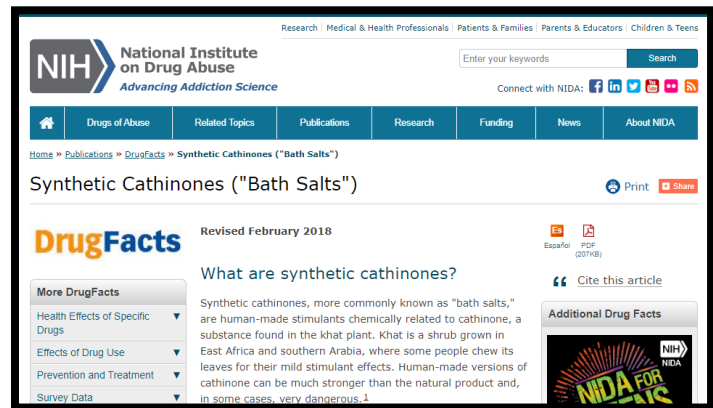
In Europe, Canada, and the northeastern and central U.S, the use of a group of stimulant-like chemicals commonly known as “bath salts” or “salts” is increasing. These compounds are described generally as synthetic cathinones, but what is sold often varies in chemical makeup due to manufacturing in unregulated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

Key points:

- Bath salts are available via the internet as a powder which can be swallowed, snorted, or injected
- This group of compounds is highly toxic, impacting the central and autonomic nervous systems, the cardiovascular system, and renal and hepatic function (White et al, 2016; Imam, et al, 2013; Banks, et al, 2014; Winder, et al 2011)
- Immediate symptoms following bath salts ingestion can include
 - Euphoria and sexual excitement
 - Paranoia
 - Confusion
 - Hallucinations and blurred vision
 - Hyperthermia
 - Profuse sweating
 - Muscle twitching or seizure
 - Tachycardia and chest pain
 - Hypertension
 - Decreased peripheral circulation
- Long term effects may include
 - Depression and suicidality
 - Psychosis
 - Kidney damage or failure
 - Skin breakdown at injection site, rash, cellulitis
 - Muscle injury
 - Tolerance and withdrawal
- Risks of bath salts ingestion during pregnancy are unknown but given the physiological effects of the chemical, highly concerning given the autonomic and cardiovascular symptoms which can develop (see Gray and Holland, 2014)
- Treatment is supportive, and patients should be linked to intensive outpatient or residential treatment programs
- Routine toxicology tests are unable to reliably detect cathinones, and tests sent out to specialty laboratories have high false negative rates.

8.1 Provider Materials

8.1.1 NATIONAL INSTITUTE ON DRUG ABUSE



From the National Institute on Drug Abuse:

<https://www.drugabuse.gov/publications/drugfacts/synthetic-cathinones-bath-salts>

<https://teens.drugabuse.gov/drug-facts/bath-salts>

8.2 Patient Materials

8.2.1 A DRUG CALLED "BATH SALTS" BROCHURE (ENGLISH)

Please contact NNEPQIN for Spanish version.



http://www.nnepqin.org/wp-content/uploads/2018/08/BathSalts_bifold4x9_press4.pdf



SECTION 4:

Tools to Support Patient Needs

Section 4: Tools to Support Patient Needs

Treatment of a pregnant patient with a substance use disorder goes beyond standard medication assisted treatment and recovery supports. This section provides an overview of the necessary tools to support the patient, including planning for the future beyond birth as well as addressing any underlying comorbidities and risk factors.

1. [Breastfeeding](#)
 - 1.1. [Provider Materials](#)
 - 1.1.1. [AAP Committee on Drugs. The Transfer of Drugs and Therapeutics Into Human Milk: An Update on Selected Topics](#)
 - 1.1.2. [LactMed. Drug and Lactation Database](#)
 - 1.2. [Patient Materials](#)
 - 1.2.1. [ASAM Brochure: Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine](#)
2. [Doula Services](#)
 - 2.1. [Provider Materials](#)
 - 2.1.1. [Wentworth-Douglass Hospital Doula Program](#)
 - 2.1.2. [DONA International](#)
 - 2.1.3. [Birthing from Within](#)
3. [Harm Reduction](#)
4. [Infectious Diseases](#)
 - 4.1. [Hepatitis](#)
 - 4.1.1. [Hepatitis A](#)
 - 4.1.2. [Hepatitis B](#)
 - 4.1.3. [Hepatitis C](#)
 - 4.1.4. [Provider Materials](#)
 - 4.1.4.1. [The ABCs of Hepatitis](#)
 - 4.1.4.2. [Hepatitis A Questions and Answers for Health Professionals](#)
 - 4.1.4.3. [Recommendations for Screening and Follow Up of Patients at Risk for Hepatitis B](#)
 - 4.1.4.4. [Interpretation of Hepatitis B Serologic Test Results](#)
 - 4.1.4.5. [Information on Pregnancy and HCV Infection](#)
 - 4.1.4.6. [Interpretation of HCV Test Results](#)
 - 4.1.5. [Patient Materials](#)
 - 4.1.5.1. [Hepatitis A Factsheet](#)
 - 4.1.5.2. [FAQ-Hepatitis B and Hepatitis C](#)
 - 4.1.5.3. [Prenatal Exposure to Hepatitis B \(Educational Slide Show\)](#)
 - 4.1.5.4. [Hepatitis C Factsheet](#)
 - 4.1.5.5. [Hepatitis C-Q&A for the Public](#)
 - 4.1.5.6. [Hepatitis C in Pregnancy Video](#)
 - 4.2. [HIV](#)
 - 4.2.1. [Provider Materials](#)
 - 4.2.1.1. [AIDSInfo](#)
 - 4.2.1.2. [UCSF HIVE](#)
 - 4.2.1.3. [NIH Perinatal Treatment Guidelines](#)
 - 4.2.1.4. [CDC Information About PrEP](#)
 - 4.2.1.5. [CDC Information on HIV and Pregnancy \(Provider\)](#)
 - 4.2.2. [Patient Materials](#)
 - 4.2.2.1. [CDC Information on HIV](#)
 - 4.2.2.2. [FAQs About HIV and Pregnancy](#)

- 4.2.2.3. [What Women Need to Know about Pregnancy and HIV Treatment](#)
 - 4.2.2.4. [CDC Information About PrEP](#)
- 5. [Plans of Safe Care \(POSC\)/ Family Care Plans](#)
 - 5.1. [Federal Legislation](#)
 - 5.2. [Provider Materials](#)
 - 5.2.1. [Provider Letter](#)
 - 5.2.2. [Template](#)
 - 5.2.3. [Guidance document](#)
 - 5.2.4. [Webinar](#)
 - 5.2.5. [Implementation checklist](#)
 - 5.2.6. [Fact sheet](#)
 - 5.2.7. [Services list and Map](#)
 - 5.3. [Patient Materials](#)
 - 5.3.1. [POSC Patient Brochure \(English and Spanish\)](#)
- 6. [Postpartum Care](#)
 - 6.1. [10 Best Practices in Contraceptive Counseling](#)
 - 6.2. [Provider Materials](#)
 - 6.2.1. [ACOG Committee Opinion #736, Optimizing Postpartum Care](#)
 - 6.2.2. [Bedsider Birth Control Support Network](#)
 - 6.3. [Patient Materials](#)
 - 6.3.1. [Bedsider Method Explorer](#)
- 7. [Supporting LGBTQIA and Gender Diverse Patient Health](#)
 - 7.1. [Provider Materials](#)
 - 7.1.1. [Mothers and others: The invisibility of LGBTQ people in reproductive and infant psychology](#)
 - 7.1.2. [Sex & Gender 101: The First Steps to Creating Trans Inclusive Care](#)
 - 7.2. [Patient Materials](#)
 - 7.2.1. [Preparing for Pregnancy as a Non-Binary Person](#)
 - 7.2.2. [Support Resources for Families of Gender Diverse Youth](#)

1. Breastfeeding

Breastfeeding should be encouraged for pregnant and postpartum people on medication assisted treatment with either buprenorphine or methadone, in the absence of maternal or infant medical contraindications (World Health Organization, 2014; Kocherlakota, 2014).

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

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

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

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

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

1.1 Provider Materials

1.1.1 AAP COMMITTEE ON DRUGS. THE TRANSFER OF DRUGS AND THERAPEUTICS INTO HUMAN MILK: AN UPDATE ON SELECTED TOPICS.

Pediatrics. 2013;132:3:e796-e809.



<http://pediatrics.aappublications.org/content/132/3/e796>.

1.1.2 LACTMED. DRUG AND LACTATION DATABASE



<https://www.ncbi.nlm.nih.gov/books/NBK501922/?report=classic>

1.2 Patient Materials

1.2.1 ASAM BROCHURE: CHILDBIRTH, BREASTFEEDING AND INFANT CARE: METHADONE AND BUPRENORPHINE



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

2. Doula Services

What is Doula?

A doula is a “person trained and experienced in childbirth who provides continuous physical, emotional and informational support to the mother before, during and just after birth.” (Doula Organization of North America (DONA)).

A doula is not a midwife, but is instead a non-clinical support for pregnant and parenting people. A doula:

- Provides information and support during pregnancy and birth
- Provides guidance to navigate the healthcare system and in decision making
- Provides breastfeeding and newborn care support
- Provides postpartum care
- Provides partner and family support
- Refers to medical/health, social and community supports
- Advocates
- Provides care and models care for infant, encourage development of parenting skills
- Collaborates with health care team

There is no one national or statewide certifying body for doulas. However, certification for doulas typically covers childbirth education, postpartum care, and breastfeeding lactation. More comprehensive doula education includes trauma informed, culturally competent, antiracism and equitable healthcare delivery curricula.

Doula Benefits

<i>Maternal Health</i>	<i>Emotional Health</i>	<i>Infant health</i>	<i>Public Health</i>
Decreases likelihood of cesarean deliveries ^{1,2}	Decreases chance of negative feelings about birth experience ^{2, 5}	Decreases risk of low Apgar scores ²	Can reduce racial disparities ^{4,5}
Shorter duration of labor ²	Increases sense of empowerment and efficacy during birthing process ^{1, 5}	Increases likelihood of breastfeeding ¹	Reduces risk of interventions which may translate to cost savings ³
Decreases likelihood of medical interventions like labor induction ²		Decreases likelihood of low birth weight ¹	
Decreases use of any analgesia ²			

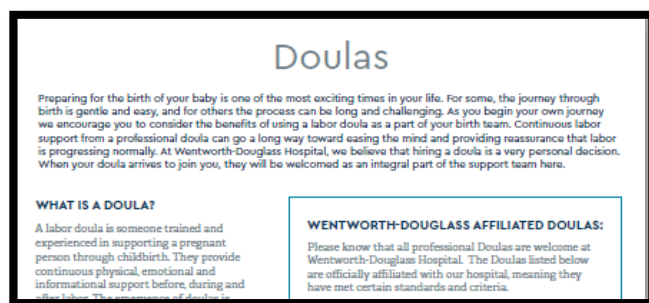
Potential Benefits for Pregnant/Parenting People Impacted by Substance Use

The emotional health benefits of a doula are a particularly compelling reason to connect them to a pregnant/parenting person impacted by substance use. This population may need extra social support and could especially benefit from having an advocate in the healthcare setting that could help reduce stigma and avoid traumatization. Barriers to obtaining doula services for a pregnant/parenting person center around cost as they currently are not a reimbursable service through Medicaid or commercial insurance carriers in NH. However, hospital based programs are emerging (see resources section for more information) that may offer low cost options.

2.1 PROVIDER MATERIALS

2.1.1 Wentworth-Douglass Hospital Doula Program

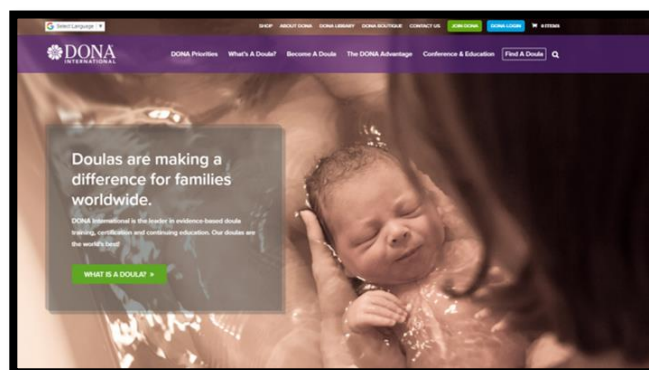
Can connect patients to a network of hospital-affiliated doulas. Low cost scholarships available.



https://www.wdhospital.org/files/4516/0132/8779/Doulas_2020.pdf

2.1.2 DONA International

Doula Organization of North America. Provides certification, education, and directory of doulas.



<https://www.dona.org/>

2.1.3 Birthing From Within

Childbirth educator and doula certification services. Also offers parent education.



<https://birthingfromwithin.com/>

References

1. Gruber, Kenneth J., PhD, Cupito, Susan H., MA, Dobson, Christina F., MEd (2013). Impact of Doulas on Healthy Birth Outcomes. The Journal of Perinatal Education. Vol 22 Issue 1, DOI: 10.1891/1058-1243.22.1.49
2. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. (2017). Continuous support for women during childbirth. Cochrane Database Syst Rev. Jul 6;7doi: 10.1002/14651858.CD003766.pub6.
3. Kozhimannil, Katy B., Rachel R. Hardeman, Fernando Alarid-Escudero, Carrie A. Vogelsang, Cori Blauer-Peterson, and Elizabeth A. Howell. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. Birth 43, no. 1. 20–27. <https://doi.org/10.1111/birt.12218>.
4. Bey, A., Brill, A., Porchia-Albert, C., Gradilla, M., Strauss, N. (2019) Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. Ancient Song Doula Services,

Village Birth International, and Every Month Counts. <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>

5. Taylor, J., Novoa, C., Hamm, K., Phadke, S. (2019) Eliminating Racial Disparities in Maternal and Infant Mortality- A comprehensive Policy Blueprint. Center for American Progress. <https://cdn.americanprogress.org/content/uploads/2019/04/30133000/Maternal-Infant-Mortality-report.pdf>

3. Harm Reduction

What is meant by harm reduction?

According to the Academy of Perinatal Harm Reduction, a simple way to define harm reduction is that this is “the acknowledgement that anything we choose to do carries risks - and that there are things we can do to minimize those risks.” From this premise, much of what we do in obstetrics is about harm reduction.

With regards to substance use during pregnancy, a harm reducing approach recognizes that legal and illegal substance use is part of our world, and that we should choose to work to minimize harmful effects rather than ignore them or punish pregnant or postpartum people who use substances. Furthermore, it is well established that getting prenatal care is the most important thing that a pregnant person can do to improve outcomes. Therefore, **providing welcoming and respectful care for all pregnant people, which encourages, rather than prevents, participation in prenatal care, is essential.**

The [National Harm Reduction](#) coalition provides the following definition for, “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs³.” The Academy for Perinatal Harm Reduction has published a [toolkit](#) and other harm reduction resources for families and providers.

Preventing maternal mortality

In New Hampshire, opioid overdose has become the leading cause of pregnancy associated death. The majority of these preventable maternal deaths are occurring during the postpartum year (New Hampshire Maternal Mortality reports 2018, 2020). An important harm reduction approaches include expanding access to the lifesaving drug [naloxone](#). The ***Alliance for Innovation in Maternal Health Care for Pregnant and Parenting People with Substance Use Disorders Patient Safety Bundle*** recommends distribution of naloxone to all postpartum people at the time of hospital discharge after childbirth.

State or community level harm reduction resources

- [NHHRC](#)
- [NH SSPs](#)
- [Academy for Perinatal Harm Reduction](#)
- [National Harm Reduction Coalition](#)
- [Resources for Safer Drug Use](#)

³ <https://harmreduction.org/about-us/principles-of-harm-reduction/>

4. Infectious Diseases

4.1 Hepatitis

4.1.1 HEPATITIS A

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

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

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

Immunization

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

4.1.2 HEPATITIS B SCREENING & DIAGNOSIS

Patients with opioid use disorders, a history of injection drug use or inhalation (“snorting”), non-professional tattoos or piercings, or sexual or household contact with people with hepatitis B or injection drug history should be screened for hepatitis B virus (HBV).

Increased injection drug use has led to a rise in the prevalence of Hepatitis B due to injection drug use in some regions of the United States (see

<https://www.cdc.gov/hepatitis/statistics/2015surveillance/pdfs/2015HepSurveillanceRpt.pdf>)

Standard prenatal labs include screening for HBsAg (hepatitis B surface antigen, indicating the presence of active infection). Persons at risk for HBV infection should also be tested for anti-HBc (hepatitis B core antibody, indicating previous or current infection) and anti-HBs (hepatitis B surface antibody, indicating immunity from either disease or vaccination). This additional testing determines whether the person is vulnerable to infection and should be offered vaccination (CDC, 2017). Additional information about hepatitis B serologic testing, including clinical guidelines for perinatal management, see:

<https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>

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

Patients who test positive for HBsAg should be referred for further evaluation and management to an infectious disease specialist, gastroenterologist, or hepatologist.

Patients who test positive should receive the following information:

- Hepatitis B is a chronic disease of the liver which can cause permanent liver damage.
- Hepatitis B is highly contagious, and precautions are necessary to prevent transmission to partners and household members. All household members should be screened and offered immunization if non-immune.
- HBV is spread through contact with semen or vaginal secretions (CDC, 2016). Condoms should be used for sexual activity involving exposure risk.
- Avoid sharing razors, toothbrushes, etc. Hepatitis B is not spread through kissing an infected person, eating or preparing food, or via the respiratory route.
- Infants exposed to hepatitis B prenatally should receive hepatitis B immunoglobulin (HBIG) and HBV immunization immediately after birth. Without prophylaxis, an estimated 40% of exposed newborns will develop chronic hepatitis B. The need for treatment should be discussed prenatally and the delivery hospital notified in preparation (see algorithm: <https://www.cdc.gov/hepatitis/hbv/pdfs/PrenatalCareProviderPoliciesAndProcedures.pdf>).
- Breastfeeding is not contraindicated in the context of hepatitis B infection (CDC, 2016); however, breastfeeding is not recommended if nipples are bleeding, or open lesions present.

4.1.3 HEPATITIS C DIAGNOSIS & TREATMENT

KEY POINTS

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

4.1.4 PROVIDER MATERIALS

4.1.4.1 The ABCs of Hepatitis

Centers for Disease Control (CDC)

The ABCs of Hepatitis – for Health Professionals			
	HEPATITIS A is caused by the hepatitis A virus (HAV)	HEPATITIS B is caused by the hepatitis B virus (HBV)	HEPATITIS C is caused by the hepatitis C virus (HCV)
U.S. Statistics	• Estimated 6,700 new infections in 2017	• Estimated 22,200 new infections in 2017 • Estimated 862,000 people living with chronic HBV infection in 2016	• Estimated 44,700 new infections in 2017 • Estimated 2.4 million people living with HCV infection in 2016
Routes of Transmission	Fecal-oral route. HAV is transmitted through: • Close person-to-person contact with an infected person • Sexual contact with an infected person • Ingestion of contaminated food or water Although viremia occurs early in infection, bloodborne transmission of HAV is uncommon.	Percutaneous, mucosal, or nonintact skin exposure to infectious blood, semen, and other body fluids. HBV is concentrated most highly in blood, and percutaneous exposure is an efficient mode of transmission. HBV is transmitted primarily through: • Birth to an infected mother • Sexual contact with an infected person • Sharing contaminated needles, syringes, or other injection drug equipment Less commonly through: • Needle-sticks or other sharp instrument injuries • Organ transplantation and dialysis • Interpersonal contact through sharing items	Direct percutaneous exposure to infectious blood. Mucous membrane exposures to blood can also result in transmission, although this route is less efficient. HCV is transmitted primarily through: • Sharing contaminated needles, syringes, or other equipment to inject drugs Less commonly through: • Birth to an infected mother • Sexual contact with an infected person • Unregulated tattooing • Needle-sticks or other sharp instrument injuries

<https://www.cdc.gov/hepatitis/resources/professionals/pdfs/abctable.pdf>

4.1.4.2 Hepatitis A Questions and Answers for Health Professionals

Centers for Disease Control (CDC)

Hepatitis A

Hepatitis B

Hepatitis C

Hepatitis D

Hepatitis E

Viral Hepatitis Home

Statistics & Surveillance

Overview and Statistics

What is the case definition for acute hepatitis A?

Clinical Criteria
An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine)

AND

a) jaundice or elevated total bilirubin levels ≥ 3.0 mg/dL, OR
b) elevated serum alanine aminotransferase (ALT) levels >200 IU/L,
AND
c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis
Confirmatory laboratory evidence:

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive,

OR

- Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

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

4.1.4.3 Recommendations for Screening and Follow Up of Patients at Risk for Hepatitis B

Centers for Disease Control (CDC)

Recommendations for Routine Testing and Follow-up for Chronic Hepatitis B Virus (HBV) Infection		
Population	Recommendation	
	Testing	Vaccination/Follow-up
Persons born in regions of high and intermediate HBV endemicity (HBsAg prevalence $\geq 2\%$)	Test for HBsAg, regardless of vaccination status in their country of origin, including: – Immigrants – Refugees – Asylum seekers – Internationally adopted children	If HBsAg-positive, refer for medical management. If negative, assess for on-going risk for hepatitis B and vaccinate if indicated.
US born persons not vaccinated as infants whose parents were born in regions with high HBV endemicity ($\geq 8\%$)	Test for HBsAg regardless of maternal HBsAg status if not vaccinated as infants in the United States.	If HBsAg-positive, refer for medical management. If negative, assess for on-going risk for hepatitis B and vaccinate if indicated.

<https://www.cdc.gov/hepatitis/hbv/HBV-RoutineTesting-Followup.htm>

4.1.4.4 Interpretation of Hepatitis B Serologic Test Results

Centers for Disease Control (CDC)

Interpretation of Hepatitis B Serologic Test Results

Hepatitis B serologic testing involves measurement of several hepatitis B virus (HBV)-specific antigens and antibodies. Different serologic "markers" or combinations of markers are used to identify different phases of HBV infection and to determine whether a patient has acute or chronic HBV infection, is immune to HBV as a result of prior infection or vaccination, or is susceptible to infection.

HBsAg	anti-HBc	anti-HBs	Interpretation
negative	negative	negative	Susceptible
negative	positive	positive	Immune due to natural infection
negative	negative	positive	Immune due to hepatitis B vaccination

Hepatitis B surface antigen (HBsAg):
A protein on the surface of hepatitis B virus; it can be detected in high levels in serum during acute or chronic hepatitis B virus infection. The presence of HBsAg indicates that the person is infectious. The body normally produces antibodies to HBsAg as part of the normal immune response to infection. HBsAg is the antigen used to make hepatitis B vaccine.

Hepatitis B surface antibody (anti-HBs):
The presence of anti-HBs is generally interpreted as

<https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>

4.1.4.5 Information on Pregnancy and HCV Infection

Centers for Disease Control (CDC)

Pregnancy and HCV Infection

Should pregnant women be routinely tested for anti-HCV?
At this time, pregnant women should be tested for anti-HCV if they have or are suspected to have risk factors for HCV infection (20, 25, 26). CDC is in the process of reviewing the evidence to determine if additional HCV screening recommendations, specific to pregnant women, are warranted.

What is the risk that an HCV-infected mother will spread HCV to her infant during birth?
The overall risk of an HCV-infected mother transmitting infection to their infant is approximately 4% to 7% per pregnancy. Transmission occurs at the time of birth, and no prophylaxis is available to prevent it. The risk is significantly higher if the mother has a high viral load or is coinfectd with HIV. Most infants infected with HCV at birth have no symptoms and do well during childhood. More research is needed to find out the long-term effects of perinatal HCV infection (27).

Should a woman with HCV infection be advised against breastfeeding?
No. There is no evidence that breastfeeding spreads HCV. While there is currently not enough information on the risks of transmission through breastfeeding by HCV-positive mothers with cracked or bleeding nipples, precautions may be considered (28).

When should children born to HCV-infected mothers be tested to see if they were infected at birth?

<https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#g1>

4.1.4.6 Interpretation of HCV Test Results

Centers for Disease Control (CDC)

Interpretation of Results of Tests for Hepatitis C Virus (HCV) Infection and Further Actions

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

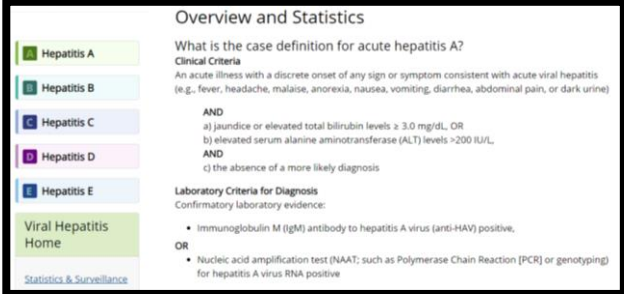
TEST OUTCOME	INTERPRETATION	FURTHER ACTIONS
HCV antibody nonreactive	No HCV antibody detected	Sample can be reported as nonreactive for HCV antibody. No further action required. If recent exposure in person tested is suspected, test for HCV RNA.*
HCV antibody reactive	Presumptive HCV infection	A repeatedly reactive result is consistent with current HCV infection, or past HCV infection that has resolved, or biologic false positivity for HCV antibody. Test for HCV RNA to identify current infection.
HCV antibody reactive, HCV RNA detected	Current HCV infection	Provide person tested with appropriate counseling and link person tested to care and treatment.†
HCV antibody reactive, HCV RNA not detected	No current HCV infection	No further action required in most cases. If distinction between true positivity and biologic false positivity for HCV antibody is desired, and if sample is repeatedly reactive in the initial test, test with another HCV antibody assay. In certain situations,‡ follow up with HCV RNA testing and appropriate counseling.

https://www.cdc.gov/hepatitis/hcv/pdfs/hcv_graph.pdf

4.1.5 PATIENT MATERIALS

4.1.5.1 Hepatitis A Factsheet

Centers for Disease Control (CDC)



The factsheet is titled "Overview and Statistics" and includes a sidebar with links to Hepatitis A, B, C, D, and E, as well as "Viral Hepatitis Home" and "Statistics & Surveillance". The main content defines acute hepatitis A, lists clinical criteria (fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine), and provides laboratory criteria for diagnosis (elevated bilirubin or ALT levels, and absence of other diagnoses).

Overview and Statistics

What is the case definition for acute hepatitis A?

Clinical Criteria
An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine)

AND
a) jaundice or elevated total bilirubin levels ≥ 3.0 mg/dL, OR
b) elevated serum alanine aminotransferase (ALT) levels >200 IU/L

AND
c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis
Confirmatory laboratory evidence:

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive,

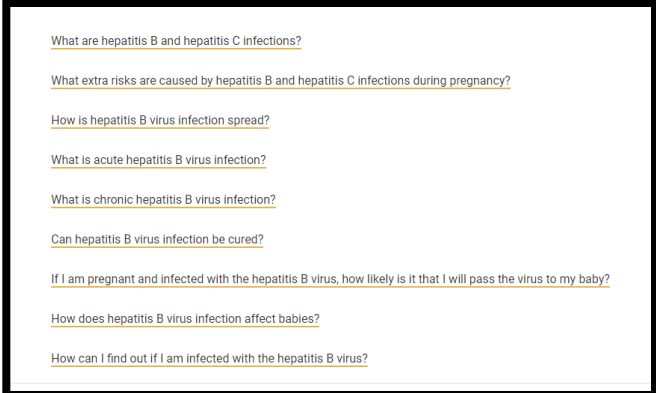
OR

- Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

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

4.1.5.2. FAQ Hepatitis B and Hepatitis C

From the American College of Obstetricians and Gynecologists



A list of frequently asked questions regarding hepatitis B and C infections during pregnancy, including topics like extra risks, transmission, acute and chronic infection, cure, and effects on babies.

[What are hepatitis B and hepatitis C infections?](#)

[What extra risks are caused by hepatitis B and hepatitis C infections during pregnancy?](#)

[How is hepatitis B virus infection spread?](#)

[What is acute hepatitis B virus infection?](#)

[What is chronic hepatitis B virus infection?](#)

[Can hepatitis B virus infection be cured?](#)

[If I am pregnant and infected with the hepatitis B virus, how likely is it that I will pass the virus to my baby?](#)

[How does hepatitis B virus infection affect babies?](#)

[How can I find out if I am infected with the hepatitis B virus?](#)

<https://www.acog.org/Patients/FAQs/Hepatitis-B-and-Hepatitis-C-in-Pregnancy>

4.1.5.3 Prenatal Exposure to Hepatitis B (Educational Slide Show)

Centers for Disease Control (CDC)



The slide show features a title "Hepatitis B and Your Healthy Baby" and a subtitle "An Educational Slide Set for Women Who Have Hepatitis B". It includes a photograph of a smiling woman holding her baby.

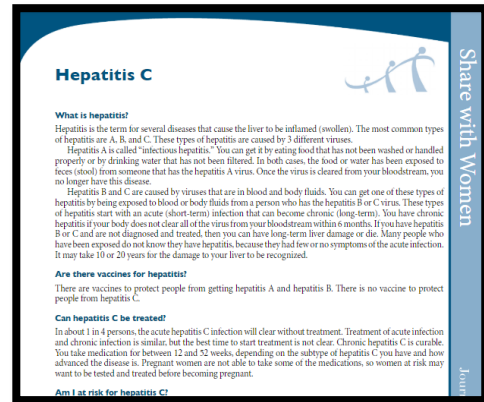
Hepatitis B and Your Healthy Baby

An Educational Slide Set for Women Who Have Hepatitis B

https://www.cdc.gov/hepatitis/Partners/Perinatal/Presentations/HealthyBaby/HepB_And_YourHealthyBaby-eng.pdf

4.1.5.4 Hepatitis C Factsheet

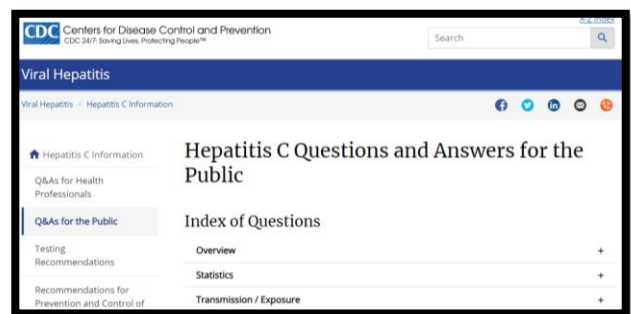
American College of Nurse Midwives



<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12623>

4.1.5.5 Hepatitis C-Q&A for the Public

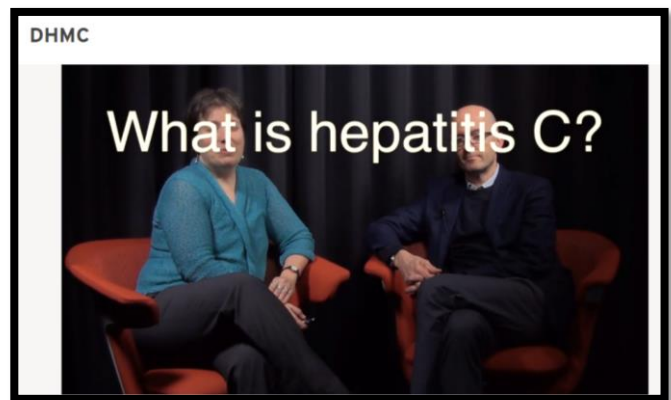
Centers for Disease Control (CDC)



<https://www.cdc.gov/hepatitis/hcv/cfaq.htm>

4.1.5.6 Hepatitis C in Pregnancy Video

A conversation with Dr. Tim Lahey, Infectious Disease



<https://dhmc.wistia.com/medias/dhsjkydhv1>

4.2 HIV Resources for Providers & Patients

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

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

Pre-exposure prophylaxis (PrEP)

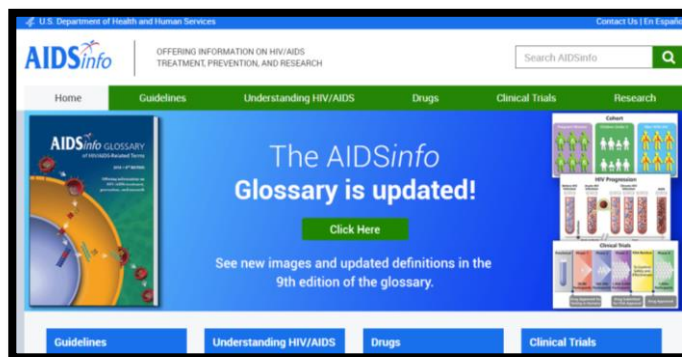
Pre-exposure prophylaxis helps people avoid infection with HIV and should be offered to anyone at risk, including people who use injection drugs or exposed through sexual contact with an HIV positive partner. PrEP consists of HIV medication taken daily to proactively lower risk of infection. When taken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

PrEP must be prescribed, and is covered by many insurance plans. A medication assistance program is available if PrEP is not covered by a specific insurance plan: <https://www.gilead.com/purpose/medication-access/us-patient-access>

4.2.1 PROVIDER MATERIALS

4.2.1.1 AIDSinfo

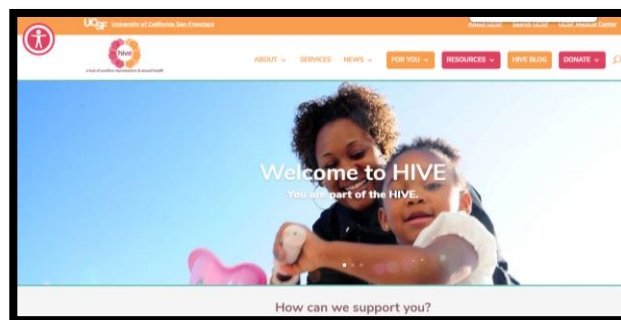
The U.S. Department of Health and Human Services site, a comprehensive resource for clinical guidelines, factsheets, and infographics to facilitate evidence-based care for people living with HIV



<https://aidsinfo.nih.gov/>

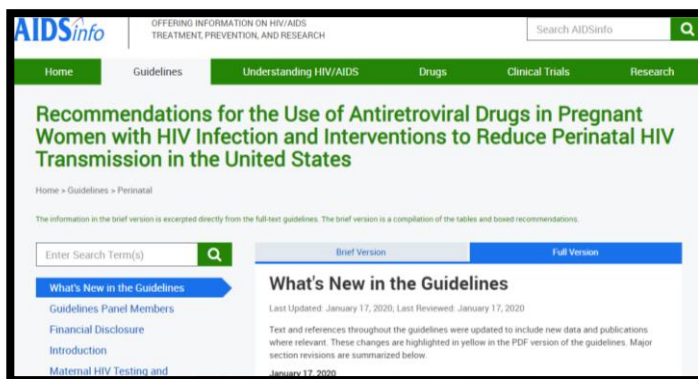
4.2.1.2 UCSF HIVE

University of California-San Francisco



<https://www.hiveonline.org/>

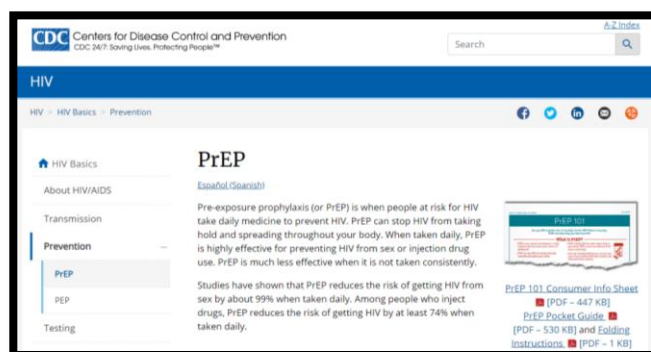
4.2.1.3 NIH Perinatal Treatment Guidelines



<https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0>

4.2.1.4 CDC Information About PrEP

Available in Spanish as well



<https://www.cdc.gov/hiv/basics/prep.html>

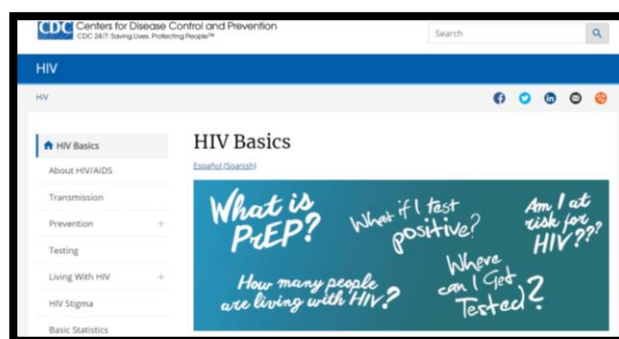
4.2.1.5 CDC Information on HIV and Pregnancy (Provider)



<https://www.cdc.gov/hiv/group/gender/pregnantwomen/>

4.2.2 PATIENT MATERIALS

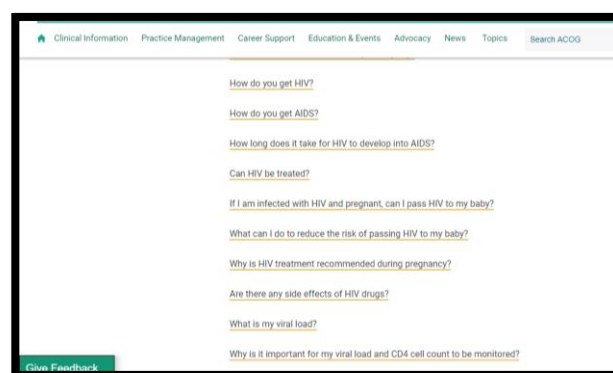
4.2.2.1 CDC Information on HIV



<https://www.cdc.gov/hiv/basics/index.html>

4.2.2.2 FAQs About HIV and Pregnancy

American College of Obstetricians and Gynecologists



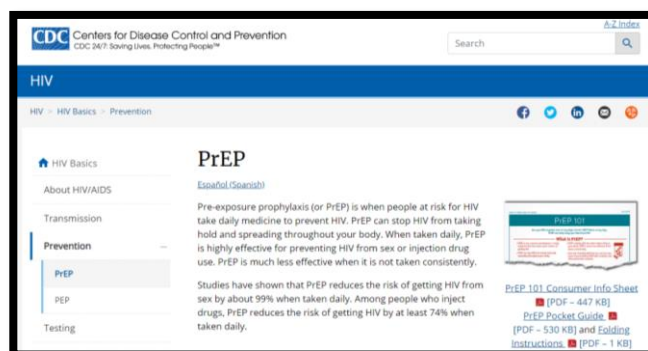
<https://www.acog.org/Patients/FAQs/HIV-and-Pregnancy>

4.2.2.3. What Women Need to Know about Pregnancy and HIV Treatment



<https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/hiv.html>

4.2.2.4. CDC Information About PrEP



<https://www.cdc.gov/hiv/basics/prep.html>

5. Plans of Safe Care (POSC) / Family Care Plans

5.1 Federal Legislation

Federal law requires that all infants determined to be affected by prenatal substance use must have a Plan of Safe Care in place at the time of discharge. As amended in 2010, the Child Abuse Prevention and Treatment Act (CAPTA) requires states to include in their state plans an assurance that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program relating to child abuse and neglect that includes the development of a plan of safe care for the infant born and identified as “being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder”.

Title V, Section 503, “Infant Plan of Safe Care,” of S. 524, “Comprehensive Addiction and Recovery Act of 2016” was signed into law on July 22, 2016. The bill amends CAPTA to address the health and substance use disorder treatment needs of the infant and affected family or caregiver; and to ensure the development and implementation by the State of monitoring systems regarding the implementation of plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

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

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

Key points

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

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

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

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

Vermont

- Information about the VT POSC process (patient-facing): <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Safe-Care-Mothers.pdf>
- Flowchart describing the VT POSC process: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/CAPTA-Flowcharts.pdf>
- VT POSC template: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Hospital-Plan-Safe-Care.pdf>

New Hampshire

- State Law: <https://legiscan.com/NH/text/SB549/id/1728560>
- Guidance Document: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/12/POSC_GuidanceDocument_8-15-19.pdf
- Information about the NH POSC process: <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>
- Frequently Asked Questions about the NH POSC: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_FAQ_v.6-1.pdf
- NH POSC template: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_Template_v.14_FillableForm-2.pdf

Maine

- Maine has not passed legislation regarding the care of substance affected infants since 2013. This law, LD 257, includes the following language:
- For each infant whom the department determines to be affected by illegal substance abuse or, to be suffering from demonstrating withdrawal symptoms resulting from prenatal drug exposure or to have fetal alcohol spectrum disorders, develop, with the assistance of any health care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant and, in appropriate cases, refer the child or birthing person or both to a social service agency or voluntary substance abuse prevention service (HP 194- LD257, June 4, 2013)
- This is currently accomplished through notifying the Maine Office of Child and Family Services about the birth of an infant meeting the criteria described above.

5.2 Provider Materials

5.2.1 PROVIDER LETTER



http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/FINAL_POSC_ProviderLetter_7-15-19.pdf

5.2.2 POSC TEMPLATE

The POSC includes private health information. For electronic versions of this form, visit:

<https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

English version- [MS Word Format](#), [PDF Format](#)

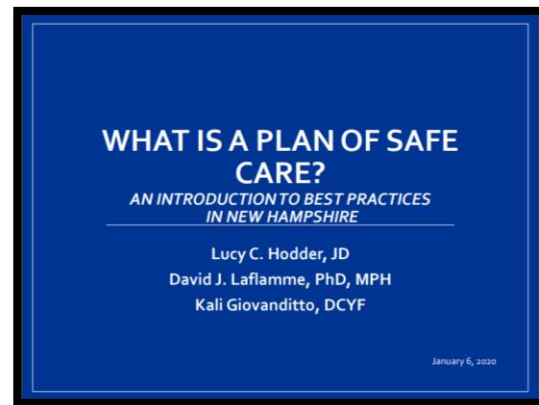
Spanish version – [MS Word Format](#), [PDF Format](#)

5.2.3 GUIDANCE DOCUMENT

This document provides general guidance about Plans of Safe Care (POSCs)¹ as well as answers to questions received from professionals related to Plans of Safe Care.

http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/POSC_GuidanceDocument_8-15-19.pdf

5.2.4 WEBINAR POSC 101



Recording: https://jsi.zoom.us/rec/play/7Jlkdr-rqDM3GdWU4wSDAPd4W9W_Lq6s0SNL86UOmkm0ACMDNAWkM-RBZfuhwYg-if33-m_iWiX2TgM?continueMode=true

Slides: <http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/POSC101Webinar.pdf>

5.2.5 IMPLEMENTATION CHECKLIST

Implementing a new process requires quality planning to systematically design a process that will work for your specific practice or site. Use the following checklist to identify and monitor activities to plan and implement Plans of Safe Care.

New Hampshire Plan of Safe Care (POSC) Implementation Checklist					
Implementing a new process requires quality planning to systematically design a process that will work for your specific practice or site. Use the following checklist to identify and monitor activities to plan and implement Plans of Safe Care.					
Category	Activity	Implementation Status			Notes (e.g., staff training, communications, written procedures, etc.)
Planning	In Process	Complete			
Staffing	Determine members of POSC implementation team.				
	Determine the responsibilities of each team member.				
	Determine a decision making process for the team.				
Template	Determine the timeline for POSC implementation.				
	Determine if this POSC template will be used, or if a practice-specific form will be used.				
	Determine if an electronic or paper form will be used.				
	Determine where the forms will be stored.				
Workflow	Establish a process for updating the form and maintaining form versions.				
	Determine the specific "who," "what," "when," and "where" the POSC will be completed.				
	Establish and document a protocol for the flow of how the POSC will move between staff or offices.				
Referrals	Develop an inventory of community service providers and contact information.				
	Establish internal referral mechanisms. (If appropriate)				
	Establish external referral mechanisms.				
Follow Up	Develop and foster community provider partnerships.				
	Develop protocol for organizing how referrals will occur, and to whom.				
Follow Up	Establish protocol for patient follow up, method of follow up, and frequency of follow up.				

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5.2.6 FACT SHEET

Key Facts about Perinatal Substance Exposure

Supporting Mothers & Infants:
Key Facts about Perinatal Substance Exposure

- Substance use disorders including opioid use disorders are a chronic recurring brain disease. As with other chronic diseases, proper ongoing treatment is essential for recovery and good health outcomes.
- Medication Assisted Treatment (MAT) with methadone or buprenorphine, along with evidence-based behavioral interventions, is the standard of care for pregnant women with opioid use disorder. Insufficient clinical research is available to support the safety of extended-release injectable naltrexone during pregnancy. Breastfeeding while on MAT is safe and is strongly encouraged for maternal-child health and bonding, unless medical contraindications are present (such as HIV or use of substances).
- Sustaining MAT after birth of a baby helps women maintain recovery, prevents return to use of substances, and reduces risk of overdose death. The duration of time a person needs to be on MAT to sustain recovery varies.
- Neonatal Abstinence Syndrome (NAS) describes a group of symptoms an infant may experience when withdrawing from in-utero exposure to opioids. It is treatable and can be managed safely in a non-intensive care setting. It is not an addiction.
- Many infants with NAS can be managed effectively and safely with the Eat Sleep Console (ESC) approach, which encourages parental presence, rooming-in, skin-on-skin contact, swaddling, "on demand" feedings, and other comfort measures. This often eliminates the need for opioid replacement medication for the newborn, and has been shown to substantially shorten the time infants spend in the hospital.
- Tobacco exposure is harmful to both the pregnant woman and her fetus. There is conclusive evidence of lasting harms to infants from in-utero exposure including premature birth, small for gestational age (SGA), and increased risk for Sudden Infant Death Syndrome (SIDS). Pregnant and newly parenting women should be offered support to reduce or stop use of tobacco products through nicotine replacement therapy and behavioral treatment.

Language Matters

Use encouraging and supportive approaches, including nonjudgmental, person first language to encourage women to seek and continue care for themselves and their children.

Refer to the person's disease in clinical terms. Examples include:

- Women with an opioid use disorder
- Infant with neonatal abstinence syndrome

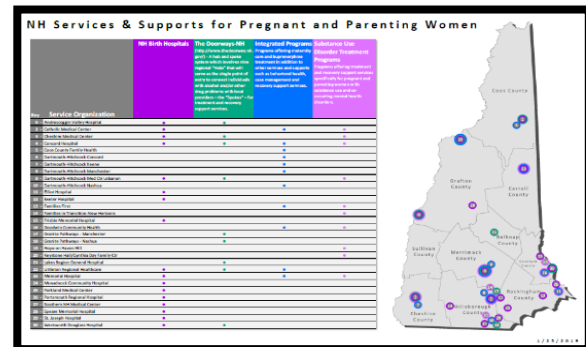
Refer to back page for additional facts.

http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/FINAL-POSC_FactSheet.pdf

5.2.7 POSC SERVICES LIST AND MAP

[illegible]

https://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/PregnantParentingServicesList_6-20-19.pdf



http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/FINAL_MAP_ServicesSupports_PregnantParenting_11x17.pdf

5.3 Patient Materials

5.3.1 POSC PATIENT BROCHURE (ENGLISH AND SPANISH)



English

Word format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/02/FINAL_POSC_PatientBrochure_English_Word-2.docx

PDF Format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/POSC_PatientMaterial_1-10-20.docx.pdf

Spanish

Word format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/02/FINAL_POSC_PatientBrochure_Spanish_Word-3.docx

PDF Format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/SPANISH_POSC_PatientBrochure_1-14-20.pdf

6. Postpartum Care

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

Postnatal visits may include usual obstetrical assessments, including healing from delivery itself and support for breastfeeding; as well as sequential screening for postpartum depression; intimate partner violence; assessment of material needs; and counseling for tobacco cessation if indicated.

Pregnancy intention and need for contraception should be assessed at each visit unless a birthing person received immediate postpartum long acting reversible contraception (LARC). The traditional 6-week postpartum period should be extended for birthing people with OUD/SUD as continuity of relationships is critically important and this is a vulnerable time (ACOG, 2018).

NNEPQIN/AIM Checklist for Post-Discharge Care

- Close postpartum follow-up with frequent visits
 - Review relevant portions of the *Plan of Safe Care* made at hospital discharge
 - Rescreen and brief intervention for return to substance use
 - Postpartum depression screening
 - Monitor for relapse
 - Screen for intimate partner violence at 6 weeks and when indicated
 - Smoking cessation reinforcement or continued cessation counseling when indicated
 - Rescreen for social determinants of health and assess resource needs at each visit,
 - coordinate with case worker/social service providers
 - Assist patient in scheduling appointments for infectious disease management when indicated
 - Facilitate transition for recovery-friendly primary care provider if not established
 - Breast-feeding support
 - Provide contraception and counsel on birth spacing (10 Best Contraceptive Practices; Postpartum Contraceptive Access Initiative (PCAI))
 - Consider providing support and services for longer than the traditional 6 week postpartum period (ACOG Committee Opinion #236)

Postpartum screening

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

Supporting breastfeeding

Methadone, buprenorphine, and naloxone are all compatible with breastfeeding, and breastfeeding is highly recommended for infants at risk for neonatal opioid withdrawal (NAS/NOWS). Please refer to the section on breastfeeding in this toolkit

Family Planning

Immediate post-placental long acting reversible contraception (LARC) is a convenient option for birthing people desiring long-term contraception that is compatible with breastfeeding. Placement under epidural anesthesia or trans-cesarean is particularly attractive for birthing people who have a history of sexual trauma or/and experience anxiety related to pelvic examination. Clinicians providing care for birthing people with substance use disorders should work to ensure that this option is available at the anticipated birth hospital, and offer it prenatally.

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

Transitions of care

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

Working with treatment providers

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

Referral to specialty care

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

Referral for home visiting and other services

At each postpartum visit, providers should ask about and assist birthing people to follow up on referrals to public health nursing and other child and family services available in the community. *Please see additional references sections for literature.*



10 Best Practices in Contraceptive Counseling

Background

Origin

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

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

Application for Women with SUDs

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

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

Framework Design

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

Further Training

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

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

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

Summary

The 10 Best Practices in Contraceptive Counseling:

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

Key Points:

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

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

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

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

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

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

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

<p>Research says</p> <p>Pregnancy ambivalence—including among women who want to leave the prospect of having a baby to “chance”—is associated with gaps in protection, less accurate and consistent use of birth control, more method switching, and extended periods without using contraception.</p>	<p>What to say & do</p> <p>Ask the One Key Question®: “Would you like to become pregnant in the next year?”</p> <ul style="list-style-type: none"> • If “no,” discuss preventing pregnancy • If “yes,” discuss preconception care • If patient is unsure, here are key points to communicate: <ul style="list-style-type: none"> i. Pregnancy is healthiest when planned. ii. Being unsure can lead to gaps in protection. iii. Making a Reproductive Life Plan is a great way to reflect on goals of having or not having children and to identify steps to take to reach those goals. iv. Continue counseling as usual
<p>Additional Resources:</p> <ul style="list-style-type: none"> • One Key Question® - https://powertodecide.org/select360 consulting. • Main, M. (2016). One Key Question: Would You Like to Become Pregnant in the Next Year? <i>Northwest Bulletin: Family and Child Health</i>, 30. Center of Excellence in Maternal and Child Public. Retrieved from https://depts.washington.edu/nwbfch/archives/one-key-question-would-you-become-pregnant-next-year. • Delaware Health and Social Services- Division of Public Health. Adult Life Plan Brochure. Retrieved from http://dhss.delaware.gov/dhss/dph/chca/dphfp services1c.html. • U.S. Department of Health and Human Services: Office of Population Health. Preconception Health and Reproductive Life Plan. https://www.hhs.gov/opa/title-x-family-planning/preventive-services/preconception-health-and-reproductive-life-plan/index.html. 	

4 – Simplify choice process

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

5 – Make a plan for accurate use

Research says	Using a method inaccurately or inconsistently undermines the efficacy of many methods. For example, the perfect use effectiveness rate of the pill is greater than 99% but the typical use effectiveness rate is 91%. This disparity is because of inaccurate and inconsistent use of the pill and translates into thousands of unintended pregnancies. Issues of use accuracy and consistency are critical to address	What to say & do
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- “How will you remember to take your method as described?”
- “What will you do if you make an error using your method?”
- “How will you remember to pick up your refills?”

→ Discuss common errors made when using method the patient is considering.

6 – Make a plan for side effects

Research says	Switching methods is often associated with gaps in protection or switches to less effective methods. Side effects are one of the most common reasons patients give for switching methods.	What to say & do
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- “Most side effects are temporary, usually lasting 2-3 months.
- I’m going to share a few common side effects. Tell me which, if any, might be hard for you and I’ll help you make a plan to deal with them.”

→ Discuss common side effects for the method the patient is considering

7 – Address lifestyle and broader context (POISE)

Research says	In addition to the attributes of a given contraceptive method, you need to make sure that the chosen method fits with the lifestyle and life circumstances of the patient, more generally. It is not enough to just talk about effectiveness, side effects, and other method characteristics. A good choice considers broader considerations as well.	What to say & do
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- Pros and Cons: “What are the positives and negatives for you using this method?”
- Others’ Views: “How would people important to you feel about you using this method?”
- Image: “How does this method fit with how you see yourself?”
- Self-Efficacy: “If you decided to use this method, how easy or hard do you think it would be for you to use it correctly?”
- Emotions: “What positive and/or negative feelings do you have about this method?”

8 – Make a plan for method switching

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

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

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

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

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

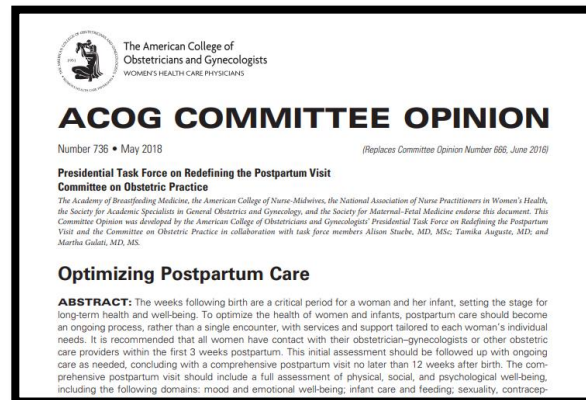
Remember, most of these methods do not protect against STDs.
 Use a condom to lower your chances of getting an STD.



www.nnepqn.org/clinical-guidelines/

6.2 Provider Materials

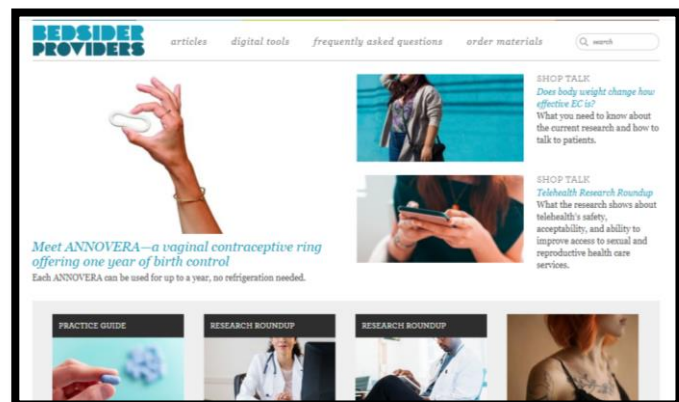
6.2.1 ACOG COMMITTEE OPINION #736, OPTIMIZING POSTPARTUM CARE



<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>

6.2.2 BEDSIDER BIRTH CONTROL SUPPORT NETWORK

Resources and educational materials for contraceptive practice

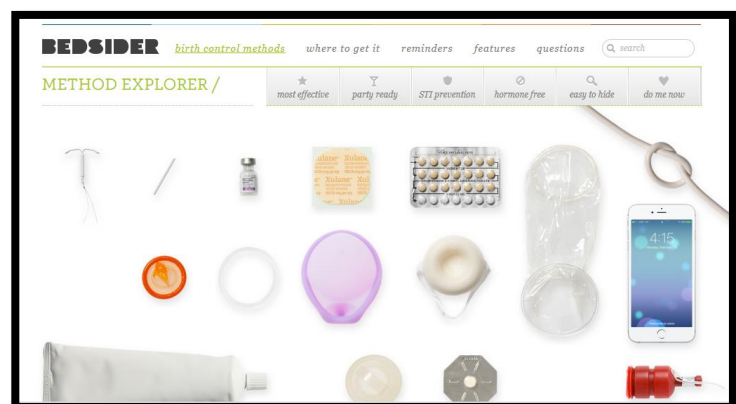


<https://providers.bedsider.org/>

6.3 Patient Materials

6.3.1 BEDSIDER METHOD EXPLORER

Interactive site with digital patient education materials



<https://www.bedsider.org/methods>

7. Supporting LGBTQIA and Gender Diverse Patient Health

Maternal and obstetric care for Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit + (LGBTQIA2S+) and gender diverse people is critical and necessary, but has gained visibility in the medical community only recently. There are many ways to provide affirming care to all patients including: asking a patient for their pronouns, offering psychosocial support, providing hormone therapy and other practices that aim to align a person's physical experiences with their gender identity. Provider education in this area is critical. People in the LGBTQIA2S community have historically experienced discrimination especially in healthcare setting. This is partly due to underreported and under researched experiences with pregnancy for this population and the prominence of the heteronormative framework of most maternal and obstetric care. Many unique considerations exist for maternal and obstetric care of gender diverse patients.

Considerations for Perinatal Care

Supporting all patients' physical and mental health is critical, especially for those who are trans, non-binary or gender diverse as they have historically faced higher rates of discrimination. For pregnant and parenting people this may look like affirming the person's pregnancy in a way that is safe such as calling ahead for certain services to assure they are inclusive or ensuring that all clinic staff use gender affirming language in the workplace and providing them with education around gender, sex and sexuality. Affirming the identity of a patient is the first step to providing proper care. Simply asking how a person would like to be referred to can create safety and trust between patient and provider.

Education around trans inclusive medical care is also crucial. This may look like systems-level and/or interpersonal interventions. Hormone therapy and other practices that aim to align a person's physical experiences with their gender identity are areas where patient education are crucial. Providing resources for pregnant and parenting people about gender affirming parenting may also be helpful.

As an example of affirming medical interventions for a transgender man's pregnancy, Hahn et al., 2019¹ found the following teaching points:

- Testosterone should not be considered a contraceptive. Testosterone may lead to amenorrhea and cessation of ovulation. However, although testosterone may reduce fertility, fertilization is possible despite prior or active use of testosterone and while amenorrheic from testosterone use.
- Testosterone is not currently recommended during pregnancy owing to possible irreversible fetal androgenic effects. An optimal interval between discontinuing testosterone and conceiving is unknown at this time.
- Although transgender and gender-diverse people previously on testosterone may adjust well to pregnancy, lack of testosterone use during fertilization and pregnancy may lead to or exacerbate gender dysphoria.
- Testosterone may be excreted in small quantities in human milk and may affect milk production. Currently, it is not recommended to use testosterone while chestfeeding, until more information is known about the effects of testosterone use on human milk.

7.1. Provider Materials

7.1.1 MOTHERS AND OTHERS: THE INVISIBILITY OF LGBTQ PEOPLE IN REPRODUCTIVE AND INFANT PSYCHOLOGY

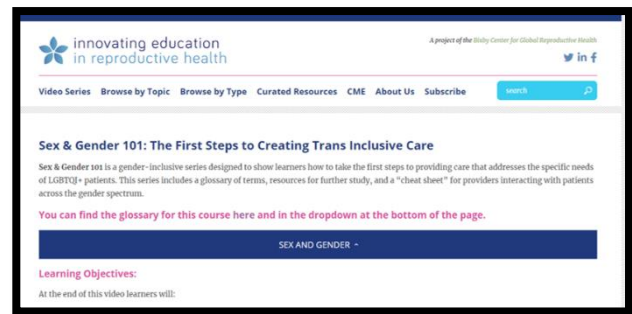
Editorial article

Zoe Darwin & Mari Greenfield (2019). Journal of Reproductive and Infant Psychology, 37:4, 341-343, DOI: 10.1080/02646838.2019.1649919



<https://www.tandfonline.com/doi/full/10.1080/02646838.2019.1649919/>

7.1.2 SEX & GENDER 101: THE FIRST STEPS TO CREATING TRANS INCLUSIVE CARE



<https://www.innovating-education.org/course/gender-inclusive-care/>

7.2 Patient Materials

7.2.1 PREPARING FOR PREGNANCY AS A NON-BINARY PERSON

Resource from Family Equality



<https://www.familyequality.org/resources/preparing-for-pregnancy-as-a-non-binary-person/>

7.2.2 SUPPORT RESOURCES FOR FAMILIES OF GENDER DIVERSE YOUTH

Resource from HealthyChildren.org



<https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/Support-Resources-for-Families-of-Gender-Diverse-Youth.aspx>

References

1. Hahn M, Sheran N, Weber S, Cohan D, Obedin-Maliver J. Providing patient-centered perinatal care for transgender men and gender-diverse individuals: A collaborative multidisciplinary team approach. *Obstetrics and gynecology*. 2019 Nov;134(5):959.



SECTION 5:

BEST PRACTICE IMPLEMENTATION
AND QUALITY IMPROVEMENT

Section 5: Quality Improvement and Implementation Resources

Whether you're implementing new practices or reinforcing or updating existing practices, it is important to continuously evaluate the care you and your team provide patients. This section provides tools to assist practices who would like to assess the care they provide patients with substance use disorders.

1. [Assessing the Quality of Care](#)
 - 1.1 [Provider Survey](#)
 - 1.2 [Care Improvement Questionnaire](#)
2. [Implementation Support for Perinatal SUD Care Management](#)
 - 2.1 [Best Practice Checklist for use in EMR](#)
 - 2.2 [Buprenorphine Induction Algorithm](#)
 - 2.3 [Opioid Use Disorder Clinical Pathway](#)
3. [Perinatal Substance Use Disorder Projects and Programs](#)
4. [Perinatal Opioid Use Learning Collaborative-Data Collection Materials](#)
 - 4.1 [Process Map](#)
 - 4.2 [Sample Outcomes Summary Form](#)

1. Assessing the Quality of Care

The following tools may be used by practices to assess the quality of care provided to pregnant patients. One tool assesses providers' attitudes towards patients' substance use. The second tool assesses a patient's experience receiving care from a practice. Results from these brief surveys may inform educational opportunities for providers, or adjustments to practice policies or protocols.

1.1 Provider Survey

This survey was developed by the National Centre for Education and Training on Addiction, Adelaide, South Australia.

Health Professional Attitudes Towards Licit and Illicit Drug Users: A Training Resource

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

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

1.2 Care Improvement Questionnaire

Developed by Dartmouth-Hitchcock Medical Center Team but heavily influenced by PROMIS questionnaires

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

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

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

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

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

2. Implementation support for perinatal SUD care management

2.1 Best Practice Checklist for use in EMR

This checklist was developed as a tool used in a data collection learning collaborative facilitated by Dartmouth-Hitchcock.

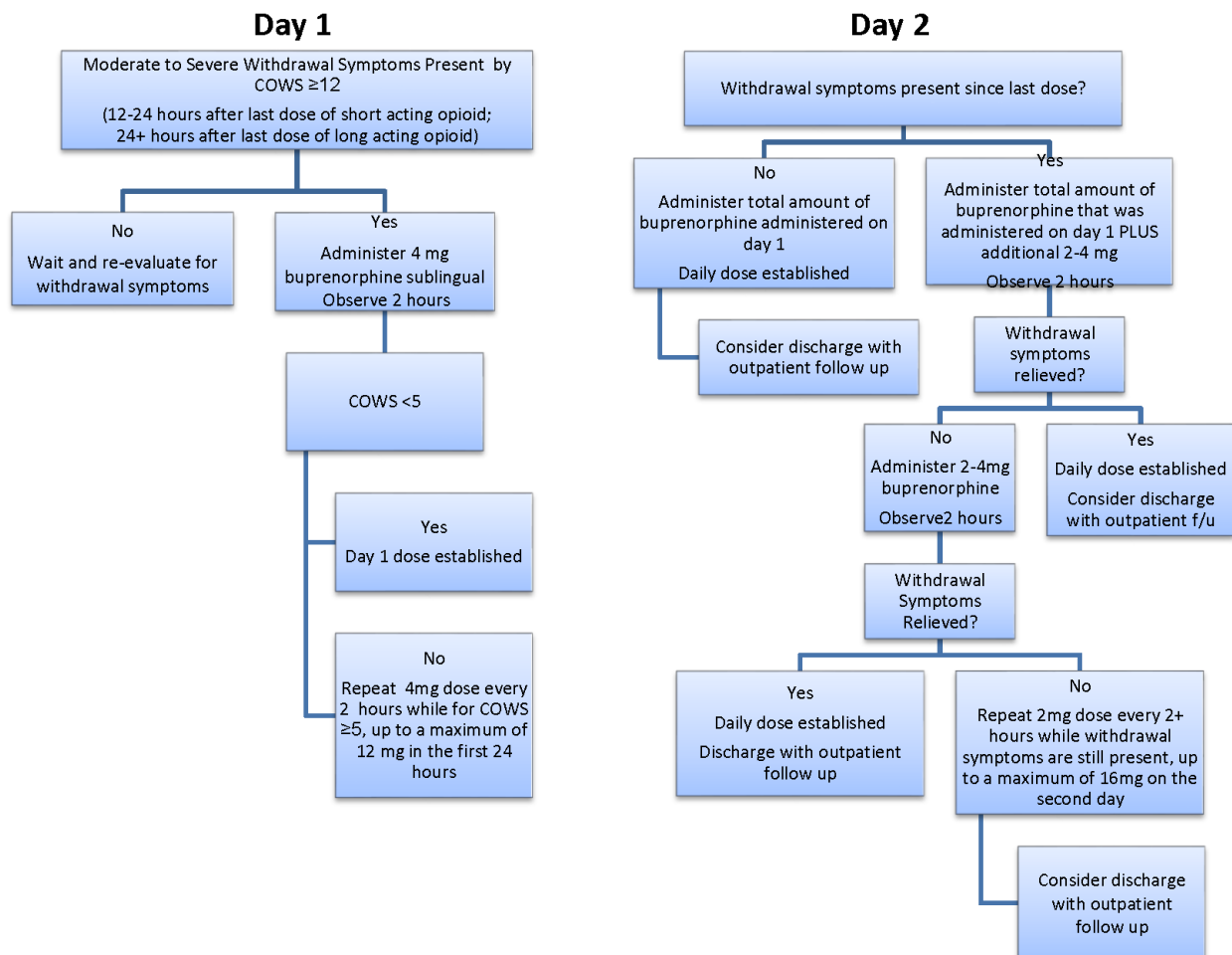
Element	Date	Comments
Federal consent to share information with treatment provider		
HIV status		
HBsAg, HBcAb, HBsAb		
Hepatitis C antibody		
HCV viral load and genotype <i>(if indicated)</i>		
Hepatic Function Panel		
Serum Creatinine		
Institutional drug testing policy reviewed		
Plan of Safe Care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

Review Plan of Safe Care		
Review institutional drug testing policy		
NAS/newborn care		
Breastfeeding		
Pain management		
Family Planning		
Pediatrician identified		
Repeat Hepatitis A or A/B vaccine		
OTHER		

2.2 Induction Algorithm

Source: Dartmouth-Hitchcock Medical Center

Buprenorphine Induction Algorithm (inpatient)



2.3 Opioid Use Disorder Clinical Pathway

The following pathway is intended to provide a guide for clinicians seeking to operationalize best practice in the care of pregnant people with substance use disorders including opioid use disorders, and is adapted from a similar pathway developed by the Alliance for Innovation in Maternal Health.

ANTEPARTUM CARE (OUTPATIENT)

FOLLOWING IDENTIFICATION OF SUBSTANCE USE IN PREGNANCY

- Ask about symptoms of withdrawal if substance identified causes physiologic dependence (for example, opioids, benzodiazepines, alcohol)
- Assess for signs and symptoms of acute withdrawal (COWS assessment)
 - Early: agitation, anxiety, muscle aches, increased tearing, insomnia, runny nose, sweating, yawning
 - Late: abdominal cramping, diarrhea, dilated pupils, goose flesh, nausea, vomiting
- Refer immediately to one of the following for treatment and/or stabilization depending on gestational age, substance suspected of causing withdrawal, and acuity:
 - Emergency Room
 - Obstetric Triage
 - Inpatient treatment center

<ul style="list-style-type: none"> • Screen for comorbid psychiatric conditions <ul style="list-style-type: none"> ◦ If positive, ensure Behavioral Health needs are met through referral or integrated care
<ul style="list-style-type: none"> • Screen for comorbid domestic violence <ul style="list-style-type: none"> ◦ If positive refer to local domestic violence advocacy service
<ul style="list-style-type: none"> • Complete a detailed medical, surgical, obstetric, and prenatal history
<ul style="list-style-type: none"> • Provide physical examination if patient consents
<ul style="list-style-type: none"> • Assess for other immediate psychosocial needs
<ul style="list-style-type: none"> • Obtain recommended lab testing in addition to routine prenatal labs (NNEPQIN checklist) <ul style="list-style-type: none"> ◦ HIV ◦ Screen for Hepatitis B disease or immunity: HepBsAg, anti-HBcore, HBsAb <ul style="list-style-type: none"> ▪ Consider immunization as indicated ◦ Screen for hepatitis C: HCV antibody <ul style="list-style-type: none"> ▪ If positive draw HCV PCR, LFTs ◦ Serum creatinine ◦ Consider gamma-glutamyl transferase (GGT) if active alcohol use suspected ◦ Assess risk factors for tuberculosis and screen if indicated ◦ Discuss institutional practice regarding urine toxicology (drug testing) <ul style="list-style-type: none"> ▪ Requiring routine urine toxicology as a part of prenatal care may be a deterrent to engagement. However, urine toxicology can also be helpful, if requested by a patient (e.g. if court ordered) ▪ Urine toxicology should never be used to <i>screen</i> for drug or alcohol use, unless a patient is unconscious⁴ or otherwise incapacitated and results are essential for care ▪ Patient consent is required for urine toxicology unless a patient is unconscious or unable to consent. ▪ When performed, toxicology testing should include: synthetic opioids (e.g., buprenorphine, fentanyl, oxycodone). Fentanyl and benzodiazepines may not be detected with standard drug test and may require more specific testing. Consult with individual lab to ensure both synthetic opioids and benzodiazepines are included. ◦ Order baseline EKG before starting methadone
<ul style="list-style-type: none"> • Perform dating ultrasound upon entry to care
<ul style="list-style-type: none"> • Determine appropriate level of care and arrange referrals to treatment when indicated and accepted by woman (Wright et al, Figure 1) <ul style="list-style-type: none"> ◦ Refer for medically supervised inpatient detoxification if alcohol or benzodiazepine dependent ◦ If psychiatric or medical instability, refer for emergency psychiatric or medical care services.
<ul style="list-style-type: none"> • When appropriate, provide the pregnant/postpartum person information re. area treatment providers (SAMHSA treatment directory)
<ul style="list-style-type: none"> • If a pregnant person is currently in a treatment program: <ul style="list-style-type: none"> ◦ Obtain appropriate CFR42 Part 2 consent to communicate with treatment provider (Legal Action Center sample consents) ◦ Coordinate care with mental health/treatment provider or center and provide a warm Handoff when possible
<ul style="list-style-type: none"> • Counsel about recommended substance use management, risks to pregnancy, fetus, infant and explore treatment options <ul style="list-style-type: none"> ◦ Recommended treatment for OUD during pregnancy is MOUD with buprenorphine or methadone; explore options, arrange appropriate referrals. ◦ Recommended management of alcohol use during pregnancy is complete abstinence; explore options arrange appropriate referrals. ◦ Recommended management of marijuana use during pregnancy is abstinence; explore options to assist patient.
<ul style="list-style-type: none"> • Counsel about risks of tobacco use and offer smoking cessation strategies
<ul style="list-style-type: none"> • Counsel about maternal/fetal/neonatal risks of polysubstance use (SAMHSA Factsheet #6)
<ul style="list-style-type: none"> • Check state Prescription Monitoring Program

⁴ SAMHSA Clinical Guidance Document (2018)

<ul style="list-style-type: none"> • Be aware of potential pharmacologic interactions with Buprenorphine/Methadone (McCance-Katz et al, Table 2)
<ul style="list-style-type: none"> • Discuss naloxone and offer prescription (Narcan toolkit)
<ul style="list-style-type: none"> • Assess need for bowel regimen for constipation
<ul style="list-style-type: none"> • Assess need for anti-emetics and antacids for hyperemesis/reflux <ul style="list-style-type: none"> ◦ Note: avoid Zofran for people on methadone to avoid risk of prolonged QTc interval
<ul style="list-style-type: none"> • Consultation and Referral considerations may include, but are not limited to: <ul style="list-style-type: none"> ◦ Social Work ◦ Case Management ◦ Maternal Fetal Medicine if medically complex
<ul style="list-style-type: none"> ◦ Cardiology with prior history of endocarditis ◦ Infectious Disease if HIV or HCV/HBV positive, Gastroenterology if HCV/HBV positive ◦ Dental care
<ul style="list-style-type: none"> • Schedule short interval follow up for prenatal care: prenatal care attendance is associated with improved outcomes⁵
FOLLOW-UP CARE
<ul style="list-style-type: none"> • Reassess and treat opioid side effects
<ul style="list-style-type: none"> • Assess for changes in psychosocial and medical needs
<ul style="list-style-type: none"> • Ask about cravings and treatment effectiveness at every visit
<ul style="list-style-type: none"> • Provide continued tobacco cessation counseling and treatment for patients who smoke
<ul style="list-style-type: none"> • Periodically review PDMP for patient prescription history
<ul style="list-style-type: none"> • Offer urine toxicology, with patient consent, in third trimester, to allow time for confirmatory testing prior to admission if necessary.
<ul style="list-style-type: none"> • Document treatment coordination in medical record to facilitate postpartum discharge planning
SECOND AND THIRD TRIMESTER CARE
<ul style="list-style-type: none"> • Schedule detailed second trimester anatomy scan
<ul style="list-style-type: none"> • Schedule third trimester growth scan <ul style="list-style-type: none"> ◦ Monitor growth with serial assessments as indicated
<ul style="list-style-type: none"> • Antenatal testing only if clinically indicated; e.g., IUGR. (Reddy et al, Box 1) <ul style="list-style-type: none"> ◦ For patients on methadone: When antenatal testing is indicated, try to schedule at least 4-6 hours after last methadone dose to reduce false positive NST and/or BPP.
<ul style="list-style-type: none"> • Repeat HIV, HCV, RPR, GC/CT in third trimester <ul style="list-style-type: none"> ◦ Repeat HBsAg if initial HBsAb testing negative
<ul style="list-style-type: none"> • Verify and update MOUD medication/dose/status with treatment provider/center prior to birth <ul style="list-style-type: none"> • Advise pregnant people to bring buprenorphine to hospital admission for safe storage and dose verification; and last dose letter for patients receiving methadone.
<ul style="list-style-type: none"> • Discuss pain management options for labor and birth <ul style="list-style-type: none"> ◦ Consider Anesthesiology consult for the pregnant people with high anxiety, difficult IV access, or other co-existing medical issues pertinent to anesthesia
<ul style="list-style-type: none"> • Educate family about NAS/NOWS, breastfeeding <ul style="list-style-type: none"> ▪ Options for Rooming in if provided at anticipated birth hospital ▪ Maternal participation in Eat, Sleep, Console if utilized at anticipated birth hospital ▪ Encourage skin-to-skin and breastfeeding (SAMHSA factsheet #11)
<ul style="list-style-type: none"> • Provide Patient/family education to include: <ul style="list-style-type: none"> ◦ Hospital policies (SAMHSA Factsheet #7) <ul style="list-style-type: none"> ▪ NAS/NOWS assessment/management/length of stay ▪ Breastfeeding ▪ Maternal/newborn toxicology and reporting requirements

⁵ El Mohandes, 2008; Goodman, Saunders, Frew et al, 2021

<ul style="list-style-type: none"> • Provide education about <ul style="list-style-type: none"> ○ Signs and symptoms of pregnancy complications ○ Importance of prenatal care ○ Plan for fetal surveillance ○ NAS/NOWS assessment/management/length of stay ○ Maternal/newborn toxicology and reporting ○ Importance of postpartum care
<ul style="list-style-type: none"> • Consider prenatal consult appointment with pediatrician/neonatologist at delivering institution
<ul style="list-style-type: none"> • If delivering hospital is unable to care for infant with NAS/NOWS, discuss antenatal transfer of care versus neonatal transfer after delivery if treatment becomes necessary
<ul style="list-style-type: none"> • Provide non-coercive contraceptive counseling (SAMHSA Factsheet #7) <ul style="list-style-type: none"> ○ Offer post-placental IUD insertion or implant prior to discharge, if available at institution.
GENERAL CONSIDERATIONS OF METHADONE MAT IN PREGNANCY
<ul style="list-style-type: none"> • For people on methadone prior to pregnancy, encourage to continue current treatment relationship. <ul style="list-style-type: none"> ○ May need increased dose in throughout pregnancy
<ul style="list-style-type: none"> • Patient/family education <ul style="list-style-type: none"> ○ Risk and benefits of methadone treatment in pregnancy ○ Daily visit requirement at treatment center ○ Insurance coverage and/or cost ○ Conflicting long-term studies on outcomes in children exposed in utero ○
GENERAL CONSIDERATIONS OF BUPRENORPHINE IN PREGNANCY
LITERATURE DOES NOT SUPPORT SWITCHING FROM BUPRENORPHINE/NALOXONE TO BUPRENORPHINE MONOTHERAPY DUE TO PREGNANCY
<ul style="list-style-type: none"> • In order to maintain plasma concentrations above 1ng/mL to prevent withdrawal symptoms, consider increasing frequency of dosing (3-4 times per day) (Caritis, S.N. et al)
<ul style="list-style-type: none"> • Patient/family education <ul style="list-style-type: none"> ○ Risk and benefits of buprenorphine treatment in pregnancy ○ Insurance coverage and/or cost ○ Induction process requires patient to be in moderate withdrawal ○ Limited data on long-term outcomes of children exposed in utero
<ul style="list-style-type: none"> • Consider possible “graduation” to monthly prescription as indicated
INPATIENT OBSTETRIC CARE
IF INITIAL CONTACT IS IN OBSTETRIC ED/TRIAGE OR L&D
<ul style="list-style-type: none"> • Refer to above “Upon entry into care and identification of substance use in pregnancy”
<ul style="list-style-type: none"> • Initiate clinical pathway for acute opiate withdrawal or elective induction to MOUD <ul style="list-style-type: none"> ○ ASAM buprenorphine course
<ul style="list-style-type: none"> • Consider acute withdrawal in the differential diagnosis of a pregnant person with intractable, nausea, vomiting, or abdominal pain
<ul style="list-style-type: none"> • Assess for signs and symptoms of placental abruption or labor
ADMISSION FOR LABOR AND BIRTH
<ul style="list-style-type: none"> • Request release of information to confirm MOUD medication and dose with addiction provider <ul style="list-style-type: none"> ○ Note: Inpatient provider without a DATA2000 waiver may legally prescribe buprenorphine and methadone to maintain the pregnant person’s treatment dose during hospitalization, but a waiver is required to prescribe buprenorphine at time of discharge

<ul style="list-style-type: none">Continue buprenorphine/methadone at usual dosing (SAMHSA Factsheet #8)<ul style="list-style-type: none">Consider dividing total daily dose of buprenorphine into every 6-8 hour dosing for maximal effects (ACOG Committee Opinion 711)
<ul style="list-style-type: none">Prescribe nicotine replacement as indicated
<ul style="list-style-type: none">Labs<ul style="list-style-type: none">Routine labs for labor and birthRepeat HIV/Hepatitis screening if not repeated in third trimesterUrine toxicology with consent
<ul style="list-style-type: none">Notify pediatric provider of admission for delivery and determine need for neonatal team at birth
<ul style="list-style-type: none">Consults<ul style="list-style-type: none">Neonatology consult if not previously doneSocial work/Care managementAnesthesiologyLactationIf non-prescribed substance use is first disclosed at time of birth, or substance- related complications are present, consider consultation with addiction or Maternal Fetal Medicine specialist.
<ul style="list-style-type: none">Offer immediate postpartum long-acting contraception as provided by facility (ACOG Committee Opinion #670)
<ul style="list-style-type: none">Involve the postpartum person, social work, and pediatrics/neonatology to establish a Plan of Safe Care.
PERIPARTUM PAIN MANAGEMENT (OHIO MOMS PAIN MANAGEMENT PROTOCOL)
<ul style="list-style-type: none">General Considerations:<ul style="list-style-type: none">Maintenance medication does not treat painWomen using MAT or with history of long term opioid exposure may require higher and more frequent dosing of narcotic medications for intrapartum and postpartum pain<ul style="list-style-type: none">Opioid dependent women have increased sensitivity to painful stimuli (hyperalgesia)Opioids dependent women experience tolerance to opioid treatment for analgesiaHigher doses of full opioid agonists will be required to displace buprenorphine and provide analgesia
<ul style="list-style-type: none">Pharmacologic interactions<ul style="list-style-type: none">Avoid partial agonist/antagonists in treating pain (i.e., nalbuphine or butorphanol) as these can cause precipitated withdrawal for patients who are physiologically dependent on opioids. Fentanyl is the preferred opioid analgesic for this reason.
<ul style="list-style-type: none">Neuraxial analgesia is preferred for cesarean birth or other procedures<ul style="list-style-type: none">If general anesthesia is necessary, be aware of increased risk of airway compromise or drug interactions with concomitant use of stimulants
INTRAPARTUM (EXECUTIVE SUMMARY ON OPIOID USE IN PREGNANCY BOX 2)
<ul style="list-style-type: none">Educate L&D and postpartum staff on opioid pharmacology and appropriate pain control
<ul style="list-style-type: none">Provide continuous labor support during active labor<ul style="list-style-type: none">1:1 staffingOffer Doula services if available and affordable
<ul style="list-style-type: none">Avoid fetal scalp electrodes in women with HIV or HCV
<ul style="list-style-type: none">Recommend early labor neuraxial anesthesia with continuous dosing to provide pain relief for labor and birth<ul style="list-style-type: none">Epidural analgesia using opioids (e.g. fentanyl) in usual labor doses may not be effective in opioid dependent patients.May be necessary to use higher doses of local anesthetics or nonopioid adjuvants such as clonidineIf neuraxial anesthesia is not feasible or available, consider the following:

- Nitrous oxide
- Short acting opioids
- *Do not use nalbuphine or butorphanol for analgesia or pruritis as these can precipitate withdrawal*
 - *If withdrawal inadvertently precipitated, withdrawal symptoms can be reversed with full agonists or for those in treatment with buprenorphine a 2-4 mg dose*

POSTPARTUM CARE (REDDY ET AL)

- Vaginal birth pain management
 - Consider scheduled doses of NSAIDs and acetaminophen rather than prn dosing
 - Avoid acetaminophen with evidence of liver impairment
- Cesarean birth pain management may include the following:
 - Intrathecal or epidural opioids for postpartum pain control
 - May not be fully effective requiring other options
 - Higher concentrations of local anesthetics or non-opioid adjuvants (e.g., clonidine) in epidural solutions
 - Consider PCA for additional coverage if needed but use PCA by demand only and patient monitored carefully for respiratory depression
 - Intraoperative ketorolac when appropriate
 - Scheduled Nonsteroidal anti-inflammatory drugs and acetaminophen
 - Avoid acetaminophen with evidence of liver impairment
 - Alternative pain management includes gabapentin, transversus abdominis plane (TAP) blocks, and IV acetaminophen but further data needed
- When opioids used for complicated vaginal or cesarean birth:
 - Practice shared decision making
 - Monitor closely for over sedation.
 - If somnolent, decrease pain medication dose or consult the addiction treatment provider to adjust dose of MAT
 - Provide close follow-up
 - Prescribe limited quantities
 - Taper rapidly transitioning for non-opioid options
 - Consider hydromorphone for patients on buprenorphine, due to high receptor binding capacity

POSTPARTUM SUPPORT

- If breastfeeding is desired and institutional policy allows, provide lactation consultation and breast feeding support ([SAMHSA Factsheet #11](#))
- Provide patient and family education to include:
 - Caring for NAS babies ([Stronger Together video](#)) (*NNEPQIN strongly urges patient education on the Eat, Sleep, Console Model, contact NNEPQIN for more information*)
 - Signs and symptoms of newborn withdrawal
 - Comfort care measures
 - Maternal care needs
 - Signs and symptoms of postpartum depression
 - When to notify a provider (obstetric and newborn)
- If on methadone, monitor for increased somnolence and contact treatment provider if dose decrease appears necessary.

DISCHARGE PLANNING (SAMHSA FACTSHEET #15)

- Counsel patients to avoid postpartum discontinuation of treatment due to increased relapse rates for SUD after delivery (*NNEPQIN strongly urges the prescription of naloxone at discharge, please see the Naloxone section of NNEPQIN toolkit*)
- Coordinate hospital discharge with addiction treatment provider so treatment can continue after discharge without interruption, this is especially important with methadone treatment which typically requires daily observed dosing.
- For patients on buprenorphine, a provider with buprenorphine waiver can prescribe a prescription at usual dose to bridge patient until next appointment with treatment provider
- Provide contraceptive counseling and access to contraception if desired

<ul style="list-style-type: none"> • Develop Plan of Safe Care/Family Care Plan per state and institutional policy <ul style="list-style-type: none"> ◦ Engage birthing person, social worker, nursing, and/or pediatric/neonatal team to define plan of safe care.
<ul style="list-style-type: none"> • Determine discharge pain management plan <ul style="list-style-type: none"> ◦ Maximize NSAIDs and nonpharmacologic measures ◦ If opioids are required at discharge, prescribe only the quantity likely to be used
<ul style="list-style-type: none"> • Schedule postpartum visits, with first postpartum visit within 1-2 weeks
<ul style="list-style-type: none"> • Provide education on safe storage and disposal of medications
POSTPARTUM CARE (OUTPATIENT)
CLOSE POSTPARTUM FOLLOW-UP WITH FREQUENT VISITS
<ul style="list-style-type: none"> • Rescreen and brief intervention for return to substance use (SAMHSA Factsheet #16)
<ul style="list-style-type: none"> • Provide postpartum depression and anxiety screening
<ul style="list-style-type: none"> • Screen for intimate partner violence
<ul style="list-style-type: none"> • Provide smoking cessation reinforcement or continued cessation counseling as indicated.
<ul style="list-style-type: none"> • Provide on-coercive contraceptive counseling and ensure access to contraception as desired
<ul style="list-style-type: none"> • Individualize timing of transition to recovery-friendly primary care, and provide support services as needed⁶
<ul style="list-style-type: none"> • Assess resource needs at each visit and coordinate with case worker/social service providers
<ul style="list-style-type: none"> • Assist the woman in scheduling appointments for hepatitis C treatment when indicated
<ul style="list-style-type: none"> • If continuing to breast feed, ensure access to lactation specialist

⁶ ACOG, 2018. Optimizing postpartum care Committee opinion #736

3. Perinatal Substance Use Disorder Project and Programs

		PERINATAL SUBSTANCE USE DISORDER PROJECTS/PROGRAMS (see below for description of each)				
		Neonatal Abstinence Syndrome (NAS) Collaborative	Perinatal Opioid Use Disorder (OUD) Learning Collaborative	NH Pediatric Recovery Friendly Practices	21st C Cures Act - Integrated MAT for Pregnant & Postpartum Women	Patient Centered Outcomes Research Institute (PCORI)
Participating NH Hospitals and Other Providers	Community Served					
Androscoggin Valley Hospital	Berlin	X				
Coos County Family Health Center	Berlin		X		X	
Valley Regional Pediatrics	Claremont		X ¹	X		X ¹
Concord Hospital	Concord	X	X			X
Dartmouth-Hitchcock	Concord		X			X
Memorial Hospital	Conway	X	X			X
Parkland Hospital	Derry	X				
Garrison Women's Health	Dover		X			X
Wentworth Douglass Hospital	Dover	X				
Goodwin Community Health Center	Dover/Somersworth				X	X
Exeter Hospital	Exeter	X				
Lamprey Health Care	Exeter		X			X
Cheshire Medical Center (D-H Keene)	Keene	X	X		X	X
Lakes Region General Healthcare	Laconia	X ¹¹				
Alice Peck Day Memorial Hospital	Lebanon	X ¹¹	X ¹	X		X ¹
Dartmouth-Hitchcock	Lebanon	X	X	X	X	X
Littleton Hospital	Littleton	X				
North Country Women's Health	Littleton		X			
Catholic Medical Center	Manchester	X	X			
Elliot Hospital	Manchester	X				
Manchester Community Health Center	Manchester		X			X
Dartmouth-Hitchcock	Manchester/Bedford		X		X	X
Dartmouth-Hitchcock	Nashua		X		X	X
Southern NH Medical Center	Nashua	X				
St. Joseph Hospital	Nashua	X				
Newport Primary Care (affiliated w/New London Hospital)	Newport		X ¹	X		
Monadnock Community Hospital	Peterborough	X				
Speare Memorial Hospital	Plymouth	X				X
Portsmouth Hospital	Portsmouth	X				
Frisbee Memorial Hospital	Rochester	X				

¹ Prenatal Care is provided by Dartmouth-Hitchcock at this site

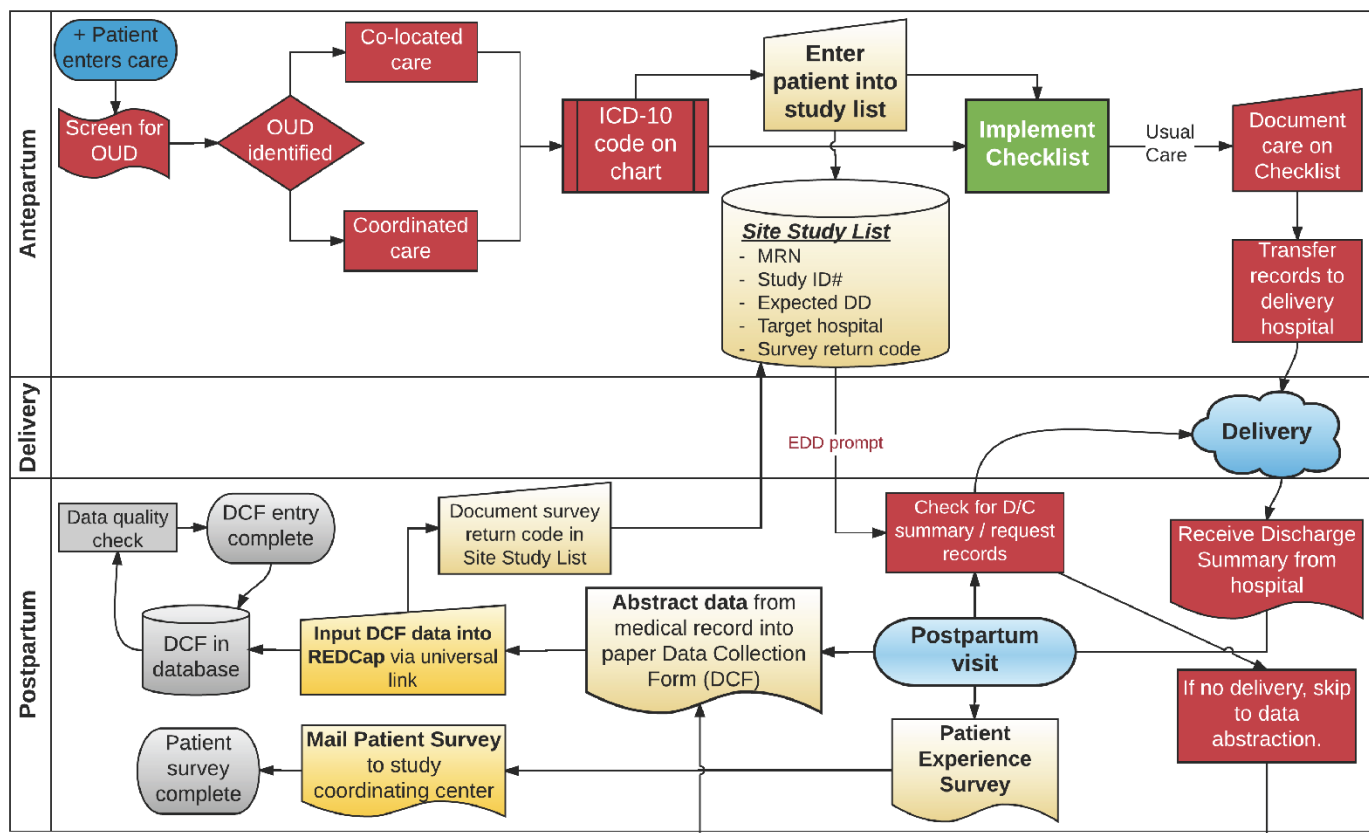
¹¹ Practice sites participated in NAS collaborative until Spring 2018 (birthing centers now closed)

Project / Program Description	Collaborative focused on optimizing newborn outcomes through simplified NAS Eat, Sleep, Console (ESC) assessments, optimal baby- and family-centered non-pharmacologic care, and Plans of Safe/Supportive Care.	Collaborative focused on improving prenatal and postpartum care for women with OUDs and optimizing outcomes for their baby and their family.	Initiative focused on building recovery-friendly pediatric practices to support healthy development of children 0-3 whose caregiver(s) are impacted by addiction.	Integration of MAT including group therapy, care coordination, peer recovery coaching, & other supports.	Observational research study to explore the impact of integrated vs. referral-based models of MAT on maternal & neonatal outcomes.
Target Audience	NNEPQIN providers and community professionals interested in optimizing newborn care.	Selected teams involved in implementing NNEPQIN Toolkit.	Selected NH pediatric practices	Selected NH OB sites	At least 21 sites across NH, VT and ME, currently under recruitment.
Open/Closed Initiative	Open	Open	Closed (Will be open to others after trial period)	Closed	Open
Contact Information	Dr. Bonny Whalen Bonny.L.Whalen@hitchcock.org	Daisy Goodman Daisy.J.Goodman@hitchcock.org	Dr. Steven Chapman Steven.H.Chapman@hitchcock.org Holly Gaspar holly.gaspar@hitchcock.org	Dr. Julia Frew Julia.R.Frew@hitchcock.org	Daisy Goodman Daisy.J.Goodman@hitchcock.org

4. Perinatal Opioid Use Learning Collaborative-Data Collection Materials

The following set of materials were developed by Dartmouth-Hitchcock and provided to participants of a data collection learning collaborative aimed at improving care for pregnant patients, starting with universal screening for substance use.

4.1 Process Map



www.nnepqn.org/clinical-guidelines/

Outcomes Summary

Please complete for all OUD patients at 12 weeks postpartum.

Did patient transfer care or become lost to follow up prior to delivery?

- ☐ Yes
☐ No

Date of delivery:

_____(mm/dd/yy)

Social/Behavioral Demographics

Tobacco/nicotine use during pregnancy:

- ☐ Non-smoker
☐ Former smoker
☐ Smoked during pregnancy
☐ Quit during pregnancy
☐ Vaped during pregnancy
☐ Used Smokeless tobacco
☐ Nicotine replacement therapy (NRT) →
☐ Unknown
(check all that apply)

If **NRT** prescribed, please specify type:

- ☐ Patch
☐ Gum
☐ Lozenges
☐ Other
(check all that apply)

Transportation status:

- ☐ Has own transportation (driver's license and car)
☐ Receives ride from family member, friend, or partner
☐ Medicaid ride service
☐ Public transportation
☐ Unknown
(check all that apply)

Housing status:

- ☐ Rents/owns (includes staying with partner)
☐ Staying with family member
☐ Staying with friend
☐ At risk for losing housing
☐ Incarcerated
☐ Staying in shelter
☐ Unknown
☐ Other:
(check all that apply)

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

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

Prenatal Treatment History

Did patient <u>transfer</u> care from another prenatal practice?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
If transferred , how many visits did patient have at previous provider?	<input type="checkbox"/> 1 visit <input type="checkbox"/> More than 1 visit <input type="checkbox"/> Unknown
If transferred , what was the gestational age at first OB visit at previous provider?	_____weeks
Was MAT treatment for OUD co-located?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not receiving MAT
Treatment for opioid use disorder during pregnancy:	<input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine (Subutex) <input type="checkbox"/> Buprenorphine/Naloxone (Suboxone) <input type="checkbox"/> Naltrexone, oral <input type="checkbox"/> Naltrexone, injectable <input type="checkbox"/> No MAT <input type="checkbox"/> Other/Unknown (check all that apply)
Is psychiatric diagnosis other than OUD included on the problem list?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

Care Process Measures	
Is a substance use diagnosis included on the problem list?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the checklist present in the record?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
If yes, was checklist used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was information about the risk of non-prescribed drugs and alcohol given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was smoking cessation education and/or treatment given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was marijuana use discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was breastfeeding education given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Naloxone (Narcan) discussed and Rx offered?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Was Plan of Safe Care discussed?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
If yes , was a plan of safe care initiated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did domestic violence screening take place using a validated screener?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checklist process comments (optional):	

Prenatal Screening	
Hepatitis C antibody screen:	<input type="checkbox"/> Positive → <input type="checkbox"/> Negative <input type="checkbox"/> Not tested or results not available
Hepatitis C viral load screen (if Ab positive):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested or results not available
HIV screen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested or results not available
Drug screening in Third Trimester for non-prescribed substances:	<input type="checkbox"/> Positive → <input type="checkbox"/> Negative <input type="checkbox"/> Not tested or results not available
If positive , please indicate substance(s):	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: (check all that apply)

If opioids , please indicate opioid(s):	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine (non-prescribed) <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) <i>(check all that apply)</i>
Was patient screened (or re-screened) for hepatitis C in the third trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A already known
Was patient screened (or re-screened) for HIV in the third trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A already known
Was patient screened for sexually transmitted infections (gonorrhea, chlamydia, or syphilis)?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
Gonorrhea:	First trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested Third trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested
Chlamydia:	First trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested Third trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested
Syphilis:	First trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested Third trimester: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested
Prenatal Complications	
Was patient admitted during pregnancy for any reason other than for delivery?	<input type="checkbox"/> Yes → <input type="checkbox"/> No

If yes , please specify reason for admission:	
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Delivery Outcomes

Was discharge summary received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient's age in years at time of delivery:	_____ years
Gestational age at delivery (weeks and days):	_____ weeks _____ days
If <38 weeks , please specify reason:	
Birthweight in grams:	_____ grams
Was this a multiple or twin birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mode of delivery:	<input type="checkbox"/> NSVD (nonsurgical vaginal delivery) <input type="checkbox"/> Operative vaginal delivery (vacuum assisted/forceps) <input type="checkbox"/> Cesarean section
Did patient experience severe maternal morbidity during hospitalization?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
If yes , please indicate type of maternal morbidity:	
Maternal length of stay during delivery hospitalization (elapsed time from delivery to discharge):	_____ days
If >3 days , please specify reason for prolonged stay:	<input type="checkbox"/> Normal OB management <input type="checkbox"/> Complications →
If complications , please specify type:	<input type="checkbox"/> Prenatal <input type="checkbox"/> Delivery-related <input type="checkbox"/> Postpartum <input type="checkbox"/> Other
Drug screening for non-prescribed substances at time of delivery hospital admission:	<input type="checkbox"/> Positive → <input type="checkbox"/> Negative <input type="checkbox"/> Not tested or results not available

If positive , please indicate substance type(s):	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: (check all that apply)
If opioids used, please specify type of opioid(s):	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) (check all that apply)
What type of feeding was infant receiving at discharge?	<input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Unknown (check all that apply)
Are APGAR Scores available?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
APGAR Scores (1, 5, and 10-minute):	▪ 1-minute: _____ ▪ 5-minute: _____ ▪ 10-minute: _____

Neonatal Outcomes	
Infant length of stay in hospital (days):	_____ days
Did baby require NICU care?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes , how many days were spent in NICU?	_____ days
Did baby require medication to treat symptoms of neonatal abstinence syndrome (NAS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Did umbilical cord or meconium test positive for <u>non-prescribed</u> substances?	<input type="checkbox"/> Yes → <input type="checkbox"/> No
If <u>positive</u> , please specify:	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opioids (Heroin, Fentanyl, Buprenorphine, Other pain medications, Methadone) → <input type="checkbox"/> Cannabis <input type="checkbox"/> Spice (synthetic Cannabis) <input type="checkbox"/> Cocaine <input type="checkbox"/> Sedatives/Tranquilizers (Ambien, Benzodiazepines, Barbiturates) <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Bath Salts <input type="checkbox"/> Ecstasy/MDMA <input type="checkbox"/> GHB <input type="checkbox"/> Ketamine <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter medications <input type="checkbox"/> Other: <i>(check all that apply)</i>
If <u>opioids</u> used, please specify:	<input type="checkbox"/> Heroin <input type="checkbox"/> Fentanyl <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Methadone <input type="checkbox"/> Other pain medications (e.g. oxycodone) <i>(check all that apply)</i>
Was infant referred to DCYF?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant discharged home with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No → If no, please indicate reason:

Postpartum Care	
Did postpartum visit occur within 8 weeks after delivery?	<input type="checkbox"/> Yes → <input type="checkbox"/> No →
If <u>yes</u> , please check all that apply:	<input type="checkbox"/> Visit within 2 weeks <input type="checkbox"/> Visit within 4 weeks <input type="checkbox"/> Visit within 6 weeks <input type="checkbox"/> Visit within 8 weeks <i>(check all that apply)</i>
If <u>no</u> postpartum visit, please specify reason:	

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



SECTION 6:

OTHER LEARNING OPPORTUNITIES
FOR PROVIDERS

Section 6: Other Learning Opportunities

This section provides information on New Hampshire-based resources for providers looking to further develop their expertise around the perinatal care of pregnant patients with substance use disorders. This includes a task force from the Governor's Commission on Alcohol and Other Drugs, peer support, and various collaborative efforts.

1. [Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and Other Drugs](#)
2. [Center for Addiction Recovery in Pregnancy and Parenting and Provider to Provider Q&A service](#)

1. Perinatal Substance Exposure Task Force of the NH Governor's Commission on Alcohol and Other Drugs



The mission of the Perinatal Substance Exposure Task Force is to identify, clarify, and inform the Governor's Commission about issues related to perinatal substance exposure: including ways to lessen barriers pregnant people face when seeking quality healthcare; aligning state policy and activities with best medical practices for pregnant and newly parenting people and their children; and increasing public awareness about the dangers of exposure to prescription and illicit drugs, alcohol and other substances during pregnancy.

For more information about the Task Force and how you can become involved, visit <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/>

2. Center for Addiction Recovery in Pregnancy and Parenting and Provider to Provider Q&A service



Managed by Dartmouth-Hitchcock Medical Center, the Center for Addiction Recovery in Pregnancy and Parenting (CARPP) is a multidisciplinary network of experienced clinicians and researchers working together to support recovery from addiction for people who are pregnant and parenting, and to promote healthy growth and development in their children.

CARPP's work informs clinical services, research, education, and advocacy in the treatment of pregnant and parenting people and their young children who are impacted by substance use disorders. We support providers who care for these families with resources and guidance for program implementation, with a particular

focus on the impact of opioid use disorders.

In addition to curating and providing links to important resources, CARPP providers are available to answer questions from providers about the care of pregnant and parenting people with substance use disorders on its **provider to provider Q&A service**. This provider-to-provider service offers education and guidance by phone or email with the goal of increasing our collective capacity to care for this population in the community.

For more information about CARPP and its available supports, visit <https://med.dartmouth-hitchcock.org/carpp.html>

3. Alliance for Innovation in Maternal Health: <https://safehealthcareforeverywoman.org/aim/>

4. Centers for Disease Control Maternal Mortality Prevention: <https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html>



SECTION 7:
ADDITIONAL REFERENCES

Section 6: Additional References

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Planned Parenthood

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