Reference Guide for Reproductive Health Complicated by Substance Use

Revised November 2020

Referral and Resource Information

Sober Moms, Healthy Babies:
sobermomshealthybabies.org

Managed Care Organizations (MCO) MCO Main - Nevada:
dhcfp.nv.gov/Members/BLU/MCOMain

Dignity Health EMPOWERED Program:
Support and resources for prenatal, postpartum,
and early childhood development in Southern Nevada
dignityhealth.org/las-vegas/classes-and-events/community-programs/nas
1-702-492-8593

Maternal Opioid Treatment Health, Education, and Recovery (MOTHER) Program:
hrpregnancy.com/mother-project/
Las Vegas: 1-702-382-3200
Reno: 1-775-404-5000

Crisis Support Services of Nevada Substance Use Hotline:
1-800-450-9530 or text IMREADY to 839863

Crisis Support Services of Nevada Crisis Hotline:
1-800-273-8255 or text CARE to 839863

Foundation for Recovery Warmline:
1-800-509-7762

Trac-B Exchange Warmline:
1-866-687-2879

Substance Abuse Prevention and Treatment Agency (SAPTA) Certified Treatment Finder:
behavioralhealthnv.org

Quest Counseling and Consulting:
questreno.com/nas-program
1-775-786-6880

Neonatal Abstinence Syndrome (NAS) Prevention Program at Renown Health:
1-775-982-6373

Nevada Tobacco Quitline:
nevada.quitlogix.org/en-US/
1-800-QUIT-NOW

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Introduction to SBIRT

Substance misuse, dependency, and substance use disorders are common among Nevada adult populations. These issues are also occurring during pregnancy at an alarming rate with far reaching effects on both mother and infant. To date, the single best strategy we have to identify and help those that want assistance is adding screening and referral to treatment, known as Screening, Brief Intervention and Referral to Treatment (SBIRT), into the clinical setting. Medical professionals are often the first line to aid in this effort. Note that this document uses the term "medical professional" to be inclusive of doctors and advanced practitioners. The intention for this guide is to provide basic directives for successfully implementing SBIRT, specifically how to apply it to pregnant and non-pregnant women of reproductive age populations. While it by no means is all inclusive to address every question that might arise when providing care for this special population, it is designed to include specifics to help you implement SBIRT in your practice. We hope that you find it easy to use, and a convenient resource to assist in both national and state efforts that are actively working towards developing strategies to improve physical and behavioral health, safety, and recovery outcomes for this vulnerable population.

WHAT Are We Doing?

- Performing Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use in every pregnant woman and non-pregnant woman of reproductive age.
- What is SBIRT?

- **Screening** – Assessing for substance use using standardized tools.

- **Brief Intervention** – Engaging in a short conversation, providing feedback, and advice.

- **Referral to Treatment** - Providing a referral for additional treatment.

WHY Are We Doing This?

- Opioid overdose is now the leading cause of accidental death among adults, surpassing motor-vehicle accidents, gun violence, and homicide.[23]
- Drug-induced deaths are the leading cause of death for reproductive-age women in the United States.[17, 18]
- Rates of Opioid Use Disorder (OUD) in pregnant and postpartum women have also increased, with some shocking statistics from recent studies:
    - Over 40% of pregnant women enrolled in Medicaid receive a prescription for opioids.[30]
    - Drug-related deaths contribute to pregnancy-associated deaths, with substance use being a preventable, causal, or correlating factor in maternal mortality.
    - Several obstetrical complications have been associated with opioid use in pregnancy, including pre-eclampsia, miscarriage, premature delivery, fetal growth restriction, and fetal death.[24]
- OUD can lead to Neonatal Abstinence Syndrome or Neonatal Opioid Withdrawal Syndrome (NAS/NOWS).
- Rates of NAS/NOWS have increased more than 300% in the past decade at an average cost of over $200,000 for each case.[25, 26]

Drug-related deaths contribute to pregnancy-associated deaths, with substance use being a preventable causal or correlating factor in maternal mortality.

As a medical professional, you can directly help prevent maternal, fetal and newborn complications and meet your duty of providing the standard of care by performing SBIRT for substance use with every pregnant woman and non-pregnant woman of reproductive age.

- In Nevada, inpatient admissions for NAS have doubled since 2011. White, non-Hispanic patients have significantly higher NAS rates compared to all other races. The average length of stay for newborns with NAS in 2018 was 19 days.
- Most major health authorities including American College of Obstetricians and Gynecologists (ACOG) and The Society for Maternal-Fetal Medicine (SMFM) regard screening for substance use to be a part of comprehensive obstetric care. SBIRT for substance use needs to be done as part of your duty as a medical professional. It is the standard of care.
- Substance use disorder, which includes OUD, is a primary chronic disease similar to diabetes and hypertension, and is not a moral failure or weakness.
- Pregnancy is an ideal window of opportunity for the treatment of OUD that will reduce maternal, obstetric, fetal, and infant morbidity and mortality.
- The standard of care for treatment of OUD is Medication for Opioid Use Disorder (MOUD). Note that this document uses MOUD instead of Medication-Assisted Treatment (MAT).
    - It reduces the risk of mortality almost 6-fold, comparable to the baseline for the regular population.[27]
    - While in treatment, return to non-prescribed substance use rates are similar to that of diabetes and better than those for hypertension and asthma.[10] Note that this document uses the phrase "return to non-prescribed substance use" instead of the term "relapse".

WHERE Are We Supposed to Do This?

- In all settings where a pregnant woman or non-pregnant woman of reproductive age seeks services.
    - OB/GYN Offices.
    - Maternal Fetal Medicine Offices.
    - Primary Care Offices (Family Medicine, Internal Medicine, etc.).
    - Emergency Rooms.
    - Triage/Labor & Delivery.
    - Urgent Care.
    - Specialty Offices (Behavioral Health, Pain Management, etc.).
    - Government Agencies (Health District, Criminal Justice System, etc.).

WHO Can Do This?

- A wide variety of health care staff can perform SBIRT, including physicians, nurses, nurse practitioners, physician assistants, licensed midwives, and licensed clinical social workers.
- For the purposes of this effort, we are focusing on medical professionals that are licensed to practice in the state of Nevada.

WHEN Are We Supposed to Do This?

All Physicians, Advanced Practitioners and Nurses

- When a pregnant woman or non-pregnant woman of reproductive age is being seen for the first time (first contact).

  - or -

  When you first recognize a pregnancy.

- Additionally, on an annual basis, if you are providing continuous care for a pregnant woman or non-pregnant woman of reproductive age.

Doctors and Advanced Practitioners Involved in Prenatal Care

- At minimum on the first prenatal visit.
- Repeat during the 3rd trimester.
- You can decide to perform it at other points along in the pregnancy (for example at each trimester, after a return to non-prescribed substance use, etc.).

Billing and Payment for SBIRT

- There are payment codes for these services.
- Please check with your specific plan, payer, Managed Care Organization (MCO), etc. regarding specific coding and reimbursement.
- Providers should negotiate with payers to pay for these services which have shown to have favorable return on investment when performed.
- In general, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS), you will most likely be using the following:

Procedure Code	Provider Type	Prov Spec	Payment at 100% of 2020 Medicaid Rate	Description
99408	17	215	$43.75	Alcohol and/or substance abuse screening and intervention, 15-30 minutes
99409	17	215	$85.21	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
H0049	17	215	$9.75	Alcohol/Drug Screening
99408	20		$34.48	Alcohol and/or substance abuse screening and intervention, 15-30 minutes
99408	24		$22.86	Alcohol and/or substance abuse screening and intervention, 15-30 minutes
99408	74		$22.86	Alcohol and/or substance abuse screening and intervention, 15-30 minutes
99408	77		$22.86	Alcohol and/or substance abuse screening and intervention, 15-30 minutes
99409	20		$66.53	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
99409	24		$44.12	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
99409	74		$44.12	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
99409	77		$44.12	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
H0049	20		$9.75	Alcohol/Drug Screening
H0049	24		$9.75	Alcohol/Drug Screening
H0049	74		$9.75	Alcohol/Drug Screening
H0049	77		$9.75	Alcohol/Drug Screening

PT 17/215-Substance Abuse Agency Model, **PT 20**-Physician, M.D., Osteopth, D.O., **PT 24**-Advanced Practice Registered Nurse, **PT 74**-Nurse Midwife, **PT 77**-Physician's Assistant

Using SBIRT

HOW Do I Do This?

Screening

- Screen using a standardized questionnaire such as the 5Ps or National Institute on Drug Abuse (NIDA) Quick Screen that asks questions about alcohol, tobacco, and substances, both legal and illegal.
- Screen universally. This means every pregnant woman or non-pregnant woman of reproductive age. Do not screen based on suspicion, physical appearance, race, ethnicity, etc. (known as targeted screening).

Screening Questionnaire	Urine Drug Testing
Easily administered but takes medical professional's time	Requires laboratory or testing equipment
No consent needed	Requires specific patient consent
May open window to further discussion after initial denial	Opens initial discussion of substance use but may open adversarial patient-medical professional relationship May decrease office visits to avoid future detection
Economical	More expensive
Asks about a wide variety of substances	Limited to substances included in testing
Distinguishes type of use	Does not distinguish between occasional and regular use
Detects any amount of substance	Detection limited by cutoff values, false positive, and false negative results
Broad detection window (years)	Narrow detection window (days)

- Guidelines for conducting universal screening:
  - In private – with the person alone. No friends, family, or significant others.
  - Using an accepted questionnaire such as the 5Ps or NIDA Quick Screen.
  - Using an empathic, compassionate, non-judgmental approach that lets the woman know all women are asked the same questions.
- Patient-centered screening allows for normalizing the purpose of screening, asking the patient for permission and addressing confidentiality prior to beginning the screening process.

5Ps:

5Ps Screening Tool[34]

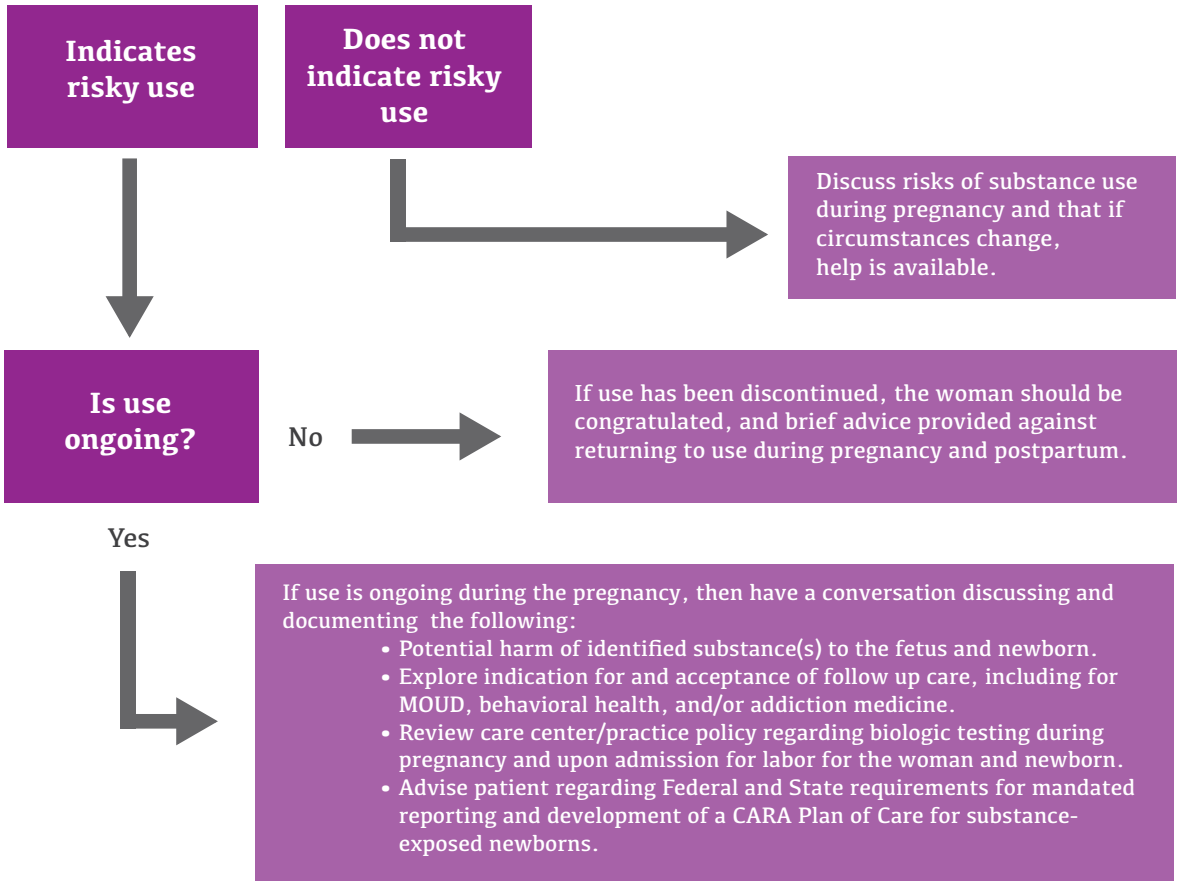
Please see appendix for an example of how to perform SBIRT if using the 5Ps.

NIDA Quick Screen:

NIDA Quick Screen[35]

Brief Intervention

- Effective Brief Intervention includes 3 steps:
    1. Offer feedback.
    2. Listen and be empathetic to the patient's motivation for substance use.
    3. Explore other options to address patient's motivation for substance use.



Referral to Treatment

- For patients accepting of follow up care, refer to:
  - Medication for Opioid Use Disorder.
  - Behavioral Health and/or Addiction Medicine.
  - Case Management.
- Consider referral to Maternal Fetal Medicine as opioid exposure has been associated with lower birth weights, preterm birth, decreased head circumference, and birth defects.
- Medication for Opioid Use Disorder Considerations:

Considerations	Oral Buprenorphine	Methadone
Patient Selection	May be preferable to patients who are new to treatment or do not like or want methadone	May be preferable to patients who do not like or want buprenorphine
Dispensing	May be prescribed in office setting [31]	Requires daily visits to a federally certified opioid treatment program
Risk of Medication Interaction	Few known interactions	Medications that use cytochrome P450 pathway
Mechanism of Action	Partial opioid agonist/antagonist with ceiling effect	Full opioid agonist with no ceiling effect
Risk of Overdose and Death	Generally lower than full opioid agonists (i.e. methadone)	Generally greater than mixed agonist/ antagonist opioids (ie. buprenorphine)
Ability to fill at pharmacy	Possible at pharmacy	Must be administered and dispensed for treatment of OUD at federally certified opioid treatment program, which also may enhance follow up
NAS/NOWS	Generally less incidence, milder symptoms, shorter duration. NOWS is associated with known fetal brain abnormalities	Generally higher incidence, more severe symptoms, and longer duration. NOWS is associated with known fetal brain abnormalities
Dosing frequency	Generally one to two times a day but can be flexible up to four times a day	Generally one time a day but can be twice a day

*Always consult with a medical professional before engaging to determine the best treatment option.

Management After SBIRT for Patients that Screen Positive

For medical professionals that are involved in preconception, prenatal, intrapartum (delivery), and/or postpartum care of patients on an ongoing basis, please review the individual clinical pathways that apply to the care you deliver.

Preconception Clinical Pathway

- Obtain recommended lab testing.
    - Human immunodeficiency virus (HIV).
    - Sexually Transmitted Infections (syphilis, gonorrhea, chlamydia).
    - Hep A, HepBsAg, Anti-HBcore, HBsAb and consider immunization as indicated.
    - HCV antibody. If positive draw HCV PCR, LFTs.
- Screen for psychiatric conditions and refer as appropriate.
- Screen for domestic violence/intimate partner violence and refer as appropriate.
- Screen for medical issues and refer as appropriate.
    - Diabetes.
    - Thyroid.
    - Hypertension.
- If patient is currently on MOUD with methadone or buprenorphine.
    - Discuss possibility of weaning in the non-pregnant patient if appropriate.
- Discuss risks of NAS/NOWS on buprenorphine vs methadone.
    - Discuss transition to buprenorphine from methadone if appropriate.
- Discuss contraception including Long-Acting Reversible Contraception (LARC).

Prenatal Clinical Pathway

First prenatal visit (in addition to regular OB care).

- Perform universal screening using either 5Ps or NIDA quick screen.
- Perform Brief Intervention and Referral to Treatment if positive screen.
- Assess for signs and symptoms of acute withdrawal and refer immediately to emergency room, OB ER/Triage, or Inpatient treatment center depending on acuity:
    - If the patient was exhibiting signs of acute withdrawal (from any substance) then they should be referred immediately to the emergency room, OB ER/Triage etc. for evaluation and treatment as needed.
    - If there is concern for, or if the patient is withdrawing from benzodiazepines and/or alcohol, then priority should be given to have the ER, OB ER/Triage, Inpatient Hospital, etc. evaluate those substances specifically (benzodiazepines and/or alcohol) first; before others such as opioids.
    - Screen for co-occurring psychiatric conditions and refer as appropriate.
    - Screen for co-occurring domestic violence/intimate partner violence and refer as appropriate.
    - Assess for other immediate psychosocial needs.

OUD is frequently associated with psychiatric disorders and other substance use disorders. Behavioral health referral is strongly recommended.

- Obtain recommended lab testing in addition to routine prenatal labs.
    - HIV.
    - Other sexually transmitted infections, including Syphilis, Gonorrhea, Chlamydia.
    - HepBsAg, anti-HBcore, HBsAb and consider immunization as indicated.
    - HCV antibody. 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.
- Determine appropriate level of care and arrange for referrals to treatment when indicated and accepted by the woman.
- Provide counseling on recommended substance use management, risk to pregnancy, fetus, infant and explore treatment options.
- Medical professionals should counsel pregnant women who use nicotine that reducing or stopping smoking can reduce the severity of NOWS (see resources page for information on the Nevada Tobacco Quitline).
- Provide counseling on maternal/fetal/neonatal risks of polysubstance abuse.

- Check Nevada's Prescription Monitoring Program (PMP) record (including other states where applicable).
- Discuss Narcan/Naloxone and offer prescription for instances of inadvertent maternal overdose.
    - Possible consultation and referrals may include, but are not limited to:
        - Social Work, Case Management, Cardiology, Infectious Disease, Gastroenterology, and Dental.
        - Consider referral to Maternal Fetal Medicine as opioid exposure has been associated with lower birth weights, preterm birth, decreased head circumference, and birth defects.

Prenatal Clinical Pathway

* The use of an antagonist such as naloxone to evaluate opioid dependence in pregnant women is contraindicated because induced withdrawal may precipitate preterm labor or fetal distress. Naloxone should be used in the case of maternal overdose to save the woman's life and can be used in the combination buprenorphine/naloxone product for opioid use disorder treatment as the naloxone is minimally absorbed when taken as prescribed. (The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder - 2020 Focused Update).

When is Biologic Testing Appropriate?

Biologic Testing

- Should be offered in specific pre-determined emergent medical situations, with the woman's consent (unless unable due to loss of consciousness).*
- Each practice or hospital should have explicit criteria for testing to avoid profiling and discrimination.
- Some medical situations include:
    - Obtunded or unconscious patient.
    - Patient is falling asleep mid-sentence or shows evidence of intoxication.
    - Patient with physical evidence of injection use.
    - Patient with unexplained soft tissue infections or endocarditis.
    - As part of treatment of a patient to whom you are prescribing MOUD.
    - Patient with acute clinical complications such as:
        - Placental abruption.
        - Preterm labor.
        - Preterm premature rupture of the membranes (PPROM).
    - Patient with no prenatal care or previously identified use during pregnancy at time of delivery.
    - Outpatient practices should have a separate and distinct consent form and document patient acceptance regarding biologic testing.

When to Perform Biologic Testing

Universal biologic testing alone is not recommended. Biologic testing, when performed, should be used in conjunction with universal questionnaire screening and only with the woman's informed consent and when its benefits outweigh any potential harms.[19] Note that medical professionals are not required to report positive toxicology screens of pregnant women to Child Protective Services (CPS) in Nevada.

Outpatient Prenatal Biologic Testing

Routine urine drug testing is not highly sensitive for many drugs, does not distinguish between occasional versus chronic use, and may result in false-positive and negative results that are misleading and potentially devastating for the patient. Even with patient consent, urine testing should not be relied upon as the sole or valid indication of drug use. Positive urine screens should be followed with a definitive drug assay.[20] Biologic testing should have a separate consent form to ensure patient education and ensure the patient was informed.

Intrapartum Biologic Testing

When medically indicated, women should be tested immediately on admission to a labor and delivery setting and not after they have been treated with any medication that could cause a positive test result. If the pediatrics team requests testing of a woman because the baby is showing signs of withdrawal, it is preferable to test the baby; the woman may test positive because of the pain medicine she may have received at delivery or postpartum.[21]

Postpartum Biologic Testing

For a pregnant patient with a substance use disorder, medical professionals should be aware that the postpartum period is a time of increased vulnerability. Therefore, assessment for risk of returning to non-prescribed substance use, which may include drug testing with patient consent, may be part of the postpartum visit.[22]

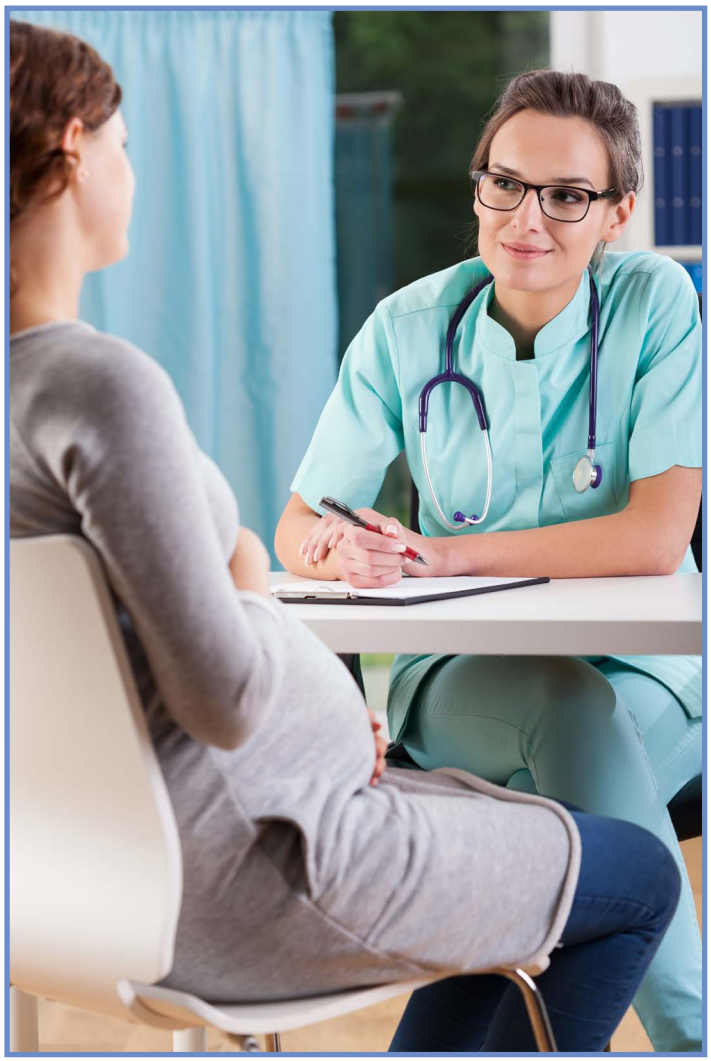
* National Advocates for Pregnant Women NAPW. Clinical Drug Testing of Pregnant Women and Newborns . Association of State and Territorial Health Officials. astho.org/Webinars/Clinical-Drug-Testing-of-Pregnant-Women-and-Newborns_NAPW/05-16-19/. Published March 2019.

Follow Up Care

- Reassess and treat for opioid side effects.
- Assess for changes in psychosocial and medical needs.
- Provide continued tobacco cessation counseling and treatment for patient who smokes.
- Review Nevada's PMP every trimester and prior to any controlled prescription.
- Urine biological testing with consent when indicated.

Second and Third Trimester Care

- Schedule and/or provide second trimester ultrasound to screen for anomalies. Preference should be given to a health care worker who can perform detailed fetal anatomic ultrasound examination (CPT Code 76811).
- Schedule and/or provide third trimester growth scan (28-32 weeks).
- Repeat SBIRT during the third trimester.
- Antenatal testing, only if clinically indicated.
- Repeat HIV, HCV, RPR, gonorrhea and chlamydia in third trimester. Repeat HBsAg if initial testing was negative.
- Verify and update MOUD medication/dose/status with MOUD prescriber prior to birth.
- Discuss pain management options for labor and birth and assist in development of plan (see pages 14 and 15 for more information).
- Provide patient/family education to include:
    - Hospital policies on NAS/NOWS, breastfeeding, maternal/newborn toxicology and reporting requirements.
    - Signs and symptoms of potential pregnancy complications.
    - Importance of prenatal care.
    - Plan for fetal surveillance.
    - Parenting classes.
- Consider prenatal consult with pediatrician/neonatologist at delivering hospital.
- Provide contraceptive counseling to include LARC at hospital after delivery, if available.



Intrapartum Clinical Pathway (Delivery)

- Perform Universal screening using 5Ps or NIDA quick screen.
- Perform Brief Intervention and Referral to Treatment if positive screen.
- When possible, confirm MOUD medication and dose with MOUD prescriber. Attending medical professional can prescribe this medication to maintain outpatient dose during hospitalization. (DATA 2000 waiver not required to administer/dispense while inpatient).[32]
- Continue buprenorphine/methadone at usual dose. Consider split dosing to BID/TID for maximal analgesic effect.
- Labs
    - Hepatitis B and C testing, if not previously performed in the 3rd trimester.
    - Syphilis testing (RPR or FTA antibodies as appropriate).
    - Routine labs for labor and birth, repeat HIV testing if not completed during 3rd trimester, urine biologic screening test with consent.
- Notify pediatrician of admission for delivery and determine need for neonatal team at birth.
- Consults
    - Neonatology (if not previously done).
    - Social Work/Case Management.
    - Anesthesiology.
    - Lactation.
    - If substance use first disclosed or detected at time of birth, consider Maternal Fetal Medicine, Behavioral Health, or Addiction Medicine.
- Offer immediate postpartum long-acting contraception if available.
- Discharge planning.
- Avoid discontinuation of treatment due to increased risk of returning to non-prescribed substance use rates after delivery.
- Provide contraception counseling and determine plan if LARC not already provided.
- Determine discharge pain management plan (see pages 14 and 15 for more information).
- Notify MOUD prescriber of plan for discharge and schedule follow up with first visit in 1-2 weeks.
- Schedule more frequent postpartum follow ups with first visit in 1-2 weeks.
- Involve multidisciplinary team to develop CARA Plan of Care.
    - The federal government passed the Comprehensive Addiction and Recovery Act (CARA) of 2016 which added requirements for states through the Child Abuse Prevention and Treatment Act (CAPTA), to focus on the effects of substance use on infants, children, and families.
    - As part of CARA, a Plan of Care is required for infants with prenatal substance exposure or exhibit symptoms of withdrawal to identify any possible medical issues.
    - The plan will connect families to resources to keep the baby healthy by including referrals related to infant health and development, financial help, and childcare, in addition to connecting parents/caregivers to resources such as public benefits, support groups, well-baby visits and substance use treatment.
    - Those responsible for creating the plan will be part of a multidisciplinary team to include medical professionals, medical staff, child welfare experts, behavioral health professionals, and others as appropriate.
    - Ideally this plan is established during pregnancy, but will be required prior to discharge from the hospital.
- For more information on CARA, please visit dpbh.nv.gov/Programs/ClinicalSAPTA/Womens_Substance_Use_Prevention_and_Treatment/Women_s_Substance_Use_Prevention_and_Treatment/.

Intrapartum (Delivery) Pain Control Clinical Protocol

- Patients with OUD potentially have a higher tolerance to opioids in addition to opioid-induced hyperalgesia, resulting in experiencing more severe pain during delivery and in the immediate postpartum period.
- The goal for pain control should be to control withdrawal, cravings, and adequately control pain (not necessarily eliminate) such that the woman is able to mobilize, breastfeed, and otherwise care for her baby.
- Overall, strategies should employ continuing medications for MOUD, in addition to nonpharmacologic-adjunctive and non-opioid pharmacologic approaches.

Pain Management During Hospitalization for Vaginal Delivery

- Continue daily dose of MOUD medication (hospital should provide medication). There is evidence that dividing the dose into 2-3 doses can improve pain control. For example, if the patient is on 6 mg of buprenorphine twice daily, they may have improved pain control at 4 mg every 8 hours.
- Encourage regional labor anesthesia (epidural) in early labor or as soon as contractions are perceived to be uncomfortable.
- Adjunctive approaches such as ice pack, heating pad, hydrocortisone and local anesthetic application to the perineum.
- Options for non-opioid pain management include:
    - Acetaminophen: 500 mg every 6 hours by mouth.
    - Ibuprofen: 600 mg every 6 hours by mouth.
    - Ketorolac (Toradol): 15mg/30 mg intravenous/intramuscular every 6 hours for 48 hours if pain not managed/utilizing ibuprofen or oral NSAIDs are not tolerated.
- If using opioid based medication for breakthrough, consider oxycodone usage. As Tylenol is already being utilized in maximum doses, oxycodone alone is recommended. This should be uncommon unless the patient has required moderate to extensive perineal repair, if the other above management strategies are utilized.
- Avoid inhaled nitrous oxide as it may be less effective in opioid-dependent women and may increase the risk of sedation with concurrent use.
- Avoid opioid agonists/antagonist such as nalbuphine or butorphanol as they can precipitate withdrawal.

Pain Management During Hospitalization for Cesarean Delivery

- Continue daily dose of MOUD medication. There is evidence that dividing the dose into 2-3 doses can improve pain control. For example, if the patient is on 6 mg twice daily, they may have improved pain control at 4 mg every 8 hours and hence dosing in this manner for post op cesarean pain is recommended.
- Encourage regional labor anesthesia (epidural) in early labor or as soon as contractions are perceived to be uncomfortable.
- Options for non-opioid pain management include:
    - Acetaminophen: 500 mg every 6 hours by mouth.
    - Ibuprofen: 600 mg every 6 hours by mouth.
    - Ketorolac (Toradol): 15mg/30 mg intravenous/intramuscular every 6 hours for 48 hours if pain not managed/utilizing ibuprofen or oral NSAIDs are not tolerated.
- If the above measures are not sufficient, consider augmentation with patient-controlled analgesia with a full agonist with strong affinity such as fentanyl or hydromorphone for 24 hours.
- If using opioid-based medication for breakthrough initially or after 24 hours, consider oxycodone on a scheduled rather than PRN basis for better control, less overall dosage, and shorter duration of treatment. As Tylenol is already being utilized in maximum doses, oxycodone is recommended. Consider scaling back after the first 48 hours, ideally with discontinuation prior to discharge.
- Use a shared decision-making approach with the patient, using her pain medication requirements during hospitalization as a starting point. If deciding to continue narcotics on discharge, the treatment of acute pain rarely requires more than 3 days of medication with no refills given prior to an in-person examination.
- Avoid opioid agonists/antagonist such as nalbuphine or butorphanol, as they can precipitate withdrawal.

Postpartum Clinical Pathway

- Rescreen for return to substance use by asking about drug and alcohol use and monitoring for return to non-prescribed substance use.
- Perform postpartum depression screening.
- Screen for domestic violence/intimate partner violence at 6 weeks and whenever indicated.[28]
- Provide smoking cessation reinforcement or continued cessation counseling as indicated.
- Consider providing support services longer than traditional 6-week postpartum period.
- Assess resource needs at each visit and coordinate with case worker/social services providers.
- Assist in scheduling appointments for disease management as indicated (Hepatitis, HIV, Syphilis, etc.).
- Facilitate transition to recovery-friendly primary care if not already established.
- Provide breastfeeding support if indicated.
- Breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications. Women should be counseled about the need to suspend breastfeeding in the event of a return to non-prescribed substance use.
- Provide counseling on safe sleep practices. Parental alcohol and/or illicit drug use in combination with bed-sharing places the infant at particularly high risk of Sudden Infant Death Syndrome (SIDS).[29]
- Provide further contraceptive counseling on birth spacing if immediate postpartum LARC not placed.

Care Coordination[33]

Providing adequate transitions of care pre- and postnatally that include outpatient support structures with expertise in addressing the needs of both mothers with opioid use disorder (OUD) or substance use disorder (SUD) and their exposed newborns can improve outcomes and support the development of protective factors that reduce or mitigate the effects of adverse life experiences for children and their families. Early interventions like home visits are a prime example of this. The use of warm handoffs is encouraged and has multiple benefits, including:

- ✔ Increases patient safety through improved communications and provides an opportunity to question, clarify, and confirm information.
- ✔ Builds partnerships for improved care, outcomes, and experiences.
- ✔ Increases shared decision making and patient/family engagement.

Warm handoffs should:

1. Be in person (whenever possible) and in front of the patient and/or family.
2. Include an introduction by the discharging team member to the next care provider.
3. Include pertinent details related to prenatal care and the acute care stay.
4. Include a review of the discharge goals and plan.
5. Include a review of next steps and who is responsible.
6. Include a review of what is important to the patient/family. Provide an opportunity for all participants, including patient and family, to question, clarify, and confirm information.

Partnering With Mom, Other Infant Caregivers, & Other Health Care and Medical Professionals

- Involve the mother and newborn in outpatient support programs as early as possible, ideally prenatally for the mother.
- Maintain an updated list of outpatient resources (federal, state, and local) that families can access.
- Develop a dyad centered CARA Plan of Care that identifies and incorporates key community care resources and supports for mom and baby.[36]
- Inform and educate mothers on these referrals and highlight the benefits of these programs.
- Provide education and information on the possibility of NAS and how it is managed.
- Invite members of collaborative team to meet with the pregnant woman and other family members before delivery –she should know the whole team.
- Provide education and support for the benefits of breastfeeding and skin-to-skin contact.
- Provide education on the importance of a healthy home environment; connect with home visiting.
- Provide information about family planning and contraception options.
- After delivery, continue to establish a therapeutic relationship with parents/caregivers and engage and empower parents to be involved with the care of their newborn.

Appendix 1

SBIRT Example if using 5Ps for screening

Answers	Zone	Indicated Action
"No" to all questions	Low	Positive Reinforcement
"Yes" to parents or peers questions	Moderate	Review risk, perform brief intervention or referral
"Yes" to partner, past, or present questions	Harmful or Severe	Refer for further assessment and possible specialized treatment

Low

- "Hello, would you mind taking a few minutes to talk with me about some of the answers you provided on your medical questionnaire? Please keep in mind that we ask these questions of every single pregnant woman because we are only interested in offering help for the health of mom and baby."
- "You listed no on all answers related to drugs and alcohol. I am glad to see that you are not using alcohol, tobacco, drugs, or medications except those cleared by me and your other providers."
- "This is important because these substances can cause increased risks to you and your unborn baby during your pregnancy such as birth defects, low birth weight, miscarriage, and premature birth."
- "They also may cause long-term damage to your unborn baby such as developmental and behavior problems."
- "Please continue to avoid alcohol, tobacco, and drugs and check with me before taking any medications not prescribed by me."

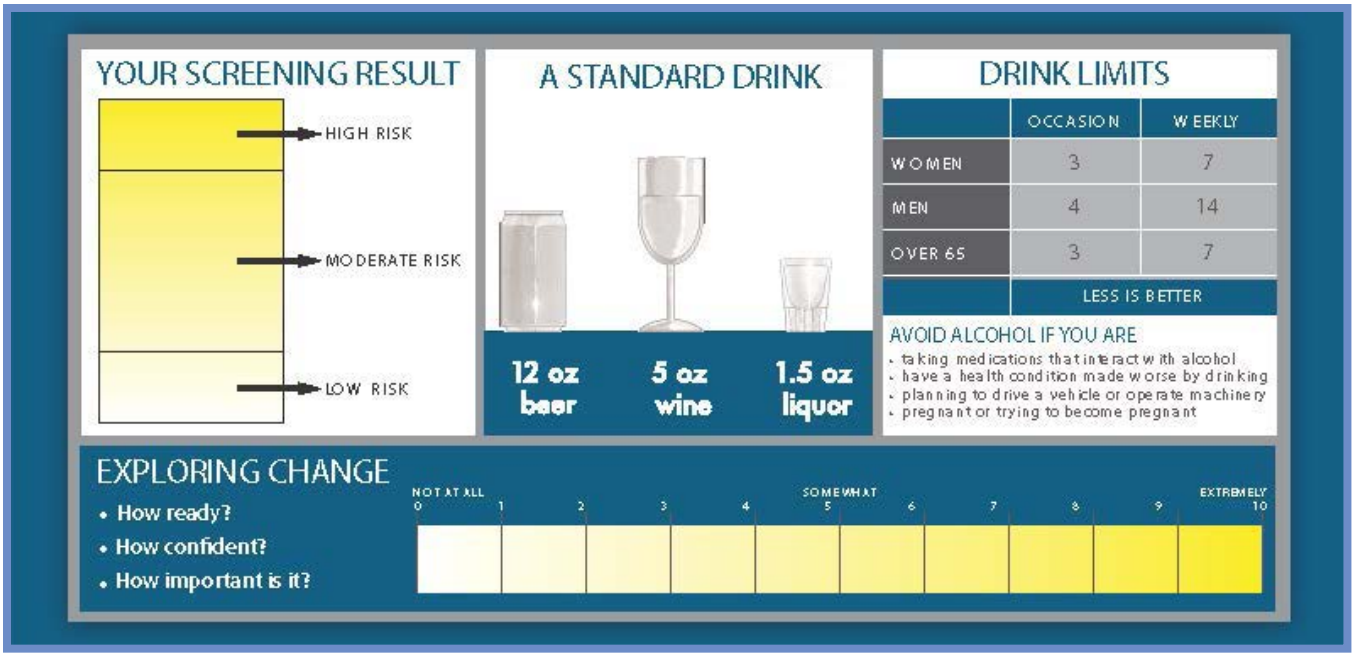
Moderate

- "Hello, would you mind taking a few minutes to talk with me about some of the answers you provided on your medical questionnaire? Please keep in mind that we ask these questions of every single pregnant woman because we are only interested in offering help for the health of mom and baby."
- "You listed that your (parents/peers) have had an issue with alcohol or drugs. Can you tell me a little bit more about that?"
- "Have you ever had a problem with drugs or alcohol in the past?"
- "Sometimes patients who give similar answers on this questionnaire are continuing to use drugs or alcohol during their pregnancy."
- "I recommend to all my pregnant patients not to use any amount of alcohol or drugs because these substances can cause increased risks to you and your unborn baby during your pregnancy such as birth defects, low birth weight, miscarriage, and premature birth."
- "They also may cause long-term damage to your unborn baby such as developmental and behavior problems."
- "Please continue to avoid alcohol, tobacco, and drugs and check with me before taking any medications not prescribed by me."

Harmful or Severe

- "Hello, would you mind taking a few minutes to talk with me about some of the answers you provided on your medical questionnaire? Please keep in mind that we ask these questions of every single pregnant woman because we are only interested in offering help for the health of mom and baby."
- "Sometimes patients who give similar answers on this questionnaire are continuing to use drugs or alcohol during their pregnancy."
- "Help me understand through your eyes the good things about using (drugs/alcohol)."
- "What are some of the not so good things about using (Drugs/alcohol)?"
- "On a scale from 1 to 10, with 1 being not ready at all, and 10 being completely ready, how ready are you to make changes in your (drug/alcohol) use?"
- "Why did you choose that number rather than (lower number)?"
- "What are some steps you can take towards the goal of having a healthy pregnancy and baby?"
- "There are resources specifically for pregnant women with substance use issues to get the help they need for the healthiest pregnancy and baby possible. Can we have them reach out to you and to help get you to your goal?"

Readiness Ruler



Provide Feedback	• "I saw you completed the screen- is it OK if we look at/discuss the results?" • "Compared to all people who are screened, your results suggest *high/moderate/low* risk drinking." • "I am *not at all/somewhat/pretty* concerned about your score."
Explore Change	• "Let me ask- What do you like about drinking?"; "What do you like less well?" • "On a scale of 1-10, how ready/confident are you about changing your drinking?" • "Why is your score *X and not X-2*?"
Explore Options	• "If you were to change your drinking, what are some options you could try?" • "What has worked for you in the past when you decided to make a change?"
Wrap Up	• "So let's wrap up and review- you see changing your drinking as *very/somewhat/not* important and identified some good reasons and options to go along with that." • "How about we follow up at your next visit in *X* weeks and see how it is going?"

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This guide can be used for other risky behaviors, such as tobacco or illicit drug use.

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www.frfasd.org

Helpful Links With Information Related to Opioids During Pregnancy

From CDC:

Pregnancy and Opioid Pain Medications - English
https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf

El Embarazo y Los Medicamentos Opioides - Español
https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-esp-a.pdf

From SAMSHA:

Publications and Digital Products
https://store.samhsa.gov/?f[0]=series:5602

From MotherToBaby:

Opioid Fact Sheets
https://mothertobaby.org/fact-sheets/opioids/

Helpful Links With Information Related to Marijuana During Pregnancy

From CDC:

What You Need to Know About Marijuana Use and Pregnancy
https://www.cdc.gov/marijuana/factsheets/pregnancy.htm

From SAMHSA:

Marijuana and Pregnancy
https://www.samhsa.gov/marijuana/marijuana-pregnancy

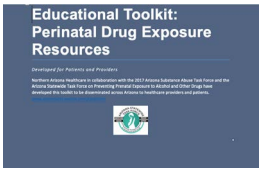
From MotherToBaby:

Marijuana Fact Sheet
https://mothertobaby.org/fact-sheets/marijuana-pregnancy/pdf/

From March of Dimes:

Pregnancy and Marijuana Use
https://www.marchofdimes.org/materials/MOD-Marijuana-Fact-Sheet_July282015.pdf

Additional Resource



From Arizona Statewide Task Force:

Perinatal Drug Exposure Fact Sheets can be found at this website by clicking on the "Drug Toolkit Providers/Patients" word document.
https://azprenatal.wixsite.com/taskforce/pregnancy-and-parenting

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