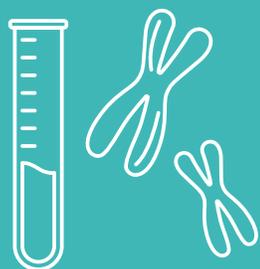


Reference Guide for Labor and Delivery Complicated by Substance Use

Revised February 2021



Referral and Resource Information

Crisis Support Services of Nevada

Call number 1(800) 273-8255 or Text Care to 839863

<https://cssnv.org/>

Behavioral Health Nevada

<https://behavioralhealthnv.org/>

2-1-1

(This site also provides assistance to those with Medicaid Managed Care organization (MCO)

Call 2-1-1 or 1-866-535-5654

Text your zip code to 898211

Chat with Nevada 211 on FB or twitter

<https://www.nevada211.org/healthcare-services/>

Nevada State WIC Administration

[http://dpbh.nv.gov/Programs/WIC/dta/Locations/xWomen, Infants and Children \(WIC\) - Locations/](http://dpbh.nv.gov/Programs/WIC/dta/Locations/xWomen, Infants and Children (WIC) - Locations/)

Northern Nevada WIC clinics

<http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/WIC/dta/Locations/WIC%20Hands%20Roster%208-23-18.pdf>

Find the closest clinic to Me:

<https://nevadawic.org/clinics/>

DHCFP/Medicaid assistance for recipients Care Coordination

(Member Support, Find a Provider, Get Help, District Office, Programs and Services, and Request Records)

<http://dhcfp.nv.gov/Members/Home/>

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Introduction

Substance misuse, dependency, and substance use disorders (SUDs), including opioid use disorder (OUD), are prevalent among Nevada adult populations, including among individuals of reproductive age. Subsequently, OUD also occurs during pregnancy at an alarming rate with far reaching effects on both the parent and infant. SUD is a primary chronic disease similar to diabetes and hypertension, not a moral failure or character weakness, and should be treated as such by the medical professionals who care for pregnant patients and their infants. To date, the single best evidence-based strategy we have to identify and help those that desire assistance is incorporating screening and referral to treatment, known as Screening, Brief Intervention and Referral to Treatment (SBIRT), into the clinical setting.

Currently, pregnant patients with SUD who present to Labor & Delivery (L&D) units, may receive significant variation in services. These differences include identification and treatment of SUD, identification and treatment for the infant(s), reproductive planning, and care coordination. Practice variance without the use of common generally accepted expert guidelines may potentially lead to parental and/or neonatal complications before, during, and/or after delivery.

This reference guide aims to address some of these variances and provide a resource with best practices, guidelines, and protocols for medical professionals involved in the care of pregnant patients with OUD who are admitted to L&D units for delivery and their infants up until discharge. The target audience is medical professionals who are licensed in the state of Nevada, which includes physicians, nurse practitioners, physician assistants, registered nurses, licensed midwives, lactation consultants, licensed clinical social workers, and case managers. However, this does not preclude others such as government agencies, specialty offices, and first responders from using this as a resource or in various clinical situations where contact with a pregnant patient is made (e.g., seen in triage but not admitted, admitted for a non-labor related issue, etc.).

In general, the critical principles of care for this patient population are:

1. All patients should be screened for substance use with a standardized accepted questionnaire.
2. Each patient with OUD should be on medication for OUD (MOUD).
3. Every patient should be provided with adequate pain relief during labor, delivery, and the postpartum period.
4. All patients without specific medical contraindications should be encouraged to breastfeed.
5. For neonatal withdrawal (NAS/NOWS), the standard of care is keeping the patient/infant dyad together and utilizing nonpharmacologic interventions as much as possible.
6. Every patient should receive non-coercive contraception counseling and have immediate, easy access to the contraception of their choice prior to hospital discharge.
7. The patient/infant dyad should receive resources and support to optimize health and social outcomes and prevent family disruption resulting from infant removal.
8. The patient/infant dyad should receive adequate outpatient follow up that addresses their needs, especially during the first year postpartum.

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 health care environments and patient situations.

Acronyms

AAP – American Academy of Pediatrics	MFM – Maternal Fetal Medicine
ACOG – American College of Obstetricians and Gynecologists	MI – Motivational Interviewing
ASAM – American Society of Addiction Medicine	MOUD – Medication for Opioid Use Disorder
BI – Brief Intervention	NAS – Neonatal Abstinence Syndrome
BID – Two Times a Day	NICU – Neonatal Intensive Care Unit
BNI – Brief Negotiated Interview	NIDA – National Institute on Drug Abuse
CAPTA – Child Abuse Prevention and Treatment Act	NOWS – Neonatal Opioid Withdrawal Syndrome
CARA – Comprehensive Addiction and Recovery Act	NSAID – Nonsteroidal Anti-Inflammatory Drug
CDC – Centers for Disease Control and Prevention	NRS – Nevada Revised Statute
CPS – Child Protective Services	OIH – Opioid-Induced Hyperalgesia
DATA 2000 – Drug Addiction Treatment Act 2000	PCA – Patient Controlled Analgesia
DPBH – Department of Public and Behavioral Health	PCL-C – Post Traumatic Stress Disorder Checklist-Civilian
ESC – Eat, Sleep, Console	PHQ-9 – Patient Health Questionnaire
EtG – Ethyl Glucuronide	PMP – Prescription Monitoring Program
FASD – Fetal Alcohol Spectrum Disorder	POC – Plan of Care
FDA – Federal Drug Administration	POISE – Pros and Cons, Others' Views, Image, Self-Efficacy, Emotions
FNASS – Finnegan Neonatal Abstinence Syndrome Scoring System	PPROM – Preterm Premature Rupture of Membranes
FRAMES – Feedback, Responsibility, Advise, Menus of options, Empathy, Self-efficacy	PRN – As Needed
FTA – Fluorescent Treponemal Antibody	PTSD – Post Traumatic Stress Disorder
GAD-7 – General Anxiety Disorder Scale	PVS – Partner Violence Screen
GC-MS – Gas Chromatography-Mass Spectrometry	QL2 – Quadratus Lumborum Type 2
GGT – Gamma-Glutamyl Transferase	RPR – Rapid Plasma Reagin
HIV – Human Immunodeficiency Virus	RT – Referral to Treatment
HRSA – Health Resources and Services Administration	SAMHSA – Substance Abuse and Mental Health Services Administration
HTLV – Human T-cell Lymphotropic Virus	SBIRT – Screening, Brief Intervention, and Referral to Treatment
HSV – Herpes Simplex Virus	SIDS – Sudden Infant Death Syndrome
IUD – Intrauterine Device	STI – Sexually Transmitted Infection
LactMed – Drugs and Lactation Database	SUD – Substance Use Disorder
LARC – Long Acting Reversible Contraception	SURP-P – Substance Use Risk Profile-Pregnancy
L&D – Labor and Delivery	TAP – Transverse Abdominis Plane
LFTs – Liver Function Tests	TEA – Trustworthiness, Expertise, and Accessibility
MAT – Medication Assisted Treatment	TID – Three Times a Day
MDQ – Mood Disorder Questionnaire	WAST – Woman Abuse Screening Tool
	WHO – World Health Organization
	WIC – Women, Infants, and Children Program

Screening, Brief Intervention, and Referral to Treatment

Drug-induced deaths are now the leading cause of death for reproductive-age women in the United States.^{1,2} Prevention, identification, and reduction of alcohol, tobacco, and drug use during pregnancy and the postpartum period are critical to support the health and well-being of patients and their infants. Additionally, pregnancy is an ideal window of opportunity for the treatment of SUDs that will reduce parental, obstetric, fetal, and infant morbidity and/or mortality. Fortunately, effective interventions for OUD exist, including Medication for Opioid Use Disorder (MOUD), but optimizing outcomes can only occur when properly trained health professionals recognize and treat SUDs and substance exposed infants. In this effort, we rely heavily on obstetric clinicians, hospitals, and their inpatient care personnel. They are the first health care contact for most pregnant patients with OUD and need to lead the effort to screen, assess, and refer these patients as well as provide for their obstetrical needs.³



- **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.

Screening

Screening is a process of identifying patients with possible substance misuse or abuse problems. The screening process does not exactly identify the type of problem a person might possess or how serious it might be. Instead, screening determines whether a problem exists or whether further assessment is needed. In practice, this means a health care professional assesses a patient for substance use utilizing standardized screening tools when a pregnant patient is admitted to L&D. The goal is to identify patients who have a risk factor, which leads to further evaluation to determine if SUD truly exists. For the purposes of this effort, it is important to identify factors that could affect the care of the patient intra- and postpartum.

- **Who to Screen:** ALL patients admitted for labor. This is called “Universal Screening.” Do not screen based on non-medically based diagnoses or suspicions as this increases the likelihood of implicit biases (e.g., physical appearance, race, ethnicity, etc. known as targeted screening).
- **Who Can Perform Screening:** A wide variety of health care staff including physicians, nurses, nurse practitioners, physician assistants, licensed midwives, and licensed clinical social workers.
- **When to Screen:** Ideally at the time the patient is admitted during a pregnancy encounter.
- **How to Screen:**
 - Universally - every pregnant patient. This eliminates any potential biased or discriminatory practices.
 - Use a standardized accepted questionnaire-based tool such as the 5Ps⁴ (see Appendix for an example of how to perform SBIRT using the 5Ps), National Institute on Drug Abuse (NIDA) Quick Screen⁵, or the Substance Use Risk Profile-Pregnancy (SURP-P)⁶ that asks questions about alcohol, tobacco, and substances, both legal and illegal.
 - In private – ideally with the patient alone and without friends, family, or significant others.
 - Use an empathic, compassionate, and non-judgmental approach that lets the patient know ALL patients are asked the same questions.
 - Patient-centered to normalize the purpose of screening, asking the patient for permission and addressing confidentiality prior to beginning the process.



When Screening is Positive

- A positive screen does not automatically trigger a diagnosis of SUD. Rather, it should prompt further evaluation to determine current substance use, identify current and future risks for the patient and infant, and confirm or rule out the diagnosis of SUD, including degree of severity.
- Perform a brief intervention to gauge a patient's readiness for change, explore options for treatment, and acceptance of follow up care (see section on Brief Intervention for more info).
- Refer to treatment that provides the appropriate level of care that is the best match with the patient's needs (see section on Referral to Treatment for more info).
- Assess for signs and symptoms of acute withdrawal and treat as appropriate. If there is concern for, or if the patient is withdrawing from benzodiazepines and/or alcohol, priority should be given to those substances first.
- Screen for co-occurring psychiatric conditions and refer as appropriate. Options include (see Appendix for examples):
 - Patient Health Questionnaire (PHQ-9) for depression.
 - General Anxiety Disorder Scale (GAD-7) for anxiety.
 - Abbreviated Post Traumatic Disorder (PTSD) Checklist-Civilian (PCL-C) for PTSD.
 - Mood Disorder Questionnaire (MDQ) for bipolar disorder.
- Screen for co-occurring domestic/intimate partner violence and refer as appropriate. Options include (see Appendix for examples):
 - Partner Violence Screen (PVS).
 - Woman Abuse Screening Tool (WAST).
- Assess for other psychosocial/social determinants of health needs such as housing, transportation, education, employment, access to foods, etc.
- Labs:
 - Routine labs for labor and birth.
 - If not performed in the third trimester: HIV, Hepatitis B and C.
 - Syphilis (RPR or FTA antibodies as appropriate).
- **If no prenatal care, consider:**
 - Other sexually transmitted infections including Gonorrhea and Chlamydia.
 - Liver function tests (LFTs) and serum creatinine.
 - Gamma-Glutamyl Transferase (GGT) or Ethyl Glucuronide (EtG) if active alcohol use is suspected.
 - Assessing risk factors for tuberculosis and screen if indicated.
- For patients already receiving MOUD: When possible, confirm MOUD medication and dose with MOUD prescriber and continue during hospitalization (all hospitals should provide the medication and not use the patient's own supply; see section on Medication for Opioid Use Disorder for more info).
- Notify pediatrician of admission for delivery and determine need for neonatal team at birth.
- Consults for:
 - Neonatology (if not previously done).
 - Social Work/Case Management.
 - Anesthesiology (pain management).
 - Lactation (breastfeeding).
 - If substance use first disclosed or detected at time of admission, consider Maternal Fetal Medicine, Behavioral Health, and/or Addiction Medicine.
- Involve multidisciplinary team to develop a Comprehensive Addiction and Recovery Act (CARA) Plan of Care (POC) (see section on Care Coordination for more info).

- Check Nevada’s Prescription Monitoring Program (PMP) record (including other states where applicable).
- Discuss Narcan/naloxone (opioid antagonist) and offer prescription for instances of inadvertent patient overdose. Senate Bill 459 allows a clinician to prescribe an opioid antagonist to a family member, friend, or someone in a position to help another person at risk of overdose. Additionally, pharmacists can furnish naloxone without a prescription.⁷
- Provide contraceptive counseling and determine plan to include Long Acting Reversible Contraception (LARC) and offer immediate postpartum LARC if available (See section on Reproductive Planning for more info).
- Care coordination and discharge planning (see section on Care Coordination for more info).



Biologic Toxicology Testing

Understanding biologic (urine, blood, saliva, etc.) toxicology testing and its limitations is important for providing optimal care to patients who use substances during pregnancy. Pregnant and postpartum patients along with their infant are typically drug tested in medical settings without their knowledge or explicit, informed consent. Additionally, the results (including false positives) can have devastating consequences for the patient and infant when used inappropriately by other agencies and can result in punitive consequences. Universal screening, using a questionnaire-based tool, should not be confused with biologic testing which historically has been applied inconsistently and can result in a testing system damaged by bias. Note that medical professionals are not required to report positive toxicology screens of pregnant patients to Child Protective Services (CPS) in Nevada.

Patient Biologic Toxicology Testing

- Universal biologic toxicology testing alone is not recommended. Biologic toxicology testing, when performed, should be used in conjunction with universal questionnaire-based screening and only with the patient’s informed consent and when its benefits outweigh any potential harms.⁸
- To test, every patient must be able to give informed consent. This requires a clear explanation of why testing is being performed, the benefits, and the risks including the potential legal, criminal, or child welfare consequences.

- Every patient has the right to withhold consent and coercive language should not be used.
- Each hospital should have explicit criteria for testing to avoid profiling and discrimination. Ensure criteria do not indirectly target low-income patients or patients of color.
- Biologic toxicology testing should be offered in specific predetermined emergent medical situations, with the patient's consent (unless unable due to loss of consciousness).⁹ Behaviors (e.g., signs of acute intoxication) are more important as prompts for testing than selective indicators of risk.

Triggers for testing may include, but are not limited to:

Patient is obtunded or unconscious.

Patient is falling asleep mid-sentence or shows evidence of intoxication.

Patient with no prenatal care.

Patient with previously identified use during pregnancy, SUD, or treatment.

Patient receiving MOUD.

Patient with physical evidence of substance use or withdrawal:

- Marked dilated or constricted pupils.
- Rapid eye movements or nystagmus.
- Tremors.
- Track marks, abscesses, or injection sites.
- Inflamed or eroded nasal mucosa or nose bleeds.
- Increased pulse and blood pressure.
- Increased body temperature.
- Gum or periodontal disease.
- Soft tissue infections or endocarditis.

Patient with inappropriate behavior:

- Sedation or disorientation.
- Inebriation.
- Agitation, aggressiveness, or violence.
- Psychosis or hallucinations.
- Euphoria or depression.

Acute clinical complications:

- Placental abruption.
- Preterm labor.
- Preterm premature rupture of membranes (PPROM).
- Unexplained severe hypertension.

- If performed, biologic toxicology testing should occur immediately on admission to an L&D setting and not after the patient has been treated with any medication that could cause a positive test result.¹⁰
- If the pediatrics team requests biologic toxicology testing of a patient (informed consent required) because the infant is showing signs of withdrawal, it is preferable to test the infant (informed consent not required) as the patient may test positive because of medicine received at delivery or postpartum.¹¹
- Positive results need to be confirmed (confirmatory testing) with Gas Chromatography-Mass Spectrometry (GC-MS) before they are considered accurate. False positives occur from common medications including antihistamines, antidepressants, antibiotics, decongestants, analgesics, antipsychotics, and over-the-counter products.
- A positive testing result, in and of itself, does not represent child abuse or neglect. Hospitals must ensure that the multidisciplinary team caring for these patients and their infants includes social workers trained in care and treatment resources for affected families.
- Be knowledgeable about what substances are tested for and the composition of the testing available at your institution, as specific tests, panels, and methods vary from site to site and can be challenging to correctly interpret.
- There are multiple limitations to biologic toxicology testing. A negative result does not rule out substance use or SUD and a positive result does not confirm SUD. Additionally, testing does not provide information on how recently or the quantity of substance used, only the presence/absence of a substance at a predetermined cutoff value. In comparing questionnaire screening to biologic toxicology testing, consider the following:

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)

Infant Biologic Toxicology Testing

- Each hospital should have explicit criteria for testing to avoid profiling and discrimination. Ensure criteria do not indirectly target infants of low-income patients or patients of color.
- Review and understand the various testing methods available, including the advantages and limitations of each (e.g., urine, meconium, cord blood, etc.).
- Biologic toxicology testing is limited by substance levels/concentrations and timing. If performed, collect samples, and send for analysis as soon as possible after delivery.
- Informed consent is not required for biologic testing of the infant.
- Biologic toxicology testing of the infant should be informed by:
 - Interviewing the patient about all substances and medications used during pregnancy (see section on Screening for more info).
 - Assessing the clinical status of the infant.
 - Toxicology screening of the patient (informed consent required).
- Consider biologic toxicology testing when:
 - There is limited or unavailable diagnostic information about the patient.
 - The clinical picture indicates risk for in utero exposure, including but not limited to:
 - Patient with limited or no prenatal care.
 - Patient exhibits otherwise unexplained signs and symptoms of intoxication or withdrawal.
 - Infant exhibits otherwise unexplained signs and symptoms of potential substance exposure.
- All positive results, including unexpected positives, should be confirmed (confirmatory testing) with Gas Chromatography-Mass Spectrometry (GC-MS) and/or a more time specific test sample (e.g., meconium, umbilical cord).
- Due to assay limitations, a negative biologic toxicology result does not represent an absence of in utero substance exposure, specifically if the infant exhibits clinical signs consistent with NAS and all other diagnoses have been appropriately ruled out.



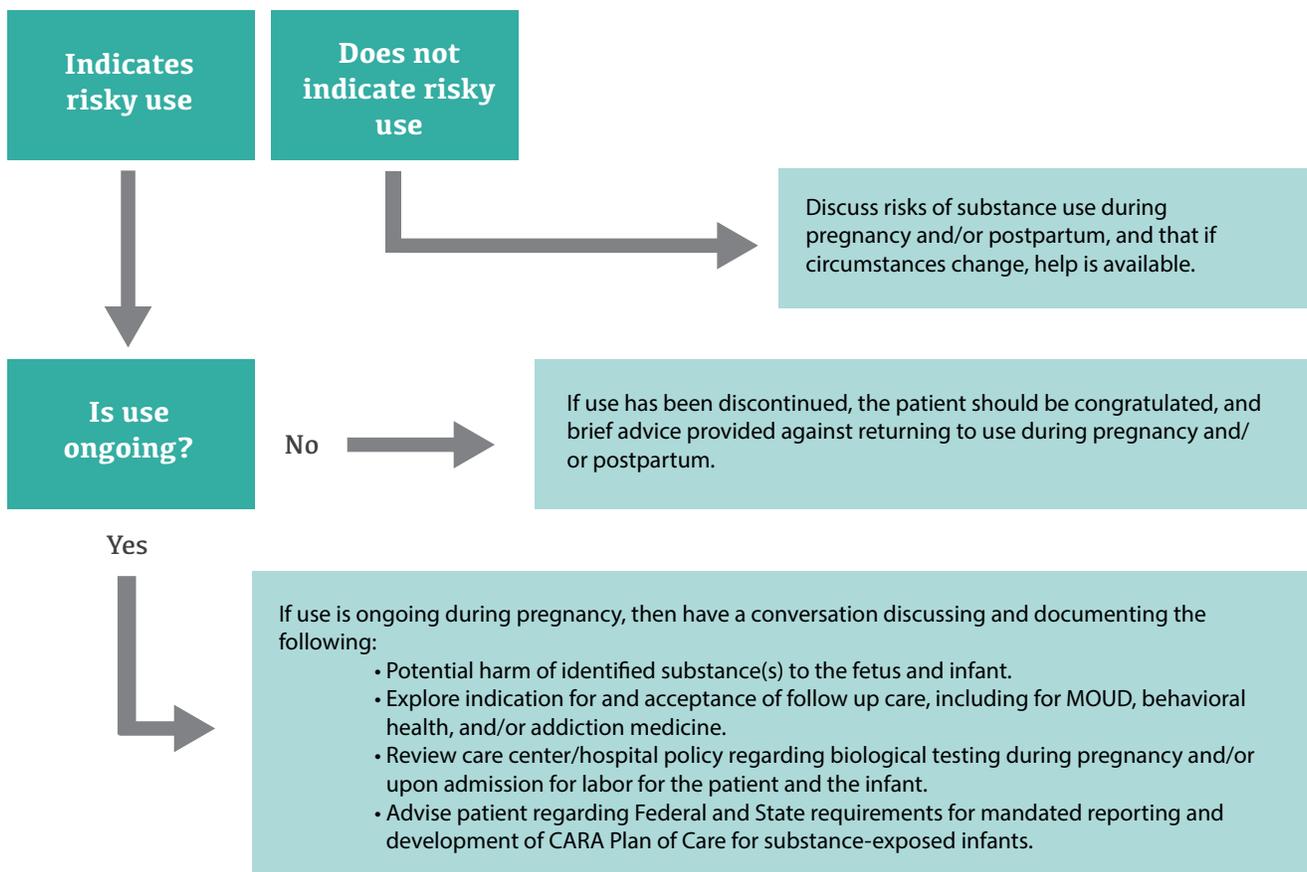
Brief Intervention

Brief Intervention (BI) focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. It is part of a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with SUDs, as well as those who are at risk of developing these disorders. BI is appropriate for patients identified through screening to be at risk for substance use problems. Additionally, BI provides an opportunity to communicate your concerns with the patient, and provide information about why you are concerned. You can then encourage the patient to address the problem, and provide help in seeking treatment. In general, BI is a patient-centered structured conversation that employs the principles of Motivational Interviewing (MI). These interventions have been shown to improve outcomes for patients with substance use, the ultimate goal being to reduce the risk of harm from continued use.

There are various models for BI including the Brief Negotiated Interview (BNI)¹² and Feedback, Responsibility, Advise, Menu of options, Empathy, Self-efficacy (FRAMES).¹³

Brief Intervention incorporates the following steps:

1. Introducing the issue/subject.
2. Offering feedback.
3. Talking about change, assessing the patient's motivation for change, enhancing their motivation for change, and setting goals.
4. Summarizing, coming up with a plan, and/or reaching closure.



Referral to Treatment

Patients identified as needing more intensive treatment are referred to specialty SUD treatment professionals. The primary goals of referral to treatment (RT) are to identify an appropriate treatment program and to facilitate engagement of the patient in treatment. RT can be a complex process involving coordination across different types of services. It requires a collaborative effort between those involved in the SBIRT process and specialty treatment to ensure the patient has access to, and engages in, the appropriate level of care.

- Each patient will require an individualized plan that is developed in collaboration with the health care team. A shared decision-making approach is essential to ensure that the treatment plan developed is feasible and acceptable for the patient.
- Intensity of use, availability of treatment options, and conflicting responsibilities and preferences are critical factors in determining the appropriate level of care. These levels of care, defined by the American Society of Addiction Medicine (ASAM), include:
 - Level 1 – Outpatient Office Based.
 - Level 2 – Intensive Outpatient Centers.
 - Level 3 – Residential Treatment Centers.
 - Level 4 – Medically Managed Inpatient Treatment.
- For patients accepting of follow up care, refer to:
 - Medication for Opioid Use Disorder (See section on Medication for Opioid Use Disorder for more info).
 - Behavioral Health and/or Addiction Medicine.
 - Social Work/Case Management.
- Maintain a list of local treatment options and know resources in your area (see section on Care Coordination and the Appendix for more info).
- If a patient is being referred to treatment for substance use, then it is highly likely the infant was exposed and will need a CARA Plan of Care (See section on Care Coordination for more info).



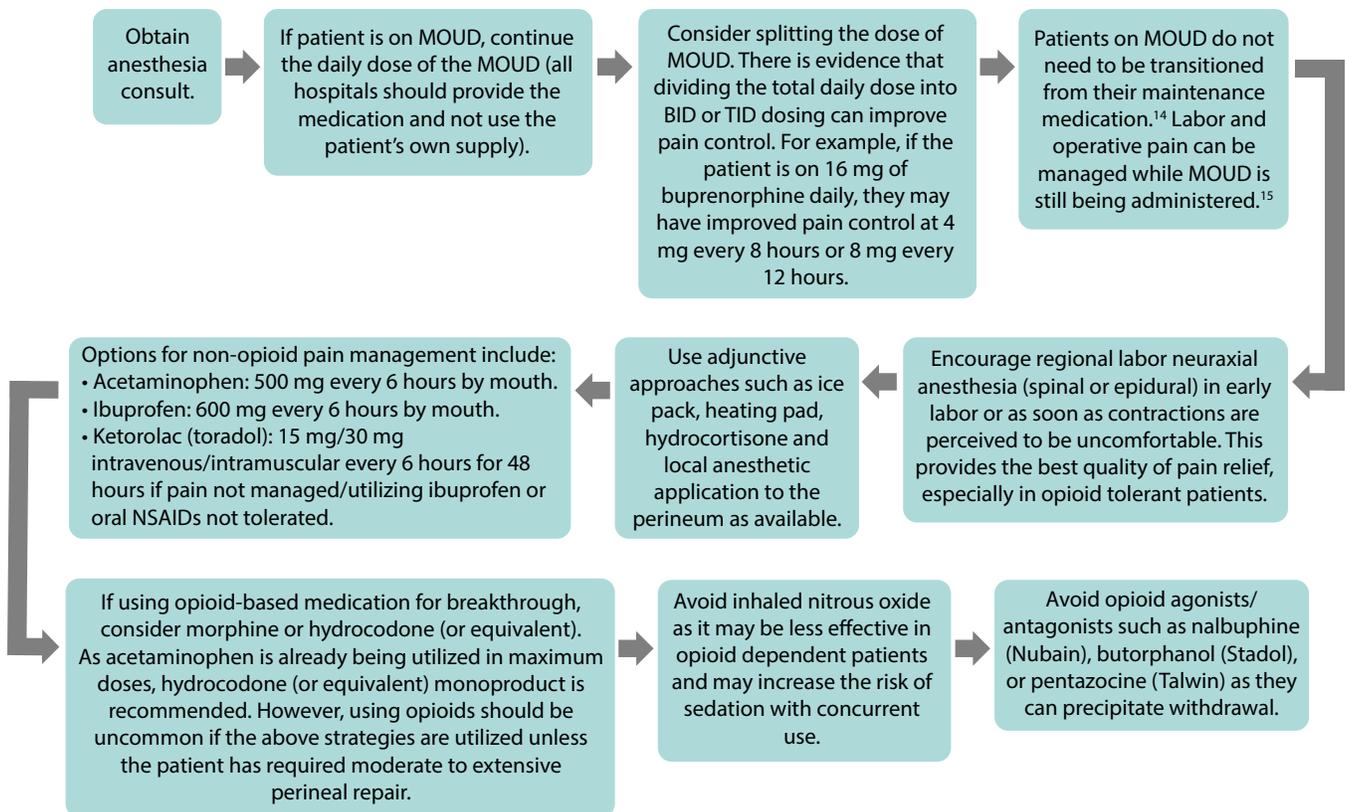
Intrapartum Pain Control

A pregnant patient with OUD, in treatment or not, needs pain relief during labor, delivery, and the postpartum period. Patients with OUD potentially have a higher tolerance to opioids in addition to opioid-induced hyperalgesia (OIH), resulting in experiencing more severe pain during delivery and in the immediate postpartum period. As such, it is likely these patients might require higher and more frequent dosing of narcotic medication for pain.

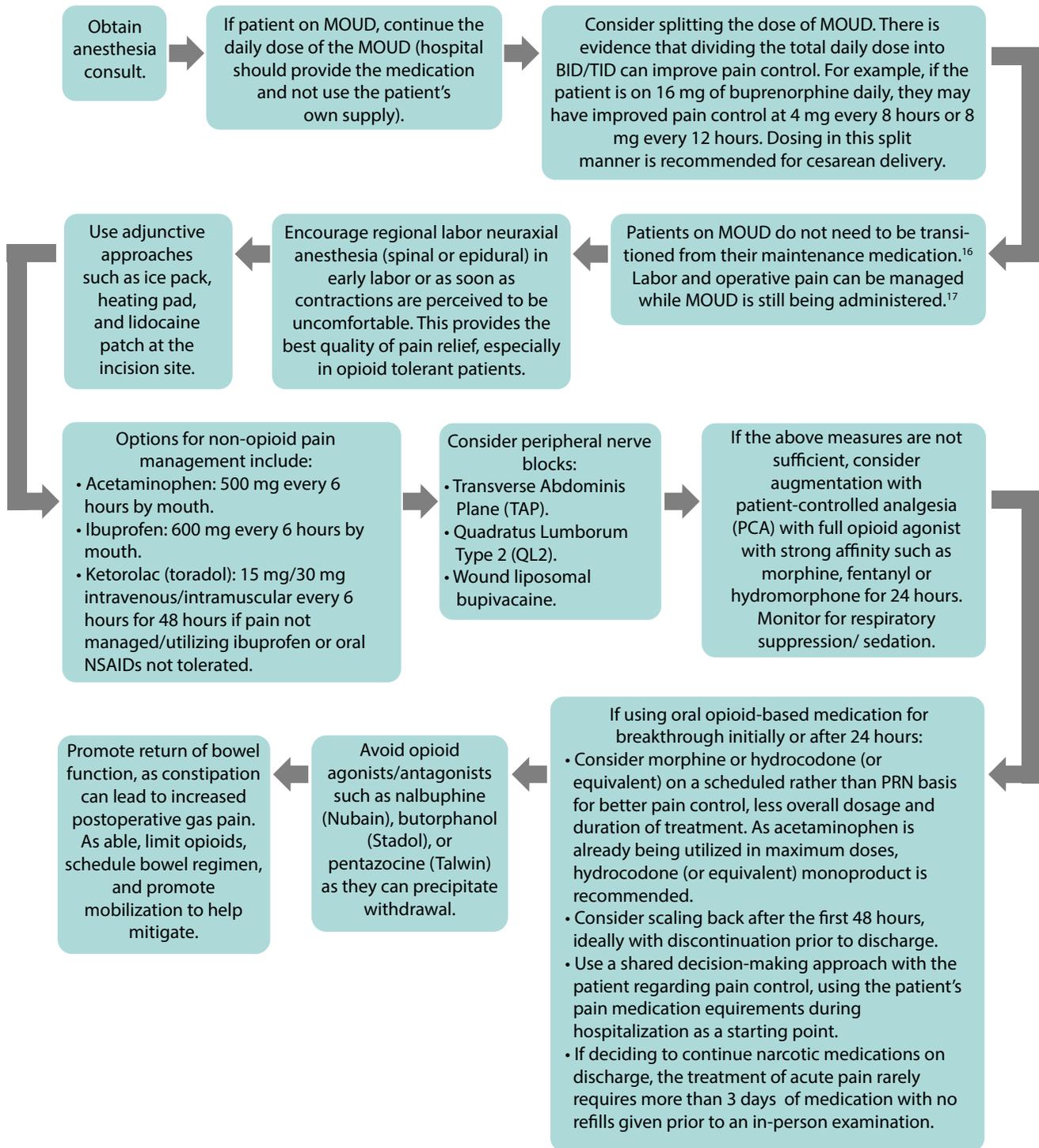
The goal for pain control should be to control withdrawal, cravings, and adequately control pain (not necessarily eliminate) such that the patient is able to mobilize, breastfeed, and otherwise care for the infant. Overall strategies should employ continuing medications for MOUD, in addition to nonpharmacologic-adjunctive and non-opioid pharmacologic approaches. For all patients, immediate skin-to-skin, breastfeeding, early ambulation, and promotion of rest periods can improve overall perception of, and coping with pain.

Naturally, patients may be anxious about how pain will be controlled during labor and delivery and/or fear a return to substance use (also known as “relapse”). Assure patients that they will receive adequate pain relief during labor, delivery, and the postpartum period. A common myth is that short-term opioids will result in a return to substance use when in fact inadequate pain treatment is more likely to cause a return to substance use. Ideally, consultation with an anesthesiologist at your facility will take place to review and develop an anesthetic treatment plan that addresses the patient’s needs and accounts for the available options at the facility.

Pain Management During Hospitalization for Vaginal Delivery



Pain Management During Hospitalization for Cesarean Delivery



Medication for Opioid Use Disorder

The standard of care in the treatment of OUD includes MOUD. It is important to offer treatment, as pregnancy is a window of opportunity for treatment of chronic diseases, including SUDs/OUD. This opportunity should not be lost after delivery as patients are at particularly high risk of overdose and death in the first year postpartum.¹⁸ MOUD reduces the risk of mortality almost sixfold, comparable to the baseline for the regular population.¹⁹ Additionally, while in treatment with MOUD, treatment is quite effective with response and adherence rates similar to that of other chronic diseases like diabetes and better than those for hypertension and asthma.²⁰

Medication Options

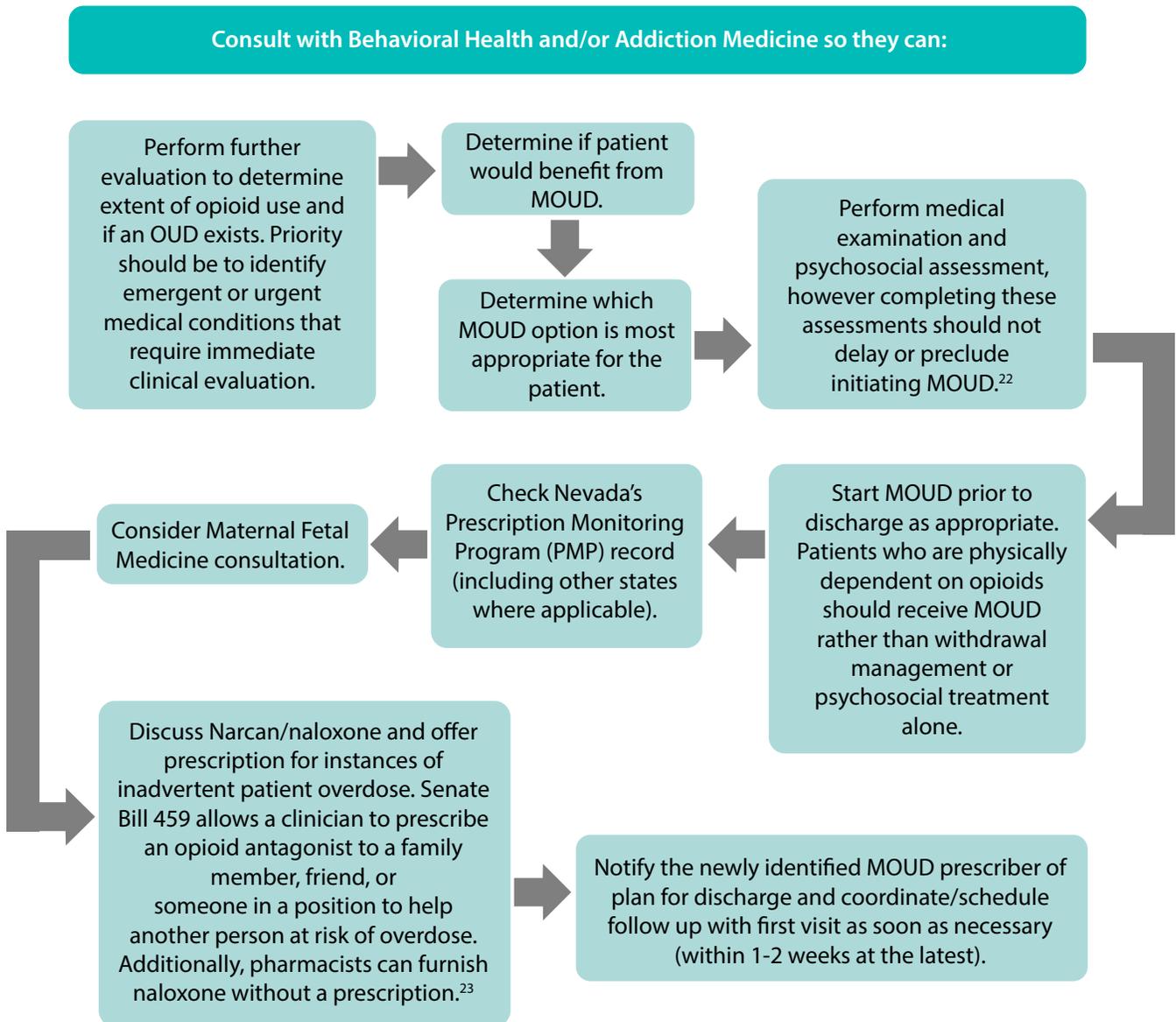
- To date, there are three FDA approved MOUD options for the treatment of OUD: buprenorphine, methadone, and naltrexone.
- During pregnancy, buprenorphine or methadone are acceptable treatment options for MOUD (the evidence base for naltrexone in pregnancy is emerging and it might one day become more generally accepted). However, buprenorphine has been found in general to have lower incidence of NAS/NOWS, milder symptoms, and shorter duration.²¹
- Postpartum, all three available medications are acceptable and the choice between them should involve a shared decision-making process with the patient, taking into account the differences, clinical picture, and availability of treatment systems.

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 (e.g., methadone)	Generally greater than mixed agonist/antagonist opioids (e.g., 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.

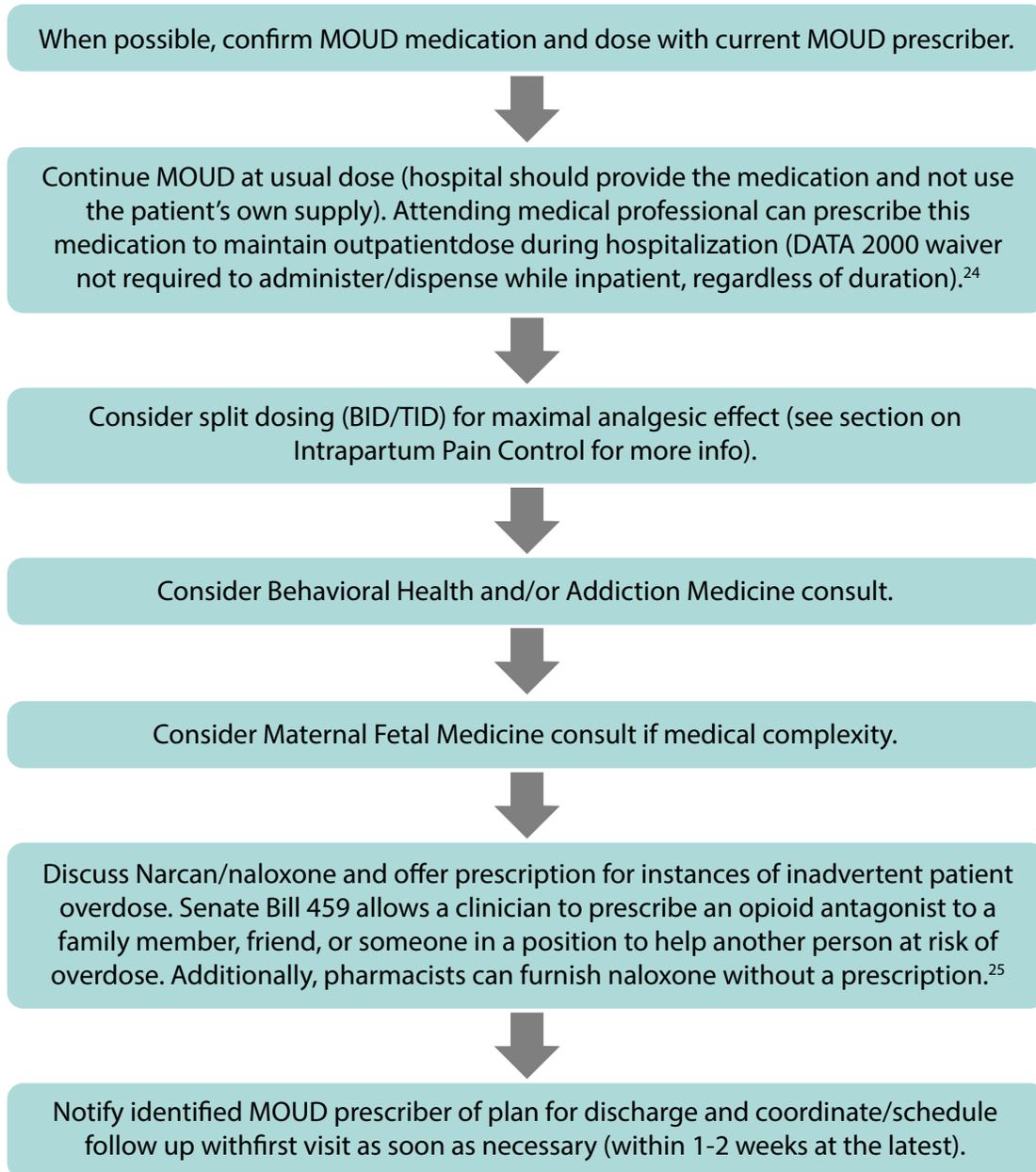
Patient Not on Medication for Opioid Use Disorder

For the patient that screens positive for opioid use, is not currently on MOUD at the time of admission, and is accepting of treatment:



Patient on Medication for Opioid Use Disorder

For the patient that is already on MOUD at the time of admission, the primary goal will be to continue their medication during hospitalization and avoid discontinuation of treatment due to increased risk of returning to non-prescribed substance use, overdose, and death after delivery.



Neonatal Withdrawal

Neonatal withdrawal, commonly referred to as Neonatal Abstinence Syndrome (NAS), is a constellation of signs and symptoms experienced by the neonate that occurs when prenatal exposure to a substance is interrupted at birth. A variety of substances and medications can lead to NAS including but not limited to:

- Sedative-hypnotics (e.g., barbiturates).
- Anticonvulsants (e.g., gabapentin).
- Anxiolytics (e.g., benzodiazepines).
- Selective Serotonin Reuptake Inhibitors (e.g., sertraline, fluoxetine).
- Selective Norepinephrine Reuptake Inhibitors (e.g., venlafaxine).
- Opioids (e.g., morphine, hydrocodone, methadone, buprenorphine, heroin).
- Illicit and licit substances (e.g., tobacco, alcohol, cocaine, methamphetamine).

The severity of NAS is not well understood but appears to be multifactorial including:

- Maternal factors – nutrition, infection, stress, comorbid psychiatric conditions.
- Maternal exposures – type of substances used, timing of exposures, polysubstance use (including alcohol and tobacco), concurrent use of certain medications.
- Genetics, epigenetics.
- Metabolism – placental, patient, and infant.
- Infant factors – preterm birth, infections, and medications.
- Environmental factors – assessing, diagnosing, and treating NAS.

When the withdrawal syndrome is linked to opioid exposure specifically, it is referred to as Neonatal Opioid Withdrawal Syndrome (NOWS) and the neonate is likely to exhibit additional signs and symptoms, and require different medication treatment than withdrawal caused by other substances. NOWS can be associated with metabolic and gastrointestinal symptoms not commonly found in NAS caused by other exposures. However, when other substances are used in combination with opioids, the withdrawal syndrome can be more severe and prolonged. Common findings include:

- Irritability, fussiness, high-pitched cry.
- Difficulties with feeding or gaining/maintaining weight.
- Vomiting and diarrhea.
- Yawning, sweating, nasal stuffiness, and sneezing.
- Trouble sleeping.
- Tremors, twitching, increased muscle tone, and seizures.

While the long-term effects of NAS are not well understood, given the evidence, it appears that infants with NAS are at increased risk of:²⁶

- Low birthweight.
- Jaundice.
- Seizures.
- Ear infections.
- Vision problems.
- Sudden Infant Death Syndrome (SIDS).
- Developmental delays.
- Motor problems.
- Behavioral and learning problems.
- Speech and language problems.

Unfortunately, rates of NAS/NOWS have increased more than 300% in the past decade at an average cost of over \$200,000 for each case.^{27,28} In Nevada, inpatient admissions for NAS have doubled since 2011, and the average length of stay for infants in 2018 was 19 days. Given the far-reaching implications of NAS, it is extremely important to appropriately monitor, diagnose, and treat cases to hopefully lessen the incidence and impact as much as possible. Every hospital should have written guidelines and protocols for NAS to lessen intra-clinician/unit variability.

Monitoring

The onset and timing of NAS/NOWS can be variable due to multiple factors including whether the infant was exposed to short acting (e.g., heroin, hydrocodone) and/or long acting (e.g., buprenorphine, methadone) opioids, in addition to various other medications/substances.

- All hospitals should have a protocol for NAS/NOWS monitoring.
- Ideally, monitoring will take place in a non-NICU space (e.g., Postpartum, Infant Nursery, Pediatrics, etc.).
- Monitoring for infants at risk of NAS/NOWS should be informed by:
 - Interviewing the patient about all substances and medications used during pregnancy (see section on Screening for more info).
 - Assessing the clinical status of the infant.
 - Toxicology testing of the patient (informed consent required) and infant (informed consent not required). Toxicology testing may include urine, meconium, and/or cord blood. All positive results should be confirmed.
- Infants with suspected or confirmed exposure to opioids should be monitored for a minimum of 4 days (96 hours).
- Methadone or polysubstance exposed infants should be observed for a minimum of 5 days (120 hours).
- Common NAS scoring systems include the Finnegan Neonatal Abstinence Syndrome Scoring System (FNASS) and more recently modified versions of the FNASS. Treatment (medication) is usually given to the neonate when hard cutoff values of the scoring are exceeded. However, some shortcomings of using this method alone include:
 - Overlap with normal infant behavior.
 - Some symptoms (e.g., nasal stuffiness, sneezing) do not warrant medication treatment.
 - Does not promote the use of nonpharmacologic measures.
 - Scoring is often done when symptoms are noticed in the moment.
- One evidence-based approach that is gaining popularity, to be used instead of or in conjunction with the FNASS, is the Eat Sleep Console (ESC) method.²⁹ Advantages of this method include:
 - Based on essential infant functioning (ability to eat, sleep, and be consoled) vs. other factors.
 - Promoting keeping parent/caregiver and infant dyad together.
 - Promoting parent/caregiver involvement and education.
 - Promoting use of nonpharmacologic treatment as first-line (standard of care).
 - Decreasing lengths of stay, exposure to medication, and hospitalization costs.
- Assessments should be performed every 3 hours, but only if the infant is awake, after feeding, and while being held by parent/caregiver.



Treatment

There are various methods for treating NAS/NOWS. Differences include the clinical setting where treatment takes place and the length and type of treatment. Unfortunately, these differences can result in inadequate, missed, and/or unnecessary exposure to treatments (medications/NICU) for the infant. The primary goal is to maintain the parent/infant dyad as much as possible and avoid any of the above. Treatment that promotes baby-centered, function-based, non-pharmacologic care, with the patient as the primary means of treatment may be more effective in reducing lengths of treatment and stay than treatments that focus on specific medications, protocol standardization, or home-based pharmacotherapy (e.g., infant is discharged while still on methadone).³⁰

All hospitals should have a protocol for NAS/NOWS treatment.

Ideally, treatment will take place in a non-NICU space (e.g., Postpartum, Newborn Nursery, Pediatrics, etc.).

A multidisciplinary team should be involved:

- Physician and Nursing – Education, monitoring, ESC, pharmacologic interventions.
- Social Work – Assess needs, appropriate referrals, program supports.
- Child Life – Support parents, offer volunteer “cuddlers”.
- Occupational Therapy – Assess oral intake, provide recommendations.
- Nutrition – Daily weights, early supplementation with formula or breast milk.
- Lactation – Encourage breastfeeding, education, breast pumps.
- Care Coordination – Assure all appropriate referrals and follow-up care in place prior to discharge.

Nonpharmacologic interventions are considered first line treatment for NAS/NOWS. They are centered around helping not only the infant self-regulate, but also the parent/caregiver to understand and respond to the infant’s cues.

Interventions include:

- Rooming-in - Parents/caregivers are the newborn’s primary care providers. Perform an assessment to assure safety and appropriateness for rooming-in of the newborn and patient. Rooming-in is the standard of care.
- Low stimulation environment – Reduce lights, noises, visitors, and exams while infant is sleeping.
- Infant Soothing – Swaddling, swaying, skin-to-skin contact, pacifiers.
- Breastfeeding – Encouraged unless contraindicated, lactation consult.
- Feeding on demand – Cluster feeding is common, early supplementation of formula or breast milk, feeding until content.
- Diaper Dermatitis – Provide barrier cream and proactive prevention of skin breakdown from day one.

For infants not meeting functional expectations/assessments and nonpharmacologic interventions have been optimized and maximized, pharmacologic interventions include:



Consider trial of morphine every 3 hours as needed (PRN) instead of scheduled dosing.



As the evidence base is continually growing, consider methadone or buprenorphine as options in lieu of morphine.



If opioid supplementation is not sufficiently treating NAS/NOWS, consider clonidine as a second line/adjunctive option over phenobarbital.



Consider a standardized protocol for initiation and escalation, but definitely for weaning pharmacologic treatment.



Consider complete weaning/discontinuation of pharmacologic treatment prior to discharge. Infants should NOT be discharged on medication.



An infant who cannot maintain adequate hydration or who loses weight despite optimal management should be evaluated to rule out other medical conditions, and consideration should be given to transferring the infant to a NICU.

Discharge Criteria

Transitions of care, which include hospital discharge, place the infant at risk due to potential gaps in services, education, communication, and transfers of care. Implementing discharge checklists can help support this transition by providing the team and individuals responsible for the transition with a form of communication and consistency. Discharge assumes that the parent/caregiver is ready for discharge and that the infant is safe to leave the hospital with the parent/caregiver. Hospitals should implement an infant discharge checklist specific for those exposed to substances and/or with NAS/NOWS. This checklist should be in addition/supplementation to standard infant discharge procedures and ensure the following:

- All hospitals should have a protocol for NAS/NOWS discharge.
- Infant was appropriately monitored and treated for NAS/NOWS:
 - If medication was used, the infant is weaned off medication and observed for a minimum of 48 hours after discontinuation (weaning should follow a standardized hospital protocol). Outpatient tapers should be avoided when possible.³¹
 - If medication was not used, the infant has been observed for a minimum of 4 or 5 days (depending on substance exposure) using a monitoring method for NAS/NOWS during that time (see section on Monitoring for more info).
- Infant is successfully feeding, sleeping, and easy to console.
- Parent/Caregiver is responding to the infant's needs in a safe and responsive way.
- Parent/Caregiver received information regarding:
 - Recognition of infant signs of NAS/NOWS and have contact information of responsive medical personnel to call with concerns.
 - Techniques to soothe the infant and ways to recognize and respond to infant dysregulation/cues.
 - Safe sleeping, such as the Safe to Sleep campaign,³² and that the infant has its own place to sleep.
 - Follow-up plans that include home visits and early pediatric appointments (within 2-5 days of discharge). Outpatient resources, especially pediatricians, should be informed of the infant's substance exposure.
- CARA POC has been completed, necessary notifications to CPS have been made, appropriate referrals are in place (e.g., early intervention), and appointments made (e.g., home visiting nurse, pediatrician).



Breastfeeding

Breastfeeding and human milk are the standards for infant feeding and nutrition.³³ It is recommended for almost all patients, and the United States Surgeon General, World Health Organization (WHO), and American Academy of Pediatrics (AAP) recommend exclusively breastfeeding for the first six months unless contraindicated:³⁴ Contraindications include:

- Infection with Human Immunodeficiency Virus (HIV) regardless of viral load or treatment history.
- Infection with Human T-cell Lymphotropic Virus (HTLV) types 1 and 2.
- Active Herpes Simplex Virus (HSV) with lesions present on the breast.
- Hepatitis B or C and has cracked or bleeding nipples (otherwise ok to breastfeed).
- Active untreated tuberculosis.
- Use of illicit substances.
- While not an absolute contraindication, as there is insufficient data on marijuana use during lactation and breastfeeding, its use is discouraged.³⁵

Benefits

Breastfeeding confers many benefits to both the infant and patient:

Patient	Infant
Improved bonding	Improved attachment
Lower risk of Type 2 diabetes	Lower risk of Type 1 diabetes
Lower risk of high blood pressure	Lower risk of infections
Lower risk of ovarian cancer	Lower risk of Sudden Infant Death Syndrome (SIDS)
Lower risk of breast cancer	Lower risk of obesity
More rapid recovery following childbirth	Lower risk of asthma
Lower food costs	Lower severity of Neonatal Opioid Withdrawal Syndrome (NOWS)/Neonatal Abstinence Syndrome (NAS) in those at risk

Considerations

The decision to breastfeed or not (outside of contraindications) should be a collaborative one with the patient and clinician. The patient should feel empowered to make this informed decision after being provided information about the benefits and risks as appropriate. Please check your hospital's specific policy, but some considerations for recommending breastfeeding or not include:

May Be Recommended	May Not Be Recommended*
Patient is enrolled in an MOUD program with significant social support, plans to continue treatment, has counselor recommendation, and has demonstrated stability in treatment.	Patient has a medical condition or takes medications that are contraindicated.**
Patient's pain management medications after delivery are not contraindicated for infants.	Patient did not receive prenatal care.
Patient's toxicology results were negative except for prescribed medications at delivery.	Close to delivery, the patient has a pattern of regular illicit or licit substance use meeting criteria for an active SUD.
Patient has received consistent prenatal care.	Patient is not willing to engage in SUD treatment or is engaged in treatment but not willing to provide consent for contact with the program.
Patient plans to consider SUD treatment in the postpartum period.	Patient's toxicology results were positive for substances or their metabolites indicating recent use of substances not prescribed for the treatment of a medical condition.
If the infant has significant NAS/NOWS.	Patient does not have confirmed plans for postpartum SUD treatment and pediatric care.
	Patient has an aversion (e.g., history of sexual trauma).
	Patient demonstrates behaviors or other indicators of an active SUD.

*If the patient meets one or more of these criteria, further evaluation should be conducted to determine whether the patient can support safe infant breastfeeding.

**For more information regarding specific medications and breastfeeding, you can check the Drugs and Lactation Database (LactMed): <https://www.ncbi.nlm.nih.gov/books/NBK501922/>

Ten Steps to Successful Breastfeeding³⁶

The Ten Steps to Successful Breastfeeding is a framework developed by experts and consists of evidence-based practices that have been shown to increase breastfeeding initiation and duration. The steps have been endorsed by the major maternal and child health authorities including the AAP, ACOG, CDC, and United States Surgeon General:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant patients about the benefits and management of breastfeeding.
4. Help patients initiate breastfeeding within one hour of birth.
5. Show patients how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in – allow the parents/caregivers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer patients to them on discharge.

Patients on Medication for Opioid Use Disorder

- Review hospital breastfeeding policy with patient.
- Provide patient with information on the benefits and risks as appropriate.
- Obtain lactation consult.
- Provide support whether the patient chooses to or not and/or is able to or not breastfeed and respect the decision.
- Patients stable in treatment on MOUD, regardless of medication dose, should be encouraged to breastfeed unless otherwise contraindicated.
- Buprenorphine and methadone levels in breast milk are very low and pose little risk to infants. Buprenorphine particularly so, as it has poor oral bioavailability.
- In the buprenorphine/naloxone product, naloxone has poor bioavailability when taken sublingually or transmucosally, making it less likely to transfer to the neonate via breast milk.³⁷
- If patient is on methadone, advise against abrupt cessation of breastfeeding due to risk of NAS/NOWS.³⁸
- Consult with pediatric clinician to confirm they are aware of patient's medication use.
- Inform patient that the infant is at risk of NAS/NOWS and that breastfeeding may help reduce the length and severity of NAS/NOWS.
- Advise patient that if there is a return to illicit substance use including marijuana, it is recommended to discontinue breastfeeding until further evaluation.



Reproductive Planning

Patients with SUDs, specifically OUD, have much higher rates of unintended pregnancies, estimated to be 86%, when compared to the general population.³⁹ Not only are pregnancies in patients with SUD complicated by additional risks and adverse outcomes, but unintended pregnancies are further complicated by poor maternal and fetal outcomes.⁴⁰ Moreover, among this population, only about half used contraception, and of those that did, the majority were not using LARC.⁴¹ Health care professionals should offer all patients of reproductive age, including those with SUDs, non-coercive contraceptive counseling and discuss different forms of birth control and the effectiveness of each method before they are discharged from the hospital.

According to ACOG, contraceptive counseling and access to contraceptive services should be a routine part of SUD treatment. In particular, obstetric care clinicians should counsel patients about the option of immediate postpartum long-acting reversible contraception (LARC), which has few contraindications and is highly effective and convenient. Ultimately, the goal is to empower patients to achieve their desired inter-pregnancy spacing and family size.

Specific Recommendations Include:

- Discuss reproductive planning with all patients. This includes those with or without SUD.
- Reproductive counseling should be non-coercive, discuss the different forms of contraception, and include the effectiveness of each method.
- Have a conversation with the patient about the importance of contraception and the effects of unintended pregnancies.
- Judgment about a patient's suitability for parenthood should not drive contraceptive counseling or recommendations regarding specific methods available and appropriate options.
- Respect and support patient autonomy and shared decision-making, even if they chose not to use contraception.
- Immediate postpartum LARC insertion should be offered if available. Consider LARC as a first line option that is also compatible with breastfeeding. It is an excellent time to place the device as many patients do not attend their 6-week postpartum visit.
- Ideally, each patient should have the option to receive LARC prior to leaving the hospital.
- For patients with a history of sexual trauma and/or anxiety related to pelvic examinations, consider placement while under neuraxial anesthesia or at the time of cesarean delivery.
- Discuss condom use for Sexually Transmitted Infection (STI) protection.
- At a minimum, patients should receive the option to leave the hospital with a prescription for contraception, contraceptive supplies, or a contraception plan.⁴²

10 Best Practices in Contraceptive Counseling⁴³

The 10 Best Practices in Contraceptive Counseling were developed to improve contraceptive use and help families prevent unintended pregnancies. It provides an evidenced-based framework for clinicians to use in discussing birth control options with patients and supporting them to use the method of their choice consistently and correctly, so their reproductive plans can be achieved.

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.



Care Coordination

Providing adequate transitions of care postpartum that include outpatient support structures with expertise in addressing the needs of both patients with OUD or SUD and their exposed infants 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. These include tailored discharge planning, CARA Plan of Care completion, and transitions of care. This is especially important for the postpartum period as patients are at higher risk of overdose.⁴⁴ Many of these recommendations can be started at the time of admission to L&D.

Discharge Planning

- Invite members of the collaborative team to meet with the patient and other family members before delivery – the patient should know the whole team.
- Continue to establish a therapeutic relationship with parents/caregiver and engage and empower parents to be involved with the care of their infants.
- Provide education and support for breastfeeding and skin-to-skin contact.
- Provide education on the importance of a healthy home environment and connect with home visitation and support (see section on In Home Visitation and Support for more info).
- Provide contraception counseling and determine a plan if not already done (see section on Reproductive Planning for more info).
- Provide education and information on the possibility of NAS/NOWS and how it is managed (see section on Neonatal Withdrawal for more info).
- Provide all necessary referrals as appropriate (see section on Referrals for more info).
- For those on MOUD, avoid discontinuation of treatment due to increased risk of returning to non-prescribed substance use rates postpartum.
- Notify identified MOUD prescriber of plan for discharge and coordinate/schedule follow up with first visit as soon as necessary (within 1-2 weeks at the latest).
- Determine discharge pain management plan (see section on Intrapartum Pain Control for more info).
- Provide patients with a list of medications administered during hospitalization and those prescribed at discharge.
- Schedule more frequent postpartum follow-ups with first visit in 1-2 weeks, and biweekly until at least 6 weeks.
- Provide outpatient resources for the breastfeeding dyad to support any lactation concerns.
- Involve multidisciplinary team to develop a patient/infant dyad centered CARA Plan of Care prior to discharge (see section on CARA Plan of Care for more info) and provide a copy of the plan to the parent/caregiver.
- Ensure necessary notifications to CPS has been made as appropriate. Note that medical professionals are not required to report positive toxicology screens of pregnant patients to Child Protective Services (CPS) in Nevada (see section on CARA Plan of Care – Frequently Asked Questions for more info).
- Ensure referral and linkage to necessary services/resources (see section on Transitions of Care for more info).
- Use a warm handoff strategy at the time of discharge (see section on Transitions of Care for more info).

Transitions of Care

Clinicians should ensure that patients have access to SUD treatment as necessary. The care of patients with SUD into the postpartum period is of paramount importance and requires a high degree of communication and coordination with multiple parties and agencies in addition to referrals for resources as appropriate. Institutions should maintain an updated list of outpatient resources (local, state, and federal) that families can access (see front page for specific information on resources). In general, referral options that are recovery, pregnancy/postpartum, and/or family friendly should be prioritized.

Referrals

- Substance use treatment specialty care.
- Disease Management specialists (Hepatitis, HIV, Syphilis, etc.).
- Behavioral Health for co-occurring mental health.
- Home visiting and support.
- Smoking cessation.
- Pediatrics.
- Primary Care.
- Social Work and/or Case Management.
- Lactation support.
- Women, Infants, and Children Program (WIC).
- Parenting Classes.
- Child Welfare Services/CPS.

In-Home Visitation and Support

Home Visitation Programs are geared towards improving the health of families and providing better opportunities for their children. They provide families with the necessary resources and skills to raise children who are physically, socially, and emotionally healthy. Nationally, the Health Resources and Services Administration (HRSA) Federal Home Visiting Program provides an array of services to vulnerable families.⁴⁵ Home visits may include:

- Supporting preventative health.
- Assisting patients on how best to breastfeed and care for their babies.
- Helping parents understand child developmental milestones and behaviors.
- Promoting parents' use of praise and other positive parenting techniques.
- Working with patients to set goals for the future, continue their education, and find employment and childcare solutions.



Warm Handoffs

At the time of discharge, key information can be easily lost or forgotten. A warm handoff process can reduce the risk of communication breakdowns that compromise patient safety and jeopardize a smooth and cohesive transition of care. The use of warm handoffs is encouraged and has multiple benefits, including:

- Increasing patient safety through improved communications and providing an opportunity to question, clarify, and confirm information.
- Building partnerships for improved care, outcomes, and experiences.
- Increasing 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 clinician.
3. Include pertinent details related to postpartum care.
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 the patient and family, to question, clarify, and confirm information.

CARA Plan of Care⁴⁶

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. CARA requires a CARA Plan of Care (POC) to be developed when an infant has been identified by a health care professional as affected by substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder (FASD).

The purpose of the CARA POC is to identify the needs and services for the infant and family. It should be a dyad (patient and infant) centered plan that identifies and incorporates key community care resources and supports for the patient and infant.⁴⁷ The goal of CARA is not to remove children or punish patients for substance use, but to ensure child safety and address the health and substance use disorder treatment needs of both the affected infant and family or caregiver.

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. The CARA POC should be developed in partnership with the patient and the care team. Ideally this plan will be established during pregnancy, but the hospital is responsible for its completion prior to discharge.

Defining a Substance Affected Infant

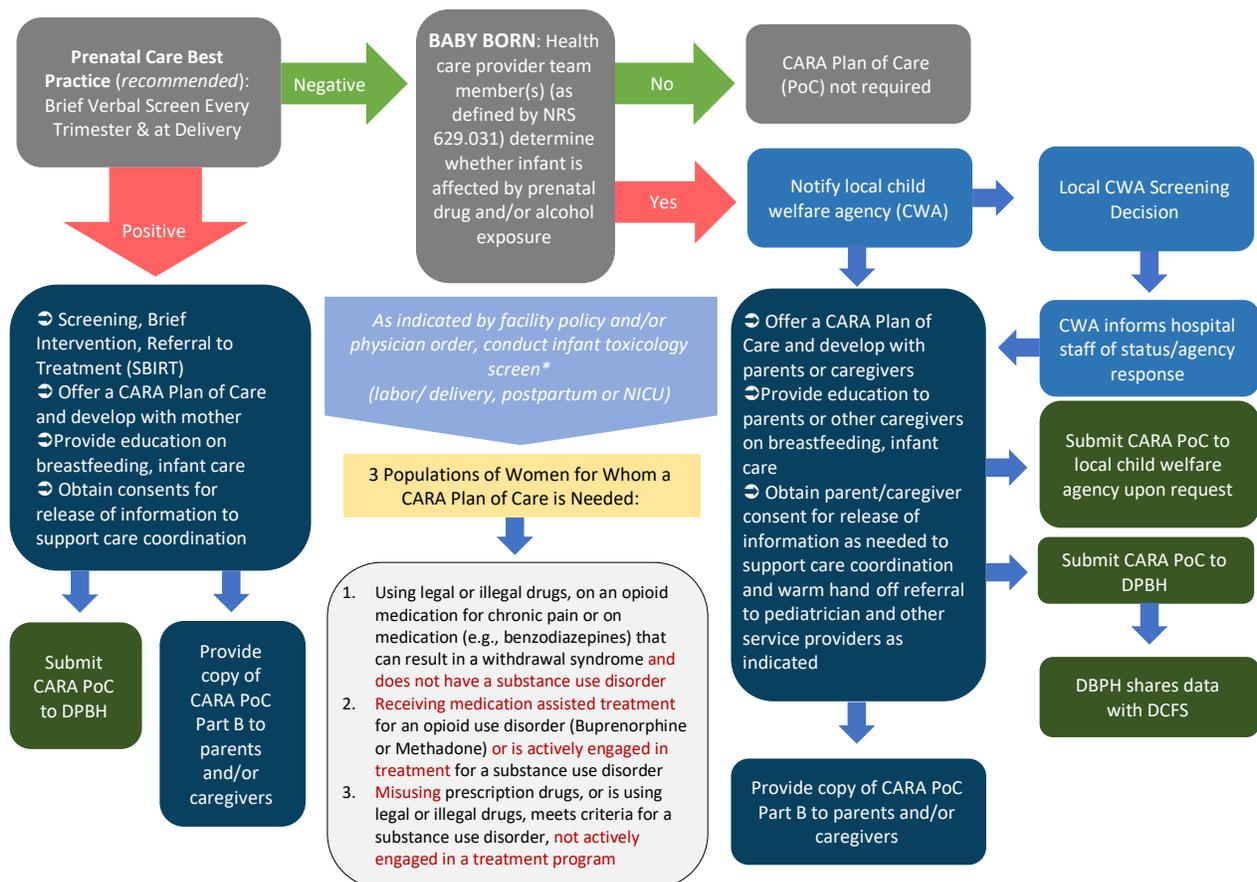
A parent/caregiver will be offered a CARA POC when an infant, defined as a child less than one year of age, has been determined to be affected by a legal or illegal substance and/or whose birthing parent has a substance use disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.”

In Nevada, the definition of a “substance affected infant” is an infant:

- Whose birthing parent is receiving medication assisted treatment for a substance use disorder and/or is actively engaged in treatment for a substance use disorder; **or**
- Whose birthing parent is misusing prescription drugs, or is using legal or illegal drugs, and meets criteria for a substance use disorder, but is not actively engaged in a treatment program; **or**
- Who is experiencing symptoms of withdrawal; or is likely to experience symptoms of withdrawal, based on chronic, habitual, regular or recurrent use of a controlled substance by the mother during pregnancy; **or**
- Who displays the effects of a Fetal Alcohol Spectrum Disorder (FASD).

The following depicts the processes for developing a CARA Plan of Care for infants who are affected by substance use and their caregivers to facilitate linkage to services and care coordination for families. See the Appendix for the CARA Fact Sheet for Providers.

Nevada CARA Plan of Care Flowchart



*Informed consent needed for maternal toxicology screen; consent not required for infant toxicology screen, Please refer to the Sober Moms, Healthy Babies website <https://sobermomshealthybabies.org/plan-of-safe-care/> for additional resources that are available to describe Plans of Care to patients and caregivers as well as links to printable handouts for parents and caregivers.

Appendix

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 patient 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 and afterward such as birth defects, low birth weight, miscarriage, premature birth, and withdrawal.”
- “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 patient 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 and afterward such as birth defects, low birth weight, miscarriage, premature birth, and withdrawal.”
- “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 patient 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 health pregnancy, delivery, and baby?”
- “There are resources specifically for pregnant women with substance use issues to get the help they need for the healthiest pregnancy, delivery, and baby possible. Can we have them reach out to you and to help get you to your goal?”

CARA Fact Sheet



COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA)

A FACT SHEET FOR HEALTH CARE PROVIDERS

WHAT IS CARA?

The federal government passed the Comprehensive Addiction and Recovery Act of 2016, (CARA) which added requirements for states through the Child Abuse Prevention and Treatment Act (CAPTA), to focus on the effects of substance abuse on infants, children and families.

CARA requires a CARA Plan of Care to be developed when an infant has been identified by a health care provider as affected by substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure or Fetal Alcohol Spectrum Disorder (FASD). **The purpose of the CARA Plan of Care is to identify the needs and services for the infant and family.**

In Nevada, health care providers who deliver or provide medical services to an infant in a medical facility and who identify the infant as being substance affected are responsible for ensuring a CARA Plan of Care is established for the infant before the infant is discharged from the medical facility pursuant to Nevada Administrative Code (NAC) 449.

The goal of CARA is not to remove children or punish mothers for substance use, but to ensure child safety and address the health and substance use disorder treatment needs of both the affected infant and family or caregiver.

HOW IS NEVADA DEFINING A SUBSTANCE AFFECTED INFANT?

A parent will be offered a CARA Plan of Care when an infant, defined as a child less than one year of age, has been determined to be affected by a legal or illegal substance and/or whose mother has a substance use disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.”

The consensus definition of a “**substance affected infant**” is an infant:

- Whose mother is receiving medication assisted treatment for a substance use disorder and/or is actively engaged in treatment for a substance use disorder; or
- Whose mother is misusing prescription drugs, or is using legal or illegal drugs, and meets criteria for a substance use disorder, but is not actively engaged in a treatment program; or
- Who is experiencing symptoms of withdrawal; or is likely to experience symptoms of withdrawal, based on chronic, habitual, regular or recurrent use of a controlled substance by the mother during pregnancy; or
- Who displays the effects of a Fetal Alcohol Spectrum Disorder (FASD).

WHO DECIDES IF AN INFANT IS AFFECTED?

A qualified health care provider will determine if an infant is substance affected and should use the definition above to guide them in making the determination.

DO HOSPITALS COMPLETE A CARA PLAN OF CARE WHEN ONLY THE MOTHER’S URINE DRUG SCREEN IS POSITIVE AND THE INFANT’S SCREEN IS NEGATIVE, WITH NO WITHDRAWAL SYMPTOMS OR SIGNS OF FASD?

A CARA Plan of Care is completed when the health care provider determines if the infant is substance affected as defined above.

IF A POSITIVE DRUG TEST (MECONIUM, CORD BLOOD) IS RECEIVED AFTER THE MOTHER AND INFANT ARE DISCHARGED HOME, IS THE HOSPITAL STAFF RESPONSIBLE FOR CONTACTING THE FAMILY POST-DISCHARGE TO COMPLETE THE CARA PLAN OF CARE?

The hospital is responsible for completion of the CARA Plan of Care prior to discharge for all infants who are identified as substance affected. A positive toxicology result is not required to establish a CARA Plan of Care. The CARA Plan of Care’s purpose is to provide appropriate services that aid the health, development and safety needs of the infant, the mother and family members; it is distinct from Child Protective Services (CPS) role.

WHAT ABOUT LEGAL SUBSTANCES (E.G, MARIJUANA, PRESCRIBED MEDICATION, ALCOHOL, ETC)?

Specific substances are not included or excluded in the definition of a substance affected infant. The definition should be used as guidance when determining if an infant is substance affected by any substance, whether legal or illegal. If an infant is determined to be substance affected by any substance, a CARA Plan of Care is required to be offered.

WHAT IF THE MOTHER REFUSES THE CARA PLAN OF CARE?

The CARA Plan of Care is voluntary. If the mother refuses to participate in the development of a CARA Plan of Care, this should be noted on the form that is submitted to the Department of Public and Behavioral Health (DPBH). A notification to CPS will still need to be made as the infant was identified as substance affected.

WHEN DOES THE CARA PLAN OF CARE NEED TO BE SUBMITTED BY HOSPITAL STAFF?

The CARA Plan of Care needs to be completed prior to discharge and is required to be given to the caregiver prior to the infant being discharged from the hospital. The plan must then be submitted to DPBH upon discharge but not later than 24 hours following discharge.

DOES THE HOSPITAL UPLOAD POSITIVE TOXICOLOGY REPORTS ON THE MOTHER AND BABY?

No. Only the CARA Plan of Care form needs to be uploaded.

HOW DOES CARA IMPACT MY MANDATED REPORTING OBLIGATION?

When an infant is determined to be substance affected a notification to CPS is required. Nevada Revised Statute (NRS) [432B.220](#) outlines abuse or neglect reporting requirements for persons who deliver or provide medical services to newborn infants. The health care provider is responsible for both completion of the CARA Plan of Care and notification to CPS. A CARA Plan of Care is not the same as a notification to CPS nor does the completion of a CARA Plan of Care negate the mandated reporting obligation to CPS. A notification to CPS may also be made if a health care provider has any concerns about the family or safety of the infant, regardless if the infant was determined to be substance affected.

DO I NEED TO NOTIFY CPS BEFORE A BABY IS BORN?

No, CPS is notified after a child is born.

WILL CPS INVESTIGATE EVERY NOTIFICATION?

No. Prenatal substance exposure, in and of itself, does not constitute maltreatment. CPS will take into consideration many risk factors to determine if an assessment should be initiated. Risk factors may include, immediate safety concerns, mother's attentiveness to infant in the hospital setting, mental health history, mother's participation in substance use treatment, prior CPS reports on the family, ability to meet the infant's basic, medical and developmental needs, support system and willingness to engage in services that address the well-being and safety of the infant.

DOES THE HOSPITAL PROVIDE CPS WITH THE CARA PLAN OF CARE?

CPS may request it directly from the health care provider pursuant to [NRS 432B.230](#), [NRS 432B.270](#) and NAC 449.

DO I NEED TO CREATE AN INFANT PLAN OF CARE IF THE INFANT IS DISCHARGED DIRECTLY TO CPS CUSTODY?

Yes. Even when CPS assumes custody of the infant, there must be a CARA Plan of Care in place prior to the infant's discharge. The CARA Plan of Care is provided to the family as well as CPS when there is an open case.

FOR MORE INFORMATION AND RESOURCES RELATED TO THE CARA PLAN OF CARE, PLEASE VISIT:

[Department of Public and Behavioral Health – Perinatal Substance Use Treatment Network](#)

Screening Tools

5Ps Screening Tool⁴⁸

BEHAVIORAL HEALTH RISKS SCREENING TOOL For Pregnant Women

Patient/Client Name _____ DOB _____
 Is patient pregnant? YES NO Gestational Age _____ Date _____
 Provider Site _____ Screener Name _____

Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

1. Did any of your parents have a problem with alcohol or other drug use?	PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Do any of your friends have a problem with alcohol or other drug use?	PEERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Does your partner have a problem with alcohol or other drug use?	PARTNER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	PAST	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Check YES if she agrees with any of these statements. - In the past month, have you drunk any alcohol or used other drugs? - How many days per month do you drink? _____ - How many drinks on any given day? _____ - How often did you have 4 or more drinks per day in the last month? _____	PRESENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you smoked any cigarettes or used any tobacco products in the past three months?	TOBACCO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with other people, or take care of things at home?	EMOTIONAL HEALTH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled or made to feel afraid?	VIOLENCE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PROVIDER USE ONLY

Brief Intervention/Brief Treatment	Y	N	NA
Did you State your medical concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Advise to abstain or reduce use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Check patient's reaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Refer for further assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Provide written information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Developed by the Institute for Health and Recovery (IHR), Massachusetts, February, 2007. Adapted by the Southern Oregon Perinatal Task Force in partnership with AllCare Health Plan, Oregon, May 2013.

National Institute on Drug Abuse (NIDA) Quick Screen⁴⁹

Quick Screen Question: <u>In the past year</u>, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol <ul style="list-style-type: none"> • For men, 5 or more drinks a day • For women, 4 or more drinks a day 					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Patient Health Questionnaire (PHQ-9)⁵⁰

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ 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
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems 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	_____

Generalized Anxiety Disorder Scale (GAD-7)⁵¹

GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than 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 is 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

Total Score _____ = Add Columns _____ + _____ + _____

If you checked off any problems, how difficult have these problems 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

Abbreviated Post Traumatic Stress Disorder Checklist-Civilian (PCL-C)⁵²

The Abbreviated PCL-C

The Post-Traumatic Checklist – 6-item Civilian Version

These questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate (by circling) how much you have been bothered by each problem **in the past month**.

For these questions, the response options are:

- | | | | | |
|--------------|----------------|--------------|---------------|-------------|
| 1 | 2 | 3 | 4 | 5 |
| “not at all” | “a little bit” | “moderately” | “quite a bit” | “extremely” |

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
2. Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
3. Avoided activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
4. Feeling irritable or having angry outbursts?	1	2	3	4	5
5. Difficulty concentrating?	1	2	3	4	5
6. Feeling jumpy or easily startled?	1	2	3	4	5

Notes:

.....

.....

.....

A score of 14 or more is suggestive of difficulties with post-traumatic stress and further assessment and possibly referral for treatment is indicated.

The Abbreviated PCL-C: Lang, A.J., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, 43, 585-594.

Based on the full PCL by: Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Mood Disorder Questionnaire (MDQ)⁵³

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>
3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?		
<input type="checkbox"/> No problems <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem		

Domestic/Intimate Partner Violence Screening Tools

Women Abuse Screening Tool (WAST)⁵⁴

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

Partner Violence Screen (PVS)⁵⁵

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?

Helpful Links With Information Related to Opioids During Pregnancy



From SAMSHA:

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

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



From MotherToBaby:

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

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