Reference Guide for Reproductive Health Complicated by Substance Use

Revised April 2025

Referral and Resource Information

988 Suicide and Crisis Lifeline
Call or text 988
https://cssnv.org/

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

Nevada 211
https://www.nevada211.org/

Nevada Certified Community Behavioral Health Centers
https://dhcfp.nv.gov/Pgms/CCBHC/CCBHC_Main_NEW/

Nevada State Opioid Response
https://nvopioidresponse.org/

Perinatal Substance Use Treatment Network
https://dpbh.nv.gov/Programs/ClinicalSAPTA/Womens_Substance_Use_Prevention_and_Treatment/Women_s_Substance_Use_Prevention_and_Treatment/

Sober Moms, Healthy Babies:
https://sobermomshealthybabies.org/

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

Contributors

Revised by 2025 Perinatal Health Initiative Core Team

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Acronyms

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

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 people 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 person and non-pregnant person 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.[1]
- Drug-induced deaths are the leading cause of death for reproductive-age people in the United States.[2, 3, 4]
- Rates of Opioid Use Disorder (OUD) in pregnant and postpartum people have also increased, with some shocking statistics from recent studies:
  - Over 40% of pregnant people enrolled in Medicaid receive a prescription for opioids.[5]
  - 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.[6]
  - 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.[7, 8]

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 person and non-pregnant person 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.[9]
  - 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".

Reducing Stigma around Substance Use

One key strategy for reducing stigma is universal screening/SBIRT.

> **"Stigma remains the biggest barrier to addiction treatment faced by patients."**[17]

Empathize with Patients

- Many individuals with substance use disorders (SUDs) have histories of trauma. Approximately 60% of young people diagnosed with post-traumatic stress disorder (PTSD) develop a substance use disorder.[11] Among adolescents receiving treatment for SUDs, 70% report a history of trauma. Adverse childhood experiences (ACEs) significantly increase the likelihood of developing a mental and/or substance use disorder later in life.[12]
- Offering empathy and support to patients is an essential aspect of care and not a futile endeavor. The positive impact of prevention, diagnosis, and treatment of SUDs parallels that of managing chronic conditions like Diabetes Mellitus or Hypertension. Recognize that you may be the first—or only—healthcare professional to inquire or offer help, making your role vital in initiating care and support.

Person-Centered Language

- Use person-first language that prioritizes the individual over their diagnosis.
- This approach is critical because:
  - It refrains from defining individuals solely by their medical conditions.
  - It aligns with accepted standards for discussing people with chronic medical conditions or disabilities.
  - It fosters a neutral, nonjudgmental perspective while maintaining clinical accuracy.
  - Research indicates it reduces stigma and enhances treatment outcomes.[13]
- Avoid stigmatizing terms and instead adopt positive, person-first language. Refer to the "Words Matter" table on pages four and five for examples of appropriate terminology.[14]

Instead of…	Use…	Because…
✗ Pregnant opiate addict	✓ Pregnant woman with an OUD	ⓘ Person-first language helps to focus on the person and not their disorder. While they may have history of substance use, it is not their only identity. ⓘ The change shows that a person "has" a problem, rather than "is" the problem. ⓘ The terms avoid eliciting negative associations, punitive attitudes, and individual blame.
✗ Addict	✓ Person with substance use disorder	
✗ User	✓ Person with OUD or person with opioid addiction (when substance in use is opioids)	
✗ Substance or drug abuser	✓ Patient	
✗ Junkie	✓ Person in active use; use the person's name, and then say "is in active use."	
✗ Alcoholic	✓ Person with alcohol use disorder	
✗ Bad influence	✓ Person who has had many life challenges	
✗ Former addict	✓ Person in recovery or long-term recovery	
✗ Reformed addict	✓ Person who previously used drugs	
✗ Slip, Lapse, Relapse	✓ A return to use	
✗ Addicted baby	✓ Baby born to mother who used drugs while pregnant ✓ Baby with signs of withdrawal from prenatal drug exposure	ⓘ Babies cannot be born with addiction because addiction is a behavioral disorder; they are simply born manifesting a withdrawal syndrome. ⓘ Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions. ⓘ Using person-first language can reduce stigma.
✗ Neonatal abstinence syndrome (NAS) baby	✓ Baby with neonatal opioid withdrawal/NAS	
✗ Crack baby	✓ Newborn exposed to substances	
✗ Habit	✓ Substance use disorder ✓ Drug addiction	ⓘ "Habit" inaccurately implies that a person is choosing to use substances or can choose to stop. ⓘ "Habit" also dismisses and undermines the seriousness of the disease.

Instead of…	Use…	Because…
✗ Abuse	For prescription medications: ✓ Misuse ✓ Used other than as prescribed ✓ Diverted ✓ Self-medicating For illicit drugs and other substances: ✓ Use	ⓘ The term "abuse" was found to have a high association with negative judgments and punishment. ⓘ "Legitimate use" of prescription medications is how the medications are prescribed to be used. Any consumption outside these parameters is "misuse."
✗ Opioid substitution or replacement therapy ✗ Medication-assisted treatment (MAT)	✓ Opioid agonist therapy ✓ Pharmacotherapy ✓ Addiction medication ✓ Medication for a substance use disorder ✓ Medication for opioid use disorder (MOUD)	ⓘ MOUD is medication for an illness that does not produce euphoria when used as directed. ⓘ It is a misconception that medications merely "substitute" one drug or "one addiction" for another. ⓘ The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.
✗ Clean	For toxicology screen results: ✓ Testing negative ✓ Drug free For non-toxicology purposes: ✓ Being in remission or recovery ✓ Abstinent from drugs ✓ Not drinking or taking drugs ✓ Not currently or actively using drugs	ⓘ Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions. ⓘ It is important to set an example with your own language when treating patients who might use stigmatizing slang. ⓘ Use of such terms may evoke negative and punitive implicit cognitions.
✗ Dirty	For toxicology screen results: ✓ Testing positive For non-toxicology purposes: ✓ Person actively using substances	ⓘ Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions. ⓘ Such terminology may decrease patients' sense of hope and self-efficacy for change.

Trauma-Informed Approach

- A trauma-informed approach shifts the focus from "What's wrong with you?" to "What happened to you?" and recognizes that behaviors and symptoms are often adaptations to trauma.
- This methodology ensures a safe, respectful, and supportive clinical environment.
- Core principles of a trauma-informed approach include the "Four R's":[15]
  - **Realize** the widespread impact of trauma.
  - **Recognize** the signs and symptoms of trauma in patients.
  - **Respond** by integrating knowledge about trauma into practices and procedures.
  - **Resist re-traumatization** by minimizing potential triggers and fostering trust.

Addressing Bias

- Universal screening using validated questionnaires for all patients reduces bias and ensures equitable care.
- Selective screening is prone to conscious and unconscious biases, which may result in overburdening certain populations while leaving others undiagnosed.[16]
- Universal biological testing is not endorsed by leading organizations such as the American College of Obstetricians and Gynecologists (ACOG), Society for Maternal-Fetal Medicine (SMFM), and American Society of Addiction Medicine (ASAM). Refer to page 15 for guidelines on appropriate circumstances for biological testing.

WHERE Are We Supposed to Do This?

- In all settings where a pregnant person or non-pregnant person 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 person or non-pregnant person 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 person or non-pregnant person 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
	20		$34.48	
	24, 74, 77		$22.86	
99409	17	215	$85.21	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes
	20		$66.53	
	24, 74, 77		$44.12	
H0049	17	215	$9.75	Alcohol/Drug Screening
	20, 24, 74, 77			

PT 17/215-*Substance Abuse Agency Model,* **PT 20**-*Physician, M.D., Osteopath, 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 person or non-pregnant person 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 person know all people 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[18]

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

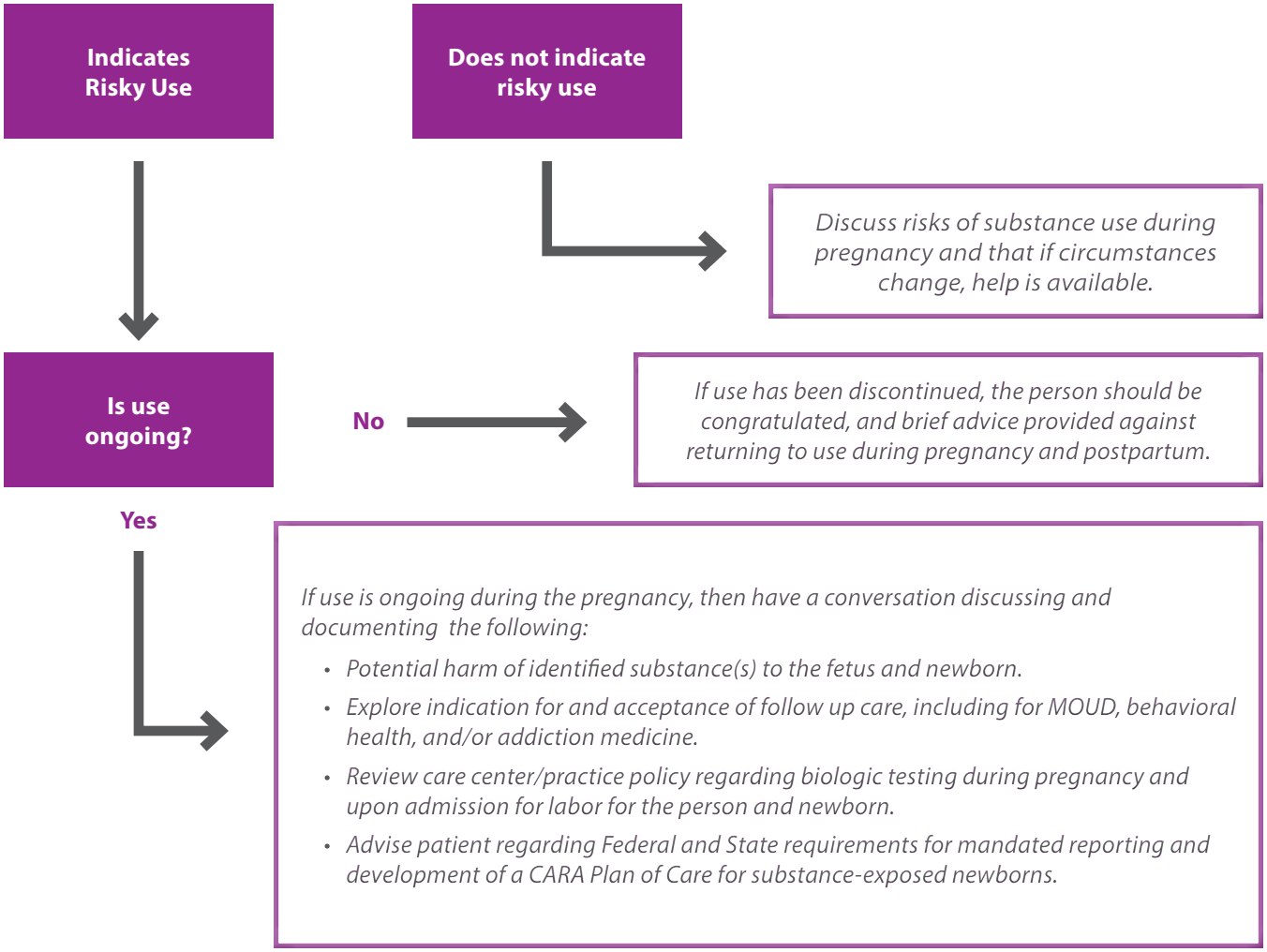
NIDA QUICK SCREEN:

NIDA Quick Screen[19]

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[20]	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

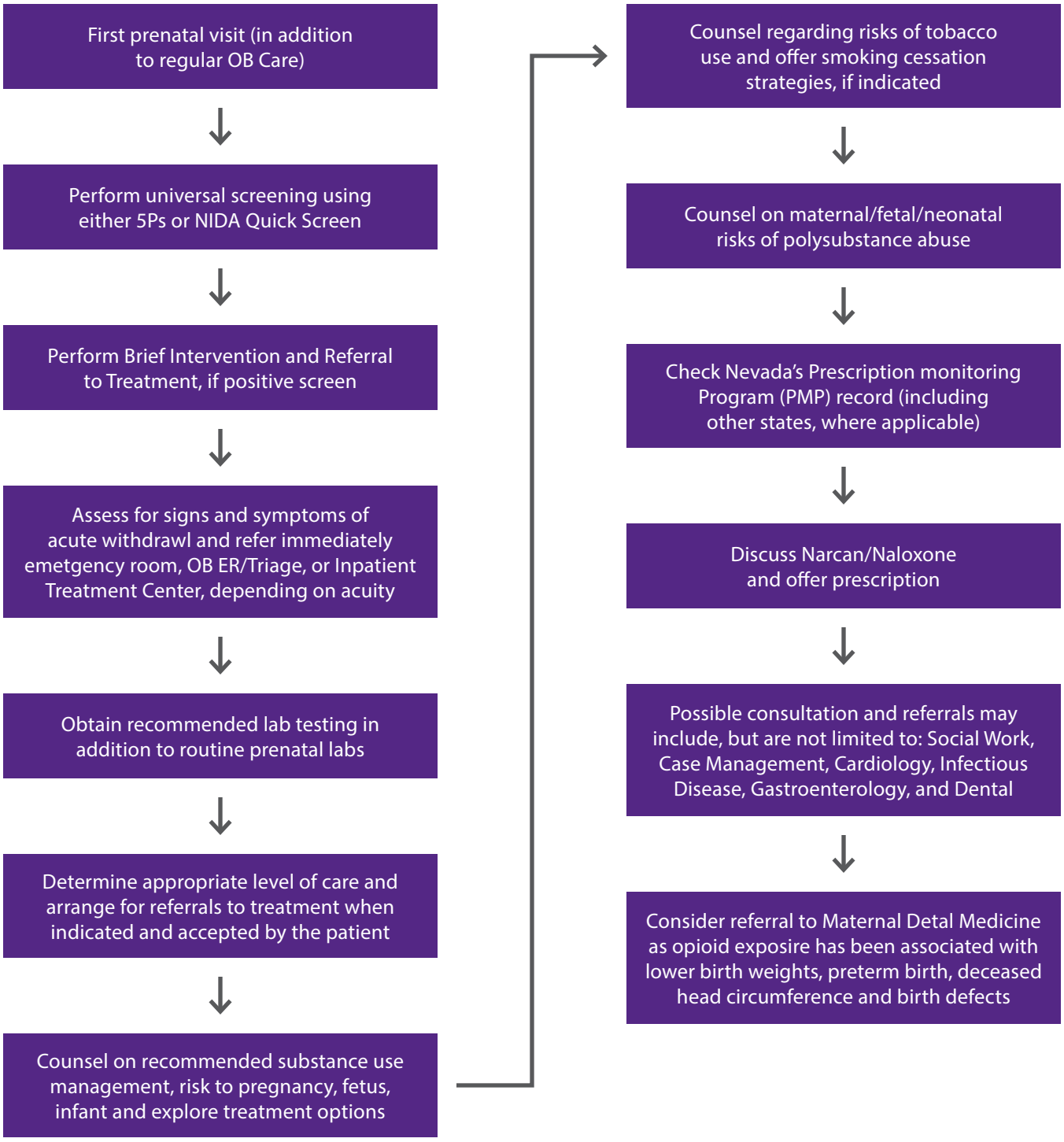
First prenatal visit (in addition to regular OB care).

- 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 person.
- Provide counseling on recommended substance use management, risk to pregnancy, fetus, infant and explore treatment options.
- Medical professionals should counsel pregnant people 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 FLOW CHART



* *The use of an antagonist such as naloxone to evaluate opioid dependence in pregnant people 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 person'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 person'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 is not recommended. Biologic testing, when performed, should be used in conjunction with universal questionnaire screening and only with the person's informed consent and when its benefits outweigh any potential harms.[21] Note that medical professionals are not required to report positive toxicology screens of pregnant people 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.[22] Biologic testing should have a separate consent form to ensure patient education and ensure the patient was informed.

INTRAPARTUM BIOLOGIC TESTING

When medically indicated, people 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 person 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.[23]

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* *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*

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.[24]

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).[25]
- 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.

NEONATAL ABSTINENCE SYNDROME (NAS)/NEONATAL OPIOID WITHDRAWAL SYNDROME (NOWS)

Neonatal withdrawal requires prenatal exposure to a substance and clinical signs such as:

- excessive crying,
- fragmented sleep,
- tremors,
- increased muscle tone, and
- gastrointestinal disfunction[38]

- 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 person 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 people 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. (See screening tools in Appendix 1)
- Perform postpartum depression screening. (See screening tools in Appendix 1)
- Screen for domestic violence/intimate partner violence at 6 weeks and whenever indicated.[26]
- 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 people who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications. People 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).[27]
- Provide further contraceptive counseling on birth spacing if immediate postpartum LARC not placed.

Care Coordination[28]

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. Offering a CARA Plan of Care prenatally is recommended. Please see the flow chart in Appendix 3. 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.[29]
- 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 person 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: Screening Tools

5Ps Screening Tool[30]

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	☐ YES				☐ NO
2. Do any of your friends have a problem with alcohol or other drug use?	PEERS	☐ YES				☐ NO
3. Does your partner have a problem with alcohol or other drug use?	PARTNER		☐ YES			☐ NO
4. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	PAST		☐ YES			☐ 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		☐ YES			☐ NO
6. Have you smoked any cigarettes or used any tobacco products in the past three months?	TOBACCO		☐ YES			☐ 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				☐ YES	☐ 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			☐ YES		☐ NO

PROVIDER USE ONLY

Brief Intervention/Brief Treatment	Y	N	NA
Did you **State** your medical concern?	☐	☐	☐
Did you **Advise** to abstain or reduce use?	☐	☐	☐
Did you **Check** patient's reaction?	☐	☐	☐
Did you **Refer** for further assessment?	☐	☐	☐
Did you **Provide** written information?	☐	☐	☐

Review risk.

Refer to tobacco cessation program or addictions and/or recovery programs.

Refer to domestic violence prevention.

Refer to mental health program.

Develop a follow-up plan with patient.

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.

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 person 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 person 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 person 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?"

National Institute on Drug Abuse (NIDA) Quick Screen[31]

NIDA *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 • **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)[32]

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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

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

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 _____

A2663B 10-04-2005

Generalized Anxiety Disorder Scale (GAD-7)[33]

GAD-7

Over the last 2 weeks, 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)[34]

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 "not at all" **2** "a little bit" **3** "moderately" **4** "quite a bit" **5** "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)[35]

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?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

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?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Women Abuse Screening Tool (WAST)[36]

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)[37]

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?

Appendix 2: Helpful Links

Helpful Links With Information Related to Opioids During Pregnancy

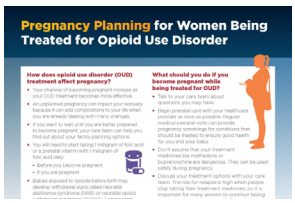
FROM CDC

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 SAMHSA

Publications and Digital Products

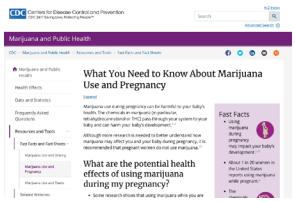
https://store.samhsa.gov/?f[0]=series:5602

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 SAMSHA

Marijuana and Pregnancy

https://www.samhsa.gov/marijuana/marijuana-pregnancy

MotherToBaby
Fact Sheet
Marijuana (Cannabis)

FROM MOTHERTOBABY

Marijuana Fact Sheet

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

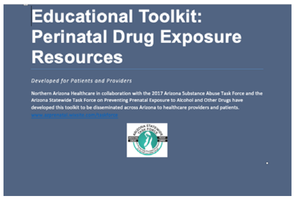
fact sheet
march of dimes
Pregnancy and Marijuana Use
Key Points

FROM MARCH OF DIMES

Pregnancy and Marijuana Use

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

Additional Resource



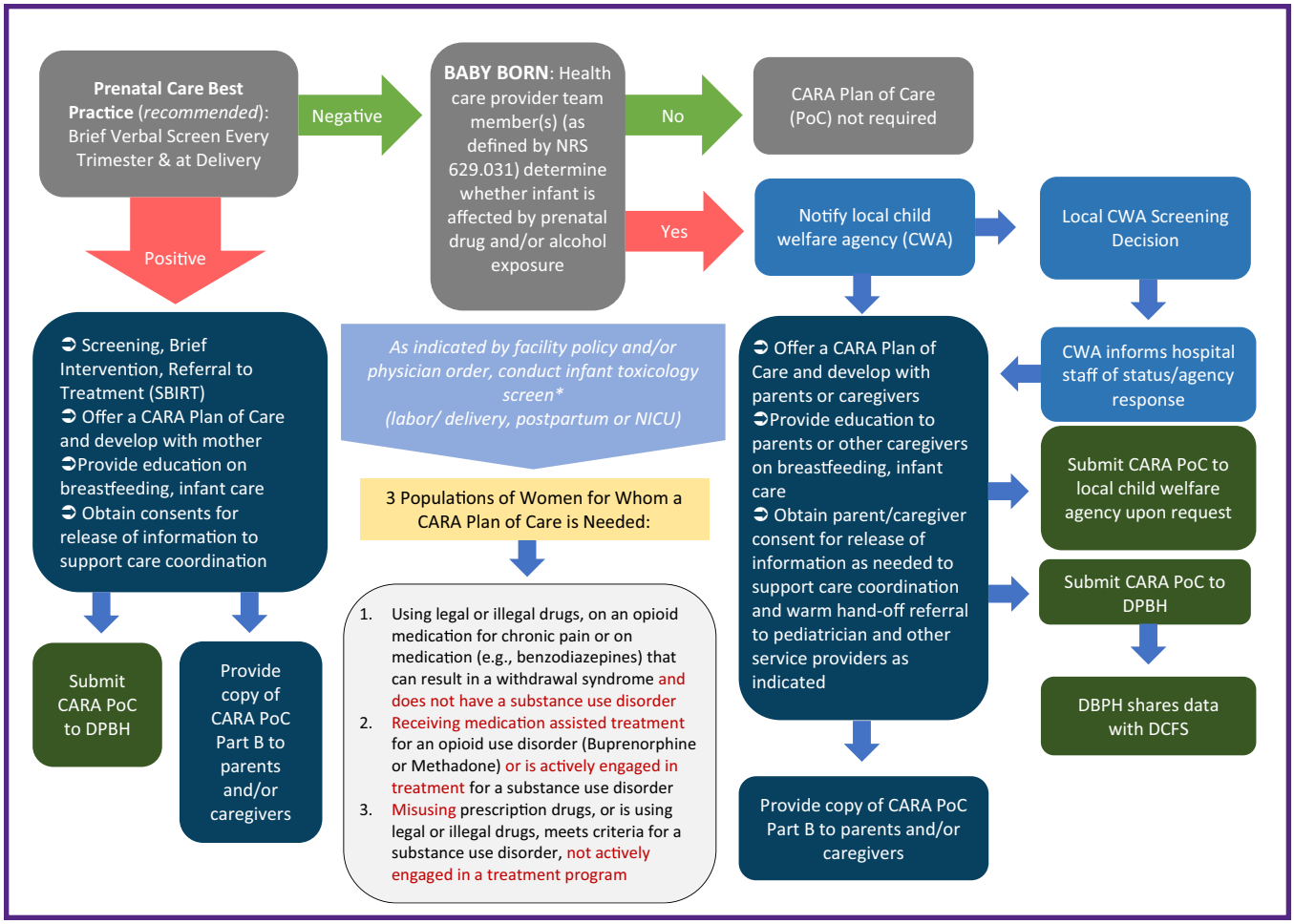
Educational Toolkit:
Perinatal Drug Exposure
Resources

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

Appendix 3: Nevada CARA Plan of Care Flowchart[39]



**Informed consent needed for maternal toxicology screen; consent not required for infant toxicology screen.*

Appendix 4: Adaptations & References

Content Has Been Adapted and Reproduced From:

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- Substance Use Disorders in Pregnancy. SMFM Special Report March 2019
- Substance Use in Pregnancy. A Clinician's Toolkit for Screening, Counseling, Referral and Care. Regional Perinatal Advisory Group, June 2014 https://www.harfordcountyhealth.com/wp-content/uploads/2016/05/RPAG-Substance-Use-in-Pregnancy-Toolkit-2014.pdf
- Northern New England Perinatal Quality Improvement Network. A Toolkit for the Perinatal Care of Women with Substance Use Disorders. March 2019 https://www.nnepqin.org/clinical-guidelines/
- OHIO MOMS Care Coordination Model. http://momsohio.org/sites/momsohio/files/2018-12/MOMS%20Decision%20Tree_F4_6-27-16.pdf
- Maine Snuggle Me. The Snuggle ME Project https://lmsmedia.vtoxford.org/NAS%20Universal%20Training/NAS%20Resources/Guidelines/Hospital%20Polices%20Procedures/The%20Snuggle%20Me%20Project%20Maine.pdf
- SBIRT Oregon. http://www.sbirtoregon.org/

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2 https://pdfs.semanticscholar.org/a54d/2c0d1aa10b4632de0d9aa3993f30a9df5696.pdf?_ga=2.74294298.902574186.1649897351-884307386.1649897351

3 Centers for Disease Control and Prevention. Annual surveillance report of drug-related risks and outcomes—United States, 2017. In: Vol surveillance special report 1. Atlanta (GA): Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2017.

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5 VOL. 133, NO. 6, JUNE 2019 Smid et al Pregnancy-Associated Drug-Induced Deaths in Utah

6 Committee on Obstetric P. Committee Opinion No. 711: Opioid use and opioid use disorder in pregnancy. Obstet Gynecol. 2017;130(2):e81–e94.

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8 Tolia; Patrick; NEJM 2015 https://www.ncbi.nlm.nih.gov/pubmed/25913111

9 Jacobs; Cangiano; Primary Care 2018 https://www.ncbi.nlm.nih.gov/pubmed/30401353

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