After the Positive Screen: A Toolkit & Quality Improvement Initiative to Support

Pregnant People With Substance Use Disorders

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Abstract

Local Problem. Pregnant patients with substance use disorders (SUDs) require comprehensive care, yet many prenatal practices lack standardized management protocols. A collaborative nurse-midwifery and obstetric practice in the Pacific Northwest needed an efficient system for identifying and managing substance use in the absence of dedicated social work support.

Methods. This quality improvement project implemented a toolkit designed to support provider response to patients at risk for substance use over 9 weeks. Toolkit components included a scripted brief intervention and referral to treatment (SBIRT) documentation and a prenatal SUD care checklist with integrated community resources. Provider surveys assessed their comfort level with SUD care before and after implementation. Plan-Do-Study-Act cycles based on the Institute for Healthcare Improvement model guided workflow modifications.

Results. Of the 56 patients screened, 10 (17.9%) tested positive for substance use risk. Tobacco was the most prevalent n=7 (12.5%), followed by past substance use n= (7.1%) and current substance use n=2 (3.6%). Screening, Brief Intervention, and Referral to Treatment (SBIRT) documentation improved from 25% to 83.3% after electronic health records (EHR) template modification. Provider comfort with mandated reporting increased from 33.3% to 75%, though pre- and post-implementation survey participation decreased from 43% to 19%.

Conclusion. While screening successfully identified at-risk patients, implementation inconsistencies and declining provider engagement indicate need for workflow refinement. Future improvements should incorporate patient perspectives and balance coordination benefits against documentation risks.

Introduction

Author Note

I acknowledge the importance of gender-inclusive language in healthcare research. Throughout this manuscript, I have used gender-neutral terms such as "pregnant patients" rather than "pregnant women" to recognize that pregnancy experiences extend beyond the female gender identity. When citing previous literature, I retain their original terminology while acknowledging these sources may employ limited approaches to screening for patients' gender identities. I remain committed to language that respects all gender identities while maintaining clinical accuracy.

Problem Description

Substance use disorder (SUD) is defined as the chronic use of substances, such as drugs including alcohol, that causes clinically significant distress, impairment of health, and continued use despite significant substance-related problems (American Psychiatric Association, 2013). The ramifications of unmanaged SUDs significantly impact the individual, their families, and their communities. Substance use disorder prevalence among pregnant people is on the rise globally and nationally (Tavella et al., 2020). In the United States, opioid use disorder (OUD) increased 333% between 1999 and 2014 (Haight et al., 2018; Shen et al., 2020). Per the National Survey on Drug Use and Health, 13.9% of pregnant people reported illicit drug use within the last month (SAMHSA, 2023). Substance use disorders increase the risk for maternal and neonatal complications including preterm labor, intrauterine growth restrictions, placental abruption, cesarean delivery, neonatal abstinence syndrome (NAS), as well as maternal and neonatal mortality (Jarlenski et al., 2020; Maeda et al., 2014). According to a report from nine

maternal mortality review committees across the United States, SUDs were linked to 8.2% of pregnancy-related deaths (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018).

To address the complex needs of pregnant people with SUD, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends health care providers implement "women-centered," tailored programming, which incorporates trauma-informed care, parenting education, family planning, assistance with other resources like housing and child care, and screening and treatment of other mental and physical health conditions (SAMHSA, 2018). In the general population of pregnant people, personalized approaches to prenatal care have been shown to increase health literacy and improve contraception, birth, and breastfeeding outcomes (Ledford et al., 2018). Individuals with SUD who receive tailored prenatal care have a demonstrated increased adherence to prenatal visits and higher rates of breastfeeding (Joshi et al., 2021; Sutter et al., 2019). For these individuals, tailored care could include several specific strategies including discussing harm reduction techniques for safer substance use, receiving referrals to address social determinants of health, and working with care providers aware of best practices for SUD in pregnancy (Joshi et al., 2021; National Harm Reduction Coalition, 2020; SAMHSA, 2018). However, a national review of public and private substance use treatment facilities in the United States revealed that 81-95% of pregnant people have an unmet need for tailored prenatal care and substance use treatment (Terplan et al., 2015). It is essential, then, that prenatal health care providers prioritize implementing processes and protocols to support pregnant people with SUDs specific needs. In doing so, providers will be empowered to partner with the pregnant individual as they access ongoing care related to SUD.

A nurse-midwife- and obstetrician-led collaborative prenatal clinic connected to a suburban community hospital in the Pacific Northwest does not have formal processes to provide tailored support to pregnant patients with SUD. Presently, the interventions, approaches, and resources provided to patients vary drastically between providers with no clear consensus on best practices. The clinic seeks to create an evidence-based process that allows for tailored prenatal care when responding to pregnant individuals with SUD (see Appendix Q).

Available Knowledge

Health literature provides context to the challenges and gaps prenatal care providers experience when caring for pregnant people with SUDs. Given patients' complex clinical and social needs, prenatal care providers often report feeling overwhelmed and under-resourced to provide high quality, tailored care (Merritt et al., 2022). While professional organizations such as the American Congress of Obstetricians and Gynecologists (ACOG, 2017), American College of Nurse Midwives (ACNM, 2018), and SAMHSA (2018) have developed guidelines and best practices for caring for these patients, their applicability to practice varies. Community characteristics, prevalence of substances, and differences in local legislation and policy necessitate clinical guidelines be tailored to each specific clinical environment. This brief review of evidence focuses on key components of tailored prenatal care for individuals with SUDs and proposes an intervention to integrate these components into practice.

Screening, Brief Intervention, and Referral for Treatment (SBIRT)

Both ACOG (2017) and SAMHSA (2018) recommend universal screening and assessment of all pregnant people for substance use including opioids using the Screening, Brief Intervention, and Referral for Treatment (SBIRT) tool. Evidence-based tools validated for

screening in pregnancy include the NIDA Quick Screen, ASSIST, SURP-P, and 5 P's (ACOG

2017, SAMHSA 2018). After a positive screen, the healthcare provider should provide a brief

intervention to offer education and gauge the pregnant person's interest in stopping or reducing

substance use. The brief intervention may happen multiple times over the course of the

pregnancy and should last no longer than 10 minutes. Providers should first determine if

patients' substance use is at low, moderate, or high risk; this may be done using a flow chart or

tool such as the one provided by Massachusetts Child Psychiatry Program for Moms (MCPAP,

2021). A patient at moderate risk may benefit from appropriate referrals, frequent follow-up

visits, and regular, nonjudgemental assessment of their desire to change their behavior (Reese et

al., 2023). Individuals at high-risk would benefit from encouragement about their decision to

disclose, motivation for positive behavior change, and discussion about how the provider may

offer support (Reese et al., 2023). Providers should then assess patients' readiness to change their

substance use behavior on a scale of 0 to 10. Patients are likely to have complex feelings about

their SUD and may not be immediately ready for a referral to treatment. In this case, trauma-

informed counseling on harm reduction strategies is essential to build trust and ensure retention

in care (citation).

After implementing the brief intervention, providers should provide tailored referrals to

treatment and auxiliary resources. One model utilized to support referral facilitation is the

interprofessional-shared decision making (IP-SDM) model, which engages the pregnant person

in making the best choice for themselves (citation). In this model, the pregnant person is

introduced to treatment options and their benefits and risks. The pregnant person is then asked to

clarify their own values around what is most important for their care, a key aspect of decision

making, as well as their logistical feasibility. This process could occur over several prenatal visits. Once a patient has made a choice about the treatment modality they would like to explore, the provider and patient collaborate on the treatment plan and support for follow up. Howard & Clark (2017) found that providers knowledgeable of this model demonstrated less stigma towards patients and increased external referrals for support.

Providers should consider referring patients to integrated maternity and SUD treatment settings based on the severity of the patient's SUD and clinic feasibility. Sutter et al. (2019) reported that patients who participated in a colocated care model reported increased motivation to remain in treatment through the pregnancy and greater trust with their provider. This type of clinic may include a prenatal care provider with knowledge of buprenorphine and other evidence-based substance use disorder treatment prescribing, addiction medicine and mental health support, social workers, case management, syringe exchange services, naloxone access, and peer support (Rizk et al., 2019). Midwives as pregnancy providers should be included in this care team. In their retrospective cohort study Mcrae et al. (2019) report that odds of preterm birth were lower among patients with SUD who received midwifery care in the antenatal period compared to obstetric care. If a referral to such a program is not possible, providers should be prepared to offer referrals to trusted community resources.

Discussions about Medication for Opioid Use Disorder

A key component of SBIRT involves discussion of the risks and benefits of pharmacologic treatment of SUDs. Both the American College of Obstetricians and Gynecologists (ACOG, 2017) and American College of Nurse Midwives (ACNM, 2018) recommend treating opioid use disorder with medication for opioid use disorder (MOUD) as

first-line management of SUD through pregnancy and the postpartum period. Medication for opioid use disorder is associated with reduced return to opioid use, fewer instances of overdose and preterm birth, and greater adherence to prenatal care (Krans et al., 2021). Both ACOG (2017) and SAMHSA (2018) recommend SUD treatment over detox and recommend the collocation of SUD services and prenatal care. Though this may not always be possible, SAMHSA (2018) recommends that all antepartum care providers have awareness of the risks and benefits of MOUD to provide the most appropriate linkages to care. Methadone (MTD) and buprenorphine (BUP) are two types of opioid-agonist therapies most often prescribed to pregnant patients. Methadone is a full mu-opioid receptor agonist that can only be administered for SUDs (it can be rx'd by providers at any clinic if pt has a pain diagnosis) at dispensing clinics requiring near daily visits. Buprenorphine is a partial mu-opioid agonist that can be prescribed in the outpatient setting. During pregnancy, safe withdrawal may require hospitalization or admission to a detoxification facility depending on a patient's particular context. BUP is available as monotherapy or with the complete mu-opioid antagonist naloxone (BUP-NX) (Link et al., 2020). Suarez et al. (2022) and Kanervo et al. (2023) emphasize favorable neonatal outcomes, including significantly lower rates of NAS requiring treatment, in the use of BUP and BUP-NX compared to MTD. Mullins et al. (2020) suggest the equivalence of BUP-NX and BUP therapies in managing OUD in pregnancy. The literature overall points towards more favorable neonatal and maternal outcomes with use of any type of MOUD compared to no treatment (Kanervo et al., 2023; Suarez et al., 2022). Prenatal care providers should be prepared to engage in meaningful conversations with pregnant patients about the risks and benefits of each type of therapy, supporting them to choose the option that works best for them.

Harm Reduction as a Tool for Prenatal Care

While total abstinence from substances may be the safest option, some individuals may not be ready for or able to achieve this. Harm reduction is the idea that risk will never be eliminated and, therefore, individuals must do their best to minimize their harm. In their definition of harm reduction, the Academy of Perinatal Harm Reduction (2023) states that substance use may have compelling and valid benefits for an individual; it is the job of the community to see this and support them to achieve health, whatever their definition of health may be. In practice, providers discuss routine prenatal care topics with all patients such as prenatal vitamins, nutrition, warning signs of pregnancy complications, and testing for diseases that can be transmitted from parent to child. The National Harm Reduction Coalition (2020) also recommends providers be well-versed in harm reduction strategies for safer substance use to have tailored conversations with patients about their goals. Potential strategies for any substance include encouraging individuals to arrange transportation and childcare before they use, set limits on when and where they use, switch to a safer method of use based on the specific substance, have Naloxone on hand and use with a trusted person or a safe-use hotline (National Harm Reduction Coalition, 2020). The National Harm Reduction Coalition (2020) and the MCPAP (2021) have compiled specific strategies for substances including alcohol, cannabis, opioids, stimulants, and nicotine. Dialoguing about these strategies can have significant positive health impacts. In their systematic review of 63 studies, Charlet & Heinz (2017) found that alcohol reduction, not just abstinence, was associated with health benefits to the parent and their child including decreased psychiatric symptoms, lower stress levels, improved cardiovascular functioning, and pathology-confirmed liver recovery.

Providers should discuss SUD-specific topics during pregnancy to prepare patients for the intrapartum and postpartum periods while promoting autonomy. As described by Joshi et al. (2021), many pregnant people with SUDs report fear of the state. Providers should proactively discuss their responsibility in navigating mandatory reporting, obtain informed consent if drug testing is indicated, and collaborate closely with stakeholders to develop a Plan of Safe Care if indicated (National Harm Reduction Coalition, 2020). Lactation is another essential area of discussion; Howard et al. (2018) and Narbey et al. (2024) discuss how knowledge about lactation and stigma drive infant feeding choice and parental self-efficacy to feed. According to the Academy of Breastfeeding Medicine, trained providers can reduce barriers to lactation for patients with SUDs by providing evidence-based education prenatally (Harris et al., 2023). Additional intrapartum and postpartum topics the National Harm Reduction Coalition (2023) highlight include pain management, postpartum mood disorders, contraception, and the potential of NAS.

Checklists as an Avenue for Tailored Prenatal Care

Checklists are a simple, readable tool that prompt reminders and document completion of numerous tasks. They are utilized in numerous settings to help providers conduct complex procedures and care for patients with complex conditions (citation). In the surgical context, checklists are routinely utilized for procedure, patient, and provider safety, and are particularly effective when created by the providers using them (Gillespie & Marshall, 2015). The effectiveness of checklists depends upon whether they are clinically relevant, not burdensome, and seen as a crucial part of improving care. As such, checklist development and implementation

should involve close collaboration with the clinicians who will be utilizing it (Gillespie &

Marshall, 2015).

Prenatal checklists for SUDs are a recent innovation developed by statewide quality

improvement organizations such as the Illinois Perinatal Quality Care Collaborative, the

Northern New England Perinatal Quality Improvement Network, and the California Medication

Assisted Treatment Expansion Project (Crew et al., 2020). When caring for patients with SUDs

providers must navigate complex legislation, co-manage care with other providers, and be

prepared to discuss a variety of topics not typically discussed in prenatal care. The checklist can

be used to track the provision of brief interventions and referrals, discussions about MOUD, and

other referrals the patient may need such as housing, childcare, and transportation. It can also

facilitate essential and personalized conversations to prepare the patient for the intra- and

postpartum periods. Examples of this include plans for labor pain management, preparation for

NAS, breastfeeding education, and developing a PSC. Care providers across different care sites

can see what tasks have been completed and collaborate with greater ease when the checklist is

housed within an EHR. This may be of particular use in settings where prenatal care and SUD

treatment services are not collocated to promote continuity of care.

Two studies evaluating the efficacy of a prenatal checklist for individuals with SUD were

identified. Both Goodman et al. (2019) and Wendt et al. (2024) reported an increase in several

evidence-based practices when using the checklist for patients with SUD, including emergency

naloxone prescription, tracking prescription monitoring reports, contraceptive planning, nicotine

replacement prescribing, breastfeeding counseling, and repeat hepatitis C screening in the third

trimester. Wendt et al. (2024) also reported increased rates of prenatal screening for substance

use, social determinants of health, and intimate partner violence because of the checklists. These findings suggest the checklist may be a promising intervention to facilitate tailored care provision to patients navigating SUD prenatally.

Rationale

ACOG (2017), SAMHSA (2018), and the National Harm Reduction Coalition (2020) have demonstrated that treating SUDs in the prenatal period using a harm reductionist framework is an evidence-based best practice. However, it takes 17 years on average for best practices to be incorporated into clinical practice (Gassas, 2021). The Institute for Healthcare Innovation's Plan-Do-Study-Act (PDSA) framework may assist the implementation of interventions by translating science into practice to improve patient outcomes. The four-stage model is focused on structured yet iterative change wherein teams can test changes and gain insight to the project's needs through the repetition of cycles of (Institute for Healthcare Improvement, n.d.).

The OUD Clinical Care Checklist, developed by the California Medication Assisted Treatment Expansion Project, includes several crucial components of tailored prenatal care for patients with SUD (Crew et al., 2020). Among the many recommended interventions, patients must first be adequately screened for SUDs using the SBIRT model, and provision of a Brief Intervention and Referral to Treatment and other relevant resources must subsequently be documented. Patients should be screened for comorbid mental and physical health conditions, and consent should be obtained for the pregnancy care team to communicate with SUD treatment providers. Providers should prescribe naloxone as a lifesaving strategy and discuss mandated reporting policies ahead of time. Testing for sexually transmitted infections, such as hepatitis B and C and HIV, is also recommended and should be repeated if the patient is at increased risk for

acquisition in the third trimester (ACOG 2017; Crew et al., 2020). Providers may consider referring patients to anesthesia, pediatrics, and lactation to discuss best practices for labor and postpartum. Providers should provide education about contraceptives, care and support of the newborn, NAS, breastfeeding, and rooming in.

The PDSA framework is relevant to the creation of the checklist as it requires location- and population-specific information to apply. As there is no checklist that currently exists specifically for use in the state where this project was conducted, the OUD Clinical Care Checklist was adapted from the Oregon Pregnancy and Opioids Workgroup Recommendations (Oregon Health Association, 2018). Many of the clinical recommendations are in alignment with those offered in the OUD Clinical Care Checklist, with an additional recommendation to check the state's Prescription Drug Monitoring Program (PDMP) for individuals using opioids at least once during the pregnancy (Oregon Health Association, 2018). The Academy of Perinatal Harm Reduction (2023) and National Coalition for Harm Reduction (2020) also recommend patients consider developing a birth plan and consult with a doula for advocacy and support during labor and postpartum.

Specific Aims

The purpose of this project was to create a toolkit, consisting of a checklist and resource list, to ensure the tracking and completion of key tasks in the antenatal period to increase continuity of care for patients with SUD and support provider efficacy to care for this community. The following list of specific aims was developed to provide actionable goals to the project objective:

- By September 30, 2024, 80% of prenatal care providers will have responded to a survey regarding provider gaps in knowledge to care for patients with SUD.

- By September 30, 2024, 80% of providers will have viewed an educational presentation reviewing evidence-based best practices for SUD in pregnancy.

- By December 1, 2024, 80% of patients with a positive screen for SUD will have received a brief intervention and referral to treatment with documentation in the chart.

- By December 1, 2024, 80% of patients with a positive screen for SUD will have a checklist for prenatal SUD care management pulled into their chart.

- By December 31, 2024, 80% of prenatal care providers will have responded to a post-intervention survey reassessing provider knowledge of caring for patients with SUD.

Methods

Context

The setting for this project was a nurse-midwifery and obstetric collaborative practice associated with a suburban community hospital in the Pacific Northwest (PNW). The primary stakeholders in this quality improvement project were the clinic-based care provider team of 5 nurse-midwives, 5 obstetricians, and 3 student nurse-midwives (hereafter referred to as midwives). Twenty-five percent of patients identified Spanish as their preferred language, and 51% of respondents identified as Hispanic, Mexican, Mexican American, Latinx, Puerto Rican, or of Spanish origin. Thirty-nine percent of respondents identified as non-Hispanic white, with the remaining 10% of the community comprised of patients who identify as non-Hispanic Black, African American, Asian, or Pacific Islander. At the time this project took place the number of births for the faculty practice was between 600 to 800 births annually. The number of patients with SUD was unknown as the clinic did not have a screening process; anecdotally, midwives shared that the collaborative practice cared for about 5 patients with a SUD per year. The office did not have a social worker or case manager to assist in resource connection and patient support.

Stakeholder discussions revealed that the practice needed efficient, streamlined systems to ensure adequate resource connection by providers themselves.

Intervention

The primary intervention of this project was to create a resource to enhance the continuity of care and resources providers offer pregnant patients with SUDs. While co-located SUD treatment and pregnancy care are the gold standard in caring for this population, this project isolated its efforts to the creation of a project to bring providers into alignment with evidence-based guidelines, center principles of trauma-informed care, minimize workflow changes, and improve chances for success. In pursuit of this goal, this project was developed and implemented concurrently with two other student DNP projects. The other members of the project team built workflows to implement the 5 P's screening tool during patients' new obstetric visit, with one project focused on intimate partner violence screening and the other concentrated on substance use disorder screening. The project described in this paper acted as an adjunct to the latter project; when an individual screened positive for high risk of substance use in pregnancy the interventions of this project were to be implemented. These interventions would ideally provide an appropriate place for care plan documentation, compiled salient community resources, and regularly sought feedback from stakeholders about the ease of use and applicability. Specifically, the intervention consisted of (1) scripting to complete a brief intervention and referral to treatment and appropriately document it within the 5 P's tool in the new obstetric visit note (see Appendix D), (2) a prenatal SUD checklist tailored to the care environment and based on best practices from the literature (see Appendix F), (3) a list of community and auxiliary resources relevant to the checklist such as referral sources for SUD treatment and information sheets to

discuss lactation (see Appendices I-O), and (4) printed reminders and resources for clinic providers on the imagined workflow when using the checklist (see Appendix G).

The brief intervention and referral to treatment scripting was developed using best practices from the literature. The language and overall framework took specific inspiration from SBIRT Oregon, an online resource compendium developed by providers for providers in Oregon to address and counter barriers to completing the SBIRT (OHSU Family Medicine, 2024). The SUD checklist was developed specifically for the suburban collaborative practice based on tools developed by the California Medication Assisted Treatment Expansion Project, the Illinois Perinatal Quality Care Collaborative, and the Northern New England Perinatal Quality Improvement Network (Crew et al., 2020). The checklist's development was iterative to ensure the checklist was tailored to the specific policies and practice environment of the clinic. Ongoing feedback were solicited from individuals who were employed at or familiar with the facility, including an addiction medicine specialist, family medicine physician, pediatrician, lactation consultant, midwives, obstetricians, a nurse, a doula, and a community health worker - all individuals who had cared for pregnant patients with substance use disorders and their families in some capacity. Based on this team's expansive feedback, community and auxiliary resources were compiled to augment the utility of the toolkit. These resources were made available through smartphrases in Epic, the electronic health record, printed for access in the clinic, and lived in a secure digital folder on OneDrive.

An educational session was hosted for providers at a practice meeting on September 17th via Webex and provided an overview of evidence regarding best practices in prenatal care for patients with SUD, demonstrated how to populate the checklist of the EHR and the location of the resource list, and generated buy-in for the intervention (see Appendix P). The presentation

slides were then emailed to providers with a pre-implementation survey to understand gaps in

knowledge and care provision for people with SUD (see Appendix A) Printed reminders,

including an intervention flowsheet to support provider ease (see Appendix G), and physical

copy versions of all available resources were left in physician and midwife work rooms.

When patients provided affirmative answers for past substance use, present use, or

tobacco use using the 5 P's tool (see Appendix C), those individuals were considered "high risk"

for substance use in pregnancy. Providers were instructed to conduct the first part of the

intervention: a brief intervention and referral to treatment using a specific dot phrase (see

Appendix D), which included optional scripted language to guide the conversation. Providers

had access to resources to discuss the risks (see Appendix J) and harm reduction techniques (see

Appendix O) of using various substances. The 5 P's tool and SBIRT scripting were in the

"subjective" section of the note. At the end of the visit, providers were to document the SBIRT

results in the "assessment" section of the note using the provided template (see Appendix E), add

the appropriate ICD-10 code to the patient's Problem List, and insert the prenatal SUD checklist

(see Appendix F) under the appropriate problem. The checklist provided an overview of

important tasks to complete when caring for patients with substance use disorder, as well as

several dot phrases that provided information, resources, and handouts to guide collaborative,

trauma-informed discussion with patients. Among these resources included lists of local

resources for MOUD access (see Appendix H) and general pregnancy support (see Appendix M),

a compendium of relevant professional guidelines (see Appendix I), doula and peer support

information (see Appendix K), scripting to review the criminal legal implications of perinatal

substance use (see Appendix L), and substance-specific lactation information (see Appendix N).

Providers were emailed weekly with reminders to participate in the interventions and informally asked for feedback throughout the PDSA cycles. Data were not collected during the fifth week of the intervention; this time was used to aggregate data and make any changes to the intervention. At the end of the intervention cycles, a post-intervention survey (see Appendix B) mirroring the initial questionnaire was sent to providers to gauge differences in metrics this intervention sought to address.

Study of the Intervention

The project spanned over the course of 10 weeks from September 30, 2024 through December 1, 2024. Two Plan-Do-Study-Act cycles were implemented from September 30th through October 27th, and then November 4th through December 1st. Between October 28th through November 3rd a first round of analysis was completed, and informal stakeholder feedback was solicited; data were not collected during this period of time.

The following was completed in preparation of the first PDSA cycle: a pre-implementation survey of clinic providers, the development and presentation of a presentation for providers, discussions with stakeholders and collaborative partners, checklist and resource creation and dot phrase creation, and data storage planning. Each week of the PDSA cycles began with an email reminder to providers to complete the SBIRT and appropriately document screenings for eligible patients. After the first week of intervention implementation, feedback was informally solicited in these emails. Eligible patients' charts were reviewed at the end of each week, and qualitative and quantitative data were documented in a secure spreadsheet. Quantitative data included patients' responses to the 5 P's questions, the percentage of eligible patients who had the checklist pulled into their chart and the percentage of eligible patients who

received SBIRT counseling. A post-implementation survey of clinic providers was conducted at the end of both PDSA cycles.

Measures

During the 10-week project period (September 30, 2024 - December 1, 2024), eligible patients were identified at their first pregnancy visit with the provider and screened for substance use disorders using the 5 P's tool. Patients who screened positive for past substance use, present substance use, having a partner who was using substances, including cigarette smoking were considered eligible for the project. An audit of these patients' charts was conducted during the 10-week period, including review of their problem List, provider documentation, and subsequent visit documentation. Providers were also given online surveys both before and after implementation of the intervention to assess their comfort in caring for pregnant patients with SUD using Google software. Informal feedback was collected via email communication throughout the PDSA cycles. Qualitative and quantitative data derived from the EHR audit were anonymized, managed using Excel, and securely stored using OneDrive software.

Analysis

The pre- and post-implementation Likert scale surveys were evaluated utilizing the frequency as a percentage of each answer choice. A bar graph was created to display the results of this survey and display provider comfort with caring for pregnant patients with SUDs. Comments for the final question of the surveys were additionally analyzed using qualitative coding, and general themes were shared. The percentage of individuals who viewed the educational survey wasalso shared as a percentage.

Quantitative data were interpreted to identify the frequency of percentage for patients who screened positive for SUDs who received the brief intervention and referral to treatment

with documentation in their record, and the percentage of patients who had the prenatal SUD

checklist pulled into their chart under the appropriate diagnostic code. SBIRT documentation and

checklist implementation were also analyzed via a chart review using qualitative coding.

Ethical Considerations

Data collection involved reviewing the charts of patients who received care in the

ambulatory clinic over the two PDSA cycles. No protected health information (PHI) was

retrieved or stored, and no data collected in the secure spreadsheet could be linked back to a

specific patient. Patient confidentiality and privacy were maintained in accordance with

institutional policy. Provider participants in the pre- and post-surveys were notified of the

voluntary nature of the surveys and were not incentivized or compensated for completing the

surveys. Qualitative comments were de-identified in final project presentations. The project was

submitted to the institution's Investigational Review Board and was determined not to be human

subjects' research.

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Results

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Of the 56 individuals screened using the 5 P's screening tool during the quality

improvement period, ten (17.9%) screened positive for high risk of substance use in pregnancy.

Question-specific responses revealed varied substance use patterns, as reflected in Table 1. For

past difficulties with alcohol or other drugs (Question 4), 7.1% (n=4) responded affirmatively,

while 91.1% (n=51) denied past substance-related problems and 1.8% (n=1) declined to answer.

Regarding current substance use (Question 5), 3.6% (n=2) reported use in the past month,

while 96.4% (n=54) denied current use. Chart reviews of the initial pregnancy visit notes

revealed that both individuals who disclosed current substance use reported marijuana

consumption. Tobacco use in the previous three months (Question 6) was reported by 12.5% (n=7) of screened patients, with 87.5% (n=49) denying recent smoking or vaping.

Table 1
5 P's Screening Tool Responses

	Yes	%	No	%	Declined	%	Not Screened	%
Q4	In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?							
Screened Patients (n=56)	4	7.1	51	91.1	1	1.8	n/a	n/a
Q5	In the past month, have you drunk any alcohol or used other drugs, including cannabis?							
Screened Patients (n=56)	2	3.6	54	96.4	0	0.0	n/a	n/a
Q6	Have you smoked any cigarettes or vaped any nicotine in the past three months?							
Screened Patients (n=56)	7	12.5	49	87.5	0	0.0	n/a	n/a

Note. Responses to questions four, five, and six of the 5 P's screening tool. Positive responses to any of these questions indicate "high risk" for substance use in pregnancy, and these individuals were targets of the intervention.

Among the ten patients who screened positive, substance use patterns were complex and often overlapping. Seven patients (70%) reported tobacco use, with several noting they had already quit upon learning of pregnancy. Three patients (30%) disclosed marijuana use, with two reporting current use and one noting past use. Three patients (30%) had a history of alcohol use disorder, and two patients (20%) reported past opioid use disorder with current methadone treatment. Three patients (30%) answered yes to more than one question related to "high risk" for substance use in pregnancy. Two individuals reported both smoking tobacco in the last three months and prior opioid use disorder (answering yes to questions 4 and 6), and one individual reported smoking tobacco in the last three months and current marijuana use.

The relationship between positive screens and implementation of intervention components revealed inconsistencies in care delivery. Sixty percent (n=6) of patients had a

completed SBIRT documented in their chart. Based on EHR documentation, it appeared that the

individual context of the visit may have impacted whether the provider documented an SBIRT;

these results are described in Figure 1. Regarding the SUD checklist, just 40% (n=4) of

individuals had it added to their EHR under the correct SUD-related diagnostic code. Only one

patient had both interventions documented, suggesting a potential disconnect in the execution of

the complete intervention protocol.

Rates of SBIRT documentation and SUD checklist utilization varied based on the

substances used by patients, as visualized in Figure 2. Of the individuals (n=2) who disclosed

opioid use disorder and were currently on methadone, only one had the SUD checklist added to

their chart. This individual's chart documentation revealed specific planning for follow-up tasks

from the checklist, such as obtaining consents for MOUD providers, while the other patient's

documentation did not reveal whether further discussion was had about how pregnancy might be

impacted by tobacco or methadone use. Among those (n=7) who reported tobacco use,

intervention implementation varied notably. No patient had both the checklist included and

SBIRT documented despite the same presenting risk factor. Two individuals had "tobacco use"

already listed in their problem list, but only one of these individuals had the SBIRT documented;

the other individual declined the cessation assistance in the form of the SBIRT. Current

marijuana users (n=2) showed similar documentation inconsistencies - one had both the

substance use checklist added to their problem list with completed SBIRT documentation, while

the other lacked both interventions despite the same reported use.

These findings indicate that while the screening tool successfully identified patients with

substance use risks, the implementation of intervention components was not consistently tied to

specific substance use patterns or risk levels. Factors beyond the type or severity of substance

use may have influenced whether providers completed SBIRT documentation or SUD checklist implementation.
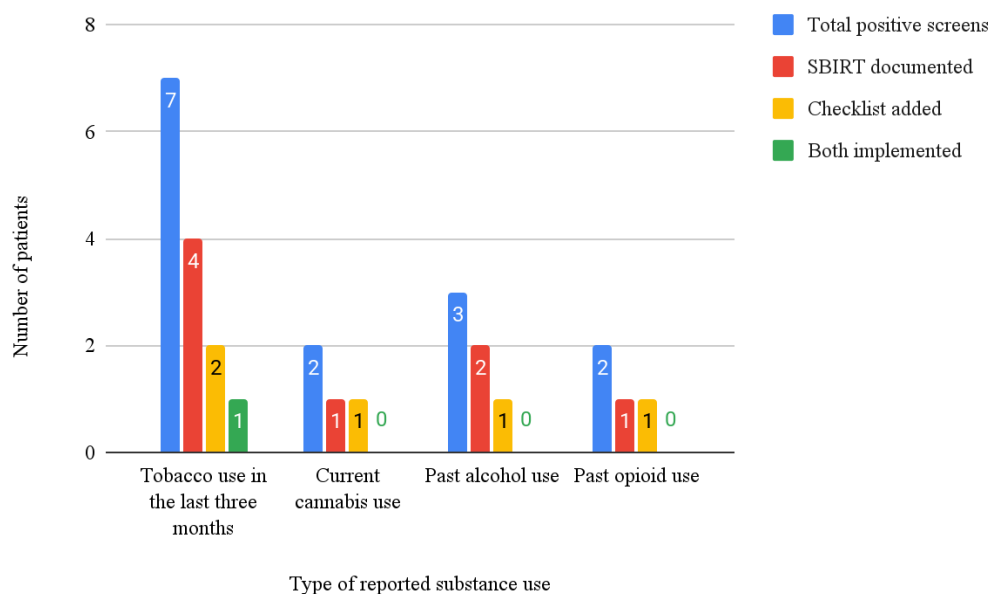
Figure 1
Reasons SBIRT Was Not Documented
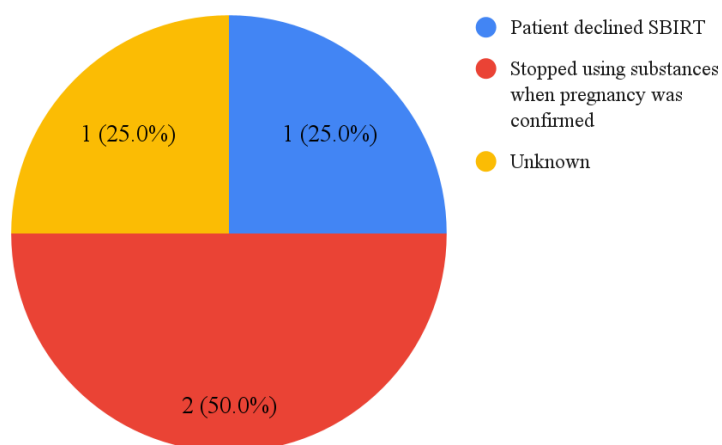
Note. Reasons SBIRT was not documented, revealed through qualitative chart review

Figure 2
Rates of SBIRT Documentation and Checklist Utilization Per Substance

Note. Some patients reported multiple types of substance use, resulting in overlap between categories

Figure 3 demonstrates the PDSA cycle timeline. At the beginning of the cycle, changes to the interventions were planned to be made based on individual provider feedback obtained from

responses to weekly email updates sent every Monday. Any larger changes to the intervention would be made during the built-in buffer time in week 5. During week 3, stakeholders provided feedback that the 5 P's template and SBIRT documentation should not be split between the "subjective" and "assessment" sections of the note, and that more documentation would be successfully completed if the two sections of the template were not split. A plan was made to move the SBIRT documentation to directly succeed the 5 P's template in the "assessment" section. The editing capacity for new obstetric visit template was accessible to only one provider in the practice, and the update process to incorporate the desired change took three weeks to complete. The template change may have helped improve SBIRT documentation rates in subsequent cases. Before the template was updated, only one of four (25%) eligible patients had a documented SBIRT. ⌷

Figure 3
PDSA Cycle Timeline

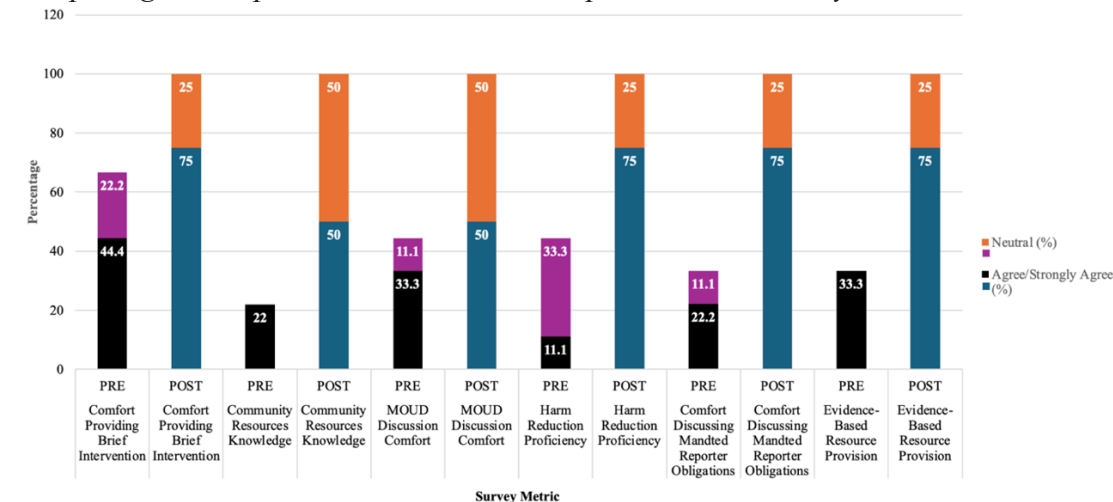|	Week								
	1	2	3	4	5	6	7	8	9
Weekly reminder email to providers									
5 P's documentation moved from "assessment" to directly underneath screening tool in "subjective"									

Before implementation of the project, an educational presentation was viewed by 12 of 21 total providers, a rate of 58%. This presentation was meant to inform providers of the intervention and evidence-based best practice, preparing them to execute the intervention tasks. An anonymous pre-implementation Likert scale survey was sent to the 21 students and providers

working in the outpatient setting to gauge provider comfort with skills important to providing evidence-based care for patients with SUDs. As the survey was conducted anonymously, no specific data was collected on the type of provider that completed the survey. Nine individuals (43%) completed the survey. The survey revealed several key areas of provider discomfort. Most providers indicated limited knowledge of community resources, with only 22.2% reporting familiarity. Regarding specific skills, 44.4% felt comfortable providing brief interventions and referrals, while less than half expressed confidence in other crucial areas. Notably, 55.6% were uncomfortable discussing medication for opioid use disorder (MOUD) and resources, and the same percentage reported difficulty incorporating harm reduction principles into conversations with pregnant patients. Two-thirds (66.7%) expressed discomfort discussing mandated reporter obligations. In the optional open-response section, 7 providers offered detailed feedback about resource limitations. Their responses highlighted significant gaps in local resource knowledge and institution-specific protocols. While one provider noted that a physician colleague with specialization in obstetrics and addiction medicine was available for consultation, others expressed a need for more comprehensive support, including dedicated time, social services consults, and direct in-clinic resources. Training gaps were also evident, with two respondents noting they had not yet received education on evidence-based management of substance use disorders in pregnancy. Two student providers specifically indicated they would defer to midwives for follow-up care.

A total of 4 providers or students (19%) completed the post-intervention survey. Results showed improved provider confidence in several key areas compared to the pre-implementation survey, as visualized in Figure 4. Provider comfort with brief intervention and referral improved, with 3 (75%) agreeing they felt comfortable with this process. Knowledge of community

resources also increased, with 2 (50%) of respondents reporting they felt knowledgeable about resources and comfortable discussing MOUD options. Regarding harm reduction, 3 (75%) agreed they were proficient at incorporating these principles into patient conversations. Provider comfort with discussing mandated reporter obligations improved substantially, with 75% expressing comfort in these discussions. The implementation process was generally well-received, with most providers disagreeing that the SBIRT script created an additional burden. In the open-response sections, providers identified several areas for workflow improvement. Two respondents suggested modifying the 5 P's screening tool, noting it was "quite long" and recommending its integration earlier in pregnancy care at ultrasound dating visits. Providers also requested clearer pathways for providing resources after positive screens, with one noting that available resources seemed "generic" and another expressing uncertainty about resource provision having not yet identified patients with substance use. One provider specifically mentioned the utility of institution-specific referrals and email communication with SUD providers. Regarding implementation tools, while the SBIRT script was praised as "good" and helpful for guidance in the visit, the checklist was described as "confusing and long" with a suggestion to eliminate sections that were not applicable based on the specific patient situation.

Figure 4

Comparing Pre-Implementation and Post-Implementation Survey Results

Discussion

Summary

   This quality improvement project sought to enhance care for pregnant patients with substance use disorder (SUD) in a collaborative prenatal clinic. Over a 10-week period, 56 patients were screened for SUD, with 17.9% (n=10) identified as high-risk, a figure aligning with national estimated rates of substance use among pregnant people (SAMHSA, 2023). Despite aiming for 80% implementation, only 60% (n=6) of eligible patients had a documented SBIRT, and just 40% (n=4) had the SUD checklist incorporated into their chart. Pre-intervention provider survey response rate fell short of the 80% goal, with only 43% (n=9) of providers responding.

   However, this baseline data revealed key gaps in provider knowledge and comfort with managing SUD in pregnancy, confirming the need for this intervention. Prior to the intervention 51% (n=12) providers reviewed the educational survey, falling short of the 80% goal but providing context to the intervention and addressing gaps in provider knowledge. Post-intervention, provider comfort with SBIRT, harm reduction, and discussing mandated reporting increased, though the survey response rate remained low at 19% (n=4). A significant but

promising workflow efficiency was identified during the PDSA cycle: relocating the SBIRT documentation to directly follow the 5 P's screening tool in the chart significantly improved documentation rates from 25% to 83.3%. While the project did not fully achieve its aims, it highlighted the need for standardized SUD care processes and resources in prenatal settings. Project strengths included the use of evidence-based practices, an approach tailored to the specific clinical environment, and the iterative PDSA framework. This initiative provides valuable insights for enhancing care and adds an additional layer to the limited but growing body of evidence evaluating interventions caring for pregnant people with SUD.

Interpretation

This quality improvement project revealed both successes and challenges in implementing standardized screening and intervention tools for substance use disorders in prenatal care. With the educational materials, increased knowledge, and this toolkit, providers were equipped to provide a brief intervention and create a plan for care with patients at high risk for substance use in pregnancy, utilize a tailored checklist to manage the multidisciplinary considerations related to caring for these individuals. and access several evidence-based resources to augment care provision. These improvements contrast with the prior lack of standardized, clinic-wide efforts to collaboratively care for this population.

The patterns of substance use identified through screening offer important insights to the intervention design. Among the 10 individuals who screened at high risk for perinatal substance, tobacco use emerged as the most prevalent substance (70%), followed by past alcohol use (30%), past opioid use (20%), and current marijuana use (20%). The overlap in substance use patterns, with 30% of positive screens reporting multiple substances, validates the importance of comprehensive intervention tools that can address polysubstance use. It also highlights an

important limitation of the intervention design: while the SBIRT scripting was developed to address all substances, including tobacco and marijuana use, the SUD checklist focused more heavily on substances traditionally associated with criminal legal surveillance, such as opioids and alcohol. Though tobacco cessation and lactation resources were included in the toolkit's auxiliary resources (see Appendix N), their placement outside the immediate EHR workflow may have created barriers to consistent utilization during patient counseling. The variation in intervention implementation for patients using marijuana further illustrates the challenges of standardizing care for different substance use patterns. Of the two patients who reported current marijuana use, one received SBIRT documentation without checklist implementation, while the other had the opposite experience. This inconsistency, combined with limited evidence about the dangers of marijuana use in pregnancy, suggests a need for more substance-specific guidance within the intervention tools.

The implementation data revealed a notable disconnect between screening and intervention completion. While the screening successfully identified at-risk patients, only 60% received documented SBIRT interventions, and just 40% had the SUD checklist added to their charts. Only one patient received both interventions, suggesting systematic barriers to full protocol implementation. Inconsistent implementation patterns across different substance types suggest that the intervention tools may have been more suitable for certain substances than others. For instance, among patients with documented opioid use disorder on methadone, only one of two had the SUD checklist implemented, despite these cases presumably requiring the most comprehensive care coordination. A crucial finding emerged from the mid-implementation workflow modification, during the second PDSA cycle. Moving the SBIRT documentation to directly follow the 5 P's template, rather than existing in a separate part of the note template

altogether, resulted in a dramatic improvement in documentation rates, from one out of four (25%) eligible patients pre-modification to five out of six (83.3%) post-modification. The rapid identification of workflow barriers and subsequent improvements in documentation rates demonstrates the value of the PDSA framework to optimize care delivery tools.

The provider pre- and post-implementation surveys revealed meaningful improvements in several key areas, such as with comfort with mandated reporting discussions (from 33% to 75%) and with community resource knowledge (from 22.2% to 50%). This reflects providers' increased readiness to provide appropriate referrals and have important conversations with patients, ideally creating transparency, building trust, and improving patient retention to care – all principles in alignment with the harm reduction framework (Academy of Perinatal Harm Reduction, 2023). However, the stark decrease in survey participation from pre- to post-implementation (43% to 19%) limits the ability to draw definitive conclusions about the intervention's impact on provider confidence and competency. It also highlights challenges in timing the PDSA cycles, with the decreased post-survey completion rate likely due to survey distribution and project completion occurring shortly before the winter holidays. While many individuals across disciplines informally expressed excitement about the project during development, actual implementation revealed significant reservations. Some providers viewed substance use screening and intervention as outside their scope of work and not "essential care" - a perspective that conflicts with evidence-based recommendations for universal screening. This resistance highlights a crucial gap between best-practice guidelines and some providers' perceptions of their role in delivering this care.

Provider feedback highlighted specific challenges with the intervention tools, particularly the length of the 5 P's screening tool and the complexity of the checklist. A possible solution

could involve making the checklist editable, allowing tailoring to patients' specific needs rather than serving as a static document. The suggestion to integrate screening earlier in pregnancy care at ultrasound dating visits indicates potential opportunities for workflow optimization. Providers also described available resources as "generic" and expressing uncertainty about resource provision processes. This feedback, combined with requests for clearer pathways and institution-specific referrals, suggests that the intervention's resource component may need further development to meet provider needs effectively.

The PDSA cycle revealed the importance of flexibility in implementation, as demonstrated by the success of the new obstetric note modification. However, the three-week delay in implementing this change highlights institutional constraints that can impact quality improvement efforts. Future interventions should account for potential administrative delays in planning implementation timelines, and PDSA leaders should have adequate access to all project-related materials prior to intervention initiation. The short PDSA cycle also limits the ability to draw conclusions about the intervention's long-term sustainability and generalizability. However, the rapid identification of workflow barriers and subsequent improvements in documentation rates after template modification demonstrates the value of quick-cycle improvements in optimizing care delivery tools.

Overall, these findings highlight the complex interplay between evidence-based recommendations, workflow optimization, provider attitudes, and patient needs in implementing substance use screening and intervention protocols in prenatal care. Future iterations of this intervention should consider these factors while maintaining focus on the goal of providing comprehensive, evidence-based care for pregnant patients with substance use disorders.

Limitations

   Several limitations may have influenced the outcomes of this quality improvement project. As this project took place in conjunction with efforts to implement an antenatal substance use disorder screening for the first time, not all individuals who may have qualified for the intervention were screened. For example, one individual had a new obstetric visit during this project's PDSA cycles and disclosed a history of substance use disorders. The provider who completed this visit did not utilize the correct new obstetric visit note template, and as a result the 5 P's screening tool and products of this intervention were not completed for the individual. Chart review revealed that the provider and patient discussed the patient's goals for their pregnancy in the context of substance use and made a follow-up plan for care. Though the interventions were not implemented for this patient, the positive outcome of this encounter suggests that the educational component of the project may have influenced provider behavior even when the formal screening tools were not utilized. This observation indicates that while compliance with the specific intervention tools was inconsistent, the project's broader goal of increasing provider awareness and competency in addressing perinatal substance use may have been partially achieved through the educational session and general awareness-raising activities.

   Additional educational and measurement limitations warrant consideration when interpreting these results. The educational session, designed to enhance provider knowledge and generate buy-in, was viewed by only 12 of 21 (58%) providers and students. This incomplete participation may have contributed to inconsistent implementation, as providers who missed the session may have lacked full understanding of the intervention's components and rationale. Furthermore, the anonymous nature of the pre/post-implementation surveys prevents differentiation between responses from experienced providers versus student clinicians rotating

through the practice. Without this demographic information, we cannot determine whether the reported improvements in provider comfort and knowledge represent changes among established clinicians or primarily reflect student learning during their rotations. This limitation is particularly significant considering that student providers indicated in pre-implementation feedback that they would defer to midwives for follow-up care. The survey results may therefore overrepresent the perspectives of providers with less direct responsibility for ongoing care management, potentially masking persistent knowledge gaps or implementation barriers among the core provider team responsible for long-term patient care.

In addition to the challenges with screening and provider participation, the project's methodology was limited. The small sample size of patients who screened positive for high substance use risk (n=10) during the 10-week implementation period limited opportunities for multiple PDSA cycles and timely iterating of interventions. Technical constraints impacted the project's implementation, as the project team's lack of direct control over the new obstetric visit template hindered timely modifications that could have improved workflow efficiency. Simple adjustments, such as relocating the SBIRT documentation, required coordination with external stakeholders and resulted in delays that affected the interventions' effectiveness. Future iterations of this project or others like it should anticipate and plan for challenges related to the electronic health record.

The project would have benefited from the support of a multidisciplinary working group to facilitate more dynamic refinement of the toolkit. While this author aimed to consult with stakeholders and content matter experts through project development and implementation, the post-intervention survey feedback revealed that providers had valuable insights that could have informed comprehensive improvements sooner in the PDSA cycles. A broader working group

that included individuals performing the intervention could have assisted in tailoring the project to clinic needs; their ongoing insight might have assisted to refine the checklist content, maintain up-to-date referral lists with specific points of contact, and critically examine the implications of current practices. The lack of this working group also limited the project's ability to implement the multi-pronged, multidisciplinary approach that research has shown to be most effective in caring for patients with substance use disorders in pregnancy (Johnson et al., 2024; Narbey & Cline, 2024). Comprehensive care models incorporating multiple touchpoints, providers of a variety of backgrounds, and novel support services lead to better outcomes for this population. However, the resource constraints of both this project and the antenatal practice necessitated a more focused intervention that, while valuable, could not fully realize the benefits of an integrated care approach. Future efforts to address how providers respond when patients screen positive for substance use disorders must consider assembling a committed team who are regularly able to provide input and iterate on a variety of topics related to the interventions, including important ethical concerns. For instance, the implications of documenting substance use diagnoses - particularly if they are in the patient's past - warrants careful consideration given the criminal legal implications of mandated reporting and risk of stigmatization from other providers. To create a culture in which patients feel safe to disclose sensitive information, a nuanced approach to both the intervention protocol and documentation that balances clinical utility with patient protection is needed.

A final limitation involves the scope of substance screening and providers' awareness of polysubstance use patterns. While the 5 P's screening tool addresses general substance use, this project may not have fully captured concurrent use of multiple substances. Current evidence indicates growing patterns of polysubstance use, particularly concurrent methamphetamine and

opioid use, with methamphetamine often containing illicit fentanyl (England & Chapman, 2025l; Khan, Mazumdar, & Rao, 2023). Provider hesitation during screening may have affected the identification of polysubstance use patterns, as patients who disclosed opioid use might have been reluctant to disclose methamphetamine use due to heightened stigma or fear of judgment. This limitation highlights the importance of providers staying informed about evolving substance use patterns within their communities. While this quality improvement project established a foundation for substance use screening and intervention, future iterations should emphasize education about contemporary polysubstance use trends, particularly the relationship between opioid and stimulant use. Such knowledge would better equip providers to anticipate potential co-occurring substance use even when patients disclose only a single substance, enhancing the comprehensiveness of subsequent interventions.

Conclusion

The integration of interventions to address substance use in prenatal care demonstrated both the feasibility and challenges of implementing evidence-based care within existing clinical workflows. The 5 P's screening tool successfully identified substance use risk factors among 17.9% of screened patients, highlighting the critical need for processes and resources to address substance use disorder perinatally. However, the variable execution of the toolkit underscores the complexity of translating screening results into comprehensive care delivery.

To maintain the intervention, several elements warrant modification. The dramatic improvement in SBIRT documentation rates following EMR template modification (from 25% to 83.3%) demonstrates that responsive, streamlined documentation processes are essential for consistent implementation. Second, provider engagement and buy-in remain crucial challenges, as evidenced by the decline in survey participation, mixed feedback about the length and

feedback indicating some providers view substance use screening as non-essential care. Addressing these perspectives through ongoing education and support will be vital for long-term sustainability. The SUD checklist, while comprehensive, would benefit from becoming more dynamic and adaptable to specific substance use patterns. Given the high prevalence of tobacco use and active marijuana use in the screened population, developing more robust guidance for these substances should be prioritized. Additionally, the resource compendium would be more effective if integrated directly into clinical workflows rather than existing as separate digital and printed materials.

A critical consideration for future iterations of this work is the fundamental tension between documentation requirements and harm reduction principles in caring for pregnant patients with SUDs. Many pregnant people may hesitate to discuss substance use with healthcare providers due to fears of criminalization and legal consequences (Joshi et al., 2021). While this project included provider education on mandated reporting requirements, resulting in improved provider comfort discussing these obligations (from 33.3% to 75%), it did not extensively address how providers could advocate for patients within criminal legal systems. The checklist and documentation tools were designed to enhance provider communication and care coordination, but their implementation exists within this complex context of substance use criminalization – a significant impact that was not measured in this project. The successful identification of workflow barriers through the PDSA cycle provides a foundation for future improvements. However, the lack of patient voice in this initial implementation represents a significant limitation. As articulated by the Academy of Perinatal Harm Reduction (2023) and the National Harm Reduction Coalition (2020), a core principle of harm reduction is the meaningful involvement of people with lived experience. Future quality improvement cycles

should prioritize collaboration with people who have navigated pregnancy while using substances, ensuring that tools and workflows reflect their experiences and needs. Future projects should also develop methods to track and evaluate whether increased documentation and screening lead to criminalization or other adverse outcomes for patients. This data collection and patient collaboration are particularly crucial given the complex interplay between healthcare documentation, legal obligations, and patient and family safety.

As demonstrated by the project findings, this toolkit has the potential to support the health and needs of pregnant patients who use substances. The findings also highlight the need for continued refinement and adaptation to meet the specific needs of both patients and providers. Future iterations must carefully balance the benefits of standardized care with the potential risks of increased documentation and surveillance. The approach developed through this project is as a starting point for similar practice environments seeking to implement evidence-based, harm-reduction-centered substance use care within existing clinical structures.

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Appendix A
Pre-Implementation Survey

For each of the following statements, please choose the response that most accurately reflects your level of agreement.

1. When a pregnant patient discloses substance use to me, I feel comfortable with the process of providing a brief intervention and referral to appropriate resources.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

2. I feel knowledgeable about community resources for substance use disorder and how to connect patients to them.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

3. I feel comfortable talking about resources for patients with substance use disorder, including talking about options for medication for opioid use disorder (MOUD).
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

4. I am proficient at incorporating referrals and resources based on harm reduction in conversations with pregnant patients with substance use disorder, such as talking about birth plans and safer substance use.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

5. I am comfortable discussing mandated reporter obligations with pregnant patients with substance use disorders.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

6. I have the resources I need to provide evidence-based care to patients with substance use disorder.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree
Please explain your answer to this question. <comment box provided>

Appendix B
Post-Implementation Survey

For each of the following statements, please choose the response that most accurately reflects your level of agreement.

1. When a pregnant patient discloses substance use to me, I feel comfortable with the process of providing a brief intervention and referral to appropriate resources.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

2. I feel knowledgeable about community resources for substance use disorder and how to connect patients to them.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

3. I feel comfortable talking about resources for patients with substance use disorder, including talking about options for medication for opioid use disorder (MOUD).
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

4. I am proficient at incorporating referrals and resources based on harm reduction in conversations with pregnant patients with substance use disorder, such as talking about birth plans and safer substance use.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

5. I am comfortable discussing mandated reporter obligations with pregnant patients with substance use disorders.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree

6. I have the resources I need to provide evidence-based care to patients with substance use disorder.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree
Please explain your answer to this question. <comment box provided>

7. Utilizing the SBIRT script has created a burden for providers.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree
Please explain your answer to this question. <comment box provided>

8. Utilizing the prenatal SUD checklist has created a burden for providers.
(1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree
Please explain your answer to this question. <comment box provided>

Appendix C
5 P's Screening Tool

5 P's Screening for Substance Use & Intimate Partner Violence
We know pregnancy is an important time for you. We want to address anything that can be harmful to you or your baby and help make your pregnancy as healthy as possible. We've started asking all of our patients about some things that can have a big impact on our health.
Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me about abuse or neglect involving children, elderly or people with disabilities.

Parents: Did any of your parents have a problem with alcohol or other drug use? YES***/NO ▾

Peers: Do any of your friends have a problem with alcohol or other drug use? YES***/NO ▾

Partner: Does your partner have a problem with alcohol or other drug use? YES***/NO ▾

Past: In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? YES***/NO ▾

Present: In the past month, have you drunk any alcohol or used other drugs including cannabis? YES***/NO ▾

 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? ***

Smoking: Have you smoked any cigarettes or vaped any nicotine in the past three months? YES***/NO ▾

Violence: Are you currently or have you ever been in a relationship where you were physically hurt, threatened, controlled, emotionally abused or made to feel unsafe? YES***/NO ▾

Appendix D
SBIRT Scripting (.pastpresentsmokingscript)

{***Delete below before signing visit***}
Brief Intervention & Referral to Resources

Raise subject & ask permission	*Thank you for answering my questions. Any substance or medication you use in pregnancy can have an impact on your health and the baby's. Is it okay if we talk more about XX and pregnancy? I'm here to listen without judgment and support you however I can.* • *What are your goals with substance use in this pregnancy?* • *I know people use drugs for a lot of reasons. What do you like most/least about using XX?* •
Provide feedback & offer educational handouts	*So, on one hand {PROS], and on the other hand [CONS]. I have some information on the risks of using substances in pregnancy. Would it be okay if I shared it with you?* **Review educational handouts (.SUDobsubstances).** *Because of these risks, I recommend avoiding using substances as much as possible during pregnancy.*
Investigate readiness for change using 1-10 scale	• *What are your thoughts/concerns?* • *On a scale of 1-10, with 1 being not ready at all and 10 being completely ready, how ready do you feel to make any kind of change to your use?* • *Why did you choose this number and not a lower number, like 1 or 2?*
Create an action plan	• *What are some steps you could take to reduce the things you don't like about use that you shared with me earlier?* • *What are some steps that you could take to achieve your goals of having a healthy pregnancy?* • *These sound like great ideas, would it be okay if I wrote them down in your chart?*

Offer referral to resources	*I have resources and people often find helpful to achieve these goals. Would you like to talk more about them?*
	• **Provide education & resources in AVS (.SUDOBsubstances) (.SUDobmatresources) (.SUDOBharmreduction)**
	• **OUD, alcohol, stimulants:**
	    ○ Discuss harm reduction strategies for safer use **(.SUDOBharmreduction)**
	    ○ Patients may have strong of ideas of where they would like to go and what kind of care they need, follow their lead
	    ○ **Refer to Dr. Willingham / OBAT Clinic at Orenco Station** for in-person care. Patients can call (503) 597-3130 OR providers can directly **route charts to P TUA OBAT** in Epic. Appointments scheduled in 1-2 weeks
	    ○ **Refer to HRBR clinic for virtual care.** Good option for those who would like medication ASAP. Appointments scheduled next day or within one week by calling (503) 494-2100
	• **Tobacco** - provide prescriptions and cessation and harm reduction counseling as indicated. Refer to HRBR clinic for virtual support if needed.
	• **Marijuana** - provide cessation and harm reduction counseling as indicated. Refer to HRBR clinic for virtual support if needed.
	• *Thank you for talking with me. Can we plan to follow up at your next visit? You can also reach me in these ways.*

Appendix E
SBIRT Scripting (.sudsbirtdocumentation)

Discussed patient's positive 5P's screening for ***.

SBIRT was completed.** Discussed the risks of substance use in pregnancy and explored options for supporting harm reduction and cessation of substance use. We reviewed hospital policies on mandated reporting.*** We discussed that substance use disorders are chronic diseases with treatments available. We discussed the benefits of MAT include improved pregnancy outcomes and pregnancy risk reduction. Referral to MAT, behavioral health counseling/recovery services, prescription medication*** was offered. The patient accepted/declined ***. Lab testing was obtained ***. Narcan prescription was provided ***. Education materials on substance use were provided. Substance use checklist was added to problem list in patient chart.

Appendix F
Substance Use Disorder Checklist (.sudobchecklist)

Checklist Element	Done?	Provider Instructions (can delete and/or add patient-specific notes if needed)
Provide **brief intervention & referral to appropriate resources** utilizing SBIRT guide in note, document appropriately	☐	**All substances** - Review handouts about substances & risks .SUDobsubstances Discuss harm reduction strategies for safer use & community resources for care, add to AVS .SUDobharmreduction .SUDobMATresources **OUD, alcohol, stimulants:** • Patients may have strong of ideas of what kind of care they need, follow their lead • **Refer to Dr. Willingham / OBAT Clinic at** Orenco Station for in-person care. Patients can call (503) 597-3130 OR providers can directly route charts to **P TUA OBAT** in Epic. Appointments scheduled in 1-2 weeks • **Refer to HRBR clinic for virtual care.** Good option for those who would like medication ASAP. **Appointments scheduled next day** or within one week by calling (503) 494-2100 **Tobacco** - provide prescriptions, cessation/harm reduction counseling and referrals as indicated. **Marijuana** - provide cessation/harm reduction counseling and referrals as indicated
Discuss Naloxone as strategy for opioid overdose prevention and prescribe if using any substances including cocaine/methamphetamine illicit fentanyl is often found as a contaminant	☐	
First Trimester - Opioids and/or Stimulants and/or Alcohol		
Obtain consents for obstetric team to communicate with MOUD treatment providers, behavioral health providers, and other relevant team members	☐	
Offer referrals to supportive programs such as WIC, Healthy Families, etc.	☐	.SUDobgeneralresources to AVS, refer to appropriate programs
Obtain recommended lab work: HIV, Hep B, Hep C, GC/CT, RPR, TB	☐	Consider Hep B vaccination for those who are HBsAg negative but at high risk of Hep B infection
Assess partner / family substance use, and provide connections to care as needed	☐	.SUDobmatresources to AVS

Second Trimester - Opioids and/or Methamphetamines and/or Alcohol		
Review expectations around contacting DHS, mandated reporting, and parent/baby discharge plan	☐	.SUDobdhsscript to guide conversation. .SUDobcriminallegal in AVS if patient would like more information about criminal/legal implications .SUDobpeers and/or .SUDobdoulas in AVS if patient wants these resources .SUDobUDS for more info about UDS
Review anticipatory guidance about neonatal abstinence syndrome (NAS), engaging in non-pharmacologic care of substance-exposed newborn, and postpartum care plans.	☐	.SUDobNAS to AVS, review with patient
Discuss plan for feeding baby when using substances.	☐	To breast/chestfeed in hospital, one negative UDS to non-prescription medications is typically protocol. UDS positive for prescribed substances only (methadone, buprenorphine) is appropriate. .SUDoblactation in AVS, review with patient
Discuss birth plan & refer to doula.	☐	.SUDobdoulas in AVS
Third Trimester - Opioids and/or Stimulants and/or Alcohol		
Repeat recommended lab work: HIV, Hep B, Hep C, GC/CT, RPR, TB	☐	
Review role of Project Impact and inpatient social work at HMC. Provide Project Impact and inpatient social work with FYI re: patient's upcoming admission	☐	Page Impact (17402) at least one week in advance with FYI about patient if patient's admission to hospital is known • Hours: M-F, 8am-5pm • Addiction medicine specialists - assess patients, offer support (medication, pain management, peer support specialist, resources) & connection. Can facilitate DHS calls.

Appendix G
Collaborative Project Workflow

Updated NOB Workflow
Positive Screen
Fall 2024

All patients scheduled for NOB visits

MA rooms patient alone, hands patient clipboard with EPDS/GAD7 & 2 safety cards

Provider conducts 5 Ps screening as part of history taking and documents in NOB note .HMCNEWOB

If positive for violence:

Shared decision making: patient leads next steps

Follow-up may include:

Assess and plan for patient safety *(scripted)*

Provide referrals to community resources

Share resources verbally or in AVS *(if safe to do so)* .IPVRESOURCES

If positive for substance use:

Parents, peers, or partners

Provide education and support *(scripted)*

Present, past, or smoking

Provider completes the following:

Complete SBIRT *(scripted)* & provide education about substance use in pregnancy .SUDobsubstances

Review harm reduction strategies & provide referrals for MOUD .SUDobharmreduction .SUDobMOUDresources

Add diagnosis to **Problem List**

Add checklist to Overview & Plan in Problem List .SUDOBCHECKLIST

OHSUHealth
Hillsboro Medical Center

Key: MA Provider

Appendix H
Substance Use Disorder Treatment Resources (.sudobmatresources)

This document was available via the smartphrase, on OneDrive and printed for use in office.

Program	Contact Information & Location
Resources at OHSU	
Office Based Addiction Treatment (OBAT) Clinic at OHSU Orenco Treatment for alcohol and opioid use disorders. Medication prescribing for oral naltrexone, Vivitrol, buprenorphine.	(503) 597-3130 Patients can call Orenco Station and say they are interested in OBAT, staff will take a message and a member of the OBAT team will call to discuss if our program is a good fit for your needs. Can typically get patients into a visit in 1-2 weeks. **Providers can directly refer by routing a patient's chart to P TUA OBAT in EPIC** www.ohsu.edu/primary-care/hillsboro-medical-center-primary-care-clinic-orenco-station-ohsu-health-partner-clinic
HRBR (Harm Reduction and BRidges to Care) Telehealth program that can make appointments within 24 hours - 2 days of calling. Services for: alcohol use disorder (AUD), opioid use disorder, nicotine use disorder, kratom use disorder, methamphetamine use disorder, behavioral health support for SUDs/MOUD, peer support services, HIV and Hepatitis C screening, hepatitis C treatment. We can prescribe medications including naltrexone and buprenorphine.	(503) 494-2100 Open for virtual visits Monday through Friday 10:00 am-7:00 pm For virtual visits patients will need: • A smart phone or tablet with Wi-Fi or data • A private space • To be in the state of Oregon www.ohsu.edu/school-of-medicine/general-internal-medicine/harm-reduction-bridges-care-hrbr
Methadone Treatment Programs	
Comprehensive Treatment Center (CTC) of Portland Prospective patients who meet the enrollment criteria will be scheduled for an intake appointment at the location where they will receive treatment. All patients must bring the following with them to their intake appointment: • Proof of a valid identification • The intake process will take between two and four hours.	Walk-in hours vary by locations, usually 6-7am, call or see website for uptodate hours **Hillsboro Mobile Unit**: 601 NE 34th Ave, Hillsboro, OR 97124 (Must complete intake at CTC-Belmont), (855) 475-2286 www.ctcprograms.com/location/hillsboro-mobile-unit/
CODA What to expect: First, you'll meet with a counselor and answer questions about yourself and how CODA can help. This initial appointment takes 30-60 minutes to complete. Our medical providers assist each patient in determining the appropriate medication based on their specific needs. Most patients receive medication immediately after the initial medical appointment. Bring health insurance information and photo ID to the appointment.	**Hillsboro Recovery Center**: 720 SE Washington St., Hillsboro, OR 97123 503-648-0753 Scheduled methadone intakes appointments: Monday – Thursday, 7:00 am – 11:00 am Walk-in screenings: Monday – Thursday, 7:00 am – 11:00 am Clinic Hours (for established patients): Methadone Monday – Friday, 5:30 am – 12:30 pm, 1:30 pm – 3:50 pm codainc.org/services/opioid-treatment-program/
Ideal Option Low-barrier, walk-in medication-assisted treatment for substance use disorder. Treatment for alcohol, opioid, and methamphetamine use disorders.	(509) 491-3031 541 SE Oak St Suite D, Hillsboro, OR 97123 Walk-in 7:30am - 6pm, Monday - Friday www.idealoption.com/suboxone-clinics/hillsboro
Clinics that provide outpatient, intensive outpatient and inpatient/residential treatment	

Fora Health Centers We provide day treatment (20+ hours a week), intensive outpatient (9-19 hours a week), outpatient (0-8 hours a week), and DUI services. Treatment consists of individual sessions with counselors, groups, peer mentors, family therapy and mental health services. Payment Accepted: Federal, or any government funding for substance use treatment programs IHS/Tribal/Urban (ITU) funds, Medicaid (OHP)	(503) 535-1151 **Hillsboro:** 205 SE 3rd Ave Suite 100, Hillsboro, OR 97123 https://forahealth.org/
CODA We offer family and individual treatment; assessment, counseling groups, medication-assisted treatment at some sites; toxicology testing, supported employment; DUII services, care coordination and case management. CODA outpatient provides both general and intensive treatment modalities.	(855) SEE-CODA (855-733-2632) **Hillsboro Recovery Center**: 720 SE Washington St., Hillsboro, OR 97123 503-648-0753
Withdrawal Management (Detox)	
Hooper Detox Services: Walk-ins are encouraged to arrive by 7:30am, Mon-Fri for morning triage; however, walk-ins may not be admitted on the same day based on capacity	(503) 238-2067 1535 N Williams Avenue, Portland, OR 97232 www.centralcityconcern.org/recovery-location/hooper-detoxification-stabilization-center/
Peer Support	
Mental Health & Addiction Association of Oregon Peer Support Program Peer support program for people with substance use challenges. Peers are usually in recovery from substance use disorders and may have experience parenting in recovery. They can answer questions, offer support, and connect you to resources like housing, treatment, and employment. Program is free/no cost. Must be 18 years or older and mark that you would like support with substance use disorder on the intake form.	Referral form: https://hipaa.jotform.com/230465659323156 Program website: www.mhaoforegon.org
Resources for pregnant patients only	
Project Nurture Holistic program for pregnant people who use or have used substances based around peer support and founded on harm reduction and trauma-informed care. All sites offer: • Pregnancy care with a midwife or doctor • Addiction treatment with a licensed counselor • Medications for Opioid Use Disorder • Case management and advocacy for accessing community resources • Peer support from other pregnant people, peer mentors and/or doulas • Consultation for interested patients and providers ***When calling for a referral, mention you are pregnant and your due date, and ask for a referral to Project Nurture.***	**CODA/OHSU** *Prenatal care*: CODA, Inc. (1027 E Burnside St, Portland) or Richmond Clinic (3930 SE Division St, Portland) *Birth*: OHSU (3181 SW Sam Jackson Park Rd, Portland) **Contact:** CODA: Liberty Martinez Bird - (855) SEE-CODA, or Richmond Clinic: Hannah Kamsky - (503) 418-3900

Last updated August 2024

Appendix I
Clinical Guidelines

The following clinical guidelines were available in OneDrive and in-person for providers to easily reference.

Committee Opinion No. 473: substance abuse reporting and pregnancy: the role of the obstetrician-gynecologist. (2011). *Obstetrics and gynecology*, *117*(1), 200–201. https://doi.org/10.1097/AOG.0b013e31820a6216

Committee Opinion No. 479: Methamphetamine abuse in women of reproductive age. (2011). *Obstetrics and gynecology*, *117*(3), 751–755. https://doi.org/10.1097/AOG.0b013e318214784e

Committee opinion no. 496: At-risk drinking and alcohol dependence: obstetric and gynecologic implications. (2011). *Obstetrics and gynecology*, *118*(2 Pt 1), 383–388. https://doi.org/10.1097/AOG.0b013e31822c9906

Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. (2017). *Obstetrics and gynecology*, *130*(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235

Committee Opinion No. 722: Marijuana Use During Pregnancy and Lactation. (2017). *Obstetrics and gynecology*, *130*(4), e205–e209. https://doi.org/10.1097/AOG.0000000000002354

Committee Opinion No. 807: Tobacco and Nicotine Cessation During Pregnancy. (2020). *Obstetrics and gynecology*, *135*(5), e221–e229. https://doi.org/10.1097/AOG.0000000000003822

Harris, M., Schiff, D. M., Saia, K., Muftu, S., Standish, K. R., & Wachman, E. M. (2023). Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). *Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine*, *18*(10), 715–733. https://doi.org/10.1089/bfm.2023.29256.abm

Appendix J
Substance-Specific Patient Teaching

Patient facing substance-specific resources were pulled from the following document. They were available as smartphrases, via OneDrive, and printed for in-person use.

National Harm Reduction Coalition. (2020). Pregnancy and substance use: a harm reduction toolkit. Retrieved from https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit

Smartphrases were as follows:
- .sudobalcohol
- .sudobbenzo
- .sudobcannabis
- .sudobopioids
- .sudobstimulants
- .sudobtobacco

Appendix K
Peer Support (.sudobpeers) & Doula Support (.sudobdoulas)

Peer Support Specialists

Peer support specialists are people in recovery from substance use disorders. They can answer questions, offer support, connect you to resources, and often have shared experience with parenting while in recovery. They may be present for the birth and support you in the hospital. They can also help you make and achieve goals, like getting to appointments on time, picking up medications, or taking whatever steps you feel would be important to your recovery.

Peer support specialists are paid for by Medicaid in Oregon, so should be free for you to access. You must be 18 years or older.

To connect with a peer support specialist, fill out this form: https://hipaa.jotform.com/230465659323156

Last updated August 2024

Doula Resources

Doulas are non-medical providers who give physical and emotional support during pregnancy, birth, and postpartum. They provide support during pregnancy and can help you prepare for childbirth and caring for a baby. During labor, doulas can help with pain management, emotional support, and coping during labor. They can help you advocate for your needs. Pregnant people who receive doula care have been shown to be less likely to have birth complications.

Yasiin's Luv: Doula practice by Telia Anderson, a certified recovery coach and birth and postpartum doula. Have several experienced doulas on staff. Accepts Medicaid. https://www.yasiinsluv.com/

Christy Hall: Doula with 20+ years of experience, specializes in caring for people with substance use disorder in the Portland metro area. Accepts Medicaid. http://www.christythedoula.com/

Community Doula Alliance: Doula matching organization for Black, Indigenous, and people of color. Must sign up between 10-32 weeks of pregnancy. Accepts Medicaid. https://communitydoulaalliance.com/

Black Parent Initiative: Provide culturally specific doula support for Black and multi-ethnic families. Accepts Medicaid. https://www.thebpi.org/

Portland Doula Love: Large doula matching service. Doulas may or may not have training in substance use disorders and harm reduction, so it is important to specify if this is important to you on intake forms. Accepts Medicaid. https://portlanddoulalove.com/

Last updated August 2024

Appendix L
Substance Use Criminalization Information

The following scripting was provided to discuss substance use criminalization (.sudobdhsscript)

Share .SUDobcriminallegal in AVS, if interested in doula/peer after conversation add .SUDobpeers . SUDobdoulas, if wanting more info about UDS share .SUDobUDS ***

Would it be okay if we had a conversation about DHS? I know talking about this can feel difficult, and I want you to know that I have seen this go well for many families. I am here to support you and will try my best to answer any questions you have.

- Considerations around making a report
    - In Oregon, reports are only filed after the baby is born, not during pregnancy. **It is not a crime in the state of Oregon to use drugs while pregnant.**
    - While there are laws that help guide whether or not a report is filed, the decision to file a report is usually made on a case-by-case basis. In general, **health care providers are mandated to make a report when:**
        - An infant is exhibiting signs of exposure to substances
        - Patient has positive UDS or is actively using drugs
    - **If you're on methadone or buprenorphine, a report may NOT be required.**
- Expectations after birth
    - **The inpatient social worker or Project Impact typically contacts DHS.**
    - You are invited/encouraged to make the call yourself or join them while they are making the call
    - Social worker/Project Impact will support you through each step of the call, be present as much/as little as you would like them to be.
    - Difficult to know how DHS will respond in each situation. **Thinking through your protective factors/plan of safe care is crucial.**
- Strategies for patients navigating DHS - how to navigate a situation in which it may feel like there is no control?
    - **Have a trusted advocate to support you to make decisions and navigate the systems.**
        - Friends, families, advocates
        - Peers and doulas: answer questions, offer support, and connect you to resources, support in hospital/at birth
    - **Build protective factors prenatally (Plan of Safe Care)**
        - Highlight strengths as parent & plans once baby is born
        - Think about what DHS might require if they are contacted and build that now, including:
            - Get/maintain safe housing, medical care, mental health care, treatment for SUD
            - Support system of people to support you and your baby
            - Have infant care items like diapers, lactation/formula, etc
- Urine/meconium drug screen expectations
    - **You have the right to know what tests are being performed on you, why, and how results will be used. You have the right to decline any test. This includes urine drug screens.**
    - There is no specific law in Oregon that a UDS must be performed if substance use is suspected in pregnancy. - - You have the right to ask for a confirmatory test if you disagree with the result.
    - Urine drug screen
        - Not collected on all patients - may ask to collect one if substance history is unknown
        - Negative UDS (or UDS negative for all except prescription substances like buprenorphine, methadone) can be positive to DHS
    - Meconium drug screen (baby's first bowel movement)
        - Rarely change the hospital plan due to long processing time
        - Can help care if baby has symptoms have signs of withdrawal and UDS is negative
        - Negative meconium drug screen can support your case
        - Your permission is required unless DHS has custody

Resources:
Comprehensive Addiction & Recovery Act (CARA)
Fact sheet about Child Abuse Prevention & Treatment Act (CAPTA) from National Advocates for Pregnant Women
Plans of Safe Care Requirements - Oregon
Propublica - State by State Legislation for pregnancy criminalization of SUD

Last updated August 2024

Patient facing resources about the criminal legal system and drug screening were pulled from the following document. They were accessible using the smartphrases .sudobcriminallegal and .sudobuds, one OneDrive, and in person.

National Harm Reduction Coalition. (2020). Pregnancy and substance use: a harm reduction
toolkit. Retrieved from https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit

Appendix M
General Pregnancy Resources (.sudobgeneralresources)

Resources for Pregnancy

WIC: Nutrition supplemental benefit, in addition to SNAP, for pregnant people and/or those who have children age 0-5 years old. If you qualify for SNAP or OHP, you qualify for WIC. If you don't, you should still apply as the income requirements are different for WIC. You do not need to be a citizen to apply but must live in Oregon.

Multnomah County: call 503-988-3503 or fill out this form: https://www.multco.us/wic
Washington County: Call 503-846-3555 or fill out this form: https://forms.co.washington.or.us/form/wic-web-referral
Clackamas County: call or text 503-655-8476

Multnomah County

Nurse Family Partnership: Nurse home visit program in pregnancy until baby is 2 years old to provide extra support for first time parents. To qualify, must have OHP, must be having first child, and must join before 26 weeks of pregnancy.

To apply call 503-988-3520 or fill out this form:
https://docs.google.com/forms/d/e/1FAIpQLSed-NaqLyI-Y8TXWJq--anivHaNWmmabZ1I1jAav7KLZbMz8g/viewform?gxids=7628

Healthy Families: Support for families from pregnancy through ages 0-3 for the baby. No insurance/income requirements, no requirements on number of children. Must join program before baby is 3 months old.

To apply call 503-988-3520 or fill out this form:
https://docs.google.com/forms/d/e/1FAIpQLSetj0vd-KW4461FIgkWaagEIgr_CYIgQsGVEpMu2coriu7DrA/viewform?gxids=7628

Healthy Birth Initiative: Afrocentric care for pregnant people living in Multnomah County who are African American/Black. Services include case management, transportation, classes, and father engagement programs.

To apply call 503-988-3387 or fill out this form:
https://docs.google.com/forms/d/e/1FAIpQLSed-NaqLyI-Y8TXWJq--anivHaNWmmabZ1I1jAav7KLZbMz8g/viewform?gxids=7628

Mother & Child Education Center: Offers baby/pregnancy/postpartum supplies, diapers, formula, sometimes larger items like strollers, books/toys for ages 0-5. Also offer free online birthing, newborn care, and safe sleep classes.

To receive items, call (503) 249-5801 or if Spanish call/text (503) 913-9360
Register for free classes: https://www.momchildpdx.org/services

Washington County

Maternal Child & Reproductive Health Program: Complete one form with your provider and you will be assigned to the appropriate programs. Available programs include:

- **Nurse Family Partnership**
- **Babies First** - similar to Nurse Family Partnership, nurse home visits until the child is 5 years old. Does not have to be the first baby.
- **Cocoon** - case coordination for families who have children with special needs ages 0-21
- **Help Me Grow** - helps families access local resources

Form: https://www.washingtoncountyor.gov/hhs/documents/mcrh-referral-form-fillable/download?inline

Clackamas County

Public Health Nurses: Complete one form and you will be assigned to the appropriate programs. Available programs include:

- **Babies First**
- **Cocoon**

Form: https://clackamascountyh3s.sjc1.qualtrics.com/jfe/form/SV_50aTY8bs9pEHsqi

Last updated August 2024

Appendix N
Substance-Specific Lactation Information (.sudobgeneralresources)

Patient facing substance-specific resources were pulled from the following document. They were available as smartphrases, via OneDrive, and printed for in-person use.

Lactation guidance and patient education. (2023). https://waportal.org/partners/pregnant-parenting-children-families-and-substance-use-workgroup/lactation-guidance-and-patient-education

Smartphrases were as follows:
- .sudoblactationalcohol
- .sudoblactationbenzo
- .sudoblactationcannabis
- .sudoblactationopioids
- .sudoblactationstimulants
- .sudoblactationtobacco

Appendix O
Harm Reduction Resources (.sudobharmreduction)

Harm reduction information was pulled from the following document. They were available as the smartphrase above, via OneDrive, and printed for in-person use.

National Harm Reduction Coalition. (2020). Pregnancy and substance use: a harm reduction toolkit. Retrieved from https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit

Appendix P
Educational Presentation

Prenatal Substance Use & Intimate Partner Violence Screening and Response

Midwifery DNP Quality Improvement Projects

FALL 2024 | PRESENTED BY: EHSA DHOLIA, LEAH HOLMES & SHARLOTTE IRWIN

Prevalence and Impact of Perinatal Substance Use
- 13.9% of pregnant people report illicit drug use in past month
- 8.2% of pregnancy-related deaths caused by substance use disorder (SUD)
- SUD increases the risk of maternal & neonatal complications such as:
  - Preterm labor
  - Intrauterine growth restrictions
  - Placental abruption
  - Cesarean birth
  - Neonatal abstinence syndrome
  - Perinatal mortality

Prevalence and Impact of Perinatal IPV
- 1 in 3 women worldwide have experienced intimate partner violence (IPV)
- As many as 20% of pregnant people have experienced IPV
- IPV increases the risk of maternal & neonatal complications such as:
  - Limited or delayed initiation of prenatal care
  - Smoking and alcohol use
  - Miscarriage
  - Placental abruption
  - Homicide
  - Preterm birth
  - Infant NICU admission
  - Perinatal mortality

Effective screening & care for patients can improve health outcomes and save lives.

Professional Recommendations
Substance Use:
- ACOG, USPSTF, SAMHSA, and WHO recommend screening, brief intervention, and referral to treatment (SBIRT) for identifying and managing perinatal SUD
- CMQCC and ACOG recommend universal verbal substance use screening using a validated instrument at the first prenatal visit and at regular intervals throughout pregnancy

Intimate Partner Violence:
- USPSTF recommends routine, universal screening for IPV as a regular part of women's healthcare
- ACNM recommends regular screening for current or past experience of IPV using best practices and validated instruments
- ACOG recommends screening for IPV during the first prenatal visit, at least once per trimester, and postpartum
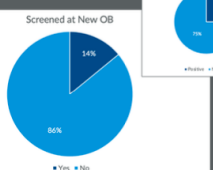
Trauma-Informed Care
Using a trauma-informed care approach, providers:
- Understand that anyone may have experienced trauma
- Administer universal screening for substance use and intimate partner violence
- Respond to disclosure with understanding and empathy
- Engage in shared decision-making regarding next steps

Baseline Data - IPV
July 1, 2024 – August 25, 2024
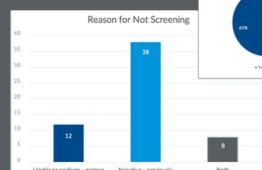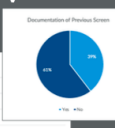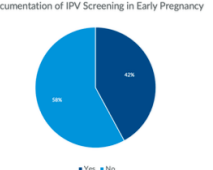
Baseline Data - IPV
July 1, 2024 – August 25, 2024

Baseline Data - IPV
July 1, 2024 – August 25, 2024

Project Implementation
September 30, 2024 – December 1, 2024

Project Goal:
- Establish a standardized, evidence-based and trauma-informed process for universal SUD and IPV screening and education within prenatal care to reduce associated morbidity and mortality

Slide 11 — Updated NOB Workflow (Fall 2024)
Flowchart: All patients scheduled for NOB visits → MA rooms patient alone, hands patient clipboard with EPDS/GAD7 & 2 safety cards → Provider conducts 5 Ps screening as part of history taking .HMCNEWOB → After history-taking, MA or provider brings patient's support person to exam room → Provider completes visit

Slide 12 — Updated NOB Workflow, Positive Screen (Fall 2024)
Flowchart (illegible detail)

Slide 13 — Reminders
- Providers will receive a reminder email at the start of every week
- There will be a note on the schedule in EPIC next to every New OB with a reminder to screen

Slide 14 — Rooming
- Front desk staff will inform patients that they will be roomed alone at the start of the visit using standardized script
  - Will assure patients that their support person will join after history-taking is completed
- Medical assistants (MAs) will room patients alone, handing them a clipboard with EPDS/GAD7 and two safety cards from Futures Without Violence
  - Using a standardized script, MAs will explain that every patient receives these cards because relationship violence is so common
  - Will inform patients that they can keep the cards, share them, or leave them at the clinic

Slide 15 — 5Ps Screening
- The screening tool will be integrated into the New OB note template that all providers will use: .HMCNEWOB

Slide 16 — Positive for Violence
Resources and provider script on next slide

Slide 17 — (table: Responding to IPV Disclosure)

Slide 18 — Patient Safety & Confidentiality

Slide 19 — Positive for Parents, Peers, Partner

Slide 20 — Positive for Past, Present, Smoking
- Conduct Brief Referral & Referral to Treatment
  - 10-15 minutes to understand patient's willingness to change behaviors, identify strategies and support networks, and create an action plan
  - Goal is NOT a commitment to abstinence, but instead to build trust and rapport with patient so they return for future care
  - SBIRT is billable in Oregon!
    - Can bill Medicaid up to 60 times in calendar year
    - SBIRT greater than 15-29 minutes: $23-$27 (CPT 99408)

SBIRT script on next slide

Assessment & Plan
Documentation

Screening for intimate partner violence and substance use:
Was patient seen confidentially? YES/NO***
Universal IPV education provided (safety cards given to patient)? YES/NO***

Did the patient screen positive for **Violence**?
Yes/No

Did the patient screen positive for **Parents, Peers or Partner**?
Yes/No

Did the patient screen positive for **Past, Present or Smoking**?
Yes/No

Additional follow-up shown on next slides

Assessment & Plan
Documentation for Violence or Parents, Peers, Partner

Assessment & Plan
Documentation for Past, Present, Smoking

- After completing the SBIRT:
  - Complete documentation below (in alignment with what OHP requires for billing for SBIRT)
  - Add resources to AVS
  - Add relevant SUD diagnosis/diagnoses to Problem List & add checklist (*.SUDOBCHECKLIST*) to Overview & Plan under the diagnosis

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SUD OB Checklist

An evidence-based tool to track tasks relevant to care of the perinatal patient with SUD and ensure standardized care across the practice.

Tips for Use:
- Plan to look at the checklist once per visit & cover relevant topic(s)
- Visits are short, provide handouts! Dot phrases are included in the checklist with lots of information to provide patients with baseline information & providers with talking point about each topic
- Caring for pregnant patients with substance use disorder involves a committed community. Don't do this work alone - use resources in the checklist to provide referrals & ensure patients get what they need!

The checklist is pictured on the following two slides

Thank You

Esha Dholia, dholia@ohsu.edu - SBIRT & SUD OB Checklist
Leah Holmes, ebyl@ohsu.edu - IPV screening
Sharlotte Irwin, irwinsh@ohsu.edu - SUD screening

Appendix Q
Cause & Effect Diagram