



Mother and Newborns Affected by Opioids SBIRT Simulations Guide

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Simulation resources:

- SBIRT slide set (available online ilpqc.org)
- “Words Matter- addressing implicit bias” video (available online ilpqc.org)
- NIDA and 5Ps screening questionnaires for each case
- Tools to reference/utilize during simulation
- Simulation
- Facilitator Evaluation Tool

Overview of simulations included:

1. Krystal’s prenatal Visit-High-risk substance use in pregnancy
 - 30-minute simulation to help providers recognize opioid use disorders prenatally with the goal of fast tracking the patient to MAT through an LD admission.
2. Jenny’s LD Admission-High-risk substance use in pregnancy
 - 30-minute simulation to help providers connect a patient to MAT during delivery admission and complete appropriate elements of the OUD Clinical Care Checklist including linkage to Recovery Support services.
3. Sasha’s triage visit to LD- Moderate-risk substance use in pregnancy
 - 20-minute simulation to help providers distinguish appropriate treatments for a patient who does not meet criteria for OUD, but is taking opioid for chronic pain management.
4. Abby’s triage visit to LD- Moderate-risk substance use in pregnancy
 - 10-12 min simulation to help providers recognize and counsel on risk for substance use disorders including marijuana during pregnancy

Appendix for simulation attendee materials:

1. Examples of validated screening tools for each case (NIDA, 5Ps)
2. Patient education materials about substance use during pregnancy
3. Institution’s community mapping tool to be added by facilitator
4. ILPQC SBIRT Card Sasha
5. ILPQC OUD Protocol
6. ILPQC SUD/ODU Treatment Algorithm
7. ILPQC OUD Clinical Care Checklist

Mothers and Newborn Affected by Opioids

SBIRT Simulations Learning Objectives

The goal of these simulations is for the attendee to learn to develop partnerships with women with OUD to optimize outcomes for mother and baby by practicing empathy and effective communication skills and understand OUD as an urgent OB issue with key clinical steps needed to improve outcomes. Reducing stigma and improving empathy across the clinical team helps empower women to engage in treatment to reduce maternal overdose death, improve pregnancy outcomes and increase the number of women who can parent their baby; and empowers women to participate in non-pharmacologic care of the newborn (breastfeeding, rooming in, Eat-Sleep-Console) that improves maternal and newborn outcomes.

By the end of the program, providers should be able to:

1. Recognize that Opioid Use Disorder (OUD) is a life-threatening chronic disease with an effective treatment [*medication assisted treatment (MAT)*] available and an urgent obstetric issue that all OB providers must address with key clinical steps across prenatal, delivery, and postpartum care.
2. Effectively utilize the institution's selected validated OUD screening tool and provide a brief intervention for screened positive patients to briefly assess SUD/OUD diagnosis, counsel on OUD risks in pregnancy/postpartum, counsel on benefits of treatment, and assess patient goals / readiness for treatment.
3. Activate the appropriate key steps in the ILPQC SBIRT/OUD Clinical Algorithm and OUD Protocol for pregnant or postpartum patients who screen positive for opioid use disorder including initiation of the OUD Clinical Care Checklist.
4. Acknowledge and begin to address clinical individual and clinical team implicit biases working with patients with substance use disorder and understand how using non-discriminatory and empathetic language across the clinical team reduces stigma and improves patient care. Helping clinical teams focus on patient strengths empowers providers and patients.
5. Verbalize the importance of actively linking pregnant and postpartum women with OUD to MAT and Behavioral Health Recovery Services to reduce maternal overdose deaths, improve pregnancy outcomes and increase the number of women who can parent their newborns.

Learning Objectives

Cognitive:

- Recognition of opioid use disorder as a life-threatening chronic disease, the leading cause of pregnancy associated maternal death in Illinois, and an urgent obstetric issue with effective treatment (*medication assisted treatment (MAT)*) options available that all OB providers must address with key clinical steps when women with OUD are identified.
- Activation of the OUD Protocol, including appropriate use of the SBIRT/OUD Treatment Algorithm, initiation of the OUD Clinical Care Checklist, consideration for inpatient versus outpatient management for MAT start, appropriate lab orders such as Hep C screen, Narcan counseling and prescription, and arrangement of appropriate consultations, including social work, Maternal-Fetal Medicine, psychology / addiction treatment, neonatology, and anesthesia.
- Understanding of the recommendations for timely treatment of opioid use disorder in pregnancy, including MAT and Behavioral Health/ Recovery Treatment Services to reduce maternal overdose death, improve pregnancy outcomes and increase the number of women who can parent their baby.

Behavioral:

- Improve communication skills to reduce stigma, using empathy and unbiased language, when screening and providing care for women with OUD/SUD during pregnancy, delivery or postpartum.

Guide to the SBIRT Simulation Bundle

This simulation bundle is meant to be personalized and tailored to your hospital needs. You will find 4 different case scenarios to choose from. Each scenario has accompanying sample patient questionnaires. You are free to utilize the sample SUD/OD screening tools, but if your hospital has chosen a different validated screener, please feel free to utilize your selected SUD/OD screening tool.

5 simple steps to a successful simulation

1. Download the SBIRT Simulation Slide set on the ILPQC website (ilpqc.org).
2. Review the “Words Matter” video to determine if participants will review prior to simulation or during the simulation (available here).
3. Review the SBIRT Simulation case scenarios to determine appropriate scenarios for your team and time frame.
4. Print out the tools for attendee to reference/utilize during simulation seen in the appendix
5. Review the facilitator materials in preparation and have a great simulation!

Scenario Set Ups

All case scenarios can be set up in the following manner:

Room Configuration: Two chairs at front of room

Equipment: (to be used as needed)

- Patient completed SUD/OD validated screening tool
- See examples for NIDA, 5Ps, Institute for Health and Recovery Integrated Screening Tool
- Patient education materials on substance use during pregnancy
- Institution’s OUD Community Mapping Tool (document with local information to link women to OUD care and treatment)
- ILPQC SBIRT Card
- ILPQC OUD Protocol
- ILPQC OUD Clinical Care Checklist
- ILPQC SBIRT/OD Clinical Treatment Algorithm

Manikin: N/A

Simulator: A standardized patient actor

Participant: 1 medical professional (MD, RN, CNM, PA)

Attendee material: Debriefing checklist to complete while watching the simulation

Facilitator Introduction

Simulation Introduction

Sample Introduction:

The opioid epidemic is one of the largest public health crises in the United States today. Women who are pregnant or postpartum are not immune to this epidemic. Opioid use in pregnancy has increased drastically in recent years as the result of increased opioid prescriptions, abuse of prescription opioids, and illicit opioid use, resulting in maternal opioid overdose as a leading cause of maternal mortality nationwide and the leading cause of pregnancy associated death in Illinois. The rate of maternal opioid overdose deaths has increased 175% from 2008-2017 in Illinois. It surpasses more commonly recognized causes of maternal mortality, such as hemorrhage, emboli and hypertensive disorders. All pregnant and postpartum women with Opioid Use Disorder (OUD) urgently need our attention. As obstetric healthcare providers, we need to recognize that OUD is a life-threatening chronic disease with an effective treatment (medication assisted treatment (MAT) available and we must do better to identify and treat these women.

The purpose of this simulation is to train obstetric providers to identify pregnant women with OUD (incorporate use of a universal validated SUD/OUD screening tool prenatally and on L&D), provide a brief intervention with counseling on risks of OUD and treatment options, and assess readiness for treatment, including MAT and linkage to Behavioral Health / Recovery Services with timely OB follow up. Providers will learn key steps of the SBIRT OUD Clinical Algorithm and OUD protocol including starting the OUD Clinical Care Checklist. Ideally for women with OUD ready to start treatment providers will consider obstetric admission for fast track MAT start or urgent linkage to an outpatient or inpatient treatment program. Admission also provides opportunity for efficient completion of the OUD Clinical Care Checklist. Providers should be able to counsel patients for other substance use disorders or risks for substance use identified during universal screening and refer for appropriate level of care. Given the complex nature of OUD, we will also practice using unbiased language to facilitate empathetic, open communication with our patients. Participants will understand that reducing stigma across the clinical team empowers women and improves outcomes for mothers and babies affected by opioids.

Timeline for Simulation

- **5 minutes**- Welcome and Simulation Introductions from Facilitator
- **Optional additions:**
 - **35 minutes**- “Words Matter” video (Option to assign as pre-work for participants to view video prior to in-person simulation training)
 - **10 minutes**- Brief PowerPoint MNO Simulation Slide Deck for providers to review before starting simulations
- **XX minutes**- Simulations with debriefs (time will be determined by simulations chosen)

Facilitator Case Study Introductions

Case scenario 1: Krystal's initial prenatal visit

20min simulation + 15min debrief

Case read to everyone:

"Krystal is a 31-year-old G2P1001 who comes to her first prenatal visit at 20 weeks. She is currently in grad-school and has a toddler at home. She found out that she was pregnant one month ago when she and her partner noticed she was gaining weight, but she did not seek care until now due to lack of insurance. Please interview the patient using <insert institutions selected screening tool>and provide a brief intervention if appropriate."

Case scenario 2: Jenny's labor and delivery admission

15min simulation +15min debrief

Case read to everyone:

"Jenny 28 yo G4P1112 at 36 weeks presenting to LD for painful contractions. She is currently insured through her employer, but has had minimal prenatal care due to fear of the healthcare system and losing her baby. She is currently rating her contraction pain 3/10 and the nurse reports that she performed a sterile vaginal exam and the patient is currently 3/80/-2. The nurse also had the patient complete the hospital's screening tool and you see that she reports using alcohol or drugs during this pregnancy. Please interview the patient using <insert institutions selected screening tool>and provide a brief intervention if appropriate."

Case scenario 3: Sasha's triage visit to labor and delivery

10min simulation + 10 min debrief

Case read to everyone:

"39 yo G1P0 at 24 weeks presenting to triage to rule out pre-eclampsia. She diagnosed with gestational hypertension and is going to be discharged home on medication. She has received prenatal care with a private attending at your hospital. Please interview the patient using the <insert institutions selected screening tool> and provide a brief intervention if appropriate. "

Case Scenario 4: Abby's triage visit to labor and delivery

5-7 min simulation + 5 min debrief

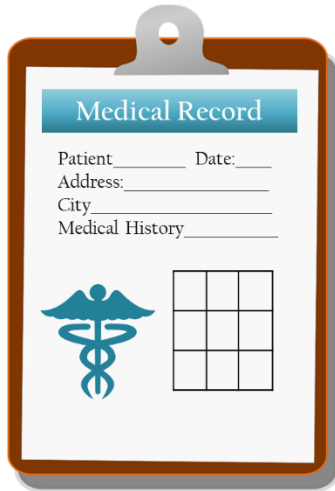
Case read to everyone:

"24 yo G1P0 at 30 weeks presenting to triage with leakage of fluid. She ruled out for spontaneous rupture of membranes and is going to be discharged home. She has received prenatal care with a private attending at your hospital. Please interview the patient using the <insert institutions selected screening tool> and provide a brief intervention if appropriate."

Case Studies 1 & 2 Patient Information

Case Scenario #1

Krystal- presenting for initial prenatal visit



Patient Description

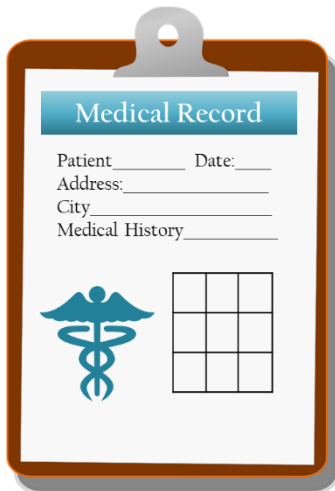
31 yo G2P1001 at 20 weeks presenting for first prenatal visit. She is a graduate student with a toddler at home and did not receive PNC until this point due to lack of insurance coverage. She is familiar to your practice as she delivered her last baby 2.5 years ago with your partner. After she completes the screening tool, you see that she reports using alcohol or drugs during this pregnancy.

History

Obstetrics – 1 prior NSVD with no prenatal care to date
Medical – healthy
Surgical – none
Social – opioid use

Case Scenario #2

Jenny- presenting to L&D for delivery admission



Patient Description

28 yo G4P1112 at 36 weeks presenting to LD for painful contractions. She has had minimal prenatal care and is unknown to the healthcare team. After she completes the screening tool, you see that she reports using alcohol or drugs during this pregnancy.

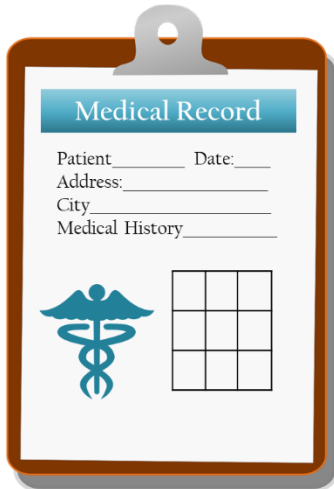
History

Obstetrics – 1 prior LTCS for a preterm infant, 1 successful term VBAC, SAB, Current pregnancy with scant prenatal care to date
Medical – Prior diagnosis of OUD with MAT 5 years ago
Surgical – none
Social – recently moved here

Case Studies 3 & 4 Patient Information

Case Scenario #3

Sasha- triage visit to labor and delivery



Patient Description

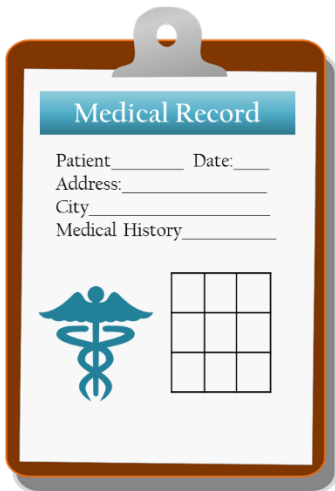
39 yo G1P0 at 24 weeks presenting to triage to rule out pre-eclampsia. She diagnosed with gestational hypertension and is going to be discharged home on medication. She has received appropriate prenatal care with a private attending at your hospital. After she completes the <insert institutions selected screening tool>, you see that she currently taking OxyContin daily.

History

Medical – Degenerative Disc Disease with bulging Cervical Discs C5-C6
Surgical – none
Social – none

Case Scenario #4

Abby's- triage visit to labor and delivery



Patient Description

24 yo G1P0 at 30 weeks presenting to triage with leakage of fluid. She ruled out for spontaneous rupture of membranes and is going to be discharged home. She has received appropriate prenatal care with a private attending at your hospital. After she completes the <insert institutions selected screening tool>, you see that she used marijuana and alcohol prior to pregnancy and that her mother has a history of alcoholism.

History

Medical – Hypothyroidism
Surgical – none
Social – History of marijuana and alcohol use prior to pregnancy
Family – Mother - alcoholism

Case Study 1-Krystal's prenatal visit

General scenario information

Case read to everyone:

Krystal is a 31-year-old G2P1001 who comes to her first prenatal visit at 20 weeks. She is currently in grad-school and has a toddler at home. She found out that she was pregnant one month ago when she and her partner noticed she was gaining weight, but she did not seek care until now due to lack of insurance. Please interview the patient using <insert institutions selected screening tool>and provide a brief intervention if appropriate.

Participant challenges:

- Using non-biased language to discuss opioid use disorder
- Provide correct information about substance use risks including briefly discuss: risk of overdose for mom during pregnancy and the postpartum period, and risk of neonatal opioid withdrawal / NAS.
- Provide correct information regarding benefits of treatment (MAT/Recovery Treatment Programs) including: reduced maternal overdose deaths, improved pregnancy outcomes and increase number of women who can parent their baby.
- Provided correct information about benefits of maternal engagement in non-pharmacologic care of opioid exposed newborn (breastfeeding, rooming in and Eat-Sleep-Console) including neonates: reduced need for medication use, shorter post-delivery hospital stay.
- Able to assess readiness to start treatment, discern the appropriate level of care and provided active linkage to care for MAT and Behavioral Health/ Recovery Treatment Services.
- Demonstrated awareness of the urgency of MAT start for patients ready to start treatment, included recommendation or consideration of hospital admission to fast track MAT start and linkage to treatment programs, and showed understanding of need to initiate OUD Clinical Care Checklist for all pregnant and postpartum women with OUD (includes Narcan counseling, Hep C screen etc).

Instructions for the "mom": Your character is elementary school teacher who is currently not employed and is working towards her master's degree in education. Two years ago, shortly after having her toddler, she was involved in a car accident, and she has struggled with chronic back pain since then. Since the car accident, she has become dependent on opioids. She uses Norco or Percocet daily. She gets her medications from different doctors and friends. She has not discussed OUD with a provider before and she is embarrassed to be sharing her dependency on opioids. Her family and friends are not aware of her issue with opioids. She tried heroin once when she had difficulty obtaining opioid pills. She asks about the effects of opioids on the baby, she does not seem to be aware of overdose risks of OUD, but she is worried about the effect on her pregnancy and she is interested in treatment for opioid dependence. She has tried to reduce her opioid use since finding out she was pregnant, but she has been unable. She is highly motivated for change and would rank her readiness as an "8" on the readiness ruler. She also begins to complain of acute signs of withdrawal – nausea, abdominal cramping and myalgias. She would prefer to go home from clinic to arrange childcare for her toddler prior to hospital admission for acute opioid withdrawal. If the patient is recommended to be directly admitted to the hospital due to the urgency of her medical condition, however, she is willing to do this.

Case Study 1-Krystal's prenatal visit Scenario logistics and progression

Scenario Logistics

Expected Interventions:

- Initial problem identification
- OB provider notified of screen positive result
- OB providers engages in brief intervention to counsel patient and assess readiness for treatment
- Assess diagnosis of SUD/OD and severity (DSM-V criteria is helpful)
- Patient provided additional education materials about OUD and treatment
- Admission to LD for Fast Track MAT initiation

Likely Progression:

- Patient expresses desire for treatment for OUD
- Review OUD risks and treatment options and benefits of treatment
- Activate the OUD Protocol, utilize the SBIRT/OD Clinical Treatment algorithm and admit patient to LD for fast track MAT induction
- Providers may utilize the IL Doc Assist program for a free addiction medicine phone consult for pregnant / postpartum patients to assist with MAT start
- Initiate the OUD Clinical Care Checklist
- Order appropriate labs (including HepC)
- Provide Narcan counseling and offer prescription or dispense Narcan
- Obtain appropriate consultation (social work, neonatology, psych/addiction treatment, Maternal Fetal Medicine, anesthesia)
- Obtain two-way consent to share information with treatment provider
- Make appropriate referrals prior to discharge for placement in Recovery Treatment Program (Inpatient, Intensive Outpatient, or other program).
- Providers may use the IL OUD Hotline to identify Recovery Treatment Program available options or may use their hospitals OUD Mapping Tool to identify local resources
- Schedule timely OB and behavioral health follow-ups
- Discharged into a recovery treatment program

Expected Endpoint:

- Creation of action plan with patient for opioid use disorder treatment
- Patient admitted to L&D
- MAT induction start and completion of OUD Clinical Care Checklist during admission including consults, Narcan counseling and appropriate screening labs.
- Provided a warm hand off to appropriate referral resources identified
- Discharge to Recovery Treatment Program
- Close OB and Behavioral Health follow up scheduled

Case Study 1-Krystal's prenatal visit Facilitator scenario interventions

Patient hands completed <Insert screening tool here> to provider.

1. What important patient responses are noted on the screening tool?
2. How do you raise subject with the patient?
3. What additional history do you want to obtain?

Patient provides additional history of opioid use disorder, including history of heroin use. She is concerned about effects of opioids on the baby.

4. How do you provide feedback on the patient's responses?
5. What is the current recommendations and standard of care for women with opioid use disorder? What resources would you utilize to ensure current evidence based practice?
6. How can substance use affect the patient and her pregnancy? How can treatment reduce risks for the patient, her pregnancy and her baby? How does treatment improve the chance of the patient being able to parent her baby?
7. Should she be referred to any specialists?
8. Should be admitted to labor and delivery for opioid use disorder treatment? How can you provide information to the patient to help her make an informed decision on this fast track treatment option? Are there resources/supports to help her with her concerns about setting up care for her toddler at home?
9. Do you need to order any particular labs or studies?
10. Are there medical therapies available in pregnancy for treatment of opioid use disorder?
11. How can you assess the patient's readiness for medical treatment of opioid use disorder?

Linking moms to MAT / Recovery Services

- Reduces overdose deaths for moms
- Improves pregnancy outcomes
- Increases # women who can parent their baby as DCFS is much less likely to intervene when a mother is on MAT and/or in a Recovery Treatment Program prior to delivery.

Patient voices interest in medical treatment for opioid use disorder (she is an 8 on the readiness ruler) and mentions her current symptoms. She would like more information about MAT.

12. Review efficacy and benefits of buprenorphine and methadone
13. Should her treatment be initiated as an inpatient or outpatient? What are the benefits of admission to start treatment (MAT) and linkage to a recovery treatment program?
14. Can the patient breastfeed with these medications?

Patient voices concern about the care of her toddler if she was to be admitted for MAT induction.

15. During the inpatient setting who is able to prescribe

According to ABC 2015 guidelines, women receiving MAT (ie. Methadone & Buprenorphine) for OUD are considered eligible for breastfeeding. Breastfeeding or the provision of breastmilk should be encouraged for these women as the current literature is supporting that the severity of NAS may be reduced with breastfeeding.

According to national guidelines, a non-waivered provider can continue/order MAT when a patient is **admitted** to the hospital or initiate treatment of acute withdrawal. Within 3 days of treatment, patient should be stabilized and transferred to a waived or licensed provider.

methadone or buprenorphine for the patient when she is admitted for acute signs of withdrawal?

16. How many days could a non-waiver provider prescribe MAT for the patient while she is admitted?

17. What items in the OUD Clinical Care Checklist need to be completed prior to discharge?

Case Study 2-Jenny's delivery admission Scenario logistics and progression

Case read to everyone:

Jenny is a 28 year old G4P1112 at 36 weeks presenting to LD for painful contractions. She is currently insured through her employer, but has had minimal prenatal care due to fear of the healthcare system and losing her baby. She is currently rating her contraction pain 3/10 and the nurse reports that she performed a sterile vaginal exam and the patient is currently 3/80/-2. The nurse also had the patient complete the hospital's screening tool and you see that she reports using alcohol or drugs during this pregnancy. Please interview the patient using <insert institutions selected screening tool>and provide a brief intervention if appropriate.

Participant challenges:

- Using non-biased language to discuss opioid use disorder
- Provide correct information about substance use risks including: risk of overdose for mom during the postpartum period, effects on pregnancy, and risk of neonatal opioid withdrawal / NAS.
- Provide correct information regarding benefits of treatment (MAT/Recovery Treatment Programs) including: reduced maternal overdose deaths, improved pregnancy outcomes and increase number of women who can parent their baby.
- Provided correct information about benefits of maternal engagement in non-pharmacologic care of opioid exposed newborn (breastfeeding, rooming in and Eat-Sleep-Console) including neonates: reduced need for medication use, shorter post-delivery hospital stay.
- Discern the appropriate level of care for patient and provide linkage to care after delivery
- Able to assess readiness to start treatment, discern the appropriate level of care and provided active linkage to care for MAT and Behavioral Health/ Recovery Treatment Services.
- Demonstrated awareness of the urgency of MAT start for patients ready to start treatment and showed understanding of need to initiate OUD Clinical Care Checklist for all pregnant and postpartum women with OUD (may find helpful to reference the SBIRT/OUD Clinical Algorithm).

Instructions for the "mom": Your character is employed fulltime at a local department store. Her opioid use began when she was very young after suffering from a traumatic childhood event. Her obstetrical history includes one cesarean delivery for a preterm infant at the age of 16. That baby was placed for adoption and your character prefers not to disclose many details in front of her partner. Her history also includes a successful VBAC delivery 5 years ago. During her last pregnancy at another hospital, she was able to start MAT during the pregnancy and be connected to support services for her opioid use. Her current partner is the father of that baby and was very supportive during that time. She was in MAT for the first 1.5 years after her delivery, but after relocating for her partner's job, she was not able to link care with a new MAT provider and began taking opioids again. Prior to this pregnancy she had one spontaneous miscarriage. After the miscarriage, she successfully stopped her opioid use for 4 months. Once she became pregnant she tried to continue to avoid opioids, but with the increased pregnancy pain she has been taking Vicodin daily. She gets her medications from different doctors and old friends. She has not discussed OUD with any of her current providers as she is embarrassed to be sharing her dependency on opioids again. She has avoided attending her OB visits out of fear of judgment, but her family and friends are aware of her struggle with opioids. If asked, she does seem to be aware of overdose risks of OUD, and is very worried about the effect on her pregnancy. She is very interested in connecting to treatment again for opioid dependence, but has been uncertain how to do so in her new location. She is highly motivated for change and would rank her readiness as a "10" on the readiness ruler

Case Study 2-Jenny's delivery admission Scenario logistics and progression

Expected Interventions:

- Initial problem identification: universal OUD screening tool with screen positive result for OUD (screen may be completed by other members of clinical team)
- OB provider notified of screen positive result
- OB providers engages in brief intervention about opioid use disorder risks for mom and pregnancy, treatment options and benefits of treatment and assesses readiness for treatment start and linkage to Behavioral Health / Recovery Treatment Services including social work.
- Patient provided additional education materials about OUD and treatment

Likely Progression:

- Patient expresses desire for treatment for OUD
- Review OUD risks and treatment options and benefits of treatment
- Activate the OUD Protocol, utilize the SBIRT/OUD Clinical Treatment algorithm and admit patient for delivery and MAT induction during the delivery admission
- Providers may utilize the IL Doc Assist program for a free addiction medicine phone consult for pregnant / postpartum patients to assist with management of OUD during delivery and MAT start.
- Initiate the OUD Clinical Care Checklist to be completed before hospital discharge
- Order appropriate labs (including HepC)
- Provide Narcan counseling
- Obtain appropriate consults (ie. social work, neonatology, psych/addiction treatment, Maternal Fetal Medicine, anesthesia)
- Make appropriate referrals prior to discharge for placement in Recovery Treatment Program (Inpatient, Intensive Outpatient, or other program).
- Providers may use the IL OUD Hotline to identify Recovery Treatment Program available options or may use their hospitals OUD Mapping Tool to identify local resources
- Schedule timely OB and behavioral health follow-ups
- Discharged into a recovery treatment program

Expected Endpoint:

- MAT induction start and completion of OUD Clinical Care Checklist during admission prior to delivery discharge.
- Discharged to Recovery Treatment Program
- Close OB and Behavioral Health follow up scheduled including a 2-week postpartum maternal health safety check.

Case Study 2-Jenny's delivery admission Facilitator scenario interventions

Patient hands completed <Insert screening tool here> to provider.

1. What important patient responses are noted on the screening tool?
2. How do you raise subject with the patient?
3. What additional history do you want to obtain?

Patient provides additional history of opioid use disorder, including history of MAT. She is concerned about risk of overdose and effects of opioids on the baby.

4. How do you provide feedback on the patient's responses?
5. What are medical recommendations for substance use (alcohol, tobacco, opioids) during pregnancy and how can providers briefly best counsel the patient?
6. What are the current recommendations and standard of care for women with opioid use disorder? What resources would you utilize to assist with a brief intervention/ counseling the patient and assist with next clinical steps to reduce risk for the patient?
7. How can substance use affect the patient and her pregnancy? How can treatment reduce risks for the patient, her pregnancy and her baby? How does treatment improve the chance of the patient being able to parent her baby?
8. Should she be referred to any specialists?
9. How can you provide information to the patient to help her make an informed decision on MAT treatment options during her delivery admission? Why is it optimal to start MAT before hospital discharge?
10. Do you need to order any particular labs or studies?
11. How can you appropriately assess the patient's readiness for medical treatment of opioid use disorder while she is in labor or during the delivery admission?

OUD is a life threatening illness. The postpartum period is the highest risk period for maternal overdose death, the leading cause of pregnancy associated deaths in Illinois. Starting MAT and linking women to a Recovery Treatment Program and providing NARCAN prior to delivery discharge significantly reduces risk of maternal death in the postpartum period.

Patient voices interest in medical treatment for opioid use disorder (she is a 10 on the readiness ruler).

12. Review efficacy and benefits of buprenorphine and methadone
13. Can the patient breastfeed with these medications?

Patient voices concern about her baby and wants to start methadone or buprenorphine induction right away.

14. Who is able to prescribe Methadone or Buprenorphine for the patient when she is admitted for delivery?
15. How many days would you anticipate the patient being inpatient for?
16. What items in the OUD Clinical Checklist need to be completed prior to delivery discharge?
17. What other services are important to connect the patient to prior to hospital discharge?

Linking moms to MAT / Recovery Treatment Services

- Reduces overdose deaths for moms
- Improves pregnancy outcomes
- Increases # women who can parent their baby as DCFS is much less likely to intervene when a mother is on MAT and/or in a Recovery Treatment Program.

Patients with OUD should be discharged to a Recovery Treatment Program and/or Behavioral Health Services for immediate or short interval follow up and have a 1-2-week postpartum maternal health safety check scheduled with OB prior to leaving the hospital. For help connecting patients to available Recovery Treatment Services, reach out to the **Illinois Referral Helpline for Opioids & other substances (833)-2-FNDHELP, available 24-7.**

Questions about MAT induction during the delivery admission? IL DocAssis will provide free addiction medicine phone consult services for OB providers caring for pregnant and postpartum women and can assist with MAT induction, OUD management or treatment for withdrawal. **Call 1-866-986-2778, M-F, 9a-5p**, off hours leave message for call back next business day.

Case Study 3-Sasha's triage visit

General scenario information

Case read to everyone:

Sasha is a 39 year old G1P0 at 24 weeks presenting to triage to rule out pre-eclampsia. She is diagnosed with gestational hypertension and is going to be discharged home on medication. She has received appropriate prenatal care with a private attending at your hospital. Please interview the patient using the <insert institutions selected screening tool> and provide a brief intervention if appropriate.

Challenges:

- Using unbiased, non-judgmental language to discuss opioid use disorder versus opioid use for chronic pain and that women using opioid use for chronic pain can develop opioid use disorder.
- Discuss her provider for pain medication and her pain management strategies during pregnancy.
- Provide correct information about substance use risks including: risk of overdose for mom during the postpartum period, effects on fetus/pregnancy, and risk of neonatal opioid withdrawal / NAS.
- Provide correct information about Narcan as a risk reduction strategy for patients who use opioids regularly.
- Provided correct information about benefits of maternal engagement in non-pharmacologic care of opioid exposed newborn (breastfeeding, rooming in and Eat-Sleep-Console) including neonates: reduced need for medication use, shorter post-delivery hospital stay.

Instructions for the "mom": Your character is currently unemployed and is on disability. She volunteers at her local nursing home and has tried many years with her partner to have this baby. She was a competitive tennis player during college and through her 20s. After playing competitively, she was worked as a private tennis instructor. Unfortunately, she has totally stopped playing due to significant neck and shoulder pain. She has suffered for many years and tried many treatment options including physical therapy, corticosteroid injections, acupuncture and chiropractic care to address her pain. About 3.5 years ago she was diagnosed with Degenerative Disc Disease with bulging Cervical Discs C5-C6. She has been unable to perform her job which was very rewarding to her. She has suffered from depression and was referred to her pain clinic where they prescribe her medication for her chronic pain. She takes Percodan (oxycodone/aspirin) daily for her pain. When asked about her medication, she feels very defensive and fears being judged. She wants people to know, "she is not an addict" and will use those words when any provider begins to questions her. Once provided accurate information in a non-judgmental manner, she is willing to discuss pain management strategies for reducing opioid needs in pregnancy, open to receiving appropriate consults/referrals (ie. Neonatology, Maternal-Fetal Medicine) and is interested in learning more about breastfeeding and non-pharm care for opioid exposed newborns. She is willing to discuss Narcan as a medication to have on hand as a risk reduction strategy for someone who takes opioids regularly.

Case Study 3-Sasha's triage visit Scenario logistics and progression

Expected Interventions:

- Initial problem identification
- OB provider notified of screen positive result
- OB providers engages in brief intervention using non-judgmental, empathetic language about opioid use risks for mom and pregnancy and risk of neonatal opioid withdrawal / NAS.
- Patient provided additional education materials about NAS and offered neonatology consult.

Likely Progression:

- Patient reviews past medical history
- Patient education about opioid use and risks of opioid use in pregnancy
- Initiate the OUD Clinical Care Checklist with applicable elements for chronic pain
- Order appropriate labs (including HepC, tox screen with consent)
- Provide Narcan counseling as a risk reduction strategy for patients who use opioids regularly
- Obtain appropriate consults (consider neonatology, Maternal Fetal Medicine, anesthesia, social work)

Expected Endpoint:

- Create an action plan
- Schedule a short term interval follow-up visit
- Made appropriate referrals and provide a warm-handoff

Case Study 3-Sasha's triage visit Facilitator scenario interventions

Patient hands completed <Insert screening tool here> to provider.

1. What important patient responses are noted on the screening tool?
2. What do you want to do?
3. How do you raise subject with the patient?
4. What additional history do you want to obtain?

Patient provides additional medical history of chronic neck pain and shoulder pain. She is taken back by the questions and questions why she is being asked them stating, "I am not an addict!"

5. How do you provide feedback on the patient's responses?
6. What are medical recommendations for opioid use (alcohol, tobacco, opioids) during pregnancy?
7. How can opioid use affect overdose risks for mom during pregnancy and the postpartum period, effects on pregnancy, and risk of neonatal opioid withdrawal / NAS?
8. What information do you need to provide about benefits of maternal engagement in non-pharmacologic care of opioid exposed newborn (breastfeeding, rooming in and Eat-Sleep-Console) including neonates: reduced need for medication use, shorter post-delivery hospital stay and the neonate?
9. Should she be referred to any specialists?

Patient voices understanding in why it is important for her to be given this education. She expresses interest in non-pharmacologic pain management strategies, is willing to discuss Narcan as a risk reduction strategy for patients who use opioids regularly and desires a peds/neo consult to discuss NAS and the maternal/family role in non-pharmacologic care of the opioid exposed newborn.

10. Review breastfeeding opioid use recommendations.
11. What elements of the OUD Clinical Care Checklist are important to complete outside of the peds/neo consult?
12. How do you discuss Narcan as a risk reduction strategy with someone who regularly uses opioids, but does not consider themselves to have an opioid use disorder?
13. When should the patient follow up with her OB?

For patients who take Opioids for chronic pain, be sure to perform the following elements on the OUD Clinical Care Checklist:

- Recommended lab tests: including Hep C screen and serial urine toxicity screens with patient permission
- Provide Narcan counseling as a lifesaving strategy for all women taking opioids regularly
- 3rd trimester serial Ultrasound for fluid / growth
- Risks of OUD and NAS education
- Neonatology consult to discuss NAS risk/management
- Consider MFM, anesthesia consult depending on situation
- Consider addiction medicine / social work consult to discuss risks of OUD and if patient would benefit from MAT depending on the situation.
- Contraceptive Counseling

Case Study 4-Abby's triage visit General scenario information

Case read to everyone:

Abby is a 24-year-old G1P0 at 30 weeks presenting to triage with leakage of fluid. She is ruled out for spontaneous rupture of membranes and is going to be discharged home. She has received appropriate prenatal care with a private attending at your hospital. Please interview the patient using the <insert institutions selected screening tool> and provide a brief intervention if appropriate.

Challenges:

- Using unbiased language to discuss substance use disorder and risk
- Provide correct information about substance use risks including: risks to patient, effects on pregnancy, and risk of neonatal exposure to substances
- Provide correct information about substance use effects on fetus, neonate

Instructions for the "mom": Your character works part-time at a retail store. Prior to pregnancy, she occasionally drank alcohol and recreationally used marijuana. She drank 1-2 times per week and reports that a few times per year, she would have more than 5 drinks at a time. She would only smoke marijuana on the weekends with her partner at social events. She stopped drinking alcohol and smoking marijuana when she found out she was pregnant. She is not planning to drink alcohol or smoke marijuana during this pregnancy, but her partner still drinks alcohol and smokes marijuana regularly. Her mother is an alcoholic, who is undergoing treatment with Alcoholics Anonymous.

Case Study 4-Abby's triage visit Scenario logistics and progression

Expected Interventions:

- Initial problem identification
- Brief interview about substance use disorder of marijuana and alcohol prior to pregnancy

Likely Progression:

- Patient reviews family history of alcoholism
- Patient education about substance use disorder and risks of substance use in pregnancy
- Make appropriate referrals and provide a warm-handoff

Expected Endpoint:

- Create an action plan
- Schedule a short term interval follow-up visit

Case Study 4-Abby's triage visit Facilitator scenario intervention

Patient hands completed <Insert screening tool here> to provider.

1. What important patient responses are noted on the screening tool?
2. What do you want to do?
3. How do you raise subject with the patient?
4. What additional history do you want to obtain?

Patient provides additional family history of mother with alcoholism. She has not used any alcohol this pregnancy, but she wonders if having a glass of wine during pregnancy is okay. She reports she has stopped using marijuana. She mentions that her partner is still drinking alcohol and smoking marijuana.

5. How do you provide feedback on the patient's responses?
6. What are medical recommendations for substance use (alcohol, tobacco, opioids) during pregnancy?
7. How can substance use affect the patient, her pregnancy, and the neonate?

Patient voices understanding that alcohol is not safe in pregnancy. She expresses commitment to not drink alcohol during pregnancy. She asks if alcohol or marijuana use is okay with breastfeeding.

8. Review breastfeeding, marijuana and alcohol use recommendations.
9. When should the patient follow up with her OB?

There is increasing concern about the use of marijuana or other similar products in pregnancy and in breastfeeding mothers. Data continues to suggest that cannabis may produce long-term sequelae, such as reduced cognition and changes in mood and reward. Both human cohort studies and studies in animals clearly suggest that early exposure to cannabis is not benign and that cannabis exposure in the perinatal period may produce long-term changes in behavior and mental health.

SBIRT simulation participant checkpoints

Debriefing Points	1	2	3	4
Screen patient with a validated screening tool for risk of SUD/OD				
Recognition of patient with SUD/OD risks, recognition of patients with opioid use disorder with assessment of severity (can use DSM-5 criteria) as applicable				
Open-ended questions				
Brief intervention, including motivational interviewing				
Patient education about risks of opioid use including maternal overdose risks, adverse pregnancy outcomes and NAS				
Patient education about benefits of treatment (MAT and Recovery Treatment Programs) including: reduction in overdose risk, improved pregnancy outcomes and reduced need for DCFS intervention/increased chance to parent (as applicable)				
Patient education about benefits of engaging in non-pharm care of opioid exposed newborn (breastfeeding, rooming in, Eat-Sleep-Console) including neonates reduced need for pharm treatment and shorter hospital stay (as applicable)				
Non-biased, empathetic language				
Initiation of SBIRT/OD Clinical Treatment Algorithm and OUD Protocol to link women to care				
Utilization of OUD Clinical Care Checklist (key care elements such as Narcan Counseling for overdose risk reduction, Hep C screen)				
Assessed patient readiness for treatment				
Acute opioid withdrawal recognition and management as applicable				
Inpatient management plan, understands important option of admission for fast track MAT /MAT start during delivery admission vs link to outpatient MAT as applicable				
Linkage to Behavioral Health / Recovery Treatment program, prenatal or post hospital discharge with close follow up				
Awareness of risks of overdose for mom in the postpartum period and appropriate follow up scheduled prior to delivery discharge				
Knowledge of where to seek additional help (IL Doc Assist number for free addiction medicine perinatal phone consult to assist with MAT start or management; IL OUD Hotline for linkage to OUD treatment programs)				
Close OB and/or behavioral health follow-ups				

Scenario 1 & 2

Simulation participant assessment

- Recognized current and past opioid use on screening tool
- Raised subject of opioid use with patient
- Used open-end questions to obtain more information
- Asked patient method of administration of opioids
- Identified patient's reasons for wanting to use opioids
- Identified patient's reasons for wanting to stop using opioids
- Assessed patient's goals for pregnancy and readiness for change

- Provided feedback about patient responses
- Used non-biased and non-judgmental language
- Discussed medical recommendation for substance use
- Discussed benefits of treatment
- Provided patient education handouts
- Discussed risk of opioids for maternal overdose, pregnancy risks and risks to neonate.
- Activated the OUD protocol
- Utilized the SBIRT/OUD Clinical Treatment Algorithm
- Initiated the OUD Clinical Care checklist
- Ordered appropriate labs
- Ordered appropriate referrals for patient (MFM, neonatology, social work, Psych/Addiction Medicine)
- Provided Narcan counseling as an overdose risk reduction strategy

- Assessed patient readiness for treatment and reviewed options for medical treatment of OUD
- Assessed for acute signs of withdrawal
- Recommended inpatient management for management of acute opioid withdrawal, fast track MAT induction and provided warm hand off if outpatient management appropriate.
- Addressed patient questions about buprenorphine and methadone
- Provided correct information about maternal engagement in non-pharmacologic
- Explained rationale for immediate inpatient management of acute opioid withdrawal to patient
- Reviewed anticipated next steps for patient on OUD clinical care checklist
- Developed discharge plan to Recovery Treatment Program (inpatient/ intensive outpatient or other program)
- Scheduled close OB follow up and behavioral health follow up prior to hospital discharge.
- Knowledge of where to seek additional help (IL Doc Assist number for free addiction medicine perinatal phone consult to assist with MAT start or management; IL OUD Hotline for linkage to OUD treatment programs)

Scenario 3 & 4

Simulation participant assessment

- Recognized current or past substance use on a validated screening tool
- Recognized family history of substance use on a validated screening tool (scenario #4 only)
- Raised subject of substance use with patient (opioids, alcohol and/or marijuana)
- Used open-end questions to obtain more information about substance use
- Questioned about patient's reasons for wanting to use substances
- Questions about patient's desire to increase non-pharmacologic intervention to treat chronic pain (scenario #3 only)
- Questioned about patient's reasons for deciding not to use alcohol and marijuana in this pregnancy (scenario #4 only)

- Provided feedback about patient responses
- Used non-biased and non-judgmental language
- Discussed medical recommendation for substance use in pregnancy
- Provided positive reinforcement for patient's decision
- Provided patient education handouts
- Discussed effects of alcohol and marijuana use on pregnancy, in addition to exposure to second-hand smoke
- Ordered appropriate referrals for patient and provided a warm hand off

- Addressed patient questions
- Created action plan
- Scheduled concrete time to follow up with primary OB
- Informed patient that you would talk to primary OB about this conversation



Appendix

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are confidential.
- A *single "YES"* to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
 No Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
 No Yes
3. Does your *Partner* have a problem with alcohol or drug use?
 No Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
 No Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
 No Yes

Staff Signature: _____ Date: 6/1/2019

Interpreter Used: No Yes Interpreter Name: _____

Case #1- Krystal
NIDA Quick Screen V1.0¹

Patient Name: Krystal

Sex: F () M

Age 31

Interviewer: A. Smith

Date: 6 / 1 / 19

STEP 1 – Ask the NIDA Quick Screen Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For *each* substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

Introduction (Please read to patient)

Hi, I’m _____, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

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

- If the patient says “**NO**” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If patient says “**Yes**” to **one or more days of heavy drinking**, note that *patient is an at-risk drinker*. Please see NIAAA website “How to Help Patients Who Drink Too Much: A Clinical Approach” http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to advise, assess, assist, and arrange help for at risk drinkers or patients with alcohol use disorders.
- If patient says “**Yes**” to **use of tobacco**: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see “Helping Smokers Quit: A Guide for Clinicians” <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/>
- If the patient says “**Yes**” to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are *confidential*.
- A *single "YES"* to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
 No Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
 No Yes
3. Does your *Partner* have a problem with alcohol or drug use?
 No Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
 No Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
 No Yes

Staff Signature: _____ Date: 6/1/2019

Interpreter Used: No Yes Interpreter Name: _____

Case #2- Jenny
 NIDA Quick Screen V1.0¹

Patient Name: Jenny

Sex: F () M

Age 28

Interviewer: A. Smith

Date: 6 / 1 / 19

STEP 1 – Ask the NIDA Quick Screen Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For *each* substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

Introduction (Please read to patient)

Hi, I’m _____, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

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

- If the patient says “**NO**” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If patient says “**Yes**” to **one or more days of heavy drinking**, note that *patient is an at-risk drinker*. Please see NIAAA website “How to Help Patients Who Drink Too Much: A Clinical Approach” http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to advise, assess, assist, and arrange help for at risk drinkers or patients with alcohol use disorders.
- If patient says “**Yes**” to **use of tobacco**: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see “Helping Smokers Quit: A Guide for Clinicians” <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/>
- If the patient says “**Yes**” to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are confidential.
- A single "YES" to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?

No Yes

2. Do any of your friends (*Peers*) have problems with alcohol or drug use?

No Yes

3. Does your *Partner* have a problem with alcohol or drug use?

No Yes

4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)

No Yes

5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)

No Yes

Staff Signature: _____

Date: 6/1/2019

Interpreter Used: No Yes

Interpreter Name: _____

Case #3- Sasha
NIDA Quick Screen V1.0¹

Patient Name: Sasha

Sex: F () M

Age 39

Interviewer: A. Smith

Date: 6 / 1 / 19

STEP 1 – Ask the NIDA Quick Screen Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For *each* substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

Introduction (Please read to patient)

Hi, I’m _____, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

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

- If the patient says “**NO**” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If patient says “**Yes**” to **one or more days of heavy drinking**, note that *patient is an at-risk drinker*. Please see NIAAA website “How to Help Patients Who Drink Too Much: A Clinical Approach” http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to advise, assess, assist, and arrange help for at risk drinkers or patients with alcohol use disorders.
- If patient says “**Yes**” to **use of tobacco**: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see “Helping Smokers Quit: A Guide for Clinicians” <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/>
- If the patient says “**Yes**” to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

The 5Ps Prenatal Substance Abuse Screen For Alcohol and Drugs

The 5Ps* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women's *parents, peers, partner*, during her *pregnancy* and in her *past*. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are *confidential*.
- A *single "YES"* to any of these questions indicates further assessment is needed.

1. Did any of your *Parents* have problems with alcohol or drug use?
 No Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
 No Yes
3. Does your *Partner* have a problem with alcohol or drug use?
 No Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
 No Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
 No Yes

Staff Signature: _____ Date: 6/1/2019

Interpreter Used: No Yes Interpreter Name: _____

Case #4- Abby
 NIDA Quick Screen V1.0¹

Patient Name: Abby

Sex: F () M

Age 24

Interviewer: A. Smith

Date: 6 / 1 / 19

STEP 1 – Ask the NIDA Quick Screen Question

Instructions: Using the sample language below, introduce yourself to your patient, then ask about **past year** drug use, using the NIDA *Quick Screen*. For *each* substance, **mark in the appropriate column**. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

Introduction (Please read to patient)

Hi, I’m _____, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

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

- If the patient says “**NO**” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If patient says “**Yes**” to **one or more days of heavy drinking**, note that *patient is an at-risk drinker*. Please see NIAAA website “How to Help Patients Who Drink Too Much: A Clinical Approach” http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to advise, assess, assist, and arrange help for at risk drinkers or patients with alcohol use disorders.
- If patient says “**Yes**” to **use of tobacco**: Any current tobacco use places a patient at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see “Helping Smokers Quit: A Guide for Clinicians” <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/>
- If the patient says “**Yes**” to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.



Prescription Pain Medicine, Opioids, and Pregnancy: What All Pregnant Women Need to Know

What are opioids?

Opioids are a class of drugs that includes prescription pain relievers such as oxycodone and hydrocodone, the illegal drug heroin, and dangerous synthetic opioids such as fentanyl, carfentanil, and other analogues. Opioids work in the brain to reduce pain and can also produce feelings of relaxation and euphoria.

Prescribed opioids include:

- Buprenorphine (Belbuca, Butrans, Subutex, Suboxone)
- Codeine
- Fentanyl (Actiq, Duragesic, Sublimaze)
- Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Methadone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Duramorph, Roxanol)
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone (Opana)
- Tramadol (ConZip, Ryzolt, Ultram)



Your doctor may prescribe an opioid for you if you've had surgery, dental work, an injury, or after you deliver your baby. Prescription opioids are important pain medications that can provide relief for acute or chronic pain. Unfortunately, they can also be prescribed inappropriately and misused. Misuse or chronic use of prescription opioids increases the risk of developing opioid use disorder (OUD) and may lead to overdose. If you take opioids during pregnancy they can also cause serious problems for your baby.

What is opioid use disorder?

Opioids can be dangerous and addictive. Symptoms of opioid use disorder include developing a need for higher doses in order to feel the same effect; using more than the amount of the drug that is prescribed; taking non-prescribed opioids such as heroin; having work, school, or family problems caused by your opioid use; feeling a strong urge or desire ("craving") to use the drug; and experiencing painful withdrawal symptoms if you abruptly stop taking opioids. Taking higher doses of opioids or using opioids for extended periods of time increases the risk of developing OUD.

What are health risks of using opioids?

Opioids can be deadly. One of the biggest risks is overdose. Higher doses, not taking opioids as prescribed, or mixing opioids with some other medications or drugs can cause people to pass out, stop breathing, and die. Nationally, the number of deaths involving opioids, has quadrupled since 1999, and drug overdoses are now the **leading cause of death in the United States for people under the age of 50**. Among Illinois women of childbearing age, the number of opioid-related deaths nearly tripled between 2008 and 2017. **Naloxone** (brand name Narcan) is a drug that stops the effects of opioids, and it can save your life if you overdose. It comes in the form of a nasal spray. Ask your doctor about naloxone. You should always have a supply of naloxone with you if you have an opioid use disorder, or if you have friends or relatives with this disorder.

Are opioids safe for my baby?

If you take opioids during pregnancy, your baby can be exposed to them in the womb and have symptoms of withdrawal after birth. In newborns, this is called neonatal abstinence syndrome or NAS. Even if you use an opioid exactly like your provider says to, it still may cause NAS in your baby. The symptoms of NAS can range from mild to severe, and may include excessive crying, poor feeding or sucking, fever, vomiting and diarrhea, tremors and irritability, and/or low birthweight. In Illinois, the rate of NAS in newborns increased more than 50% in the 5 years between 2011 and 2016.

NAS usually lasts days or weeks. If a baby is showing signs of withdrawal, loving and caring may be some of the best medicine. The combination of swaddling, cuddling, breastfeeding, skin-to-skin contact, and in some cases, medicine can help your baby. A pediatrician will check in on your baby after birth in the hospital and decide if medication is needed and how long your baby will need to stay in the hospital. On average, babies in Illinois with NAS stay in the hospital five times longer after delivery than babies without NAS.

What is the best way to treat opioid use disorder during pregnancy?

Medication-assisted treatment (MAT) is the best course of action during pregnancy and after the baby is born. These medications, called methadone and buprenorphine, are long-acting opioids that, in the right doses, stop withdrawal, reduce cravings, and block effects of other opioids. Receiving treatment with MAT makes it more likely the baby will grow normally and have fewer NAS symptoms after birth. In addition to medication, treatment involves counseling, social support, and prenatal care, to help women have a healthier pregnancy and start on the road to recovery.

What about breastfeeding?

Women without HIV who are already taking opioid pain medications regularly as prescribed (and not using illicit drugs) are generally encouraged to breastfeed. Be sure to ask your health care provider about breastfeeding when taking any medications. During breastfeeding, avoid opioids, like codeine, whenever possible, or ask your doctor for the lowest possible dose because of the possible risks to your baby.

If you're pregnant and taking opioids

- Don't start or stop taking any opioid until you talk to your health care provider
- Talk to your prenatal care provider about all opioids, pain medicines, or other medicines you take, even if they're prescribed by another health care provider
- Make sure every health provider you see knows you are pregnant before they prescribe any medication, particularly prescriptions for any opioid
- Ask your provider about other kinds of pain medications you can take instead of opioids or alternative non-medication strategies for pain control

If you are no longer pregnant and you're using opioids

- Use effective birth control until you've stopped taking the opioid or have discussed plans for a healthy pregnancy with your doctor
- Talk to your provider about taking a safer pain medicine or an alternative non-medication strategy for pain control

Resources

Illinois Helpline for Opioids and Other Substances:
1-833-2FINDHELP



ILLINOIS HELPLINE
for Opioids & Other Substances
833-2FINDHELP



Brief Interview & Referral for Opioid Use Disorder Script

<p>Raise subject</p>	<ul style="list-style-type: none"> • Thank you for answering my questions. From what I understand from your screening, you are using XX - is it OK if we talk more about XX and pregnancy? • Help me understand, through your eyes, what connection (if any) do you see between your use of XX and this pregnancy? • People use drugs for many reasons: what do you like most/least about using X?
<p>Provide Feedback (including patient education handouts)</p>	<ul style="list-style-type: none"> • Sometimes patient's who give similar answers are continuing to use drugs and alcohol during their pregnancies. • I have some information on risks substance use in pregnancy. Would you mind if I shared them with you? Share education handouts. • Because of those risks, I recommend avoiding drugs and alcohol use during pregnancy. For women using opioids regularly, medication assisted therapy, such as Methadone or Buprenorphine, is recommended during pregnancy and after to improve outcomes for both mom and baby.
<p>Investigate Readiness (Use readiness ruler)</p>	<ul style="list-style-type: none"> • What are your thoughts about the information I just shared? • Do you have any concerns? • On a scale of 1-10, how ready are you to make any kind of changes in your use of XX? You marked ____ . That's great. • Why did you choose ____ and not a lower number like a 1 or 2?
<p>Create Action Plan (Provide a warm handoff)</p> <p><small>Adapted from: Wright, SBIRT in pregnancy, AM J Obstet Gynecol., 2016 and Northern New England Perinatal Quality Improvement Network</small></p>	<ul style="list-style-type: none"> • What are some steps you could take to reduce the things you don't like about using that you shared with me earlier like ____ ? Restate answers the patient shared earlier. • What steps can you take to reach your goal of having a healthy pregnancy and healthy baby? • Those are good ideas! Is it OK for me to write down the steps/plan you just shared with me? • I have additional resources and people that patients often find helpful for achieving these goals? Discuss options, schedule consults, identify navigator and make referrals to MAT/ BH counseling/recovery services. • Thank you for talking with me. Can we schedule a date to check in again?

READINESS RULER

How ready are you to make a change?

NOT READY

VERY READY

1	2	3	4	5	6	7	8	9	10



Illinois Referral Helpline
Opioids & other substances:
 1-833-2FINDHELP
 Helpline.IL.org

Documenting and Billing

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for screen positive

Documentation should include time spent counseling along with details of the interaction including:

1. Face-to-face interaction with the patient
2. Assessed readiness for change
3. Advised the patient about risks
4. Recommended MAT treatment / Behavioral health counseling/ recovery services for the patient
5. Referrals made to link patient to care

Example language

"I met with _____ to discuss her positive (ie. 5P's/NIDA) screening. We discussed the risks of alcohol and drug use during pregnancy, and explored options for supporting abstinence from alcohol and illicit drugs. We reviewed patient information describing hospital policies on prenatal substance use and reporting requirements. We discussed that OUD is a chronic disease with treatment available. We discussed benefits of MAT including improved pregnancy outcomes and maternal risk reduction. Referral to MAT, behavioral health counseling/recovery services, behavioral health and social work follow up was offered. She accepted/declined _____. Education materials on OUD/NAS were provided with referral for prenatal pediatric consult on NAS. OUD clinical care check list was included in patient chart. Time spent in counseling was (<=30 / >30 min) minutes."

Insert Clinical Care Checklist & obtain recommended lab testing:

- HIV HCV antibody Hepatitis B

Billing Codes:

G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. audit, DAST), and brief intervention; 15 to 30min

G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. audit, DAST), and brief intervention; greater than 30min

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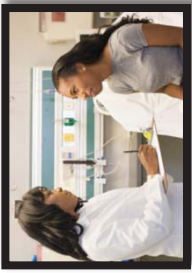
Help is here
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ILLINOIS HELPLINE
for Opioids & Other Substances

MNO-OB OUD Protocol



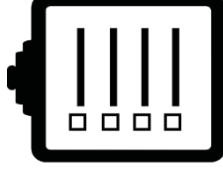
Screen and document positive result



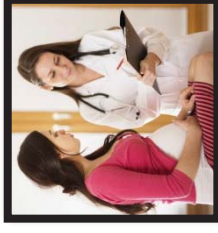
Provide SBIRT risk assessment and brief counseling re: benefits of treatment, next steps for linking patient to care



Activate care coordination and navigation to link woman to MAT, and behavioral health counseling/recovery programs



Insert and complete OUD clinical care checklist in electronic medical record (or paper chart) (prenatal / L&D)



Provide patient education re: OUD and NAS, and engaging in newborn care via neonatology consult, counseling, hand-outs.

Activating the OUD protocol for every screen positive woman, every time:

ILPQC OUD Clinical Care Checklist

IL Doc Assist for free Perinatal
 OUD Addiction Med Consult:
 1-866-986-ASST (2778)

Checklist Element	Date	Comments
Antepartum Care		
Counsel on MAT, assess readiness for treatment, warm handoff for MAT start		
Counsel and link to behavioral health counseling /recovery treatment services		
Social work consult or navigator who will link patient to care and follow up		
Obtain recommended lab testing-		
<ul style="list-style-type: none"> • HIV / Hep B / Hep C (if positive viral load & genotype) • Serum Creatinine/ Hepatic Function Panel 		
Institutional drug testing policies and plan for testing reviewed		
Urine toxicology testing for confirmation and follow up (consent required)		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Neonatology/Pediatric consult provided, discuss NAS, engaging mom in non-pharmacologic care of opioid exposed newborn, and plan of safe care.		
DCFS Reporting system reviewed, discuss safe discharge plan for mom/baby		
Screen for alcohol/tobacco/non-prescribed drugs and provide cessation counseling		
Screen for co-morbidities (ie: mental health & domestic violence)		
Consent for obstetric team to communicate with MAT treatment providers		
Consider anesthesia consult to discuss pain control, L&D and postpartum		
Third Trimester		
Repeat recommended labs (HIV/HbsAg/Gc/CT/RPR)		
Ultrasound (Fluid/Growth)		
Urine toxicology with confirmation (consent required), and review policy		
Review safe discharge care plan and DCFS process		
Patient Education: OUD/NAS, participating in non-pharmacologic care of the opioid exposed newborn, including breastfeeding, and rooming in.		
Comprehensive contraceptive counseling provided and documented		
During Delivery Admission		
Social work consult, peds/neonatology consult , (consider) anesthesia consult		
Verify appointments for support services (MAT/Recovery Treatment Programs)		
Confirm Hep C , HIV, Hep B screening completed		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Provide patient education & support for non-pharmacologic care of newborn		
Review plan of safe care including discharge plans for mom/infant		
Schedule early postpartum follow-up visit (within 2 weeks pp)		
Provide contraception or confirm contraception plan		

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BOLD Text = elements tracked with monthly data collection for all women with OUD. Also track completion of checklist for all women with OUD. v:10/10/19

OUD SBIRT/Clinical Algorithm



Provide Universal SUD/OUD screening with validated tool

Screen positive SUD/OUD

OB provider to see patient, provide brief intervention to assess diagnosis, counsel risks, assess readiness for treatment (SBIRT Counseling)

+ Risk factors:
provide brief intervention discuss risk reduction

Withdrawal symptoms &/or ready to start MAT

Admit to hospital for Fast-Track MAT start

Stabilize MAT and discharge to Recovery Treatment Program

Unclear if MAT indicated, Not ready to start MAT or Outpatient MAT available

Initiate outpatient stabilization with Social Work support

Warm Handoff to Behavioral Health/ Recovery Treatment Program

Inpatient Treatment Program
Intensive Outpatient Treatment
Behavioral Health Treatment Support
Peer Support Program

Start OUD Clinical Care Checklist

- Hep C screen
- Narcain Counseling
- Serial Tox screen w/ consent
- Neo/Peds consult
- Social Work Consult
- Anesthesia consult
- MFM consult
- Contraception counseling

Provide standardized patient education: OUD/NAS, mom's important role in care of opioid exposed newborn (breastfeeding, rooming in, eat-sleep-console)

Document OUD in problem list : 099.320

Bill for SBIRT:
< 30 min G0396
≥ 30 min G0397

Close OB follow up every 1-2 weeks (pregnancy and postpartum)

IL OUD Hotline
MAT/Recovery Treatment Locations:
1-833-2-FINDHELP
IL Doc Assist for free Perinatal OUD
Addiction Med Consult:
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