

Care for Pregnant and Postpartum People with Substance Use Disorder Change Package

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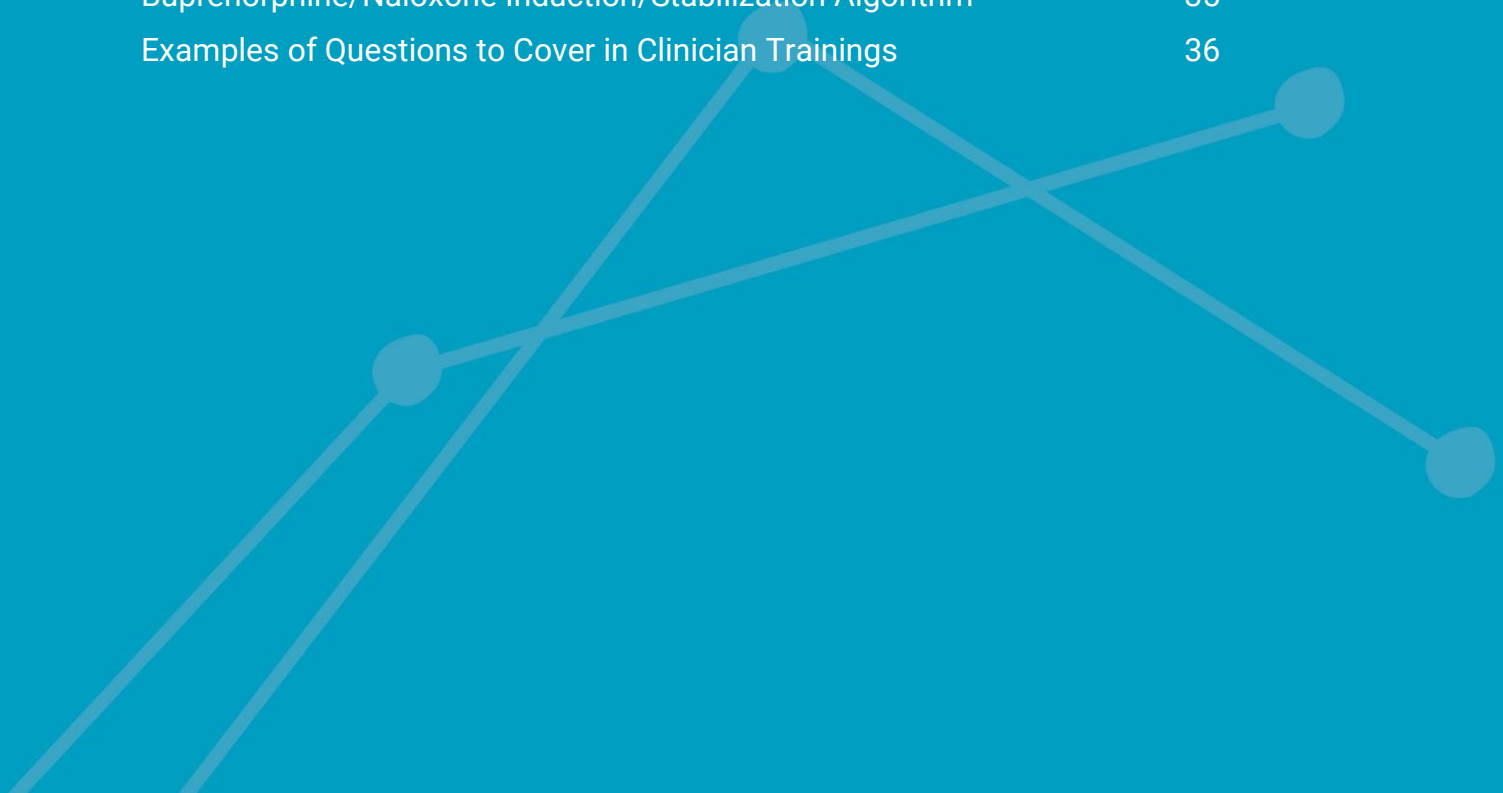
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Introduction

The Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement (QI) initiative. AIM works through state and community-based teams to align national, state, and hospital-level QI efforts to reduce preventable maternal mortality and severe morbidity across the United States.

The AIM Patient Safety Bundles are a core part of this work. To promote the successful implementation of these bundles, AIM partnered with the Institute for Healthcare Improvement (IHI) to create a series of associated change packages. This specific change package is designed to support Perinatal Quality Collaboratives (PQCs) and other state-based initiatives to leverage the [AIM Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle](#) (CPPPSUD Bundle) more effectively.¹

Why is this important?

Substance use disorders (SUDs) during the perinatal period, more than any other chronic medical condition, are highly stigmatized and often associated with severe legal and personal consequences for pregnant people. Even though substance use is common across class, gender, and race/ethnicity, regulation of substance use during pregnancy is disproportionately used as an instrument of structural violence against birthing people of color and those who are low income.²

In the context of the ongoing struggle for reproductive autonomy, it critical that the care of pregnant and parenting people with substance use conditions is guided by principles of reproductive justice, defined as “The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”³ The CPPPSUD Bundle represents an effort to describe essential elements of respectful care and to provide high-level implementation guidance.

Improving care for birthing people with substance use disorders involves change across care settings and disciplines. This change package was created to provide some of the many resources available for teams implementing the AIM Care for Pregnant and Postpartum People with SUD Patient Safety Bundle and aims to destigmatize substance use disorder and lay the foundation for respectful, equitable, and supportive care for all.

What is a change package?

A change package is a document listing evidence-based or best-practice changes specific to a topic and is usually organized around a framework or model. In this case, the Care for Pregnant and Postpartum People with Substance Use Disorder Change Package is structured around the CPPPSUD Bundle.

Changes packages, including this one, are structured around the following components:

- **Primary Drivers:** Major processes, operating rules, or structures that will contribute to moving toward the aim. In this change package, the primary drivers are based on AIM's Five Rs Framework (Readiness, Recognition & Prevention, Response, Reporting/Systems Learning, and Respectful Care).
- **Change Concepts:** Broad concepts (e.g., "move steps in the process closer together") that are not yet specific enough to be actionable but that will be used to generate specific ideas for change.
- **Change Ideas:** Actionable, specific idea for changing a process. Change ideas can come from research, best practices, or from other organizations that have recognized a problem and have demonstrated improvement on a specific issue related to that problem.

Taken as a whole, a change package has the potential to seem overwhelming. Based on the priorities of your state and community, we encourage you to start small by testing a couple of ideas connected to the aim you set. Through iterative tests of change (also known as Plan-Do-Study-Act (PDSA) cycles), you will have an opportunity to learn what works and what does not in your efforts to improve your processes. Initially, these cycles are carried out on a small scale (e.g., one patient on one day) to see if they result in improvement. Teams can then expand the tests and gradually incorporate larger and larger samples until they are confident that the changes will result in sustained improvement.

How to prioritize changes?

No team is expected to test all the listed change ideas. Consider this a menu of options from which you may choose what to tackle first. Each team will review their baseline data, progress to date, organizational priorities, and select an area(s) to prioritize. For example, some may start with one driver. Others may start by tackling one idea across all drivers. Start by choosing an area that you think could lead to an easy win.

You can also leverage the following tools to help you decide where to start:

1. [Pareto chart](#): A type of bar chart in which the various factors that contribute to an overall effect are arranged in order according to the magnitude of their effect. This ordering helps identify the "vital few" — the factors that warrant the most attention.⁴
2. [Priority matrix](#): A tool that can better help you to understand important relationships between two groupings (e.g., steps in a process and departments that conduct that step) and make decisions on where to focus.⁵
3. [Impact-effort matrix](#): A tool that helps identify which ideas seem easiest to achieve (least effort) with the most effects (highest impact). The ideas identified via this tool would be a great place to start.⁶

Change Package

A Note on Symbols

Respectful, Equitable, and Supportive Care

In addition to having an independent section in this change package dedicated to the CPPPSUD Bundle's fifth R (Respectful, Equitable, and Supportive Care), all change ideas in other primary drivers that fall under this R are marked with a ♦ symbol.

Additional Considerations

It is understood that every team utilizing this change package will be at a different point in this work. If your organization is further along in your obstetrical SUD improvement work and has found reliability in some of the change ideas below, we suggest testing the additional considerations that are in *italics* and marked by the * symbol.

Readiness

Change Concept	Change Idea	Key Resources and Tools
Provide education to pregnant and postpartum people related to substance use disorder (SUD), naloxone use, harm reduction strategies, and care of infants with in-utero substance exposure	Develop education materials for pregnant and postpartum people that are culturally relevant and translated into most common languages spoken by population served ♦ <i>Have folders pre-filled with culturally appropriate education materials and referral resources</i> * ♦	Substance Abuse and Mental Health Services Administration (SAMHSA): Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants ⁷ Academy of Perinatal Harm Reduction (APHR): Free Resources ⁸ The Center on Parenting and Opioids: Substance Use and Recovery in Pregnancy and Early Parenting ⁹ Example Instructions Before Getting Started on Buprenorphine (included in Appendix B)
	Create educational videos, to play in waiting rooms, that describe a spectrum of options (treatment, harm reduction) and how to access them <i>Use subtitles/closed captioning for all video content</i> * ♦	
	If available, engage community health workers in providing educational information and treatment options	Behavioral Health Leadership Institute: Community Health Worker Toolkit (pg. 44-45) ¹⁰
	Reliably use interpreter services at all points of care ♦ <i>Check in with patients regularly to see if their preferences have changed (e.g., someone who preferred English in prenatal care may need an interpreter in a crisis)</i> * ♦	US Department of Health & Human Services (HSS): National Culturally and Linguistically Appropriate Services (CLAS) Standards ¹¹ HSS: CLAS in Maternal Health Care ¹²

		Manchester Community Health Center: Culturally Effective Care Center of Excellence Toolkit ¹³
	Develop standard communication materials and processes for speaking with patients about exactly what to expect if they lose custody of their babies. Include steps needed to initiate a reunification process if patient wants to pursue. ♦ <i>These processes and the aggressiveness with which they are pursued may vary by state, district office, and even individual case worker due to interpersonal as well as structural racism or other forms of bias* ♦</i>	Dartmouth Health: Frequently Asked Questions About Substance Use in Pregnancy¹⁴ San Francisco BIPOC Family Justice Summit Report¹⁵
Develop trauma-informed protocols and anti-racist training to address health care team member biases and stigma related to SUDs	Engage context experts (also known as people with lived experience) in developing institutional policies and protocols ♦	IHI: Experience-Based Co-Design of Health Care Services¹⁶ Journal of Public Health Management and Practice: Using Human-Centered Design for More Inclusive Maternal Health¹⁷
	Develop labor and deliver (L&D) protocol for on-demand start of medications for opioid use disorder	SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants⁷ Buprenorphine/Naloxone Initiation in Pregnancy: Example Policy and Procedure (included in Appendix B) Buprenorphine/Naloxone Induction/Stabilization Algorithm (included in Appendix B)
	Incorporate medications for opioid use disorder (MOUD) into training for all clinicians	The American College of Obstetricians and Gynecologists (ACOG): Caring for Pregnant and Breastfeeding Women with Opioid Use Disorder ¹⁸

		Providers Clinical Support System (PCSS): MOUD Waiver Training Courses ¹⁹
	Develop clear and consistent hospital policies about drug testing and screening for pregnant people that are grounded in informed consent and emphasize testing for clinical indications only	SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants (pg. 18) ⁷ National Advocates for Pregnant Women (NAPW): Confronting Pregnancy Criminalization (pg. 40) ²
	Train clinicians to have transparent, honest, trauma-informed discussions ♦ <i>Use simulations or role-play strategies to help providers become more comfortable having conversations about SUD *</i>	ACOG Committee Opinion 825: Caring for Patients Who Have Experienced Trauma ²⁰ SAMHSA's National Center for Trauma-Informed Care ²¹
	Train clinicians in the actual requirements for reporting SUD and correct misconceptions to prevent unnecessary reporting <i>Include information about the rollout of events after a report is filed*</i> <i>The specific rules and requirements vary by context (state, district, case). Develop a standard approach to collecting and reporting data within your institution. *</i> <i>Each institution should examine its own reporting practice: * ♦</i> 4. <i>Who is reported and for what reasons? Disaggregate data by race, ethnicity, payor.</i> 5. <i>Are some providers reporting more than others? Why?</i>	Examples of questions to cover in clinician trainings (included in Appendix B)
	Identify alternatives to calling child welfare that are supportive to families ♦	San Francisco BIPOC Family Justice Summit Report ¹⁵

	Design systems that support the full range of patients, including those who do not want to parent	SAMHSA: A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders ²²
	Educate all clinicians that optimal, trauma-informed SUD and mental health care is lifesaving to birthing people and their babies ♦ <i>Involve students/residents in trainings early and often*</i>	SAMHSA's National Center for Trauma-Informed Care ²¹ SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach ²³ National Harm Reduction Coalition: Pregnancy and Substance Use: A Harm Reduction Toolkit ²⁴
	Use huddles at key points of care to review care plans to confirm that all people with SUD are receiving optimal care. If they are not, use huddle to plan to improve care.	IHI: Huddle Tools ²⁵
Provide clinical and non-clinical staff education on optimal care for pregnant and postpartum people with SUD, including federal, state, and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements.	Build or adapt clinician-facing resources and training programs on management of care for pregnant people with SUD <i>Include resources on institutional and state policies related to drug testing*</i>	SAMHSA Video: The Management of Care for Pregnant Women with Opioid and Other Substance Use Disorders ²⁶
	Develop clear educational resources that address common myths about institutional and state policies for child protection reporting <i>Include information on racial inequities along the child welfare pipeline—from testing to reporting to removal to foster system to loss of parental custody* ♦</i>	Camden Coalition: Creating Safe Care: Supporting Pregnant and Parenting Patients Who Use Drugs ²⁷ California ACEs Aware Initiative: Do No Harm: Rebuilding Trust & Keeping Families Together ²⁸

	Train all clinical and non-clinical staff in harm-reduction best practices for SUD, e.g., how to check and treat injection sites, naloxone prescribing, safer injection kits, etc.	National Harm Reduction Coalition: Pregnancy and Substance Use: A Harm Reduction Toolkit ²⁴
	Empower all clinicians working with perinatal patients to prescribe and distribute naloxone and to counsel patients/families/community members on administering it	Implementation of a Prenatal Naloxone Distribution Program to Decrease Maternal Mortality from Opioid Overdose ²⁹
	Create or link to a hotline for providers that helps connect patients to MOUD and recovery treatment services	SAMHSA Division of Pharmacologic Therapies ³⁰ • Phone: 240-276-2700 • Email: DPT@SAMHSA.HHS.gov
Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, starting in prenatal setting	Prescribe naloxone at discharge and train families and support people in using it	American Medical Association (AMA): How to administer Naloxone ³¹ AMA: Naloxone: 5 Tips on talking with patients, families ³²
	Create naloxone distribution toolkit for inpatient and outpatient settings	North Carolina Naloxone Distribution Toolkit ³³ National Harm Reduction Coalition: Overdose Prevention Resources ³⁴ APHR: Pregnancy and Substance Use: A Harm Reduction Toolkit ³⁵ National Harm Reduction Coalition: Find Harm Reduction Resources Near You ³⁶
Establish a multidisciplinary care team to provide coordinated clinical pathways for people experiencing SUDs	Establish a team of clinical and non-clinical providers to support the implementation of evidence-based practices	
	Improve access and reduce barriers to medication-assisted treatment (MAT) and MOUD	

	<i>Consider engaging emergency medical services (EMS)/community first responder teams *</i>	
Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families for social determinants of health needs, behavioral health supports, and SUD treatment.	Develop relationships and communication pathways with mental health providers and substance use resources in your community, ensuring that these programs do not exclude pregnant people <i>Consider establishing this as your team sets up a Screening, Brief Intervention, and Referral to Treatment (SBIRT) process*</i>	Massachusetts General Hospital (MGH) Center for Women's Mental Health: SBIRT for Women with Alcohol and Drug Use During Pregnancy³⁷
	Develop relationships and communication pathways with intimate partner violence resources in your community <i>Working with community members to help build these relationships is essential* ♦</i>	
	Encourage site visits across health care systems, community-based organizations, SUD treatment centers, etc. to support shared understanding of services and supports available	
	Develop relationships with community-based organizations that provide robust, evidence-based, trauma-informed parenting supports ♦	Center for Health Care Strategies: An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers³⁸ Fierce Healthcare: 4 steps to build effective community partnerships³⁹

Recognition and Prevention

Change Concept	Change Idea	Key Resources and Tools
Screen all pregnant and postpartum people for SUDs using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission	Work with a multidisciplinary team (providers, nurses, social workers, people with lived experience, experts on SUD) to develop protocol for obtaining informed consent for using self-reported screening tools and ensuring informed consent is in place before screening ♦	New Hampshire SBIRT Implementation Playbook for Perinatal Providers ⁴⁰
	Develop a training focused on acquiring informed consent and administering validated self-reported screening tools with respect and without bias and require it for all clinicians who interact with pregnant and postpartum people with SUD ♦	New Hampshire SBIRT Implementation Playbook for Perinatal Providers ⁴⁰
	Standardize screening tools for conditions associated with SUD (e.g., hepatitis C screening)	Society for Maternal-Fetal Medicine (SMFM): Hepatitis C in pregnancy—updated guidelines ⁴¹ ACOG Committee Opinion 752: Prenatal and Perinatal Human Immunodeficiency Virus Testing ⁴²
	Include “equity pause” to look at bias risk within multidisciplinary care planning and to ask, “What are considerations to ensure respectful care without discrimination?” ♦ Please note, an equity pause is an emerging idea being tested in different fields. If you are interested in trying it, start small and consider testing on admission, during shift changes, or at transfer to postpartum. It mirrors an operating room time-out to prevent harm. <i>Consider race, ethnicity, language, gender identity, history of SUD, obesity, mental health issues, unplanned pregnancy and history of</i>	

	<i>pregnancies, marital status, housing status, education level, etc. as potential areas of bias for providers* ♦</i>	
Screen each pregnant and postpartum person for medical and behavioral health needs and provide linkage to community services and resources	Work with a multidisciplinary team that includes people with lived experience to develop protocols for obtaining informed consent for medical, behavioral health, and social determinant screening and ensuring informed consent is in place before screening ♦	IHI: Experience-Based Co-Design of Health Care Services ¹⁶ Journal of Public Health Management and Practice: Using Human-Centered Design for More Inclusive Maternal Health ¹⁷
	Require specific training on acquiring informed consent and administering behavioral health screenings with respect and without bias ♦	
	If resources are not available, look for opportunities to advocate for them	SAMHSA: Behavioral Health Treatment Services Locator ⁴³ SAMHSA: National Helpline ⁴⁴ Federal Communications Commission: Dial 211 for Essential Community Services ⁴⁵ 988: Suicide and Crisis Lifeline ⁴⁶
	Work with a multidisciplinary team that includes people with lived experience to develop protocols for obtaining informed consent for social determinants of health screening and ensuring informed consent is in place before screening ♦	
	Partner with patients to connect them to community-based resources with a warm handoff ♦	

Response

Change Concept	Change Idea	Key Resources and Tools
Assist pregnant and postpartum people with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive in an intersectional manner, and discuss readiness to start treatment, as well as referral for treatment with warm hand-off and close follow-up	Support families in getting access to early developmental enrichment (e.g., Early Head Start) <i>If creating a Plan of Safe Care (POSC), include referrals there. The stated goal of the Comprehensive Addiction and Recovery Act (CARA), a provision of the Child Abuse Prevention and Treatment Act (CAPTA), is that all infants affected by prenatal substance exposure receive appropriate developmental assessments and supports. *</i>	
	Provide spectrum of SUD treatment options to all patients regardless of diagnosis	
	Whenever possible, dispense naloxone on site during prenatal visit, L&D, and/or postpartum visits to both patient and family/support person	North Carolina Naloxone Distribution Toolkit ³³ Illinois Perinatal Quality Collaborative (ILPQC): Transforming Care to Save Mothers from Overdose Death ⁴⁷ ILPQC: Narcan/Naloxone How-to Poster ⁴⁸
	If legal in your state, train all clinicians on safe injection and have supplies available to be distributed in clinics, office practices, L&D, & emergency department (ED)	APHR: Harm Reduction in Practice ⁴⁹ APHR: Safer Injecting ⁵⁰
Establish specific prenatal, intrapartum, and postpartum care pathways that facilitate coordination among multiple	For birthing people who choose to parent, prioritize dyadic care that protects parent/child relationship ♦	The Center on Parenting and Opioids: Substance Use and Recovery in Pregnancy and Early Parenting ⁹

providers during pregnancy and the year that follows	Offer patient navigation support to all patients ♦	
	Prioritize patient/family needs and well-being over policies in POSC <i>Invite birthing person to lead POSC conversations to center their needs and well-being*</i> ♦	
	Develop realistic and helpful POSC that offer support and utility to families as opposed to placing additional demands on families ♦	National Center on Substance Abuse and Child Welfare: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families ⁵¹ New Hampshire Center for Excellence on Addiction: Plans of Safe Care (POSC) ⁵²
Offer comprehensive reproductive life planning discussions and resources	Offer trauma-informed and non-coercive family planning options to all patients	National Clinical Training Center for Family Planning: Trauma-Informed Care in the Family Planning Setting ⁵³ Reproductive Health National Training Center: Providing Trauma-Informed Care in Family Planning Clinics Webinar ⁵⁴ Partners in Contraceptive Choice and Knowledge ⁵⁵

Reporting and Systems Learning

Change Concept	Change Idea	Key Resources and Tools
Identify and monitor data related to SUD treatment and care outcomes and process metrics for pregnant and postpartum people with disaggregation by race, ethnicity, and payor as able	Host regular, formal, and multidisciplinary (including people with lived experience) reviews of data related to SUD treatment and outcomes for people who are pregnant or postpartum. Conduct this review with an equity and social justice lens and ensure that data is disaggregated by race, ethnicity, and payor ♦ <i>Collect Race, Ethnicity and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) data, as well as payor data to identify potential bias and need for systemic changes * ♦</i> <i>Consider forming regional group to encourage collaborative learning across health systems *</i>	American Hospital Association: A Framework for Stratifying Race, Ethnicity and Language Data⁵⁶ The Fenway Institute: Tools to Help Healthcare Organizations Collect Sexual Orientation and Gender Identity Data⁵⁷ Advancing Health Equity: Diagnosing the Disparity⁵⁸
	Review disaggregated data on toxicology testing practices, screening, MOUD, and care of infants at the hospital level to uncover inequities in practice by institution <i>Data should be disaggregated by race, ethnicity, payor (a proxy for income and/or insurance status) at minimum, and if possible, also preferred language and SOGI * ♦</i>	
	Collect patient-reported data on experience, e.g.: Did you feel welcomed?; Did you experience discrimination?; etc. ♦ <i>Identify and encourage use of previously validated Patient Reported Outcome Measures (PROMs)</i>	
	Work to develop a parsimonious set of the most relevant data to collected related to caring for pregnant people with substance use disorder (some data typically collected isn't always useful and can be burdensome to collect)	

	Have run charts of data visible to staff with both outcome and process measures	
	Collect data on criminalization, child welfare engagement, and family policing, and review disaggregated data to identify inequities	
Convene inpatient and outpatient providers and community stakeholders, including those with lived experience, in an ongoing way, to share successful strategies and identify opportunities to improve outcomes and system-level issues	Develop a comprehensive set of outcomes of interest that move beyond neonatal abstinence syndrome (NAS) and overdose	
	Have health equity rounds (similar to department grand rounds) led by someone with experience in caring for pregnant people with SUD  <i>Start doing this at least quarterly*</i>	
	Develop process for providing specific system-level feedback	

Respectful, Equitable, and Supportive Care

Change Concept	Change Idea	Key Resources and Tools
Integrate pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, shared decision-making that incorporates the pregnant and postpartum person's values and goals	Review hospital or office practice policies on mandated reporting of substance use by birthing people to evaluate whether they are accurate and equitable ♦ <i>Use REAL data to inform these decisions)* ♦</i> <i>Reflect on the following questions: * ♦</i> • <i>Are policies written?</i> • <i>Are policies communicated to patients transparently?</i> • <i>Do staff follow policies?</i> • <i>Who is being reported?</i> • <i>Whose infants are removed from their custody?</i>	Sample drug testing policy: Zuckerberg San Francisco General (see pages 8-9 for Family Safety Time Out checklist)
	Update hospital policies on restrictions on where patients are allowed to be in/out of the hospital that are respectful and equitable ♦	
	Identify opportunities for patients to share their feedback outside of formal surveys ♦	MGH: Nondiscrimination Statement ⁵⁹ MGH: Patient Rights and Responsibilities ⁶⁰
	Emphasize inclusive and person-centered language ♦	SAMHSA: Words Matter: How Language Choice Can Reduce Stigma ⁶¹ The ADOPT Project: Person First Language for Substance Use Disorders ⁶²

Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals	Respect and honor cultural beliefs about parenting and center a family's well-being ♦	San Francisco BIPOC Family Justice Summit Report ¹⁵
	Clarify patient's goals for pregnancy and values that need consideration in co-creation of treatment plan ♦	SAMHSA: A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders ²²
	Offer to connect the pregnant or postpartum person to community-based resources regardless of whether they refuse treatment ♦	National Harm Reduction Coalition: Pregnancy and Substance Use: A Harm Reduction Toolkit ²⁴

Appendix A

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Appendix B

Instructions Before Getting Started on Buprenorphine

Example instructions adapted from Dartmouth Health

[Insert your institution logo and contact information here]

The process of getting someone on the correct dose of buprenorphine is divided into three phases: Induction, Stabilization, and Maintenance. Because of its interactions with other opioids (including heroin, methadone, oxycodone (Percocet), morphine (MS Contin), hydrocodone (Vicodin), methadone, or fentanyl, it is very important that you not take any opioids for at least 12 hours before you come in to start buprenorphine treatment. To avoid sudden onset of severe withdrawal symptoms (“precipitated withdrawal”), a person should be in at least moderate withdrawal when they receive their first dose of buprenorphine.

The induction process begins on Day 1 and takes place either in the office or on the Birthing Unit at [hospital address] depending on how far along you are in your pregnancy. This process can take most of the day, or you may be admitted to stay overnight in the hospital.

On Day 1, please:

- Come to _____ by 8:00 am.
- Wear comfortable clothing.
- Bring something to do to help pass the time, since you will be there for a while
- Bring another adult support person with you if you’d like, but please do not bring children. If this is a barrier, please let your provider know and we will do our best to help find solutions.
- Plan to spend the entire time with us in a comfortable room with a TV. We will ask that you not leave the inpatient unit during induction and stabilization. If you are starting buprenorphine in the outpatient clinic, we ask that you stay in the clinic until the maximum dose for the day has been reached.
- [Hospital name] is smoke-free, so if you smoke, we will offer you a nicotine patch or gum to help you stay comfortable.

You will be asked to give an observed urine sample for a drug screening test. This is for your safety, to be avoid any possible interactions with buprenorphine. One of the nurses will do an assessment called the “COWS” (Clinical Opiate Withdrawal Scale) to measure your signs and symptoms of withdrawal every few hours.

Induction: You will receive an initial dose of buprenorphine, and then the COWS will be repeated every two hours and your dose increased until your withdrawal symptoms are effectively treated. The maximum dose you can receive on Day 1 is 12 mg. If needed, we will give you other medications to make you more comfortable during induction.

Stabilization: on Day 2 we may increase your dose if needed to resolve withdrawal symptoms, with a maximum dose of 16 mg on Day 2 or Day 3. This will be done either in the hospital or the clinic. The goal during the stabilization phase is to figure out the minimum dose of buprenorphine needed to eliminate withdrawal symptoms and cravings. Most people will stabilize at a dose of 16 mg per day or less.

Maintenance: After the right dose is established, we will continue to check in with you every week to make sure you are on the right dose. Some pregnant people need to increase to a maximum dose of 24 mg during the latter half of pregnancy because the way the body processes buprenorphine changes during pregnancy.

Your Induction is scheduled on: _____ at 8:00 am. If you are running late or can't make this time work, please call the Charge Nurse to reschedule so we don't worry about you: _____

Buprenorphine/Naloxone Initiation in Pregnancy

Example policy and procedure adapted from Dartmouth Health

I. Purpose of Procedure: To standardize buprenorphine/naloxone initiation during pregnancy.

II. Procedure Scope: Providers and RNs caring for pregnant women on the Inpatient Obstetric Unit and OB/GYN Clinic at [names]

III. Definitions

- Buprenorphine Initiation: Buprenorphine Initiation: Transition of substance use from illicit opioids to buprenorphine/naloxone utilizing the lowest dose needed to minimize symptoms of withdrawal and cravings and prevent use of illicit opioids.
- Buprenorphine/naloxone (AKA Suboxone®): Appropriate treatment for women with opioid use disorder utilizing three phases: initiation, stabilization, and maintenance.
 - A partial agonist at the mu opioid receptor and antagonist at the kappa receptor. It can precipitate an opioid withdrawal syndrome if administered to a patient who is physiologically dependent on opioids and has receptors occupied by opioids at the time buprenorphine is initiated. Note that precipitated withdrawal is caused by buprenorphine itself, and not by the naloxone on combination formulations. When buprenorphine/naloxone is used sublingually as directed, naloxone is minimally absorbed.
 - A patient should no longer be intoxicated or experiencing residual effects from her last dose of an opioid when receiving her first dose of buprenorphine/naloxone. Therefore, a period of abstinence is required (a minimum of 12-24 hours after last use of a short-acting opioid) and patients should be experiencing moderate withdrawal symptoms before initiating buprenorphine/naloxone treatment.
 - Clinical Opioid Withdrawal Scale (COWS): A scoring tool to quantify withdrawal symptoms and guide in the buprenorphine/naloxone initiation process. Withdrawal symptoms are classified with the following score ranges: Mild (5-12). Moderate (13-24). Moderately Severe (25-36). Severe (greater than 36).

IV. Criteria for initiation

- Inpatient Initiation Criteria: Women with acute medical or surgical illness, significant polysubstance use, use of long-acting opioids or who are presenting at a gestational age post-viability often require inpatient admission for close monitoring and clinical evidence of opioid withdrawal (COWS 12 or more). Women with co-occurring benzodiazepine, polysubstance, or alcohol use should be cared for in an inpatient setting, preferably at a substance abuse treatment facility and with psychiatry or addiction medicine consultation.

- Outpatient Initiation Criteria: Women in the first or second trimester 20-28 weeks gestation without complicating factors above, and with history of opioid use disorder and clinical evidence of opioid withdrawal (COWS 12 or more) may be considered for closely monitored initiation in the ambulatory setting.

V. Procedure

Attending provider (must be waived to prescribe buprenorphine on an outpatient basis in order to bridge patients to a destination treatment program)

- Assist patient in identifying treatment provider for follow-up after induction/stabilization
 - Obtain release of information.
- Consider psychiatric consultation if concerns related to a co-occurring psychiatric disorder.
- Notify team to provide multidisciplinary support during initiation process:
 - Inpatient and outpatient: OB care provider with buprenorphine waiver, recovery coach, etc.
 - Inpatient: Social worker, behavioral health team.
- Review with and verbally obtain consent from patient for initiation of buprenorphine/naloxone treatment.
- Verify that patient has not taken an opioid for a minimum of 12-24 hours (short-acting opioid).
- Determine baseline COWS score, verifying a score of 12 or more.
 - Common physical symptoms of opioid withdrawal:

Early Withdrawal	Fully Developed Withdrawal
(8-24 hours after last use)	(1-3 days after last use)
Lacrimation and/or rhinorrhea	Tachycardia
Diaphoresis	Hypertension
Yawning	Tachypnea
Restlessness	Fever
Insomnia	Anorexia or nausea
Dilated pupils	Extreme restlessness
Piloerection	Diarrhea and/or vomiting
Muscle twitching	Dehydration
Myalgia	Hyperglycemia
Arthralgia	Hypotension
Abdominal pain	Tachycardia
	Hypertension
	Tachypnea

- Diagnosis: “Maternal drug use complicating pregnancy, antepartum” and “acute opioid withdrawal.”
- Initiates order set “Perinatal Buprenorphine/Naloxone Initiation.”
- Obtains baseline laboratory testing to include:
 - Urine toxicology (with confirmation, including fentanyl)

- Ethyl glucuronide/ethyl sulfate (alcohol metabolites)
- Complete metabolic panel
- Complete blood count (CBC) with differential and platelet count
- Hepatitis B surface antigen, hepatitis B surface antibody, hepatitis B core antibody (IgM and Total), and hepatitis C antibody with reflex to hepatitis C quantitative RNA (unless already known positive)
- If known hepatitis C antibody positive, draw hepatitis C quantitative RNA instead of antibody.
- HIV (4th generation expedited)
- Other prenatal labs, if not completed, including gonorrhea, chlamydia, and syphilis.

VI. Induction

Day 1

- Fetal assessment
 - Inpatient and outpatient: Obtain nonstress test (NST) on admission if greater than 28 weeks gestation; otherwise obtain fetal heart tones (FHT).
 - Outpatient: Assess FHTs prior to leaving the clinic at the end of day 1.
- Order buprenorphine/naloxone as indicated by the attached algorithm using the COWS assessment.
 - Do not administer more than 12 mg buprenorphine/naloxone on first day.

Day 2

- Order and adjust dose in accordance with the attached buprenorphine algorithm.
 - Do not give more than 16 mg buprenorphine/naloxone on second day.
 - A reactive NST should be obtained prior to discharge for patients with gestational age equal to or greater than 28 weeks gestation.
 - Patient may be discharged on day 2 with next day follow-up with a waived buprenorphine prescriber in the OB clinic, or substance use treatment provider.

Day 3

- Evaluate patients still experiencing withdrawal symptoms (COWS of 5 or more) in outpatient clinic.
- May increase dose by 2 mg up to a maximum dose of 20 mg.

VII. Medications for symptom reduction

- Adjunctive therapy may be used with or without buprenorphine/naloxone initiation for the treatment of opioid withdrawal symptoms.
 - Clonidine 0.1 mg orally every 6 hours PRN withdrawal symptoms (hold if systolic blood pressure (SBP) less than 105 mmHg)
 - Dicyclomine 20 mg orally every 6 hours PRN abdominal cramps
 - Loperamide 2 mg orally every 6 hours PRN diarrhea
 - Acetaminophen 650 mg orally every 6 hours PRN pain scale 1-5
 - Acetaminophen 975 mg orally every 8 hours PRN pain scale 6-10

- Hydroxyzine HCl 50 mg orally every 6 hours PRN anxiety
- Diphenhydramine 50 mg orally nightly PRN sleep

VIII. Nursing responsibilities

- Assesses vital signs and FHT or NST, as ordered based on gestational age.
 - Note: A reactive NST is not a prerequisite to initiating buprenorphine/naloxone as opioid withdrawal can affect NST reactivity.
- Collects witnessed urine sample for toxicology, described above
- Collects and send ordered blood tests.
- Assesses initial COWS prior to administration of buprenorphine/naloxone, administer
 - Day 1: If COWS 12 or more give buprenorphine/naloxone 2 mg/0.5 mg sublingual. If less than 12, do not give dose until increased symptoms are reported, to avoid precipitated withdrawal.
 - Day 2: If COWS 5 or more, give total Day 1 Suboxone® sublingual dose plus additional buprenorphine/naloxone 2 mg/0.5 mg sublingual. If COWS less than 5, give total Day 1 buprenorphine/naloxone dose.
- Obtains fetal assessment as ordered (FHT or NST).
- Observes for 2 hours and repeats COWS assessment
 - If COWS less than 5, notify provider.
 - If COWS greater than or equal to 5, give the following Suboxone® sublingual dose:
 - If Day 1, administer 4 mg Suboxone® sublingual.
 - If Day 2, administer 2 mg Suboxone® sublingual.
- Observe for 2 hours, repeats COWS assessment, and notify provider.
 - If COWS less than 5 and FHTs are 110-160 bpm or NST is reactive, patient can be discharged to home.
 - If COWS 5 or more, notify provider.
- Once maximum dose is reached for the day, decrease COWS assessment frequency to every 4 hours while awake to guide administration of adjunctive medications (above).
 - Provide education as appropriate to patient and when involved to family or support member.

IX. Discharge to community-based opioid treatment programs

- The prescribing provider and team arrange follow-up with the outpatient treatment program of the patient's choice, or with a residential treatment program.
- If the appointment cannot be made within 24 hours (i.e., weekend or holiday), arrange for waived provider for buprenorphine/naloxone prescription as needed to bridge patient to the next available appointment, ideally providing no more than 1 week of medication.
- Prior to discharge, provide prescription for Naloxone Nasal Spray (4 mg/0.1 mL, administer 1 spray in nostril for opioid overdose, repeat in 3 minutes in other nostril PRN if unresponsive).
 - When possible, provide instructions for use of Naloxone Nasal Spray to family or support member.

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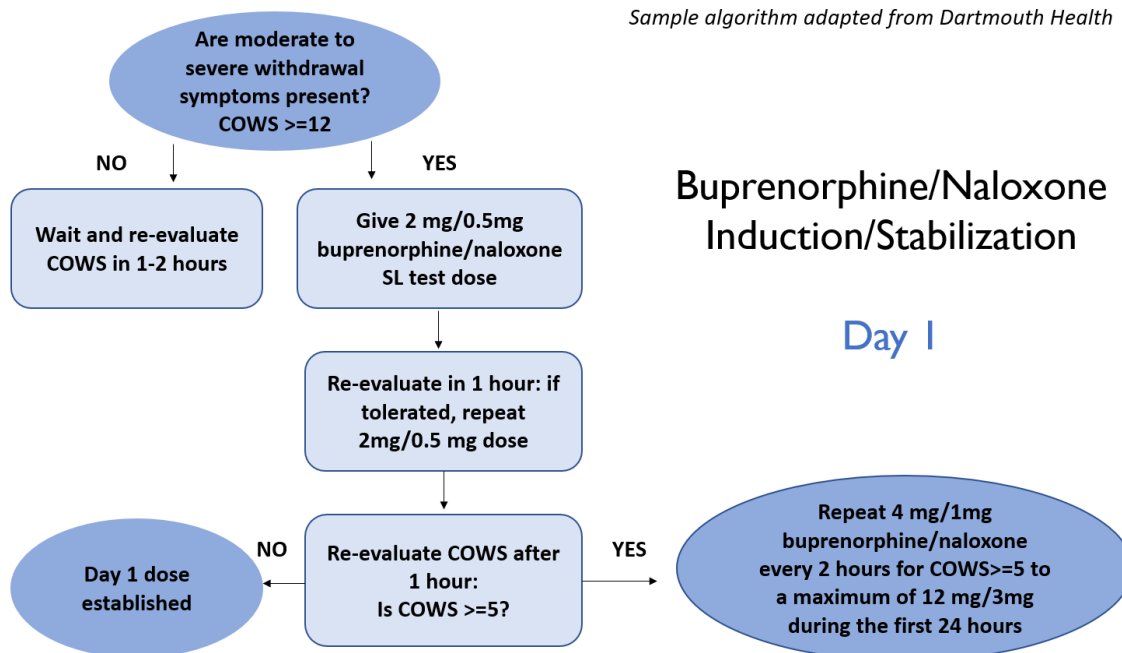
are for reference ONLY. Please refer to the electronic copy for the latest version.

Reference ID #11435, Version #1. Approval Date: 07/10/2018

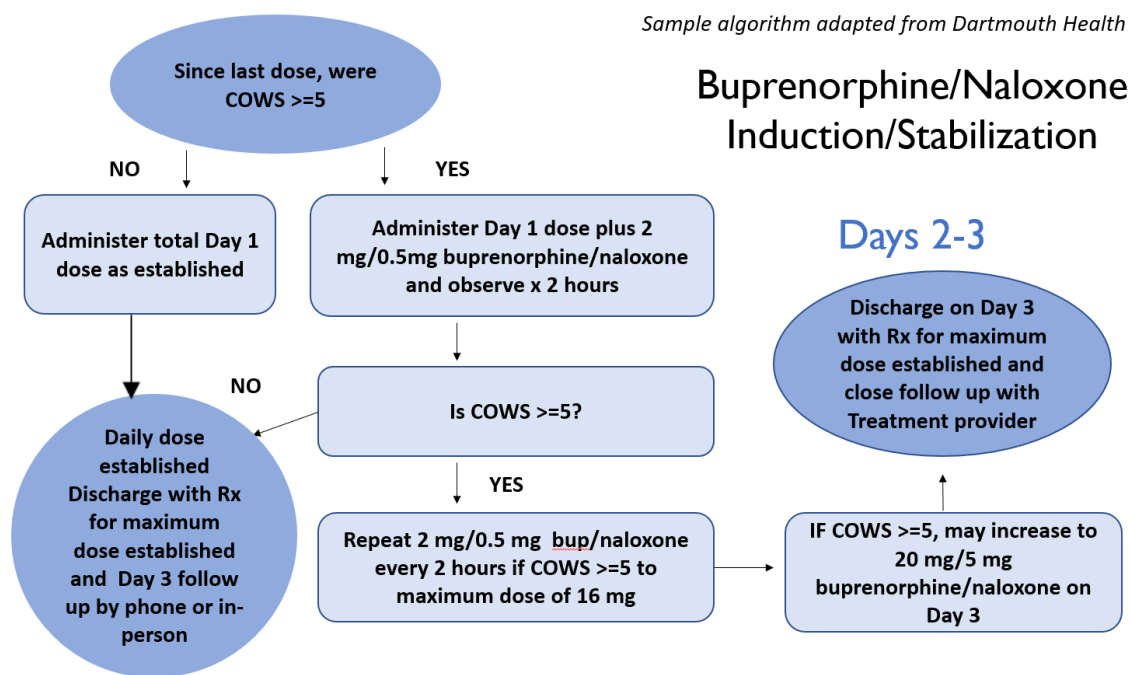
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Buprenorphine/Naloxone Induction/Stabilization Algorithm

Sample algorithm adapted from Dartmouth Health



Sample algorithm adapted from Dartmouth Health



Examples of Questions to Cover in Clinician Trainings

1. What do the state laws require?
 - a. Is drug testing required?
 - b. Are providers required to call your state's version of child protective services (CPS) if drug use is suspected DURING pregnancy?
 - c. Are providers required to call CPS if drug use is suspected at birth?
2. Does the institution have a written policy about mandated reporting?
3. What are the criteria for reporting in the institution (e.g., is "nonprescribed drug use" a criterion? Does this include cannabis in states where it's not legal?
4. Is the policy of the institution based on the inaccurate assumption that substance use by a pregnant person is an indicator of poor parenting? Or is mandated reporting based solely on concern for abuse or neglect of a child?)
5. What is the process for deciding whether a report will be made (team approach, individual provider — who/when/how)
6. How is the parent informed that a report will be made, and are they present when it is made
7. What usually happens after a report is made?