Community Care
OF NORTH CAROLINA

Pregnancy Medical Home Program Care Pathway

Management of Substance Use in Pregnancy

March 2019

Table of Contents

Appendices

Introduction

Substance use is a persistent challenge in our society across all demographic groups and raises specific concerns and complications in pregnancy. Screening, brief intervention and referral to treatment (SBIRT) is an evidence-based approach to addressing substance use in clinical practices and is endorsed in the obstetric setting. Brief interventions in the prenatal care setting serve as teachable moments and may help women with substance use in pregnancy to reduce or eliminate use. For some women, the SBIRT approach will lead to treatment and recovery. The benefits of the pregnant woman's behavioral change have proven to be effective in improving birth outcomes for the newborn.

Authors

Ugonna Anyanwu, MD
John Byron, MD
Jeffrey Denney, MD
James DeVente, MD, PhD
Frank Harrison, MD
Stephen Lies, MD
Kate Menard, MD, MPH
Arthur Ollendorff, MD
Mark Picton, MD
Russell Suda, MD
Velma Taormina, MD
Lydia Wright, MD
Elizabeth Stringer, MD
Katie Borders, MD
Paul Sparzak, MD
John Allbert, MD
Tristan Sanz, MD
Beverly Gray, MD

Acknowledgements

The CCNC Pregnancy Medical Home leadership would like to thank the following contributors to this pathway for sharing their expertise:

Melissa L. Godwin, LCSW,
Behavioral Healthcare Resource Program
School of Social Work
University of North Carolina at Chapel Hill

Paul D. Kelly
SBIRT Coordinator
Northwest Community Care Network

Amelia Mahan, MSW, LCSW
Behavioral Health Program Manager
Community Care of North Carolina
Jim Bernstein Community Health Leadership Fellow, Class of 2015

Ray McBeth, PhD
SBIRT Coordinator
Northwest Community Care Network

Sara McEwen, MD, MPH
Executive Director
Governor's Institute

Matthew Prentice, MSW
SBIRT Project Coordinator
Governor's Institute

Connie Renz, MSW, LCSW, LCAS
Consultant
Retired Director of UNC Horizons

Starleen Scott Robbins, MSW, LCSW
State Women's Services Coordinator
NC Division of Mental Health, Developmental
Disabilities and Substance Use Services
Addictions & Operations Management Section

Samantha Wiegand, MD
Clinical Instructor and Fellow
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
University of North Carolina at Chapel Hill

Community Care OF NORTH CAROLINA

1 | Screening of Patient for Substance Use

Use universal verbal/written screening with patients at the initial prenatal visit, in each trimester and during the postpartum period.[1] Urine drug testing is not recommended for screening but may be useful in monitoring compliance with substance use disorder treatment.

Establish a non-judgmental approach to addressing substance use.

- See Appendix E for guidance on how to conduct a brief intervention

Complete the Pregnancy Medical Home (PMH) Risk Screening Form with new OB patients at the beginning of the first prenatal visit

- Questions 8-13 on the "patient" side of the form are standardized substance use screening questions, adapted from the Modified 5 P's instrument[2]
- A clinician (nurse, nurse practitioner, midwife, physician assistant, or physician, per DMA Policy 1E6, Section 5.3.1) should review both sides of the screening form with the patient before the patient leaves and follow upon any positive responses in detail

Complete a validated substance use screening tool such as the 5Ps every trimester and at the postpartum visit.

Gather additional information to assess the patient's risk for problems with drugs or alcohol from the following sources or others as appropriate:

- Review the patient's current medication regimen with the patient, including asking her about any misuse of prescription medications
- Check the PMP Aware (Multistate Controlled Substance Reporting System)[3] and CCNC's records for prescription fill history to identify potential misuse of prescription drugs
    - See Appendix D for information about the use of the PMP Aware
- Ask about any past or current substance use disorder treatment, including residential, outpatient, medication-assisted treatment for opioid use disorder, 12-step programs or other treatment modalities

Record relevant information in the medical record. See Appendix G for guidance related to the documentation and disclosure of substance use information.

[1] American College of Obstetricians and Gynecologists: At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice. Committee Opinion No. 422. Obstet Gynecol 2008: 112; 1449-60.
[2] Kennedy C, Kinkelstein N, Hutchins E, Mahoney J. Improving screening for alcohol use during pregnancy: The Massachusetts ASAP program. Maternal Child Health J. 2004 Sept; 8(3): 137-47.
[3] https://northcarolina.pmpaware.net/login

- Federal regulations restricting the disclosure of substance use disorder treatment information do not apply to patient self-disclosure to her provider or substance use information gathered from other medical providers
- Providers should only include medically necessary and accurate information with no subjective comments when documenting and disclosing information related to substance use

Refer to the PMH Care Pathway on Perinatal Tobacco Use for guidance on the management of patients who report tobacco use during pregnancy on the PMH Risk Screening Form.

2 | Assessment of Substance Use

Complete further assessment based on information gathered above. If patient answers "yes" to Risk Screening Form questions about current use of drugs or alcohol (question 13), about use of drugs or alcohol prior to pregnancy (question 12), or about past problems with drugs or alcohol (question 11), or screening findings indicate any potential concern about the patient's use of alcohol or other substances including misuse of prescription medications.

Ask the patient to specify what substance(s) she was referring to when responding to these questions.

Ask about frequency of use ("What do you mean by rarely, sometimes, or frequently?").

- Ask the patient how many days per week on average she uses or was using each substance and about times when she may have used more
- Ask the patient to specify how much of each substance she uses or was using at one time
- Ask when the last use was for each substance

For patients who report past problems with alcohol or other substances:

- Ask the patient to describe her past difficulties with substance use
- Ask the patient to describe her experience with substance use in previous pregnancies
- Offer support and referral for further substance use assessment or treatment as needed
- Encourage the patient to disclose to you any concerns about substance use at this time or during the pregnancy and let her know that you will be checking in with her about substance use during the pregnancy

3 | Intervention with Patient

Offer a brief intervention to raise awareness of the risks of alcohol and other substance use in pregnancy and to increase the patient's motivation to acknowledge and address any problems related to use of these substances.[4]

- Include a clear recommendation delivered in a non-judgmental, caring, and respectful manner to discontinue use of alcohol and illicit substances immediately for patients with any current use
    - See Appendix E for guidance on how to conduct a brief intervention
- Patients on opioid therapy for chronic pain management or medication-assisted treatment for opioid dependence should not be advised to discontinue treatment; those using opioids illicitly should be referred for medication-assisted treatment
    - See Appendix A for further guidance on management of opioid dependence in pregnancy

Provide clear, accurate information to all patients on possible effects of all common substances on the fetus.

- Offer easy-to-read written materials and links to websites with reliable information for patients on substance use in pregnancy
    - See Appendix H for patient education resources
- Encourage patients to bring questions about substance use to future prenatal visits

For patients without current or recent substance use and without a history of significant problems with alcohol or other substances:

- Reinforce positive behavior of abstaining from alcohol and other substance use during pregnancy
- Reinforce benefits of avoiding alcohol and other substance use during pregnancy and for women's health in general, at subsequent visits
- Reassess alcohol and other substance use once per trimester and at the post-partum visit, or if potential risk indicators are noted that warrant reassessment
    - See Appendix B for risk indicators

For patients who have a history of problems with alcohol or other substance use but no current use:

- Provide support for ongoing non-use and reinforce positive behavior of abstaining from alcohol and substance use during pregnancy

[4] American College of Obstetricians and Gynecologists: Motivational Interviewing: A tool for Behavior Change. Committee Opinion No. 423. Obstet Gynecol 2009; 113: 243-6.

- Consider further assessment of treatment, if warranted
- Schedule more frequent prenatal visits
- Consider referral to a pregnancy care manager, especially if there are concerns about the potential for return to use of substances

For patients who have stopped using alcohol or other substances recently or since learning of the pregnancy:

- Provide support for ongoing non-use and reinforce positive behavior of abstaining from alcohol and substance use during pregnancy
- Consider further assessment or treatment, especially for patients who have only recently discontinued substance use
- Schedule more frequent prenatal visits
- Ensure that the patient has a pregnancy care manager
- Discuss referral options with the patient
    - See Section 4 for referrals

For patients with current substance use (see Appendix A for guidance specific to patients with current opioid use):

- Assess the patient's perception of the problem and readiness to change her behavior, including her desire to stop using alcohol or other substances and her willingness to accept a referral for substance use disorder assessment and/or treatment
- Ensure that the patient has been referred to a pregnancy care manager
- Schedule more frequent prenatal visits
- Discuss referral options with the patient
    - See Section 4 for referrals

For patients who do not agree to abstain from use and who do not want a referral for substance use disorder assessment or treatment:

- Utilize motivational interviewing techniques to engage the patient in ongoing discussion about her substance use
- Focus on strategies to reduce risk, such as decreasing use, increasing safety around use, and promoting optimal self-care
- Regularly reassess the patient's readiness to change and adjust the plan of care accordingly, including offering referrals for substance use assessment and/or treatment again

Consider the use of urine drug screening for patients with a history of or with active substance use (see Appendix B for urine drug screening considerations):

- Elicit the patient's permission to perform urine drug screening randomly during the pregnancy

- Conduct urine drug screening once per trimester or more often for patients with active use during pregnancy

4 | Referral to Substance Use Disorder Treatment

Patients who may benefit from a referral to a substance use disorder treatment provider for a substance use assessment include: (1) those who have tried to stop using alcohol or other substances in the past without success, (2) those who are currently using alcohol or other substances during pregnancy and are not confident in their ability to stop, and/or (3) those who are not ready to stop but who are willing to meet with a substance use disorder treatment provider for assessment.

Make a referral for substance use disorder assessment for any patient who would benefit from this service.

- Explain that a substance use disorder assessment with a behavioral health provider is a consultation, rather than a requirement that she enters substance use disorder treatment

For outpatient or community treatment referrals for a substance use disorder assessment, if a substance use disorder provider is known to the practice, make a referral directly to that provider, preferably by phone with the patient present, or using whatever existing local referral process is already in place.

- When speaking with the treatment provider, request an appointment for the patient to receive an assessment and for service recommendations (which are to be reported back to the prenatal care provider, with signed written consent)
- Prenatal care providers should establish pathways for referral and for coordination of care with local substance use disorder treatment providers

If the practice does not know of a substance use treatment provider, call the Local Management Entity/Managed Care Organization (LME/MCO) Screening, Triage, and Referral (STR) line with the patient's consent and ideally with the patient present.

- The LME/MCO will conduct an assessment and link the patient to a treatment provider in the community
    - LME/MCO STR phone numbers can be found here
- Pregnant patients who are uninsured or on Medicaid and are using substances are a priority population for the state LME/MCO system

    - If the pregnant patient is using substances intravenously, they are the top priority above all other populations[5]
- When speaking with the LME/MCO, request an appointment for the patient to receive an assessment and for service recommendations (should be reported back to the prenatal care provider with signed written consent)

For patients requesting a substance use disorder treatment program:

- Contact the NC Perinatal Substance Use Coordinator through the Alcohol/Drug Council of North Carolina at 800-688-4232 for assistance identifying a program or managing the referral process.
    - The NC Perinatal and Maternal Substance Use Disorder Initiative and CASAWORKS for Families Residential Initiative coordinates 28 evidence-based, gender-specific substance use disorder treatment programs for pregnant and parenting women across the state
    - See Appendix K for more information
- Refer the patient directly to a community-based substance use disorder treatment program if a program that can meet the patient's current needs is known to the practice
- Prenatal care providers should be familiar with local substance use disorder treatment providers, including having established pathways for referral to treatment and coordination of care

For patients in need of acute stabilization prior to entry into a community-based and/or residential treatment program, utilize available inpatient options, including the state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs) or tertiary centers that manage pregnant patients with acute substance use disorder treatment needs.

- The three state ADATCs all accept pregnant women from their catchment areas (pregnant women are a priority population)
    - The Julian F. Keith ADATC serves patients in the western counties of the state, and the R.J. Blackley ADATC covers the central part of the state
    - In addition to serving women from Eastern Carolina, the Walter B. Jones ADATC in Greenville, NC accepts pregnant women statewide, including those with high-risk pregnancies, and can provide medication-assisted treatment for opioid use disorder on site
- To refer to an ADATC, complete the Regional Referral Form available on the Department of State-Operated Healthcare Facilities (DSOHF) website
    - Fax the form to the number listed on the website for the ADATC to which the referral is being made, then follow up with a phone call to the Admissions Coordinator, whose number is also posted on the DSOHF website
    - The NC Perinatal Substance Use Coordinator, who can be reached at 1-800-688-4232, can help facilitate referrals to these facilities

[5] https://www.samhsa.gov/grants/block-grants/sabg

    - The pregnancy care manager can be recruited to manage this communication with the ADATC as this process can be time intensive
        - The admission of a patient for acute substance use care requires finding an available bed in an ADATC, and this process is being examined to improve its efficiency
        - Transportation of the patient to the ADATC is not included in the admission process
- See Appendix A for patients needing induction of medication-assisted therapy for opioid use disorder

For all referrals, have patient sign consent/release of information form in order to coordinate care with the treatment provider.

- To share information on substance use assessment and treatment, substance use treatment providers will have the patient sign a 42 CFR, Part 2-specific release of information form
- See Appendix G for more information on release of information forms specific to substance use treatment

Identify and address potential barriers to the patient following through with the referral.

- Potential barriers may include transportation, childcare, or fears about how she will be treated in the behavioral health setting

Refer the patient for pregnancy care management if she is not already working with a care manager.

- Ensure the pregnancy care manager is aware of the referral for assessment/treatment in order to assist the patient in following through and addressing barriers to attending an appointment for substance use disorder assessment

5 | Management of Patients Receiving SUD Treatment

Management of patients who are currently receiving substance use disorder treatment:

- If patient is currently involved in substance use disorder treatment, the prenatal care provider should work closely with the substance use disorder treatment provider to coordinate care
- See Appendix A for patients needing induction of medication-assisted therapy for opioid use disorder

Ask the patient about participation frequency and quality of treatment received.

- If current treatment is not meeting the patient's needs, work with the pregnancy care manager, the substance use treatment provider and/or the LME/MCO to explore alternative treatment options

Have the patient sign consent for release of information in order to provide coordinated care.

- See Appendix G for more information on release of information forms specific to substance use treatment
- The provider or a delegate should confirm reported medication use by reviewing prescription history in the PMP Aware

Contact the substance use treatment provider to coordinate care.

- Review medications being prescribed in both the treatment and prenatal settings with the substance use treatment provider

Maintain contact with the substance use treatment provider

- Maintain contact over the course of pregnancy and postpartum period

Identify and resolve barriers to the substance use treatment adherence.

Ensure the patient has a pregnancy care manager.

6 | Summary of Recommendations for Management of Substance Use in Pregnancy

Substance use is a persistent challenge in our society and raises specific concerns and complications in pregnancy. The American College of Obstetrics and Gynecology recommends that providers use a protocol for screening, brief intervention, and referral to treatment as an evidence-based approach to addressing substance use in their practice. Below are key recommendations for incorporating this into the Pregnancy Medical Home setting. If it is determined a patient has a substance use disorder and your practice is unable to care for them as a result of deeming them 'high risk,' for continuity of care it is the obligation of your practice to continue providing care until transfer of care can be confirmed to a practice with the ability to provide such care.

1. **Use universal verbal/written screening in a nonjudgmental manner at the initial prenatal visit and across pregnancy. Urine drug screening is not recommended universally.**

- The PMH Risk Screening Form includes substance use disorder screening questions
- Review the patient's medications, check the Prescription Monitoring Program (PMP) Aware, and ask the patient about past/current substance use problems or treatment to further assess risk

2. **If screening findings indicate any potential concern about the patient's use of alcohol or other substance misuse, ask the patient for more information (type of substance used, frequency, volume, date of last use, any history of treatment).**
    - For patients who report a history of problems with substance use, ask the patient to describe these problems and her experience with substance use in prior pregnancies; offer support and refer for further substance use assessment or treatment as needed

3. **Offer a brief intervention to each patient to raise awareness of the risks of alcohol or other substance use in pregnancy and to increase the patient's motivation to address any problems related to use of these substances.**
    - For patients without current/recent substance use or a history of problems with alcohol or other substances, reassess substance use once per trimester and at the postpartum visit, or if warning signs are noted
    - For patients with current/recent substance use or a history of problems with alcohol or other substances, make a plan for change or for support of continued non-use
        - For patients who are ready to change, consider referral for substance use disorder assessment, similar to a recommendation for consultation with a specialist for any potential medical complication
            - Patients who have recently discontinued alcohol or other substance use on their own may benefit from referral as well
        - For a patient who is not ready to change, utilize motivational interviewing techniques to engage the patient in ongoing discussion about her substance use, focus on risk reduction strategies, and reassess readiness to change regularly

4. **Refer to a behavioral health provider for substance use disorder assessment and/or treatment.**
    - If an appropriate behavioral health provider is not known to the prenatal care practice, call the local LME/MCO with the patient present
    - Contact the NC Perinatal Substance Use Coordinator at 800-688-4232 for assistance in identifying a treatment program for pregnant women
    - For patients in need of acute stabilization prior to entry into a treatment program, utilize available inpatient options, include the Alcohol and Drug Abuse Treatment Center or tertiary centers that can manage substance use in pregnancy
        - Utilize the NC Perinatal Substance Use Coordinator to facilitate inpatient admission and subsequent follow up, 800-688-4232
    - For patients who report a history of problems with substance use, ask the patient to describe these problems and her experience with substance use in prior pregnancies; offer support and refer for further substance use assessment or treatment as needed

5. **If the patient is currently receiving substance use disorder treatment, the prenatal care provider should obtain consent for release of information and coordinate care with the substance use disorder treatment provider.**

6. **All patients with substance use issues should be connected to a pregnancy care manager and should be seen for more frequent prenatal visits.**
    - Consider the use of urine drug screening with the patient's permission and with attention given to the panel selection for the screen
    - See Appendix B on urine drug screening

7 | Summary of Recommendations for Opioid Use in Pregnancy

Women of childbearing age may be taking opioids in a variety of circumstances, including by prescription for the treatment of pain, through medication-assisted therapy (either methadone, or buprenorphine) for the management of opioid use disorder, misuse of prescription medications, or illicit use of street substances like heroin. Opioid dependence creates a unique set of challenges during pregnancy. Below are key recommendations for optimal management of this condition in the Pregnancy Medical Home setting based on the guidance in Appendix A on the management of opioid use.

1. **Patients who take opioids may experience physical dependence and tolerance; some may also have an addiction or opioid use disorder.**

2. **Pregnant women receiving opioid therapy for chronic pain management or medication-assisted treatment (MAT) for opioid use disorder should not be advised to discontinue treatment due to high risk of return to use and pregnancy complications associated with withdrawal.**

3. **Patients with an active opioid use disorder should be referred for medication-assisted treatment (MAT) if they are not already receiving MAT.**
    - Stabilization of opioid use with MAT as soon as possible (within one week) is recommended to reduce fetal exposure to the toxicity of volatile cycling between intoxication and withdrawal

4. **The prenatal care provider should work with the patient and the delivery facility to establish a plan for pain management during labor, delivery and postpartum.**

5. **Patients taking opioids during pregnancy should receive education about the possibility of neonatal abstinence syndrome and its management and should have consultation with the newborn care team at the intended delivery facility in the third trimester of pregnancy.**

6. **Patients on medication-assisted treatment (MAT) for opioid use disorder should remain on treatment during pregnancy and postpartum.**
    - Doses may need to be adjusted due to metabolic changes of pregnancy
    - Patients who are stable on methadone should not be switched to buprenorphine during pregnancy

7. **The prescriber of opioid therapy for pain management during pregnancy should:**
    - Review the current pain management regimen
    - Assess alternative medications or treatment modalities and discuss tapered reductions with pain management to lower dosing levels which need to be therapeutic for pain while avoiding withdrawal symptoms
    - Check the PMP Aware
    - Perform urine drug screening

8. **If the pain prescriber is not comfortable managing opioid therapy during pregnancy, the prenatal care provider should seek consultation from a pain specialist, if available, but may need to assume responsibility for prescribing the pain management regimen during pregnancy.**
    - It may be helpful to utilize a pain agreement when prescribing opioids as part of prenatal care
    - See Appendix C for additional guidance and a sample pain contract/treatment agreement

9. **Pregnant patients at risk for acute withdrawal due to discontinuation of opioid use may be managed in the inpatient or outpatient settings.**
    - For outpatient management, refer patients who are willing to accept a referral for MAT to a provider that serves the patient's community and accepts pregnant patients
    - For inpatient management, consider referral to a state operated Alcohol and Drug Abuse Treatment Center or if available, admit to local hospital for stabilization while arranging follow-up with a MAT program
    - For patients who do not accept a MAT referral, assess the patient's willingness to be referred for a substance use disorder assessment with a behavioral health provider
    - The NC Perinatal Substance Use Coordinator can help facilitate referrals to substance use disorder treatment and detox facilities
        - The Coordinator can be reached through the Alcohol and Drug Council of North Carolina at 1-800-688-4232

10. **Consider joining UNC MAT ECHO to increase skill and ability to manage a patient who is taking buprenorphine for an opioid use disorder.**

Appendix A: Management of Opioid Use in Pregnancy

1. Background

Women of childbearing age may be taking opioids in a variety of circumstances, including:

- By prescription for the treatment of pain
- Through medication-assisted therapy (either methadone or buprenorphine) for the management of opioid dependence
- Misuse of prescription medications (taking medications other than how they were prescribed, including medications that were prescribed for another person or that were obtained illegally), and/or
- Using heroin or other illegal opioids

People who take opioids, whether by prescription or illicitly, may have one or both of the following responses:

- Physical dependence**:** The person will experience unpleasant physical withdrawal symptoms if the opioid is abruptly discontinued.
- Opioid use disorder/addiction**:** The person is using opioids for the purpose of getting high and/or for their perceived impact on pain, stress, anxiety, depression, or other conditions. Addiction is the most severe form of opioid use disorder and is associated with compulsive or uncontrolled use of one or more substances.

Pregnant patients on opioid therapy for chronic pain management or medication-assisted treatment (MAT) for opioid dependence should be advised to continue treatment due to risk of relapse and pregnancy complications associated with withdrawal (Kaltenbach et al, 1998).

Patients taking prescriptive narcotics for pain should be educated on their medications, the potential for overdose and withdrawal in their babies. Referral to pain management should be considered for patients with intractable pain. Patients taking opioids illicitly should be referred for MAT, either to an opioid treatment program (for methadone or buprenorphine) or to a medical provider who has DEA approval to prescribe buprenorphine. Patients taking opioids should have naloxone made available to them, in case of overdose. Ensure that her local pharmacy carries naloxone under the NC State Health Director's standing order and that she can access. For low/no cost naloxone for individual patients, call NC Harm Reduction Coalition at (336) 543-8050.

Patients who request opioid detoxification during pregnancy should be referred to an experienced consultant. No standard protocols exist for opioid detoxification in pregnancy. The American Society of Addiction Medicine recommends detoxification in the second trimester, if it is to be undertaken at all. Relapse after opioid detoxification increases the risk of overdose death in substance-using pregnant patients and fetal morbidity and mortality (SAMHSA, A Collab. Approach…Disorders, 2016). For patients who choose opioid detoxification, prenatal visits should include screening for relapse (patient report and urine drug screening), ongoing support, and willingness to revisit the use of MAT if the detoxification plan is not successful.

2. Guidance for working with all patients taking opioids during pregnancy

- Ideally, patients taking opioids in pregnancy would be managed by a team of collaborative specialists with the Prenatal Care Provider being the team leader. Referrals to addiction medicine specialists is not a "handoff of care" (Jones, Deppen 2017) but the acquisition of recommendations to integrate into the comprehensive obstetrical plan
- The obstetrical care should be empathic at all provider sites, and thereby encourage patient hope and participation in care
- The obstetrical plan (OP) should include more frequent prenatal visits
- The OP should provide education on NAS and include a referral to the pediatric team at the intended delivery facility during the third trimester to discuss the plan for neonatal assessment and management of neonatal abstinence symptoms, if present
- The OP should include a pain management consultation to establish a plan for pain management during labor and delivery
- The OP should provide education about the value of breastfeeding for infants exposed to opioids during pregnancy. For more information, refer to the Academy of Breastfeeding Medicine Clinical Protocol #21: Guidelines for Breastfeeding and the Drug-Dependent Woman.

3. Management of patients who are currently receiving medication-assisted treatment for opioid use disorder

- Patients on MAT for opioid use disorder should continue this treatment during pregnancy (ACOG 2017); on average, both methadone and buprenorphine recipients will need a 3-dose increase over the course of the pregnancy (Jones, Deppen 2014). MAT medications should be managed by the current prescribing provider.
    - The prenatal care provider should obtain a thorough history of how long the patient has been on medication-assisted therapy, the dose, its effectiveness, her relationship with the treatment provider, and whether the treatment provider is aware of the pregnancy
    - Patients already stable on methadone treatment should not be encouraged to switch to buprenorphine during pregnancy
- If current treatment is not meeting the patient's needs, work with the pregnancy care manager, substance use disorder treatment provider, and/or LME/MCO as applicable to explore alternative treatment options

4. Management of patients in chronic pain treatment taking prescribed opioid medications

The prenatal care provider should work collaboratively with the prescriber of the pain management regimen and other members of the care team (behavioral health, physical therapy, etc.) and should take the following steps (Meyer 2014):

- Obtain a release of information so all members of the team may share clinical information
- Work with the care team to determine if the patient will continue chronic opioid therapy during the pregnancy and ensure that all care team members are aware of risks associated with withdrawal during pregnancy

- For patients continuing opioid treatment during pregnancy:
  - Establish who will prescribe the pain regimen during pregnancy, including dose and duration (e.g., limiting to 30-day supply). The obstetrical caregiver should be ready to accept this role as the PMH team leader.
  - Establish which provider will check the PMP Aware (see Appendix D) for duplicate prescriptions or medications that increase risk when on opioid therapy (e.g., benzodiazepines, sedative hypnotics). A physician can delegate someone under his/her supervision to run the queries on the patient (see Appendix D).
  - The opioid prescriber should take responsibility for performing urine drug screening (see Appendix B for UDS considerations)
  - Develop a plan for postpartum evaluation and treatment
  - Ensure safe storage of opioid medications, including use of a lockbox if there are children present in the home
  - If the pain prescriber is not comfortable managing opioid therapy during pregnancy, the prenatal care provider may continue the current regimen with the understanding that the pain provider will reassume care following the pregnancy. The prenatal care provider should take the following steps:
    - Obtain records to confirm diagnosis, current mediations and doses, and treatment history
    - If available, obtain a Pain Medicine consult to review the goals of chronic opioid therapy for pain management and to assess alternative medications or treatment modalities
    - Complete a work-up as appropriate for the pain disorder (e.g., renal ultrasound, x-ray, etc.) and per recommendations of the Pain Medicine consultant
    - Treat with minimal opioids and investigate alternatives, such as lidocaine patches, cyclobenzaprine, gabapentin, acupuncture, trigger point injections, or physical therapy. This may mean a gradual reduction of opioid analgesic to the lowest effective dose (NCPOEP).
    - Emphasize sleep hygiene
    - Refer for Behavioral Health consultation as appropriate
    - Consider written/verbal pain agreement (see Appendix C)
- For patients not continuing opioid therapy for pain management during pregnancy:
  - Determine who will manage the patient's discontinuation of treatment
  - Taper 10% of initial dose every 4-7 days
  - Assess for physical withdrawal symptoms and for pain control
  - Emphasize alternative therapy, including behavioral health and coping skills
  - Seek ongoing input from pain medicine for exacerbations

5. Management of patients in need of acute treatment for opioid use disorder:

Pregnant patients at risk for acute withdrawal due to discontinuation of opioid use may be managed in the inpatient or outpatient setting. Some patients admitted to the hospital in the antepartum period for other reasons may need management to address opioid withdrawal.

- Outpatient management for patients who accept MAT:

    - Make a referral to a MAT provider that serves the patient's community. Instruct the patient to abstain from narcotics for 24 hours prior to intake or follow guidance from the substance use treatment provider.
    - Prescribe as needed to cover the patient until the intake MAT appointment
    - Practices with a high volume of patients with opioid use disorder should consider having a provider within the practice become licensed to prescribe buprenorphine to facilitate access to treatment for pregnant patients (see Appendix L for more information on becoming a buprenorphine prescriber)
- Outpatient management for patients who do not accept MAT:
    - Follow harm reduction guidance (Section 3 in pathway above)
    - Assess the patient's willingness to be referred to a Behavioral Health provider for a substance use assessment (Section 4 in pathway above)
    - See the patient for more frequent prenatal visits and assess readiness for treatment at each visit
    - For patients with chronic pain treatment needs, see Section 3 above
- Inpatient Management:
    - Consider referral to a state-operated Alcohol and Drug Abuse Treatment Center (ADATC). The three state ADATCs, operated by the NC Division of State Operated Healthcare Facilities, accept pregnant women from their catchment areas. Pregnant women are a priority population.
        - The Julian F. Keith ADATC serves patients in the western counties of the state, and the R.J. Blackley ADATC covers the central part of the state.
        - In addition to serving women in eastern Carolina, Walter B. Jones ADATC in Greenville, NC accepts pregnant women statewide, including those with high-risk pregnancies, and is able to provide medication-assisted therapy for opioid use disorder on site
        - To refer to an ADATC, complete the Regional Referral Form available on the Department of State-Operated Healthcare Facilities (DSOHF) website
        - Fax the form to the number listed on the website for the ADATC to which the referral is being made, then follow up with a phone call to the Admissions Coordinator, whose number is also posted on DSOHF's site
    - Admit locally for stabilization while arranging follow-up with a MAT program. Seek expert consultation for assistance with methadone or buprenorphine induction, if needed.
- Utilize the NC Perinatal Substance Use Coordinator for assistance identifying a program or managing the referral process, including an ADATC. The Coordinator can be reached through the Alcohol/Drug Council of North Carolina at 1-800-688-4232.
    - See Appendix K for more information
- Refer the patient for pregnancy care management if she does not already have a pregnancy care manager

6. References for Appendix A

- American College of Obstetricians and Gynecologists: Opioid Use and Opioid Use Disorder in Pregnancy Committee Opinion No. 711. Obstet Gynecol 2017; 119: 1070-6

- Jones HE, Deppen K, Hudak M, et al: Clinical Care for Opioid-Using pregnant and postpartum women: The role of the obstetric providers; AJOG, April 2014, pgs 302-310, CDC Expert Panel Proceedings convened in 2012.
- Jones HE, Martin PR, Heil SH, Kaltenbach K, Shelby P, Coyle MG, et al.: Treatment of opioid-dependent pregnant women: clinical research issues. Substance Abuse Treatment 2008; 35(3):245-259
- Kandall SR, Albin S, Lowinson J, Berle B, Eidelman AI, Gartner LM: Differential effects of maternal heroin and methadone use on birthweight. Pediatrics 1976; 58(5): 681-6
- Kaltenback K, Berghella V, Finnegan L: Opioid dependence during pregnancy: Effects and management. Obstet Gynecol Clin N Am 1998: 25 (1):139-151
- Meyer M. The Perils of Opioid Prescribing During Pregnancy. Obstet Gynecol Clin N Am 2014; 41:297-306
- NC Pregnancy and Opioid Exposure Project (http://ncpoep.org)
- SAMHSA: A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978, 2016
- SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder. HHS Publication No. (SMA) 18-5054. Rockville, MD, 2018

Appendix B: Urine Drug Screening (UDS) Guidance

ACOG Statement: ACOG Committee Opinion No. 633 (2015, reaffirmed 2018) states that "routine screening for substance use disorder should be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status. Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not required."

Indication for UDS: UDS is useful in monitoring patients with or at high risk of SUD, as well as patients receiving controlled substances as part of pain management or SUD medication assisted treatment. The physician should be aware of metabolism pathways and careful with panel selection as some of the more common drugs of use are not part of the standard panel. The physician should discuss the purpose, risks, and benefits of the use of UDS with the patient and should stress that maternal and infant safety is the primary purpose.

If risk indicators are identified at any time during pregnancy or postpartum, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate. Risk indicators include:

- Little or no prenatal care
- Inappropriate behavior (e.g., disorientation, somnolence, unfocused anger)
- Physical signs of substance use or withdrawal
- Smell of alcohol/chemicals
- Recent history of SUD or treatment

Positive UDS Results: Test results that suggest illicit drug use or prescribed medication misuse should be discussed with the patient. The discussion should occur in a positive, supportive fashion to strengthen the physician-patient relationship, encourage healthy behaviors, and produce behavioral change when needed and should include a referral to an addiction specialist.

If you believe a patient may be diverting a medication, she should be notified to come into the office between scheduled appointments for a random pill count. If a random pill count reveals the medication quantity falls short of amounts expected from prescribing instructions, it is vital to perform a point of care urine drug screen (UDS) with confirmation. A UDS confirmation negative for the prescribed opioid and/or its metabolites is strong evidence of diversion, and the medication should be discontinued, and alternative treatments initiated. If the physician believes the diversion represents a significant risk to public health, consideration should be given to reporting the individual to law enforcement or asking the NC Controlled Substance Reporting System (CSRS) for assistance.

UDS Reimbursement: The NC Medicaid code is G0434 ($19.84). CPT codes 80100 ($17.94) and 80101 ($16.98) can be used for qualitative drug screening tests that use chromatographic methods for multiple (80100) and single (80101) drug classes. CLIA waivered tests are highly recommended as they cost $4-8 and require far less documentation than non-CLIA tests.

Appendix C: Pain Contracts/Treatment Agreements

The North Carolina Medical Board (NCMB), in its "Policy for the Use of Opiates for the Treatment of Pain," recommends the use of written informed consent and a treatment agreement when treating chronic pain with opioid medications. Agreements, or "pain contracts," are signed by both the provider and patient and identify the goals of treatment.

The agreement typically addresses the patient's responsibility to use the medication(s) safely, to only obtain opioids from one physician/practice, and to undergo periodic drug testing, and the physician's responsibility to be available or have coverage for unforeseen problems and to prescribe scheduled refills. The agreement should include guidelines about prescription refills, how monitoring will occur (e.g., random pill counts and urine drug screening), and conditions under which drug therapy may be discontinued (e.g., violation of agreement).

In the circumstance that a pain contract or treatment contract is violated by a pregnant patient, the medication therapy may not be abruptly discontinued. Federal Guidelines state "Administrative discharge of a pregnant patient is a medically high-risk undertaking. As with all patients, interventions to address problematic behavior should be intensive and begin at the earliest suggestion of concern. Transfer to treatment in another program is preferable to medically supervised withdrawal in pregnancy. It may be helpful for the program to establish transfer agreements for treatment for this purpose in advance of the need. In the rare event a pregnant patient is administratively withdrawn and discharged, the program must ensure referrals are followed through to completion. Provider(s) should carefully follow up the patient's pregnancy and opioid use disorder." [6]

A sample pain agreement can be found on CCNC's website.

[6] Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Appendix D: Use of the Prescription Monitoring Program (PMP) Aware

What is the PMP Aware?

- A controlled substance prescription reporting system that allows registered dispensers and prescribing practitioners to review a patient's controlled substances prescription history on the web

How does the system work?

- All prescriptions for controlled substances, schedule II through V, dispensed in North Carolina are reported into the PMP Aware database
    - Pharmacies are required to report the data every 72 hours
- Prescribers and pharmacists can register to gain access to the online system to look up a patient's controlled substances prescription history
    - Prescribers may legally query the system for their patients only
- Registered prescribers can also delegate someone under their supervision to run queries for their patients
    - The delegate must register with the NC CSRS and will have their own login credentials
    - Guidelines and directions for setting up a delegate account can be found on the website

What should I do with this data?

- The PMP Aware is intended to assist you in providing better care to your patients through monitoring their safety and adherence to legally prescribed controlled substances
    - It is important that you inform your patients that you are using this system to ensure their well-being and quality of care
    - It is also important to assure your patients that the PMP Aware data is not openly shared with nonregistered providers or law enforcement and not used as means to exclude them from future physical and behavioral health services
- If the data reveals that the patient may be seeking, misusing, or diverting large quantities of controlled substances or seeking prescriptions from multiple providers, then the practitioner should discuss this with the patient in a nonjudgmental manner and contact the PMP Aware to discuss with a representative
- If you believe the patient is abusing controlled substances, educate the patient about the risks and refer the patient to a behavioral health provider for substance misuse screening, assessment, and/or treatment if needed

What shouldn't I do with this data?

- The PMP Aware is not intended as a mechanism to exclude or discharge patients without first offering intervention or referral treatment for management of substance use and/or pain
- The PMP Aware is also not intended as a law enforcement investigative or reporting tool
    - If you suspect the patient is inappropriately requesting controlled prescriptions from multiple providers, otherwise known as "doctor shopping," or committing prescription fraud, please contact the PMP Aware program representatives for further guidance
    - Contact 919-733-1765 or NCControlSubstance.Reporting@dhhs.nc.gov

Appendix E: Strategies and Scripts for Brief Interventions and for Discussing Substance use with Pregnant Patients: FRAMES and Brief Negotiated Interview Script

Being open, honest, non-judgmental, and respectful is the first step in establishing rapport in order to talk with patients about substance use and help them make the next step towards addressing it.

- Keep messages clear, simple, and realistic
- Don't predict the outcome of a particular pregnancy
- Deliver personal, individually-tailored messages
- Stress the positive
- Help women assess their risks
- Motivate risk reduction and encourage ongoing hope
- Be sensitive to legal implications

Establish a non-judgmental approach to screening, by using the following script: "At this practice, we ask all of our patients about drug and alcohol use to make sure we are providing the best possible care for you and your baby. Your answers will not affect our commitment to ensuring you receive high-quality prenatal care. What you tell us is confidential and used for medical care purposes only."

Find more detailed approaches in the 'Strategies to Communicate Risk' in Section 5 of the Perinatal Substance Use Manual available from the NC Division of Public Health Women's Health Branch.

There are various frameworks for structuring a brief intervention to address substance use. Below are the Brief Negotiated Interview/Active Referral to Treatment (BNI ART) Institute that summarizes the process of a brief intervention and referral for treatment and the FRAMES model, which is included in the ACOG Fetal Alcohol Spectrum Disorders Toolkit.

Brief Intervention Steps & Sample Interview Script

1. **Raise subject and ask permission**
   a. Acknowledge positives where applicable.
   b. Ask to review lifestyle factor information gathered (use has already been established)

Sample Script

1a. "I'm glad you came today for prenatal care."
- Review positives: ex., overall health, lab results, early access of prenatal care

1b. "I'd like to review lifestyle factors that may affect your health and the health of the baby; would that be ok?" (Pause and listen)

2. Provide Feedback

a. Review screening questions
b. Make connection between substance use and potential impact on health of baby

Sample Script

2a. "From what I understand you are currently using [insert substance]."
2b. "What do you know about [insert substance] effects on the health of the baby?" (Pause and listen)

- Reflective listening, state what she has said: "Your understanding is that [insert substance] doesn't have an effect on the baby."
- "What we do know about [insert substance] and the developing baby is that it can cause problems such as [insert medical information]."
- "What do you think about that information?" (Pause and listen)

3. Enhance Motivation

a. Explore pros and cons of continued use of substance
    - Use reflective listening
    - Assess readiness to change
    - Reinforce positives
    - Develop discrepancy between ideal and present self

Sample Script

3a. "Help me understand the good parts about [insert substance] for you." (Pause and listen)

- "And now we know about some not good parts for the pregnancy. Are there other parts of [insert substance] that have caused problems for you or that you don't like?" (Pause and listen)
- "On the one hand you said… (restate pros)"
- "On the other hand you said… (restate cons)"
- "Where does this leave you? On a scale of 1-10 of readiness to change, where would you put yourself?" (Show readiness ruler)
- "Why that number and not a lower one?" (Pause and listen) "Are there other reasons to change?" (Pause and listen)
- How does this fit with where you see yourself in the future?" (Pause and listen)

4. Negotiate and Advise

a. Negotiate goal
b. Benefits of change
c. Reinforce resilience/ resources
d. Summarize
e. Provide handouts
f. BNI-ART, SBIRTNC, Handmaker & Hester

Sample Script

4a. "If you do decide to stop using [insert substance], at least during your pregnancy, you have a better chance of having a healthy baby."

4b. "If you choose to make that decision, I believe you can do it." (Pause and listen; if she expresses doubt about ability to make changes, offer help through a referral)

4c. "It can be challenging to do alone, and you don't have to. I have someone I'd like to connect you with who has a lot of experience supporting women to make behavior change."

4d. "What is the next step?"

4e. Review plan for change, document, and agree to check in on plan at next prenatal visit. Provide mother to baby fact sheet. Provide warm handoff for assessment and treatment referral.

FRAMES

F Feedback

Compare the patient's level of drug or alcohol use with patterns that are not risky. She may not be aware that what she considers normal is actually risky. Inform the patient that any drug or alcohol use in pregnancy is considered risky. Check the patient's understanding of the effects of substance use on herself and her fetus and whether these effects are of concern to her.

R Responsibility

Stress that it is her responsibility to make a change.

A Advice

Give direct advice (not insistence) to change her behavior.

M Menu

Identify situations that involve the use of drugs or alcohol and offer options for coping.

E Empathy

Use a style of interaction that is understanding and involved.

S Self-efficacy

Elicit and reinforce self-motivating statements such as, "I am confident that I can stop drinking." Encourage the patient to develop strategies, implement them, and commit to change.

Appendix F: Overview of Child Abuse Prevention and Treatment Act (CAPTA), Reporting of Substance-Exposed Pregnancies, and Sample Script for Providers

In North Carolina, substance use during pregnancy is not reportable to the Department of Social Services.

The Keeping Children and Families Safe Act (2003) Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized in 2003. This federal law requires states to create policies and procedures to address the needs of infants born and identified as being affected by illegal substance use or withdrawal symptoms resulting from prenatal drug exposure. This includes appropriate referrals to child protection service systems and for other appropriate services.

CAPTA includes a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence. North Carolina's policy and practice is consistent with this requirement, and includes prenatal alcohol exposure as cause to refer to child protective services.

Local Departments of Social Services (DSS) accept referrals for infants reported to have been exposed to substances prenatally, at the time of birth. When a referral is made by the health care provider, DSS utilizes a structured intake tool that includes the question, "Has the parent's alcohol/drug use resulted in a positive screening at the child's birth?" DSS's role is to assess the safety of the infant in the current family and living situation. The DSS assessment will indicate what response is necessary for the health and safety of the infant.

References for Appendix F

US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. "The Child Abuse Treatment and Prevention Act." June 2003.

North Carolina Department of Health and Human Services, Division of Social Services, Family Services Manual, Volume I: Children's Services, Chapter VII: Child Protective Services. 19-65.

Appendix G: Guidance on Documentation and Disclosure of Information Related to Substance Use and Its Treatment

Federal substance use confidentiality regulations (42 CFR, Part 2) do not apply to patient self-disclosure to her OB/GYN provider or to information gathered from anyone who is not a substance use treatment provider, such as a care manager, primary care physician, emergency department, etc. In the health record, OB/GYN providers should be careful, when documenting and disclosing information related to substance use, to include only medically necessary and accurate information with no subjective comments. ACOG Committee Opinion Number 633 (2015, reaffirmed 2018) states that "concerns about breaching confidentiality and causing harms through disclosure can be appropriately addressed by including only accurate and medically necessary information in the medical record and informing the patient why and how this information will be included."

Any diagnosis or treatment information received from a "Part 2 facility" (i.e., a substance use treatment provider that is supported by federal funds) should be accompanied by a specific release of information form that will include language regarding 42 CFR, Part 2, as well as a written notice prohibiting redisclosure. This treatment information should be kept in a separate secure file.

Appendix H: Patient Education Resources

March of Dimes

This website provides information for patients on the effects of tobacco, alcohol, and drug use during pregnancy. There is information focused on how these substances may harm the patient as well as affect her pregnancy. There are also resources for those that would like help stopping use of these substances.

CDC: Alcohol Use in Pregnancy

This website is available in English and Spanish and provides information about why alcohol is dangerous in pregnancy, as well as how much and when. Resources are provided for those that are interested in help to quit drinking. Free posters and brochures on this topic are available to order or download on this webpage.

ACOG FAQ on Tobacco, Alcohol, Drugs & Pregnancy

This fact sheet provides information on how the use of various substances may affect the patient's pregnancy. Information about receiving treatment and why this is important is provided. Questions on why the patient should tell their health care provider about substance use is also included.

Alcohol Drug Council of North Carolina: Women's Services

This is the webpage for the Women's Services section of the Alcohol/Drug Council of North Carolina website, a statewide organization which can assist patients in finding a residential or outpatient treatment program. For information and help, call Judith Johnson-Hostler at (800) 688-4232 or email jjones@alcoholdrughelp.org.

North Carolina Coalition Against Domestic Violence

This website is available for women who are involved with a controlling and/or abusive partner and may need assistance with information, shelter, and legal issues. The state program has information and connections to local programs across North Carolina. A list of NC Domestic Violence Service Providers statewide and by county is available under the "Get Help" tab. The NC Domestic Violence Hotline is 1-800-799-SAFE (7233). If providing this information to a patient, note that not all of the pages open with the pop up box providing instruction on how to quickly navigate away from the site.

UNC Horizons

This is the website of UNC Horizons, one of the residential programs in North Carolina which serves pregnant and parenting women and their children. This website includes information about the services offered, FAQs, and success stories.

Intermountain Healthcare: Prescription Pain Medication in Pregnancy

This patient education fact sheet from Intermountain Healthcare provides information on opioid pain medication. This includes a section on how this medication may affect the baby including the risk of NAS.

Intermountain Healthcare: Substance Use During Pregnancy

This patient education fact sheet from Intermountain Healthcare provides information on various substances and their potential effects on pregnancy. Resources are listed for those that would like more information or help locating treatment for substance use.

MothertoBaby

These printable fact sheets are available in English and Spanish and information on the effect of different substances such as cocaine and marijuana during pregnancy and beyond.

UCSF: Substance Use During Pregnancy

This patient education website from UCSF Medical Center provides a brief summary on the effect of different substances on the baby.

Appendix I: Provider Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)

This is the website of SAMHSA, a federal agency dedicated to developing effective programs for individuals and families struggling with mental health or substance use issues. Its website has thorough, reliable information on alcohol and drugs and free publications available for ordering or download. To download or order publications from the SAMHSA website, click here.

Relevant publications include the following Treatment Improvement Protocols (TIPs):

- TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment
  - Offers guidelines to help clinicians influence the change process in their clients by incorporating motivational interventions into substance use treatment programs
  - Describes different motivational interventions that can be used at all stages of change
- TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
  - Practice guidelines help physicians make decisions about using buprenorphine to treat opioid addiction
  - Includes information on patient assessment, protocols for opioid withdrawal, and the treatment of pregnant women, teens, and polysubstance users
- TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
  - Gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal
  - Discusses screening, assessment, and administrative and ethical issues

The following two compendiums from SAMHSA treat the topics of forming a collaborative community-wide network for care providers of pregnant women with SUD and providing clinical guidance for this population on a case by case type of presentation basis. Both treatises are excellent guides for creating a community-wide and individual patient-based care, respectively, for this complex group of patients.

- A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. http://store.samhsa.gov
- Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. http://store.samhsa.gov

Report of the Surgeon General, 2016

This compendium covers the topic of addiction in its totality with more contemporary resource material extending up to 2016. It includes a very useful and timely chapter on the Neurobiology of Substance Use which elucidates the CNS circuitry of pharmacologic addiction.

- U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

US Center for Disease Control and Prevention (CDC)

This website has an effective, clear treatment of SBIRT (screening, brief intervention, referral for treatment) in pregnancy and the peripartum period from the CDC, which convened an Expert Meeting on Perinatal Illicit Drug Abuse in Atlanta in September 2012. This article represents the formal conclusions from that meeting: The Role of Screening, Brief Intervention, and Referral to Treatment in the perinatal Period. AJOG, November 2016, p539-547.

NIH: National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) website is part of the National Institutes of Health (NIH) and focuses entirely on the use of alcohol, drugs, and other substances. It also has great information and publications to share. This website contains information about drugs of use. Under each of these is a webpage with specific information about these drugs, and some, such as marijuana and heroin, include specific information about the potential adverse effects of using the substance during pregnancy.

American Society of Addiction Medicine (ASAM)

This website has information of interest to physicians, including on the topic of Medication-Assisted Treatment (MAT).

ACOG Committee Opinions

The following list of relevant ACOG Committee Opinions may be helpful as additional resources on each of these specific topics.

- Committee Opinion No. 711: Opioid Use & Opioid Use Disorder in Pregnancy; August 2017
- Committee Opinion No. 496: At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications; August 2011, Reaffirmed 2013
- Committee Opinion No. 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist; January 2011, Reaffirmed 2014
- Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice, June 2015, Reaffirmed 2018

North Carolina Pregnancy and Opioid Exposure Project (NC POEP)

This website is sponsored by the NCDHHS and provides the NC guidance on pregnancy and

opioid exposure as well as other relevant informational materials. This website also includes brief video vignettes about the NC Perinatal Substance Use Program and a demonstration of a brief intervention with a pregnant woman about substance use in pregnancy.

Alcohol Drug Council of North Carolina: Women's Services

This is the webpage for the Women's Services section of the Alcohol/Drug Council of North Carolina website, a statewide organization which can assist patients in finding a residential or outpatient treatment program. For information and help, call the NC Perinatal Substance Use Specialist, Judith Johnson-Hostler, at (800) 688-4232 or email jjones@alcoholdrughelp.org.

NC Healthy Start: Perinatal Substance Use Project

This website has information about referrals to treatment and updated bed availability at NC facilities is linked on this site. There is also information on how to access training and technical assistance, as well as publications for professionals available through this website.

North Carolina Coalition Against Domestic Violence

This website is available for women who are involved with a controlling and/or abusive partner and may need assistance with information, shelter, and legal issues. The state program has information and connections to local programs across North Carolina. A list of NC Domestic Violence Service Providers statewide and by county is available under the "Get Help" tab. The NC Domestic Violence Hotline is 1-800-799-SAFE (7233).

Health Cares About Intimate Partner Violence

This website has resources for healthcare settings and includes links to technical assistance from the National Health Resource Center on Domestic Violence. There is a Screening and Counseling Toolkit for providers under "How to Screen." Under "Specific Setting – Reproductive Health," there is a list of resources including the ACOG Committee Opinion No. 518; February 2012 on Intimate Partner Violence.

UNC Horizons

This is the website of UNC Horizons, one of the residential programs in North Carolina which serves pregnant and parenting women and their children. This website includes information about the services offered, FAQs, and success stories.

NC Governor's Institute: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

This website has information on the role of screening, brief intervention, and referral for treatment in the perinatal period. (Wright TE, Terplan M, Onderama SJ, et el; American Journal of Obstetrics and Gynecology, 2016: 215: 539-547).

Appendix J: Reimbursement and Coverage of Substance Use Disorder Services for Pregnant Women

SBIRT Counseling in the Prenatal Care Setting

North Carolina Medicaid covers two CPT codes associated with SBIRT counseling:

- CPT 99408 – Alcohol and/or substance use (other than tobacco) structured screening and brief intervention services; 15-30 minutes
- CPT 99409 – Alcohol and/or substance use (other than tobacco) structured screening and brief intervention services; greater than 30 minutes

These codes can be billed in addition to prenatal care services, including the global fee or other OB package codes, and in addition to tobacco cessation counseling codes. These codes can be billed by physicians, nurse practitioners, physician assistants, certified nurse midwives, and health departments.

Coverage of Substance Use Disorder Treatment for Pregnant Patients

Substance Use Disorder and behavioral health services are covered for pregnant Medicaid beneficiaries, including for women in the Medicaid for Pregnant Women (MPW) category. All pregnant women with Medicaid coverage, regardless of coverage category, are exempt from co-payments for pregnancy-related services, including prescription drugs and behavioral health. For details, see the February 2013 NC DMA Provider Bulletin article "Psychiatric Services Available to Pregnant Medicaid Beneficiaries."

Buprenorphine Coverage

North Carolina Medicaid covers buprenorphine as part of the pharmacy benefit. This medication requires prior approval. The one-page fact sheet from NC DHHS, "Opioid Dependence Therapy Agents PA Request Form" form can be found on the NC Tracks website under "Opioid Dependence Therapy Agents." Therapy may be approved for up to 9 months during pregnancy and in 2 month increments thereafter during breast feeding.

Appendix K: The NC Perinatal & Maternal Substance Use Initiative and the CASAWORKS for Families Residential Initiative

The North Carolina Perinatal and Maternal Substance Use Initiative and CASAWORKS for Families Residential Initiative represent a nationally recognized statewide approach to the social and health challenges associated with family addiction. The 28 programs, located in 13 counties across the state, use evidence-based treatment models. All the programs in the Initiatives are "cross-service area," meaning they accept women from any part of the state; this helps to meet the need of pregnant and parenting women who do not have gender-or family-responsive treatment in their home communities.

More than 20 years of research show that women are motivated to engage with treatment and recovery by concern for their children or pregnancy but that they are often unwilling to seek treatment if it means leaving their children. The NC Initiatives address this by providing family-responsive care that includes, but is not limited to, behavioral health treatment services for pregnant and parenting women, parenting support, arrangement for treatment and prevention services for children, referral for and coordination with medical care for women, and referral and coordination for pediatric and developmental care for children. Job readiness and job coaching are key provisions in the 8 CASAWORKS for Families sites which have a primary goal of self-sufficiency.

Through a capacity management system with an online bed availability list, health care providers, Department of Social Services social workers, and treatment providers can refer women and their children to the services they need anywhere in the state. Women in need of services can also access this system to identify appropriate treatment resources statewide. Providers and women can contact the NC Perinatal Substance Use Coordinator at 1-800-688-4232 for assistance identifying a program for managing the referral process. A flyer describing the Perinatal Substance Use Coordinator's services can be found here.

Appendix L: Guidance on Prescribing Buprenorphine in Pregnancy

What is buprenorphine?

- Buprenorphine is an opioid medication used to treat opioid addiction and can be dispensed for take home use, by prescription
    - Physicians must take Waiver Training in order to prescribe or dispense
- Buprenorphine is an opioid partial agonist
    - It produces typical opioid agonist effects and side effects, but its maximal effects are less than those of full agonists like heroin and methadone
    - At low doses buprenorphine produces sufficient agonist effect to block withdrawal symptoms
    - The agonist effects of buprenorphine increase linearly with increasing doses of the drug until at moderate doses there is a "ceiling effect," meaning that it carries a lower risk of use, addiction, and side effects compared to full opioid agonists
- Buprenorphine is available in a variety of formulations including Suboxone®, Subutex®, Zubsolv® and can be a single ingredient product or it can be mixed with naloxone to create a combination ingredient product
    - Naloxone formulations render the combination product less conducive to misuse (e.g., injection)
- This fact sheet from the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provides an overview of buprenorphine treatment

Is buprenorphine safe during pregnancy?

- Studies have found that treatment with buprenorphine has similar outcomes to methadone treatment during pregnancy
    - Source: Meyer MC1, Johnston AM, Crocker AM, Heil SH. J Addict Med. 2015 Jan 22. [Epub ahead of print] Methadone and Buprenorphine for Opioid Dependence During Pregnancy: A Retrospective Cohort Study.

Where can I find information on how to become a buprenorphine provider?

- Qualified physicians can receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid addiction treatment
    - This waiver allows qualifying physicians to prescribe medication-assisted treatment for opioid addiction with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA), including buprenorphine
- Physician waiver qualifications can be found at on SAMHSA's website

- ASAM, APA, and AAAP all offer 8-hour online training for physicians to complete the training requirement for CSAT certification to prescribe buprenorphine in office-based treatment of opioid-dependent patients

How can I find buprenorphine providers?

- SAMHSA's website has a physician and treatment program locator
- The National Alliance of Advocates for Buprenorphine Treatment's website offers a few different options for locating physicians and programs

Additional links

- http://buprenorphine.samhsa.gov
- http://pcssmat.org
- http://pcss-o.org