Reference Guide for Substance Use during Pregnancy

SBIRT-see accompanying algorithm below

Screen

- Screening of all pregnant women at first prenatal visit and end of second trimester
- Elicit use/abuse prior to pregnancy as well as current use
- Ensure that all women are screened in a respectful and non-judgmental manner. Normalize the process in your office protocol.
- Understand that how screening is handled impacts the pregnant women's use of prenatal care
- Identify co-morbidities including psychiatric illness and domestic violence.

Brief Intervention

- Advise all women, even non-users. Share medical advice related to use/abuse and impact on pregnancy and outcome.
- Provide feedback on screen results if substance use/abuse identified:
    - Provide positive reinforcement for patient honesty in answering screening questions
    - Ask what she knows about the effect on pregnancy/newborn and how the use/abuse affects her health and life.
    - Readiness to change behavior/accept treatment: "would you like to stop?". If using scale, 0 (not likely) to 10 (very likely)
    - Signs of acute withdrawal or intoxication
- Express concern about level of use when appropriate "I know you want a healthy pregnancy and baby. It's important you don't use any____ while pregnancy because…"
- Advise to stop all use. If physically dependent, refer to appropriate resources (see referral to treatment)
- Determine level of risk. Screening alone does not diagnose a substance abuse disorder.
- Assess and validate a women's reaction and discuss her feelings/thoughts. Assess her ability to change
- May include urine toxicology (UTOX2.) Send confirmatory testing for positives if patient denies use. Pain panel if in treatment with methadone/buprenorphine. Standard urine tox will not detect synthetic opioids, designer drugs and some benzos; consider pain panel instead of UTOX if suspected.

Referral to treatment

- Offer to help based on readiness to change. "We both have the same goals, healthy pregnancy and baby." Ask what she will do and agree on a plan.
- Praise all efforts to change
- Refer for inpatient stabilization/detox if Alcohol/Benzodiazepine/barbiturate dependent or medically/psychiatrically unstable
- Refer to addiction treatment. Resources to help with referral include:
    - *Opioid Addiction in Pregnancy* trifold
    - Addiction Treatment resource list in WHI Clinical Sharing in Epic
    - To assist in referrals
        - Contact Jennifer Ayala RN, BSN at 440-312-7713
        - Contact hospital social workers
    - Obtain consent/release for coordination of care between Ob provider and addiction treatment provider/center.

Antepartum 1st trimester

- SBIRT screening at first visit (See algorithm on page 3). **The purpose of screening is to stratify into zones of risk.**
- Positive SBIRT screening should prompt further questioning to determine substance use risk.
- Assessment may include urine toxicology (UTOX2) with patient consent. Send confirmatory testing for positives if patient denies use. Pain panel if in treatment with methadone/buprenorphine. Standard urine tox will not detect synthetic opioids, designer drugs and some benzos; consider pain panel instead of UTOX2 if suspected.
- If patient already in treatment program, obtain consent for coordination of care with treatment provider
- Screen for mental health problems and domestic violence as there is significant correlation with substance use.
- Check patient's OARRS record (accessible directly from Epic sidebar)
- Draw Hepatitis C in addition to STIs and HIV
- Dating Ultrasound upon entry into care
- For assistance in referrals contact: Jen Ayala RN BSN 440-312-7713; *Opiates in Pregnancy* trifold. For treatment resources see *Addiction Treatment Resources in Pregnancy* in Epic Clinical Resource Sharing
- Give patient information about maternal drug use including both maternal/fetal/neonatal risks *(see WHISBIRT Smartset for patient education.)*
- Consider more frequent visits

Antepartum 2nd and 3rd trimesters

- Develop pain management plan for labor. Most patients will likely need epidural for adequate pain control. Total buprenorphine can be divided into q 6 hour dosing for pain relief
- 18-20 week anatomy ultrasound
- Give patient information for NAS and what to expect during both maternal and neonatal hospitalization
- Consider monthly Ultrasounds starting at 28-32 weeks to monitor growth and fluid
- Consider repeating HIV/Hep C/STI
- Discuss contraceptive options and make plan. Sign consents for postpartum LARC and tubal ligation when indicated.
- Schedule NAS Pre-Natal consults with neonatology at 36 weeks by contacting Kelly Williams at williak5@ccf.org or 216-401-7575. If patients do not complete consult prenatally then consult neonatology on admission.
- Inform patient that drug testing may be performed on admission and on baby after delivery. Social services will be contacted if illicit drugs are detected.
- Discuss extended LOS for newborns for NAS scoring
- Review breastfeeding guidelines with mothers. When stable in treatment on buprenorphine or methadone and not using illicit drugs, mothers should be encouraged to breastfeed. Breastfeeding is not recommended if mothers continue to use illicit drugs, including marijuana.
- Perform random urine drug toxicology to monitor how well patient is doing with treatment. The standard urine drug test will not detect methadone or buprenorphine, instead pain panel is recommended for patient in treatment.

Intrapartum

- Urine toxicology (UTOX2) with patient consent on admission. Send confirmatory testing for positives if patient denies use. Pain panel if in treatment with methadone/buprenorphine. Standard urine tox will not detect synthetic opioids, designer drugs and some benzos; consider pain panel instead of UTOX if suspected.
- While patient is admitted to the hospital, an attending provider may legally prescribe buprenorphine and methadone to maintain a patient's outpatient dose during hospitalization.
- Consult Ob Pharmacists (by vocera) for assistance with medication management during admission
- Anticipate that an opioid dependent mother will require higher and more frequent dosing of narcotics for pain

- Methadone and buprenorphine should be continued at their normal dose. Consider split dosing of total dose for increased analgesic effects
- **Do not use Nubain or Stadol for pain control during labor in opioid dependent patients. All patients should be asked about substance use history prior to use of these medications and informed that these drugs can precipitate acute withdrawal**
- If Nubain or Stadol causes acute precipitated withdrawal, symptoms can be reversed with IV Fentanyl or Morphine
- Care management consult should be ordered
- Alert pediatrics/neonatology. NICU consult on admission if not completed previously.
- Offer LARC
- Regional analgesia is a safe and effective way to control pain for both vaginal and cesarean births. Patient may require increased doses of pain medication.
- If opioid use, not previously recognized, is disclosed at time of delivery consider inpatient psychiatric consult or phone consultation with addiction specialist or treatment center. Withdrawal in labor can be managed with IV or PO opioids then patient transitioned to treatment after delivery.

General Postpartum

- Women who are stable in treatment on buprenorphine or methadone and do not use illicit drugs should be encouraged to breastfeed. Breastfeeding is not recommended when mothers continue to use illicit drugs, including marijuana.
- Skin to skin and rooming in should be encouraged
- Have plan in place for continuation of treatment following discharge as postpartum patients are especially vulnerable to relapse. Treatment dosage should be re-evaluated by addiction treatment provider or center immediately after discharge.
- Encourage and provide contraception, consider LARC as first line option

Postpartum Vaginal

- Patients on chronic opioids are more sensitive to pain and should be managed appropriately. Order scheduled doses of NSAIDS and Acetaminophen rather than prn.
- Continue regular maintenance dose of Methadone or buprenorphine following delivery.
- For all vaginal deliveries regardless of opioid use: Avoid prescribing routine narcotics unless patient has had a complicated vaginal delivery, i.e. Extensive perineal lacerations, third or fourth degree lacerations.

Postpartum Cesarean

- Continue maintenance dose of Buprenorphine or Methadone. Consider split dosing of total dose for increased analgesic effects
- Scheduled IV Toradol and Tylenol then schedule NSAIDS/Tylenol around the clock after 24 hours
- Oral opioids added for breakthrough pain in addition while maintaining buprenorphine and methadone
- Follow Ohio Opioid Prescribing rules when prescribing narcotics at discharge for all cesarean section patients.

Screen for substance abuse using 4Ps screening tool in Epic

All **positive** answers should trigger further questioning to determine use, level of risk and when appropriate readiness to change. **See brief interview in box below.** Urine toxicology with consent

Negative screen or Low risk

- No past or current use
- Low level of use stopped prior to immediately upon known pregnancy

- Reinforcement and support of current behavior
- Verbal and/or written information of risks of use
- Rescreen 24-28 weeks

Moderate Risk

- High Use in past, including recent treatment
- Stopped use late in pregnancy
- Continued low level use

- **Brief intervention and Motivational interviewing** (increase patient motivation to change)
- Frequent follow-up visits to reassess
- Offer referral to substance abuse counselor
- Rescreen 24-28 weeks

High Risk

- Current substance use while pregnant

Referral to treatment

Denies need for treatment

- Provide information about maternal-fetal risks
- Address psychosocial co-morbidities
- Close interval follow-up

Acute withdrawal?

Yes

No

Go to ER/Ob triage for immediate evaluation and treatment

Inpatient for stabilization/detox if:

- Alcohol/benzo/barbiturate dependent or
- Unstable medically or psychiatrically

- Referral to residential or intensive outpatient treatment **OR**
- Referral to office-based addiction treatment provider or MAT
- **AND** counseling with substance abuse counselor
- **AND** sign consent to coordinate substance abuse treatment plans

TABLE 2
Components of brief interview (modified[41])

Raise subject	• "Thank you for answering my questions—is it ok with you if we talk about your answers?" • "Can you tell me more about your past/current drinking or drug use? What does a typical week look like?"
Provide feedback	• "Sometimes patients who give similar answers are continuing to use drugs or alcohol during their pregnancy." • "I recommend all my pregnant patients not to use any alcohol or drugs, because of risk to you and to your baby."
Enhance motivation	• "What do you like and what are you concerned about when it comes to your substance use?" • "On a scale of 0—10, how ready are you to avoid drinking/using altogether? Why that number and not a ____ (lower number)?"
Negotiate plan	• Summarize conversation. Then: "What steps do you think you can take to reach your goal of having a healthy pregnancy and baby?" • "Can we schedule a date to check in about this next time?"

Wright. SBIRT in pregnancy. Am J Obstet Gynecol 2016.

Resources for Assistance

- Jen Ayala RN, BSN 440-312-7713
- Opiate Addiction and Pregnancy Trifold
- Addiction Treatment Resource in Epic
- Fairview social workers: Barb Gareau (216-339-1913) or Samantha Juhn (216-317-2553)
- Hillcrest social workers: Jenny Bayer (216-704-1714) or Kaia Trubiano (216-267-8658)
- CCF Behavioral Health 216-363-2122)

Adapted from: Snuggle ME Project, retrieved from maine.gov; Substance Use Disorders in Pregnancy, Guidelines for Screening and Management, rev. ed. 2016, Washington State DOH; Wright et al. The role of screening, brief intervention, and referral to treatment in the perinatal period. AJOG Nov. 2016

Billing and Coding for Substance Use Screening and Counseling

Service	CPT Code	Description	Notes
Screening only (without intervention)			
Medicaid/Commercial Insurance	96160	Administration of patient focused health assessment instrument with scoring and documentation, per standardized instrument	Used to bill for negative or low risk screen results
Screening with intervention			Use WHISBIRT Smartnote or Smartphrase to document intervention and time spent
Medicaid	G0396	Alcohol and/or substance (other than tobacco) abuse structed assessment and brief intervention, 15-30 minutes	
	G0397	Alcohol and/or substance (other than tobacco) abuse structed assessment and brief intervention, >30 minutes	
Commercial Insurance	99408	Alcohol and/or substance abuse Structured screening and brief intervention services, 15-30 minutes	
	99409	Alcohol and/or substance abuse Structured screening and brief intervention services, >30 minutes	
Tobacco counseling	99406	Smoking and tobacco cessation counseling visit, 3-10 minutes	Counseling discussion and time spent must be documented
	99407	Smoking and tobacco cessation counseling visit, >10 minutes	Counseling discussion and time spent must be documented
Substance Use counseling			Must account for >50% of visit time and number of minutes of counseling must be specified
	99212	Total visit 10-14 minutes	
	99213	Total visit 15-24 minutes	
	99214	Total visit >=25 minutes	

Z13.9 Encounter for screening (SBIRT)

-for negative screen, low risk, or interventions <15 minutes

Z71.41 Alcohol abuse counseling and surveillance

-PLUS specific F10 series code for alcohol related disorders

Z71.51 Drug abuse counseling and surveillance PLUS specific drug code

-F11 series for opioid use

-F12 series for marijuana use

F17.2 Nicotine dependence

References

American College of Obstetricians and Gynecologists. Opioid use and opioid use disorder in pregnancy. Committee Opinion no. 711. Obstet Gynecol 2017;130:e81-94.

Department of Family Medicine, Oregon Health and Science University. SBIRT Oregon. Available at: www.sbirtoregon.org. Accessed February 19, 2017.

Krans EE, Patrick SW. Opioid use disorder in pregnancy. Obstet Gynecol 2016;128:4-10d

NNEPQIN. Toolkit for the perinatal care of women with opioid use disorders. Available at: http://www.nnepqin.org/wp-content/uploads/2017/08/ToolkitOUD_Complete_Toolkit.pdf. Accessed January 13, 2018.

The Snuggle ME Project: Embracing drug affected babies and their families in the first year of life to improve medical care and outcomes Maine. Maine Centers for Disease Control, Department of Health and Human Services. Available at: https://www.maine.gov/dhhs/mecdc/documents/SnuggleME-Project.pdf. Accessed April 8, 2017.

Washington State Department of Health. Substance use disorders during pregnancy: Guidelines for screening & management rev 2016. Available at: https://here.doh.wa.gov/portals/14/materials/950-135-PregSubs-en-L.pdf. Accessed April 18, 2017.

Wright TE, Terplan M, Ondersma SJ, et al. The role of screening, brief intervention, and referral to treatment in the perinatal period. Am J Obstet Gynecol 2016;215:539-47.