Substance Use In Pregnancy and Postpartum Toolkit

Oregon Perinatal Collaborative

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Inclusive language notice:
This toolkit is intended to improve care and outcomes for pregnant and postpartum people who have a wide range of gender identities. For this reason, we use both gendered and non-gendered terms including “birthing person/people,” “patient,” “mother,” and “maternal,” to reflect this range of identities. We affirm that respecting individual patient preferences regarding gendered language throughout their care is essential to respectful, patient-centered care.

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Section I: Purpose and Background

Oregon has one of the highest rates of alcohol and non-prescribed drug use in the United States (SAMHSA). Untreated mental health conditions, including substance use disorders (SUDs), are the current leading cause of preventable maternal death in Oregon (MMRC, 2025; Bruzelius & Martins, 2022). While SUDs are more common among men than women, the gender gap is narrowing (McHugh, 2018). Women are more likely to begin substance use at an earlier age and experience more severe adverse medical, psychiatric, and functional consequences related to SUDs, when compared with men (McHugh, 2018). Violence and other forms of abuse, including early childhood adverse events, are common experiences for women with SUD (Duka, 2023). When people with SUD become pregnant, they often present late to care and receive limited or no care due in part to the stigma surrounding substance use during pregnancy, fear of child removal, and systemic barriers such as lack of coordinated perinatal and treatment service (Paris et al, 2020; SAMSA, 2024; Shadowen et al, 2021). Parental substance use, in turn, is the most common reason for early foster care placement and puts children at high risk for the long-term adverse health effects associated with foster care (McConnell, 2020).

Yet, substance use disorders are treatable conditions, and pregnancy provides a window of opportunity for intervention. In the perinatal period, people's motivation and capacity for change increase and there are opportunities to connect with care through hospitals, clinics, and community services. When met with key interventions--delivered with support, transparency, and respect--health outcomes for the birthing person and child are improved, and expensive and avoidable emergency room visits and hospitalizations for medical, obstetric, and newborn complications can be reduced (McConnell, 2020).

To make meaningful change related to perinatal SUD, clinical quality improvement work must be thoughtfully designed and consider the needs and priorities of this patient population both inside and outside of healthcare—including housing, social support, transportation, food, and other basic needs. The longstanding silos between physical and behavioral/ mental healthcare must be addressed and integration of people with lived experience of substance use and pregnancy, including those in long term recovery who have specific education and professional training, often called peer support specialists, into the design and implementation is necessary. The long history of systemic racism in the United States has shaped the access and experience of Black, Indigenous, and all people of color inside and outside of healthcare and the stigma associated with substance use during pregnancy can be amplified in communities of color. Quality improvement work aimed at the prevention of pregnancy related morbidity and mortality related to perinatal SUDs must consider these factors and work to advance health for all.

Perinatal Quality Collaboratives (PQCs), including the Oregon Perinatal Collaborative (OPC), are state or multistate networks of teams working to improve the quality of care for mothers, birthing people, and babies. Members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible (CDC). In 2025, the OPC facilitated a multidisciplinary workgroup in Oregon to create this toolkit which will support clinical and non-clinical individuals and teams caring for pregnant patients with substance use disorder. Using the Alliance for Innovation on Maternal Health (AIM) patient safety bundle as core content, this toolkit is designed to improve care, outcomes, and clinical decision making and promote quality and equity statewide. The goal of this toolkit, supporting resources and a planned hospital-based quality improvement initiative is to decrease preventable maternal morbidity and mortality from substance use disorders and improve the health and wellbeing of birthing women and babies in Oregon.

To support teams implementing this toolkit, quality improvement information and tools are included. Simple tools, like those provided by the Institute for Healthcare Improvement (IHI) can be used by teams with minimal introduction or training. These tools help teams take complex topics like substance use disorders in pregnancy and organize them into prioritized, manageable steps that can be implemented, resulting in meaningful change that benefits clinicians, birthing people, and our communities.

Key resources for this toolkit include:

AIM Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle

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

How to Use the Toolkit

This toolkit was designed to be helpful for all roles and settings that support pregnant patients throughout the pregnancy and postpartum period. Recognizing the different emphasis, roles, and responsibilities, it is organized into sections for different audiences.

Section II is aimed primarily at the hospital labor and delivery/ birthing units but has information that will also be useful in other settings. It is intended for a multidisciplinary audience and certain elements included may be outside the scope/ responsibilities of a specific role (e.g. diagnosis) but are presented as part of the total team care elements.

Section III provides quality improvement tools, tailored to hospital teams but potentially useful for all audiences.

Section IV contains links to specific toolkit style information and/or brief resources for:

- Anesthesia, emergency departments, IT/informatics, payors/CCOs, pharmacy and security (brief resources)
- Clinics providing prenatal/ postpartum care
- Lactation
- Pediatrics
- Social work/care/case management
- Traditional health workers
- Treatment/behavioral health providers

Section V includes operational considerations for hospitals

Section VI (Appendix) includes resources for each section of Section II as well as definitions and references

Section II: Steps for Improvement (The 5 Rs)

Readiness: Every Care Setting

Key readiness takeaway:

Hospital-based teams can improve outcomes for people with perinatal SUD by adopting a non-judgmental and evidence-informed approach to care. By including people with lived experience of perinatal SUD in planning and implementation of change processes, we increase our chances of successfully delivering care to those who need it.

- Provide clinical and non-clinical staff education on optimal care for pregnant and postpartum people with SUD, including:
    - Assisting families to complete an Oregon Family Care Plan and the process for public health data collection when it has been completed.
    - Understanding federal, state, and organizational child welfare reporting requirements, and best practices for when a child welfare report needs to be made.
- Establish/identify a multidisciplinary care team to provide coordinated clinical pathways for people experiencing SUDs.
    - Inclusion of THWs (peer support specialists, doulas, etc.) in multidisciplinary teams is critical and efforts must be taken to address power dynamics that can prevent meaningful inclusion and contribute to burn out in this role.
- Develop trauma-informed protocols and anti-racist training to address health care team member biases and stigma related to SUDs.
- 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 support for pregnant and postpartum families for Oregon Family Care Plans, social determinants of health needs, behavioral health supports, and SUD treatment.
    - Include peers/ traditional health workers/ doulas as both a direct referral and a partner in supporting patients accessing other referrals. If this role does not exist in the community, initial work should address this gap.
- Develop and provide patient and family education related to substance use disorder (SUD), naloxone use, harm reduction strategies, and care of infants with in-utero substance exposure.

- Engage partners to assist pregnant and postpartum people and families in the development of Oregon Family Care Plans, starting in the prenatal setting.
    - Include peers/ traditional health workers/ doulas as trusted support in these discussions when possible.

Recognition & Prevention: Every Patient

Key Recognition & Prevention Takeaway:

The screening encounter is an opportunity to build rapport between patients and care teams, provide intervention for risky substance use, and help people engage with care and support for clinical and non-clinical needs.

Universal screening for substance use is an opportunity to build rapport between patients and care teams, provide instrumental care, and link people to support and resources for clinical and non-clinical needs.

- Screen all pregnant and postpartum people for SUDs using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission.
- Screen each pregnant and postpartum person for medical and behavioral health needs and provide linkage to community services and resources.
- Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and provide linkage to resources.

Response: Every Event

Key response takeaway:

Standardized care pathways and warm handoff practices with community partners allow hospitals to provide priority care to people with perinatal SUD during pregnancy and through the first year postpartum.

- Assist pregnant and postpartum people with SUD to receive evidence-based, person-directed SUD treatment that is welcoming and inclusive and, discuss readiness to start treatment, as well as referral for treatment with warm hand-off and close follow-up.
    - Consider harm reduction strategies and include peers/ traditional health workers/ doulas as trusted support in these discussions when possible.
- Establish specific prenatal, intrapartum and postpartum care pathways that facilitate coordination among multiple providers during pregnancy and the year that follows.
- Offer comprehensive reproductive life planning discussions and resources.

Reporting & Systems Learning: Every Unit/Care Setting

Key reporting and systems learning takeaway:

By adopting briefing and debriefs, non-punitive case-reviews, and tracking of outcome and process measures, teams will continue to improve care over time and see the results of their work in improved health outcomes.

- 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.
- Establish a culture of multidisciplinary planning, huddles and debriefs that can help identify successes, opportunities for improvement and action planning for patients in the hospital with complex needs related to perinatal SUD.
- Convene, in an ongoing way, inpatient and outpatient providers and community stakeholders, including those with lived experience, to share successful strategies and identify opportunities to improve outcomes and system-level issues.

Respectful, Equitable, and Supportive Care

Key respectful, equitable and supportive care takeaway:

By building a culture of support, transparency, and respect in care for families impacted by SUD, we improve our care and outcomes. By inviting people with lived experience of perinatal SUD to participate in design and implementation of change, we improve our chances of success.

- Integrate pregnant and postpartum people as part of the care team to establish trust and ensure shared decision-making that incorporates the pregnant and postpartum person's values and goals.
- Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals.
    - THWs and all team members who advocate for client refusal or harm-reduction choices are to be supported in this advocacy. It is recognized that this may require more discussion to determine how to best navigate clinical systems that may have policies or cultural norms that need to be addressed to support the client choice.
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support people to understand diagnosis, options, and treatment plans.
- Consider cultural and community specific needs in all support/ services and plans of care, and refer to resources when desired and available.

Section III: Quality Improvement and Data

Quality Improvement Overview

It can be difficult to know where to start with any quality improvement initiative. As teams consider the needs for patients with substance use disorders during pregnancy or postpartum, it is important to first review and consider local current state and opportunities within each section of the 5 R's (Readiness, Recognition & Prevention, Response & Reporting, and Respectful, Equitable and Supportive Care). Once the current state and opportunities are identified, teams can prioritize their work and begin to gather a multidisciplinary team of experts to lead the work. Engaging all impacted stakeholders (including, but not limited to people with lived experience, providers, nursing, social workers, and pharmacists) caring for the maternal/ newborn dyad early in the work is critical to ensure all expert input is incorporated into any processes or practices. This early engagement builds trust and momentum. See Section V for more operational considerations.

Example Quality Improvement Tools

A number of tools are available from the Institute for Healthcare Improvement to support quality improvement processes. The tools below are appropriate for all individuals and teams, regardless of quality improvement training.

1. Driver Diagram
2. Flowchart
3. PDSA Worksheet
4. Project Planning Form
5. Run Chart Tool

Additional quality improvement resources are also listed here for easy access/ review:

- Video on Quality Improvement in Healthcare (8min)
- IHI Essentials Toolkit
- IHI Forming the Team

Data Collection & Analysis Overview

The Oregon Perinatal Collaborative uses the Oregon Maternal Data Center (OMDC) to measure and report on perinatal outcomes. The OMDC is a dynamic, Web-based tool launched in 2015 that helps hospitals calculate, report and improve performance, in a way that is low-burden. Participating hospitals submit patient discharge data—that they already collect—along with a limited set of clinical data to the OMDC's secure website, which automatically generates a wide range of perinatal performance metrics and patient-level drill-down information. The OPC and Comagine Health are primary sponsors of the OMDC.

Type of Measure	Description	Example
Process	Used to monitor the adoption and implementation of evidence-based practices. By using data to track processes of care and examining these data disaggregated by race, ethnicity, and other social and structural drivers of health, facility teams can identify areas for improvement and intervention.	% of deliveries that were screened for substance use disorder
Structure	Used to assess if standardized, evidence-based systems, protocols, and materials have been established to improve patient care. Through adoption and regular review of structures, facility teams improve their readiness to respond to an obstetric event and provide high quality care to every patient, every time.	Validated verbal screening tool/ resources shared with prenatal sites.
Outcome	Used to examine changes that occur in the health of an individual, group of people, or population that can be attributed to the adoption of clinical best practices. Outcome measures should be disaggregated by race, ethnicity, and other social and structural drivers of health to examine inequities.	% of deliveries with opioid use disorder (OUD) who received medication for opioid use disorder (MOUD)

Section IV: Links to Focused Area Content

- Brief resources for anesthesia, emergency departments, IT/ informatics, payors/ CCOs, pharmacy and security
- Clinics providing prenatal/ postpartum care
- Lactation
- Pediatrics
- Social work/care/case management
- Traditional Health Workers
- Treatment/Behavioral Health Providers

Recommendations for Policy Change

While is it urgent that we improve care for pregnant and postpartum people who have substance use disorders now, it is also important that we make upstream policy and structural changes to reduce substance use disorders and create systems where wraparound, integrated physical and behavioral health care is accessible to anyone seeking care. The following population-based policy changes are needed to improve the health of our communities and to reduce substance use, not just in pregnancy and postpartum, but over the whole life cycle.

Policy Change Resources

American Society of Addiction Medicine Policy Statements
Partnership to End Addiction. Ending the Opioid Crisis: A Practical Guide for State Policymakers
NASHP: State Strategies for Preventing Substance Use and Overdose Among Youth & Adolescents
National Governor's Association: Addressing the Link Between Trauma & Addiction
CDC Injury Center: Policy Approaches to Preventing ACEs

Policy changes to reduce substance use disorders:

Many of the policy changes that are needed to reduce substance use disorders in our communities target social determinants of health such as poverty, adverse childhood events, and structural racism that increase the likelihood of substance misuse and addiction. Effective prevention of addiction would mean that people's basic needs are met, and they are connected in healthy communities especially during pregnancy and early childhood. Key policy levers include:

- Living wage requirements
- Policies that support affordable housing & provide emergency housing to pregnant and postpartum families
- Funding to improve access to food including SNAP, WIC, food banks, & school lunches
- Pregnancy, postpartum, and early childhood home-visiting programs
- Child tax credits
- Funding for universal access to high quality childcare & early childhood education
- Long-term, developmentally appropriate social and emotional learning and risk and protective factor curricula in schools
- School-based behavioral health and SUD treatment

- Universal mental health and SUD screening in primary care
- Funding for behavioral health workforce development
- Policies that improve access to behavioral health care and social support
- Medicaid Expansion
- Insurance coverage requirements for Medication Assisted Treatment and Naloxone

Policy Changes to Improve Access to Care for pregnant & postpartum people with SUD in Oregon

- See SB 691 from 2025 Oregon legislative session for model legislation
- Remove barriers to payment for peer delivered services in medical and behavioral health settings
- Create a Medicaid bundled payment for wraparound, integrated physical & behavioral health care with peer support for perinatal SUD
- Provide funding for expansion of Nurture programs in Oregon
- Change Oregon Administrative Rules to prioritize postpartum entry to treatment (up to 12 months), as is already done in pregnancy
- Fund and plan for workforce development and cross-training to support perinatal SUD care. Possibilities include:
    - Loan forgiveness for working with maternal and SUD populations
    - Funding for addiction medicine fellowships that include CNMs and Nurse Practitioners
    - Funding for behavioral health and SUD training for maternity providers
    - Funding for perinatal health training for behavioral health providers
    - Formalized pathways for mentorship/training for maternity providers wanting to gain experience in SUD treatment
    - Mandatory SUD and mental health continuing education for maternity providers and nurses
- Allow direct admission to hospital for treatment of SUD during pregnancy and postpartum
- Create a newborn day rate as in Washington state to allow hospitals to bill for stabilizing care for the for birthing parent with SUD while newborn is hospitalized
- Consider a state funded hospital-based detox/stabilization program for pregnant patients where the most unstable people who need hospitalization can come for specialty care
- Provide funding to support an increase in residential and other treatment programs for pregnant people, women, and mothers with an OUD throughout the state. This is a particular challenge in rural and frontier Oregon

- Enhance the Oregon Psychiatric Access Line (OPAL) to include maternal mental health consults
- Create a perinatal specific state addiction consult line
- Create financial incentives for hospitals to develop and integrate SUD services (addiction medicine)
- Remove rule that says if someone has abstained from using substance for 30 days that they do not longer qualify for residential treatment (this is an issue postpartum with some frequency)
- Fund work group to plan for best practices for SUD treatment in rural Oregon
- The OHA, in partnership with the Oregon Perinatal Collaborative and Comagine Health, should implement a surveillance strategy for perinatal substance use related outcomes

Section V: Operational Considerations

Operational Considerations for Hospitals

Each site will need to evaluate local resources and infrastructure to support successful implementation of this toolkit. The following considerations are not exhaustive but are provided as a prompt for local teams to begin the necessary detailed discussions and generation of additional questions that will support successful implementation of the toolkit.

- Do you currently have multidisciplinary team members to support quality improvement work to optimize SUD care in your hospital? Consider an OB champion, newborn champion, nursing champion (maternal and newborn), behavioral health, anesthesia, pharmacy, peers/ specialized doulas, security, etc.? Should you include others?
    - Have these team members worked together outside individual care before? What do you need to create team-based care?
- Are there OB providers available 24/7 at the hospital to prescribe/ initiate medications for opioid use disorder (MOUD) and/or medically manage withdrawal symptoms?
    - If there are not OB providers available, are there other providers in the hospital offering this care who could consult?
- Do you have providers/ clinics in the community who will continue treatment for OUD with MOUD following discharge?
    - Where is the closest Opioid Treatment Program (OTP) where patients can access methadone? What are their hours? What is their intake process? Do they also offer buprenorphine?
    - Are there providers/ clinics offering Office Based Opioid Treatment (OBOT) for patients who want to continue treatment with buprenorphine? Do they care for pregnant patients, or would they?
- Do you have relationships with community partners who support patients and families with SUD with wrap around support outside the hospital?
    - If not, what do you need to start building these important relationships (e.g. treatment providers, community recovery support, temporary housing, peer support services, harm reduction services, legal aid, food, home visiting programs, family relief nurseries, etc.)?
- Does your hospital have a guideline for responding to in-hospital substance use, intoxication, or possession?
    - Does this include an alternative to calling security and/or law enforcement and clarity on when to involve security?

    - Does your hospital security team need training on substance use disorder and trauma-informed responses for people with SUD and/or integration of security team members into this project?
    - Do your organization's security policies need updating to remove barriers to care for people with SUD?
- Do you have access to baseline data to help inform priorities for your team? Consider data on universal verbal screening, % of substance use disorders among deliveries at your site, % of deliveries with opioid use disorder who receive medication for opioid use disorder, % of deliveries that are discharged with naloxone in their hands.
    - If you don't have this, what would it take to get it?
    - If you do have it, have you validated it and identified any coding or documentation practices that need to be addressed?
- Do you have tools, such as 5 Ps, for verbal screening or specific order sets/guidelines for initiation of treatment medications, in your electronic health record that make these practices easy for the clinical team?
    - Are screening flowsheets visible across settings and to all disciplines (prenatal care and inpatient settings)?
- Do you know the processes and have support for making changes to the electronic health record if updates are needed to support SUD best practices?
    - Should/ could an informaticist be a part of your QI team?
    - What is your process for trialing to ensure the content/ workflows meet the needs of the team before building into EHR?
- Does your facility have trained peers or specialized doulas who support pregnant/ postpartum patients with SUD in the hospital setting?
    - If not, what do you need to add this important role to the team?
    - Are there peers within another organization in your community who you can partner with?
- Does your team know the resources available for clinicians for consultation or referral for pregnant/ parenting patients with SUD?
- Does your team know resources to access during a non-medical tension points related to a patient with SUD in the hospital? For example, if a family member of a patient is suspected of using substances in the hospital or if a patient has brought personal items into the hospital that are not permitted according to hospital policies.
- Does this work have robust support from organizational leadership/ executive sponsors?
    - How can you strengthen/ build this support?
    - How does this initiative align with leadership and organizational priorities and other initiatives already underway?

- What known challenges (clinical or logistic) do you need to address early in your work to support maternal and newborn patients to stay together and have their care coordinated and aligned, whenever possible (dyad care models)?
- Does your team know your organizational governance structure and how to navigate it if you need to make changes to policies/ procedures/ etc.?
    - Consider physician governance, nursing governance, pharmacy & therapeutics and others, if applicable and confirm process and timelines for meetings/ approval.
- What training does your team need to support best practice in the care of patients with SUD?
    - Bias/ stigma, trauma informed care, motivational interviewing, overview of SUD, identifying substance use/ withdrawal on L&D, treatment options/ information including medication for opioid use disorder and other use disorders, use and how to educate patients/ families on naloxone, harm reduction, breastfeeding support, NOWs management, pain management, etc.
- Is your team aware of and comfortable with Oregon Family Care Plans?
    - Are you working with prenatal care partners to complete these during pregnancy?
    - Who on your team supports completion in the hospital?
    - Has your hospital adopted a notification process when an Oregon Family Care Plan is completed to meet state requirements?
    - What is the role of other team members related to Oregon Family Care Plans?
- Does your team have access to clear information and processes to navigate/ coordinate with your local child welfare office?
    - Do you have a relationship with your local child welfare office so you can learn about their processes and policies and coordinate between systems?
    - What training can you offer about how your hospital will meet the requirement to support people using substances while pregnant (ORS 430.915), mandatory reporting requirements, and benefits of family preservation?
    - Can your team speak to the difference between notification (public health data reporting) and reporting (to child welfare) requirements?
    - Are there clear written policies to guide reporting that are accurate, up to date, and family centered to guide actions when report needs to be made?
    - Are there alternatives to reporting that your team can explore for all families with in utero substance exposure?
    - What services does Oregon Department of Human Services (ODHS)/ Child Welfare offer to support families impacted by substance use in your region, for example Family Preservation programs like Family Involvement Teams (FITs)?

If such programs do not exist in your region, how can you advocate for these supports through ODHS?

- Has your team received information on charting/ documentation best practices regarding care of patients with SUD?
    - Does your team need training/ guidance on best practice related to language and terminology surrounding SUD?
- Does your team have a culture of, and systems for, briefing and debriefing that can be used with patients with SUD to support team members and improve care?
    - If not, what would it take to create this?
- Has your team created space to discuss the tension between the importance of honoring self-determination and patient readiness with clinician moral distress/ moral dilemma?
    - If not, what do you need to begin to develop this?
    - What supports are available for the team or individuals to address the emotional impact of poor outcomes, vicarious trauma, compassion fatigue, etc.

Section VI: Appendix

Readiness Resources

Bias & stigma

- Reducing Stigma | Why Words About Addiction Matter BMC
- Video: What is Stigma?
- Anti Stigma Institute

Trauma-informed Care

- Trauma Informed Oregon: Trauma Informed Care Trainings and Courses
- Do No Harm: Building Trust, and Keeping Families Together (ACES Aware)

Implementing Medication for Opioid Use Disorder at the Hospital

- Bridge: Blueprint for Hospital Opioid Use Disorder Treatment

Harm Reduction and Overdose Prevention

- OHA Overdose Prevention
- Save Lives Oregon
- Academy of Perinatal Harm Reduction Education and resources for providers and patients on how to reduce the harms of substance use during pregnancy.
    - Their toolkit

Education for Providers and Teams

Pregnancy related

- Oregon ECHO Network: Addiction Medicine Programs An interactive educational and community-building case-based learning series for healthcare professionals throughout the state of Oregon.
- ASAM: Treatment of Opioid Use Disorder in Pregnant Patients (8-hour, online course. Learn to identify, assess, diagnose, and manage pregnant and postpartum patients with opioid use disorder (OUD). Covers all medications for OUD and education needed to prescribe. Fulfills the 8-hour opioid education requirement for DEA license renewal.

Newborn related

- American Academy of Pediatrics: Care of the Infant with Opioid Exposure Overview of the impact of the opioid crisis on the mother-infant dyad and recommendations for management of the infant with opioid exposure.
- A Public Health Response to Opioid Use in Pregnancy: Pediatrics, American Academy of Pediatrics

Lactation related

- Washington State Lactation and Substance Use: Guidance for Health Care Professionals

Peers/ Doulas/ Community Health Workers

- SAMHSA: Peer Support Role
- OHA: Oregon Traditional Health Worker Toolkit: Include overview, scope of practice and benefits of integration.

Family Care Plans (Plan of Safe Care)

- Oregon Family Care Plans: Includes guidance for healthcare professionals and downloadable fillable form
- Healthcare Provider Toolkit: Creating Safe Care for Pregnant and Parenting Patients Who Use Drugs (Camden Coalition) National information and tools (checklists, scripts, etc.) to support pregnant and parenting people who use drugs.

Child Welfare Reporting

- Oregon Revised Statute (ORS) 430.915 Support for Pregnant People Using Substances
- Development of a Clinical Decision-Making Framework to Address Parental Substance Use and Child Safety
- Administration for Children and Families CAPTA Guidance: US Department of Health and Human Services Guidance on the Child Abuse Prevention and Treatment Act (CAPTA).
- ODHS: Mandatory Reporting: Oregon Department of Human Services (ODHS) site that includes training and resources/ materials about mandatory reporting in Oregon.

Building Effective Partnerships between Community-Based Organizations and Health Care

- CHCS: An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers

Patient and Family Education Materials

- Dartmouth-Hitchcock: Substance Use and Pregnancy
- University of Oregon Centering on Parenting and Opioids: Tips for a Healthy Pregnancy When You Have an Addiction
- Save Lives Oregon
- Academy of Perinatal Harm Reduction

Recognition and Prevention Resources

Universal Screening for Substance Use

- SBIRT NH: Perinatal Playbook
- SBIRT: 5Ps Screening Tool
- SAMHSA: Screening, Brief Intervention, Referral for Treatment

Screening and Treatment for Infectious Disease

- PATHS – Peer Assisted Telemedicine for Hepatitis C and Syphilis Very effective, low barrier strategy working to eliminate Hep C across Oregon
- OHA: Congenital Syphilis
- OHA: Viral Hepatitis in Oregon
- Oregon Hepatitis Elimination Room
- OHA: HIV Prevention (PrEP and PEP)

Screening for Behavioral Health & Social Drivers of Health Needs

- Oregon Family Care Plan Form
- OHA Social Needs Screening Tools
- Mental Health Screening Tools: Policy Center for Maternal Mental Health

Warm Hand-off & Community-based Resources

- CMQCC Best Practice N.30: Warm Hand-Off
- Oregon 211

Response Resources

Consult Lines

- OHSU Addiction Consult Line
- National Clinical Consultation for Substance Use (UCSF)

Oregon Perinatal SUDs Programs

- Nurture Oregon
- Project Nurture

Treating Opioid Use Disorder in Pregnancy

- Oregon Pregnancy and Opioids Workgroup Recommendations (coming soon!)
- SAMHSA: Clinical Guidance for Treating Pregnant Women with Opioid Use Disorder and Their Infants

Accessing Medication for Opioid Use Disorder

- Harm Reduction and Bridges to Care Clinic OHSU (HRBR) Telehealth medication for opioid use disorder
- Boulder Care Telehealth Addiction Treatment
- Recovery Now: Oregon Treatment Access Line (Lines for Life): Search tool to locate treatment services, including medication for opioid use disorder and other substance use disorders, as well as peer support services
- SAMHSA Advisory: Low Barrier Models of Care for Substance Use Disorder

Starting Medication for Opioid Use Disorder at the Hospital

- Asante Example OB Opioid Use Disorder and Withdrawal Order Set
- OHSU MOUD Policy 2022

Methadone Dispensing at Hospital Discharge

- Dispensing Methadone at Hospital Discharge Article: Article outlining OHSUs approach to implementing the “72-hour rule” change, including steps/ recommendations.
- Sample Guideline for Methadone Dispensing and Discharge Procedure

Naloxone

- OHA Naloxone Discharge Requirements for Hospitals : OHA guidance and frequently asked questions on OAR 333-505-0055 outlining requirements for hospitals.
- Oregon Perinatal Naloxone Toolkit

Perinatal Mental Health

- Postpartum Support International (PSI): Helpline 5am-8pm PST and other resources in English and Spanish.
- Oregon Psychiatric Access Line (OPAL): For co-occurring psychiatric consultation
- National Maternal Mental Health Hotline: 24/7 free hotline with call/ text options available in English and Spanish.

Recovery Hotlines

- Oregon Hope Line (Judgement-free support for people struggling with substance use)
- David Romprey Oregon Warmline 1-800-698-2392 (24-7 non-judgmental and confidential peer support line)

Family Planning

- Reproductive Health Screening Tool Options

Reporting and Systems Learning Resources

- Oregon Overdose Prevention Dashboard
- AIM Data Collection Plan: Substance Use Disorder

Respectful, Equitable and Supportive Care Resources

Supportive, patient-centered care

- KARNA: Building a Culture of Support

Opportunities for Patient Feedback Outside Formal Surveys

- MoMMAs Voices Patient Family Partners
- Example Hospital Patient Bill of Rights
- Massachusetts General Nondiscrimination Statement

Example Programs with Culturally & Linguistically Aligned Services (not exhaustive)

- Lines for Life: Culturally Specific Mental Health Resources: Culturally specific mental health resources, including addiction/ recovery. (Statewide)
- Project Network - Lifeworks NW: Residential mental health and recovery services for women 18 and up with or without children; culturally focused for African American women, but all cultural background welcome. (Portland)
- Great Circle Opioid Treatment Program: Opioid treatment program of the Confederated Tribes of Grande Ronde for native and non-native clients. (Salem & Portland)
- Ko-Kwel Wellness Opioid Treatment Program: Opioid treatment program serving indigenous people from federally recognized tribes. (Eugene)

Definitions

Birth Doula: A birth companion who provides personal, non-medical support to birthing people and families throughout a person's pregnancy, childbirth and postpartum experience. A doula may receive additional education/ training specific to support pregnant and postpartum people with SUD and/or also have specific education/ training as a peer support specialist and may be referred to as a "specialized doula" in these situations.

Family care plan (Oregon Family Care Plans): CAPTA and CARA legislation requires states to develop **Family Care Plans** for infants with prenatal substance exposure and their families "to ensure the safety and well-being of such infant following release from the care of healthcare providers including through **addressing the health and substance use disorder treatment** needs of the infant and affected family or caregiver". The Oregon Family Care Plan is a document that providers and patients can use together to fulfill this requirement.

Harm reduction: A set of practical, evidence-based strategies aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on the belief in, and respect for, the rights of people who use drugs. (National Harm Reduction Coalition)

Medications for opioid use disorder (MOUD): Medications used to treat opioid use disorder. Methadone and buprenorphine are first line medication options to treat pregnant women with OUD. (CDC)

Opioid use disorder (OUD): A chronic, treatable disease that involves a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences. (ACOG)

Peer support specialist: A person in active recovery from an SUD and has had training to provide professional peer services to another individual with similar life experience. Some peers have additional training and certification specifically related to perinatal health, such as doula training. Note that this role title is designated by the Oregon Health Authority (OHA) and other certifying bodies may use different terms for similar role (e.g. certified recovery mentor, etc.).

Person with lived experience: An individual who has experienced a substance use disorder during pregnancy or postpartum periods.

Postpartum: The first 12 months following the end of a pregnancy, regardless of pregnancy outcome.

Screening for SUD: The first component of SBIRT (Screening, Brief Intervention, and Referral to Treatment), screening is the first step in identifying risky substance use and connecting women with substance use disorders to care. During pregnancy verbal screening tools, such as the 5 Ps, can help identify people who might benefit from more in-depth assessment of their substance use and care needs. (AMCHP)

Stigma: In the context of substance use disorders, stigma is a set of negative attitudes and stereotypes that lead to discrimination and can create barriers to treatment and health care and make these conditions worse. (NIDA) Types of stigma include individual/ internalized, interpersonal/ enacted, and organizational/ institutional.

Substance use disorder (SUD)/ addiction: A treatable chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. (ASAM)

Traditional health workers (THW): Trusted individuals from their local communities who may also share socioeconomic ties and life experiences with the people they work with. This term, used by the Oregon Health Authority (OHA), refers to multiple worker types including peer support specialist and birth doula defined above.

References

Key References for Education

Simon R, Snow R, Wakeman S. Understanding why patients with substance use disorders leave the hospital against medical advice. A qualitative study. Subst Abus. 2020;41(4):519–525. https://doi.org/10.1080/08897077.2019.1671942

American College of Obstetricians and Gynecologists. Caring for patients who have experienced trauma. Committee Opinion No. 825. Washington, DC: American College of Obstetricians and Gynecologists; 2021. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma

Harvey L, Boudreau J, Sliwinski SK, Strymish J, Gifford AL, Hyde J, Linsenmeyer K, Branch-Elliman W. Six moments of infection prevention in injection drug use: an educational toolkit for clinicians. Open Forum Infect Dis. 2022;9(1):ofab631. https://pmc.ncbi.nlm.nih.gov/articles/PMC8794071/pdf/ofab631.pdf

Patrick SW, Barfield WD, Poindexter BB; Committee on Fetus and Newborn, Committee on Substance Use and Prevention. Neonatal opioid withdrawal syndrome. Pediatrics. 2020;146(5):e2020029074. https://doi.org/10.1542/peds.2020-029074

Young LW, Ounpraseuth ST, Merhar SL, Hu Z, Simon AE, Bremer AA, Lee JY; ACT NOW Collaborative. Eat, sleep console approach or usual care for neonatal opioid withdrawl. N Engl J Med. 2023;388(25):2326-2337. https://doi.org/10.1056/NEJMoa2214470

Reece-Stremtan S, Marinelli KA; Academy of Breastfeeding Medicine. ABM clinical protocol #21: guidelines for breastfeeding and substance use or substance use disorder, revised 2023. Breastfeed Med. 2023;18(9):691-705. https://opqic.org/wp-content/uploads/2025/03/ABM-Clinical-Protocol-21-SUD_English.pdf

Lloyd Sieger M, Nichols C, Chen S, Sienna M, Sanders M. Novel implementation of state reporting policy for substance-exposed infants. Hosp Pediatr. 2022;12(10):841-848. https://doi.org/10.1542/hpeds.2022-006562

Taylor JL, Wakeman SE, Walley AY, Kehoe LG. Substance use disorder bridge clinics: models, evidence, and future directions. Addict Sci Clin Pract. 2023;18(23). https://doi.org/10.1186/s13722-023-00365-2

References in Toolkit

Bruzelius E, Martins SS. US trends in drug overdose mortality among pregnant and postpartum persons, 2017-2020. JAMA. 2022;328(21): 2159–61. https://doi.org/10.1001/jama.2022.17045

Duka S, Rahman S, Hansen SE, Esernio-Jenssen D. The Effect of Maternal Adverse Childhood Experiences (ACEs) on Substance Use During Pregnancy. Matern Child Health J. 2023 Dec;27(Suppl 1):153-165. doi: 10.1007/s10995-023-03768-4. Epub 2023 Sep 21. PMID: 37733152; PMCID: PMC10691987.

Maternal Mortality and Morbidity Review Committee, Oregon Health Authority. Oregon Maternal Mortality and Morbidity Review Committee Report, 2023.

McConnell JK, Kaufman MR, Grunditz JI, Bellanca H, Risser A, Rodriguez MI, Renfro S. Project Nurture Integrates Care And Services To Improve Outcomes For Opioid-Dependent Mothers And Their Children. Health Aff (Millwood). 2020 Apr;39(4):595-602. doi: 10.1377/hlthaff.2019.01574. PMID: 32250679.

McHugh RK, Votaw VR, Sugarman DE, Greenfield SF. Sex and gender differences in substance use disorders. Clin Psychol Rev. 2018 Dec;66:12-23. doi: 10.1016/j.cpr.2017.10.012. Epub 2017 Nov 10. PMID: 29174306; PMCID: PMC5945349.

Paris R, Herriott AL, Maru M, Hacking SE, Sommer AR. Secrecy Versus Disclosure: Women with Substance Use Disorders Share Experiences in Help Seeking During Pregnancy. Matern Child Health J. 2020 Nov;24(11):1396-1403. doi: 10.1007/s10995-020-03006-1. Epub 2020 Oct 6. PMID: 33025236.

Shadowen C, Wheeler R, Terplan M. Patient and provider knowledge of and attitudes toward medical conditions and medication during pregnancy. Addict Sci Clin Pract. 2021 Mar 29;16(1):22. doi: 10.1186/s13722-021-00228-8. PMID: 33781326; PMCID: PMC8008637.

Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnancy People with Opioid Use Disorder. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants

Substance Abuse and Mental Health Services Administration. Interactive NSDUH State Estimates. Retrieved 8/26/25 from NSDUH State Estimates.

Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report