Tools for Clinics Providing Prenatal/Postpartum Care

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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Introduction and Background

This document was created for clinics providing prenatal and postpartum care, primarily focused on highlighting important operational considerations for teams as they look to implement best practices in the care of pregnant and postpartum people with substance use disorders.

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 active 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 the full Perinatal SUD toolkit which will support clinical and non-clinical individuals and teams caring for pregnant patients with substance use disorder. The goal of the OPC Perinatal Toolkit, content for specific audiences such as this toolkit, 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.

Toolkit for Clinics

The Reproductive Health National Training Center developed a job aid and measurement tool in 2024 to support implementation of the AIM toolkit in the clinic setting and reaffirmed content in 2025. Rather than developing an Oregon specific clinic focused toolkit, the Oregon Perinatal Collaborative provides links to these resources. To support these tools, this document includes operational considerations for teams to discuss, as well as key resources from the hospital-based toolkit that are helpful to clinics as well.

Both the Oregon and the RHNTC resources are organized in what are referred to as the "5 R's," which comes from a national organization called the Alliance for Innovation on Maternal Health (AIM). The categories in the 5 Rs include **R**eadiness, **R**ecognition & Prevention, **R**esponse, **R**eporting & Systems Learning and **R**espectful, Equitable, and Supportive Care. These categories help the person/ team using the toolkit to approach the care and strategies in a way that allows all necessary components to be addressed in smaller pieces that support each other.

Reproductive Health National Training Center (RHNTC) Resources
- Website Link
- Job Aid

Additional detail/information is available in OPC Perinatal SUD Toolkit

Operational Considerations/Planning

Each site will need to evaluate local resources and infrastructure to support successful implementation of the Oregon or RHNTC clinic focused version of the AIM 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 outlined best practices.

- Do you currently have multidisciplinary team members to support quality improvement work to optimize SUD care in your clinic? Consider a provider and management/leadership champion, medical assistants, nurses, front office staff, social workers, peers/specialized doulas, other traditional health workers, security, informatics, etc.? Should you include others?
  - Have these team members worked together outside individual care before? What do you need to create team-based care?
- Is security called to respond to your clinic? Do they need specific training on 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 pregnancies/ deliveries at your site, % of pregnancies/ deliveries with opioid use disorder who receive medication for opioid use disorder, % of pregnant people who leave the clinic 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/ clinic and inpatient/ hospital 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 clinic/ outpatient setting?
  - If not, what do you need to add this important role to the team?

- o 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 non-medical tension-points related to a patient with SUD in the clinic? For example, if a patient or staff are feeling unsafe or a patient or family member is using substances in the clinic.
- Do you have relationships with community partners who support patients and families with SUD outside the clinic?
  - o 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 this work have robust support from organizational leadership/ executive sponsors?
  - o How can you strengthen/ build this support?
  - o 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 throughout the perinatal period, whenever possible (coordinated care between adult and pediatric providers, lactation, doulas, home visitors, etc)?
- Does your team know your organizational governance structure and how to navigate it if you need to make changes to policies/ procedures/ etc. For the clinic?
  - o 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?
  - o Bias/ stigma, trauma informed care, motivational interviewing, overview of SUD, treatment options/ information including medication for opioid use disorder and other use disorders, naloxone administration, how to educate patients/ families on naloxone, harm reduction, breastfeeding support, NOWs, pain management approach for people with SUD, etc.
- Is your team aware of and comfortable with [Oregon Family Care Plans](#)?
  - o Are you working to complete these during pregnancy?
  - o Who on your team supports completion in the clinic?
  - o Has your hospital adopted a notification process when a Family Care Plan is completed to meet state requirements?
  - o What is the role of other team members related to 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 clinic will meet the requirement to support people using substances while pregnant (ORS 430.915), Family Care Plans, mandatory reporting, and benefits of family preservation?
  - Can your team speak to the difference between notification of substance-exposed infants and reporting requirements/ processes?
  - Are there clear written policies to guide reporting that are accurate, up to date, and family centered to guide actions when a 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 patient self-determination and readiness with staff/ clinician moral distress/ moral dilemma when a patient continues to use?
  - 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.

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Appendix for Clinic

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)](#)

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.
- [Provider Clinical Support Systems: Medications for Opioid Use Disorder](#) (In depth trainings for prescriber on methadone, buprenorphine and other medications, meet the 8-hour DEA requirement)

Lactation related

- [Washington State Lactation and Substance Use: Guidance for Health Care Professionals](#)

Peers/ Doulas/ Community Health Workers

- [SAMHSA: Peer Support Role](#)
- [Peer Support Oregon](#)

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- 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.
- Camden Coalition Toolkit

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
- Reverse Overdose Oregon | Nasal Naloxone Training Video
- 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
- [SAMHSA Clinical Guidance](#)
- [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](#)

Naloxone
- [OHA: Opioid Overdose Reversal Medications](#): Includes resources including FAQs for individuals, prescribers.
- [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 training specific to support pregnant and postpartum people with SUD and/or also have specific education and 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)

Mandatory Reporter of Child Abuse: A person in a role that is required by law in Oregon to make an immediate report when they have had contact with a child they reasonably suspect was abused or contact with a person who is believed to have abused a child. In Oregon, certified Traditional Health Workers are mandatory reporters. *NOTE: Mandatory reporting applies to adults with developmental disabilities as well but is not addressed specifically here.*

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 education and 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 (eg certified recovery mentor, etc).

Perinatal: While different definitions can be used, perinatal refers to the period before, during and following birth. For the purposes of this toolkit, perinatal refers to the beginning of pregnancy through 12 months following the end of pregnancy (regardless of pregnancy outcome).

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.