Transcript: Approaches to Clinical Management for Substance Use Disorder During Pregnancy

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I am pleased to introduce you to today's presenter. Amanda Stehura is a technical expert at JBS International, Inc. and a behavioral health professional with over 13 years of community-based program implementation and development experience across nonprofit, locally driven, and state government entities. She applies her background in mental health, substance use, and risk reduction to improve maternal and child health outcomes in pregnant and parenting women. It is now my pleasure to turn the webinar over to Amanda. Amanda, please go ahead.

Amanda Stehura: Hi, thank you. Good morning or afternoon to everyone who's joining today. I am Amanda Stehura, and I am with JBS International, Inc. I'll just get started. There's going to be multiple objectives for today, but the overall objective of the webinar is to leave here with just a better understanding of the importance of recognizing the many factors that can impact outcomes associated with pregnancy and substance use. Understanding this is just going to be better for us as providers to understand our own personal biases, our practices, and our systems before we can provide the best care for this group.

We are going to do this by defining the challenges and risks of perinatal substance use and highlighting practices for integrating behavioral health and medical care for this group. We're going to cover the importance of health care providers in understanding the negative impact that stigma surrounding substance use during pregnancy has on a pregnant woman's willingness to accept prenatal care, as well as how to create supportive, non-judgmental environments that encourage women to engage in care early on in their pregnancy.

In addition, we will cover the importance of coordinating care as an essential piece for providing pregnant women with substance use disorders the support they need across health care and community services. That includes aligning medical care with behavioral health care and relevant community-based supportive services, as we know that partnerships between health care providers, social services, and community organizations just further facilitate that holistic care that leads to better maternal and child health outcomes.

Next slide, please. During our time together, we will review the risks associated with perinatal substance use and explore strength-based ways health care providers can adopt evidence-based practices just to further optimize maternal and child outcomes. We will address the stigma associated with perinatal substance use and emphasize that importance of working with your community partners, like child welfare, your local agencies that may be involved with some of the patients and their family members, and then the value of incorporating some of these peer supports on the care team to facilitate some of these holistic care opportunities.

Then we'll just end with some additional type Q&A questions that you may have for me or additional thoughts that you might have. Next slide, please. We're first going to just discuss and jump into some of the challenges and risks that are associated with substance use in pregnancy. This really will just end up covering reasons for reluctancy to care and cover the individual, institutional, and those systemic barriers to care.

Next slide, please. In highlighting some of the risks that are associated with perinatal substance use, we know that substance use during pregnancy can lead to poor health and safety outcomes for both mother and baby. Awareness of these risks and associated prevention and mitigation strategies can then just help health care providers better adopt or adapt current evidence-based approaches that improve the likelihood of achieving a positive pregnancy, birth, and those postpartum outcomes.

What do we know? I know this is going to be a high-level overview of things we already know, but just want to give us a little history lesson and what's current. What do we know? We know that women are most vulnerable in the problematic substance use is in their reproductive years. Thinking about the reproductive years, you have hormonal fluctuations that can affect how substances are metabolized and experienced. Estrogen can enhance the brain's reward systems and response to substance use, often experiencing faster progression from first use to consistent use due to those hormonal and metabolic differences.

During these years, we know that women also tend to experience a higher chance of anxiety or depression due to these hormonal fluctuations. Polysubstance use is common and can increase adverse maternal and fetal outcomes. We also know, which is not unknown to us, is that untreated behavioral health conditions are the leading cause of pregnancy-related deaths.

Then, just thinking about depending on what your state says about substance use in pregnancy, there may be more severe implications for child abuse, neglect, or even involuntary commitment. The likelihood of receiving timely care is oftentimes lower just due to fear. Then we know that children born to mothers that have untreated behavioral health conditions have a higher likelihood of developing developmental

delays and other behavioral health issues, which I will get into a little bit later on in the presentation.

Next slide, please. We know substance use during pregnancy brings some individual barriers to care, or really the reasons why one might not want to seek out help. I just listed here a few reasons why care is not taken or not taken early on in pregnancy. Some of that has to do with fear and distrust. Fear and distrust are large pieces of this. Women begin to think about their state laws. What is their state saying about pregnancy and substance use, or what they may have heard from others, such as, will I be incarcerated for my use during pregnancy? Will I lose custody of my unborn child or my other children, or will I be judged for knowingly using while I know that I'm pregnant?

There's also resource limitations that come into play as well. I don't have the means for care or what if my insurance that I have currently isn't covering enough of the care that I need? Most women want help, but then oftentimes have children that need childcare during times of appointments or might need inpatient care, but there isn't inpatient treatment anywhere that allows older children if they have older children in the house. They might have an opportunity to go to inpatient treatment that offers childcare for other children, but oftentimes it's seen with age restrictions.

A lot of the times, we'll see a three to five, but if you have older children sometimes, that often becomes a barrier to inpatient care if needed. Then there's also things like transportation issues, unemployment, and then housing concerns. There's overall risks. With substance use, there tends to be a higher count of unplanned pregnancy, or oftentimes it goes undetected due to use. Maybe mom didn't know that she was pregnant and didn't receive timely prenatal care because of the unknowing, or they have no support at home. They don't have any kind of social support system, or they might have a history of negative events in their life. They're just overly scared. They're pregnant and they're using.

Next slide, please. In addition to individual barriers, there exist institutional barriers. Those are the ones that exist on the clinic level around standard operating procedures or common practices. There might be some implementation burden. For example, the complexity of cases with pregnancy and substance use, with providers often feeling overwhelmed. It's not just a medical condition that they can treat. There are other factors that need to be addressed that eat at time.

Providers also think about reimbursement challenges. How and what can I get reimbursed for if I go in depth around discussing substance use, or if I complete an initial screening on substance use, what do I do next, or thoughts around, is this outside of my scope? What do I do if even I open up this can of worms, give or take? What happens next? Do I have all the resources I need to do my part in this?

There's also insufficient capacity. We regularly see siloed referral networks. Although we strive to open up the communication and coordination, silos still exist within our networks. Obviously, there's a shortage of specialty care. Oftentimes, depending on where you're situated, there might be no delivery hospitals that are less than a few hours away, or there's no specialty services available in the area that could address a high-risk pregnancy. There's also limited implementation structure. Thinking about,

does my leadership see a benefit in incorporating substance use practices, particularly around pregnant women within my health center?

As far as we're too aware, we have workforce limitations. I'm sure we've all seen this. There's overall staffing shortages that exist across disciplines, placing already our hard roles into overdrive to compensate for some of those staffing issues. We're seeing that on the maternal and child health areas as well. There are maternal and child health deserts. Again, going back to no availability of obstetric care or birthing hospitals. There often exists the limited training and knowledge base just to feel comfortable providing what we're going to call a brief intervention if a positive screening for substance use becomes available. Next slide, please.

I know we talked about individual and institutional barriers. I want to talk a little bit about systemic barriers and what we know. We know that service gaps exist. We know that fewer than 25% of treatment facilities provide specialty care for pregnant women, specifically with substance use disorder. I always like to think about a rural area and how prenatal care is often in those areas, lacking and very limited. Again, going back to the lack of obstetric clinics or delivery hospitals. When we throw substance use and pregnancy into that mix of already having a lack of OB (obstetrics) clinics and delivery hospitals, that gap grows even larger due to provider training or awareness of substance use specifically related to women.

There often obviously is barriers to collaboration. In particular, information and data sharing is always a topic of discussion and being overly cautious about not getting into trouble for sharing too much information or thinking that, this is not my job, it's out of my scope, or I have other things in my workday or week that take priority over spending however amount of time it is to do these screenings and have these discussions with pregnant patients with substance use.

I mentioned state policy here again because, as we know, states just differ on how they classify substance use during pregnancy and what constitutes child abuse and neglect, and then mandatory reporting to Child Welfare for substance use or a newborn born affected by substances. Specifically, when do I need to report? It is important, I will say this, to understand what your state says about pregnancy and SUD (substance use disorder), and if it's in their laws or statutes.

I'm going to pop a link here in the chat. It's from the Legislative Analysis and Public Policy Association that just outlines your state's stance on pregnancy and SUD, and what that looks like, just so you can see forefront, what patients coming into care with substance use could expect to happen based on some of the laws and statutes for your state in particular.

Next slide, please. All right. I have a couple of polling questions in here. We're always thinking about opportunities to engage you all. These polls just help us understand a little bit about the TA needs you might have around topics for opportunities and future. I want you to think about what your health center's biggest challenge is in addressing pregnancy and substance use. Is it just the resources? Is it stigma internally or system-wide, or is it about who do I need to bring to the table across providers and agencies?

I'll give you guys just a few seconds here to pop in what you're seeing most and your biggest challenges in addressing this group.

All right. It looks like we might be slowing down a little bit here. If you've got an extra second to pop in your responses, I'm going to have Bailey then just share the results of the poll here in just five, four, three, two, one. All right. Looking at this, it looks like some of you guys are saying that your biggest challenge is the care coordination piece amongst other providers and agencies. That's not uncommon. That goes hand-in-hand again with what you guys put here and identifying the appropriate resources.

Then I see stigma in there. Still got some folks that put that, and I see maybe someone else put it in the Q&A. This is not uncommon. I think that's what the barrier is, thinking about who needs to be at the table. How do I make those contacts? Am I comfortable enough with having the resources at hand and what I need to walk my patient through for these? Great job. All right. We can stop that sharing. All right. When we think about treating pregnant women in substance use, adopting a strength-based approach to care is best.

Next slide, please. Providing strength-based recovery support in a health care setting just builds more trust. We talk about trust and fear and trust, and that's oftentimes a big barrier to women coming into care. Having this strength-based recovery support in our health care center just builds trust, promotes confidence, and supports the patient's life and health goals overall. This approach just increases the likelihood that your patients remain connected to care and then just further reduces the risk of resumed use.

When looking at this, we want to utilize a collaborative approach to coordinating care. That's completely vital to just ensuring that the limited community resources are maximized, and then in that results in positive outcomes. Understanding that you, as a provider, are not alone in the care of a pregnancy that is associated with substance use.

When you're looking at this diagram here, having an integrated care approach around perinatal care and behavioral health, like screening, brief intervention, and referral treatment, also known as SBIRT, and then just being connected to providers, whether that's internal to your health center or external, those medications for opioid use and medication-assisted treatment providers. It's important to know what the other providers are doing with our patients and having that ability to talk to each other about challenges and progress. Not siloing ourselves for the care of others. It also helps prevent some duplication, and then just can help us be more informative amongst different providers for the benefit of our patients.

When you take a look here to the right, you'll see collaborative care. I often see collaborative care as the foundation for practice. This is allowing your patients to drive their treatment and services, providing those warm handoffs for increased follow-up and community partnerships. That's the behavioral health-related and all the social support services that are available in your community. It is far more impactful to be able to walk a patient through the expectations of a referral you're making and its benefits. You, as the provider, knowing exactly, point A to Z, what the

expectation is, should you do a referral to a particular agency, and you're able to communicate that to your patient as well.

Moving on to strength-based care, like motivational interviewing, which I want to stress that anyone on staff can utilize at any point in a patient's care. That comes down to the front office all the way down to the clinical folks, and then focusing on the mother-baby dyad, which is intended to keep mother and baby together and is beneficial for both physically and emotionally, just for proper regulation and development.

Lastly, here, as part of this diagram, is stigma reduction. Just paying close attention to the language that we're using daily to represent a group. Adding in the great work and impact of doula services, and even more so, doulas who are persons in recovery. Then, utilizing peer recovery support specialists and community health workers, which in essence really are the backbone to services and can alleviate a lot of the provider burden.

Next slide, please. To date, we know that the single best strategy we have to identify is adding screening, referral, treatment, and brief intervention, also known as SBIRT, into the clinical setting, and medical professionals are, oftentimes, that first line to aid in this effort. I'm sure most of you on this webinar have talked about SBIRT. You might be doing SBIRT in your health center, or you've been on a handful or more of trainings on SBIRT. I won't go deep into this, but I just want to highlight a couple of things before I move on.

A couple of guidelines: you want to complete a screening with the person alone. You don't want to have friends and family or significant others in the conversation because sometimes it won't give you a lot of great information, and sometimes they will be a little bit resistant to answer certain questions based on who might be in the room. Using accepted questionnaire, particularly the 5 Ps, is often a really good one for pregnant and parenting women with substance use.

Then, just being empathetic, compassionate, non-judgmental, and letting the patients know and feel that all women are asked the same questions. Then again, just thinking about that patient-directed screening around normalizing the purpose of the screening and asking patients for permission to share protected health care information prior to doing the screening at all. What is the expectation of who is going to be seeing this information, the coordination and collaboration of referrals, being completely honest and transparent about how that process works?

Then I'll just end on saying SBIRT detects concerns early on, as we know. It just brings over, enhances the patient-provider relationship. Presenting the collaborative model of these are who's on our team, who they might see, who they're going to be referred to. Having an open dialogue reduces the stigma that's associated with substance use, especially during pregnancy, and can be leveraged just to improve the impact of care planning and goals.

Next slide, please. I told you I wasn't going to talk too much on SBIRT, but I want to bring it back to pregnancy and some of the barriers and benefits here, so because we know it works so well, I just wanted to highlight a few of the benefits and some of the barriers as it relates to just pregnant women with substance use. In general, in

regards to benefits, it's important to screen each patient as early as possible in pregnancy because we know that early detection of substance use allows for early intervention and it minimizes potential harm to mother during her pregnancy.

Furthermore, pregnancy presents one of the best opportunities for health care professionals to address and intervene with a woman who uses substances. The child's birth oftentimes can be a very powerful motivation to seek treatment for use. There are also some barriers. We often find that providers feel unprepared after a positive screen, like I mentioned before. What do I do now?

Feeling as though they have the limited time to be impactful and then just limited knowledge of resources to provide adequate referrals, or even fear harming that relationship that they have with a patient. If they start asking questions, if they do a brief intervention, bringing substance use to light, even thinking about there could potentially be some legal issues depending on your state, if we start having conversations about this. Those are just additional risks, but they're far less harmful than not having these discussions at all.

Next slide, please. I think it's important to be sure that we understand some of the methods for which we can determine substance use. I wanted to highlight the two ways by breaking down verbal screening versus urine drug testing. Even before patients show up, the responsibility is to create a welcoming environment, and that's on the provider and the clinical system to make care safe or safer and to make it safe for patients to disclose information to us. Where we treat as much as we can with the information internally. We're not oversharing, and we're not violating trust by oversharing health information.

When we think about verbal screenings, those are really just conversational questions in nature. Often, self-report and they're often the first line and universal for everyone. No clinical permission is needed, it doesn't take up much provider time, and it really opens up a window of communication. You often have broader detection windows. You can talk about a month or a year, or any types of use, the amount, and even a brief history of substance use.

When you think about urine drug testing, it requires lab or equipment to do it. It requires clinical permission. It's often more expensive. It's often limited to substances that are included in the testing and does not distinguish between occasional irregular use, as a potential screening questionnaire could. It has some narrow detection windows. However, it's very valuable and can be used to confirm or for clinical decision making if medication-assisted treatment or medication, or opioid use disorder is needed.

I will say that when requesting a urine screen, if that's the route that we need to go down based on where the patient is and the best plan, we want to be sure and clear in pregnancy around drug testing. What happens to that information? Who it gets sent to, and how much we can control and not control? Just being very transparent with them about the process from A to Z, what that looks like.

I'll end this slide by just saying that the slides here, to get you thinking about what's really needed to begin services and safely. More or less, what can be less intrusive from the beginning to then gain that trust, so if this is a new patient coming in.

Screening questions could be the first step. Less intrusive at the beginning, and then based on the conversation and the need, other opportunities for screening can take place after that. Just thinking about, we got them in the door, let's start having these conversations first to keep them engaged and build that trust.

Over the next few slides or so, I just want to focus a bit on some practices or best practices just for interaction and treatment of pregnant and parenting, and with substance use. The first best practice I want to discuss is motivational interviewing. Again, I'm sure most of you know what motivational interviewing is, but again, it's one of the really powerful tools that just facilitate the behavior change that we want to see happen with our patients by giving them the power to explore those motivations and resolve some of that ambivalence with our assistance and support.

We know people are often complex, and with that can come some often showing some contradictions. By utilizing motivational interviewing, like our active listening, we can center the care for the patient and place them in the driver's seat. That's what we want. I want to also focus on that. Just remember not to focus on diagnosing someone with a substance use disorder, but really, the premise of motivational interviewing is we're seeking to understand the why, the feeling, and the emotion behind the use.

Motivational interviewing flips the script from, I have a problem, I came here for you to fix my problem, to what are the goals, and how can we get there? By fostering that collaborative and empathetic environment, motivational interviewing helps your patients take responsibility of their own change process, just further leading to more sustainable outcomes in the end.

Next slide, please. I want to start off this slide by posing a rhetorical question. Don't feel like you need to add any commentary on this, but just want you to think about this a minute. When we think of warm handoffs, what are the odds that someone, oftentimes ourselves, put off a referral that is written down on a piece of paper? Or we might forget to call based on, if we go to the doctor's office and they tell us, "Here, you need this specialist." Or let's think about the amount of information given in a first appointment. Here's who you need to contact, here's where this starts, here's where your medication starts.

Now, throw substance use into that, and talking about all the resources. Can be overwhelming. Oftentimes, a patient will say, "Okay, where do I start? In knowing this, I think it's direly important to be connected to the community providers, both statewide and local, and the availability of those processes for those services. You want to be able to walk your patient through the process verbally and physically, depending on integrated care and how your health system is set up, when applicable.

You want to be able to do a warm handoff, whether that's physically, walking them over to the next station, and what that might look like, or walking them verbally through, "I'm going to start the referral for you. Here's when you should expect a call. Here is the next start of this." You want to be able to give them an idea of what that's going to look like, expectation-wise, of how this referral process is going to go. You, as the provider, should know an intake process or referral process based on whatever community resource that you're sending them to.

I will start off by saying you want to be able to identify and connect mothers and newborns to services in the community. That's going to include maintaining an updated list of those outpatient, inpatient resources that your families can access. Although I will say that we're not salespersons, we need to sell mothers and their caregivers and the people in their household on the benefits of these programs. What can they get from these services? Having linkages to programs that provide developmental, psychological, and family support, like home visiting-type programs or other in-home support services. Being able to walk them through that process.

We also want to be sure that we remain connected to our patients through the referral process by completing those comprehensive releases of information. It's not just, I'm referring you to X, Y, Z, here you go, and that's it. You want to be able to develop a conversation back and forth from those community providers that you're referring to, so that she can provide the best care for mom, baby, and the family. Really focusing on what is readily available to families. We want to prioritize the resources of immediate need and both provider and patient understanding of those resources that may take a longer period.

Again, going back to understanding how referral processes happen and the workflow of that with your resources, because you're not going to want to send mom somewhere that may take a longer time, or you can do the referral and then be able to give a list and referral and linkage to other things in the meantime to help mom become engaged and remain engaged. This is just going to lead to offering services to assist while they're in the process. You might have a referral over here that we know takes longer, just being able to then have a bunch of other referrals and engagement tactics to keep mom engaged while the larger referral is in process.

Next slide, please. Another best practice is preserving the mom and mother-baby dyad. I know this slide is more so about post-deliverance than pregnancy, but I thought it was important to include this information about supporting mothers through the transition and have conversation on what is and can be made available to her at delivery so that she can feel empowered to advocate for herself regarding her wants and needs.

We want to be sure that as part of the end goal at delivery that we keep the mother-baby dyads together if it is safe to do so. If you don't know what the mother-baby dyad is, it's basically just that interconnected relationship between a mother and infant during that postpartum period and beyond. The bond begins in pregnancy and then just becomes significantly more important in the postpartum period.

We are just naturally wired for connection. What this dyad does is just emphasizes that a mother and baby are not isolated individuals, but they're seen more as single unit where the well-being of one is deeply intertwined with the well-being of the other. Some examples of this could be that skin-to-skin contact, breastfeeding, and just the responses of mother to a baby's cues, which all contribute to the baby's physical and emotional health and well-being.

When we prioritize keeping mothers and babies together and close, we create that foundation for rest, healing, and thriving together. Thinking about the hospital portion of this, rooming in has consistently been associated with reduced need for medication to treat neonatal abstinence syndrome and a shortened neonatal hospital

stay. Rooming in is now seen as a standard of care. Should it be offered to all mother-baby dyads? When it's safe to do so?

Then, thinking about breastfeeding, breastfeeding has overall positive effects on both patients. If mother is prescribed a medication for opioid use disorder, exposure is very small and often outweighs the risk, should mom return to use and breastfeeding should occur. It's really just, is it part of mom's birth plan, and is it safe and appropriate to do?

When we think about keeping the dyad together, when the dyad is separated, it increases stress for both mom and baby. Cortisol levels rise, making it harder for them to regulate their emotions. It often delays maternal recovery. Oxytocin drops, which can lead to increased depression, anxiety, which we talked about. Then, not to mention the impact it can have on those with substance use. It can also delay the infant recovery when they're exposed to substances, so just longer hospital stays.

Next slide, please. All right, another poll question. I know we covered a bit on this slide, on this already, but just thinking about your health center, which areas do you feel the most improvement in providing care to pregnant women and SUDs? Thinking about, is it the integration piece of primary and OB setting that you need the most improvement in? Is it training around pregnancy and SUD with the focus on stigma? Is it access to compassionate care for pregnant women, or is it a coordination of care between OB, primary care, and then all of the community resources that she needs during pregnancy? Give you guys here a few moments.

All right. It looks like the polls have slowed down. Maybe. All right, I'll give you guys a countdown of five seconds if you haven't put it in there just to put whatever you need in there. Five, four, three, two, one. Bailey, if you want to share. Perfect. What makes sense is going for that first poll that you guys did, the coordination piece of coordinating all of your internal folks with all of the community resources. Which makes sense because it's what you guys put in there a little bit from that first poll.

A close second would be behavioral health integration with the OB and primary care, and then staff training, a little bit less, and then just access to compassionate care was low, which is really good, guys. Good for that. All right, if we want to stop that. Then we can move on to the next slide. All right. Moving on to stigma. We know stigma exists. The next few slides are just going to go over some strategies, just to improve access and just engagement, and care.

Move on to the next slide, please. This slide shows some of the thoughts. Women who use substances often feel when thinking about beginning the treatment and recovery journey. Individual stigma can often be created or even amplified during pregnancy. There may not have been thoughts about how others are perceiving me before I got pregnant, but now that I'm here, and there is a fear about the perception of being seen as a bad mother.

There's also what we call disclosure stigma. This group usually can anticipate negativity if symptoms or diagnoses are disclosed to others. Pregnant women often report increase or even new judgment and shame, even from those that have previously been participatory or even tolerant of their substance use, leading to further isolation just because of their current circumstance of being pregnant. You

could have had people that have engaged with your patient in substance use, but now backed off a little bit and putting in some judgment just because they're continuing use if they're pregnant.

We often see a lot of mistrust of the health care and social systems. Again, going back to the multiple system encounters like health care, child welfare, potential justice involvement, urine drug screenings, and then just understanding of what happens next, and the fear of losing their children. They've got all these systems that play a part in their pregnancy when they use substances. They're just scared. They know they've heard things happen. They have fear of being drug tested without agreeing to being drug tested. Then, again, the fear of losing their children.

Next slide, please. Moving on to institutional stigma. This is our organization's attitudes, beliefs, and policies that can affect, sometimes invisibly, how a condition or group is treated in your organization. Despite increasing acceptance of substance use as a medical condition rather than a moral failing, stigma against pregnant women remains written in the laws, in child welfare service policies, and how sometimes we allocate social services. There's biases that come into play.

How can we as providers of maternal care address this? When we look at this chart, it's very similar to the steps of motivational interviewing and what warm handoffs should look like that we already talked about. In an effort just to reduce stigma in clinical practice, we need to understand individual stigma that pregnant women face or place upon themselves, whether it's true or false, and recognize the biases we may have and hold ourselves. They want to be able to emphasize their fears.

Again, going back to recognizing and understanding what your state and local level says about substance use and pregnancy. We want to be able to let them know, yes, this is going to happen, yes, we understand why you're feeling this way, and being informed ourselves of why they may be feeling this way based on things they've heard or policies that are in place within your state or locality.

We also want to make sure that we're prioritizing the most immediate concerns based on patient and safety factors. Then try to offer resources that are readily available if other services are needing a wait time, like we mentioned before. It's also very dire not to move really fast. We want to remain eager, but we always want to be aware of our patients' wants, needs, and readiness. Being too fast can cause a disruption in the services. We just want to take it slow, a nice pace that gets our information we need without being overbearing and moving too fast based on the readiness of where our patient is in that moment.

We also want to think about specialty care is often daunting and hard to navigate. Again, talking about those warm handoffs and providing a walkthrough process around expectations help. Being able to navigate what the expectation is from A to Z with them. Then again, going back to using strength-based language. Stay away from those stigmatizing language around substance use, specifically around pregnant women.

Next slide, please. When we think about best practices, I want to highlight strength-based patient engagement. It's really just connecting women to needed care at any point of time, at any door. Another important thing to note is that the services you

see here should just be services that are provided or referred to as needed, and then just leveraged, should there be, like we talked about, waitlists of some sort, just to keep engagement in services.

Really, you can utilize these examples here as keeping a pulse check on your patient. Things like attending groups while awaiting a provider for treatment, offering universal screenings to all women, providing some form of case management services just to cover some of the support needs, offering peer supports when available, and then just scheduling real-time appointments. Try your best not to let a patient leave without scheduling something or have them call back for scheduling. Make everything timely and before they leave your office.

Next slide, please. I want to spend a little time with this. We often hear about mandatory reporters, but we also need to focus on what we're calling the role of the supporter. We need to build a relationship and trust, first and foremost, when you're talking about sensitive topics like substance use, particularly around pregnancy. Again, building that trust and that relationship.

We want to be able to demystify the process of treatment and recovery. We know treatment isn't a one-size-fits-all. It's a personal journey of support and healing. We want to make sure that we're humanizing recovery. Understanding and adopting that recovery is a process, not a single event. It's going to include setbacks. It's going to include a lot of growth. Then it's often going to include some renewed commitment throughout the process. Promoting even the smallest wins is an opportunity to remain in a relationship and building trust, and keeping them on a path of better outcomes.

Recognizing what your community feels about substance use. I know I'm laying a lot of information on that, but I think it's really important to really understand how your community feels about substance use, particularly around pregnancy. Then leveraging the opportunity for additional training. Thinking about, are there local champions in my area that can assist with this, and thought leaders? Then again, talking about stigma. Addressing stigma within yourself, in your practice, and within your health center.

Next slide, please. Thinking about care coordination strategies. Who are our partners and how can we empower our patients, ourselves, and our care team? Next slide, please. Going back to trust. We need to gain trust as a partner in a patient's recovery, where they are, wherever they're at in that process, and their plan for their journey. Given the often fragile state of opening up about substance use during pregnancy, we just want to be sure that the patient understands that they're leading the recovery plan and that providers don't push. Going back to that motivational interviewing mindset.

If we were to put on paper who should be at the table for care coordination, you're often going to see this graphic here pop up or something similar, or there may even be gaps in certain areas. It's our duty to seek to understand what the mother's current support system is. Where does she live and with whom? Who does she consider to be allies in her corner? We want to think about other providers that she's in contact with. Thinking about obstetrics, high-risk specialists, substance use providers, and community-based support or on the flip side of that, thinking about

this diagram here, really honing in on who needs to be at the table to continue to promote mom and baby health. Who are we missing from the table?

Next slide, please. As mentioned before, we want to become mandatory supporters, cheering on recovery, but also willing to have those difficult and motivational conversations. We want to emphasize the value of partnerships between health care providers, child welfare organizations, social services for supportive services, and community organizations, just to facilitate the holistic care to improve maternal and child outcomes. Thinking about partnerships with peer support and doula organizations, those can often help bridge the gap and promote a patient-directed continuum of care with ongoing support for parents and caregivers.

Having those connections to resources early on will again just help mitigate any additional stressors at delivery, at the hospital, and thereafter. Like I've said and mentioned quite a bit is being transparent about the expectations in the hospital during and after delivery. How each provider of the organization can maintain that mother-baby diet so that the mother and caregivers feel empowered, again, to advocate for themselves, just because they've got the early education from us about their rights and what's available to them.

Next slide, please. When substance use is identified during a screening, there's the expectation that we should be delivering a brief intervention and then referring patients to appropriate services thereafter. Most prenatal providers recognize the responsibility to be knowledgeable about referral resources. However, due to the widespread shortages of specialized treatment services, that often complicates the process. Making providers hesitant to conduct universal screenings due to concerns about limited follow-up options. There are often systemic barriers that could be linked to poor coordination between prenatal clinics and external social and supportive services.

Further, sometimes discouraging screening. Why would I screen if I have nothing to offer? We can improve empowerment by providing education to providers and other clinic staff around substance use, particularly pregnancy screenings, specifically those individual and system barriers that we talked about, developing protocols that outline and address staff roles, having knowledge about the resources that are readily available in the community, providing stigma training and resources by implementing that warm handoff practice as a core outcome.

Addressing these issues through better infrastructure, support system, and streamlining your processes can empower your providers to more effectively connect patients to care they need. Overall, it's our duty to improve the bridge connections to care. Thinking about developing local referral networks just to make sure that we have everything outlined about what's available, the timelines, and expectations. We want to be sure that we're advocating for policy changes and increasing funding to expand substance use services. We want to be active members in our community and thinking above and beyond what we can do for our community and our patients.

We want to make sure that we're expanding telehealth and peer-based community services just to better bridge the service gap and improve access. Then we want to leverage the technology that we already have to just streamline referrals and enhance care coordination overall. Next slide, please. Then I really just wanted to

end with just a mere list of community supports that are much more that may be available in your communities.

I just wanted to highlight that connections with these types of organizations are beneficial to the continuum recovery process. Because we know recovery is a journey on the individual level and the community. More so, recovery happens within your community. Really leveraging and building those collaborative partnerships with folks such as housing and support recovery, childcare, transportation organizations, all the social services benefits. Then, just really connecting to faith-based organizations as well. Utilizing all of those community resources within your community just to leverage outcomes for mom and baby.

Next slide, please. I know we don't have much time, but here are the next few slides to just go over some references and links for you guys here. If you want to go to the next slide, here. Particularly, I want to call out where it says Slide 14: Evidence-informed Practice Recommendations. The *Clinical Guidance for Treating Pregnant and Parenting with Opioid Use Disorder and Their Infants* is a really good document. It goes from A to Z, prenatal all the way till delivery, and the role of different providers. If you want to go to the next slide, here. Then this, more so, just talks about the engagement pieces, experts, and individual strategies around stigma reduction. Next slide.

All right. That is all that I had for content-related items. These slides will be available to you guys as well. A lot of the information when I talked about the references will also be there as well for you guys to link to.

Bailey: Amanda, I do not see any questions right now in the Q&A. If anyone would like to submit any Q&A questions, please feel free to do so. If not, we can go ahead and conclude.

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