Universal Screening for Substance Use Disorder (SUD) in Labor and Delivery

Overview

Implement universal screening for substance use disorder (SUD) with a standard, evidence-based screening tool at all locations that provide medical care to pregnant or postpartum people. A universal screening tool for self-reporting substance use disorder and identification of SUD should not be confused with toxicology testing.

Why We Recommend this Best Practice

Identification of pregnant patients with SUD as early as possible in pregnancy is critical in connecting them to treatment. Treatment for SUD, particularly OUD, during pregnancy results in better outcomes for the pregnant parent and their newborn.

Drug addiction affects all racial, ethnic, and social groups. Universally screening all pregnant patients minimizes the potential for implicit bias that can occur when providers use subjective risk factors to determine who should be screened and may also decrease the stigma associated with SUD and screening. Universal screening at the time of entry into prenatal care allows more time to intervene and mitigate the harm associated with SUD in pregnancy and to stabilize the home environment for newborns. Some patient may not have received prenatal care so it is also important to screen patients when they arrive in labor and delivery. It is important to remember that substance use is not synonymous with addiction.

Toolkit adapted from the CMQCC Toolkit

Strategies for Implementation

Step 1: Choose a screening tool

Here is a outline of two popular, validated screening tools. We suggest you select a tool from the table below. Once you choose a tool, it may be a good idea to pilot test the tool with other members of the team and get feedback on usability.

Note: There are other validated screening tools in addition to the two we suggest. This webpage offers an outline of other validated tools.

Screening Tool	Description	Pros	Cons
5Ps (Peers, Parents, Partner, Past, Pregnancy)	• 5 questions • approx. 3-5 minutes • Simple structure and non-threatening	• Free • Designed specifically for pregnant women • Recommended by WSHA's Birth Equity Group	
NIDI Quick Screen	• 3 questions • approx. 3-5 minutes • Scripted tool to support provider standardization	• Listed in ACOG bulletin • Existing online tool • Free • SMFM recommended	• Not specific to pregnancy • No training available

Step 2: Develop an SBIRT (Screening, Brief Intervention, Referral to Treatment) processes

Processes can help the care team understand who, when, and how to screen for SUD in the labor and delivery (L&D) unit. These examples may help you create a process specific to your hospital:

1. This OB Unit Plan can help you determine who, when, and how you will screen for SUD.
2. This Process Map can help visualize the screening/SBIRT process.
3. A Nursing Workflow can help guide the process after a screen comes back positive.
4. This SBIRT Clinical Algorithm may be helpful for nurses and OB providers.

Step 3: Create a Clinical Care Checklist

A checklist will help providers remember the many steps involved in the antenatal care of women and families with OUD. While these services and activities would normally be addressed over the course of prenatal care, they may need to be compressed depending on when the woman presents for care.

- ILPQC MNO-OB OUD Protocol.
- ILPQC OUD Clinical Care Checklist.

Step 4: Create a SUD screening/resource folder

Create a folder with information that can help guide what to do if a screen comes back positive. This folder can also contain patient education materials. Here is an example of what the folder may include:

Patient Education Materials

- Prescription Pain Medicines and Pregnant Women
- NAS- You are the Treatment
- NAS: What you Need to Know
- Contraception Counseling for Women with OUD
- Pregnancy and Substance Use: A Harm Reduction Toolkit

Clinical Team Resources

- OUD/SBIRT Clinical Algorithm
- OUD Clinical Care Checklist
- Narcan-Caregiver Brochure & Narcan- Save a Life Poster for OB to review and prescribe to patient
- Nurse Workflow
- MA Perinatal SBIRT Pocket Card

Strategies for Implementation

Step 5: Train staff on screening tool and process

Train staff on the screening processes and resource folder and the importance of universally screening everyone for SUD. Train OB providers on SBIRT and the clinical algorithm of what to do when a screen comes back positive.

TIP: Integrate anti-bias training into the screening tool trainings. It's important for members of the care team to recognize how implicit and explicit bias interferes with patient care.

Step 6: Pilot test your screening processes

Conduct a PDSA (Plan, Do, Study, Act) cycle on your screening processes. This doesn't have to take a long time. For example, your team could pilot test the screening process for one day, gather feedback from staff AND patients, make adjustments based on the feedback, and pilot the process again another day. Do this until any major issues or barriers are solved, *however, do not wait until you think everything is perfect to fully implement the process*

Step 7: Fully implement your universal screening process

You are now ready to implement universal SUD screening. Remember, you may still need to make some adjustments but you have taken an important step in improving care for your patients!

Urine Toxicology and the Role of Explicit/Implicit Bias in Decision-Making (CMQCC Toolkit)

Understanding toxicology testing and its limitations is important for providing optimal care to women who use substances during pregnancy. Universal screening via a validated verbal screening tool should not be confused with urine or blood toxicology, which historically has been applied inconsistently and has often resulted in a system of race and class-based testing. Thus, toxicology testing should be carefully applied with the intention of improving clinical decision-making, such as informing the pain management approach during the intrapartum period and improving efforts to link the birth parent with appropriate services and treatment.

Providers and staff should be educated on how explicit or implicit bias may impact their decision to perform biological toxicology testing on a pregnant or laboring person. Standardization of criteria for toxicology testing may help curb the impact of these biases.

Toxicology testing has a necessary role in the care of women who use substances during pregnancy. The results are useful to encourage dialogue with the patient and can be necessary for clinical decision making. However, the results can also have devastating consequences for the birth parent and baby when used inappropriately by other agencies and can result in punitive consequences. Furthermore, toxicology results are easily misinterpreted by those who are unfamiliar with the nature and limitations of testing. Limitations of testing include, but are not limited to, the following:

- Many substances may not be detected (false negatives), including synthetic opioids and designer drugs
- Risk of false positives
- Need for confirmatory testing for any positive toxicology result
- Testing does not provide information on severity or duration of use
- Testing can only assess for current or recent use
- Even if results are negative, sporadic use is not ruled out
- A positive urine toxicology does not confirm a substance use disorder (SUD) any more than a negative result rules it out

Strategies for Implementation

The evidence suggests that hospital staff are more likely to perceive Black women as being at higher risk of using drugs, even though white women have similar rates of illicit drug use. Black women are therefore more likely to be tested, and more likely than white women to face punitive consequences such as having their children placed in protective care.

Even objective medical criteria for determining who should have toxicology testing may be subject to inadvertent bias. For example, "inadequate prenatal care" is a common, and often necessary, criterion for toxicology testing. If this criterion is used as a prompt for toxicology, providers and nurses must understand that a variety of factors other than substance use may influence whether a woman can remain in care, including lack of insurance, inability to take time off of work, and lack of culturally appropriate care. All these factors are more likely to impact poor women and women of color.

Urine Toxicology Best Practices:

- Ensure policies that delineate criteria for toxicology testing do not directly or indirectly target low income women and women of color.
- Behaviors *(*e.g. signs of acute intoxication) are more important as prompts for toxicology screening than selective indicators of risk.
- Each institution should be aware of the sensitivity and specificity of the tests used at their facility.
- Each institution should have the following:
    - A clear policy, consistent with state and federal law, regarding what constitutes grounds for reporting to child protective services (CPS)
    - Education for all staff members who work with pregnant women about this policy
    - Routine reviews to ensure that the policy is being applied consistently and appropriately
- Every patient must be able to give informed consent. Informed consent requires a clear explanation of why testing is necessary, the benefits of testing, and risks of testing including the potential legal, criminal, or child welfare consequences. If the provider or nurse is unable or unwilling to thoroughly explain the typical course of events after a positive drug test at their facility, a reasonably prudent patient would not have sufficient information to make an informed decision.
- Every patient has a right to withhold consent and coercive language should not be used.
- Multiple biological substances can be used for toxicology testing, including urine, saliva, blood, hair, and meconium. Urine is often used to test pregnant women as the filtering action of the kidneys allows detection of smaller quantities for a longer period than blood.
- Toxicology tests generally fall into two types: screening tests and confirmatory tests.
- It is essential to confirm unexpected results from toxicology screening tests. If the result of the screening test matches an expected result, it is usually not necessary to obtain confirmatory testing. Examples of unexpected results might include:
    - A patient tests positive for a substance that she denies taking
    - A patient tests negative for a substance that is prescribed, and she indicates she is taking regularly
- Toxicology testing does not provide information on how recently someone used a substance or the quantity they used. Toxicology screening tests are qualitative and only indicate the presence/absence of a substance. Confirmatory testing often does report a quantitative level, but this should not be used to infer how much a person is using a substance. Many factors are involved, and any value over the cutoff level should be a qualitative positive unless evaluated by a medical review officer.
- Urine drug toxicology on admission to the hospital need to be monitored for timing of the sample related to administration of intrapartum pain medications. Fentanyl can lead to false positive opioid results. Ephedrine and vasopressin can lead to false positive amphetamine.

Resources

SBIRT

- SBIRT Provider Guide – Conducting the Brief Intervention
- Developing an SBIRT process in the maternity care context
- Process Map for SBIRT at initial OB visit
- SBIRT Resources – Pitt.edu
- SAMSHA'S guide to SBIRT.
- ASI (Addiction Severity Index) Sample.
- ASAM Continuum - Guide to Levels of Care for Substance Use Treatment.
- NNEPQIN Toolkit for Perinatal Care of Women with Substance Use Disorders. Chapter 3 on SBIRT.
- SBIRT Oregon's online curriculum guide to teaching and using SBIRT.
- Understand and implement the principles of Motivational Interviewing
- Motivational Interviewing in Addiction Treatment
- MA Perinatal SBIRT Pocket Card
- Screening for Substance Use using an SBIRT Framework (step-by-step how to develop a screening protocol)*
- Example IHR Integrated Screening & SBIRT 1-Pager

Screening

- AIM Opioid Screening Tools.
- Accuracy of Three Screening Tools for Prenatal Substance Use.
- Example Process Flow Map for SBIRT at Initial OB Visit
- Example Protocol for Women who Endorse or Screen Positive for OUD to Link to Substance Use Care Services*
- Example Algorithm/Process Flow for Substance Use Screening in Pregnancy (Prenatal and Labor and Delivery)
- Helping women get Treatment: Screening and diagnosis of OUD overview

Other

- Toxicology FAQs.
- SAMHSA-HRSA Center for Integrated Health Solutions.
- Council on Patient Safety Women's Health Care Safety Bundle for Obstetric Care for Women with Opioid Use Disorder.
- Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. SAMHSA.
- ILPQC MNO-OB Provider / Prenatal Site Letter*

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